Impact of Changing Social Structures on Stress and Quality of Life: individual and social perspectives

Work Package 7

Family Study

Ireland

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1. Introduction

The Family Study forms the third main aspect and study of the Stress Impact project and was undertaken in 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 from work (WP5).

This section is divided into three main topics

- Background on work and families
- National system for absence management
- Innovative nature of the study

1.1 Background on work and families

There is increasing evidence suggesting that today more than ever before, employees are working in an atmosphere of anxiety and stress. The contributing factors are the many and rapid changes taking place in the workplace and in society at large. Factors such as the globalisation of finance and trade, the rise in service industries, the increased use of ICTs, the increasing knowledge content of work, the intensification of work, the liberalisation of labour markets, the current flexibility of labour, the increased participation of women in the workplace; the ageing of the workforce and the population, dislocated social supports, later family formation practices and increasing care demands have all contributed to a radically different work and life situation for many people.

These changes are all implicated in the stress process. The negative impact of stress can be observed in the wide range of conditions that are associated with it. Stress has been associated not only with a variety of psychological conditions including anxiety and depression, but also with a number of highly prevalent cardiovascular conditions including heart attack and stroke. While evidence of the role of stress in cardiovascular conditions has been controversial, recent longitudinal research in the UK, with 10,000 plus participants, has demonstrated the biological plausibility of the link between psychosocial stressors from everyday life and heart disease. (Chandola et al., 2006). Stress is also considered to be a contributing factor to lower back pain and repetitive stress injuries (Power et al, 2001, Carragee, et al 2004).
The World Health Organisation predicts that by 2020 (WHO 2001), mental illness will be the second leading cause of disability world-wide, after heart disease. It is already recognised as one of the three leading causes of disability in the EU, where mental health disorders are a major reason for granting disability pensions. The most recent research from the UK shows that mental health problems now account for more Incapacity Benefit (IB) claims than back pain and that 10% of GNP in UK is lost each year due to stress. This research also shows that stress is the highest cause of absence among non-manual workers and an estimated 12.8 million working days were lost in Britain in 2003/2004 due to stress and depression or anxiety ascribed to work related stress (MIND, 2005). Over 35% of Incapacity benefit claims in the UK are made because of mental health conditions (Department of Work and Pensions, 2005).

Evidence from the literature suggests that workers on long-term absence as a result of stress are less likely to return to work than those with physical injuries or illnesses

(Watson Wyatt, 2002). In the UK 3000 people each week become eligible for long-term sickness benefits having been off work for six months. Practical experience in the UK, shows that 60% of people who are absent from work for longer than 5 weeks do not return to work at short notice, and 80% of LTAs who move onto Incapacity Benefit do not re-enter the workplace within 5 years (www.workplacelaw.net).

The Department of Work and Pensions (DWP) 2002 parliamentary report entitled 'Pathways to Work' states that once a person has been on Incapacity Benefit for 12 months, the average duration of their claim will be eight years. Figures released by the DWP indicate that incapacity benefit has the most costly budget of any benefit in the UK (The Times, May 18, 2005).

Research has shown that coping with job loss is a dynamic process that changes over time and is associated with a host of negative and psychological outcomes (Kinicki, Prussia & McKee-Ryan, 2000). The social consequences of unemployment (or joblessness i.e. time out of the labour force) include its negative impact on the mental health and well being of not only on the unemployed but also their spouses and children (Vinokur et al., 2000). Long-term absence from work due to sickness has considerable negative effects for employees and employers as well as society (Nielsen et al, 2004) and has been shown to be a strong predictor of disability pensioning (Brun et al., 2003) as well as morbidity and mortality (Kivimäki, et al., 1995). Being out of work long-term damages a person's perception of self worth, significantly harms self-esteem (Goldsmith et al., 1996) and is likely to impact on future plans, motivation and attitude towards future reemployment.

Jahoda's (1982) latent needs theory has been developed to help us understand the negative relationship between job loss and psychological health. It is based on the idea that psychological distress in the unemployed is due to the deprivation of the latent (meeting psychological needs) functions of work. This theory proposes that 5 main psychological needs go unmet when the individual is not working. These are the need for time structure, social contact outside of the immediate family, being part of a collective purpose, being engaged in meaningful activities and having social status. Work provides people with both the obvious e.g. income and the latent sources of satisfaction. Although redeployment reverses the negative impact on the mental health and well being of the unemployed persons (Vinokur et al., 2000;), high levels of social support may encourage people to stay at home when they are ill; and more social obligations at home can also prolong sickness absence. (Kivimaki et al., 1997).

As well as changes in structure and nature of work and workplaces, in the last number of decades, traditional family structures and roles have changed significantly. The numbers of single parent families and 'blended families' (parents with children from different relationships) have increased, as have the percentage of women participating in the labour force. The percentage of women in the labour force in western countries has doubled in the past 50 years (ILO, KILM 2004). In Ireland, women's participation in the labour force has increased from just under 30% in 1981 to over 60% in 2001 (OECD, 2004). A large proportion of these are women with children under 18 years of age and also women who are lone parents. Increases in female labour force participation have consequent implications for the care responsibilities for young children, dependant disabled relatives and older family members and the division of labour within the household. Taken together, these factors have changed the work / home interface and the factors which affect individuals and families considerably. It is anticipated that these trends are likely to increase over the coming years, which will in turn impact on and exacerbate stress related problems within society (Mead et al. 2000).

Research into the consequences of long-term absence on families and the role of the family in the process of absence and work resumption has not been the main focus of absence research. Brooke (1986); Steer & Rhodes (1978); Rhodes & Steer (1990) process models of absenteeism have been criticised because they are weighted towards organisational influences tending to believe that family responsibilities moderate but do not directly affect the relationship between attendance motivation and absenteeism. Whereas Erickson, Nichols & Ritter (2000) testing an expanded process model of absenteeism found that family conditions, responsibilities and attitudes significantly influenced employee absence through interactive means. Professionals and services also have an effect on the tenure of sickness absence. Allegro & Veerman (1998) believe that the traditional organizational-psychological approaches of sickness absence do not adequately explain sickness absence.

A recent study on the impact of long-term absence on the absentee (Floderus, B., et al 2005) found that negative consequences were more common than positive ones. Besides reduced financial resources, a large number of individuals experienced negative effects related to leisure activities, sleep and psychological well-being. Women and older workers experienced more positive consequences of long-term absence than men and younger workers, attributable for example, to relationships with children and partner, sleep and psychological well-being. Benefits as well as adverse effects differed depending on age, gender and health problems which shows the influence depends on the individual situation. This study also found that a high proportion of respondents experienced feelings of guilt for example due to perception of leaving colleagues and employer in the lurch, failure to fulfil their own expectations and demands.

It is recognised that men and women are increasingly sharing in the responsibilities for paid and unpaid work. Studies however, looking at the division of labour between spouses / partners have found that men are still typically the main bread winners and that working wives and mothers still retain the major responsibilities for child and family care. Also, overall working wives and mothers work more 'total hours' than their husbands / partners do (Suave,R 2002, Mead, R et al 2002).

Research indicates that young working mothers do the most 'juggling' between work, home, family and other activities (Suave,R 2002). . They are more likely to work part-time, to engage in other non standard employment for family reasons, to have work interruptions for family reasons, to stay out of the labour force for family reasons and to take time off from their jobs for family reasons (this includes elder care). Studies looking at stress and the impact on working families have found that there are gender differences in the experience of stress in working families. Female employees with caring responsibilities (for either children, adults or both children and adults) report higher levels of stress and strain than other employed groups (Mead, R et al 2002)..

The impact of work on family can be measured in terms of work-family conflict or spillover. Work-to-family spillover occurs where, demanding jobs and un-supportive workplaces lead to spillover from the job into workers' personal lives. The impact of work-family conflict is circular: if demanding work situations push workers to the limit, spillover results in high stress, poor coping skills, and insufficient time with family and friends, which in turn undermines work performance (Sauve, R. 2002). The consequences of this work-to-family spillover is not confined just to the individual workers who are trying to meet competing demands on their time and energy. Long

hours spent at work and the demands of the workplace are felt by all members of the family, as well as by employers and others in the community.

All families or households are not affected in the same way, however. The experience of work-family spillover in a lone-parent family, for instance, will differ from the experience of a two-parent family. Similarly, the perception and experience of conflict in families that have a strict division of labour by gender will be quite different from the perception and experience in families where men have taken on more of the domestic and caring labour.

Negative family experiences, such as relationship difficulties or bereavement can impact on an employees performance at work. However, research suggests that work-to-family spillover is more prevalent than family-to-work spillover (Grzywacz et al 2000, Kinnunen, U et al., 2005).

Work-to-family and family-to-work spillover can be positive as well. Employees who experience autonomy and control on the job, support from supervisors and complexity in their jobs are more likely to transfer these positive experiences from work to home. Employees who receive family support or feel confident in their family responsibilities and have happy marriages transfer those positive experiences to their work which, in turn, increases their job effort and satisfaction (Kinnunen, U et al., 2005, Butler, A.B. et al 2005)).

Family-friendly work programmes, for example alternative work schedules, flexible working times and parental leave have been introduced to try and improve positive work-family spillover. Many qualitative and quantitative benefits have been associated with family-friendly work practices. The quantitative benefits include employee time saved, increased output due to increased focus and motivation, increased employee retention, increased income, decreased expenses, decreased health-care costs and stress related illnesses, and reduced absenteeism. The qualitative benefits include improved employee morale and loyalty, enhanced employee recruitment, and enhanced public and community relations (Mead, et al 2000).

Sickness absence is a ‘complex and heterogeneous phenomenon’ (Allegro & Veerman, 1998, p. 121) combining as it does, physical, psychological and social aspects. By looking at the social construction of long term absence (LTA) and work resumption, and examining the factors involved in the experience of LTA, it was the aim of this research to describe how those individuals on LTA and, where appropriate, their significant other (i.e. husband/wife/ partner) make sense of their experiences, to describe and explain what it is like, how they feel and cope with regard to being long term absent from work and overall what could help or is potentially hindering work resumption. Although there has been some research investigating the transference of one persons job characteristics, stress and experiences on their cohabiting partner (Morrison & Clements, 1997) to our knowledge this is one of the first research studies to explore the experience of being LTA on the significant other in the life of the absentee.

1.2 The National system for absence management

It is important to be aware of the national context in which absence takes place in order to understand the results which have been obtained from the Families study. Of particular relevance here are:

- elements of the social security system as they relate to income replacement
- the rehabilitation system as it relates to the provision of treatment for people who have become absent
- the statutory and voluntary role of the employer in relation to return to work practices and systems
- the role of occupational and public health systems in relation to the absence process
- the role of labour market agencies in relation to retraining and job placement

Each of these elements can play a crucial role in affecting the initial decision to become absent, what happens when the individual becomes absent and the decision to return to work, should that happen. For example, low levels of sickness benefits act as a disincentive to become absent in the first instance and as an incentive to return to work, regardless of the health condition of the individual. Also, gaining access to the appropriate medical and rehabilitative services can considerably shorten the period of absence, while having a responsible and supportive employer also aids in the return to work process.

The national systems in relation to these services and provisions are described in detail in Workpackage 2 of the Stress Impact project. However, it is worthwhile to recall some of the main elements of the Irish system here in order to aid in the interpretation of results from this part of the study.

- Income replacement policies – In Ireland, the state has the responsibility for providing income replacement after an initial period of 3 days. Sickness benefits (disability benefit) are set at a fixed rate of 148.80 Euro. Employers often or generally make up the difference between state benefits and the original salary of the person for some period, though they are not legally obliged to do so. After 6 months absence, employees move onto disability allowance which is set at the same rate. After 12 months absence, individuals move to long term sickness benefit (Invalidity Pension) which is not related to salary and which is set at relatively low level by European standards 154.30 for those under 65 years of age and 179.30 for those over 65 years of age.

- Rehabilitation system – In Ireland, all workers are entitled to whatever appropriate rehabilitation interventions they need. These are generally provided through the public health system, though there is also a parallel private health care system which also provides services. Despite these entitlements, capacity problems exist and clients may experience delays in accessing services or in obtaining appropriate services. These problems of access are particularly acute in relation to mental health problems, where psychological services are insufficient to meet demand and where there are also problems in relation to payments for psychological services – often these are not funded by the State.

- The role of the employer – In Ireland, the employer has no statutory role to play in relation to the provision of services to aid the absent employee return to work. However, many employers play a relatively positive role, though they are not required to do so.

- The role of occupational and public health – Unlike many Member States, there is no obligation on employers to employ the services of an occupational physician. Consequently, most employers do not use occupational medical

services. (There is an obligation to ensure good occupational healthy and safety practice, but this legislative provision does not require the discipline of occupational medicine to be involved). Though occupational physicians may be involved in medical assessments regarding fitness to work following an absence period, it is more common that general practitioners undertake these tests. Consequently, the general practitioner tends to play the most important role with the health services in relation to the provision and organisation of care and rehabilitation. However, there is relatively little contact between the GP and the workplace of the absent person, and such contact as does take place tends to be on an informal basis. GPs see their primary responsibility as residing with care of the patient, and don't have responsibility towards employers. The relative weakness of the occupational health physicians means that the employers' potential interest in the return to work of the individual is often not represented with the health or rehabilitation systems.

- The role of labour market agencies – the state training agency (FAS) provides a wide range of training and retraining for people who are unemployed or long term absent from work. They generally don't provide retraining for people who may need it if they are short term absent from work.

There is one other significant issue in relation to the Irish system which concerns the case of absence due to occupational illness or accident. The Irish legal system requires that the level of liability or fault be established before compensation can be paid to the worker. In practice this means that where such injuries or illnesses occur and there is a dispute over the issue of liability, both the individual worker and the employer will often become involved in legal proceedings as will the insurer (which is usually a private sector insurer). In such cases there are significant disincentives to return to work early, as the levels of compensation payments are high by international standards. There are inevitable delays in returning to work where such circumstances exist due to the involvement and slowness of the legal system for establishing compensation.

1.3. Innovative nature of the study

Aims of the study

The main objective of the family study is to elaborate at a detailed level a representation of stress development from a whole family unit perspective. This study also aims to characterise the impact of stress on the social and family networks of study participants.

These general aims subsume a number of subsidiary aims. These are:

- To examine the differential impacts of stress and absence on different types of family units
- To obtain multi-perspective information on the experience of stress and absence
- To explore the factors that inflence the decision to become absent and the decision to return to work
- To examine the role of the family and wider social networks in these decisions
- To identify wider general issues in relation to the impact of changes in society on quality of life in general and on work and absence in particular

Why adopt a family perspective?

Family studies in the area of work absence are unknown to date. The family perspective is considered important as family members typically support and are directly affected by the actions of their members. The families 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. It was anticipated that long term absence would have both positive and negative impacts on families, on relationships between members, on the division of labour and various other aspects of family life.

In addition, it was conjectured that the role of families might vary according to the reason why the person was absent from work, with people with stress related or mental health problems being different in their family interactions than those with physical impairments. Furthermore, the family study aimed to investigate the proposal that the absence of people with stress related or mental health problems had qualitatively different impacts on other family members when compared to people with physical complaints

In relation specifically to the stress aspect of this study, stress theory has focused its investigations on the range of environmental (work or non-work related) factors which may generate stress for the individual. While some investigations do identify outcomes of stress outside of the individual, these tend to examine elements such as organisational outcomes as being and ignore the effects stress may have on people other than the individual.

In addition, the vast bulk of investigation into stress focuses almost exclusively on sources of stress to be found in the workplace. Though theory (and some research) acknowledges that stress may emanate from areas other than the workplace, there are relatively few investigations which systematically examine stress from non-work sources.

By contrast, clinical practice indicates that the effects of stress and stress related mental health disorders are not confined to the individual. Where the individual is a member of a family unit, the impact which stress related breakdown may have can be profound (regardless of whether the source of stress is work related, non-work related or due to some combination of the two). Such impacts may include disruption to primary relationships with adults and children, failure to adequately fulfil family and social roles and may ultimately lead to family breakdown. On the other hand, there is also reason to believe that the acknowledgement by the individual of a psychological problem may lead to an adjustment in family interactions and possibly resulting in an improvement of the situation.

For these reasons, it was decided to undertake a study which investigated the experience of absence in more detail and which focused on the impacts which the absence period may have on both the individual and the family. In addition, the methodology adopted for this study (which involved the use of interviews) offered many other potential benefits to the study in terms of providing additional complex and rich information to help interpret the main survey findings.

The process of becoming absent and returning to work

The standard register data available on absence from work generally provides only limited insight into the processes whereby someone becomes absent from work or returns to work. Typically, the data will provide information about medical cause of absence, length of absence and some background information on demography. Even data from survey studies such as those conducted within the Stress Impact project provide only an incomplete view of process related issues. One of the strengths of the methodology used in the families study is that it can gather rich data on process related issues in ways that survey or register data cannot. Specific issues which may be of interest in the current context include:

- Factors influencing the decision to become absent - while register data indicates a cause of absence in terms of a medical cause, the families study will allow the identification of factors from the workplace and from home and social life which may also contribute to the absence decision
- Factors influencing the decision to return to work – These factors may emanate from the individual, the family, the range of services available to the person or from the workplace

In addition to only identifying such factors, the data from the families study will also help to identify linkages between these factors and to obtain ideas about their relative strength. Such insights are especially important when designing the mix of return to work services which may be needed, particularly in relation to factors which are neither work nor health related.

Generating hypotheses for further analyses

The methodology adopted for the family study, that of face-to-face or telephone interviews using semi-structured interview techniques, was designed to allow for the acquisition of in-depth information on a range of issues relating to the absence experience. Coupled with the fact that the study is the first of its kind and with the relatively small samples used, the families study should be viewed as being mainly exploratory and heuristic in nature, rather than being concerned with the gathering of evidence for specific hypotheses.

However, the richness of the data to be gathered using this methodology will allow new insights to be generated regarding the experience of absence. Two of the most important aims of the families study relate to describing the processes of becoming absent, staying absent or returning to work, and also to examining the influences and impacts of being absent on the family unit. In addition, the data gathered in this study will generate insights into the development of symptomatology over time, both from before the absence period and during absence. The data will also provide useful insights into the relationships between the illness related causes of absence and other non-illness related factors.

Specifically, the findings from the families study may be used to generate new hypotheses which may be tested on the survey data in relation to:

- Interactions and relationships between different types of symptoms
- Interactions and relationships between health symptoms and other causes of absence
- The role of positive and negative factors within the family in relation to the decision to become absent and the decision to return to work

- The efficacy of interventions to promote rehabilitation and return to work
- The role of the employer in promoting return to work
- The role of the individual in relation to services and the decision to return to work

There will also be other issues around which hypotheses may be generated.

The respondents in this study had been absent or become absent a minimum of 26 weeks before the interviews were undertaken.

2. Methodology

The study was conducted using a qualitative approach with a sub sample of respondents who took part in an earlier longitudinal study that collected data from xxx respondents.

This earlier study was a cross national survey of LTA for medical reasons (both physical and mental) designed to identify the factors that might influence decisions with respect to absence and work resumption, document health, social, economic and practical impacts of being off work long term and to describe the participant's personal circumstance, their experiences of interventions and rehabilitation programmes. A sub-sample of the participants from this earlier research, having already consented in principle to participating further in this study, were approached and invited to be interviewed with respect to their experiences of being long term absent from work. Where appropriate the husband/wife/partner of the absentee was also invited to take part in the study by being interviewed with respect to their experiences in relation to their partner's sickness absence. In Ireland, approximately 40% of respondents indicated their willingness to participate in the Family Study. Of these 38% were interviewed.

2.1 Study tools

Four sets of tools were developed to carry out the study

- A sampling framework
- The questionnaire protocol
- An interviewers guide
- Ethical manual

2.1.1 The sampling framework

A sampling framework or matrix was developed to profile respondents who indicated that they wished to take part in the Family Study. This helped to categorise respondents demographically and also by family type and illness type, in turn, enabling the interviewers to select a good cross-section of people to participate in the study.

2.1.2 The questionnaire protocol

Two semi-structured interview protocols were developed to gather the information – one for the LTA and the other for their spouse/partner. The interview protocols, used open-ended questions to encourage respondents to provide information and experiences relevant to themselves and in their own words. The protocols had a similar basic structure however, the questions differed somewhat for the LTA and for the spouse / partner.

The interview protocols were divided into 6 sections:

The absence threshold, i.e. what factors led respondents to report sick and become absent, these factors include personal factors, work related factors and system related factors, problems experienced just before becoming sick and who was involved in the decision to take absence leave.

Prevention of absence – this issue relates to what actions were or could have been taken to prevent the respondent becoming absent, support/advice provided and how useful this support/advise was.

The impact of absence on the individual and the family – this issue relates to the impacts / consequences of absence for different members of the family – the LTA, partner, children and other dependants. Changes in the impact of absence over the period absence were also explored. Impacts were explored in terms of income, family interaction and the actions that the family took to cope with the absence. It also examines the potentially positive and negative effects of the absence.

The return to work threshold – for those who had returned to work this section examined the factors that supported the individual in returning to work. These include supports from family, employers and systemic supports which may be available and finally what problems/issues were experienced upon return to work. For those who were still absent issues around what was preventing the LTAs return were explored. These issues included the nature and type of contact with their employer, what could be done by employers, family or the LTA to improve the return to work prospect.

Rehabilitation - this section looked at the types of rehabilitation programmes offered to LTA, content and usefullness of the programme and what other programmes/ activities were considered useful in promoting return to work.

General section - This explored issues of absence more generally. Questions concerned the respondents perception of factors that affect absence in their workplace, the ways changes in society have impacted on quality of life in general and on absenteeism in particular.

2.1.3 Interviewer's guide

The interviews took place in 5 countries and given the nature of the study, in many cases more than one interviewer was involved per country. To try and ensure procedures were followed as closely as possible by all interviewers an interviewers guide was developed. This covered the aims of the study, the sampling method and procedures, instructions for arranging interviews, instructions on how to use the interview protocols and on conducting the interview.

2.1.4 Ethical manual

Interviews were to be conducted in face-to-face meetings wherever possible. Given the sensitive nature of the study, the fact that interviews could be conducted in family homes and the issues surrounding the dynamics of face-to-face interviews, an ethics and risk management manual was devised. This was used as a guideline by interviewers to ensure their safety and that the interviewee was handled in a sensitive, appropriate and acceptable manner.

2.2 Sample selection

As the study was primarily an exploratory one, the main focus was to try and get a broad view of the many issues affecting the families of long term absentees. The aim was to gain an understanding of how absence was experienced by different family

types, different illness types, and within these categories to include a range of other demographic factors. The study also looked at the impact of absence on family members and how these changed over the duration of the absence.

Family types included:	single / married (including de facto relationships); with / without children, single income / dual income families
Illness types:	the sample consisted of people with physical health problems, people with stress related or mental health problems and people who exhibited both types of problems i.e. co-morbid group as diagnosed by themselves in the main postal survey
Other demographic factors:	age, gender, occupation, returned to work / not returned to work.

A convenience and purposeful sampling strategy was adopted to ensure coverage of as broad a range of different family types, illness types and facets of respondents life. A sampling matrix was developed to assist in the selection of families for participation in the Family Study.

The target was to get a sample of 50 Long Term Absentees and their respective spouses or partners (living in the same house), where available and willing, to participate in the interview. This was sub-divided into 20 LTAs experiencing stress-related / mental health problems, 20 LTAs experiencing physical illness and 10 LTAs experiencing co-morbid symptoms.

2.3 Invitation to participate in the study

Once participants were identified as interesting subjects for interview, using the sampling matrix and criteria for selection, a letter was sent to them to invite them and their partner (where available and willing) to participate in the study. Approximately a week later the LTA was phoned to arrange an appointment to meet / talk by phone and go through the interview protocol. Invitations and interviews were done on a phased basis over a 3 month period. Prior to conducting the interview a signed consent form was completed by participants.

2.3.1 Getting in touch with participants.

In the Irish study, interviews were conducted using a mixture of different methods including meetings in family homes, public places and over the telephone. Initially, interviews were conducted with families living in close proximity to the organisation / individual conducting the interviews. These were carried out by arranging to meet the participant(s). When this pool of participants was exhausted interviews were switched to telephone interviews with participants living in a wider geographic area.

In many cases, it was not possible to conduct interviews during normal office hours because either one or other partner was working, or due to day time distractions from family members. The majority of interviews were scheduled to take place in the evening between 5.30 p.m. and 8 p.m. Interviews were taped for purposes of verification of information with the consent of the interviewee.

A total of 34 LTAs participated in the study – 13 absent due to stress-related reasons, 10 absent due to physical reasons and 11 absent due to co-morbid

reasons. In addition, 15 partners were also interviewed. There were 3 refusals and 1 interview was terminated. Interviews were conducted between January and March 2005. While it took some effort, the majority of partners agreed to participate in the study once they understood the importance of getting different perspectives on the LTA's absence and the value of their personal experience regarding the impacts of their partner's absenteeism on the family. Two LTAs did not wish to participate in the study when they were contacted about the interview and one interview was terminated, with a person suffering from a stress related illness, at their request.

Interviews were recorded using a mini-tape recorder and then transcribed. For the data analysis, the interview data was transcribed into a data matrix developed for comparing and contrasting interview information on a question by question basis.

Table 2.1 below provides a profile of the sample. It shows the number interveiws conducted with LTA's who were absent because of physical, stress-related / mental and co-morbid health complaints, their partner (where applicable), and the personal and work related characteristics of the LTA's interviewed.

Table 2.1 Profile of the sample

	Main reason for current absence:			
	Physical (N)	**Mental (N)**	**Co-morbid (N)**	**Total (N)**
Number of interviews:				
- LTA	10	13	11	34
- Partner	6	5	4	15
Return to work LTA:				
- Not	3	12	8	23
- Partly	1	0	0	1
- Completely	6	1	3	10
Family type:				
- Couple	4	3	5	12
- Couple with children	4	5	4	13
- Single	1	3	1	5
- Single with children	1	2	1	4
Income:				
- Single income	2	9	4	15
- Dual income	7	2	3	12
- Unknown	1	2	4	7
Gender LTA:				
- Male	2	6	7	15
- Female	8	7	4	19
Average age LTA in years	46,7 (SD=12,0)	45.1 (SD=9.5)	45.8 (SD=12,6)	45,8 (SD=11,0)
Education level LTA:				
- Up to second level education	4	6	5	15
- Technical training (3rd level)	2	4	3	9
- Third level undergraduate	1	-	-	1
- Postgraduate	2	1	1	4
- Other professional qualifications	1	2	2	5

	Main reason for current absence:			
	Physical (N)	**Mental (N)**	**Co-morbid (N)**	**Total (N)**
Work sector LTA:				
- Agriculture, fishing and forestry	1	-	-	1
- Manufacturing	2	4	2	8
- Building & construction	1	1	-	2
- Trade (retail & wholesale)	3	3	2	8
- Hotels & restaurants	-	-	-	-
- Transport, storage & communication	-	1	3	4
- Banking, insurance & financial services	-	1	1	2
- Public administration	-	-	-	-
- Education	-	1	-	1
- Health & Social work	1	1	1	3
- Other community, social and personal activities	2	1	2	5

	Physical	**Mental**	**Co-morbid**	**All**
Average score on CES-D scale; 10 items; 1=not-30=highly depressive	10,11 (SD=4.94)	16,85 (SD=7.40)	16,36 (SD=8.00)	14.85 (SD=7.44)
Average score on Exhaustion scale; 8 items; 1=not-4=highly exhausted	2.64 (SD=0.38)	2.55 (SD=0.62)	2.66 (SD=0.61)	2.61 (SD=0.54)
Average score on Disengagement scale; 8 items; 1=not-4=highly disengaged	2.46 (SD=0.41)	2.48 (SD=0.53)	2.53 (SD=0.36)	2.49 (SD=0.43)
Average score on General self-efficacy scale; 10 items; 10=low-40=high	31.40 (SD=2.84)	27.14 (SD=6.24)	30.55 (SD=7.02)	29.49 (SD=5.91)

2.4 Summary of Sample

Absentees in this sample, ranged in age from 22 years to 63 years of age with an average age of 45.8 years old. The distribution of age was fairly even between the illness groups. There were more dual income families and also more females in the physical illness group than in the mental illness group. This may be due to sampling effects where more females were selected to participate in this study. With the exception of the depression scale measures of psychological outcomes between the three groups are not significant. LTA's in the physical illness group are the least depressive people compared with the mental and co-morbid group.

The main work sectors represented in this sample are from manufacturing and trade (retail and wholesale).

3. Findings

3.1 Absence threshold

This section describes the LTAs experiences immediately prior to their absence, the reasons why LTAs took leave of absence from work, the factors that prompted them to become absent, the time factor involved in their decision to become absent, and who else was involved in their decision to become absent from work.

Main findings

- A wide range of reasons were given as the LTAs main reason for absence, with those in the stress-related/ mental illness group reporting the least diversity of reasons
- Factors prompting absences include ill-health, work-related factors, personal factors
- Time factor involved in considering taking leave of absence varied from none to a year
- The majority of respondents reported some on-going / underlying symptoms over a period of time
- Few people received help in making their decision to take leave of absence from contacts in the workplace
- A wide range of problems were experienced by absentees immediately before their absence. These closely reflect illness type. E.g. physical illness – pain, chronic fatigue, stress- related / mental health illness personal factors – bereavement, work-related – incident(s) at work, health – paranoia, crying, anxiety, depression
- The main person influencing their decision to leave of absence from work was their GP, followed by spouse / partner and other family members. Friends and specialists or consultants were also mentioned

3.1.1 Reason for absence

The reasons for absence varied greatly across the sample as might be expected. Reasons for absence among people suffering from stress related or mental health illnesses were less diverse than those in the other groups and included those most frequently associated with stress - anxiety, stress, depression (including postnatal depression) and fatigue. In addition, in this group more than half of those interviewed reported stress due to work related reasons such as work overload, pressure at work, bullying and harassment in the workplace. Reasons for long-term absence due to physical ill-health included illnesses due to cardio-vascular, musculo-skeletal problems (back pain, arthritis), cancer and also less common illness such as vitamin B12 deficiency, broken veins and contact dermatitis. Among the co-morbid group, physical problems were most commonly experienced jointly with stress, anxiety, burnout and depression. In most cases of co-morbid diagnosis, respondents reported that they became absent due to a physical illness (such as cancer, a work accident, eye problems, back problems) and their mental health problems symptoms manifest after a period of absence.

Experience of Co-morbid Symptoms

A woman who was absent from work because she was receiving treatment for cancer consequently began to suffer from depression. A man who was absent due to a work-related accident was consequently diagnosed with post traumatic stress disorder. Another man who was out of work with bad back problems reported becoming depressed after a length of absence.

3.1.2 Factors that prompted absence

Just as the reasons for absence varied greatly across the sample, so did the factors which prompted the person to seek leave of absence. Among the group experiencing stress-related or mental health illnesses there were reports of lifestyle factors such as not coping well and lack of sleep / concentration and other behavioural symptoms. However, and perhaps more interestingly, the majority of respondents reported work related factors – such as too much pressure at work, harassment, bullying, lack of support from management and working hours which no longer suited.

Factors reported by people suffering from physical illnesses closely reflected the problems experienced e.g. increases in the amount of pain experienced, tumour increasing in size, dermatitis getting worse and more unbearable, difficulty walking, and fatigue to mention but a few. Long term absentees experiencing co-morbid problems reported both physical issues which mirrored their symptoms e.g. pain, accident at work, collapse as well as and in addition to difficulties in coping, experiencing stress and depression and work-related issues such as heavy workload and pressure at work.

3.1.3 Time factor involved in decision to take absence leave

The absence threshold or amount of time the LTA considered becoming absent from work before taking the decision to take leave of absence from work varied from 'no time at all' to 12 months. Overall, just more than half of all respondents, made up of one third of those in the stress related group, 70% of those in the physical illness group and just less than half of those in the co-morbid group reported that there decision to take leave of absence from work occurred spontaneously and was not premeditated. Table 3.1 below outlines the number of LTAs in each illness category who thought about taking leave of absence some time before doing so. In the case of physical illnesses, the spontaneous decision to take leave of absence was usually due to an acute incident e.g. a bout of pain (e.g. chest pain) or the suddenly unbearable experience of severe pain / discomfort associated with an on-going chronic problem (e.g. back, contact dermatitis). In the case of LTAs experiencing stress related and mental health illnesses sudden onset was usually associated with a significant triggering event (e.g. bullying became too much when LTA experienced a bereavement on top of other life events and problems).

Table 3.1 Number of LTAs that considered taking leave of absence by main reason for current absence

	Main reason for current absence:			
Considered taking absence leave:	**Physical (N)**	**Mental (N)**	**Co-morbid (N)**	**Total**
No/not applicable	7	5	7	19
Yes	3	8	4	15

As might be expected, respondents in the mental illness group all experienced on-going underlying symptoms over varying periods of time and the majority of them reported contemplating taking absence leave from work for periods between 2 weeks and 8 months.

> *Psychiatric illness*
>
> Frederick became absent from work suffering from acute anxiety and panic attacks. He had been attending a psychiatrist over a period of about 3 years and was on medication for depression. Immediately prior to his absence, he felt very anxious and experienced bouts of crying, and frenzied behaviour.
>
> *"I was involved in several things at work as well as doing my own workload. I was also drinking heavily and over involved in my outside of work sport commitments. Late nights and poor sleep combined with a new baby and other family responsibilities all became too much. At my partner's suggestion, I visited my GP to discuss how I was feeling, but didn't really tell him the whole story, I acted much more competent than I felt. Then suddenly it all became too much for me and I was hospitalised. Looking back on it, the excessive activity must have been to distract me from how I felt."*

Interestingly, even though 70% of those absent for reasons of physical illness reported a spontaneous decision to take leave of absence, almost three quarters of them reported on-going underlying symptoms e.g. diabetes, arthritis or back pain. In this group the time factor for contemplating leave of absence varied from 11 weeks to 6 months. Among the co-morbid group the time lag between considering and taking absence from work was up to one year. When those with on-going problems were asked why they did not take absence leave earlier, reasons given included that they didn't feel their pain (physical) was a reason to stop work – it was part of their lives; that they (stress-related) were able to cope with their work. Other factors that influenced the delay in taking leave of absence were financial, family and work responsibilities.

In a few cases the LTA's partners perception of the time lag varied considerably from that of the LTA. In the case of an LTA experiencing stress and burnout, the LTA reported they had thought about taking leave of absence for 6 months before becoming absent whereas his partner felt that he had contemplated it for almost 2 years. In another case, a women suffering from on-going exhaustion and tiredness reported conisdering taking absence leave for 6 months before becoming absent, whereas her partner said it was more like 12 months.

Physical illness – sudden onset

Jordan a middle-aged family man with two teenage daughters would have described himself as reasonably healthy before his illness. He had not experienced any problems or illness symptoms immediately before becoming absent. He suddenly got severe chest pains. He attended his GP who recommended that he be hospitalised. Jordan then underwent a series of tests which showed that he had heart problems.

3.1.4 Problems / indicators experienced immediately before absence

As already mentioned, the majority of respondents reported experiencing some underlying problems before taking absence leave. Among those absent for physical health reasons, for example, the person absent due to contact dermatitis reported on-going problems with sore hands and feet and the person with arthritis reported an increasing difficulty walking.

Immediately before taking leave of absence, those suffering form stress-related or mental health problems reported a wide range of symptoms/ problems. These ranged from behavioural (over-eating, over-drinking), typical stress and anxiety related symptoms of acute anxiety, panic attacks, nervousness, irritability, paranoia, constant crying, sleeplessness and low self-esteem. There were also work-related problems, i.e. – lack of support from management, arrogance / mismanagement, not being able to focus at work, disillusionment with work.

Lack of support from management

Michael suffered from depression, of which his employer was aware as he had had short periods of absence related to this illness in the past. He asked his employer to reduce his working hours as he felt under considerable pressure. They ignored his request with the result that he felt overwhelmed and swamped with work and consequently had to take time off from work. His wife described his work as very intense and agreed that if his workplace had acknowledged his issues and dealt with them as he proposed, he might have felt 'listen to' and may not have had to become absent. He feels that it was unlikely that he will return to the same employer due to the employer's lack of empathy.

Arrogance of management

Rachel was absent from work due to stress related reasons. At first these were non-work reasons. In the weeks before becoming absent from work she had moved house and her father had passed away. At this stage, she was still coping reasonably well at work then she was dismissed from work for supporting a colleague involved in disciplinary action.

Those absent due to co-morbid health reasons reported physical symptoms including a lot of pain just after an accident, cysts on eyes getting bigger, headaches, stomach pains and irritable bowel syndrome in conjunction with a range of stress-related symptoms e.g. fatigue, depression, not coping with staff, no energy and depression.

3.1.5 Who was involved in the decision to take absence

Very few people reported any assistance or support from their workplace in making the decision to take absence leave. This finding, most likely, reflects the lack of comprehensive occupational health service provision in Ireland. Out of 34 cases, only 2 people reported receiving help, from people in their workplace, in making this decision. Both of these were from the group experiencing stress-related or mental health illnesses – one received support from a manager and the other from a colleague. In the case of the LTAs manager, the manager offered advice to the employee as she had experience of the employee's condition (panic attacks) through her sister's experience of the condition.

The majority of LTAs reported that people outside of the workplace were involved in their decision to take leave of absence from work. Almost three quarters of respondents cited either the GP alone or their GP along with someone else e.g. specialist, spouse / partner or other family member and friends as instrumental in their decision. The next most frequent source of support in decision making was from immediate family members, most frequently by spouses / partners followed by siblings, children and parents. In a few cases other people were involved in the decision, i.e. specialists or consultants and friends. It might have been expected that those suffering from mental health related illnesses would have mentioned mental health professionals involvement in their decision, however, this was not the case.

Parental and GP involvement

Angeline a middle aged grand-mother with one school-going child still living at home had been feeling very tired, listless and irritable over a period of time. She describes this period as about a month whereas her partner suggested that she experienced the symptoms for at least six months before becoming absent. Prompted by her mother and her GP she underwent a series of tests, with a specialist, which showed that she was suffering from a rare blood disorder.

In almost one fifth of all cases, LTAs reported that no-one, other than themselves, was involved in their decision to become absent from work. People absent for mental illness reasons were more likely to indicate this.

3.2 Prevention

This section looks at what could have been done to prevent the LTA taking absence from the workplace by either the absentee, their workplace or any other person. It also explored who offered support or advice in the workplace and outside, the nature of this support and in what ways it may be considered useful / not useful. In addition, partners were asked how well they felt the LTAs absence was handled by workplace and what suggestions they had for how things could have been handled better.

Main findings

- Few absentees felt that they, themselves could have done anything to prevent their illness.

- A large number of absentees absent for stress-related or mental health reasons felt that their workplace could have taken some action to prevent their illness.
- None of those absent due to physical illness considered that their workplace could have taken any action to prevent their absence.
- Support in the workplace was provided by colleagues, supervisors, managers, and staff and was mainly in the form of advise, empathy and useful suggestions.
- Support sources outside of work included the absentees social network and professional personnel. Types of support included advice, referrals, practical and emotional support.
- Partners who commented on how they felt their partner's absence was handled by the workplace gave negative comments.

3.2.1 Actions that could have taken to prevent illness

Very few of the respondents reported that anything could have been done by them, themselves to prevent their illness. This is understandable in the case of those experiencing physical illness and to some extent of those experiencing co-morbid illness where the on set of absence was spontaneous in the majority of cases. However, in the case of absentees experiencing mental health or stress-related illnesses it suggests a lack of personal responsibility for managing symptoms in the cases where the illness was not precipitated by work-related problems. Table 3.2 below gives details of measures taken by the LTAs, workplace or someone else, in preventing the LTA from having to take absence leave. It is broken down in terms of the reason for current absence.

Table 3.2 Number of LTAs who mention preventive measures were taken by themselves, work place and/or someone else by main reason for current absence

		Main reason for current absence:			
Measures to prevent LTA from taking absence taken by:		**Physical (N)**	**Mental (N)**	**Co-morbid (N)**	**Total**
LTA	Yes	0	0	3	3
	No	10	13	8	31
Work environment	Yes	0	8	6	14
	No	10	2	3	15
Someone else	Yes	0	0	0	0
	No	10	13	11	34

Actions by the absentee

The types of actions that absentees felt they could have taken themselves were mainly work-related and included reducing workload by doing less or getting additional help to undertake some tasks and also by taking things at a slower pace.

Actions that could be taken by absentee

An arthritis sufferer said he could have reduced his workload over the previous year

Actions that could be taken by absentee (Cont.)

An absentee experiencing co-morbid illness (back pain and burnout) said that *"I could have taken things easier, I felt that I should slow down, but commission was the driving incentive to keep working as hard as I did. I continued to lift heavy goods despite my back problems."*

A partner of an absentee felt that if his wife had reduced her workload or even looked to work part-time, she may have prevented her illness – burst veins.

Actions by the workplace

None of the group of people absent due to physical illnesses considered that their workplace could have done anything to prevent their absence. On the other hand, more than half of those with stress – related / mental health issues and just less than half of those with co-morbid –problems felt that something could have been done by their workplace to prevent their absence.

The main actions proposed by those absent due to stress-related or mental health illnesses concerned a reduction in workload and/or working time. Other actions identified by absentees included acknowledgement or appreciation of effort by supervisor (this would have made employee feel valued instead of 'used'). An absentee who was bullied felt that if the incident had been investigated and taken seriously it would have prevented her absence. Her husband also felt that if she had received some support at work she would have felt they believed her and it would have prevented her absence.

Examples of workplace actions proposed by stress-related/mentally ill absentees

A teacher suffering from bi-polar depression, who was teaching a large and disruptive class as well as experiencing other life strains felt that a reduction in the class size, to smaller groups, would have reduced the pressure she experienced. This teacher did eventually return to her place of work and copes well with her class of adult learners.

A person suffering with depression felt that a change in working hours, from shifts that included evenings, nights and weekends, to regular Monday to Friday working hours would have improved how she felt and enabled her to deal with her depression.

For those absent due to co-morbid reasons, the main workplace action proposed that might have prevented their absence was a reduction in workload. Other suggestions included improving work conditions and taking due care by maintaining equipment.

Examples of workplace actions proposed by co-morbid absentees

For a man absent with back problems – the company could have provided machinery to lift goods into the truck instead of expecting employees to lift them manually

Examples of workplace actions proposed by co-morbid absentees (Cont.)

A truck driver who suffered a work –related accident when driving a truck said the (company) should have informed him of the service history of the truck or ensured that the trucks were properly maintained. The accident was due to a mechanical problem with the truck. If he had known it was unsafe to drive he would have suggested using some other transport or refused to drive the truck.

3.2.2 Support provided by people in the workplace prior to absence

While workplace personnel were not formally involved in the absentees decision to take absence leave, almost half of absentees who had on-going symptoms had discussed their illness / problem with someone in their workplace. Table 3.3 below outlines the number of people from work that the LTAs discussed their problem with, broken down by the reason for absence.

Table 3.3 Number of LTAs who discussed health problems with people at work by main reason for current absence

	Main reason for current absence:			
LTAs discuss health problems with someone at work:	**Physical (N)**	**Mental (N)**	**Co-morbid (N)**	**Total**
Yes	2	2	5	9
No	8	0	6	14

The range of people at work who LTA had talked to about their absence included supervisors, managers, staff, colleagues, and in one case the company nurse. Colleagues were the people most often selected to share the LTAs problem. The type of support provided included advice, helpful / useful suggestions for resolving the problem and empathy or simply just being a 'listening ear'.

Workplace support prior to absence

A woman absent due to a stress-related illness confided in a work colleague. *"My colleague's sister-in-law had suffered from the same illness in the past. As well as being very empathetic, kind and understanding, she suggested I see a psychiatrist or a social worker. Just talking to her and feeling that she understood what I was going through helped to reduce the stigma I felt was associated with my illness. Her support also gave me the kick-start I needed to begin to be proactive about my illness and seek help".*

A man experiencing severe and frequent panic attacks had this to say. *"My supervisor had previously suffered from panic attacks. She was very sympathetic and understanding. She advised me to go home and take some rest and said that she would get in touch with me again in a few weeks. I felt as if she had 'given me permission' to be sick before this I kept battling on and wondering why I couldn't cope."*

Two people with physical illnesses reported that colleagues supported them by providing practical help – an absentee with arthritis and one with back problems reported that colleagues supported them by not letting them do any lifting or heavy work.

3.2.3 Usefulness of support

In all but one case, absentees rated the support received from workplace contacts as being helpful. The exception was an individual who experienced bullying at work.

Support -useful

Rachel was absent from work because she had been dismissed. Prior to her dismissal for assisting a colleague taking a disciplinary action against the company, Isabelle was experiencing stress as her father had died recently and she had moved house. Her partner and solicitor were her two main sources of support. *"I found them very supportive, and the legal advice was important to me. It gave me confidence to know that I had a support network and people understood that what had happened to me was unfair. But, sometimes it seemed unhelpful because they were impartial and did not really understand what I was going through."*

Support - not useful

Rebecca's colleagues were aware of the situation and what she was experiencing and some of them advised to leave before the bullying destroyed her. She felt helpless because while her colleagues knew what was happening, they could not change or influence the situation. She reported the bullying to her manager, however it did not stop nor was it investigated. *"While colleagues will listen and can understand and relate to what you are going through – they cannot do anything about the company – they could not change company policy or management."*

3.2.3 Support provided by people outside of workplace prior to absence

Table 3.4 shows that the majority of LTAs discussed their health problems with someone outside of work. The two main groups who provided support to absentees were their immediate social network (spouses/ partners, family and friends) and professionals. Support from their social network was most frequently provided by partners/ spouses followed by other family members (parents, siblings and children), and least often by friends. Professional support was mainly provided by GPs. The range of professionals providing support outside of the workplace to people experiencing stress-related / mental illnesses included psychologists, psychiatrists, counsellors, and local community resources e.g. community mother. Those absent due to physical illnesses mainly obtained support from specialists and consultants. Co-morbid absentees received professional support from both mental health professionals, GPs and other specialists.

Table 3.4 Number of LTAs who discussed health problems with people outside the workplace by main reason for current absence

	Main reason for current absence:			
LTA discusses health problems with someone outside workplace:	**Physical (N)**	**Mental (N)**	**Co-morbid (N)**	**Total**
Yes	4	8	7	19
No	6	4	4	14

A wide range of support was offered / available including advice, medication, emotional support, referrals and practical support.

Practical support

Irene – a single mother suffering from stress received help from her parents and siblings with looking after son. *"This gave me some time to myself, to consider what was happening and to think. I really needed a break from the responsibility of my son to give me time to recover."*

An arthritis sufferer received help from her daughter and her husband with domestic and other chores.

Emotional support

A cancer patient who experienced depression as a result of her illness. *"My husband encouraged me to give up work as did my GP. This was useful as it helped reduce the pressure and gave me time to myself. My family were wonderful, they spend lots of time with me which helped to take my mind off things."*

In all cases, respondents reported that the support they received from people outside of work was useful. The range of reasons why they felt it to be useful included:

Usefulness of support

"I got referred to a good specialist" – person experiencing mental illness

"It gave me confidence to know people cared and I that had a network of people to support me" – person experiencing stress-related illness

"It was good to talk to someone who understood what I was going through." (woman with post natal depression referring to help from a community mother).

3.2.4 Partners' perspective of how absence was handled by workplace

The majority of partners / spouses who responded to the question on how the LTAs absence was handled by his/her workplace felt that it was not well handled. Most of the comments were concerned with the lack of contact made by companies to absent employees.

Partner's view of how LTAs absence was handled

Partner of a woman who was suffereing from depression following cancer treatment and had been with a company for 10 years – '*no one from company level got in touch to see how she was. Colleagues called her and were concerned about her.'*

A woman suffering from B12 deficiency had been working in a company for 12 years and no-one from management/ supervisor contacted her to see how she was doing. *'She felt that she was just a number to them. They did not support her but yet expected her to visit the company doctor every 2 weeks to prove that she was sick. This was despite the fact that the company was receiving information from her specialist regularly (monthly visit to specialist). She had good contact with her colleagues during her absence. They phoned and called in'* (husband).

Very few responses were received to the question 'what could have been done to handle your partner/spouse's absence better?' Where suggestions were made they included – 'the company could have employed an additional person to relieve the workload, which they knew was excessive and also could have shown him more respect. The company could have accommodated her (cancer sufferer) better and given her a better solution, such as fewer hours and days off after her treatment, but instead she gave up her job.

3.3. Impact of absence on families

In this section LTA respondents and their spouses / partners were asked about the impact that their absence had on the various family members. Interviewees were asked to provide information on the consequences in terms of relationships, emotional and financial aspects and also to talk about the changes in these consequences over time.

Main findings

- Main impact was financial strain due to low disability payments
- Positive impacts included – more time with children and for domestic chores, improved relationships with spouse / partner, health improvements and better quality of life
- Negative impacts included personal (lowered self-esteem), financial, poorer relationships due to tensions at home

A variety of both positive and negative impacts on the family due to absenteeism were reported by LTAs and their spouses / partners. Positive impacts on the family related to having more time for domestic chores, more time for children, friends and spouses / partners, experiencing improvements in their relationships, having a better quality of life and for many their health improvements were significant. The negative impacts, were mainly financial, personal (lowered self-esteem and confidence) and poorer relationships with family due to tension in the home.

The main impact on families was the pressure of the financial strain which was mentioned by 83% of respondents. This issue arises because in most private employment situations, unless employees are covered by income maintenance insurance or the company agrees to keep paying their wages, long term absentees receive disability benefit which amounts to a maximum of 148.50 Euro per week. This sum might be less in the case of an LTA who is means-tested based on their spouse's income.

In general, the consequences of absence experienced by all three illness groups were broadly similar. Where there were exceptions, these were usually illness related, e.g. tension due to lack of understanding of depression. LTAs from all

groups talked about the drop in income negatively affecting the family. Many of them reported adjusting to their lowered income over the period of the absence, but for some lowered finances proved to be a continuous source of strain.

3.3.1 Impact of absence on individual

The impacts of absence on individual absentees was explored according to three main themes – emotional, relationship and financial.

Emotional consequences

The experience of emotional consequences reported by LTAs varied widely. Many LTAs reported being happier, particularly those who were absent from work for stress related reasons, as some of the pressure they felt was relieved by being at home. More than half of all respondents reported negative emotional experiences, such as feeling bored and 'fed up', missing the routine of work and missing socialising with colleagues. They also reported feeling guilty for no longer contributing financially to the family and feeling 'like a burden'. Some reported feeling drained and preoccupied and with their illness.

Emotional consequences

Samuel became stressed during his wife's illness. This was exacerbated when she died. For his sake and that of his children he took leave of absence. The main consequence for this family, aside from the emotional ones, was lowered income. Despite this Samuel felt that it was a bonus to be able to be with his children, to do the cooking, cleaning, ironing and house repairs. Over time, he felt that his absence had an increasingly negative effect on him, personally, as he had never been out of work before and missed work and having his time occupied. For the children, the main effect was positive one, as their father was there to provide them with much needed emotional support.

Relationship consequences

For many LTAs and their families absence from work was a positive experience for their relationships in that they had more time for their families, could do more of the domestic chores and simply enjoyed being at home. For others the experience was very negative. In most cases this was due to increased tension in the house caused by the impact of the LTAs illness (e.g. depression, mood swings, not coping with being in the house all the time). Three people in the sample reported a break-up of their relationship due to the strain they came under.

Relationship consequences

Maria was absent from work because of bullying. She had been threatened by a co-worker and advised to leave her job. She became nervous, irritable and experienced lowered self-esteem and lowered workability. Her absence from work had a mainly negative impact on her and her family. Besides the financial burden, her relationships suffered. There was a lot of tension and fighting to start and things got worse as time went by resulting in her splitting up from her partner. Initially, he was very supportive, but he found it very stressful the longer things went on. She also reported taking out her anger on her daughter. This eased over time.

For people with mental health or stress related problems, many reported that their spouses/ partner and children had no understanding of their illness. Some reported that hey felt their families found the duration of their illness unrealistic which, in turn, made things very difficult for them. For example, a woman with depression reported that her husband was very understanding at first, but as time went by he told her to *'snap out of it'*. This left her feeling guilty and knocked her self-esteem.

3.3.2 Impact of absence on spouses / partners

Spouses reported many of the same positive and negative impacts experienced by absentees. A few mentioned the issue of role reversal. Some went on to mention that having the person at home invaded their space i.e. having the absentee around the house all the time was very difficult to get used to.

Role reversal

A man who found himself at home due to LTA and took on chores and child care duties for the first time. It was a completely new experience as he had worked all his life. He reported really enjoying the time he spent with his children and that they became very close as a result of his absence.

In another case a man's partner had to become the main breadwinner in the household. *"This was difficult for her as she had to work longer hours to try and improve the families' financial situation. All this happened at a time when she should have been planning to retire. I felt very guilty about it."*

Space invaders

"I am used to doing my own thing. Since John has been absent from work, I find it difficult to have him around the house the whole time. He really doesn't know what to do with himself. At first, he was even following me around when I was doing housework or cooking. He still wants to go everywhere with me i.e. to the shops. I find this very difficult to deal with because I am used to my own space and enjoy spending time on my own or with my friends."

3.3.3 Impacts on children

For children, with the exception of one or two cases, the impacts reported were largely positive. Respondents reported that their children enjoyed having the absent parent at home, spending more time with them and not having to attend child-care. In some cases, LTAs reported that children noticed the financial effects, but for most, they seemed to get used to 'making do with less' over the period of the absence. Where there were negative impacts on children, it had to do with their lack of understanding of their absent parent's illness. This was particularly so of parents' with mental or stress related illnesses.

3.3.4 Impacts on other dependants

Only two absentees mentioned impacts on other dependent relatives living with them or for whom they were responsible. In both cases, impacts were positive as the LTA had more time to spend with their mother or father.

3.3.5 Overall impacts

Table 3.5 below details the positive and negative impacts on the household and is broken down by the reason for the LTAs absence. As can be seen the majority of situations reported both positive and negative impacts, expecially for those suffering for mental or co-morbid illnesses.

Table 3.5 Positive and negative impacts on the household by main reason for current absence

	Main reason for current absence:			
Impacts on household:	**Physical (N)**	**Mental (N)**	**Co-morbid (N)**	**Total**
No impact	2	2	0	4
Only positive impacts	2	2	3	7
Only negative impacts	2	3	2	7
Both positive and negative impacts	4	6	6	16

3.4 Profile of returnees and non-returnees

This section provides demographic information on the profile of LTAs who had and who had not yet returned to work at the time of the interviews.

Main findings

- More female (47.4%) interviewees had returned to work (26.7% male)
- There were no significant differences in personality scales between LTA's who have and have not returned to work
- People with a physical illness were much more likely to return to work (physical 70%, Mental, 31%, Co-morbid 18%)
- Younger LTAs were more likely to return to work
- The Work-ability-Index is likely to be one of the best scales for a prognosis on how quickly people return to work.

As shown in Table 3.6 only 13 people out of 34 LTAs, interviewed for this study, had returned to work at the time of the interviews. Proportionately more people absent due to a physical illness had returned to work, followed by those absent for mental health or stress related reasons. Almost all those who had returned to work returned on a full-time basis. There was one exception and this returned on a part-time basis for an initial period.

Table 3.6 Number of LTAs fully, partially and not returned to work by main reason for current absence

	Main reason for current absence:			
Return to work:	**Physical (N)**	**Mental (N)**	**Co-morbid (N)**	**Total**
Not	3	9	9	21
Partly	0	1	0	1
Fully	7	3	2	12

Findings suggest that age is a factor that may influence the RTW process. The mean age of the subgroup who had returned to work was 40.3 years compared to 49.2 years for those who had not returned to work yet.

3.4.1 Differences between those who had and had not yet returned to work

To assess differences between the group who had returned to work and those who had not, the psychological scales (depression, self-efficacy, exhaustion and disengagement), which were used in the main questionnaire on LTA, were analsysed in relation to the sub-sample for the family study. Interestingly, there were no real differences between these subgroups on these psychological scales. The results of these comparisons can be seen below in Table 3.7. It might be expected, that those who have not yet returned to work would experience more negative measures on some if not all scales. Other findings in this study, particularly from the impact on family section suggest that LTAs who have not returned to work may be more depressed, or have lowered self-esteem. However, these findings are not reflected in the scales below.

Table 3.7 LTA's psychological scale measures by subgroups (RTW/ not RTW)

Scales	LTA`s RTW	LTA`s not RTW
Mean score Depression scale	15,08 (SD=6,87)	14,70 (SD=7,96)
Mean score Self-efficacy scale	29,77 (SD=4,59)	29,32 (SD=6,71)
Mean score Exhaustion scale	2,62 (SD=0,47)	2,61 (SD=0,59)
Mean score Disengagement scale	2,71 (SD=0,34)	2,36 (SD=0,44)

3.4.2 Work ability and RTW

The difference in the work ability measure between those who RTW and the group not yet RTW is significant. The proportions of a good/ average physical as well as mental work ability are strikingly higher in people who have returned to work compared to LTA's in the second group (see table 3.8). This indicates that the Work-ability-Index is a good scale for measuring the prognosis of when LTAs are ready to return to work.

Table 3.8 Work ability index of the LTA's in both groups

Scales	LTA`s RTW %	LTA`s not RTW %
good/ average Physical work ability	84.6	52.4
good/ average Mental work ability	100.0	66.7

3.5 LTA's who have returned to work

This section looks at the relevant factors that influence the RTW process. It describes what factors influence the decision to return to work, who provides support in making this decision to return to work and finally looks at the type of contacts that LTA would ideally like to have with their employer. Finally, it provides an overview of the impact that the LTA's return to work had on the family.

Main findings

- The majority of all LTA's (69%) who have returned to work consider the decision to RTW as the most suitable option for them.
- GP's were the main professional group consulted in relation to LTA's to return to work
- Employers were not perceived to be active in the RTW process
- Factors that influenced RTW were:
  - improved health
  - financial reasons
  - personal need
- During RTW processes colleagues were a considerable source of support
- The majority (77%) of LTA's returned to work with the same employer

3.5.1 Factors that influence RTW

The main reasons that LTA's returned to work were because of health improvements, financial need or because of a personal need. The reasons behind their personal need to return to work covered aspects such as "getting back to normality", "to go back and face the individual who bullied me", "for my mental health". Table 3.9 below illustrates the factors which influenced the LTAs return to work, broken down by the reason for their absence.

Table3.9 Factors that influenced LTA's return to work by main reason for current absence

	Main reason for current absence:			
Factors that influenced LTA's return to work:	**Physical (N)**	**Mental (N)**	**Co-morbid (N)**	**Total**
Health improved	4	-	-	4
Financial reasons	4	-	-	4
Own choice / personal need	0	2	2	4
Other	1	2	-	3

* Note: Respondents could indicate more than one answer

Personal need

A person absent for mental health reasons – "*I needed to go back to work. My husband stopped working. This made my need to return to work more urgent. I needed some structure in my life again. Also we are going through a separation, at the moment, and it is much too difficult with the two of us in the house together."*

3.5.2 Involvement of other people in decision to RTW

In more than half of all cases other people were involved in the decision to return to work (see table 3.10). The GP was the main person with whom LTA discussed this decision, followed by family members and other professionals. The main type of involvement was to offer support and advice to LTAs. In a couple of cases more prescriptive actions were taken for example, in one case a GP suggested that the LTA become involved in a return-to-work scheme, however this was 'the exception rather than the rule'.

Table 3.10 Other people's involved in the LTA's decision return to work by main reason for current absence

	Main reason for current absence:			
Other parties involved in the LTA's decision to return to work:	**Physical (N)**	**Mental (N)**	**Co-morbid (N)**	**Total**
No	2	2	-	4
Yes:	4	3	2	9
GP	2	1	2	5
Family	2	1	-	3
Employer	-	1	-	1

Just less than half of the LTA's felt that other people's involvement in their decision to return to work was not useful. The main reason given was that these people wanted the LTA to return to work too soon and consequently the LTA felt pressured into returning when they did not yet feel ready to.

3.5.3 Ideal type of support

Returnees were asked what type of support they would have liked to have received in relation to RTW and from whom (See Table 3.11).

Table 3.11 Kind of support LTA would have liked to receive by main reason for current absence

	Main reason for current absence:			
Kind of support LTA would have liked to receive:	**Physical (N)**	**Mental (N)**	**Co-morbid (N)**	**Total**
Regular contact from work	1	3	3	7
Discussion re: changes to help LTA RTW	-	2	1	3
None	-	1	1	2

Of the many suggestions made, most related to having more or better contact from the company, referrals to services (e.g. counsellor, psychological service, a course to help RTW) and engaging in discussions about workplace changes to assist the LTA in their return to work. Returnees also took this opportunity to outline negative aspects of contact that they had with their companies.

Negative experience of company contact

A lady who suffers from diabetes said – *"I was often contacted by my manager during my absence. He put pressure on me to return to work and offered me incentives to get me back. He promised to let me work flexible hours etc. When I went back he was completely inconsiderate and he never stuck to any of his promises. The only support I received on my return was from my colleagues who helped me with some of my workload, initially."*

3.5.4 Problems LTA's faced on return to work

As shown in Table 3.12 below, the majority of LTA's mentioned that they faced some problems on their return to work.

Table 3.12 Significant issues/problems LTA faced on return to work by main reason for current absence

	Main reason for current absence:			
Issues/problems LTA faced on return to work:	**Physical (N)**	**Mental (N)**	**Co-morbid (N)**	**Total**
No / no response	1		-	1
Yes	4	2	1	7
No response	2	2	1-	5

LTA's with physical health complaints referred mainly to their physical limitations, for example "unable to do specific tasks". Other problems faced by LTAs on their return to work was trying to get back into the routine of work again, getting a proper sleep routine again, fear of work and a lack of support in the workplace. Many made reference to the lack of support and acknowledgement they received from managers with regard to making changes in their work situation

3.5.5 Support during return to work

Support during return to work was provided mainly by colleagues (see Table 3.13 below) who welcomed LTAs back, helped with some tasks the LTA was not able to do and offered support and advice. In some cases managers were supportive, however most LTAs who had returned to work mentioned that more could have been done by managers and supervisors to help them settle back into work. The types of actions that LTAs felt would have been useful ranged from communication to practical solutions of adjusting tasks, gradual part-time return plans and acknowledging and rectifying factors at work such as issues of workload and preventing stress, to mention a few.

> *Lack of management support*
>
> *My colleagues were great, it was like coming home again. However, I felt that my manager and supervisor were glad to see me, but only because the work would now get done. I was not really 100% when I returned to work and they were advised that I should have a gradual return to work. This was not facilitated. I was left feeling as though they don't care, they have no consideration for me as a person.* Person with physical illness

The majority of LTAs assessed the support they received during their return to work process as helpful. They made comments such as "it made life easier", "colleagues were very supportive" and "it was good to have someone to talk to about things". Where comments about support were negative, LTAs mainly reported issues with management and with poor leadership: "he did not want to know about my problem or work environment problems"

Table. 3.13 People from whom LTA received support during return to work by main reason for current absence

	Main reason for current absence:			
People who supported LTA during return to work:	**Physical (N)**	**Mental (N)**	**Co-morbid (N)**	**Total**
Colleagues	4	2	-	6
Manager	1	2	-	3
Family / friends	1	-	-	1
Professionals outside of work	-	-	1	1
Nobody	3	-	-	3
No response	-	2	1	3

* Note: Respondents could indicate more than one answer

3.5.6 Return to work situations

Most LTA's returned to work in the same job with the same employer. However, some returned to the same work conditions and others to different work conditions (see table 3.14). With regard to changes in the work situation that facilitated return to work, working reduced number of hours was the most frequently mentioned factor. Both of the respondents in the co-morbid illness category who returned to work, returned to work with a different employer and a different job.

Table 1.14 LTAs' return to work situation by main reason for current absence

	Main reason for current absence:			
Situation in which LTA returned to work:	**Physical (N)**	**Mental (N)**	**Co-morbid (N)**	**Total**
Same job / same employer / same work conditions	2	2	-	4
Same job / same employer / different work conditions	4	-	-	4
Different job / same employer	1	1	-	2
Different job / different employer	-	1	2	3

For 9 out of 13 LTA's the RTW situation was the most suitable option. Explanations for this judgement could be that improved health and the wish to return to the "family" of old colleagues had led to the decision of choosing the old employer and the same job again. For an example of a well managed return to work see Section 3.7

Poorly Managed RTW - Need for gradual RTW

Annette, was absent from work for physical health reasons. Her specialist felt that, while she was physically much better, that she needed to return to work on a gradual basis due to her continued fatigue, which was a symptom of her illness. The company doctor considered that she was fit to return to work full-time. *'I needed to return to work. My condition was under control, I was bored at home and really missed my work and my work friends. I also needed the structure and we needed the money. I was still very tired and agreed with my specialist that the best way for me to go back to work was to go back to a reduced working week. The company, however, did not agree with this and wanted me back full-time. I knew I would not manage this, so I have opted to work a four-day week and I take the fifth day off as part of my holiday leave allowance. All through my absence, I felt as though the company doctor and my specialist did not agree. It made me feel that the company doctor doubted professional opinion. While I am happy to be back at work and to have the social contact of work, I feel resentful about the way my return was handled. I feel as if management just want the work done and they really don't care about the welfare of their employees.'*

3.5.7 Impact of RTW on families

Table 3.15, as seen below, outlines the impact that the LTAs return to work had on the household. The most frequently mentioned positive consequences of the LTAs return to work on their families were financial and also the re-establishment of structure and routine in the household.

Table 3.15 Impact of LTA return to work on household by main reason for current absence

	Main reason for current absence:			
Impact of return to work on household:	**Physical (N)**	**Mental (N)**	**Co-morbid (N)**	**Total**
Positive	4	3	-	7
Negative	2	0	-	2

The most frequently mentioned negative aspects were around children missing the parent who returned to work and the loss of availability of LTA to contribute to the domestic situation.

3.6 LTA's who have not returned to work yet

This section describes what factors are preventing LTAs from returning to wrok, what factors respondents consider would facilitate their return to work and the type of support they have with their employer. It also considers the impact of continued absence from work on the family.

Main findings

- The main factor that prevented LTA's from returning to work was continued ill-health (LTA's and partners view).
- Of the LTA's with mental health problems two thirds have not returned to work because of depression symptoms.
- Half of the LTA's are still in contact with their employers
- Only one in five LTA's in the "Mental" group who are in contact with their company assess this as helpful
- The main factors LTAs suggested that would facilitate their return to work was to be offered a change in their work situation

Nearly two thirds of LTA's in the study group had not returned to work at the time of the interviews. As mentioned already LTAs, in this sub sample, who had not yet returned to work didn't differ in the personality scales, (such as self-efficacy, disengagement, depression) from the group who had returned to work. This is interesting, as symptoms of depression were cited by many as the main reason they have not yet returned.

3.6.1 Factors preventing LTA's to return to work

For the majority of LTA who have not returned to work, the main factor preventing their return was continued ill-health. Among those absent for reasons of mental health or co-morbid reasons some also reported symptoms of depression, stress, anxiety and concentration problems as reasons why they were not ready to return to work. Others mentioned the need to return to work gradually, to return to work part-time, or to work under different working conditions e.g. less workload, less stressful situations. A number of LTAs offered other reasons, mostly related to securing different work or different work arrangements. For example:

What prevents RTW?

A person experiencing stress '*I am not able to find a suitable job. My self esteem and confidence is very low since I became absent. I need to find a job with less stress that helps me get back into the routine of work',*

A person suffering from depression '*I need a job with more regular i.e. 9 to 5 p.m. hours'. In my last job I was working evenings and some weekend days. Shift-working is not great when you are depressed. Also you feel as though you are working when everyone else is at home.'*

3.6.2 What can be done to facilitate return to work

Respondents were asked what they felt could be done by themselves, their families or their workplaces to facilitate their return to work. The main responses were in relation to actions that could be undertaken by their workplace. A few respondents, mainly with physical illnesses, felt that they themselves could undertake personal health improvements which might impact on their overall health and in turn encourage their return to work. An example of this was where a man with high blood pressure felt he could lose weight and exercise more. None of the respondents felt that there were actions their families could undertake to promote their return to work.

Figure 3.16 below examines the other suggestions made by LTAs which might help their return to work, broken down by reason for absence. For those who made suggestions about work improvements that would help to facilitate their return to work, the majority indicated that better communication would help. E.g. more contact from the company during absence, communication to discuss possible changes to their work which may facilitate a return to work. Almost two fifths of respondents felt that changes in their work environment was an important factor that would facilitate their return, two fifths also felt that the introduction of flexible working hours would assist in their return.

Table 3.16 Other things that have been done to help LTA return to work by main reason for current absence

	Main reason for current absence:			
	Physical (N)	Mental (N)	Co-morbid (N)	Total
Change work environment	1	1	2	4
Flexible working hours	-	4	-	4
Better communication	-	1	4	5
Other	1	-	1	2
No response	1	3	2	6

* Note: Respondents could indicate more than one answer

Almost half of the respondents who had not yet returned to work reported that they were in contact with their employers during their absence from work (see table 3.17). For many these were phone calls to find out details about medical information concerning the employees absence. In cases where contact was reported to be positive it was most frequently provided by colleagues who were concerned about

the well-being of the LTA. One fifth of LTA's reported that they did not wish to have any contact with their employers. This was usually because there was some major workplace issues e.g. bullying, court case pending or redundancy.

Table 3.17 Number of LTAs who remained to be in contact with their company during absence from work by main reason for current absence

	Main reason for current absence:			
	Physical (N)	**Mental (N)**	Co-morbid (N)	Total
Contact	1	5	4	10
No contact	1	1	5	7
No response	1	3	0	4

3.6.3 What would be ideal contact with employer

When asked what would be the ideal type of contact they would like to have with their employer, almost two fifths of LTA's said they would like to have more contact / involvement from the employer. Specific aspects included more regular contact and the possibility of a RTW program (see table 3.18).

Table 1.18 Type of contact LTA would ideally like to receive from the company

	Main reason for current absence:			
Ideal company contact	**Physical (N)**	**Mental (N)**	**Co-morbid (N)**	**Total**
More regular contact	1	2	3	6
RTW programme	1	1	-	2
No contact	-	3	1	4
Other	1	-	2	3
No response	-	3	3	6

3.6.4 Impact of continued absence on family

When asked what was the impact of the continued absence of LTA on the family, the main positive impacts were about improved relationships, more time with children, being able to provide childcare and domestic issues. The main negative impact concerned the financial implications for the family. Other negative impacts mentioned were the mental health, self esteem and confidence of the LTA which were frequently reported as being lowered due to continued absence.

3.7 Rehabilitation

This section outlines the findings in relation to return to work and rehabilitation programmes available to facilitate LTAs in their return to work.

At present, in Ireland there is no obligation on employers to provide Return to Work programmes and by and large employers don't get involved in formal return to work practices. A limited number of rehabilitation options are available to LTAs. Most of these are organised by either the state (e.g. FAS – national training authority with brief for disability) or voluntary sector (e.g. Rehab and other institutes) where the focus is more on retraining than on reintegration into the existing workplace. Other initiatives in this area concern the contribution of medical / therapy interventions. An example of this is where a LTA is in contact with a GP or other professional (e.g. occupational therapists, psychologists, psychiatrists) concerning their illness and are in turn referred for therapy or counselling (in the case of mental health issues) or mediation or medically related support (in the case of physical illness).

In this sample, only two cases of respondents engaging in rehabilitation programmes surfaced. Both were people who were LTA due to mental illness.

GP initiated RTW

Albert was LTA due to work-related stress. The factors that prompted him to take absence from work were too much pressure (excessive work demands and change in work environment), harassment and being overworked. He became absent when he experienced episodes of acute anxiety combined with on-going symptoms of depression. Albert's GP and psychiatrist were involved in his decision and advised him to take leave of absence from work.

.

"My workplace knew I had difficulties as I had previously submitted GP certificates for shorter absences but they did not make any suggestions to reduce my workload. I suppose at some level, I did not really want to face my problems either. Colleagues advised me to slow down and take it easy. I was put on medication which helped reduce my anxiety and combined with time off work reduce the stress symptoms. At the moment, I am still absent from work and I am not ready to go back yet. My GP suggested that I do something to get some structure and order back in my life – so he gave me a letter and I contacted FAS to sign up for an ECDL course. Along with this, I am still going to therapy. The course gives me something to get up for everyday, it has put a routine back into my life again and I am meeting people. It is helping to improve my self esteem."

At time of interview Albert was still doing this course and attending therapy sessions.

Supervisor and GP supported RTW

Marianne suffered from a psychiatric illness. Prior to her absence, she experienced several problems relating to both work and personal behaviour – as well as her mental health problems, she was irritable, overeating, over drinking and had to contend with teaching a disruptive group in her class. A colleague whose brother suffered from the same illness advised her to see a psychiatrist or a psychologist. Marianne felt that speaking to this colleague took away the stigma she experienced in relation to mental illness and gave her the kick start she needed to become proactive in her recovery.

Through her GP she was referred to a psychiatrist who recommended that she attend a day hospital. The key worker at the hospital discussed taking part in a rehabilitation programme that included therapy, discussion and activities. A psychiatrist was in charge of the programme.

"I attended for 4 months and then decided to give it up as I felt much better. At this stage I considered RTW. With the support of my supervisor and my GP, I have returned to work (partially).

My supervisor had a big part to play in my return. He is very socially minded and understanding of people with a mental illness. Also, my GP advised me to get back into a routine and supported my decision to RTW. My supervisor was very supportive, he phoned me and had meetings with me prior to my RTW and was there for me when I returned to work.

I returned to reduced work hours and different work in the same company. It is a better option for me as it was less stressful than my previous situation (no more disruptive students) and is more mentally stimulating. I was warmly received by colleagues and management which helped my confidence hugely.
My illness and rehabilitation has been really beneficial in a personal sense, I have become more disciplined in my life and how I live. It has made me more assertive, I have rediscovered sides of my personality that I thought I had lost".

3.8 General

Respondents were asked a number of more general questions relating to their perception of changes in society and the consequent impact on quality of life and levels of stress. They were also asked what they considered were the main factors influencing absenteeism in their own workplace and what their opinions were on the impact of changes in society more generally on absenteeism. Finally, they were provided with an opportunity to raise and discuss any other pertinent issues if they wished to.

3.8.1 Changes in society and the impact on quality of life and stress

A variety of changes in society that impact on quality of life and stress were reported by respondents. These fell into 5 main categories – work-life balance, demands of the workplace, work culture, social issues and individual issues. Given the very rapid growth in the Irish economy in the last 10 years, not surprisingly, many of the comments concerned the issue of living, working and raising children in an increasingly materialistic society, where the emphasis and focus of life has become having and spending money.

Changes at the societal level concerned the increasingly rapid pace of life where it seems like 'all work and no play', and there never seems to be enough time to relax, or to spend with children, friends and other relatives. The fact that society is becoming more transient, the diminishing role and significance of the community in daily life were also mentioned as issues.

The majority of comments concerned demands of the workplace. Respondents felt that workplaces were more productivity and performance driven, with, in some instances, fewer people employed to do the same amount of work and in others targets becoming the main measure of work performance rather than quality of work. Quite a few respondents talked of increased workloads, working longer hours and having more demanding jobs. Some mentioned the influences of technology – this ranged from the increasingly mechanistic nature of jobs to the impacts of ICTs on work. Where jobs were being mechanised, work was becoming more and more boring (i.e. just pushing buttons all day, 'monitoring rather than doing' becoming the focus of jobs). ICTs i.e. mobile phones, emails and the Internet means that people are theoretically able to be contacted on a 24/7 basis and requests for information or feedback can be demanded almost instantly thereby increasing stress and workload. Respondents also mentioned the effects of frequently changing systems, technology and work practices, the loss of job security and the high expectations placed on workers as issues under this heading.

Work-life balance issues concerned the issues of 'juggling' work and family life, not having enough time for children and having less control over the environment that children are being raised in (i.e. childcare). Another interesting issue raised in relation to parenting was that of adult children (well into their mid 20s) living at home.

> *"I am still running around and doing things for my 20 and 22 year old children. They are at college and working part-time. I do the laundry and their meals. At their stage in life I was living away from home and working. I had not expected to be looking after them this long*."

Comments relating to work culture centred mainly on issues concerning management. Respondents talked about the effect of poor management skills and poor people skills on morale and consequently on performance and stress. They mentioned unrealistic expectations set by managers and the lack of acknowledgement and appreciation shown to employees by managers.

Individual issues mainly concerned the 'work ethic' of modern employees. With the greater availability of jobs people move from job to job more quickly, they don't build up loyalty to their employer and they tend to have less pride in their work. The corollary of this is that organisations lose skills and experience and continually need to re-train workers.

3.8.2 Main factors affecting absence in respondents workplaces

When asked about the factors affecting absence in their workplaces, responses fell into two main categories – work-related factors and individual factors. Work-related factors concerned the corporate culture, work environment, work tasks and management. The Individual factors included family issues, personal issues, job issues, attitudes to work and social life.

With regard to the work-related factors respondents considered that issues such as lack of job satisfaction, heavy workloads, lack of flexibility, changes in work practise and doing boring, repetitive work contributed to absenteeism. Contributing factors relating to management include, poor management, being undermined by management, unrealistic expectations of management, pressure from management and management meeting their own needs not those of the employee. Work environment factors such as sick building, poor ventilation and too much lifting attributed to absenteeism in some workplaces.

Two issues surfaced as the main ones concerning individuals. Respondents felt that often parents took time off work as a sick day (rather than a leave day) to meet their children's needs. The other main issue related to socialising too much, where absenteeism was attributed to excessive indulgence in alcohol. Other contributing issues concerned the lack of loyalty to employers, lack of interest in the job and employees having more than one job. Some respondents mentioned 'abuse of the system' (where employees took a sick day(s) for pleasure purposes) or the fact that in some workplaces it was too easy to ring in sick without consequences so people took advantage of the situation.

3.8.3 How have changes in society impacted on absenteeism?

A set of issues similar to those already outlined above were reported when respondents were asked how changes in society had impacted on absenteeism. Responses fell into four main categories work-life balance, individual issues, job / work related issues (including those relating to management) and social issues.

3.8.4 Any other comments.

At the end of the interview, respondents were thanked for their participation in the study and invited to make additional comments if they wished to. Comments concerned the interview, return to work options, outstanding issues that respondents had with being absent long-term and gripes with the welfare system. A number of respondents reported that they were pleased to have participated in the study for a range of reasons which included that it gave them an opportunity to assess what had happened to them and to review (and realise) the progress they had made. Other comments were that they hoped the research would be useful in improving the situation for future LTAs and that it was 'good to talk about things'.

Finances / money

'More money should be available from social welfare. It doesn't matter if you have worked for 10 months or 25 years, when you become sick you are entitled to the same amount of benefit (148.50 Euro per week).'

'My wife returned to work three years ago after a career break of several years. She is only entitled to 60 Euro a week 'sick pay' because her assessment is based on social welfare contributions for the last three years and ignores her previous contributions. Also, her income is subject to a means test because I am working. This is very unfair system. Furthermore, her particular illness is not covered for treatment by VHI (private medical health insurance) so we are being hit for all the medical bills as well. This is a very difficult period for us.'

Usefulness of interview

'I found the interview very positive. It was good to express how I felt and my ideas. It made me realise how far I have come. My absence has led me to become more disciplined, more appreciative of time and time management. My confidence has improved and and I am coping much better.'

Experience of being Long term absentees.

"*As a long term absentee I am experiencing the other side of life, the financial constraints, lack of contact with colleagues, bored of every day life."*

"Being out of work is driving me to 'want to work'. However, finding a suitable alternative work situation is proving difficult."

"My illness means that I am housebound now. I would love to do a course or some further education aimed at people like me and maybe even gain employment from home if I could."

RTW employment options

"I would like a better work-life balance. For reasons of childcare and other things, working a traditional 9-5 day would suit me better than working shifts and weekends as I do now."

"I really want to go back to work, however, changes will have to take place in the workplace for this to happen. I became absent with stress and anxiety after I had asked management to reduce my workload as I felt under too much pressure. They did not fulfil my request. For me to go back we will have to meet each other half way."

"I have looked for work from the disability department of FAS. I applied for two jobs and was refused twice. I find there is no encouragement to get people who are long term absent back into the workplace."

"I would like to work a 4-day week or to have a chance to job-share"

Workplace support or other support

"I am very bitter – I have received no support or contact from my workplace. I was there for 10 years. It is as though they don't care"

"I think a more proactive element provided by the health service for example, psychologist, counsellor or someone else who would help people in their return to work would be very useful."

Other comments

"I hope this study will be distributed to management. Managers who are not good at people and management skills do not realise the damage they can do to employees."

4 Conclusions

4.1 Absence threshold

The absence threshold varied according to the reason for absence and the factors attributed to absence we multi-faceted in most cases. Absence thresholds in the case of spontaneous absence (sudden onset) were low whereas in the case of contemplated absence thresholds were much higher.

Many factors influenced the decision to take leave of absence or absence threshold. These include illness specific issues, work-related factors (work environment, problems with bullying, work overload), non-work factors (bereavement, relationship issues) and in many cases a combination of some or all of these.

For absentees who contemplated taking absence leave over a period of time, there were a number of factors that prevented them from taking leave earlier

- The build up or chronic underlying cause that took time to reach 'breaking point' (for all three illness types) or specifically in the case of mental illness a significant triggering event caused the absence
- Not wanting to yield to the problems (give in to a physical problem e.g. arthritis, in the case of mental / stress-related illness, stress, bullying) / the feeling that they could still manage their work despite their illness
- Financial – they could not afford to become absent
- Concern about their responsibilities - both family and staff

While LTA was experienced across all age groups, it appears to be more prevalent among middle aged people (40-55 year olds). This may be due life cycle events where family demands, career demands and financial demands are at their most prominent, also in the case of chronic illness it is more prevalent in older age groups.

4.2 The effect of long term absence on mental health

Long term absence had both a positive and a negative impact on mental health. Some people who were absent for reasons of physical illnesses and did not report mental health problems initially reported that they were experiencing psychological distress in later sections of the interview. The main symptom reported in these cases was depression and lowered self-esteem. Also many of those who classified themselves as absent due to co-morbid illnesses reported that their physical illness came first and was followed by the mental illness after a period of absence. However, it was not always clear from the interviews that the physical illness preceded the mental symptoms. On the other hand, some of the respondents absent for mental health reasons, particularly stress and anxiety, reported mental health improvements when they stopped working. Many commented that it was a relief to have one less thing to cope with and to be able to focus on becoming well again.

4.3 Prevention

Few respondents reported that there was anything they, themselves could have done to prevent their absence. In the case of those who were absent for physical health reasons this may be expected. Where suggestions were made these concerned reducing their workload or slowing-down. None of those absent for stress-related / mental illness thought that there was anything they, personally, could do to prevent

their illness (despite mentioning issues such as on-going relationship problems). This might suggest that some people in this group had a lack of personal responsibility for dealing with aspects of their personal lives that may have contributed to their illness.

The impact of the workplace on the health of employees should not be underestimated. A number of LTAs with physical illnesses mentioned that there were actions their workplace could have undertaken e.g. in the case of someone with back problems – reduce the lifting aspect of the job, reduce his workload. The majority of respondents absent due to stress-related / mental illness or co-morbid illnesses felt that workplace actions, such as: reducing workload, dealing with bullying, changing working hours, could have helped to prevent their illness. Findings also suggest that workplaces need to have greater awareness of the needs of employees with chronic illnesses.

4.4 Decision making / support around absence

A range of people / professionals were involved in the decision to take leave of absence. GPs emerged as the main people consulted. This finding has implications for this group regarding training around dealing with work absence and their role in the return to work process.

Within the workplace the main support around absenteeism prior to absence came from colleagues followed by supervisors and least frequently by managers. The many examples of where positive support 'nudged' the LTA to seek help suggests that employee awareness of illness and also management / supervisors awareness of the indicators of illness are important.

4.5 Impact on families

The most notable impact in Ireland is the dramatic financial effect that absence has on families. The majority of LTAs were on social welfare benefits only (with no top ups from their workplaces). This represented a significant drop in earnings for LTAs. These financial effects only served to increase the pressure already felt by many LTAs.

From the many positive impacts reported by respondents, it is apparent that more family friendly work-practices are required to maintain these positive effects when LTAs return to work. Impacts such as improvements in relationships, more time to spend with children and doing domestic duties (such as housework, shopping, childcare) illustrate the lack of work-life balance in family situations prior to absence.

Negative impacts were mainly experienced as increased tension in the family and occurred, due to the illness or due to household / family routines being hindered by the newly absent person. The main negative impacts experienced by the individual were loss of social contacts / network from workplace, loss of self-esteem, concerns about future workability and guilt about being absent. These findings suggest that more support targeted at the psychosocial aspects of LTA is required during the absence process.

4.6 Return to work threshold

There were three main types of return to work scenarios reported. The most common was the same job with the same employer (partially / completely), some returned to different work conditions with the same employer and one to a different employer. The majority of respondents were not returned to work at the time of the interviews.

The majority of LTAs returned to work when they felt ready to do so. The main reason given for return-to-work was because of improved health status and conversely, the main reason for no return-to-work was continued ill-health. For other LTAs who had returned to work, the motivating factors were financial (couldn't survive on state payments or the company benefits were being stopped), boredom, needed stimulation and social contact outside the home. In these cases, it may be questioned whether LTAs were completely ready to return-to-work.

Findings from the study suggest a variety of actions that were perceived by LTAs as important in their motivation to return to work. A number of LTAs suggested that on-going contact with the company was important and the nature of this contact is critical. From the study, contact that merely sought to find out when the LTA would return to work or was made only to ask them to submit medical information was perceived as very negative. LTAs wished to feel valued and feel that their employers were concerned about their well-being. Of course in situations where conflict between LTA and employer was implicated in the absence, both the LTA and the employer may prefer to have no contact.

The importance of interventions such as reduced working-time, altered work arrangements and gradual return-to-work need to be acknowledged by employers. These were mentioned as motivating factors, by many LTAs who were still absent. For some LTAs the only solution that would return them to work was to find a different job, in some cases this might require re-training.

Again psycho-social support for LTAs during the absence process was mentioned as important in the return to work threshold. LTAs talked about lacking in confidence and not being able to face returning to the same situation that they left, as reasons for not going back to work.

4.7 Decision-making/ support in RTW

The GP emerged as one of the critical people involved in the LTAs decision to return to work. This has implications for GP training to ensure that when GPs are engaged with LTAs they have the knowledge to support absence and RTW and that they are aware of the appropriate referral professionals. Other people important in the RTW decision were partners, other professionals and supervisors.

On return to work, many LTAs reported that very little support was available to them. For those who had support, colleagues were the main source, followed by supervisors. How support is managed upon RTW is important. Supervisors and colleagues need to be briefed about any limitations they might expect and how they could make the transition more easy for LTAs.

4.8 General comments

The dramatic changes in the Irish economy over the previous 10 years has changed the society in which we live and the way we think about work and family. Responses confirmed that the pace of modern life, the pressures of dual working parents and the increase in materialism have more negative impacts on their lives. Respondents also talked about workers as less loyal because jobs are more plentiful. Given that they attributed some workplace absence to work conditions / poor work environment, social issues such as substance (primarily alcohol) abuse and some due to parental responsibilities calls for more action in relation to work practices, greater awareness on the dangers of substance abuse and more work-life balance programmes.

5 Recommendations

This Chapter outlines the main recommendations to come from the Irish qualitative study. These relate to:

- Increasing information and awareness for employers and employees
- Improving health promotion measures in the workplace
- Improving levels and types of contacts with the absentee
- Providing return to work options for the absentee
- Providing return to work programmes
- Improving rehabilitation measures
- Providing work-life balance options
- Examining the benefits system

These are outlined below.

1. Improving information and awareness

The levels of information and awareness of the issue of stress related absenteeism available to both employers and employees need to be improved. Currently, it appears that employees have little insight into stress and its consequences while employers tend not to act either at all or only in relation to prevention.

- Employees need to take a more proactive approach to stress related causes of absence. In particular, they need to be aware of the dangers in delaying absence – this common coping mechanism often leads to a prolongation of the absence period and can make illness more severe and impact negatively on recovery time.

- Employers need a greater level of general awareness of mental health issues and a knowledge of the signs which can assist in recognising onset of both physical and mental health problems

- Employers need greater knowledge of the contribution of work related issues to the causation or exacerbation of mental health problems

- Employers need to improve the quality of their contacts with the absentee. These should be early, regular and constructive rather than being absent or damaging, as they can often be.

- People in the workplace (and this applies especially to supervisory levels) need greater knowledge of the importance of dealing well with mental health issues amongst the workforce. Currently, such knowledge appears at a low level, and there are consequences for the employee both during the lead up to the absence period. During absence and upon returning to work.

2. Health promotion at work

Health promotion at the workplace can help address the issues associated with mental health and stress related absenteeism. This approach can have a positive effect both as a means of helping prevent absenteeism and also in relation to assisting in the return to work process. The specific recommendations are:

- Run programmes and provide access to information on health promotion and mental health promotion

- Increase awareness that timely (early) treatment to prevent more serious illness is an effective strategy for preventing longer term absenteeism.

- For families of people with stress-related/ mental health issues – Provide information about illness and mental health, what to expect when it happens, possible treatments for health conditions and what will be the role and actions of the employer.

- Consider setting up or providing access to support groups for absentee and for families.

- Findings from the study indicate that poor management skills (e.g. lack of or poor communications, lack of support in stress/bullying situations, unrealistic expectations) impact on employee health and well-being. Management training in this regard is essential as part of company health policy.

- Introduce employee health monitoring to identify people at an earlier stage of illness. This can be achieved through periodic health screening or as part of performance monitoring.

- Implement stress prevention programmes in the workplace. These can help prevent mental health problems and will help introduce appropriate management structures and policies and will also support employees with mental health problems.

3. Contact with absent employees and with services

The type and frequency of contact which the employer has with the absent employee can play a crucial role in determining the success of a return to work strategy. However, this is usually a problematic area with contact either being absent or minimal or else it is perceived as being threatening by the employee. The recommendations below address this important area from the employer's perspective.

- Establish a clear policy on contacts between employer and employee as part of employment contracts. This should state clearly the behaviours expected of both parties and should indicate that the aim of such contacts is to assist in the recovery and return to work process. It should also indicate that the employer may be in contact with the medical advisors of the employee. Establishing such a clear policy has the effect of removing uncertainty and suspicion of contacts from employers when they do occur. In addition, making clear the employer's genuine concern about the employee is more likely to encourage an earlier return to work.

- Contacts between the employee and the workplace should not be limited to official contacts only – informal contacts between workmates and supervisors and the absentee are beneficial to maintaining the link between the absentee and the workplace.

- When the absentee returns to work, the quality of supervisor contact plays ban important role in ensuring a successful return. Supervisors (and fellow workmates) need to understand the terms under which the employee is returning and to be supportive and accommodating to the returnee.

- Employers should make available a list of appropriate referrals or contacts available to the HR section for giving with employees if required.

- Employers should seek contact with the services which are treating the absentee. This may be arranged through a third party (such as an occupational health service) or directly. The aim of such contacts is to obtain information about the conditions under which the absentee may return to work.

4. Return to work programmes/disability management strategy

A key failing in the return to work process for absentees is a failure of policy and service co-ordination. The services involved often fail to adequately communicate and plan while both the employer and particularly the employee often feel that there is little planning of a coherent return to work process. This failing may be addressed by all of the parties involved adopting a coherent return to work strategy which is based on the principles of disability management.

- Employers should adopt a coherent policy of supporting Return to Work - this involves a range of actions including the provision of a range of return to work options, increasing the levels of awareness of staff involved, developing the role of a return to work co-ordinator. (More detail can be found on www.wrc-research.ie/return).

- Service suppliers (e.g. general practitioners, rehabilitation services, benefits agencies, vocational training agencies, insurers) need to adopt a disability strategy to improve the effectiveness of return to work efforts. This would involve communication and co-ordination of efforts between service suppliers, adopting a policy active return to work, developing links with employers and proactively managing the case of people who are absent from work. (See www.wrc-research.ie/return for details).

- Health assessments of absentees need to change their focus from assessing levels of disability towards assessing levels of residual ability to work. This has the effect of encouraging both the individual and the employer to focus on return to work.

- Employers need to play a more active role in return to work strategies, as the focus of many of the problems associated with absence are felt most acutely at the level of the employer and the employee. This may be achieved in a number of ways, e.g. through the assignment of responsibility for managing return to work, through the provision of financial or procedural incentives.

- There are a range of options available to an employer to ease the transition from absence to work. These include making available transitional work options to the returnee, active job matching, redeployment of the returnee, job design and work organisation strategies, the provisions of technical aids and redesigning the work environment. These measures may apply to people

with all types of impairment. However, for people returning to work following mental health difficulties, measures such as transitional work arrangements are especially important.

5. Work life balance

This study found that for many people with mental health problems, the experience of making the transition from work to absence was positive, at least initially. In addition, the study found that many people with incipient mental health difficulties were contemplating absence for a long time before making the decision to absent themselves from work. These findings suggest that the following kinds of interventions may help prevent absence from occurring or may help in reducing the length of absence should it occur.

- Employers should consider introducing or extending measures which promote work-life balance. These may have the effect of providing more time off work for people who are considering absence.

- Employers need to consider introducing early warning systems to identify people who may be considering absence. These could formal or informal. For example, formal systems could include health screening, or staff surveys. Informal systems could include supervisory staff or peers identifying staff under stress. (Such a system would need training to be provided to staff and a strong element of confidentiality designed into it).

6. Payments and benefits

All benefits system contains within its structures and policies the power to incentivise or disincentivise the individual in relation to claiming benefits in the first instance or in relation to returning to work. There are a number of benefits disincentives and traps which may serve to exacerbate the problems associated with absence from work, especially where absence is a relatively long-term phenomenon. Firstly, levels of short term sickness benefits in Ireland are relatively low by EU standards, while levels of long terms sickness benefits are very low by these standards. (Employers may make up the difference between benefits and take home pay in the case of short terms sickness benefits).

This regime of low benefits can have unintended effects (apart from the financial consequences for employers, employees and the State). For example, low benefits levels may discourage people from going absent for a time, thereby ensuring that when they eventually do go absent they do so for more serious health reasons (in more technical terms, the inflow to the system is relatively high and the outflows from the system are relatively low). There is evidence from the study that systems with relatively high levels of benefits can shorten the length of absence. For example, the Netherlands has a high inflow, high outflow system and has a return to work rate which is more than twice as high as the Irish rate.

Another feature of the Irish benefits system is its relative inflexibility and the time it takes to respond to changes in circumstance of the individual. For example, when a person returns to work, they may have to work a back week or month, while benefits are cut off immediately upon work resumption. Other problems may include the loss of ancillary benefits for the individual – these may exceed the amounts earned from work and in this case may act as a barrier to returning to work.

Another feature of the Irish benefits system is that it has traditionally acted almost solely as an income replacement system. In this regard it differs from many Continental European systems which are based on a social insurance model. In these systems, benefits payments are often linked to efforts to return to work. In the Netherlands this has been taken further, with employers also having a mandatory role in promoting early and timely return to work. In practice, the benefits system is linked to the behaviour of the individual, the service suppliers (e.g. medical, rehabilitation, vocational) and in some cases, the employer. Though understanding the precise mechanisms and actions of these systems is difficult, it is clear that linking benefits systems to the other systems involved in preparing the individual for return to work carries a clear capacity for building incentives for all stakeholders to promote safe and timely return to work.

These considerations lead to a recommendation to review the role of and the operation of the benefits system as it applies to both short and long-term benefits payments. This should focus on how the system is linked to the other systems which operate (health, rehabilitation, labour market) and to the other main stakeholders (especially the employer and the service providers). It should also review its focus on being an income replacement system rather than on being a return to work system.

This review should also focus on how the system operates, i.e. on how it creates, incentives, disincentives and benefits traps. A key theme in such a review should be to examine ways in which to introduce flexibility into the system.

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