Project Title

Impact on Changing Social Structures on Stress and Quality of Life: Individual and Social Perspectives

Project Acronym/Logo

Work Package 6

Professional Study: Ireland

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Table of Abbreviations

GP	General Practitioner
OHP	Occupational Health Physician
MHP	Mental Health Professional
RTW	Return to Work Specialist
MGR	Manager
HRM	Human Resource Manager
HSO	Health and Safety Officer

Section 1:
Overview and Commentary on the Professional Study

1.1 Overview of the Professional Study

The professional study is one of three interrelated studies within the Stress Impact Project- a pan European research study of long term absence from work due to stress related problems. The professional study has been designed to:

- Explore health care and employment professional's opinions and attitudes towards 'stress', long term sickness absence and work resumption,
- Identify their current policies for dealing with stress related long term absence,
- Explore and identify the interventions they use to support people back into the workplace, and
- Explore their experiences of dealing with long term stress related absence.

The findings of this research will highlight commonalities and discrepancies between and within professional health care and employment groups concerning long term stress related sickness absence and work resumption both in Ireland and across participating countries (Austria, Finland, Italy, the Netherlands and the UK). They will also be used to determine whether professional thinking on these issues is comparable to the experiences of those individuals who are, or have been, absent due to a stress related complaint. Ultimately these results and those of the other interrelated studies within the Stress Impact Project will be used to provide the basis for a theory of long term sickness absence and provide input in the future development of policies and guidelines of best practices for those professional groups.

1.2 Commentary on the Methodological Approach

1.2.1 Research Design

The methodology used in this work package was a combination of in-depth and telephone interviews.

The interview schedule was semi-structured and questions were based around the following areas:

- Stress Recognition /Diagnosis (where relevant)
- Background Experience of the Professional
- Case Studies
- Factors relating to Stress
- Interventions
- Referrals
- Return to work process
- Organisation Details (where relevant)

1.2.2 Materials

There was a specific interview schedule designed for each professional (GP, OHP, MHP, RTW, MGR, HRM and HSO) category. Prior to the commencement of the study, pilot interviews were conducted with each of these professional categories. The interview schedules were revised in line with the comments made by those interviewed (See Appendix 1).

1.2.3 Gaining Access

To recruit professionals across each of the categories, we contacted members of our National Stakeholder Network (see Appendix 2 for a complete list) with regard to accessing professionals in the required fields. This proved to be a highly successful approach, as they acted as sponsors for us and provided us with lists of people who they thought would be willing to participate in the study.

To supplement this we also completed a number of cold calls to professionals whose names were located on the Internet or in the telephone book. We were able to access a small number of professionals through this approach. This process took quite some time (around four months) but has yielded positive and interesting results.

1.2.4 Sampling

We initially contacted 64 professionals by telephone and asked them if they would participate in the study. Of this, 34 professionals agreed to participate, which is a

53% response rate. These included 5 General Practitioners, 5 Occupational Health Physicians, 5 Mental Health Professionals, 5 Return to Work Specialists, 5 Managers, 5 Human Resource Managers and 4 Health and Safety Officers. For profiles of the professionals who participated and roles and responsibilities for each of the professions, please see Appendix 3 and 4.

1.2.5 Recruiting Professionals

Through a contact of the project team, we were able to recruit General Practitioners (GPs) quite easily. The majority of the GPs who were contacted were willing to participate and did not expect remuneration. Occupational Health Physicians were recruited through our Stakeholders Network. One of the OHP's who was interviewed was also extremely helpful and referred us to 2 additional OHPs and 1 Return to Work Specialist.

The recruitment of Mental Health Professionals proved to be one of the hardest professional categories to recruit within Ireland. Reasons for this included that they did not agree with the ethos of the project around the description of stress and/or the aims of the project, that they lacked the time to participate in the study or that they lacked the experience in the area of stress and/or long-term absence to participate. Of the 5 Mental Health Professionals (MHPs) who participated, we interviewed 3 Psychiatrists and 2 Clinical Psychologists.

Initially we thought that recruiting the Return to Work Specialists would be one of the hardest professional categories to recruit, as the profession has only been developing in Ireland over the last five years. However through a contact of the project team, we were able to access 5 Return to Work Specialists (RTWs).

In the workplace, we recruited a number of professional categories-Manager, Human Resource Managers and Health and Safety Officers. Recruiting Managers proved to be extremely difficult, this was due to a lack of time, interest or experience in the area of stress and/or long-term absence. It was also very hard to contact them directly as they were extremely busy. However, we did manage to recruit 5 Managers to participate in the project.

All of the Human Resource Managers (HRMs) who were contacted were extremely interested in the study and were willing to participate. Through our Stakeholder Network we were able to recruit a number of Health and Safety Officers. One difficulty we found with this professional category was that they tended to have responsibilities above and beyond Health and Safety and did have a huge knowledge of stress or absence in the workplace.

1.2.6 Procedures

All the interviews were tape recorded with the consent of the professional and were transcribed at a later stage. The data was analysed using a Reporting Framework (see Appendix 5). Each interview took between 45 minutes and 1 hour to complete.

1.2.7 Limitations of the Study

Some limitations of the study include the sample bias. The majority of professionals (27) who were recruited were located within Dublin and therefore the sample is not representative of professionals outside of Dublin.

The reason for this was largely to do with the cost and effort it would take to complete interviews with professionals outside of Dublin. To remedy this, we conducted a number of telephone interviews with professionals who were located outside of Dublin. Due to time constraints we also conducted a number of telephone interviews with professionals in Dublin.

Also with regard to certain questions within the interview schedules, the professionals found them to be repetitive and this caused some annoyance e.g. Section 4: Open Ended Question about the Causes of Stress and then a Closed Question about the Causes of Stress. However, we felt that this was necessary in order to support cross-country interpretation.

Section 2: Findings by Type of Professional

This section examines the findings from the interviews by type of professional under a number of key headings. It also shows illustrations from the stress cases referred to during the interviews by type of professional.

2.1Issues and Trends

2.1.1 Incidence of Stress Related Complaints and Reasons for Increase/Decrease

General Practitioners

Most informants reported that stress (as a complaint) would frequently be referred to by their patients when describing their conditions. The majority of GPs interviewed indicated that references to 'stress' as a condition had increased in the past five years. Reasons provided for this included the increase in acceptance of the term 'stress', changes in lifestyles, changes in society and increase in work demands.

Occupational Health Physicians

Three OHPs stated that stress as a complaint would frequently be referred to by patients when they were describing their condition. All of the OHPs interviewed felt that the use of 'stress' as a condition had increased in the last five years. Reasons provided for this included the increased demands on people, increase in the pace of life and an increase in acceptance of the term 'stress'.

Mental Health Professionals

Four of the MHPs indicated that stress was frequently referred to by patients when describing their condition. All of the MHPs interviewed said that the use of stress as a description of a condition had increased in the last five years. Reasons for this included '*because it is a fashionable term'* (MHP 1), '*more recognised by the public*' (MHP 3) and lastly due to a '*change in society and the focus, which is less about the person and more about the material'* (MHP 4).

Return to Work Specialists

Two of the RTWs indicated that in their opinion, the incidence of stress in the workplace had increased. They attributed this to increased pressure placed on people in work and increased awareness of stress. Two other RTWs were unsure whether or not the incidence had increased. They were of the opinion that awareness of stress had increased rather than the incidence of stress. The remaining RTW proposed that the incidence of stress had stayed the same due to the stable economy in Ireland.

Managers

Four of the MGRs reported that the incidence of stress in the workplace had increased. They indicated that this was due to changes in society, changes in work patterns, the introduction of new technologies and lack of work life balance. The remaining MGR stated that the incidence of stress had stayed the same and that it fluctuated depending on what type of industry a person was working in.

Human Resource Managers

Three of the HRMs supported the view that the incidence of stress in the workplace had increased. They attributed this to increased demands placed on individuals in work and an increased acceptability of the term 'stress'. Two HRMs believed that the rate had remained the same and reported that their two organisations had very few stress cases in the last five years.

Health and Safety Officers

All of the HSOs interviewed were of the view that the incidence of stress in the workplace had increased. They attributed this to an increase in demands in the workplace, a faster pace of life, increased awareness of stress and the length of time people spend commuting to work.

2.1.2 Models of Stress

General Practitioners

One GP described stress as '*the physical or mental manifestation of the pressure put on people*' (GP 5). This feeling was echoed in three more interviews. However, one GP stated that there was good and bad stress, '*good stress helps to keep you fit whereas bad stress can take over all aspects and leads to an inability of the person to cope*' (GP 3).

No informant used a specific model of stress but rather diagnosed stress in terms of symptoms presented by a patient (e.g. sleeplessness, panic attacks, anxiety, sweating, loss of appetite) and also the patient's medical history.

Conditions where stress was felt to be a causal factor included mental disorders, tumours/cancers, digestive problems and musculoskeletal problems.

Occupational Health Physician

Stress was described in a variety of different ways. One OHP stated that '*Stress is an excessive and inappropriate response to certain circumstances, not just the stress of everyday that everyone experiences but pathological stress*' (OHP 1). Two OHPs used the word 'abnormal' to describe stress and its effects.

None of the OHPs interviewed used a specific model of stress to diagnose it. One OHP stated that they did '*not accept stress as a diagnosis*' (OHP 2) and that they would look to diagnose an underlying psychiatric illness instead. Another Occupational Health Physician stated that they would not use a specific stress model or questionnaire because then their patients could '*work out what the answers are to get the results they wanted*' (OHP 5).

For the four OHPs who did diagnose stress, the diagnostic process was based on the symptoms presented (e.g. eating patterns, sleeping patterns, concentration) and also the patient's medical history.

Conditions where stress was felt to be a causal factor included mental disorders, musculoskeletal problems and digestive problems.

Mental Health Professionals

Most MHPs described stress in terms of negative psycho-physiological reactions to an event or constellation of events in life that they find difficult to handle. One MHP also alluded to two types of stress, abnormal and appropriate. *'Abnormal is where the affect of stress would be such that the person would be impaired by it. Appropriate stress is beneficial, it actually psyches up the person and helps their performance to improve'* (MHP 1). Another MHP described stress in terms of reactive depression.

Return to Work Specialists

Stress was described by the Return to Work Specialists in terms of an imbalance between what a person can do and what that person was expected to do, whether this was in the workplace or at home.

Managers

No organisation had a specific definition of stress that was known to their Managers. When asked to describe stress in their own words, they used words and phrases like 'pressure', 'reaction to environment', 'response by the individual to external factors' and so on. They tended to position the source of stress within the workplace. However one MGR identified home life as a factor.

Human Resource Manager

Three of the organisations in which the HRMs worked had a specific definition for stress. One organisation defined stress '*as a complex phenomenon which incorporates aspects of the individuals, the situation and the person's response to the situation*' (HRM 4). Another organisation defined stress '*as a situation when the body has to push itself beyond the norms for a prolonged period of time*'(HRM 5). The other organisation defined stress'*as a process of transactions in which a person's resources are matched against the demands of the environment. Reactions to stressors depend on a) the number and strength of stressors, b) the ability to cope and c) how a stressor is perceived*' (HRM 3). The other two organisations did not have definitions of stress although they were in development.

When asked to describe stress in their own words, the Human Resource Managers used words like ‘cope’, ‘demands’, ‘lack of control’ and ‘imbalance’. One HRM felt that ‘*a little stress is not a bad thing*’ (HRM 1).

Health and Safety Officers

None of the organisations in which the HSOs worked had a specific definition for stress that was known to the Health and Safety Officers. When asked to describe stress in their own words, the HSOs used words and phrases like ‘mismatch’, ‘adverse effect’ and ‘mental and physical overload’.

2.1.3 Most Frequent Diagnosis

General Practitioners

The most frequently used diagnostic labels by the General Practitioners interviewed were Anxiety (5 GPs), Depression (4 GPs), Backache (4 GPs) and Fatigue (4 GPs). Stress was only frequently used by 2 GPs and Burnout by 1 GP.

Occupational Health Physicians

The most frequently used diagnostic labels used by the Occupational Health Physicians interviewed were Backache (4 OHPs), Depression (3 OHPs) and Anxiety (3 OHPs). Stress as a diagnostic label was only frequently used by 2 OHPs.

Mental Health Professionals

The most common diagnostic label used by MHPs amongst groups were depression, adjustment disorder, anxiety, post-traumatic stress, panic and reactive depression.

Return to Work Specialists

The most common diagnosis utilised by Return to Work Specialists were occupational stress (2 RTWs), musculoskeletal problems (2 RTWs), depression and anxiety (2 RTWs) and chronic pain (1 RTW).

2.1.4 Identifying Stress

Managers

All of the MGRs reported that they had encountered stress in employees within the organisation. Some signals used to recognise stress included absenteeism, reduced workload, looking distressed and a change in behaviour.

Human Resource Managers

All of the Human Resource Managers interviewed had encountered stress in employees within their organisations. Some signals of stress they reported using included: the arrival of a medical certificate on their desk, involvement of an employee in a disciplinary issue and/or poor work performance.

Health and Safety Officers

Three of the HSOs interviewed had encountered stress in employees within their organisations. The other Health and Safety Officer had encountered stress in employees through the other role they occupied, that of Training and Development Manager. Some signals that they used to identify stress included: irritation and fatigue symptoms on the part of an employee, the occurrence of an accident and an increase in absenteeism.

2.1.5 Problems and Reservations in Diagnosing Stress

General Practitioners

Only one informant described problems in diagnosing stress, this was because *'patients can hide symptoms'* (GP 5). Three of the GPs had reservations in using stress as a primary diagnosis. They felt that stress could not be used as a primary diagnosis until the patient had acknowledged, understood and accepted this as a primary diagnosis.

Occupational Health Physicians

There was little consensus amongst the OHPs on this issue. One OHP would not diagnose stress at all instead they would look for an underlying psychiatric illness. Two other OHPs felt that the diagnosis of '*stress was a debilitating thing'* (OHP 3)

and that it was merely a *'description of symptoms'* (OHP 4). Another Occupational Health Physician was of the opinion that the label of stress was not as important as the treatment that the person needed. Some methods of getting around this were the use of stress as a secondary diagnosis rather than a primary diagnosis.

2.1.6 Knowledge of Stress

General Practitioners

All of the GPs felt that they had sufficient knowledge/awareness of stress to deal with most situations that arose on behalf of their patients. The GPs interviewed had between 10 and 30 years practice experience. Within their own practices they estimated between 20% and 70% of patients had stress as a primary condition.

Occupational Health Physicians

Three of the OHPs felt that they had sufficient knowledge/awareness of stress to deal with most situations that arose on behalf of their patients. The other OHPs felt that even though they may not have sufficient knowledge, they would know exactly where to direct a patient if they needed to. The OHPs had between 4 and 24 years practice experience. Within their own practices they estimated between 10% and 20% of patients had stress as a primary condition.

Mental Health Professionals

All of the Mental Health Professionals felt that they had sufficient knowledge /awareness of stress to deal with most situations which arose on behalf of their clients. They had between them 10 and 50 years of practice as a Mental Health Professional. Stress as a primary diagnosis accounted for between 5% and 75% of their client base.

Return to Work Specialists

Only 2 Return to Work Specialists expressed the view that they had a sufficient knowledge/awareness of stress to deal with most situations that arose on behalf of their clients. However the remaining 3 RTWs considered that they would be able to direct their clients to an appropriate person to deal with them. Areas in which RTWs expressed a need for more information included a common definition of stress and practical guidelines on how to help a person with a stress related condition.

The RTWs had between 4 and 17 years of experience in the area of return to work and/or case management. Within their client base they had between 3% and 25% of clients with stress as a primary diagnostic label.

Managers

All of the Managers stated that they had sufficient knowledge/awareness of stress to deal with most situations that arose on behalf of their staff. The MGRs were responsible for between 4 and 1670 employees.

Human Resource Managers

Four of the HRMs were of the opinion that they had sufficient knowledge/awareness of stress to deal with most situations which arose on behalf of their staff. The remaining HRM stated that they needed information around structuring and organising work, developing a stress policy/strategy and lastly information on the legal framework around stress. The HRMs interviewed had between 4 and 31 years of experience in Human Resources.

Health and Safety Officers

Three of the Health and Safety Officers were satisfied that they had sufficient knowledge/awareness of stress to deal with most situations which arose on behalf of their staff. However one HSO felt that some practical guidelines were needed on dealing with stress. They had between 4 and 15 years of experience in Health and Safety.

2.1.7 Causal Factors in Stress

General Practitioners

A wide range of factors were identified as causes of stress. Some of the most common ones which were unprompted included: relationship problems with family or work colleagues (4 GPs), financial problems (3 GPs), and bullying cases (2 GPs). In relation to those causal factors which were prompted, the factors which were most often referred to included: Job (3 GPs), Sleep (3 GPs), Finances (2 GPs), Health (2 GPs) and Relatives (2 GPs).

Occupational Health Physicians

Occupational Health Physicians mentioned a variety of causal factors of stress to which patients referred including their job, marriage problems, problems with their children, financial problems and personal issues such as gambling or alcohol issues. When prompted, the factors most often specified included: Relationship with Partner (5 OHPs) and Job (3 OHPs).

Mental Health Professionals

A wide range of factors were identified as causes of stress. Some of the most common ones included: financial problems, relationship problems with children, partners or work colleagues and work related problems such as *'demands of the jobs being beyond their fulfilment, frequent changes without their notification, lack of support from colleagues or work superiors, lack of clarity about their role and lack of control over what they are doing'* (MHP 5). In relation to prompted responses, causal factors most often referred to, included: Relationship with Partner (5 MHPs), Finances (3 MHPs), Children (3 MHPs) and Loneliness (3 MHPs).

Return to Work Specialists

Some common factors stated by the RTWs as causal factors to which clients referred to included work (work overload, change in job roles and bullying or harassment), family life, emotional loss through death or separation and a history of depression. When prompted, the factors most often specified, included: Job (4 RTWs), Health (4 RTWs), Relationship with Partner (4 RTWs), Living Conditions (3 RTWs), Children (3 RTWs) and Loneliness (3 RTWs).

Managers

According to the Managers causal factors that employees referred to when talking about stress included work pressures, doing routine mundane work, lack of sleep, bullying, personal and health issues. When prompted, MGRs indicated that employees often referred to the following as causes of stress: Job (3 MGRs), Children (3 MGRs) and Sleep (3 MGRs).

Human Resource Managers

According to HRMs, some causal factors that employees would refer to when they are talking about stress included personal issues, work related issues and relationship difficulties. When prompted, HRMs indicated that employees often referred to the following as causes of stress: Job (4 HRMs), Relationship with Partner (3 HRMs) and Sleep (3 HRMs).

Health and Safety Officer

HSOs reported the following causal factors that employees would refer to when they were talking about stress: lack of management support, lack of training, long commuting time and workload issues. In one case, noise on the factory floor and illiteracy were stated as causes of stress by the HSO. When prompted, HSOs said that employees often referred to the following as causes of stress: Job (2 HSOs) and Health (2 HSOs).

2.1.8 Factors Aiding Return to Work

General Practitioners

In relation to the stress cases, GPs referred to a number of factors which were important in aiding the individual to return to work. These included time out and rest (3 GPs), counselling (2 GPs) and the patient's recognition of their symptoms (2 GPs).

Occupational Health Physicians

Occupational Health Physicians referred to a number of factors which they felt helped people to return to work successfully. These included changes made to the workplace, recognition of the problem by the individual, support from family, friends, professionals and employers, for financial reasons and also having some time out.

Mental Health Professionals

In relation to the stress cases, Mental Health Professionals reported a number of factors which they felt helped people to return to work successfully. These included good information and coping strategies (Cognitive Behavioural Therapy or

Psychotherapy), good support from partner, family and the workplace, in the case of bullying removing the person who is allegedly committing the offence.

Return to Work Specialists

In relation to stress cases, RTWs specified a number of factors which they felt were important in aiding the individual to return to work successfully. Three RTWs referred to the support the individual received from themselves to keep the person motivated and stop them from being depressed. Another important factor which was referred to by all of the RTWs interviewed was the development of a return to work plan. One RTW also stated that the individual's own acceptance of responsibility helped them return to work.

Managers

In stress cases, the most important factors identified by the MGRs which enhance return to work included changes in job role and location and support from line managers on a weekly basis. Counselling was listed as being extremely helpful specifically for one of the cases mentioned. In the non-stress case, the important factor in returning them to work successfully was a graded return to work i.e. flexible and shorter hours.

Human Resource Managers

In the case of stress, the most important factors, which HRMs indicated were helpful in return to work were: that the employee knew they had the support of the employer, that he /she was introduced back on a phased return to work, that time out was provided, professional counselling or Employee Assistance Programmes.

Health and Safety Officer

According to HSOs in the case of stress, the most important factors which aided return to work included: support from the manager and family, the person recognising the problem him or herself, counselling sessions and flexible hours initially when returned to work.

2.1.9 Factors Preventing Return to Work

General Practitioners

In relation to the stress cases, GPs raised a number of issues which they felt prevented a successful return to work. These included: that the stress was related to an incident which had happened at work, that there was a lack of support either from the employer or the individual's family and lastly that there was a legal case pending.

Occupational Health Physicians

Some reasons why people did not return to work included personal traits such as selfishness and lack of motivation and also the fact that problems within the workplace such as lack of communication were not being addressed.

Mental Health Professionals

MHPs provided a number of reasons why people do not return to work including: that the individual was angry with management and the way in which their issues were dealt with, that the individual had lost hope and needed to take a different life direction and that the person was not suited to their job role.

Return to Work Specialists

A common inhibiting factor referred to by all of the Return to Work Specialists interviewed was late referral. Some of the RTWs were only meeting with individuals as late as 1 to 2 years after they first went out absent. At this point the person had been sitting at home and had lost any motivation to return to work and was also fearful of returning to a situation where nothing had changed. Stress associated with bullying was also specified as a factor which prevented people returning to work.

Managers

Some of the factors which prevented a successful return to work included the fact that the situation was not well managed, the person was not suited to the job, late intervention and/or a previous history of depression.

Human Resource Managers

Some of the factors which the HRMs indicated prevent return to work included late intervention on the part of the employer, personal traits of the employee and where there may have been an incident relating to bullying.

Health and Safety Officers

Some of the factors listed by Health and Safety Officers which prevented return to work included stressors outside of work and lack of clarity about job definition.

2.1.10 Factors Preventing Absence from Work

General Practitioners

Some factors which GPs believed would have prevented absence in the first instance included: early recognition of symptoms and treatment by the patient and the employer, if the individual had a better relationship with their Manager and/or Human Resource Manager and finally if the employer had taken certain incidents more seriously and recognised that the incident had caused stress for that individual.

Occupational Health Physicians

Some factors which OHPs believed would have prevented absence in the first instance included: early recognition and intervention by the employer, if the individual had insight into their problem, if allegations of bullying/misconduct were dealt with in a timely manner and also conducting job assessments to ensure that people were suited to the jobs that they had been hired to do.

Mental Health Professionals

Some factors which Mental Health Professionals specified as important in preventing absence in the first incidence included: early intervention by the Human Resources Department, changing jobs, preventative psychological help, and support and flexibility in the workplace.

Return to Work Specialists

Some preventative factors specified included better handling of situations by management, earlier intervention and referral and increased support from line managers to vulnerable staff.

Managers

Some factors that Managers listed that may have prevented absence in the first incidence include better management of the situation and timely recognition of the signs.

With regard to preventative interventions, all Managers stated that their organisation would be willing to do the following things in order to prevent employees going out absent:

1. Move a person into a different job role,
2. Improve the work environment through Health and Safety,
3. Put in place a partnership forum for discussions between Staff and Management,
4. Provide employees with a confidential assessment by an Occupational Health Professional and the implementation of any recommendations made,
5. Tracking and monitoring absence rates, and
6. Talking to the person in a non-confrontational manner.

All Managers indicated that their organisations would be willing to change the work organisation, employment conditions or redeploy the employee to prevent absence in the first instance.

Human Resource Managers

HRMs listed the following factors which may have prevented absence in the first instance including early intervention, redeploying the employee to another job and trying to resolve relationship issues with peers. One of the Human Resource Manager's stated that in some incidents '*it can be relationship based issues which cannot be resolved*' (HRM 3).

With regard to preventative interventions, HRMs stated that the organisations they worked for would do the following to prevent employees going out absent:

1. Raise awareness about the issue of stress,
2. Run a training programme for managers on stress,
3. Change an employee's job,
4. Reduce working hours,
5. Refer to a Occupational Health Services.

All Human Resource Managers were of the opinion that their organisations would be willing to change the work organisation, employment conditions, or work environment, undertake individual interventions, redeploy staff and provide technical aids/appliance to prevent absence in the first instance.

Health and Safety Officers

Some factors that could prevent absence in the first instance, according to Health and Safety Officers included early intervention and recognition of the symptoms, increased flexibility in the workplace and additional coaching from a manager.

With regard to preventative interventions, HSOs stated that their organisations did the following to prevent employees going out absent:

1. Conduct a return to work interview after 3 days absence and then a formal attendance review after a longer period of absence,
2. Refer the employee to Occupational Health Services and/or an Employee Assistance Programme, and
3. Manage all staff as fairly as possible.

All of the HSOs reported that their organisations would be willing to change employment conditions, or the work environment, undertake individual interventions and provide technical aids/appliance to prevent absence in the first incidence. All of the organisations had a safety statement, however only two of the organisations had included stress as a hazard in their safety statement. The remaining HSOs hoped to include stress in their Safety Statements by the end of 2005.

2.1.11 Frequently Used Interventions

General Practitioners

All of the GPs recommended some type of counselling or psychotherapeutic interventions for patients with stress related conditions. Two General Practitioners also used anti-depressants as an intervention when dealing with a patient with a stress related condition. GPs would frequently refer a patient presented with a stress related condition towards Mental Health Services (4 GPs) and/or Alternative Health Interventions (3 GPs).

Occupational Health Physicians

All of the OHPs recommended some type of counselling or cognitive behavioural therapy as a treatment/intervention for stress. One Occupational Health Physician stated that *'in many cases we do nothing and say the symptoms you are feeling are entirely normal and that we think you are fit to go back to work and there is nothing you need to do and it will all pass'* (OHP 5). OHPs indicated that they would frequently refer a patient presenting with a stress related condition towards Mental Health Services (4 OHPs), Non-Health Interventions (3 OHPs) and Psychiatric Interventions (2 OHPs).

Mental Health Professionals

MHPs reported normally using: counselling, problem solving therapy and medication for symptomatic relief in the case of stress related conditions. MHPs reported frequently referring clients with a stress related conditions to Mental Health Services (4 MHPs), Psychiatric Interventions (4 MHPs), Allied Health Interventions (2 MHPs), Counsellor/Therapist (1 MHP) and other medical interventions (1 MHP).

Return to Work Specialists

A number of different interventions were referred to by the Return to Work Specialists. These included counselling, cognitive behavioural therapy, stress management and relaxation techniques, alternative therapies and in some cases psychiatric assessments. RTWs indicated that they would frequently refer a client

with a stress related conditions to Mental Health Services (5 RTWs) and Non-Health Interventions e.g. vocational training (4 RTWs).

2.1.12 Effectiveness of Interventions

General Practitioners

Frequently used effective interventions/treatments for stress related conditions were counselling (2 GPs), cognitive behavioural therapy (1 GP), alternative therapies (1 GP) and short-term medication (1 GP). Frequently used ineffective interventions/ treatments for stress related conditions were long-term medication (2 GPs), inappropriate counselling (1 GP), long-term sick leave (1 GP) and faith healers/ herbal medicine (1 GP).

Occupational Health Physicians

Frequently reported effective interventions/treatments for stress related conditions were medication (3 OHPs), cognitive behavioural therapy (2 OHPs), courses in time management and coping (2 OHPs) and time out (1 OHP). Frequently reported ineffective interventions included counselling (2 OHPs), stress handling techniques such as comfort eating, smoking (1 OHP), long-term medication (1 OHP), unmonitored time out (1 OHP) and alternative modalities (1 OHP).

Mental Health Professionals

Frequently used effective interventions/treatments for stress related conditions, according to MHPs were problem solving therapy (2 MHPs), Exercise and Lifestyle Changes (2 MHP), Counselling (1 MHP) and Psychotherapy (1 MHP). One MHP stated that there was no one intervention, that it was a combination of all the different interventions. Frequently used ineffective interventions/treatments cited by MHPs included: medication such as sleeping tablets, tranquillisers, anti depressants as long term measures (2 MHPs), alternative therapies (1 MHP) and generic counselling (1 MHP). One MHP stated that the most ineffective intervention for stress related conditions is to treat it as an illness.

Return to Work Specialists

Frequently used effective interventions specified by Return to Work Specialists included cognitive behavioural therapy (3 RTWs), alternative therapies such as yoga, massage, relaxation techniques (2 RTWs) and the use of a mediator (1 RTW). Two of the RTWs highlighted the fact that most effective intervention were multidisciplinary in nature. Ineffective interventions which were referred to included medication (4 RTWs) and psychiatric interventions (1 RTW).

2.1.13 Referrals

General Practitioners

All of the GPs indicated that they would refer patients with stress related conditions to a counsellor/ therapist on a frequent basis. Other frequent referrals included psychiatrist (1 GP), psychologist (1 GP) and alternative health practitioner (1 GP). The reason for the referral to the counsellor/therapist was because the GPs felt that this professional was trained to deal with psychological problems and could advise the patient on their options.

Occupational Health Physicians

Three of the Occupational Health Physicians interviewed indicated that they normally referred people with a stress related condition to a psychiatrist on a frequent basis. Cognitive behavioural therapy was specified as the most indicative intervention.

Mental Health Professionals

Common sources of referrals for MHPs included GP/Medical Doctors, Self Referrals, Psychiatrists and Psychologists to these MHPs. This would be largely because they would be viewed as experts in the area of mental health and cognitive behavioural therapy which would be seen by the medical community to be the most effective tool for dealing with stress.

Return to Work Specialists

The majority of RTW clients with stress related conditions were referred by Insurance Companies (3 RTWs) and Employers (2 RTWs).

Managers

Two Managers reported that they would refer an employee with a stress related condition to the Employee Assistance Programme, which is in operation within their organisation and then onto the Human Resources Department. The remaining MGRs indicated that they would refer an employee with a stress related condition straight to the Human Resources Department.

Human Resource Managers

The HRMs indicated that they would refer employees with a stress related condition to the Employee Assistance Programme or to the Company Medical Officer/ Occupational Nurse.

Health and Safety Officers

The HSOs reported that they refer employees with a stress related condition to an Employee Assistance Programme and/or to the Company Medical Officer/ Occupational Nurse.

2.1.14 Return to Work Objective

General Practitioners

All the GPs investigated whether or not the patient was absent from work. All of the GPs have got involved in assisting a patient with a stress related condition to return to work. One GP described how they would assist a patient return to work, *'I treat the symptoms, try and establish the problem, refer them for counselling or psychiatric treatment, prescribe medication if required, advise on any lifestyle changes and then if possible assist and encourage their return to work'* (GP 2).

Whether or not they believe they should be involved in the return to work process caused some discussion. One GP stated that *' it's not specifically my call to get them back to work, it's specifically to help them'* (GP 1). Another GP felt that ideally they should become involved but they would need *'more help and backup if that were to happen more effectively as these cases can be extremely time consuming and often we*

just do not have the time' (GP 2). The remaining GPs felt that they should become involved in this process.

Occupational Health Physicians

All of the OHPs reported that they had got involved in assisting a person with a stress related condition to return to work. One OHP described how he assisted people to return to work *'I would try and organise shorter working hours and modify the workplace. I would also liase and follow up with the GP or any other medical specialists'* (OHP 5). All informants expressed the view that OHPs should be involved in the return to work process and saw this as one of their core functions.

Mental Health Professionals

All of the MHPs investigated whether or not the client was absent from work. They had all been involved in assisting a client with a stress related condition to return to work, however this would primarily be in a supportive role. On occasion they advised employers of certain strategies with regard to return to work. All of the MHPs accepted that the they should get involved in the process of returning clients with stress related conditions back to work.

Return to Work Specialists

Common steps taken by all Return to Work Specialists interviewed when assisting a client who had been long term absent to return to work included:

1. Referral received from employer or insurance companies,
2. Arrange an interview with the absent employee,
3. Establish a commitment on the part of the employee to the return to work,
4. Explore the issues the person has in returning to work and how it is best possible to remedy them,
5. Develop a return to work programme,
6. Contact the employer and arrange an interview with them,
7. Gain an agreement regarding any return to work programme that is produced,
8. Request the individual's personnel records and any further documentation needed,
9. Examine closely the work site and conduct a job demands analysis,

10. Contact the OHP or GP regarding any return to work programme that is produced,
11. Ensure that the return to work programme is signed off by all parties involved, i.e. the employee, the employer, the RTW and the GP or OHP if they have been involved,
12. Continue to monitor the individual and support them when needed,
13. Once the individual is happy, the RTW will close off the file.

Some elements of a return to work programme can include a change in hours, different location, job sharing etc. This is referred to as a graded return to work. Four of the RTW specialists had conducted a Job Demands Analysis and three had conducted a Functional Capacity Report.

Managers

With regard to return to work, Managers stated that their organisations would provide the following assistance to help employees return to work:

1. A staff counselling service,
2. Retraining, and
3. Flexibility in workload.

All of the MGRs felt that their organisations would be willing to change the work organisation, employment conditions, or the work environment, undertake individual interventions, redeploy the employee and provide technical aids/ appliances to assist employees to return to work. Three of the Managers stated that their organisation would be willing to introduce return to work measures such as case management to assist employees to return to work.

Some improvements that MGRs felt could be made to the return to work process in their organisation was as follows: expansion of the employee assistance programme, introduction of a case manager at an earlier stage and one to one interviews between employees and their line managers.

Human Resource Managers

The Human Resource Managers stated that their organisation would provide the following return to work assistance to help employees return to work:

1. Reduction in their hours,
2. A phased return to work, and
3. Professional help (whatever that was).

All of the HRMs felt that their organisations would be willing to change the work organisation, employment conditions, or the work environment, undertake individual interventions and provide technical aids/ appliances to assist employees to return to work. Two of the HRMs stated that their organisations would be willing to introduce return to work measures such as case management to assist employees to return to work.

Some improvements that HRMs indicated could be made to the return to work process in their organisation included: training line managers to deal with the issue of stress, checking in with staff who go absent sooner and letting employees know that the organisation operates a proactive approach to stress.

Health and Safety Officers

With regard to return to work, HSOs stated that their organisations would provide the following assistance to help employees return to work:

1. Practice early intervention,
2. Keep in contact with the person, and
3. Refer them to Occupational Health Doctor and follow through on any recommendations made.

All of the HSOs were of the opinion that their organisations would be willing to change the work organisation, employment conditions, or work environment, undertake individual interventions and redeploy staff to other positions. Two of the HSOs stated that their organisations would be willing to introduce return to work measures such as case management to assist employees to return to work. Three of

the HSOs stated that their organisations would be willing to run a stress awareness programmes to assist employees to return to work.

Some improvements that HSOs indicated could be made to the return to work process in their organisations were as follows: training line managers to deal with the issue, and the early intervention and recognition of stress.

2.1.15 Absence Procedures

Managers

The following absence procedures were described by all of the Managers:
Local Management Team make contact with the absent employee,

1. Employees send in medical certificates after three days of absence,
2. The Human Resource Department is advised of the absence,
3. Referral to a Occupational Health Physician after three months.

In three of the organisations, the absent employee received full pay for six months prior to going onto a company pension. The general feeling expressed was that MGRs did not and should not get involved in this process. It was generally left to the Human Resources Department. Some of the most common reasons reported for absences included physical illness such as cancer (3 MGRs), back pain (2 MGRs) and mental illness (1 MGR). Three of the organisations had formal absence procedures.

Human Resource Managers

The following are the absence procedures that were described by the Human Resource Managers:

1. Absent employee must send in a medical certificate after three days of absence,
2. The absent employee may be referred to the Company Doctor,
3. Follow through on any recommendations made by the Company Doctor.

All of the organisations had these absence procedures formalised into an absence policy. Some of the most common reasons for absence cited by the HRMs included

physical illness such as cancer (3 HRMs), heart disease (2 HRMs) and mental illness (2 HRMs).

Health and Safety Officers

The absence procedures described by the HSOs were similar to those described by the MGRs and HRMs but were not as definitive. Two of the organisations had these absence procedures formalised into an absence policy. Some of the most common reasons for absences included muscoskeletal problems (2 HSOs) and a work related injury (2 HSOs).

2.1.16 Family Interventions

General Practitioners

GPs would often involve families in the recovery process as part of a family therapy session but not necessarily in the return to work process unless the patient requested that they would.

Occupational Health Physicians

Three of the OHPs had involved families in the recovery and return to work process but only with the patient's consent.

Mental Health Professionals

Most MHPs reported that in some circumstances they would involve the family but mainly in the recovery process rather than the return to work.

Return to Work Specialists

All of the RTWs indicated that they had involved members of the client's family in the recovery and return to work process once the individual agreed.

2.1.17 Employers and Return to Work

General Practitioners

Two of the GPs had been contacted by employers of absent employees regarding absence dates.

Occupational Health Physicians

All of the OHPs had been contacted by employers to provide a report on the person and whether or not they were fit to return to work.

Mental Health Professionals

Three MHPs reported that they had been contacted by employers to provide information about why a client was absent from work and what their condition was. This type of information can only be released with the client's consent.

Return to Work Specialists

All of the RTWs had been contacted by employers as employers had either contracted/hired them or the RTWs needed to conduct a job site or job demands analysis.

2.1.18 Information for Social Protection Agencies

General Practitioners

Four GPs had been contacted by the Department of Social and Family Affairs requesting information around their patient's illness or disability that had been submitted to the Department on their medical certificate.

Occupational Health Physicians

Only two of the OHPs had been contacted by the Department of Social and Family Affairs to provide information on the illness or disability stated on the medical certificate.

2.2 Illustrations from Cases

General Practitioner

Successful Case:

This was a case of a teacher who did not want to return to work. She had left work because she was being bullied by the principal, but returned to 'face the bull' after a few sessions of counselling.

Unsuccessful Case:

This is a case of a person who worked in the social care sector who did not return to work. An incident occurred in work which affected him and he felt that his problem with this had been taken seriously at work. He was absent for a while on a sick certificate but then he decided to quit altogether.

Occupational Health Physicians

Successful Case:

A woman was absent from work for a year and a half because she felt she was been bullied. The person who had caused her this stress left the organisation and she returned to her previous job.

Unsuccessful Case:

A woman who worked for the same organisation as above and had made a complaint about bullying and harassment. She refused to go back until the complaint had been resolved. However this might take a number of months by which time her anger may have become deep set, her personality may have changed and even if it is resolved in her favour, she will (in OHP opinion) not go back to work.

Mental Health Professional

Successful Case:

A young man who worked in an office and went through an intense period of stress developed severe depression. He was out of work for over a year. However, due to the support from his girlfriend and the workplace, he recovered and returned to work on a transitional basis.

Unsuccessful Case:

A woman worked in a supermarket where an incident occurred in the workplace which triggered some substance misuse and she spiralled out of control. She was the main earner in the household and was under pressure to return to work, but she has not been ready or able to return to work yet.

Return to Work Specialist

Successful Case:

A man who worked in a cleaning company had been out of work for four months on stress. The RTW managed the case and was able to develop a return to work programme which he has completed.

Unsuccessful Case:

A woman who was out absent due to stress was not interested in returning to work.

Managers

Successful Case:

A woman who worked for a bank had been out absent for some time. The organisation redeployed her to a different job in a different location and she returned to work.

Unsuccessful Case:

A man who worked for a bank had a history of absenteeism. On his initial return to work, he returned to a different job and things seemed to be working out well. However, he went out absent after a couple of months and has now decided to leave the company.

Human Resource Manager

Successful Case:

A man whose marriage had broken up was finding it so overwhelming that he went out on sick leave. The Human Resource Manager contacted the employee and told him not to worry and to take the time out, he also nominated the line manager as a point of contact for the person, and referred the employee to the Employee Assistance Programme. The man is now involved in counselling and has returned to work successfully.

Unsuccessful Case:

A man who was out absent because of a complaint of bullying made against a colleague. The man has been out for a couple of months and will not return to work until an investigation has been completed.

Health and Safety Officer

Successful Case:

Person who did return to work was a woman who found it hard to deal with the pressures of her job. She has since completed intensive counselling and has returned to work. The company is also providing coaching for her.

Unsuccessful Case:

Person who did not return to work was suffering stress outside of work. This was outside of the persons control and the person has not returned to work yet.

Section 3: Findings by Themes

This section examines the findings from the interviews under a number of key themes.

3.1 The level of awareness about stress and absence across professionals

The majority of professionals (28) interviewed felt that they had sufficient knowledge/awareness of stress to deal with most situations that arose on behalf of their staff or clients. However, there were some areas that they would like to know more about, including: definitions for stress, practical guidelines on how to deal with stress and the legal framework around stress.

Specifically in relation to awareness of 'absence' in the workplace, all of the HRMs had an absence policy in their organisations and were aware of its content. Three MGRs and two HSOs had an absence policy in their respective organisations and were also aware of its content. Some of the most common reasons stated for absence by these professionals included physical illnesses such as cancer or heart disease, mental illnesses i.e. depression, muscoskeletal problems i.e. back pain, and work related injuries.

3.2 General description of the beliefs held about stress

Among those in the medical profession, stress was described in a variety of ways using terms like 'manifestation', 'pressure', and 'excessive'. None of them used a specific model/tool to diagnose stress, rather they diagnosed stress in terms of symptoms presented (e.g. sleeplessness, panic attacks, anxiety, sweating, loss of appetite) and the patient's medical history.

As a diagnostic label stress was only frequently used by 2 GPs and 2 OHPs. One OHP did not accept it as a diagnostic label at all and stated that they would look to diagnose an underlying psychiatric illness instead. The most common diagnostic labels used by these professionals when diagnosing stress related conditions were anxiety, depression, backache and fatigue.

The majority of MHPs described stress in terms of negative psycho-physiological reactions to events that the individual finds difficult to handle. The most common diagnostic labels among their clients were depression, adjustment disorder, anxiety, post-traumatic stress, panic and reactive depression. None of the mental health professionals who were interviewed stated that stress was a common diagnostic label among their clients.

Stress was described by the Return to Work Specialists in terms of an imbalance between what a person can do and what the person was expected to do, whether this was in the workplace or at home. The main focus of the RTWs was on occupational stress. Amongst their client group, the most common diagnostic labels were muscoskeletal problems, depression and anxiety and chronic pain.

All of the professionals from the workplace (MGRS, HRMs and HSOs) had encountered stress in their organisation to some extent. Managers when describing stress using phrases like 'reaction to an environment', 'response by an individual to external factors' and so on. They tended to position the sources of stress within the workplace. An interesting finding was that none of the organisations where the MGRs worked had a specific definition for stress.

Three of the organisations in which the HRMs worked had a specific definition for stress. The other two organisations did not have definitions of stress although they were in development. Human Resource Managers when describing stress used words like 'cope', 'demands', 'lack of control' and 'imbalance'.

Health and Safety Officers described stress in terms of a 'mismatch', 'adverse effect', and 'mental and physical overload'. None of the organisations in which the HSOs worked had a specific definition for stress that was known to them.

3.3 The issues raised in relation to stress and absence

The General Practitioners who were interviewed believe that stress is a growing problem and in order to stop this growth, symptoms need to be recognised and

professionals need to intervene earlier. Particularly in the workplace, there need to be better systems in place to address this issue and there is also a need for well-trained personnel to be in place.

One Occupational Health Physician felt that stress is the current topical issue and it will eventually be replaced by the next big issue! Another OHP stated that they are referred a lot of people with work related stress and the reality is that work is not always the cause of this stress. When the situation is investigated further, more often that not they have found that it is a family situation or something else at home which has spilled over to the workplace.

Some issues that were raised by Mental Health Professionals included: the lack of emphasise in Irish organisations on preventing stress, the need for earlier intervention, the importance of having an initial 'time out' from work, the limited use of case management in the return to work process, the need for flexibility in the return to work process, and the importance of maintaining contact with an absent employee.

Return to Work Specialists were particularly concerned with stress prevention. They stated that employers need to be educated to recognise symptoms of stress and intervene earlier, and that employees need to educate themselves also in the same respect. Education is the key to preventing stress.

Managers indicated that they had issues in relation to stress around recognition of symptoms, the secrecy that exists in workplaces over mental illnesses and the poor health service in Ireland which is not set up sufficiently to deal with stress/ depression related illnesses.

Human Resource Managers acknowledged that the area of stress is very difficult for employers to address. Employers are fearful of litigation cases being brought on the grounds of stress. They are also sceptical of some of the cases that are brought before them. One HRM also pointed out that their experiences would show that work may be part of the problem, but it is not the primary cause of stress. Lastly, the HRMs see the need for an agreed standardised definition for stress.

The only issue brought forward by a Health and Safety Officer was that stress is under reported and that there is probably a lot more of it out there.

3.4 The main interventions described

General Practitioners and Occupational Health Physicians recommended some type of counselling or cognitive behavioural therapy or psychotherapeutic interventions for patients with stress related conditions.

MHPs reported normally using: counselling, problem solving therapy and medication for symptomatic relief in the case of stress related conditions.

A number of different interventions were referred to by the Return to Work Specialists. These included counselling, cognitive behavioural therapy, stress management and relaxation techniques, alternative therapies and in some cases psychiatric assessments.

3.5 Stress and Return to Work- Effective Intervention and Activities

Frequently used effective interventions/treatments for stress related conditions were cognitive behavioural therapy, short-term medication alternative therapies such as yoga, massage, relaxation techniques and counselling.

3.6 Opinions about the 'causes' of stress

A wide range of factors were identified as causes of stress. The most frequent cause of stress which was referred to by all the professional types was the employee's job whether this was in relation to work overload, change in job roles, or bullying and harassment. Other causes of stress that were frequently referred to included personal issues (e.g. gambling, health problems), relationship problems and financial problems.

Section 4: Discussion

Current approaches adopted to stress and absence within Ireland

To be completed.

Understanding of stress and work

To be completed.

Section 5: Conclusions and Recommendations

The salience of stress and absence as a problem in your country

The adequacy of system responses in your country

Satisfaction of understanding and knowledge of stress and absence in your country

Confidence in current approaches to return to work and stress in your country

Recommendations for future action in terms of:

Initial and continuing professional development

Knowledge management and information sharing

Awareness raising

Policy development and regulation

Capacity building

Recommendations for more effective system responses

Next steps and actions towards a more effective response to stress and absence by professionals.

Annex 1: Summary of Respondent Profiles by Category

General Practitioners

Gender	Years of Experience	Location of Practice	Client Base
Male	19	Dublin	Medical Card
Female	10	Dublin	Medical Card
Male	25	Dublin	Medical Card
Male	24	Outside Dublin	Private Clients
Male	30	Dublin	Private Clients

Occupational Health Physicians

Gender	Years of Experience	Location of Practice	Sector
Male	24	Dublin	Private
Male	4	Dublin	Public
Male	12	Dublin	Private
Male	20	Dublin	Private
Male	11	Dublin	Private

Mental Health Professionals

Gender	Years of Experience	Location	Type of Clients
Female	26	Dublin	Stress and Depression
Male	20	Outside Dublin	Anxiety and Depression
Male	50	Dublin	Post Traumatic Stress
Female	10	Dublin	Anxiety
Male	11	Dublin	Stress

Return to Work Specialists

Gender	Years of Experience	Location	Client Base
Female	5	Outside Dublin	Insurance Companies
Female	10	Dublin	Employers and Insurance Companies
Female	17	Outside Dublin	Employers
Female	4	Dublin	Employers and Insurance Companies
Female	10	Dublin	Employers

Managers

Gender	Location	Sector	Number of Staff
Male	Dublin	Private	4
Male	Dublin	Public	21
Male	Outside Dublin	Private	1670
Male	Dublin	Private	50
Male	Dublin	Private	55

Human Resource Managers

Gender	Years of Experience	Location	Sector
Male	15	Dublin	Not for Profit
Female	7	Dublin	Private
Male	23	Dublin	Private
Female	4	Dublin	Private
Male	31	Outside Dublin	Private

Health and Safety Officers

Gender	Years of Experience	Location	Sector
Male	4	Dublin	Private
Male	10	Outside Dublin	Private
Female	15	Dublin	Private
Male	10	Dublin	Private

Annex 2: Roles and Responsibilities of Professional

General Practitioner:

A General Practitioner is a medical graduate who gives personal, primary and continuing care to individuals, families and a practice population, irrespective of age, gender and illness.

Occupational Health Physician:

An Occupational Health Physician is a physician who specialises in workplace safety, injuries and treatment, as well as job function issues.

Mental Health Professional:

Psychiatrist: Is a physician who specialises in the study, prevention and treatment of mental disorders.

Clinical Psychologist: Is an individual who works in the area of personality assessment and prevention and treatment of emotional and mental disorders. They would usually work with individuals, groups, or families who have personal, social, emotional, or behavioural problems.

Return to Work Specialist:

The role of a Return to Work Specialist is to facilitate the return to work of injured or ill employees.

Manager

This is a person who manages the staff on a day-to-day basis.

Human Resource Manager

Is the link between the employer and the employee. They have a wide range of responsibilities which include hiring, benefits, salaries, training etc.

Health and Safety Officer

A person who has been assigned responsibility within an organisation for health and safety.