



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

Work Package 7
Family Study

The Netherlands

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Contents

1	Introduction.....	4
1.1	Background on work and families	4
1.2	The National system for absence management.....	7
1.3	Innovative nature of the study.....	10
1.3.1	Aims of the study	10
1.3.2	Why adopt a family perspective?.....	10
1.3.3	The process of becoming absent and returning to work	11
1.3.4	Generating hypotheses for further analyses	12
2	Methodology.....	16
3	Findings	19
3.1	Absence threshold.....	19
3.1.1	Factors that prompted absence from work.....	19
3.1.2	Time considered to take leave of absence.....	20
3.1.3	Problems experienced before sick leave	21
3.1.4	Other people involved in the decision to take absence from work	21
3.2	Factors preventing LTA taking absence from work	22
3.2.1	Actions taken to prevent absence from work.....	22
3.2.2	Actions that could have been taken to prevent absence from work.....	23
3.2.3	Discuss health problems at work prior to sickness absence.....	24
3.2.4	Discuss health problems outside the workplace prior to sickness absence.....	25
3.2.5	Things that could have been done to handle partner's absence better	26
3.3	Impact of absence on individual and family	26
3.3.1	Impact on LTA	26
3.3.2	Impact on partner	28
3.3.3	Impact on children	29
3.3.4	Impact on other dependants	30
3.3.5	Positive and negative impacts on LTA's household.....	30
3.4	LTAs who have (partly or fully) returned to work	31
3.4.1	Factors that influenced LTA's return to work	31
3.4.2	Other people involved in the LTA's decision to return to work	32
3.4.3	Kind of support LTA would have liked to receive	33
3.4.4	Significant issues/problems LTA faced on return to work	34
3.4.5	Support during return to work	34
3.4.6	Situation in which LTAs return to work.....	35
3.4.7	Reception on return to work	36
3.4.8	Other things that (could) have been done to help LTA return to work.....	36
3.4.9	Impact of LTA's return to work on family	37
3.4.10	Partner's view on return to work	37
3.5	LTAs who have not returned to work yet	38
3.5.1	Factors preventing the LTA to return to work	39
3.5.2	Things companies could do to better facilitate RTW.....	40
3.5.3	Contact with workplace during absence	40
3.5.4	Partner's view	41
3.6	Rehabilitation.....	41
3.6.1	Rehabilitation program	41
3.6.2	Other services, programmes or activities contributed to the LTA's recovery	43

3.7	General issues	43
3.7.1	How changes in the way we work and live affect quality of life / levels of stress	43
3.7.2	Main factors affecting absence in the LTA's workplace	44
3.7.3	Changes in society that influence absenteeism	44
3.7.4	Opportunity for comments.....	45
4	Discussion	46
4.1	Absence threshold.....	46
4.2	Factors preventing LTA taking absence from work	46
4.3	Impact on LTA and family	46
4.4	LTAs who have returned to work	47
4.5	LTAs who have not returned to work	47
4.6	Rehabilitation.....	48
5	Recommendations.....	49
5.1	Training regarding identifying signs of mental health problems and awareness raising of mental health problems.....	49
5.2	Inform employees/ employers regarding obligations and rights according to Gate Keeper Act	49
5.3	Remain contact during sickness absence	49
5.4	A well-designed RTW plan	49
5.5	Importance of timing in return to work and gradual return to work	49
5.6	OHP and health improvement.....	50
5.7	Co-ordination of information between OHP and other health professionals	50

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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 the Netherlands, women's participation in the labour force has increased from about 40% in 1981 to over 70% 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 that 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 Work Package 2 of the Stress Impact project. However, it is worthwhile to recall some of the main elements of the *Dutch* system here in order to aid in the interpretation of results from this part of the study.

- Income replacement policies - In the Netherlands, employers are obligated to continue paying sickness benefits (70% of a person's wages) for a period of 104 weeks. In most collective labour agreements (CAOs), it is agreed that the employers supplement this payment, to a maximum of 170% of the annual wage over two years. Employers do not have to continue paying wages if employees have deliberately caused their sickness, if they hinder their recovery, or if do not accept an adjusted job in their own or in another organization. There are (private) insurances for employers that (partly) cover the costs resulting from sickness absenteeism.
- Employees may apply for a disability benefit after an uninterrupted period of 104 weeks. Employees may receive disability benefits if they are unable -fully or partially- to earn with customary labour the income of a comparable healthy person, as a result of disease or impairment. Customary labour refers to all possible jobs for a person: all generally accepted work that a person could do. Earning capacity should be reduced by at least 15%. The height of the disability benefit and the duration of entitlement vary according to age, the level of wages formerly earned, and the loss of earning capacity.
- Rehabilitation system - Employers and employees have the obligation to engage in activation/reintegration activities in the first two years of sickness. These obligations are specified in the Gatekeeper Act. Furthermore, the act defines the responsibilities of the institutions that are involved: the occupational health and safety services (Arbodiensten) are the consultants for the employers and employees, whereas the Workers Insurance Authority (UWV) is responsible for evaluating reintegration efforts.
- Role of the employer - As described above, the employer has to continue sickness benefits for the first (two) year(s) of the employee's sickness absence and has obligations with respect to their activities aimed at activation/reintegration. Employ-

ees have obligations as well regarding their activities aimed at activation/reintegration.

- Role of occupational and public health - In the Netherlands in general both Occupational health physician (OHS Service) and General Practitioner are involved when employees become sick. All companies in the Netherlands are obligated to have professional assistance in preventing and dealing with sickness absence. They can choose to obtain this assistance from an Occupational Health and Safety Service (OHS Service; Arbodienst), possibly in-company, but also from a professional specialized in the prevention of (long-term) absence. In addition, Occupational Health and Safety Services provide the main (obligatory) services of Sickness Absence Guidance. As part of the Gatekeeper Improvement Act, the OHS Service must determine within 6 weeks of absence whether the absence will be long term. It must also determine what the possibilities are for preventing long-term absence and for promoting reintegration of the sick employee. The OHS Service must report this to the employer. The sickness absence guidance is mainly the responsibility of the Occupational Health Physician within the OHS Service. Employees often consult their General Practitioner regarding their health complaints. The main task of the General Practitioner is to guard and improve the employees' health by making an early and adequate diagnosis, providing an adequate treatment, referring to medical specialist, and helping to guide employees with health problems back to normal functioning in their daily life. Because both GP and OHP are involved when employees become sick it is important that GP and OHP co-operate and communicate with one another to avoid differences in diagnosis and treatment and conflicting advice. Unfortunately, communication between these parties is poor.
- The role of labour market agencies - In July 1998, the *Act on Vocational Rehabilitation (REA)* was brought into effect. This act aims to prevent the outflow of disabled workers from the labour market and to (re)integrate unemployed people who are incapacitated for work. REA consists of several types of instruments for employers, for disabled workers or disabled people in the open labour market, and for self-employed or people starting up self-employment. For employers, there are the following instruments:
 - If employers have doubts about the hiring of a handicapped person with a (partial or full) unemployment benefit, they can hire this person the first six months for free.
 - In the first year of employment employers receive a reduction in contribution (for WAO and unemployment benefits) and, if necessary, a subsidy for extra costs. For employees older than 58 years, employers receive an additional reduction in contribution.
 - Employers can get a wage dispensation in case of insufficient performance by the employee.
 - For the first 5 years, the employer does not have to pay wages in case of sickness and the employee is not included in the calculation of the Pemba contribution, in case of disability. The period of 5 years can be extended if there is a heightened chance of sickness or disability.

There are various instruments for employees. Employed people may get a reintegration allowance if they receive an education. They may also use certain services to help them perform their work, such as an interpreter for the deaf, transport to and from work, and specially adapted chairs or computers. Employees may also ask for a personal budget, which they can spend on services that may ameliorate

their position on the labour market, such as employment-finding and career counselling.

- Health insurance - More than 60 % of the Dutch is insured for costs of sickness under the Health Insurance Act. This act covers 'normal' costs of sickness, such as a doctor's visit or medication. This act is meant for employees and their families, but also for people that are entitled to benefits and self-employed. If the income of employees reaches a certain maximum level, one should insure oneself against sickness with a private insurance.

1.3 Innovative nature of the study

1.3.1 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 influence 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.

1.3.2 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 that 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 organisa-

tional 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 that 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 that 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.

1.3.3 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 that 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 that may be needed, particularly in relation to factors that are neither work nor health related.

1.3.4 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 that 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.

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2 Methodology

In this study we have interviewed a sample of Long Term Absent Employees (LTAs). Our objective was to interview 20 LTAs with physical health complaints, 20 LTAs with mental health complaints and 10 LTAs with co-morbid health complaints, as well as the LTA's partner (if LTA is married or cohabiting). Also, efforts were made to include a wide range of people (e.g. with or without children, single or couple, returned or not returned to work, man or woman, older and younger people).

We approached LTAs who had participated in the survey study of the Stress Impact Project and had agreed to take part in a further study. We contacted the LTA by phone and asked if he/she and his/her partner were willing to co-operate in allowing an additional interview. If individuals were willing to participate in the interview, we made an appointment for the interview and sent them a letter confirming the interview, an informed consent form, and a topic list for the interview.

Although it was very difficult to get in touch with the LTAs and partners, they were generally quite willing to cooperate in the interview study. However, in 16 cases the LTA or partner did not agree with the partner interview. The main reasons for these refusals were: (1) the partner was too busy, (2) the partner was not willing to co-operate, (3) the partner would not have additional comments, and (4) the partner had a difficult time as well (e.g. health problems or problems at home). In one case, only the partner participated because the LTA did not speak Dutch well enough.

Eventually, we conducted 50 LTA interviews and 24 partner interviews. The number of conducted interviews with LTAs with physical, mental, and co-morbid health complaints, the number of interviews with their partner, as well as the general characteristics of the interviewed LTAs, are displayed in table 2.1

Table 2.1 Number of conducted interviews with LTAs with physical, mental, and co-morbid health complaints, number of interviews with their partner, and general characteristics of the interviewed LTAs

	Main reason for current absence:			Total (N)
	Physical (N) ¹	Mental (N) ²	Co-morbid (N) ³	
<i>Number of interviews:</i>				
- LTA	19	19	12	50
- Partner	7*	12	5	24
<i>Return to work LTA:</i>				
- Not	5	3	4	12
- Partly	3	3	1	7
- Completely	11	13	7	31
<i>Family type:</i>				
- Couple	4	6	2	12
- Couple with children	12	9	7	28
- Single	3	2	1	6
- Single with children	-	2	2	3
<i>Income:</i>				
- Single income	3	5	4	12
- Dual income	13	14	8	35

	Main reason for current absence:			Total (N)
	Physical (N) ¹	Mental (N) ²	Co-morbid (N) ³	
- Unknown	3	-	-	3
<i>Gender LTA:</i>				
- Male	11	9	2	22
- Female	8	10	10	28
<i>Average age LTA in years</i>	43.16 (SD=7.08)	45.24 (SD=9.55)	45.92 (SD=8.23)	44.58 (SD=8.22)
<i>Education level LTA:</i>				
- Up to lower professional education	7	1	3	11
- Intermediate general and professional education	4	7	3	14
- Completed high school	3	1	-	4
- Higher professional education	4	5	6	15
- Academic education and higher	1	5	-	6
<i>Work sector LTA:</i>				
- Agriculture, fishing and forestry	-	-	-	-
- Manufacturing	4	2	1	7
- Building & construction	1	-	-	1
- Trade (retail & wholesale)	3	2	-	5
- Hotels & restaurants	-	-	1	1
- Transport, storage & communication	1	-	2	3
- Banking, insurance & financial services	3	3	-	6
- Public administration	1	3	1	5
- Education	2	4	5	11
- Health & Social work	4	5	1	10
- Other community, social and personal activities	-	-	-	-
- Recreational, cultural and sporting activities	-	-	1	1
<i>Average score on CES-D scale; 10 items; 1=not-4=highly depressive</i>	7.26 (SD=5.31)	12.67 (SD=7.18)	12.42 (SD=6.65)	10.56 (SD=6.78)
<i>Average score on Exhaustion scale; 8 items; 1=not-4=highly exhausted</i>	2.24 (SD=0.57)	2.89 (SD=0.61)	2.55 (SD=0.54)	2.56 (SD=0.63)
<i>Average score on Disengagement scale; 8 items; 1=not-4=highly disengaged</i>	2.14 (SD=0.53)	2.58 (SD=0.43)	2.23 (SD=0.44)	2.33 (SD=0.50)
<i>Average score on General self-efficacy scale; 10 items; 10=low-4=high</i>	32.53 (SD=5.66)	29.88 (SD=5.28)	29.50 (SD=5.05)	30.79 (SD=5.44)

¹ LTAs with physical health problems reported sick due to back pain (n=5), neck, shoulder and arm/hand problems (n=3), problems at lower extremities (n=4), injury from accidents (n=3), respiratory disease (n=1), neurological disease (n=1), birth defects (n=1), and other medical conditions (n=1).

² LTAs with mental health problems reported mental disorders such as burnout, overstrain/fatigue/tension, depression, and mourning.

³ LTAs with co-morbid health problems reported sick due to mental disorders (n=3), injury from accident (n=1), problems at the lower extremities (n=1), cardiovascular disease (n=1), chronic fatigue syndrome (n=1), and skin disease (n=1). Other medical conditions that were mentioned include fibromyalgia and fatigue (n=1), osteoporosis (n=1), haemorrhage in the neck (n=1), and posttraumatic dystrophy (n=1).

As shown in table 2.1, LTAs with mental health problems generally had less favourable scores on the scales for self-esteem, depression and burnout (emotional exhaustion and disengagement). These were followed by LTAs with co-morbid health problems, while the average scores of LTAs with physical health problems on these scales were relatively favourable.

For the in-depth interviews, separate semi-structured interview protocols were used for the LTA and the partner. Both protocols addressed the following issues:

- a. absence threshold (e.g. what made an LTA report sick; problems experienced before sick leave; who was involved in the decision);
- b. prevention of absence (e.g. what could have been done to prevent absence; did LTA receive support/advice from anybody at work or outside work; was this support/advice useful or not);
- c. impact of absence on individual and family (e.g. what were consequences for individual, partner, children and other dependants; have these consequences changed over period of absence);
- d. return to work, questions for those who have resumed work (e.g. what factors influenced the LTA's return to work; who was involved in the decision to report sick and in what way; problems/issues LTA faced while returning to work);
- e. return to work, questions for those who are still absent (e.g. what is preventing LTA from going back to work; what could promote return to work; contact with the workplace);
- f. rehabilitation (e.g. participation of rehabilitation program; content and usefulness of the program; other programs or activities that contributed to rehabilitation);
- g. general questions (e.g. main factors that affect absence in the LTA's workplace; impact of changes in society on absenteeism from the workplace; other relevant additional information).

The interviews were conducted by phone and were recorded for coding purposes. Most interviews were conducted in the period January 13th to March 10th 2005.

3 Findings

In this chapter we describe the interview results for each of the following themes: absence threshold (3.1), factors preventing return to work (3.2), impact of absence on individual and family (3.3), questions for LTAs who have and have not returned to work (3.4 and 3.5), use of rehabilitation programs (3.6), and some general questions (3.7). Our main focus will be on describing the results for the total group of LTAs. We will also compare the answers provided by LTAs and those provided by their partners. In addition, we will describe differences between LTAs by:

- diagnostic group (main reason of absence: physical / mental / co-morbid)
- work resumption (full / partial / not)
- family type (couple / single, children / no children)

We have to note that most LTAs had returned to work at the time of the interview and most LTAs had a partner and children (see also table 2.1 of chapter 2). Therefore, the groups that we created differ in size. Furthermore, we will not describe differences between LTAs by income situation (dual/single income), because this distinction overlaps largely with the distinction based on family type (couple versus single).

3.1 Absence threshold

In this section we describe the period prior to the LTA's sickness absence. We describe the factors that prompted the LTA's absence from work, the period of time during which the LTA considered taking leave of absence, the problems the LTA experienced before becoming absent, and the individuals who were involved in the LTA's decision to take absence from work.

Main findings:

- Factors that prompted absence from work were physical health problems, work related factors, psychosomatic/mental health complaints, home-related factors or a combination of these factors. These factors differed between LTAs with physical and mental health problems.
- Physical health problems more often had a sudden onset, while mental health problems more often built up over time.
- Time considered to take absence leave varied from zero to over more than one year.
- LTAs experienced a wide range of psychosomatic and/or mental problems before sick leave. These problems differed between LTAs with physical and mental health problems.
- In more than half of the cases no one else was involved in the LTA's decision to take absence leave. When someone else was involved, this was mainly someone outside the workplace such as significant other, General Practitioner or other medical professional.

3.1.1 Factors that prompted absence from work

LTAs mentioned a wide range of factors that prompted them to take absence leave. These factors were related to physical health problems, mental health problems, home-related factors, work-related factors and combinations of these factors.

The types of factors seem to vary between diagnostic groups. LTAs with *physical* health problems (n=19) generally mentioned factors that were related to their physical health (for example: pain, inability to walk, memory and hearing loss, side effects of medication). In 5 cases these physical health problems were work related, such as an

injury from accident at work or a wrong working position. Also, in quite a few cases the physical health problems had a sudden onset (e.g. brain haemorrhage, accident, whiplash).

LTA with physical health problems – sudden onset

LTA got a brain haemorrhage resulting in memory and hearing loss. After the haemorrhage the LTA's sense of hearing was only functioning for 40%. Because this was an acute situation, the LTA had had no time to consider taking absence leave. LTA also had diabetes, but he could work with that.

LTAs with *mental* health problems (n=19) mentioned a variety of work-related factors, psychosomatic/mental health complaints, home-related factors, or a combination of these types of factors. Examples of work-related factors were problems with one's boss, high work pressure, and a reorganisation. Examples of psychosomatic or mental health complaints were sleeping problems, pain in chest, concentration problems, and anxiety disorders. Cited home-related factors were bereavement and adultery committed by a partner. Mental health problems in general seemed to have built up over time.

LTA with mental health problems

LTA was a group leader for children with language and/or speech disorders who got a difficult group of children with behavior problems and low IQ. Some of these children were not in the right place. Consequently, working with these children on a daily basis drove LTA to the edge. The LTA was very tired but kept on working because she did not want the children get her under. Before the LTA became absent she was extremely tired and could stay in bed all weekend. The General Practitioner said the LTA was overstrained and burned out. He advised her to stay home. LTA followed the GP's advice and did not go to work for 3 months.

LTAs with *co-morbid* health problems cited factors related to both physical and mental health problems, work-related factors, home-related factors, or a combination of these factors.

When we compared the LTA's answer with the answer of the significant other, it turned out that in most cases both answers were comparable. In 5 cases, however, partners mentioned additional factors that promoted the LTA's absence from work (e.g. partner adds work-related factors, factors in the home situation, health complaints).

3.1.2 Time considered to take leave of absence

About 40% of the LTAs had not considered taking leave of absence (see table 3.1). These individuals mentioned a sudden onset of their (health) problems or indicated that they were not aware of the seriousness of their health problems. The other 60% of the LTAs did consider taking leave of absence for a period of time varying from a couple of days or weeks to a couple of months or even more than a year. These individuals decided to continue working, sometimes part-time, until the health complaints became too severe.

Inspection of Table 3.1 suggests that individuals with physical health complaints were less likely to have considered taking absence leave.

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

Considered taking absence	Main reason for current absence:			Total
	Physical	Mental	Co-morbid	

leave:	(N)	(N)	(N)	
No/not applicable	9	7	5	21
Yes	10	12	7	29

The LTA's answers to the question "For how long (days/weeks) before you became absent from work were you considering taking absence leave?" generally were comparable with the answers of their significant other and in most cases both answers were comparable. In 2 cases, however, the significant other stated that the LTA had never considered taking absence from work, while the LTA told us that they had thought about it for about 2 months or a couple of weeks.

3.1.3 Problems experienced before sick leave

LTAs mentioned experiencing various problems just before becoming absent. These problems encompassed both physical health problems and mental health problems.

The problems experienced before sick leave vary between diagnostic groups. Problems and symptoms mentioned by LTAs with *physical* health problems were mainly of a physical nature (for instance, pain, concentration problems, shivering and fatigue, difficulty or not being able to walk or move legs). LTAs with *mental* health problems mainly reported problems and symptoms of a psychosomatic or mental nature (for instance, trouble sleeping, tension, aggressiveness, emotional or crying fits, exhaustion, tiredness, difficulty to relax, trembling, sweating). LTAs with *co-morbid* health problems cited both physical and mental health problems/symptoms immediately before becoming absent.

Answers of the LTA and the significant other did not always converge. In 2 cases, the significant other did not mention work-related factors. In 3 other cases, the significant other and the partner did not agree on the presence or severity of physical or mental health complaints.

3.1.4 Other people involved in the decision to take absence from work

More than half of the LTAs reported that there was no one else involved in their decision to take leave of absence (see table 3.2). When people were involved in the LTA's decision to take absence leave, these individuals were mainly people outside the workplace (n=18), such as the significant other, the general practitioner, or other medical professional. In only 7 cases someone at work was involved in the LTA's decision to take leave of absence, such as the occupational health physician, the team leader, a colleague, or a company nurse. These professionals generally advised or agreed with the LTA's decision to take sick leave. Four LTAs who mentioned no one else was involved in the decision to take sick leave, reported that they had discussed this matter with someone else, but made the decision by themselves.

We found some differences between diagnostic groups with respect to the people who were involved in the decision to take sick leave. LTAs with co-morbid and physical health complaints reported more often that there was no one else involved in their decision, compared to LTAs with mental health problems. Furthermore, LTAs with *physical* health complaints primarily involved the general practitioner or other medical professional, whereas LTAs with *mental* health complaints primarily involved the general practitioner, their partner and/or someone at work. LTAs with *co-morbid* health complaints primarily involved the general practitioner/other medical professional or their partner.

Table 3.2 Number of LTAs who mentioned someone was involved in their decision to take absence leave by main reason for current absence

Someone else involved in LTA's decision to take absence leave:	Main reason for current absence:			Total
	Physical (N)	Mental (N)	Co-morbid (N)	
No	11	9	9	29
Yes:	8	10	3	21
- someone at work	1	4	1	7
- someone outside work	7	8	3	18

In 7 cases the LTA mentioned that his or her significant other was involved in the decision to take absence leave, 6 LTAs with partner and children (≤ 18 years of age), and 1 LTA with partner and no children.

There were hardly any differences in the LTA's and the partner view with respect to the individuals who were involved in the decision to take leave of absence. In cases of divergence, the partner generally mentioned fewer persons who were involved.

3.2 Factors preventing LTA taking absence from work

In this section we describe what has been done to prevent the LTA from taking absence from work. We describe which actions have been taken and could have been taken by the LTA, his/her work environment or someone else. We also describe with whom the LTA discussed his or her health problems prior to absence.

Main findings:

- Few LTAs felt that something (else) could have been done by themselves, their employer, or someone else to prevent their absence from work.
- A relatively large number of LTAs with mental health problems felt something (else) could have been done by themselves or their work environment to prevent their absence leave.
- At work LTAs discussed their health problems mainly with colleagues and/or their manager. The support/advice that was offered included social and emotional support, advice on how to cope, and understanding of the LTAs condition.
- Outside work LTAs discussed their health problems mainly with partner, family, and/or friends. The support/advice they offered included practical help, social support, and distraction.

3.2.1 Actions taken to prevent absence from work

According to most LTAs nothing had been done by themselves, the work environment or anyone else to prevent absence from work (see table 3.3). Reasons for the fact that no action had been taken refer to a sudden onset of health problems or the LTA's lack of awareness regarding the severity of his/her health problems. In 17 of the 50 cases LTAs mentioned something had been done by themselves to prevent absence from work. Some examples of preventive actions were: discussing problems at work, asking for reduction in tasks and responsibilities, seeing a therapist, and having healthy lifestyle. In 5 cases LTAs reported something had been done by the work environment, for instance, offering support or psychological help, promoting safe work, and a reduction of hours or tasks.

Actions to prevent absence differed between diagnostic groups. LTAs with mental health problems more often mentioned they had done something themselves to prevent

them taking absence from work compared to LTAs with physical health problems and LTAs with co-morbid health problems.

Table 3.3 Number of LTAs who mention preventive measures were taken by themselves, work environment and/or someone else by main reason for current absence

Measures to prevent LTA from taking absence taken by:		Main reason for current absence:			Total
		Physical (N)	Mental (N)	Co-morbid (N)	
LTA	Yes	4	10	3	17
	No	15	9	9	33
Work environment	Yes	2	2	1	5
	No	17	17	11	45
Someone else	Yes	0	1	0	1
	No	19	18	12	49

In only a few cases the partner's view on what had been done to prevent the LTA to take absence from work differed from the LTA's view. In three cases the significant other reported fewer (or no) preventive measures that were taken to prevent absence.

3.2.2 Actions that could have been taken to prevent absence from work

Most LTAs felt that nothing else could have been done to prevent the LTA taking absence from work (see table 3.4). LTAs mentioned, among other things, that they could not do anything else, that their sickness absence could not have been prevented, or that everything possible had been done.

18 of the 50 LTAs said that they could have undertaken action themselves to prevent absence from work. And in 21 cases, the LTA believed that the work environment could have done something else to prevent the LTA taking absence from work. Actions from the work environment had mainly to do with the employer or manager taking a more pro-active and supportive attitude. Four LTAs reported someone else could have done something to prevent them from taking leave of absence. These other individuals included hospitals (reduction of waiting lists), the significant other, a mental coach, and a medical specialist (sooner diagnosis).

Table 3.4 Number of LTAs who mentioned other preventive measures could have been taken by themselves, work environment and/or someone else by main reason for current absence

Measures could have been taken to prevent LTA from taking absence by:		Main reason for current absence:			Total
		Physical (N)	Mental (N)	Co-morbid (N)	
LTA	Yes	2	12	4	18
	No	17	7	8	32
Work environment	Yes	4	13	4	21
	No	15	6	8	29
Someone else	Yes	1	1	2	4
	No	18	18	10	46

LTAs with mental health complaints more often thought that preventive action could have been taken by themselves and the work environment. Actions that LTAs with *mental* health complaints could have undertaken encompassed: standing up for oneself,

discussing one's problems at work, being less hard on oneself, and facing one's problems.

LTA with mental health problems

Before the LTA got absent she had frequently mentioned to her manager that the work pressure was too high. The LTA had asked for a meeting to talk about it to try and find some solutions for the problem. But this meeting did not occur, although more colleagues at work had troubles with setting their own boundaries and got overstrained. LTA even offered to lower her wage in exchange for being excused from client-related tasks, but the manager thought that was a poor idea. At work LTA received support from colleagues, but not from her manager. Looking backward, LTA believes that she should have stood up more for herself and should have protested more when she noticed she did not feel well. LTA tried too hard to please everybody and to live up to all expectations. Her employer, on the other hand, could have tried to find out what caused the LTA's complaints and find solutions for these problems.

Preventive actions that LTAs with *co-morbid* and *physical* health problems mentioned were: taking leave of absence sooner, listening more carefully to one's own body, improving communication with management, and following the advice of the general practitioner.

LTA with co-morbid health complaints

LTA became absent because of a combination of factors in her home situation (she got divorced, her father died, she had to take care of her mother, and her brother had trouble). Before the LTA became absent, she had discussed her health problems with her manager and colleagues. Her manager tried to find out what he could change for the LTA at work and if he or the LTA's colleagues could take over some of the LTA's tasks. Some of LTA's colleagues also offered to take over some of her tasks. The LTA was very pleased that these people were willing to do something for her.

In half of the cases there are no significant differences in the LTA's answers and the partner's answers. However, in 5 cases the significant other mentioned nothing could have been done to prevent LTA from taking absence leave, while the LTA mentioned something could have been done by one or more parties. In one case the significant other mentioned that the LTA him/herself could have done something (refusing extra work) and the employer could have done something (not imposing extra work), while the LTA believed nothing could have been done. In 2 cases the LTA and significant other mentioned different things that could have been done to prevent the LTA's absence from work.

3.2.3 Discuss health problems at work prior to sickness absence

About one third of the LTAs did not discuss their health problems at work prior to sickness absence. Reasons mentioned by some of these LTAs for not consulting someone in the workplace were: sudden onset of health problems, denial by LTA of health problems, and unwillingness of employer to listen to LTA.

When the LTA did consult someone at the workplace this person was mainly a colleague (n=26) and/or manager (n=18). The types of support and/or advice received from these persons were, among other things: emotional/social support, advice on how to cope, and understanding of the LTA's situation. LTA mentioned several aspects in which this support was helpful, such as feeling understood, feeling that one is not alone, and receiving help and understanding. However, LTAs also brought forward

aspects in which the support was not helpful, such as impractical advice and inadequate problem solving.

Other people at work consulted by LTAs prior to taking absence from work were the occupational health physician (n=2), company nurse (n=1) and company welfare worker (n=1).

LTAs with physical health problems were less likely to consult someone in the workplace compared to LTAs with mental and co-morbid health complaints (see table 3.5).

Table 3.5 Number of LTAs who discussed health problems with people at work by main reason for current absence

LTAs discuss health problems with someone at work:	Main reason for current absence:			Total
	Physical (N)	Mental (N)	Co-morbid (N)	
Yes	11	15	9	35
No	8	4	3	15

3.2.4 Discuss health problems outside the workplace prior to sickness absence

Some of the LTAs mentioned that they had not consulted anyone outside the workplace prior to taking absence leave (see table 3.6).

Table 3.6 Number of LTAs who discussed health problems with people outside the workplace by main reason for current absence

LTA discusses health problems with someone outside workplace:	Main reason for current absence:			Total
	Physical (N)	Mental (N)	Co-morbid (N)	
Yes	16	17	10	43
No	3	2	2	7

LTAs mainly discussed their health problems with their partner (n=20), children (n=7), (extended) family (n=13), or friends (n=17). Help offered by family and friends encompassed practical help (e.g. help in the household), social and emotional support (e.g. letting the LTA feel understood), advice and tips (e.g. slow down, stand up for yourself), and distraction.

The LTAs found this advice and support useful, in that, it felt good to talk about one's problems, it was nice to be heard, and to be understood. Especially LTAs with mental health problems mentioned that it felt good to have someone who cared and stood by them, also in bad times. Furthermore, the support gave confidence that things would turn out right, and helped LTAs to clear the situation and look at their own part in this. In addition, practical help and advice was found useful.

The aspects of the advice and support that was not useful, according to some LTAs, was that the advice was not always practical (e.g. when the LTA got the advice to leave the employer, while the LTA needed her income as a single parent), or that it did not change or solve the situation.

The GP was consulted in 8 cases. The GP gave information, referred, and advised LTA to take more breaks during work, to slow down, to listen to him or herself, and to take leave of absence. The aspects of the GP's advice and support which were useful, were that it was practical (e.g. prescribe medicine), that it led to a reduction of health complaints, that it confirmed the LTA's thoughts, and that it was nice to be heard and to be understood. Some LTAs mentioned the advice and/or support was not useful, because

the health complaints did not diminish, or because the GP prescribed medication the LTA did not want to use.

Finally, in 3 cases other professionals outside the workplace were mentioned by the LTA, including a psychologist, haptonomist, psychologists, doctors, and an alternative treatment practitioner.

3.2.5 *Things that could have been done to handle partner's absence better*

In the opinion of 7 interviewed significant others something could have been done to handle their partner's absence better. In 6 of these cases the significant other mentioned the employer or manager could have done something (e.g., the employer should have kept more in touch with LTA and could have offered other work). In the seventh case the significant other mentioned that the medical treatment (by a physiotherapist) had had adverse effects.

A total of 17 significant others thought that nothing could have been done to handle their partner's sickness absence better. In general, everything necessary had been done, or nothing else could have been done.

3.3 Impact of absence on individual and family

In this section we describe the negative and positive consequences of the LTA's absence on the LTA, his or her significant other, their children, other dependants, and the LTA's household.

Main findings:

- The LTA's absence mainly had emotional consequences for the LTA him/herself, referring to their mental state, difficulties with being home all the time and not being able to do anything, and feeling guilty.
- The LTA's absence mainly had emotional and domestic consequences for the partner, including worrying about LTA, dealing with LTA's bad mood, more household chores, and taking care of the children.
- The LTA's absence mainly had emotional and relational consequences for the children, such as the LTA was not always nice company, or it was nice that LTA was home.
- Overall, most LTAs mentioned both positive and negative impacts of their absence on their household. Positive aspects included that LTA saw things more in perspective, and had more time for the family and other activities. Negative aspects were that other family members had to help in the household, and that tensions at home occurred.
- Looking back, LTAs with mental health problems relatively often viewed their sickness absence as a positive thing that had to happen to them.
- Overall, financial consequences for LTA and family were limited.

3.3.1 *Impact on LTA*

LTAs mainly cited emotional, relational, and financial consequences of their sickness absence for them personally.

Emotional consequences mentioned by LTAs referred to their mental state (e.g. hard period, feeling down, worry), difficulties with being home all day and/or not being able to do anything, and feeling guilty (e.g. toward colleagues). Consequences that had to do with one's *self-esteem* concerned feelings of failure and loss of self-esteem.

Relational consequences mainly referred to tension at home because of LTAs being home all day and not feeling well, not being able to participate in family life like they used to, and loss of social contacts (e.g. with colleagues).

Financial consequences mainly refer to a drop in wage (loss of salary or bonuses). Financial consequences were related to having problems with housing (problems with selling the house, paying the rent for 2 houses), having a partner who does not work (or works part-time), and having children to take care of.

Other consequences referred to spending time at home (e.g. finding another job, spending time on hobbies), realizing what one's limits are, and realizing what is really important in life.

LTAs with physical problems mentioned financial and relational consequences more often compared to LTAs with mental and co-morbid health problems. LTAs with mental health problems reported more often consequences on self-esteem factors and other factors (being glad it happened to them).

Furthermore, there were some differences in types of emotional factors mentioned by LTAs with physical, mental and co-morbid health complaints. LTAs with physical health problems mentioned difficulties with being home all day and/or not being able to do anything and feeling guilty more often, while LTAs with mental and co-morbid health problems more often cited their mental state (emotional factors).

LTA with physical health complaints

LTA is a school director who could not work because of physical health problems. Emotionally this was hard, because the LTA is kind of a workaholic and is not the type to do nothing. He is now gradually returning to work, but it is hard for him to let other people do part of his tasks. He always did the job by himself and now he needs another person to assist him. That is annoying and feels unpleasant. Also, the LTA is physically unstable, has lower energy levels, is less alert, and his thinking ability is limited due to the use of strong painkillers. LTA finds his situation very difficult. Regarding the relations at home, LTA is not able to do the things with his family he used to do in a normal family situation.

Most LTAs reported that something had changed over the period of absence (see table 3.7). LTAs with *mental* health problems, compared with LTA's with physical or co-morbid health problems, reported more often that their situation had improved during the period of absence. These LTAs mentioned for example that first they had a hard time sitting at home and being in a poor mental state, but later on they accepted and recognised their situation, calmed down, learned from it, and started to focus on other things such as finding a new job or social activities.

LTA with mental health problems

LTA felt she was an enormous failure because of her absence from work. In the beginning of the absence period, she found it very difficult to be at home all day and to accept that she was in a bad state. Eventually, she accepted this and learned to use her absence period in a useful way (she had to go to therapy 3 days a week). Moreover, she noticed that, after becoming absent an enormous pressure had fallen from her shoulders. Before she became absent, going to work every day was a matter of 'surviving' every day. After her sickness absence this stopped.

LTAs with *physical* or *co-morbid* problems more often reported that their situation had gotten worse over time. For instance, they got more and more irritable and lazy over time, they became more depressed or felt trapped into their situation.

Table 3.7 Changes in consequences of absence for LTA personally over the period of absence by main reason for current absence

Have consequences changed during period of absence:	Main reason for current absence:			Total
	Physical (N)	Mental (N)	Co-morbid (N)	
No/not applicable	6	4	5	15
Yes:	11	12	6	29
- Improved	5	11	2	18
- Got worse	6	2	4	12
- Unclear	1	-	-	1
Unknown/unclear	1	2	1	4

3.3.2 Impact on partner

According to 32 LTAs their absence from work had had consequences for their partner. LTAs with *physical* health problems mentioned mainly domestic consequences; the partner had to do more in the household and care for children and LTA. LTAs with *mental* health problems more often reported emotional and relational consequences, for example: partner worried about LTA, partner had to endure emotional outbursts of partner, or partner thought it was nice and cosy that LTA was at home.

In 11 cases the partner's view differed from the LTA's view regarding the consequences of absence for the partner. In these cases, both parties mentioned different consequences or one of the parties mentioned additional consequences.

Some examples in which the partner added additional consequences

- The partner cited that the absence had had considerable financial consequences and that their lives had changed a lot (they went out less often and the amount of social contacts had decreased).
- The partner told that for months she felt that she had lost her husband (changed into another person); he used to be a caring and considerate husband, but now he was occupied with himself and was not open/receptive to his family.
- The partner mentioned that small irritations and tension at home had arisen because he had to do more in the household.

In 19 cases the consequences for the partner had changed over the period of absence (see table 3.8). In 8 cases consequences had gotten worse. For example, the LTA became less cheerful during the absence period, the relationship between the partner and LTA deteriorated, or the tension at home increased. In 8 cases (mainly mental health cases) the consequences for the partner had improved. For example, the partner's worries decreased because the LTA's situation improved, or the LTA got more energy and was able to do more in the household.

Table 3.8 Changes in consequences of absence for partner over the period of absence by main reason for current absence

Have consequences for partner changed during period of absence:	Main reason for current absence:			Total
	Physical (N)	Mental (N)	Co-morbid (N)	
No/not applicable	12	9	10	31
Yes:	7	10	2	19
- Improved	1	6	1	8
- Got worse	4	3	1	8
- Unclear	2	1	-	3

In 7 cases, it emerged that the way in which LTA's viewed the effect their absence and subsequent consequences relating to this absence had on their relationship with their partner, differed from their partners views. In most of these cases, one of the parties mentioned the consequences for the partner had not changed over time, while the other partner said they had. For example, in one case the LTA mentioned that the situation had improved for her partner, while the partner mentioned that their relationship had deteriorated and had grown silent over time.

3.3.3 Impact on children

Half of the LTAs cited their absence had consequences for their children. The consequences for the children, as a result of the LTA's sickness absence, were mainly of relational and emotional nature. For example, the LTA was not able to do the things with the children he/she used to do (e.g. playing, helping with homework), and the LTA was not always nice company (e.g. LTA was tired, irritable). It was also mentioned that the children had a hard time (were tense, rebellious, worried). However, it was also reported that children sometimes liked that the LTA was at home.

LTAs with physical health problems more often reported they could no longer do the things with their children they used to do. In contrast, LTAs with mental health problems more often mentioned that they were not nice company for the children.

LTA with physical health problems

LTA used to play and run with his children, but after his absence this was not possible anymore. LTA has to be careful with his leg and is limited in the things he can do. At first the children liked it that their father was home all day. On the other hand, the LTA could no longer do the things he used to do and was not always as kind to his children as he was before.

In 6 cases the LTA's view on the consequences of absence for the children differed from their partner's view. In most of these cases one party mentioned that the absence had had no consequences or only positive consequences for the children, while the other party reported negative consequences.

As shown in table 3.9, in 14 cases the consequences of the LTA's absence for their children (of 18 years and younger) had changed over the absence period. In most cases (mainly mental health cases) the situation had improved for the children. Over time LTA was able to do more, paid more attention, got more relaxed, or the children got used to the situation. In 4 cases (all physical health cases) the consequences for the children had gotten worse. For example, the LTA's mood got worse over time, or the children got more worried when absence continued.

Table 3.9 Changes in consequences of absence for children (18 years and younger) over the period of absence by main reason for current absence

Have consequences for children changed during period of absence:	Main reason for current absence:			Total
	Physical (N)	Mental (N)	Co-morbid (N)	
No/not applicable	13	12	10	35
Yes:	6	6	2	14
- Improved	2	5	1	8
- Got worse	4	-	-	4
- Ups and downs (waves)	-	1	-	1

- Unclear	-	-	1	1
Unknown/unclear	-	1	-	1

3.3.4 Impact on other dependants

In only 3 cases the LTA's sickness absence had consequences for other dependants. In one of these cases, the LTA was no longer able to take part in the care for her handicapped brother. In another case, the LTA took leave from work to have more time for her father. In the third case, the LTA reported that her mother and aunt's sister now received less care. In none of the cases the consequences for the other dependants changed during the absence period.

In one case, the LTA's perception about consequences for other dependants did not converge with the perception of the partner. The LTA mentioned not being responsible for any other dependants. However, his significant other mentioned they used to visit LTA's mother and the significant other's handicapped sister together on a regular basis, and after the LTA was absent from work the significant other took over this responsibility.

3.3.5 Positive and negative impacts on LTA's household

There have been positive and negative impacts on the LTA's household due to LTA's absence (see table 3.10). In most cases LTAs mentioned their absence had both positive and negative impacts on their household. Positive impacts were mainly that LTAs had learned more about themselves, had learned to focus on other things, and saw things in perspective again. It was also mentioned that they had more time for family, household and/or other activities. Negative impacts of LTA's absence on household had to do with no longer being able to do the things the LTA used to do (in the household, with the family, in social life), tensions at home, and the additional help needed from family members for the LTA and/or the household.

LTA with mental health problems

Overall, a positive consequence of LTA's absence on the household is that LTA is more aware of the fact that there is more to life than only his work and that these other things deserve more of his time and attention. A negative consequence of his absence for the family was that, in the beginning, the LTA sat home all day doing nothing and was moody and irritated.

LTAs with physical health problems more often reported only negative consequences, whereas LTAs with mental health problems more often reported only positive consequences.

Table 3.10 Positive and negative impacts on the household by main reason for current absence

	Main reason for current absence:			Total
	Physical (N)	Mental (N)	Co-morbid (N)	
Impacts on household:				
No impact	3	2	2	7
Only positive impacts	1	5	4	10
Only negative impacts	8	1	4	13
Both positive and negative impacts	7	11	2	20

The answers of the LTAs and their partner regarding the positive and negative consequences for the household are more or less in line with one another. In some cases, however, there were some real differences. One of the parties mentioned a positive or negative impact while the other partner did not, or both parties mentioned different positive or negative impacts. For example, the LTA mentioned there were no positive consequences, while the partner felt that the LTA had become a more open person, which was a very positive change.

3.4 LTAs who have (partly or fully) returned to work

In this section we describe the return to work process of LTAs who (partly or fully) have returned to work. We will describe the factors that influenced the LTA's return to work (RTW), the involvement of other individuals in the LTA's decision to RTW, the problems LTAs encountered during RTW, the support LTAs received during RTW, the way in which the LTA had returned to work (e.g. same or different job), the LTA's perception on RTW, other things that (could) have been done to help LTA return to work, and the impact of the LTA's RTW had on the family.

Main findings:

- Main factors that influenced return to work were improved health, own decision or initiative to RTW, and advice of the OHS Service.
- Main parties involved in the decision to return to work were the Occupational Health Physician/ the OHS Service and/or employer; they gave advice on RTW, thought along with LTA on how to improve health and facilitate return to work, and made a return to work plan.
- Especially LTAs with mental health problems experienced problems on their return to work, referring to the relationships with manager and/or colleagues and the demands of the job.
- LTAs mainly received support in their return to work from their manager and/or colleagues, including social and emotional support as well as practical support.
- Most LTAs returned to work in the same job with the same employer, but under (temporarily) different conditions.

As shown in the table below 31 LTAs have fully returned to work, and 7 LTAs have partly returned to work.

Table 3.11 Number of LTAs who fully, partly and not returned to work by main reason for current absence

Return to work:	Main reason for current absence:			Total
	Physical (N)	Mental (N)	Co-morbid (N)	
Not	5	3	4	12
Partly	3	3	1	7
Fully	11	13	7	31

3.4.1 Factors that influenced LTA's return to work

Main reasons for LTA's to return to work were their improved health, their own wish to return to work (e.g., they looked forward to return to work, they feared they would lose their job, or did not want to receive a disability benefit), or the OHS Service's advice was to return to work (see table 3.12).

LTAs were not always pleased with the OHP's advice (e.g. LTA felt pushed, advice came too soon). In some other cases, however, the LTAs were pleased with the OHP's

advice (e.g., the OHP protected LTA, made a careful plan to return to work, or slowed LTA down).

In four cases, LTAs reported that adjustments in the workplace influenced their return to work (e.g., colleagues took over some of the tasks, LTA got a new ergonomically adjusted workplace).

LTAs with physical health problems more often mentioned their improved health as a factor that influenced their return to work, while LTAs with mental health problems more often mentioned the OHP's advice.

Table 3.12 Factors that influenced LTA's return to work by main reason for current absence

Factors that influenced LTA's return to work:	Main reason for current absence:			Total
	Physical (N)	Mental (N)	Co-morbid (N)	
Health improved	8	4	5	17
LTA's own initiative/will/choice	3	5	4	12
Advised by OHS Service	1	8	1	10
Other	1	4	2	7

3.4.2 Other people involved in the LTA's decision to return to work

In most cases someone else was involved in the LTA's decision to return to work (see table 3.13). These other people mainly concerned the occupational health physician, the manager, or the OHS Service. Other people involved were professionals such as a physiotherapist, a psychologist, a welfare worker, a general practitioner, and a psychotherapist.

The people involved in the LTA's decision to return to work mostly discussed the return to work with the LTA (leading to an agreement on return to work), gave LTA advice on RTW, or made a return to work plan. Topics that they discussed or advised on concerned mainly the date and strategy of RTW (e.g. gradually RTW, workplace adjustments, other job).

In 3 cases the occupational health physician decided in a directive manner when and how the LTA should return to work. In one of these cases, for example, the occupational health physician put the LTA under pressure to return to work in another job.

Also, in 5 cases there were differences in opinion about work resumption. For instance, in 2 cases the LTA wanted to return to work or made a return to work plan with the manager, while the occupational health physician did not agree.

Table 3.13 Other parties involved in the LTA's decision return to work by main reason for current absence

Other parties involved in the LTA's decision to return to work:	Main reason for current absence:			Total
	Physical (N)	Mental (N)	Co-morbid (N)	
No	5	2	2	9
Yes:	9	14	6	29
- employer/manager/boss	5	2	4	11
- occupational health physician	3	11	4	18
- health and safety service (professionals)	3	3	1	7
- other people	1	6	2	9

About half of the LTAs shared the opinion that the other people's involvement in their decision to return to work was useful (see table 3.14).

Table 3.14 Usefulness of the involvement of other parties in the LTA's decision to return to work by main reason for current absence

In what way was involvement of other parties in the decision to return to work (not) useful:	Main reason for current absence:			Total
	Physical (N)	Mental (N)	Co-morbid (N)	
Useful	2	10	3	15
Not useful	2	3	1	6
Both (useful and not useful)	4	1	2	7

The useful element of their involvement concerned mainly the following issues:

- they slowed the LTA down in returning to work,
- they gave the LTA the possibility to return to work in his or her own way,
- the LTA felt supported, heard, and stimulated.

In 2 cases, the LTA also mentioned that it was good that the occupational health physician put pressure on them to return to work.

LTA with mental health problems

The LTA received good support and guidance from the occupational health physician. The occupational health physician talked to the LTA's manager when the manager gave LTA a hard time. The occupational health physician also helped the LTA to return to work, which was a difficult step for her. He made a return to work plan for LTA including gradually building up the working hours. When necessary, the occupational health physician delayed the return to work scheme. The return to work plan was a great help for LTA and the occupational health physician made her feel safe and supported. Also important was the fact that LTA wanted to return to work herself and that she had had some consultations with a coach.

When the involvement of other people was not considered useful, the following reasons were put forward:

- they wanted the LTA to return to work too soon,
- they followed the rules too tightly and did not look at the individual case,
- their help was not necessary.

LTA with mental health problems

The first time, the LTA returned to work because the occupational health physician thought it was time. However, this was not the LTA's choice and the LTA had to stop working again. The second time, LTA decided himself when to start his return to work. According to the LTA the occupational health physician misjudged the LTA's situation and the right time to return to work.

3.4.3 Kind of support LTA would have liked to receive

In 16 cases the LTA would have preferred not to have received any additional support after the support he or she had initially received (see table 3.15). In 15 cases the support could have been better, for example the manager and/or occupational health physician should have shown a more supportive attitude and should have put less pressure on LTA to return to work. Another example given was that the occupational health physician should have looked more at the individual and less at the specific standards and rules for recovery.

In the other 7 cases the LTA did not know what kind of support he would have liked to receive, or did not need or expect support from others.

Table 3.15 Kind of support LTA would have liked to receive by main reason for current absence

Kind of support LTA would have liked to receive:	Main reason for current absence:			Total
	Physical (N)	Mental (N)	Co-morbid (N)	
No other support needed	6	8	2	16
Would have expected more support	6	5	4	15
Didn't need support	1	-	-	1
Didn't expect support	1	1	1	3
Don't know	-	2	1	3

3.4.4 Significant issues/problems LTA faced on return to work

Most LTAs, especially LTAs with mental health problems, reported issues or problems they encountered during return to work (see table 3.16).

Table 3.16 Significant issues/problems LTA faced on return to work by main reason for current absence

Issues/problems LTA faced on return to work:	Main reason for current absence:			Total
	Physical (N)	Mental (N)	Co-morbid (N)	
No	8	3	3	14
Yes	6	13	5	24

LTAs with *physical* health problems mostly mentioned their physical limitations (e.g., LTA could not make certain movements, LTA was in pain). LTAs with *mental* health problems mainly referred to relationships with the manager and colleagues (e.g., manager offered little support, demanded too much, colleagues did not know what to expect), and to the demands of the job (e.g. LTA was very tired after work, LTA was not ready yet to return to work). LTAs with *co-morbid* health problems mentioned similar problems as LTAs with mental health problems.

Problems experienced during the return to work

- LTA wanted to build up his return to work too soon, but the occupational health physician, company welfare worker and manager slowed LTA down. Furthermore, the LTA found it hard not to fall back into his usual patterns.
- LTA noticed during his return to work that nothing had changed and that he encountered the same problems. Nobody did anything about it. Just like before.

3.4.5 Support during return to work

During return to work, support was mostly provided by colleagues and the manager (see table 3.17). The kind of support being offered could be divided in two categories:

- *emotional and social support*: e.g., showing interest and sympathy, listening to the LTA's story.
- *practical support*: e.g., offering adjusted tasks, allow gradual return to work, warning LTA when he/she works too hard.

Table 3.17 People from who LTA received support during return to work by main reason for current absence

People who supported LTA during return to work:	Main reason for current absence:			Total
	Physical (N)	Mental (N)	Co-morbid (N)	
Colleagues	8	8	4	20
Manager	7	8	1	16
Occupational health physician	1	2	1	4
Other people at work	1	2	-	3
Professionals outside work	1	2	1	4
Home/partner/friends	1	2	-	3
Nobody	2	2	3	7

As shown in table 3.18, most LTAs found other people's support during their return to work helpful. Examples of how support from other people was useful can be seen below:

- colleagues showed understanding,
- it was nice to be able to talk to colleagues about the situation,
- colleagues and manager gave the LTA the feeling that nothing was wrong with him/her,
- LTA could leave some of his tasks and responsibilities to others.

Aspects of the support LTAs experienced as unhelpful were for instance:

- the colleagues asked the LTA to do things he could not do (because of his injury),
- the manager did not make any arrangements,
- the colleagues did not stand up for LTA.

Table 3.18 Extent to which LTAs find other people's support during return to work helpful by main reason for current absence

Did LTA find this support helpful or unhelpful:	Main reason for current absence:			Total
	Physical (N)	Mental (N)	Co-morbid (N)	
Helpful	6	14	2	22
Unhelpful	-	-	-	-
Both helpful and unhelpful	3	2	2	7
Not applicable	4	-	2	6

3.4.6 Situation in which LTAs return to work

Most LTAs returned to work in the same job with the same employer (see table 3.19). However, in 24 cases the LTA (temporarily) did not return to work under the same conditions (e.g., got other tasks, worked less hours, got workplace adjustments).

Table 3.19 LTAs' return to work situation by main reason for current absence

Situation in which LTA returned to work:	Main reason for current absence:			Total
	Physical (N)	Mental (N)	Co-morbid (N)	
Same job with the same employer	10	12	5	27
Other job with the same employer	3	3	2	8
Same job with different employer	-	-	1	1
Other job with different employer	1	1	-	2
Return to work under the same conditions:				
Yes	5	6	3	14

No	9	10	5	24
This situation most suitable option for LTA:				
Yes	11	13	7	31
No	1	3	1	5
Yes and no	1	-	-	1
Don't know	1	-	-	1

A total of 31 LTAs considered the way in which they returned to work as the best strategy available to them at that time. Explanations for this were mostly that the LTA had recovered well enough, that the LTA could not do the old job anymore, and that the LTA still liked his or her job.

Reasons why return to work in same job with the same employer was the best option

- LTA would not have wanted it any other way. He has a nice job, and works with a nice group of teachers and pupils with whom he has good contacts. There are some interesting developments going on at school regarding renewals in education. The LTA did not want to miss that. He also would not know what other work he would like to do.
- LTA mentioned it was not her work that caused her sickness absence, so she could return to work to her old job. If her sickness absence had been caused by her work, she would not have wanted to return to the same job with the same employer.

There were 5 cases in which the LTA mentioned that there could have been a better strategy for them to return to work, such as:

- gradual work resumption (LTA got panic attacks during return to work),
- obtaining a different position (LTA got trapped in same situation as before his absence),
- more discussion with supervisor about returning to old job (LTA wanted to return to the old job),
- more time needed for return to work (LTA returned to work too soon).

3.4.7 Reception on return to work

In most cases LTA's reception from colleagues (n=29) and supervisor (n=23) on return to work was good. Most colleagues and supervisors reacted positively (e.g., they gave a warm welcome, showed understanding, were supportive). However, in some cases the LTA had not received a warm welcome from the colleagues (n=4) or supervisor (n=8). In only some of the cases LTA's mentioned a good reception from the managers. This was related to the fact that the managers did not play a major role in the return to work process. When the reception was good, the kind of reception was comparable with the reception of the supervisors and colleagues. In some cases, reception on return to work was not applicable, because the LTA returned to a new job.

3.4.8 Other things that (could) have been done to help LTA return to work

In 22 cases other things have been done to help LTA to return to work (see table 3.20). This mainly involved the LTA's own effort to find treatment for his or her health problems, to arrange his or her return to work, or to find another job.

Table 3.20 Other things that have been done to help LTA return to work by main reason for current absence

Other things that have been done:	Main reason for current absence:			Total
	Physical	Mental	Co-morbid	

	(N)	(N)	(N)	
Nothing	3	3	5	11
Not applicable	3	1	1	5
Yes	8	12	2	22

Things that the work environment could have been done were for example, give LTA the feeling he or she is welcome and needed, and think along with LTA on how to improve the LTA's health and facilitate the LTA's return to work. A thing that the LTA could have done was to stand up for him/herself, and to be open about how he/she was really doing. Things that could have been done by other persons were for instance, the OHP should have called LTA sooner for a consultation, or the OHP should have protected LTA and represent LTA's interests.

Table 3.21 Anything else that could have been done to help LTA return to work by main reason for current absence

Other things that could have been done by whom:	Main reason for current absence:			Total
	Physical (N)	Mental (N)	Co-morbid (N)	
Nothing	12	11	5	28
By LTA him/herself	1	-	1	2
By work environment	1	4	3	8
By other person	-	2	1	3

In most cases, the partners mentioned similar things that could have been done to promote RTW. There were only two cases where the answers were different, between LTA and their partner. In one of these cases, the partner mentioned that the LTA should have taken back her own work/job, as opposed to a different job position. In the other case, the health and safety service should have taken more action.

3.4.9 Impact of LTA's return to work on family

In general, the return to work did not have a large impact on the LTA's family unit (see table 3.22). The impact was, for example, that everything went back to normal, that the family income was secured, or that the relationship with children improved. In some cases the LTA mentioned that the return to work mainly had had an impact on his/herself (being glad to work again).

Table 3.22 Impact of the LTA's return to work on family by main reason for current absence

	Main reason for current absence:			Total
	Physical (N)	Mental (N)	Co-morbid (N)	
No/not applicable	6	8	5	19
Yes	8	8	3	19

3.4.10 Partner's view on return to work

Changes for LTA when LTA returned to work

In 4 out of 16 cases, the partner mentioned nothing or little had changed for the LTA when he or she returned to work. In 5 cases, partner mentioned RTW had a positive impact on the LTA. In 5 cases the return to work had both positive and negative effects on the LTA. Positive aspects for the LTA were, for instance, being among people

again, having a more regular life pattern, and feeling useful again. Negative aspects for the LTA were, for instance, being tired, being stressed, and taking more on than he/she could handle.

Changes for partner when LTA returned to work

In 5 cases, things did not really change for partner when LTA returned to work. In 4 cases, there were changes in the division of tasks in the household. In 4 cases, the partner was relieved that LTA returned to work (although in one case the partner soon noticed things were going wrong again). In 2 cases the partner had to get used to the situation, but eventually experienced it as a positive change. Also, in one case the partner mentioned that she had learned to be more considerate with LTA.

Changes for children when LTA returned to work

In 10 cases, the partner mentioned nothing had changed for the children when the LTA returned to work. In 3 cases, the partner mentioned that the LTA was not home anymore a lot of the time. In 2 cases, the children were glad that everything had gone back to normal again. In one case, the children were glad that they were allowed to do more things again and did not have to keep quiet all the time.

How LTA managed return to work

Almost all partners were positive about the way the LTA had managed his or her return to work. Partners mentioned for instance, that the LTA had worked extra hard to catch up, that the LTA had actively looked for help, and that the LTA had done everything to return to work. However, in one case the partner mentioned that LTA had let himself get carried away in his return to work and that sickness absence might occur again. Also, in two cases the partner mentioned that the LTA had returned (or may have returned) to work too early.

What could have been done to further promote LTA's RTW?

According to 11 partners nothing more could have been done by the LTA, his/her work environment or anyone else to further promote the LTA's return to work. In the other 5 cases the partner thought the work environment could have done something:

- employer could have supported LTA more,
- employer should have shown more interest,
- employer should have listened more to LTA.

3.5 LTAs who have not returned to work yet

In this section we describe the situation of LTAs who have not returned to work yet. We describe the factors that prevented RTW, the factors that could have promoted RTW, and the contacts with their workplace. As shown in table below 12 LTAs were still absent at the time of the interview.

Table 3.23 Number of LTAs who had not returned to work at the time of the interview and the number of interviewed partners by main reason for current absence

	Main reason for current absence:			Total
	Physical (N)	Mental (N)	Co-morbid (N)	
LTA	5	4	3	12
Partners	3	1	3	7

In general, LTAs who did not return to work scored less favourable on the depression scale (score=15.25), compared to LTAs who partly and fully returned to work (respectively score=7.54 and score=9.42). Also, LTAs who did not return to work scored less favourable on the self-esteem scale (score=27.33), compared to LTAs who partly returned to work (score=34.00) and fully returned to work (score=31.41).

Main findings

- Main factor preventing LTAs to return to work was their ill health.
- Most LTAs think nothing (else) could have been done to help LTA to return to work.
- Most LTAs remained in contact with their employer during their absence from work.

3.5.1 Factors preventing the LTA to return to work

The factor that was preventing all five absent LTAs with physical health problems to return to work is that they had not (yet) recovered from their health problems. All partners agreed with this statement.

In the psychological category, 2 LTAs had not returned to work because of the severity of their mental health problems, and the other 2 LTAs had not returned because there was no suitable work available. Their partners agreed with this statement.

Of the LTAs with co-morbid health problems, 2 had not returned to work because of the severity of their physical health problems, and 1 because the severity of their of mental health problems. All partners agreed with these statements.

Factors preventing LTA's return to work

- The LTA's physical health complaints (Parkinson disease) prevented the LTA's return to work. His work has become too heavy, because of his back and muscle pain and trembling.
- The LTA still had depressive moods and sudden spells of aggression, which made it impossible for LTA to start working again. LTA also had difficulties concentrating.
- Work was just not possible, because LTA was in too much pain and was not able to stand for long periods of time. She is work disabled.

3.5.1.1 What has and could have been done to help LTA return to work

According to 3 LTAs, nothing had been done to help the LTA get back to work. In 9 cases, LTA mentioned something had been done to help LTA return to work: the OHP had looked for more suitable jobs within the company (n=5), the LTA had been referred to a psychologist (n=2), or the LTA has had consultations with the OHP and the manager (n=2).

When the LTAs were asked if there was anything they could do themselves to help the return to work process, this question was often misinterpreted. In most cases, the LTA explained why there was nothing else that he/she could do. However, also some actions were mentioned, such as:

- the LTA should get stronger,
- the LTA should give signals when not feeling good,
- the LTA should be more active in social life.

When the LTAs were asked if there was anything their family could do to help them return to work, most LTAs answered ‘no’. One LTA mentioned that her family could help with the housekeeping.

According to 5 LTAs, there was nothing that could be done by anyone else to get them back to work. One LTA did not know what to answer. The other 6 LTAs mentioned that there was someone else who (or something else that) could help them to get back to work:

- Health & Safety Service,
- psychiatrist,
- flexibility of colleague,
- another job,
- guidance and encouragement.

3.5.2 *Things companies could do to better facilitate RTW*

The LTA was also asked how companies could improve their guidance to LTA’s. A summary of their answers:

- close and personal contact should be kept between company and LTA,
- the LTA should not be pushed too hard to resume work,
- a competent case manager should be assigned, who can mediate between the absentee and the employer,
- companies should take signals of stress seriously,
- the LTA should return to work as quickly as possible,
- the company should show understanding and acknowledgement for LTA,
- Occupational Health Physician and General Practitioner should be alert when employees have complaints.

3.5.3 *Contact with workplace during absence*

As shown in table 3.24 most people remained in contact with their employer during their absence from work. The nature of this contact consisted of:

- contact with management (concerning health condition),
- contacts with the Health & Safety Services,
- contacts with colleagues (sending cards and flowers),
- contact with OHP.

The aspects of this contact that proved helpful were that it was good to get appreciation and recognition from colleagues (n=4), that the OHP can provide other work and information (n=2), that the LTA is informed about the situation (n=2), and that it gave social support.

The unhelpful aspects of this contact were (n=3) that the help did not work for the LTA, that phone calls and emails were not returned, and that people sometimes only paid visits out of obligation.

Table 3.24 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:			Total
	Physical (N)	Mental (N)	Co-morbid (N)	
Contact	4	3	3	10
No contact	1	1	-	2

The type of contact LTAs ideally would like to receive from the workplace were as follows:

- more involvement,
- more frequent contact,
- more sincere and honest contact,
- more initiative from company,
- more effort in finding another job for LTA within own or other company.

Four LTAs mentioned the contact was good when it was received.

3.5.4 Partner's view

According to the partners, things that could be done to help LTA return to work were exercise/sports, adjusted or suitable work, relaxation, treatment by a psychiatrist, a peaceful workplace, and a gradual increase in the amount of working hours. According to 3 partners nothing could be done.

Advantages, of the LTA being absent from work, mentioned by the partners were that it is good for the children to have their father around (n=2), and that the LTA offered assistance in light housekeeping tasks (n=2). According to three LTAs there were no advantages.

Disadvantages mentioned by the partner were, for instance, the effects of the illness itself, the reduced opportunity to do fun things together, the deteriorated mood of the LTA, and tension caused by the new situation.

Three partners would like their partners to remain at home, mostly because the LTA's health condition would decrease if the LTA returned to work. Four partners would like the LTA to return to work, because this would be better for the LTA, or because the partner would have the house for him or herself again.

3.6 Rehabilitation

In this section we describe the return to work programs that have been offered to the LTAs as well as other services, programs and activities undertaken by LTA since becoming absent from work.

Main findings:

- Less than half of the LTAs have been offered a return to work program, which mainly involved making a return to work plan.
- These return to work programs mainly involved a plan or advice to gradually return to work.

3.6.1 Rehabilitation program

Only 40% of the LTAs had been offered a return to work program (see table 3.25). The return to work program mainly was discussed with the occupational health physician (n=12).

Table 3.25 Number of LTAs being offered a return to work program by main reason for current absence

	Main reason for current absence:			Total
	Physical (N)	Mental (N)	Co-morbid (N)	
LTA been offered a RTW program:				
No	14	8	8	30
Yes	5	12	4	20
With whom LTA discussed RTW program:				
Occupational health physician	4	6	2	12

OHP & other	-	2	1	3
Health and Safety inspector and manager	-	1	1	2
Manager	1	-	-	1
Psychologist	-	1	-	1

In most cases, the return to work program involved a return to work plan, which employee and manager were obliged to draw up according to the Gatekeeper Act. These return to work programs mainly involved a plan or advice to slowly increase the activity and amount of working hours (n=10). Other things mentioned were to adjust the LTA's tasks, and the advice to engage in cardio fitness, relaxation exercises, psycho-education and hydrotherapy. One LTA refused cooperation. She wanted to decide for herself whether she was able to work again. According to another LTA, the employer refused to accept the step-by-step plan.

In most cases the return to work program took place at the workplace (n=15). In one case the RTW program took place at the OHP's office, and in one case in another place. According to 3 LTA's this question was not applicable. People involved in the return to work program were the occupational health physician (n=15), employer/team manager (n=13), human resource department (n=1); psychologist (n=1); physiotherapist (n=1) and an ergotherapist (n=1).

Most LTAs found the return to work program useful (n=16). Some situations in which participants found the RTW programme, which was offered to them, useful were as follows:

- one could slowly increase the amount of working hours (n=6),
- the programme improved one's fitness (n=3),
- an external individual checked whether the agreements were being followed,
- time was provided to get over grief,
- one was working seriously on the problems.

LTA with mental health complaints – return to work plan

LTA made a return to work plan together with company welfare worker and manager. In the return to work plan they agreed on how to gradually build up the working hours and the LTA's tasks (preventing the LTA from biting off more she can chew). The LTA found the plan very useful. Having people around who know how to deal with her illness gave LTA something to hold on to. LTA is someone who wants to return to work too soon. Guidelines, which suggested what the LTA should and should not do, offered her support.

LTA with co-morbid health complaints – other rehabilitation program

An LTA who had cancer followed a rehabilitation program at a rehabilitation centre including cardio fitness, a course 'live with cancer', psycho education, sports, relaxation, and hydrotherapy. She discussed participation in this program with her oncologist, rehabilitation physician, occupational health physician, and management. The program was useful. 'You build up and work towards what you can handle physically. It improves your condition and it is a positive experience to be able to talk with other people who also have had cancer.'

In 2 cases LTA did not find the return to work program useful. In one case the LTA stated that there were no results at all. In the other case, the LTA did not believe in gradual work resumption ('one either goes to work full hours, or not at all').

Some LTAs made some suggestions on how to improve the return to work program. These suggestions mainly involved the OHP's role: the OHP should know more about worker's situation, the OHP should have given more guidance, or the OHP was difficult to get in touch with. In one case LTA mentioned that the employer was hindering the RTW process. Twelve LTAs who were offered a return to work program found the program useful.

LTA with mental health complaints

LTA made a return to work plan together with the return to work specialist of the OSH Service, advising LTA to gradually return to work and to try and ensure that the LTA was returning to a quiet and steady workplace. However, the employer did not listen and did not do anything with the plan. The employer could have arranged an alternative job for LTA, but that did not happen. It would have been helpful if the LTA could returned to a quiet workplace, with limited demands placed on the LTA and a supportive manager who solves problems that occur at the workplace. But the LTA's manager does not offer any help, so it does not work.

3.6.2 Other services, programmes or activities contributed to the LTA's recovery

LTAs mentioned all sorts of other services, programs and activities that they had engaged in. LTAs with physical health problems most frequently mentioned physiotherapy (n=7) followed by swimming (n=3), going for walks (n=3), and cycling (n=2). 4 LTAs with physical health problems had not engaged in any other service, programme or activity.

LTAs with mental health problems most often mentioned exercise/sports (n=8) and psychological therapy (n=7). Two LTAs with mental health problems had not engaged in any other service, programme or activity.

LTAs with co-morbid health problems mostly mentioned psychological therapy (n=3), physical therapy (n=2), and swimming (n=2). One LTA in the co-morbid category had not engaged in any other service, programme or activity.

Most activities mentioned above contributed to the return to work process.

3.7 General issues

In this section we describe the answers from LTAs and significant others to some general questions.

3.7.1 How changes in the way we work and live affect quality of life / levels of stress

We asked LTAs and their partners if and how changes in the way we work and live these days (more technology, work-life balance, diversity in the workplace) affect the LTA's or partner's quality of life or levels of stress. This question was often misunderstood or misinterpreted. As shown in the table below, 25 out of 70 of the interviewed gave evasive answers that could not be categorized as being yes, no or don't know. Those answers consisted mostly of recognition that work pace has increased, that work demands are higher nowadays, and that society has changed into a faster pace (8 answers).

Table 3.26 Answer of LTAs and partners to the question how changes in the way we work and live affect quality of live and levels of stress

Changes in way we work and live affect quality of life /			
levels of stress:	LTA	Partner	Total
Yes	17	5	22
No	15	3	18

Don't know	4	5	9
Evasive answer	14	11	25

Straightforward answers were clear and comprehensive. 17 LTAs and 5 partners agreed that changes in the way they work and live nowadays affect their quality of life and / or levels of stress. Reasons mentioned for this were, for instance, that life has become more hectic, that society focuses more on performance and results, that demands have increased, and that the use of computers has increased.

15 LTAs and 3 partners employees did not agree. Two LTAs stated that individuals just need to grow individually to keep up with societal growth. One LTA said that stress has nothing to do with society. One of the partners said that changes should be considered positive and seen as a challenge.

4 LTAs and 5 partners did not know whether to agree or not. Individuals sometimes wondered whether societal change is a cause for stress.

3.7.2 *Main factors affecting absence in the LTA's workplace*

The factors most often mentioned as affecting absence in the LTA's workplace was work pressure (n=30), followed by workload (7), reorganisations or large organisations (n=6), ill structured organisations or bad communication (n=6), tension at the workplace (n=5), physical factors (n=4) and employees having nothing to say (n=4). According to 10 LTAs and partners this question was not applicable and 9 LTAs and partner did not know what to answer.

It is remarkable that LTAs with physical health problems and their partners mentioned physical factors only once, whereas employees from the co-morbid category mentioned it three times. Furthermore, LTAs with physical health complaints and their partners mentioned workload more often compared to LTAs with mental or co-morbid health problems and their partners.

LTAs with mental health problems and their partners most often mentioned work pressure (n=12), tension on workplace (n=4), reorganisations / large organisations (n=4), ill-structured organisations / bad communication (n=3) and having nothing to say (n=3) as factors affecting absence in the LTA's workplace.

LTAs with co-morbid health complaints and their partner mainly mentioned work pressure (n=9), ill-structured organisations / bad communication (n=3) and physical factors (n=3)

3.7.3 *Changes in society that influence absenteeism*

The question whether societal change has an influence on absenteeism was confirmed by 42 participants (see table 3.27). These individuals gave the following explanations: higher work pace, higher prices, more work pressure, and higher expectations (e.g. employees are expected to be more highly qualified, to take initiative and be socially competent). One participant who answered 'no' to this question mentioned that one's character/coping abilities are more important than societal changes. Nine LTAs gave an answer that did not address the question in any form. This indicates that the question was not well understood by those participants. Interestingly, in 13 cases the partner's answers differed from the LTA's answer. Only 9 couples gave similar responses to the question.

Finally, it should be noted that this question has some resemblance to the first question of this section. The difference, however, is that the first question concerns their personal life and this question concerns society in general. 16 (out of 48) employees and 5 (out of 22) partners gave a similar answer to the first question, 32 employees and 17 partners did not.

Table 3.27 Answer of LTAs and partners to the question how changes in the way we work and live affect quality of live and levels of stress

Changes in society influence absence:	LTA	Partner	Total
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Yes	27	15	42
No	11	3	14
Don't know	6	3	9
Evasive answer	6	3	9

3.7.4 *Opportunity for comments*

19 respondents used the opportunity to add comments to the interview. Most participants who did not add comments thought that the interview had covered every subject possible.

Some complaints about society in general:

- Society has changed towards the idea that when somebody is sick, he or she is still able to perform other jobs/ things that do not involve the aspect of their work ability affected by the sickness. As a result, sick individuals get little chance to recover (n=1);
- Communication between the general practitioner and the occupational health physician is poor (n=1);
- Waiting times in hospitals are very long (n=1);
- There should be a faster reaction with absence-related issues. Also, schools should pay attention to the acquisition of skills such as responsibility and independence, how to deal with an employer, how to communicate in general (n=1);
- Every time when employee calls in sick for a short time, a lot of forms need to be filled out (n=1);
- People at work should find a balance in complimenting and criticizing one another (n=1).

One positive comment was that the guidance process for the LTA while absent and in their return-to-work was done very well by the health and safety service.

Some general comments:

- The questions were very difficult (n=1);
- Respondent does not understand why we conducted the interview (n=2);
- Respondent commented how valuable it is to do such research (n=2).

4 Discussion

4.1 Absence threshold

There are large differences between LTAs with physical health problems and LTAs with mental health problems regarding the absence threshold. Factors that prompted the absence of LTAs with physical health problems mainly concerned physical health complaints. These health complaints often had a sudden onset (e.g. accident, acute hernia, brain haemorrhage). In contrast, factors that prompted the absence of LTAs with mental health problems mainly concerned work-related factors, mental health complaints, and factors in the home situation. Their health complaints were more often cumulative. Furthermore, the problems experienced immediately before becoming absent from work differed between the two groups and closely reflected illness type.

It was also found that less than half of LTAs had involved another person in their decision to take absence from work. This other person mainly referred to someone outside the workplace (significant other, general practitioner, or medical specialist). LTAs with mental health problems were more likely to have involved another person in their decision to take absence leave, compared to LTAs with physical or comorbid health problems. This is probably related to the more sudden onset of physical health problems.

4.2 Factors preventing LTA taking absence from work

Most LTAs believe that nothing (else) could have been done to prevent their sickness absence. However, LTAs with mental health complaints more often believe that something could have been done by themselves or their employer, compared to LTAs with physical health problems. LTAs with mental health complaints could have been more assertive (stand up for oneself), and could have faced their own problems to a larger extent. Additionally, the employer of LTAs with mental health problems could have taken a more active and supportive attitude. LTAs with physical health problems more often mentioned that nothing could have been done to prevent their absence from work, mainly because of the sudden onset of the health problems.

In another Dutch study - involving reports of 253 employees on how their employer deals with mental health problems - it was also reported that employees often do not recognise their mental health problems or do not perceive them as a precursor for sickness absence. Furthermore, according to the employees the environment does not recognize their problems either, and their employer often does not show understanding and interest regarding their problems (Nederlands Kenniscentrum Arbeid & Psyche, 2004).

4.3 Impact on LTA and family

Overall, most LTAs mentioned both positive and negative impacts of their absence on their household. Positive aspects included that LTA learned more about themselves and learned to see things in perspective. They also had more time for their family and activities. Negative aspects were that LTA could no longer do the things he or she used to do, that other family members had to help in the household, and that tensions occurred at home. LTAs with mental health problems more often mentioned only positive effects or both positive and negative effects, while LTAs with physical health problems more often reported only negative effects. Moreover, when looking back after successful return to work, LTAs with mental health problems had a more positive

interpretation of their absence period. It was something that had to happen to them and which eventually made them stronger.

Considering the impact of the LTA's sickness absence on his or her family unit, it is recommended to researchers studying long-term absence to pay attention to the impact on the family unit. Both positive and negative consequences should be taken into account.

4.4 LTAs who have returned to work

Most LTAs had returned partly or fully to work at the time of the interview. Return to work mostly occurred in the same job, with the same employer. However, LTAs mentioned that their working conditions were often (temporarily) adjusted, such as less hours (gradually building up the working hours) and different/less tasks. Most LTAs thought this was the best option for them.

Improved health, own initiative, and the advice of OSH Service seem to be the best predictors of return to work. Finances play a minor role in the LTA's return to work. This probably has to do with the benefits system in the Netherlands, whereby employees receive sickness benefits in the first 104 weeks of their absence period. It can be expected that in other countries finances will be of more significance. The important role of health improvement found in this study is in line with several studies showing that a decrease in the LTA's health problems stimulates return to work (Nijboer, Gründemann & Andries, 1993; Van der Stelt, 1998).

LTAs with mental and physical health problems show differences in their return to work threshold. LTAs with physical health problems more often returned to work because their health improved. They also experienced fewer problems on their return to work, and if they did experience problems on their return to work, these problems were mainly a result of their physical limitations. In contrast, LTAs with mental health problems more often returned to work on advice of the occupational health physician or Health and Safety Service. They also experienced more problems on their return to work. They found it difficult to return to work and were afraid to become absent again. Moreover, people at work often did not know what to expect from the LTA or did not offer proper help.

The occupational health physician and employer were the main individuals who were involved in the LTA's decision to return to work. The aspect of the OHP's involvement that proved useful was that they offered LTA the opportunity to return to work gradually (building up the working hours over time). The aspect which was not useful about the occupational health physician's and employer's involvement in the decision to return to work was that they sometimes wanted the LTA to return to work too soon. Other research shows similar results; according to employees, the employer and occupational health physician often focus too much on early work resumption (Nederlands Kenniscentrum Arbeid & Psyche, 2004).

LTAs who returned to work generally received support from their colleagues and/or manager during their return to work. This support mostly involved social/emotional support and practical support. In general, most LTAs found the support of their colleagues and manager on their return to work helpful and useful.

4.5 LTAs who have not returned to work

Ill health was the main factor that prevented LTAs to return to work. Most LTAs believed that nothing (else) could have been done by themselves, their family or anyone else. In most cases, LTAs remained in contact with their company during their absence

from work. This contact was generally found to be useful by the LTAs. However, a part of these LTAs did not find this contact helpful and/or saw aspects for improvement.

4.6 Rehabilitation

Although it is obligatory in the Netherlands to develop a return to work plan, in more than half of the cases no return to work plan was available. This is a remarkable finding. When a return to work plan was available, most LTAs found this plan useful. The return to work plan generally included advice on gradually increasing activity and building up the amount of working hours. Other research too shows that the reintegration of LTAs with mental health problems is not always in line with the guidelines of the Gate Keeper Act (Nederlands Kenniscentrum Arbeid & Psyche, 2004).

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5 Recommendations

5.1 Training regarding identifying signs of mental health problems and awareness raising of mental health problems

Both employee and employer experience great difficulties in recognizing mental health problems. To prevent the employee's absence from work due to mental health complaints it is important for both employee and employer to identify signs of mental health problems at an early stage. Additionally, they should learn what measures to take in case of mental health problems. Employees and employers could be trained in these matters.

5.2 Inform employees/ employers regarding obligations and rights according to Gate Keeper Act

Employees and employers are not always well informed about their rights and obligations in case of long-term sickness absence, as described in the Gate Keeper Act. The roles of other parties involved in guiding LTAs back to work are also not always clear to them. For instance, it is obligatory that the employee and employer design a return to work plan in which activities and responsibilities are recorded. However, a return to work plan is not always made or followed. Therefore, it is important to inform employers and employees about their and other people's responsibilities regarding the Gate Keeper Act. This seems particularly relevant for individuals with mental health problems, as they often experience problems on their return to work.

5.3 Remain contact during sickness absence

It is very important for manager and colleagues to remain contact with the LTA during his or her absence from work. In this way the LTA remains involved with the work and the work place and this makes the step back to work easier for them. This is of particular relevance for individuals with mental health problems, who often encounter problems when returning to work.

5.4 A well-designed RTW plan

A well-designed return to work plan could help employer and employee to structure their actions and make the return to work process going more smoothly. A well-designed return to work plan describes who does what and when, in order to improve the LTA's health and to facilitate the LTA's return to work. Employer and employee should draw up a return to work plan together. They could ask the occupational health physician for professional advise.

5.5 Importance of timing in return to work and gradual return to work

In the Netherlands, occupational health physicians and managers focus strongly on early return to work. It is assumed that the longer one is absent from work, the more difficult it is to make the step back to work. Another assumption is that return to work can contribute to health improvement, especially for LTAs with mental health complaints. However, this study suggests that occupational health physicians and managers should be careful with putting LTAs under too much pressure to return to work. They

should give LTAs the opportunity to gradually build up their working hours and, if necessary, offer other tasks or a limited set of tasks to start with.

5.6 OHP and health improvement

Health improvement seems to be the best predictor of return to work. Therefore, it is important for the occupational health physician to see to it that LTAs take the right steps to improve their health. The parties that are involved in the LTA's return to work (employer and Occupational Health Practitioner) should also be aware of the fact that the LTA's sickness absence may have negative consequences for the household and therefore pay attention to it and advise LTA on this matter.

5.7 Co-ordination of information between OHP and other health professionals

Finally, contact between the OHP and other health professionals (e.g. general practitioner) should be optimized for exchanging information and for organizing health promotion activities. This could prevent conflicting advice and treatment.