

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



Work Package 6
Professional Study: UK

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1. OVERVIEW AND COMMENTARY ON THE PROFESSIONAL STUDY

1.1 Overview

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 health problems. The Professional Study is a qualitative study that 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.
- Explore their experiences of dealing with long term stress related sickness absence i.e. highlight case studies.

The findings of this research will highlight commonalities and discrepancies between and within professional healthcare and employment groups concerning long term stress related sickness absence and work resumption both in the UK and across participating countries (Austria, Finland, Ireland, Italy and The Netherlands). 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 these professional groups.

1.2 Commentary

The Healthcare Professionals (HP) who participated in this study included General Practitioners (GP), Occupational Health Physicians (OHP) and Mental Health Professionals (MHP). The Employment Professionals (EP) included Return to Work Specialists (RTW), Human Resource Specialists (HR) and General Managers/Company Directors (GM/CD). This was a convenience sample selected via a snowballing sampling strategy. A total of 40 professionals were interviewed using a structured interview schedule with open and closed questions. Each interview schedule shared some common standard questions, as well as questions specific to each professional group. For example, employment professional were asked about

company policies and programmes such as sickness absence policies and stress management programmes, healthcare professional were asked specifically about diagnostic procedures and possible medical interventions. The interview schedules were the same for each country, appropriately translated. This type of structured design is said to enhance reliability (Smith & Osborn 2003). The interview questions were constructed to elicit answers corresponding to and easily contained within the following seven predetermined categories:

- Frequency of Stress related complaints and incidents and reasons for increase/decrease.
- Mental Models of Stress Experience in
- Background experience and Stress Related Knowledge Case Studies
- Factors Relating to Stress
- Treatments and Interventions
- Onward Referrals
- Return to Work Policies

The interviewer stayed close to the interview schedule with little variation between interviews. The questions were read in the same specified order for each participant. For some questions the respondent was provided with a set of possible responses (e.g. sometime, often, rarely or never), other questions required an open response providing the interviewee with an opportunity to explain the reasons behind their answers. Each participant was sent the interview schedule prior to the interview to allow them the chance to familiarise themselves with the questions; they were not expected to spend any time preparing their answers.

The interviews were conducted mainly face-to-face, only a few were completed over the telephone. Each interview was recorded and the responses transcribed using a standardised reporting template. Two interviewers conducted the interviews. The use of a structured interview reduces the impact of the identity of interviewer on the responses (see Smith & Osborn 2003) and also has the advantage of speed and control which was helpful when interviewing the majority of these participants who had very busy working diaries. However they have been criticised for the constraints they can impose on interviewee's responses; in short they can limit to some extent what the interviewee can talk about (Smith & Osbourne 2003). The interviews lasted between 40 and 75 minutes.

Qualitative research does not work with the same concept of representativeness as quantitative research (Crossley 2000). Assuming that the participant's experiences i.e. those of the Healthcare and Employment Professionals are in part socially constructed, we know that when particular experiences are identified during the course of the research that it is available 'within a culture or society' and thus potentially transferable (Willig 2000). The validity of this work can be promoted on the grounds that the content is supported by evidence which is grounded, consistent and true to the data.

This sample is geographically skewed; only two participants do not work in London or the South East of England. This does raise the question of the transferability of these findings nationwide because the experience of working and/or living in the South East of England should not be generalised to the rest of the country. According to the South East of England Regional Assembly, the South East of England, often referred to as the commuter belt of England, has the highest population of all the English Regions, is one of the richest parts of the UK with owner occupation at three out of four households but at the same time this is an area with the lowest level of public investment per head of any English Region. Despite high economic growth there is a decline in the availability of key services such as child care and public transport. There is also a shortage of affordable housing and a more dispersed pattern of commuting than other regions with long and troublesome journeys to work due to the inadequate support of the existing public and private transport infrastructure, leading to increased road congestion.

This report is the findings of the UK Study.

SECTION 2: DESCRIPTION BY CATEGORIES OF PROFESSIONALS

This report contains extracts from participant's interviews. Every attempt has been made to uphold the participant's right to anonymity and confidentiality. Empty brackets indicate where narrative text has been omitted. The lists contained within this report are not in order of priority

This section describes specific salient comments or responses to the questionnaires made by each category of professional.

2.1 General Practitioners (GP) .

GP in the UK form the primary care level of the National Health Service (NHS) and as such are considered, along with dentists, pharmacists and opticians, the 'front line' of the health service. As part of their NHS duties GP provide medical advice to their patients on fitness to work which often initiates most periods of sickness absence. These official statements i.e. sick notes, may be used by patients as evidence to support claims for financial benefits as well as by employers to support claims for company sickness benefits or Statutory Sick Pay (SSP) and have implications for insurance companies; medical statements form a key part of the claim process for state incapacity benefits.

According to a report in the British Journal of Medical Practice (2002), GP will write an average of 20 such medical statements per week, most of which will be for the Department of Work and Pensions (DWP) data for short spell of sickness absence. GP are often described as fulfilling a 'gatekeeper' function to the welfare benefit system while at the same time having to strike a balance with patient advocacy.

'Increasingly GP feel themselves to be the functionaries of an oppressive economic system and obliged to control access to the benefit system, a position that conflicts with a responsibility to act as the patients' advocate' (British Medical Journal 2003).

Seven GP (6 male 1 female) working in the South and South East of England were interviewed for this study. These GP had between 2000 and 2300 patients on his or her patient list; the recommended government guidelines are between 1500 – 1800 patients. These GP had been practicing for an average of 19 years.

Frequency of Stress related complaints over the past 5 years.

The GP responded that stress was 'frequently' mentioned by their patients. Five believed that the frequency of stress related complaints had increased over the past five years, two that it has stayed the same.

Reasons for Increase

The nature of work itself is seen as a major contributing factor to the increase in stress. In particular the level of competitiveness and the effects of downsizing i.e. more is now done by less, which in turn has led to unrealistic expectations and demands from employers. This is a form of stress that is imposed over which people have little control.

The GP also talked about the internalised, often unrealistic, pressures to succeed and strive for bigger financial rewards in order to achieve and maintain high standards of living. As people compete for this success they face tough competition, work harder, struggle to balance work and domestic life, they often do not cope which, in turn, leads to stress related health problems, and feelings of failure and disappointment. This is regarded as a form of self imposed stress Reference was also made to the increase in the number of women who now work full time and have multiple role lifestyles and the effect this has on the traditional roles of men and women.

Also contributing to the increase in stress related complaints is the popularisation of 'stress' as a fashionable, vogue acceptable label. Reference was made to the role the media has played in encouraging people to visit their GP for stress related complaints.

'Being stressed is no longer 'taboo'; it is so much easier to talk about being stressed. It is so much easier to go to your GP and tell him that you are stressed. Whereas before patients might have hesitated, nowadays they come and see us straight away if they are feeling 'stressed'. I'm not saying this is a bad thing, I am saying this is why I believe I hear more about 'stress' in my consulting room. In fact I am not convinced that 'stress' itself has really increased, I just think we hear about it more' (GP 1).

Reasons for 'Stayed the Same'

Explaining why stress related complaints have 'stayed the same' reference was made to the fact that the same stress related problems and issues have been around for a long time now:

'Going back to the days of the recession, especially working and living where we do the expectation and experience of stress has remained fairly static at a high level. 'Stress' is the new catch all phrase for problems that have been around for a while now.' (GP4)

Models of Stress

Descriptions of Stress

Stress is generally described as an adverse reaction to problems or circumstances i.e. 'to life' (GP 2). The GP talk about the highly idiosyncratic nature of stress which for some patients can be caused by a single event or for others by a culmination of events. They all agree that stress is associated with feelings of not being able to cope and leads to mental and/or physical illness. Stress is viewed as an abstract concept which only exists when it is causing problems by interfering with normal functioning; it is seen as threatening.

'For my patients it is an excessive response to a situation which inhibits their normal coping mechanism leading to physical and /or psychological difficulties. As a GP I would say that 'stress' is just another word for the normal fight or flight response to a threatening situation'. (GP 5)

A few GP referred to the stressful nature of work and home life issues, overall it seems work related issues are the most frequent trigger for stress related complaints.

Diagnosing Stress

All the GP would routinely investigate further if a patient presented with a physical or mental complaint which might be stress related. This would be done by taking a full medical and social history. A thorough medical examination would be undertaken with a view to confirming or eliminating any organic causes for the presenting symptoms, physical or mental. By talking to their patients, the GP having excluded all other possible reasons, make a clinical judgement based on a process of unravelling, investigation, intuition and experience, that the presenting symptoms are indeed stress related.

'The only way to really decide if what I am seeing or hearing is indeed 'stress related' is to take a proper medical history, to listen to my patient, look for clues and tease out any psychogenic causes for their complaints. In my experience it does not take long to realise that there is something else going on.' (GP 3)

In the absence of any standardised tools to diagnose 'stress', coupled with the range of possible presenting symptoms, the GP emphasise the importance of talking and listening to their patients as the basis for any stress related diagnosis.

Stress as a Causal Factor of Certain Medical Conditions

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Fig 2.1.1 Medical Conditions Where Stress might be a Causal Factor

The only medical condition where a majority of GP believe to a 'great extent' that stress might be a causal factor is Mental Disorders.

Frequently used Diagnosis

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Fig 2.1.2 Use of Diagnostic Labels

Depression and anxiety are the most frequently used diagnostic labels. The GP explained that this is probably due to the fact that these are straightforward clinical diagnoses made using standardised tools and procedures. Several GP commented that although backache, stress and fatigue might well appear on a patient's record these are symptoms and only useful as descriptive labels.

Percentage of Patients with stress related primary diagnosis

The percentage of patients whose primary diagnosis was stress related ranged from 1% to 30% an average of 14.5%.

Problems diagnosing stress

Only one GP claimed that due to his own rigorous diagnostic procedure he had no problem diagnosing stress. However for the remaining GP diagnosing stress is problematic because:

1. Stress is not a medical diagnosis. The majority of GP feel that using 'stress' as a diagnosis is too easy, a quick fix option, a convenient label to explain away any number of symptoms or problems. Stress is often something that has been self diagnosed. In short 'stress' is a time and labour saving diagnosis, a way of avoiding having to get to the root cause of the problem:

'GP should never 'diagnose' stress on a patient's record because 'stress' is not a diagnosis, it is not a medical illness, it is an emotional reaction.[] 'Stress' may well be a major factor contributing to the symptoms so the cause of the

'stress' will have to be dealt with as part of the whole treatment but there is no prescription to write or medicine you can take to cure stress.' (GP 3)

2. Conversely sometimes the problem with 'stress' as a diagnosis, is convincing the patient that their problems are indeed stress and not medically related. Whereas some patients are more than happy to hear the word 'stress' others are not prepared, or willing to accept this as a diagnosis i.e. the cause of their problems.
3. Time constraints are viewed as a constant source of frustration and problematic for GP. GP are allocated an average of 5 minutes per consultation. This is not enough time to take a full medical history, to adequately talk and listen to patients and then make a stress related diagnosis.
4. As with any psychosomatic condition, stress always causes problems during diagnosis because it worsens any presenting condition. Thus it is often difficult to separate and differentiate causes from symptoms and confidently exclude underlying medical problems.

Reservations in using a stress related diagnosis

Three GP had no reservations diagnosing 'stress' once they were confident they had rigorously eliminated any medical or organic causes for the symptoms. The other GP were clear that 'stress' is not an illness with an aetiology and therefore should not be used as a diagnosis:

'No matter how fashionable it is to be 'stressed' it is imperative that 'stress' is not medicalised'. (GP 1)

It seems there is a risk that 'stress' might be used on a patient's record because it is less stigmatising than for example, depression or anxiety, which can both be measured (unlike 'stress') using standardised tools and procedures.

Background Experience and Knowledge of Stress

Based on their experience the GPs were confident that they had sufficient knowledge/awareness of stress to deal with most situations that they came across in their consulting rooms. In their opinion the symptoms and signs of stress, although perhaps more nebulous nowadays, had really not changed over the years. Furthermore through knowledge sharing, case reviews, medical networks, journal

articles and conferences, their 'stress' related knowledge was being constantly reviewed and updated. As practitioners their most valuable source of information is their patients.

The Case Studies (see also appendices 1)

Each GP was asked to recall and describe, if possible, two long term cases of stress related sickness absence, one where the patient successfully returned to work and one where the patient did not return to work.

Factors aiding successful return to work

The following list is a summary of the common factors from the case studies that were identified as promoting and facilitating success in work resumption:

1. Early referral and regular consultation with their GP.
2. A rigorous diagnosis, firm but fair approach which avoids encouraging or medicalising stress related problems and prolonged stress related absence.
'It is important to normalise stress related problems. Make it clear, explain to them that what they are experiencing is a normal reaction to, what is for them, excessive pressures and demands. From here you can then move on and begin to identify and deal with the real causes of their problems' (GP 3)
3. Controlled and managed time off from work.
4. Patient insight and self awareness and a positive attitude regarding return to work.
5. Sympathetic and supportive employer, a phased return to work.
6. Work place adaptations which might include redeployment or stress management programmes, anything which avoids returning the patient to the same situation that caused the problems in the first place.
7. Medication to relieve the symptoms in conjunction with talking therapies.
8. Communication between employers, employee and GP.
9. Enhanced coping strategies.

Factors inhibiting return to work.

The following list is a summary of the common factors from the case studies that were identified as inhibiting a successful return to work:

1. Allowing the problems to fester. In other words leaving it too late to seek help i.e. late referral.
2. Chronic physical problems.
3. History of mental health illness
4. Individual differences with particular reference to those patients with

obsessional personalities traits, lack of insight, self awareness and motivation and low self esteem

5. Intransigent employers who are not willing to listen to their employee.
6. Employers who refuse to acknowledge that work is the cause of the stress related illness will not accept any responsibility for the plight of their employee and hence are not prepared to make workplace changes to facilitate work resumption.

Factors that might have prevented sickness absence

The following is summary of the GPs responses:

1. There were several cases in both the successful and unsuccessful cases where the GP felt nothing could have been done to prevent the employee taking sickness, for example absence due to a history of mental illness i.e. depression. Similarly personal problems such as bereavement and marital difficulties including divorce were commented as being factors which no one can control.
2. Several GP commented on the person-organisation fit.

‘It just seems that sometimes the wrong person is in the wrong job, in the wrong company, at the wrong time. I have seen people who have been promoted who were simply not up to the job, should have stayed where they were and never accepted the promotion; now they feel failures.’ (GP 7)
3. Factors within the work place:
 - stress awareness,
 - professional working relationships
 - quality of communication
 - proactive not reactive stress management
 - healthy working environment
 - job security
 - supportive management – enhanced employee relations
 - adequate training
4. Early intervention.

Factors relating to stress

The following list is a summary of the causal factors of stress as referred to the GPs by their patients:

1. Relationship difficulties referring to both working and/or personal relationships.
2. Finances

3. The Job including work–life balance, unrealistic work loads, job suitability, job insecurity, a culture of long hours, no training and bad management i.e. the boss.
4. Home life including caring responsibilities, children, illness and bereavement.

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Fig 2.1.3 Stress Related Issues - Job , finances, friends and relationship with partner were the most frequently referred to stress related issues.

Interventions

Due to the idiosyncratic nature of stress interventions have to be tailor made; there is no off the shelf standardised cure for 'stress'.

The following is a stress intervention designed and used by one GP :

'I arrange for short targeted session of say 10 minutes over a 6-8 week period. In between these sessions I ask my patient to use mind maps to identify the root cause of their problems. During the sessions we talk about new ideas for coping, introduce positive thought and basically provide a safe environment for the patient to feel empowered. Intervention is all about listening to the patient, dealing with the symptoms and enabling them to get back to work'. (GP4)

There are some common elements to every intervention.

Tertiary Interventions

1. Taking a full medical and social history. (behavioural)
2. Elimination of any medical reasons for the symptoms.(behavioural)
3. Alleviating the physical or mental symptoms so they do not interfere or distract the patient from identifying and dealing with the root cause of the stress and learn to cope with their problems. (Behavioural and cognitive))
4. Medication in conjunction with talking therapies e.g. counselling, CBT or psychologist and time off work. (affective and behavioural)
5. Normalising the situation. (affective)
6. Encouraging the patient to use their GP as part of the treatment.

Secondary Intervention

7. Directly targeting the problem so as to remove the source of the stress. (cognitive and behavioural)

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Fig 2.1.4 Interventions/Treatments

Fig 2.1.4 indicates the popularity of certain interventions/treatments for patients with stress related illness.

Effective interventions for stress related problems

1. Any talking therapy that provides analysis and insight into the problems.
2. Listening to the patient.
3. A problem solving, patient focused approach to dealing with the issues.
4. Combination of medication and counselling coupled with a short break from work.
5. A good diagnosis.

Ineffective interventions for stress related problems

When asked to describe interventions that were in their experience ineffective in dealing with stress related complaints the GP had this to say:

1. Based on years of experience they never used ineffective interventions.
2. Any intervention that just cured the symptoms, physical or mental without dealing with the problem as a whole, is always ineffective in the long term:
‘You can not rely on the prescription pad when dealing with stress related illness, you need to look at the whole problem and deal with each issue as it comes to light.’ (GP5)
3. Non rigorous diagnosis which will prolong the problem by not identifying the root cause of the problems.

Referrals

Ideally the GP would like to refer their patients to any form of psychological intervention or mental health service e.g. counsellor, psychologist but due to the limited access and availability to these specialists, the timeliness of this intervention was often inappropriate. A couple of GP were fortunate to be able to offer their own ‘in house’ counselling services to their patients.

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Fig 2.1.5 Onward Specialist Referral

Several GP commented that they would refer patients to medical specialists in order to remove any anxiety associated with a physical problem however they were reluctant to do so for fear of medicalising ‘stress’ in the minds of their patients.

The popularity of the mental health services is due to their ability to help patients deal with their behaviour, gain insight and talk about their problems. Counsellors/therapists are good at unravelling situations especially when the problem is deep rooted.

Return to Work

All the GP assist their patients in the return to work process by helping, supporting and encouraging their patients to get back to a normal environment as soon as possible. The GP believe that their priority lies in helping their patients find answers and solutions to their problems by identifying alternative ways of thinking and coping. However,

'It is important that GP are not complicit in keeping people off work. Yes, some people do need time off to take stock of their lives, have a break from the pressures but it is not in anyone's interest for us to encourage nebulous stress related conditions. Absence from work needs to be short term, maybe a month, monitored and constantly reviewed. It should be just part of the process of getting a patient 'fit for work and should not prolong or exacerbate the problem' (GP 3)

Several GP described their role as the patient's advocate in liaising with employers (at the request of their patients) formulating a return to work programme which might include a graduated return, opening and maintaining communication between all parties and suggesting appropriate changes to facilitate long term work resumption.

The majority agree that GP **should** be involved in the return to work process. However, practically this is not viable with time constraints a GP's biggest adversary:

'Ideally yes, we should be involved, practically though, how can we. There is no time available to do the job properly – which is not ideal' (GP1)

'Yes we should help, but within limits, due to our work load and time constraints we can only do so much, we can only help in a limited way. This is very frustrating not only for us but for our patients and the employers'. (GP 2)

One GP was adamant, active ongoing involvement in the return to work process especially for work related stress complaints was not the responsibility of the GP; their time should not be wasted sorting out work place issues. In his opinion the GP is not best placed to deal with work related stress issues as they do not know the nuances of each and every person's work place: Their responsibilities go as far as promoting fitness for work.

'If the absence is due to work related stress then work needs to sort out the problems. Furthermore it is the employer's responsibility to have systems in place to monitor the welfare of their employees [] GP should only be used to sign people off, to get them fit for work not get them back to work' (GP 3)

Family Interventions

GP have been involved with members of a patient's family for collaboration, support and encouragement in the return to work process. In particular family members were useful in resolving home stressors. This involvement was often either at the request of the patient or directly by the family member but not generally at the specific request of the GP. Although family involvement was considered positively by the GP in facilitating the return to work process, a couple of GP commented that at times it can be a mixed blessing as other problems may come to light during the consultations.

Contact with Employers

All the GP have been contacted at some time by a patient's employer with regard to returning to work. The GP only talk to the employer with their patient's agreement. They referred to the difficulty in talking to employers while at the same time upholding patient confidentiality. Some GP expressed concern with regard to the motives behind such contact; they were not always convinced it was in their patient's best interest. Occasionally contact from an employer is positive in terms of discussing a return to work programme mostly it is for a routine medical update.

Contact by Department of Social Security

All the GP had been contacted by the Department of Social Security in order to provide information for standardise medical certification forms. This information includes medical descriptions of the symptoms, reasons for absence and prospects for returning to work. This information can impact on benefit entitlements. Providing this information is time consuming; the patient's permission is not required.

2.2 Occupational Health Physicians (OHP)

An occupational physician is a doctor, with specialist training and qualification, who in relation to any particular workplace will take full clinical responsibility for advising management and the work force on all health matters connected, directly or indirectly, with their employment. Specialists in occupational medicine, trained in the UK will hold a FFOM or MFOM qualification. They do not prescribe nor do they have the authority to provide sickness certification.

Occupational health aims to promote and maintain the highest degree of physical, mental and social well being of workers in all occupations 'the adaptation of work to people and of each person to their job' (Faculty of Occupational Medicine of the Royal College of Physicians www.facoccmmed.ac.uk). Occupational Medicine is the branch of clinical medicine most active in the field of Occupational Health. Cox (1993) writes that as a discipline occupational health is concerned with understanding the dynamic relationship between work, on the one hand and health on the other. This understanding is used to protect and promote healthy working environments including the effects of work on health and also health on availability and fitness for work and on work ability. Underpinning occupational health is the message that implementing preventative occupational health measures, to protect the company's most important resource i.e. the employee, can be every bit as beneficial to the business as is the maintenance of any other company asset.

The OHP interviewed for this study (2 female and 5 male) either worked as independent occupational health consultants or were employed full time, typically for large global companies dedicated to manage employee health activities and for whom the health and safety of their employees as well as those who come into contact with their products is one their highest priorities. The OHP had an average of 20 years working experience.

Frequency of Stress related complaints over the past 5 years.

The OHP responses were divided between 'frequently' and 'sometimes' when asked about the frequency of stress related complaints. Five believe the rate has increased over the past five years; two that it has stayed the same.

Reasons for Increase

1. Pressures on the economy and mass hysteria created by a culture of performance at any cost.

2. Inadequacy of management to deal with massive workplace change with particular reference to the public sector.
3. The social phenomenon of 'stress' means that there is a lack of stigma attached to the stress label. Nowadays it is perfectly acceptable to admit having some form of mental health problems be it depression or anxiety as long as it comes under the 'stress' umbrella.

'The raised awareness about 'stress' means it is more acceptable to talk about stress, it is a useful catch all phrase used to cover all sorts of symptoms. There is a propensity these days to describe feelings of unhappiness in terms mental ill health rather than a normal reaction to life events, that's why I believe in my job I would say there has been an increase in stress *related* complaints.' (OHP3)

4. Ambitions to succeed, to enable, provide and maintain highly materialistic lifestyles.
5. Increased awareness of stress leading to increased expectations and perceptions of stress

Reasons for Stayed the Same

1. Stress is a new concept, less stigmatising label for same old problems:

'Stress related complaints have been around for much longer than 5 years, it just has a different label these days but it is the same problems that we see and deal with now as we did 5 or 10 years ago.' (OHP6)
2. There is not more stress just different types of stress.

Reasons for Decrease

1. Result of successful introduction of new process and policies specifically aimed at improving organisational behaviours and detecting problems earlier.
2. It is so much easier to talk about being 'stressed', to talk about excessive work loads for example, that stress related issues are detected early and dealt with head on immediately.

Models of Stress

Descriptions of Stress

Stress is an adverse reaction to excessive pressure which is beyond an individual's level or ability to cope. It is described as a **perception** of coping, i.e. a perceived feeling, or fear of not being able to cope.

'Stress is a reaction, a mismatch between demands and ability, resources outstripping demands. Stress causes distress; it is uncomfortable and causes problems. To feel a lack of control, to be out of control is how I would describe 'stress'. (OHP 1)

This adverse reaction normally results in health related problems. OHP are clear that stress is a symptom not a disease or a medical condition. 'Stress' is and should only be used as a descriptive term because it is only a perception that something is wrong. People tend to self diagnosis and medicalise 'stress'. In essence stress is indefinable because it is a catch all phrase for a multitude of possible complaints.

Diagnosing Stress

Overwhelming the OHP responded that they would never diagnose stress because stress is not an illness or a medical condition; it is a purely descriptive term.

The OHP agreed that they would investigate further if they felt the patient had a stress related condition. The following is a summary of the diagnostic procedures (in the absence of any standardised tools or instruments) used by the OHP to confirm subjective suspicions that 'stress' related issues are the underlying cause of the complaints:

1. Take and examine a full case history.
2. Eliminate any medical or organic reasons for physical complaints.
3. Use standardised tools to confirm, for example, depression or anxiety
4. Talk to the patient and make enquiries, try and identify work or home life problem areas.

'This is all about talking to the patient; an investigation to find the root of the problem, the source of the pressure, to find any areas in their lives where they are not coping. I need to try and understand what is going on, so they can begin to understand what is happening to them. I need to satisfy myself first that what I am looking at is a reaction to life events. I can only do this by getting beyond what the patient presents in the consultation by talking to them; then we can both move on. (OHP 3)

5. Talk specifically about work related issues, with particular reference to any changes, conflicts or problems at work.
6. Use the 'pint-pot analogy'.

'There is only so much a person can take on board if they are to cope. If through consultation it is apparent that the patient has simply got too much on their plate, what ever the reasons, then I can see and explain to them that they have reached, probably exceeded their own levels of capacity and are now not coping and therefore what they are experiencing are the effects of stress'. (OHP1)

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Fig 2.2.1 Medical Conditions Where Stress might be a Causal Factor

Comment

A few OHP commented that it was impossible to say that 'stress' might be a causal factor in any of the above medical conditions because 'stress' has no aetiology and is purely descriptive but 'stress' might be **associated** with any number of the above conditions to 'some extent'. Furthermore they commented that the above list contains symptoms not medical conditions.

Frequently used Diagnosis

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Fig 2.2.2 Use of Diagnostic Labels

Other - Irritable Bowel Syndrome and Hormonal Imbalance

The OHP were asked to explain their responses. The following is a summary of their reasoning:

1. Stress

Used as a convenient purely descriptive term to explain problems arising from a mismatch of demands and ability to cope.

2. Depression

A diagnosis that can be based on standardised measurements. It is a clinical syndrome with clear clinical guidelines.

3. Fatigue

Working for a global company means international travelling. Jet lag is an inherent stressor when people frequently cross time zones as they do in this job.

4. Burnout

Burnout is not a medical term.

Percentage of Patients with stress related primary diagnosis

The percentage of patients whose primary diagnosis was stress related ranged from 0% (for those who did not believe stress should ever be a diagnosis) to 70% - an average of 19%.

Problems diagnosing stress

The OHP responded that they had no problems in diagnosing stress in their patients because they would **never** use 'stress' as a diagnosis, 'stress' being a symptom:

'Stress as a diagnosis is an easy option, you have to go further than that, you have to do something with the label. 'Stress' as a diagnosis is not helpful to anyone.' (OHP 3).

They agreed that based on years of experience they would have no problems deciding which conditions or symptoms had medical origins and which ones were psychogenic i.e. stress related. One OHP did explain that the problem with 'stress' comes from having to differentiate between what is a normal and what is abnormal reaction to events.

Reservations in using a stress related diagnosis

Mostly the OHP replied that they do have reservations in using stress as a diagnosis because it is a symptom not a diagnosis. However they suggested that they would write the word 'stress' on a patients notes as a descriptive term, a concept that plays a pivotal role in many of the complaints that present in their consulting rooms.

Two OHP commented upon their reservations in using the 'stress' label for fear of labelling their patient as someone who cannot cope with their job.

Background Experience and Knowledge of Stress

The OHP had an average of 20 years working experience. One OHP felt nobody could have sufficient knowledge to deal with most stress related situations they encountered because every situation is truly unique and multifactorial:

'Dealing with any stress related issue is a constant learning curve, I constantly seek out any new sources of information; there is no way I will never know all there is to know. I urge research to further investigate causation.' (OHP 7)

Generally the OHP were confident in their knowledge and ability to deal with most stress related issues based on years of experience, training, reading literature, attending conferences, talking to colleagues and identifying key interventions in the return to work process.

The Case Studies (see appendices)

Each OHP was asked to recall and describe, if possible, two long term cases of stress related sickness absence, one where the patient successfully returned to work and one where the patient did not return to work.

Factors aiding successful return to work

1. Early intervention, early contact and consultation with OHP.
2. Detailed and strict Return to Work (RTW) plan made in agreement with employee, employer and OHP.

3. Identifying and dealing with stressors
4. Multi discipline collaborative input.
5. Good rehabilitation based on appropriate treatment and interventions to alleviate symptoms.
6. Addressing and changing the work place stressors.
7. Cognitive Behavioural Therapy (CBT) to enable and empower the patient by teaching new coping skills and normalising the situation.
8. Good, ongoing and effective communication.
9. Supportive management.

Factors inhibiting successful return to work.

1. Inappropriate person- job fit.
2. Poor working relationships with colleagues and bosses.
3. Unwillingness to change or compromise both on the part of the employee and employer.
4. Irresolvable work differences.
5. Substantial financial reward during absence in the form of insurance salary protection taking away the incentive to return to work.
6. Attitude of the patient/employee.
7. Poor job satisfaction
8. Poor response to treatment/interventions.
9. Patient unfit for work.

Factors that might have prevented sickness absence

The following list is a summary of their responses:

1. Early intervention.
2. Not allowing problems to become chronic by quickly addressing and resolving conflict at work.
3. Adequate stress awareness so that management can recognise 'stress' warning signs such as frequent short term absences.
4. Not ignoring the signs and clues that trouble was brewing.
5. Hands on management coupled with open door policy of communication.
6. Good line manager who is actively involved with their staff on an ongoing basis.
7. Greater emphasis on improved selection processes 'hire the right person for the right job'. (OHP 1)
8. Stress management for managers.

9. Someone independent, who knows the work place, for the employee to talk to
e.g. an OH consultancy or help line.

Factors relating to stress

The following is a summary of the causal factors of stress as reported to the OHP by their patients:

1. Work with reference to work overload, relationships at work, intolerable bosses, bullying and harassment, being undervalued and underused, job insecurity, downsizing, insufficient resources and bad management.
2. Financial issues.
3. Work and home life balance
4. Family responsibilities and relationships.
5. Loss of control

'The point is stress is seldom one thing or another, so the patient might refer to work as the problem but when you start to talk to them so many other issues come to the fore front that it soon becomes hard to separate work and personal stress related issues as they both affect each other.' (OHP 4)

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Fig 2.2.3 Frequency of Stress Related Issues

Interventions

Tertiary intervention

1. Provide a safe, neutral environment for the patient to talk about their issues (affective)
2. Time off work; a break from the pressures (behavioural)
3. Onward referral to GP, counsellor or a psychiatrist as deemed appropriate to their physical or mental symptoms (behavioural)
4. Cognitive Behavioural Therapy (CBT)
5. Normalise the situation. (affective)
6. Explain the 'pint pot theory' and deal with the problems one by one to create more room to cope. (cognitive)

Secondary Intervention

7. OHP intervention on behalf of the employee by talking to line manager; looking at the identified work place stressors and advising on work place changes.
8. Arrange in house meetings with HR and line managers.
9. Enhanced communication between all parties

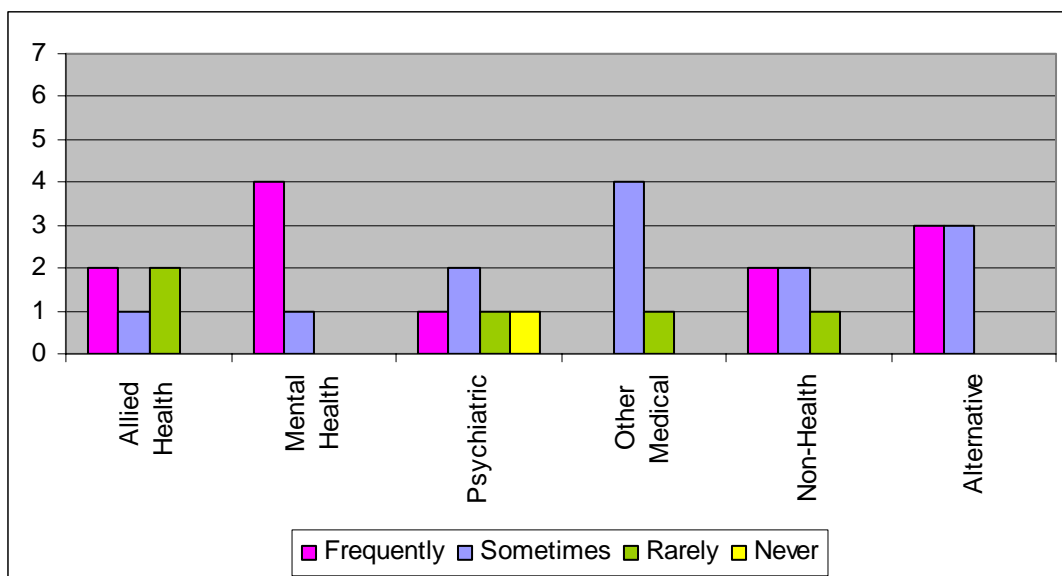


Fig 2.2.4 Rate of referral for Listed Interventions/Treatments

Effective interventions for stress related conditions

1. CBT was identified by the majority of the OHP as an effective intervention in the case of stress related complaints because it uses behaviour modification techniques to change maladaptive perceptions of coping.
‘CBT seems to empower people by encouraging them to positively reappraise their stressful situations.’ (OHP 4)
2. Early contact and intervention.
3. Talking to a professional e.g. OHP, GP, Psychologist, Counsellor getting to the root cause of the problem.
4. A Problem solving approach..
5. Organisational change.

The following quote sums up many aspects of an effective OHP intervention:

‘You need to talk to them and explain about people having different levels of coping. You need to get in early to normalise the situation. Often they will need to be referred to a counsellor or other such mental health professional to help relieve the emotional pressures. They might also need medication. They need to be empowered and learn to deal with their problems one by one. Changes might need to be made but that is my job; the first stage of any treatment is to get the patient back to normal. (OHP1)

Ineffective interventions for stress related conditions

1. Medicalising the problem.
2. Exclusive use of drugs or psychiatric interventions.
3. No liaison between employee and employer.
4. Failure to identify root cause of the problems.

5. Sickness absence which is not monitored.
6. No collaboration between professionals.
7. Not seeking professional help to deal with stress related issues.

Referrals

If the complaint is caused by a problem at work then the OHP are the best people to deal with the problem.

'It is my job to deal with any work related stress problems. That is what I am trained to do and that is what I expect to deal with. I am the specialist when it comes to work related stress issues within this company. (OHP7)

For some work related issues the patient might also be referred to the HR department. Otherwise, depending on the symptoms, the patient might be referred to their own GP for medical advice or a sickness note, or to a mental health professional for any form of talking therapy.

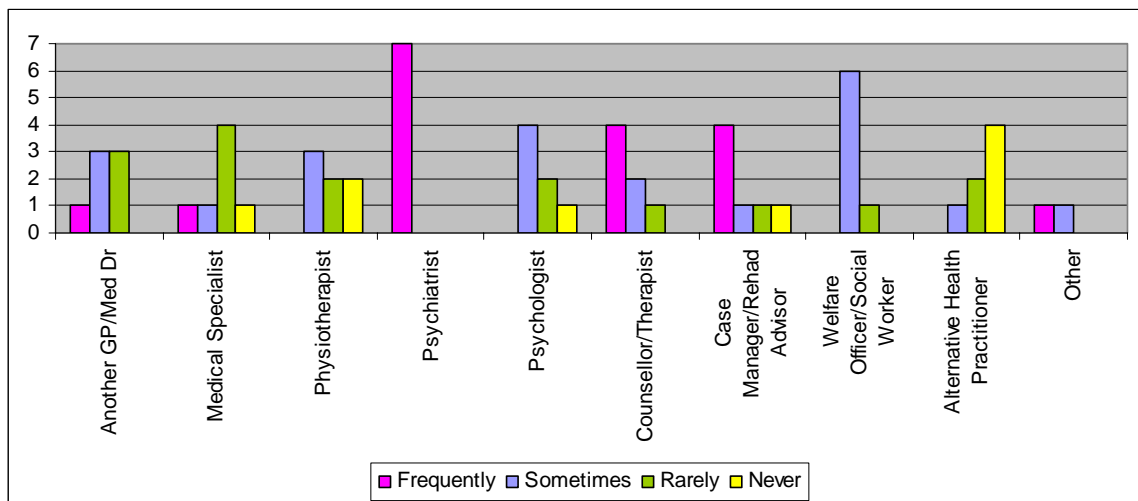


Fig 2.2.5 Frequency of Specialist Referral

Other – vocational rehabilitation specialist

Figure 2.2.5 shows how often the OHP refer their patients to specialists. Psychiatrists, Counsellors/Therapists are popular because of their analytical approach to problem solving, which it is believed is ideally suited for stress related issues.

'Most people want someone they can talk to, who can help solve their problems. Counsellors, psychologists are trained and good at pointing people in right direction, to get them out of their present situation and help them to move. When they have sorted out these issues in their mind, then I can sort out any work place problems. '(OHP 3)

Other medical specialists are used to relieve physical symptoms.

Stress is not the problem, stress is a whole spectrum of problems, if we know what we are dealing with in terms of physical and mental illness then we must use the appropriate specialist to deal with the problems'. (OHP7)

Return to Work

Every OHP has had experience, training and expertise in the RTW process. They believe a crucial part of their job is to facilitate any return to work process.

'Yes it is imperative that we are involved from start to finish in the return to work process. If someone is off work due to stress related problems then we have already failed in that we have not provided a healthy work environment for them; something has gone wrong. It is important that the patient has an advocate, to protect them from others such as their managers who might have a different agenda.' (OHP 6)

They often recommend time off work to give the patient time to identify and formulate answers to their problems, to relieve them of work pressures and provide the opportunity to receive appropriate medical intervention; engaging with the patient. At the same time the OHP keep in touch with other professionals involved in the sickness absence such as GPs, HR, line managers or higher management, maintaining lines of communication and promoting inter professional collaboration in the return to work process.

The aim of an OHP is to get their patient fit for work and agree a return to work plan. A RTW plan might involve, for example, a graduated return to work, redeployment, a different job role or working part time from home. Many of the OHP believe that work itself is therapeutic and therefore patients on sickness absence should be encouraged to return to work as soon as possible.

Family Interventions

The majority of OHP have routinely involved members of the patients' family in the return to work process. A patient's spouse/partner or close family member is viewed as a valuable part of the rehabilitation process. Their presence often helps to make the patient feel comfortable during consultations; they can reinforce what was said during meetings.

'A spouse is a very powerful influence in getting a person back to work. It seems that sharing their problems with me and their husband or wife takes a huge weight off their shoulders, allowing them to move on.' (OHP 6)

Contact with employers

OHP remains in constant contact with employers with regard to work resumption for any employee on any long term absence including stress. Contact with employers is normal practice; often the employee has been referred to the OHP by the employer. The OHP will talk through any work related issues with the employer and negotiate on behalf of the employee. They will define the boundaries and agree a return to work plan. OHP will identify problem areas within the work place, such as line managers and suggest appropriate interventions. Their role is as an independent non political advisor whose aim is to promote a 'win win' situation for all parties i.e. the employee and the employer by returning the patient to a healthy work place.

Contact with Department of Social Security

Only one OHP had ever been contacted by social security. The OHP was asked to provide standard documentation with reference to an insurance claim.

3 Mental Health Professionals (MHP)

According to the 1999 National Service Framework for Mental Health, for every one hundred individuals that consult their GP in the UK with a mental health problem, nine will be referred to a specialist service for assessment and advice, or for treatment. Mostly mental health problems cannot be managed in primary care alone.

Five mental health professionals were interviewed for this research; 3 males and 2 females. Two MHP work as part of the onsite counselling service for the staff of a large university with over 2000 employees. Two work in a counselling capacity for their local health authority as part of a job retention initiative utilising a case management approach to effective 'back-to-work planning'; One is an NHS Consultant Psychiatrist in Addictions. The number of years experience ranged from 5 years to 30 years with an average of 17 years.

Frequency of Stress related complaints over the past 5 years.

Stress is frequently referred to by the clients of the MHP when describing their condition. Three MHP believe that in their experience the incidence of stress related conditions has increased over the past, three that it has stayed at the same albeit at a constantly high level.

Reasons for Increase

Constant change in the workplace, job insecurity due to short term contracts and a culture of high expectations that never stops increasing are blamed, by some, for the increase. These factors coupled with downsizing and a lack of emotional support in the workplace means that individuals worry about not being able to cope with their increased work load and do not admit they are having problems before it is too late:

'This sequence of events leads to crisis management, and interventions that are often too late.' (MHP 1)

One MHP explained that because her referral rate for addiction has increased this suggests that there are more people are not coping with life.

'Stress often leads to changes or increases in negative health related behaviours such as drug and alcohol addiction.' (MHP 5)

Reasons for stayed the same

2 MHP believe stress has remained constantly high for many years.

'I have experience stress related problems at epidemic proportions for a number of years now. Pressures on people to perform never stop increasing' (MHP 4)

One MHP referred to the breakdown in relationships playing a key role in the decline in mental health and an increase in stress related problems

'Many relationships break down under the pressure of stressful lifestyles. In my experience 80% of all unemployed people are not in a relationship.' (MHP 2)

Models of Stress

Descriptions of Stress

MHP mainly talk about stress in terms of an inability to cope with daily life events; a loss of control. Stress is anything that pushes someone beyond their normal coping limits and can manifest itself in many ways. It is a question of balancing the equation or outstripping the body's capacity, physically and mentally to cope. It is described as an excessive anxiety brought about by feelings of being undervalued, feelings of insecurity, helplessness and powerlessness. Stress is individual, causes internal discomfort and is typified by mental disorganisation.

However:

'I seriously doubt the usefulness of the word 'stress' in helping me to help my patients sort out their problems. What exactly do we mean when we use the word 'stress' on notes, nothing really. It does not tell us anything about what is really going on, nothing about the true nature of the problems. Stress is merely the tip of the iceberg.' (MHP 5)

Common diagnostic labels

1. Anxiety and depression leading to clinical depression. Often seen as part of the stress syndrome.
2. Stress triggered by underlying life experiences.
3. Addiction – drug and alcohol.
4. Panic attacks.
5. Any behaviour that is in excess 'beyond the norm' (MHP 3) e.g. eating, fatigue, sleeping and aggression.

The percentage of the MHP clients referred whose primary diagnosis is stress related ranged from 30% to 80%.

Background experience and knowledge

Four out five MHP felt that they had sufficient stress related knowledge and experience to deal with most situations that arise on behalf of their clients. Two had a particular interest in promoting mental and physical health in the workplace. The MHP generally

believe that the more they learn by attending conferences, reading journal articles, networking and talking with colleagues, the more they can help their clients. One MHP felt that he still had a great deal to learn; in particular he expressed a wish for more tools to empower his clients.

Another MHP commented:

'Yes, I know probably all there is to know about 'stress' what causes it, what effects it, how to deal and how to manage it. I see it all the time. I have to help people put their stressed tattered lives back on course' (MHP 5)

The Case Studies

Each MHP was asked to recall and describe, if possible, two long term cases of stress related sickness absence, one where the patient successfully returned to work and one where the patient did not return to work.

The MHP counsellor commented that often they are aware whether or not their clients have returned to work.

Factors aiding successful return to work

The following list (is a summary of the common factors from the case studies that were identified as promoting and facilitating success in work resumption:

1. Engaging with counselling therapy
2. Talking about problems.
3. Allowing the MHP to take on the burden of responsibility – equating to unconditional support.
4. Insight, self awareness and understanding into stress and its manifestations.
5. Empowering
6. Assertiveness training
7. Cognitive Behavioural Therapies (CBT) – enhanced coping strategies.
8. Work place adaptations and changes e.g. change of job role, graduated return,
9. Open and honest communication.
10. Collaborative return to work programme.
11. Medical compliance
12. Support from colleagues, HR and management.
13. De-stigmatising mental health problems.

Factors inhibiting return to work.

The following list is a summary of the common factors from the case studies that were identified as inhibiting a successful return to work:

1. Inability to deal with problems.
 ‘Often people return to work too soon having not dealt honestly with their issues – they are in denial about the root cause of their problems.’ (MHP 5)
2. Impending disciplinary hearing – stress having led to drink problems.
3. Addictions
4. Levels of stress completely out of control – situation has gone too far
5. Stress that is endemic throughout the entire company.
6. Management unable or unwilling to make changes to work place.
7. Relationship with colleagues.
8. Attitude of line manager
9. Inaccurate diagnosis.
10. Stigma and ignorance surrounding mental health problems.
11. Personality of client.

Factors that might have prevented sickness absence

The following is summary of the factors in the opinion of the MHP that might have prevented the sickness absence:

1. Early awareness, insight and understanding:
 ‘Once clients understand that what they are experiencing is normal a normal stress reaction – once they understand what stress can do to them, they can then recognise the signs and deal with things before not after they become a threat to their health. (MHP 5)
2. Asking for help earlier.
3. Early intervention – making small reasonable adjustments to work load, hours or job content.
4. Being heard.
5. Management training.
6. Proper lines of communication; good company infrastructure.
7. Good management.
8. Feeling valued at work.
 ‘Sometimes all it takes is for someone at work to say thank you to the staff for all their hard work and effort. Unfortunately in large organisations like this, people are too involved in their own work to turn around and invest a little time in their staff.’ (MHP 1)
10. Emotional intelligence at work.
11. Assertiveness.

Factors relating to stress

1. Relationships – work and personal

2. Work related issues – job insecurities, work overload, downsizing, short term contracts, changes to work place.
3. Balancing work and home life.
4. Addictions

‘Sometimes it is hard to decide what came first the addiction and then the stress or the stress that led to the addiction.’ (MHP 5)

5. Finances **Error! Not a valid link.**

Fig 2.3.1 Stress Related Issues

Figure 2.31 shows that job and loneliness are the most common stress related issues.

Interventions

The MHP described a number of complimentary alternative therapeutic treatments which they recommend e.g. relaxation techniques, acupuncture (especially for addiction), and community therapies. Mainly the MHP adopt a solution based approach to the problems using a combination of cognitive therapies, talking and physical exercise. The talking therapy is normally specifically designed to detangle and then deal with each problem. Breathing exercises and physical fitness are encouraged to help relieve chronic health problems.

‘Each case is treated individually. I am there to provide emotional support, help with legal paper work, anything to relieve the pressure they are feeling but they have to want to sort things out and get fit – that comes first, a positive attitude to change.’ (MHP 2)

CBT is frequently used to help the client engage in forthright, effective assertive behaviour, help them learn coping strategies enable them to balance such things as work and home life. The MHP emphasise how important it is for their clients to comply with treatments and interventions – including medicinal treatments and to be realistic about what can be achieved and when it can be achieved.

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Fig 2.3.2. Recommended Treatments/Interventions

Effective interventions for stress related conditions

Any of the following interventions

Tertiary Interventiions

1. CBT (cognitive)
2. Life coaching (cognitive)

3. Talking and listening – providing a safe environment to able to share the problem.(affective)
4. Going beyond the symptoms of the stress; getting to the root cause of the problems.
5. Emotional support (affective)
6. Validation of their situation by someone who is independent

Secondary Intervention

7. Physical exercise. (behavioural)
8. Relaxation techniques (behavioural)
9. A recovery plan.(behavioural)

Ineffective interventions for stress related conditions

1. Only dealing with the symptoms – not the cause of the symptoms
2. Therapy not connected to a recovery plan.
3. Not seeing a mental health specialist:

‘GPs are too busy to get involved with mental health services so they just tend to rely on pills to solve the problems. Then they wonder why the patient keeps appearing in their surgery needing more time off work. (MHP 3)

4. Lack of return to work programme.
5. Sole use of medication – which should be last resort.

Referrals

The MHP were asked from whom their clients were referred.

	Yes	No
GP/Medical Dr	5	
Medical Specialist	4	1
Physiotherapist	0	5
Psychiatrist	2	3
Psychologist	2	3
Counsellor/ Therapist	1	4
Case Manager/ Rehab Advisor	2	3
Community welfare officer/ Social worker	2	3
Alternative health practitioner	2	3
Insurance companies	1	4
Legal Profession*	0	4
Self referral	5	0
Other – HR, OH, *probation and prison service	5	0

Fig 2.3.3 Rate of Referrals

The MHP's clients are mainly referred by GP, OH, and HR although referrals also come via the probation and prison services and self referral.

The typical reasons for these referrals are:

- Overuse and abuse of drugs and alcohol.
- In need of CBT to enhance such things as coping skills, problem solving and decision making
- Inappropriate emotional response to life events.
- Depression linked to physical health problems.
- Inability to function normally – mental breakdown.
- Therapeutic to facilitate return to work.
- Counselling – need to unravel and unpick problems.

Return to Work

During the initial consultation it normally becomes apparent whether or not the client/patient is absent from work. Two MHP (counsellors) did not see return to work as the specific aim of their intervention. However they believe the service they provide is an important step in preparing their clients for work resumption:

'Once the sessions are over it is quite likely that we will not hear from them again – so we do not always know whether or not they successfully returned to work. I believe that by helping them untangle the issues, identify what they can and can't do, empower them - puts them well down the road to recovery and return to work ' (MHP 1)

Three MHP frequently are directly involved in the return to work process. Often this means formalising a return to work programme, liaising with their client's employers, recommending work place changes and advising clients on legal issues. The majority of MHP facilitate and often initiate communication between their client/patient and his/her employer; they also attempt to de stigmatise the mental health label.

Yes we should definitely be involved if only in a supportive way, by addressing the psychological and emotional issues they need to overcome if they are to successfully return to work and stay at work. (MHP 1)

One MHP commented on the problems in dealing with cases of addiction:

'My involvement in getting my patient back to work is very much client led. Many of my clients avoid talking about work; do not want to return to work, work resumption is the last thing on their minds.

(MHP 5)

The first and primary aim of any MH intervention is to return the client to normal levels of functioning. Return to work is not the primary objective of MHP intervention but is often the outcome of successful treatment.

Family Interventions

Although most of the MHP had not worked with a member of their client's family in the recovery or return to work process, they indicated that they would be willing to do so if they felt it would be in their client's best interest. One MHP commented that they have involved a family member but only in the recovery process.

Contact with Employers

In the opinion of two MHP it would be unusual to be contacted by their client's employer. Those MHP who had been in contact with a client's employer had been asked to report and make recommendations for return to work; to act as a 'go between' (MHP3). One MHP commented that this contact was often quite defensive, uncooperative and not in their client's best interest.

Although the MHP is not usually a point of contact between an employee and their employer most commented that as long it was with the consent of their client they would be willing to become involved.

2.4 Return to Work Specialists (RTWS)

RTW specialists are vocational experts who adopt a case management approach to implement and sustain a successful RTW programme for their individual clients. They can intervene as early as the first day an injury or illness is reported and often become the primary contact for the employee, employer via the HR department or line manager, physician and/or insurance company, in fact anyone involved in avoiding needless worker absence and aiming to promote effective work resumption.

Five of the seven RTW specialists (5 female 2 male) were self employed consultants whose clients included insurance companies, rehab networks, companies and self referred individuals. Two of the RTW specialists worked for non profits making vocational rehabilitation organisations in the UK dealing with both physical and mental disability. The RTWS had an average of 12 years experience.

Incidence of Stress in the workplace

Six of the RTWS commented that they have experienced a steady increase in stress related referrals; therefore the unanimous opinion of the RTWS is that the incidence of stress in the work place has increased over the past five years. RTWS believe this increase is partly due to the popularisation and the acceptability of 'stress' as a label,

' [] this is a good thing because it means that more people are being picked up and not being left to cope on their own with situations over which they have no control, which are making them ill'.

(RTWS 1)

This increase is largely blamed on workplace stressors as more people struggle with conditions of employment. Mergers, acquisitions, redundancies and downsizing have brought about changes in company culture; expectations of high performance are now internalised by a smaller workforce Inadequate training particularly at management level means that often the wrong person is in the wrong job, as one RTWS explained.

'You might have a person who is brilliant at selling, has done really well as a sales person and is then promoted to sales manager. Suddenly you have a situation where the brilliant sales person is no longer selling but instead is now wrecking havoc in the workplace with the sales team because he has inadequate, interpersonal team leadership skills. This is stressful all round, for the new manager who must know he is not doing a good job and for his team members who have to put up with his poor leadership.' (RTW 7)

Models of Stress

The concept of stress is referred to as an individual perception of resources i.e. that someone feels they can or can't cope with what ever is going on in their lives. Stress is an in-balance between what can be and what cannot be dealt with, characterised by feelings of being completely out of control; the classic 'fight or flight' syndrome. The individual appraisal of a potential stressful situation is influenced by a person's experience, knowledge, skills and personality. A person who is feeling 'stressed' will often display chronic symptoms such as fatigue, be unable to relax, be overly anxious, depressed or seem completely overwhelmed by events. They often have low self esteem and low self efficacy. Stress can also have physical manifestations such as backache or headache.

Common Diagnosis

The percentage of the RTW'S clients whose primary diagnoses are stress related ranged from 5% to 65%. The following is a list of the most common presenting diagnosis

- Depression
- Chronic Fatigue Syndrome
- Anxiety back problems
- Stress – but not as a diagnosis, as a descriptive term linked to the medical condition.

Background Experience of RTWS

The RTWA all felt they had sufficient knowledge and experience to deal most situations that they came across on behalf of their clients. 'Stress' is a topical area within the field of RTWS and as practitioners they are obliged to keep fully informed and up to date.

'By adopting a holistic approach to stress related illness I work with a network of people who deal with stress related issues from different angles. This gives me access to a wide range of expertise for advice and information on interventions and treatments.' (OHP5)

Information about stress comes through knowledge sharing, attending RTW and Rehab conferences, journal articles, stress management courses, collaboration with colleagues and experience in the field.

The Case Studies (see appendices 1)

The RTWS were asked to recall and describe, if possible, two stress related cases of long term sickness absence, one where the patient successfully returned to work and one where the patient did not return to work.

Factors facilitating successful RTW

The following is a summary of the common factors that were identified as promoting and facilitating successful work resumption for those clients on stress related sickness absence:

1. Identifying and dealing with the client's needs.
2. A RTW coordinator acting as middle man between employee and employer.
3. Formulating and implementing an individually tailored RTW programme based on the needs of the client with the agreement and collaboration of their GP and employer.
4. Constant monitoring of the RTW plan
5. Supportive work place environment prepared to adapt the working environment to facilitate RTW.
6. Flexible management.
7. Assertiveness and Stress Management training.
8. CBT for coping skills and to enhance feelings of self efficacy.
9. Communication
10. Positive attitude and motivation of the client.
11. Organisational support
- 12.

Factors that Inhibited Return to Work

The following is a summary of the common factors that were identified as inhibiting work resumption for those clients on stress related sickness absence:

1. Inability by both parties i.e. the employee and the employer to resolve work place problems.

‘Sometimes there is a irretrievable break down in communication, leading to a stale mate situation where neither side is willing to compromise or make changes.’ (RTWS 2)
2. Mental Health Problems
3. Intervention was ‘too little too late’ (RTWS 7)
4. Non compliance with RTW programme.
5. Fitness of the client
6. Being off work for too long

'A client that has been off work too long can make the RTW process almost impossible. By now they will have minimal contact with their employers or colleagues, so there is only a tenuous bond and little communication. They feel disinclined to return to work, probably because they feel awkward, out of touch, worried about the attitudes of their colleagues should they return – all in all long, long term absence is not good for anyone.' (RTWS 3)

7. Age
8. Attitude of the absentee.
9. Personal circumstances of the absentee.

Factors preventing sickness absence

The following list is a summary of the common factors that in the personal opinion of the RTWS might have prevented the absence

1. Early intervention
2. Control at work
3. Better conditions of employment; a company culture that promoted health, satisfaction and well being at work.
4. Stress awareness in managers
5. Hands on Management
6. Effective bullying and harassment policies and guidelines.
7. Staff training and development systems
8. Effective communication:

'If he had felt able to go and talk to somebody at work, to share the problem, felt confident that the issues would have been resolved – in other words if there had been a system in place to allow employees to freely and openly discuss problems, then I do not believe that things would have got so bad.' (RTW 4)
9. Appropriate person-work fit
10. Perceived organisational support home.
11. Support at home.
12. Client insight

Factors Relating to Stress

The following is a list of common causal factors of stress as referred to by clients of the RTWS:

1. Finances
2. Breakdown in relationships – work and personal
3. Medical Illness
4. Work – including long working hours, job insecurity, changes at work, redeployment, unrealistic targets, threat of redundancy

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Fig 2.4.1 Stress Related Issues

Job, health and relatives are the common stress related issues as presented to the RTWS by their clients.

Interventions

Each RTW intervention has to be tailor made depending on the case specific symptoms and issues:

‘There are no common interventions because every case is different, with its own set of unique circumstance and problems therefore each case needs its own appropriate, specific tailor made programme.’ (RTW 3)

An intervention might include medical input as recommended by a client’s GP to relieve the symptoms i.e. drugs or mental health services – in particular CBT in conjunction with an agreed RTW programme. The RTWS role is firstly as spokesperson for the client and secondly as the inter-professional RTW coordinator.

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Figure 2.4.2 Interventions/Treatments Rate of Referral

Figure 2.4.2 shows that the most popular recommended interventions are the non health interventions.

Effective Treatment/Intervention

Tertiary Intervention

1. Combination of any appropriate interventions/treatment including medication, counselling, CBT and a RTW facilitator. (cognitive, behavioural & affective))
2. Vocational goals and plans worked on collaboratively. (behavioural)
3. RTW programme (behavioural)
4. Prevention through increased stress awareness. (secondary intervention)

Ineffective Treatment/Intervention

1. Sole use of medical intervention – just dealing with the symptoms
2. Failure to identify and deal with the underlying cause of the problems.
3. Any treatment used in isolation
4. Ignoring life style issues.
5. Complimentary therapies
6. Short term ‘quick fix measures’ (OHP 1)

Referrals

Referrals mainly come from insurance companies, employers and self referral. The RTWS are asked to provide assessment and recommendations for work resumption.

On occasions they are asked to intervene in order to, hopefully, prevent sickness absence.

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Fig 2.4.3 Source of Client Referral

Figure 2.4.3. demonstrates that most of the RTWS clients are referred by Insurance companies.

Return to Work

For all cases of work resumption i.e. whether or not the absence is stress related, the following basic steps are followed:

1. Empower and motivate the client
2. Assess fitness to return.
3. Collaborative input from any professional involved in treating the client e.g. GP and RTWS
4. Involve the family.
5. Open and establish lines of communication between client and employer. Establish common grounds of understanding regarding the absence; help eliminate any stigma attached to the absence.
6. Negotiate with client and employer – act as spokesperson and mediator.
7. Deal with work place issues.

‘If the case is stress related then it is my job to help identify and resolve any employment issues. This might mean negotiating radical changes to the working environment such as eliminating power differentials at work, redeployment, retraining, addressing bullies, addressing work load, hours – based on my experience the list is endless. There is no point returning someone to exactly the same or a worse situation than they had before.’ (OHP 6)
8. Coordinate, process, review and monitor RTW programme.
9. Insure that the timing is right for all parties.

There were some common problems identified by the RTWS when discussing the process of work resumption. For example, sometimes the health beliefs of the patient hinder the work resumption, for some this might mean a need for anxiety management. It is important that once the goals regarding the RTW are established that they are not altered by any party without negotiation. In some cases successful long term work resumption fails because expectations are unrealistically high, people become disappointed and are not prepared to compromise.

'This is not about one side giving away to another; this is about positive attitudes, trust, honesty negotiation, compromise and a willingness to learn from mistakes.' (OHP 6)

Contact with Family Members

There was a mixed response from RTWS with regard to the issue of involving members of their client's family in the return to work process. Half of the RTWS believe that family input was essential in facilitating the whole RTW process, by getting them to agree to and support the plan from within the home. Family involvement was seen useful from the point of view of verification of the clients situation and for helping to pin point home based issues and problems. Family input was viewed as critical for the maintenance of any RTW plan.

The other RTWS believe that family input should not be encouraged and at the very least should only be in a periphery role. It seems that there is a fine line between family support which is helpful and constructive and that which is unhelpful and destructive.

Contact with Employers

All the RTWS have been contacted directly by a client's employer or representative with regard to work resumption. Direct communication between an employer and RTWS is a normal, healthy part of the RTW process.

The RTWS establish the 'state of play' with regard to the employer's attitude regarding their client and work resumption. Generally the RTWS meet with representatives from HR and/or management; often the client is present too. The RTWS will negotiate and secure the employers agreement for a RTW programme which might include a graded return, reduced hours, reduced work, retraining, redeployment etc. It is important that the RTWS ascertain exactly what the employer is or is not prepared to accommodate and how far they are prepared to go in supporting the RTW plan. Generally it was felt that most employers are fair, willing and supportive. Any agreements or plans regarding RTW are confirmed in writing.

'Meeting with the employer on behalf of the client is all about increasing awareness regarding the situation, to dispel and rumours, to confirm my client's willingness and motivation to return to work and then to report back to my client about the aspirations of their employer.' (OHP 3)

Job Demands Analysis

Five RTWS had conducted a Job Demands Analysis on behalf of a client.

Functional Capacity Report

Four RTWS had conducted a Functional Capacity Report on behalf of a client.

2.5 Company Directors/General Managers (CD/GM)

The interviewees (3 females and 4 males) worked in London and the South East of England in both the public and private sector. The size of their organisations varied between 45 and 4200 employees and represented the world of publishing, recruitment, manufacturing company, bio technology, IT, education and public health. Five of the interviewees were company directors, of which four were managing directors, responsible for company policies and programmes, company development and staff well being. Two interviewees were company general managers; one was directly responsible for 45 employees and one for 17 managers each with managerial responsibilities for up to 30 staff. GM/CD was directly responsible for an average of 60 employees.

Stress Recognition

Five out of seven CD/GM believe that the incidence of stress in the workplace has increased over the past five years. Two believe that it has stayed the same.

Reasons for Increase

The following is a summary of the responses.

The constant pace and rate of change in the workplace is felt to be one of the significant contributing factors to this increase. People's lives are much busier, deadlines are tight and expectations to perform are so high that simple things, out of our control, such as train cancellations, traffic jams and technical failures add to our daily problems and become major sources of anxiety and stress – in short people juggle so many things in their lives that there is no margin for error.

New technology has revolutionised the work place and in some areas this has led to deskilling and retraining. Communication is instant and world wide, 24 hours a day every day of the year and the speed of this communication means that people are expected to respond and perform instantly.

'People expect instant action, an instant response anytime of day or night. 10 years ago you might have had a day or so to think about your response to a letter or a request, nowadays you have to reply immediately and you have to get it right. 'There is no cooling off period, time to think and I know from experience that sometimes you reply in the heat of the moment, a knee jerk reaction which you later live to regret.'
(CD/CM 1)

The effects of downsizing was also mentioned, people have been taken out of safe working environments and jobs for life; fewer people are expected to do more, without the luxury of job security or tenure.

The popularisation of stress as a new vogue term to describe work related pressures was also discussed. Many GM/CD believe that in fact what has really increased is **awareness** about work related stress and not in fact genuine 'stress'.

As one CD explained:

'It is nothing new to be stressed where we work, in fact if you can't work in stressful environments then don't work here. The difference is now it is so much easier to talk about things – we can use the word 'stress' to describe how we are feeling, it is a useful concept, it has given a name to something we could not name before. Stress is a convenient hook on which people can hang reasons for underperforming.' (CD/GM 7)

One CD/GM has this to say:

'I believe that part of the reason why there has been this increase is because GPs are simply too willing to sign people off sick, to move them on. They sign them off sick and that's the end of their involvement – the underlying issues are not dealt with. The employer is left to deal with problems' (CD 3)

The problems of balancing work and home life commitment was mentioned.

One CD/GM referred to the increasing demands for more open, transparent management, who are required to run things efficiently and effectively and be accountable. In his opinion this new era, ethos of openness has significantly contributed to the increase in stress for those at the management level in his company.

Reasons for Stayed the Same

Those who believe that the levels of stress have stayed the same acknowledge that the pressures at work are constantly increasing and that stress is an integral part of their working lives. However the culture and climate of the company, is such that the stress is effectively managed and monitored. Stress awareness guidelines and policies, an effective open door policy of communication, involving the staff in company changes and goal setting just some of the factors that lead to their workplace stress as being mostly positive and motivating – the adrenaline rush.

'Levels of stress here have changed but it is a good positive thing – the point is what exactly do we mean by 'stress' – people seem to think it is a bad thing, in my experience if you handle it well, deal with it head on, then you reap the benefits of 'stress' in terms of performance.' (GM/CD 5)

Models of Stress

Organisational Definitions of Stress

Only one of the seven interviewees worked for an organisation with an official definition for stress; he was unable to describe its contents.

Personal Descriptions of Stress

Stress is unanimously described as a cognitive feeling of being under pressure and not being able to cope. It is about feeling unable to control events happening around you, of feeling no longer in charge of one's own destiny, being overwhelmed, unable to deal with things, make decisions or effectively perform. When people are stressed they seem to be in a constant panic, exhausted, at times apathetic, they can be irrational and tend to overreact. Most referred to the fact that no two stress experiences are the same; stress is unique and individual.

Recognising Stress

Seven out of seven had regularly encountered stress within their organisations. In fact many believed that it is not possible to work and not encounter stress at work. Stress is not regarded by all GM/CD as something to be avoided. The signs of a bad 'stressful' situation are obvious:

'People have literally gone off the rails, they defy the rules, cannot fulfil contractual obligation, seem not to care about work or what happens to them – when it gets this bad, which it does in large organisation like this, then they need urgent medical attention' (CD/GM 4)

Irrational behaviour, anger, temper, tears, poor decision making, a lack of decision making, lack of motivation, change in personality, downturn in productivity, poor staff morale, high turnover and a high rate of short term absenteeism were obvious signals that there was a problem in the workplace.

Background and Knowledge of Stress

Five out seven felt they had enough knowledge and experience to deal with any stress related issues that they came across in their workplace. Many of them actively keep up to date by reading journals for research articles and newspapers for topical discussion points. They also use their professional networks. Knowledge sharing is encouraged via regular management meetings with line managers and HR departments. An 'open working environment' is seen as a useful way keeping abreast of issues.

This is what one CD had to say:

'No I only deal with problems on a needs want basis – I do not have the time to spend reading and finding information on stress. I know that it is in my interest to support my

staff; I do this by listening to them and dealing with them on an individual basis. Stress is part of the job here; we all have to learn to cope with it in our own way.' (GM/CD 5)

Finally one CD felt unable to deal with severe 'stress' cases and often asked for professional advice from appropriate sources such as occupational health consultants.

The Case Studies

Each GM/CD was asked to recall and describe, if possible, two cases of stress related long term (LT) sickness absence, one where the patient successfully returned to work and one where the patient did not return to work.

Two CD of the smaller companies had not had an incident of LT stress related sickness absence:

'This company has never had a case of stress related sickness absence; in fact we have never had a case of case of long term physical illness either. The point is we are a small company, we work closely as a team, responsible to each other, we cannot afford for someone to go off sick, long term, because we do not have the capacity to absorb their work. Everybody knows how important their job role is, this is a good working environment with plenty of stress but you don't work here unless you can handle it. (GM/CD 1)

Factors facilitating successful return to work:

1. Early intervention
2. Organisational support i.e. a willingness on the part of employers to facilitate RTW in any way.
3. Feeling valued at work.
4. Good communication characterised by trust and reassurance.
5. Outside medical intervention e.g. occupational health, private counselling.
6. Having a break from work.
7. Positive and encouraging attitude of colleagues.
8. Collaborative, flexible RTW programme incorporating such things as a graduated return to work, shorter working hours, reduction in work load and responsibilities.

Factors inhibiting successful return to work.

1. Attitude and personality of the employee
2. Severe mental health problems
3. Chronic physical problems; invasive medical treatment
4. Failure to deal with root cause of the problems.
5. Poor communication between employee and line manager.
6. Negative attitude of colleagues:

'By now his colleagues at work were pretty fed up as they had to cope with his work as well as their own. In hindsight I think he was a difficult character and there was a lot inherent problems within the team; frankly I think it was for the best that he did not, in the end, come back – there were too many unresolved issues.'
(GM/CD 3)

7. Generous financial compensation during sickness absence – no incentive to return.
8. Denial by management that there is a 'stress' problem at work.
9. Period off work unmanaged and too long.
10. Personal problems

Factors that might have prevented sickness absence

Three GM/CD commented that at times there was nothing that could have been done to prevent the absence, particularly if related to or exacerbated by physical illness.

The following list is a summary of their responses:

1. Early intervention.
2. Better management i.e. involving staff in organisation changes, having their finger on the pulse, hands on management, talking and listening to their staff.
3. Better communication between staff and management
4. Stress awareness (both staff and management) being able to recognise the signs; stress management policies and training.
5. Better person-job fit
6. Better team management and training.
7. Improved coping skills.
8. Nothing – circumstances beyond anyone's control.

Factors relating to stress

1. Finances
2. Relationships at work
3. Family/personal issues – divorce, house move, relationship with partner
4. Clash of work and family issues – one impacting on the other.
5. Inter team conflict
6. The boss. line manager, management
7. Heavy work demands
8. Child care problems
9. Age – too old to cope with pace of change, relocation and increase in work load.

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Fig 2.5.1., Stress Related Issues

Interventions and Absence Policies

Absence Prevention

The following is a summary of the measures discussed by the GM/CD taken by their companies to prevent long term sickness absence:

1. Promoting harmony in the workplace: treating each employee as a valued individual, providing autonomy at work and an open door policy of communication.
2. Provision of basic private medical health care and access to occupational health.
3. Smaller companies :-
 - valuing each employee
 - instil sense of responsibility and team spirit.
 - lead by example:

‘I have never had a day off work ill. I lead by example and expect my staff to follow my example. This is one of the reasons why we have such a low rate of absenteeism. Those who do go sick do so for genuine reasons.’ (CD/GM 1)
4. Early detection of problems
5. Strict adherence to absence policies which act as a deterrent.

We do not pay sick pay if they take any form of absence in the first year of their employment, we never pay more than six weeks in any event. We have an ‘out’ clauses in our employment contract which gives us the right to terminate employment – if we so wish – in the event of long term sickness absence. Basically everyone who works here knows that sickness absence is not part of our culture and cannot be tolerated.’ (GM/CD 5)
6. Absence policy which monitors short term sickness absence so that problems are flagged early
7. Larger companies – employee assisted programmes
8. Stress awareness and stress management programmes.
9. Robust management.
10. Effective HR department
11. Do not differentiate between reasons for sickness absence – climate is such that employees do not have the freedom or want to abuse the system.

Changes in the workplace

The GM/CD were asked to indicate from the following list any changes that they are aware have been made in their workplace to prevent employees going absent.

- Changing Work Organisation e.g. decreased work load, job design
- Changing employment condition e.g. changed the nature of job pay, conditions, shorter hours, job-sharing, part-time work, flexible working hours.
- Changing work Environment e.g. addressed the structure and climate at work i.e. bullying, stress management programme, improved ergonomics.
- Individual intervention e.g. sick leave, training or retraining, work or job assessment.
- Redeployment i.e. moving to another job within the organisation
- Provision of Technical Aids/Adaptations.

Changing work organisation and employment conditions received the highest response. Generally the GM/CD did not differentiate between stress related and sickness related absence. The GM/CDs would consider and implement any change, within reason, to prevent a long term absence from work.

Absence Procedures

Initially most absences are dealt with informally. Only when the absence has reached a stage where the member of staff are not be able to fulfil their employment contract are the issues dealt with formally.

Generally the onus is on the employee to ring their line manager or HR department on the first day of their absence, to then keep the company informed and up to date throughout their period of absence from work. If it seems that the absence will be long term, then proactive, open lines of communication are encouraged, upheld and promoted by all parties. If the problem is work related than these are identified and reasonably dealt with – all these procedures are implicit and dealt with instinctively according to the reasons for the sickness. All employees are expected to present a sick note upon return to work if they have been absent for more than three days. Furthermore many GM/CD of smaller companies believe that part of their absence procedure is to prevent the stress related sickness absence in the first place.

Those CD/GM representing the larger companies described the role of their HR department in monitoring sickness absence in order to flag up chronic problems. Depending on the reason for and the length of the absence there might be contact with an employee's GP in order to verify the diagnosis and where available involvement of Occupational health.

'It is difficult at times to decide what level of contact is deemed appropriate and helpful and what level might be misconstrued as being unhelpful and a form of harassment – sometimes we are in a no win situation.' (GM/CD 2)

One director referred to their procedure of return to work interviews for any employee who has been off work for whatever reason; this was seen to act as a deterrent to frequent short term absenteeism.

Absence Policies

Three out of the four GM/CD working for small companies (less than 100 employees) did not have formal absence policy. This is what one CD had to say:

‘We do not tolerate, nor do we encourage absence from work by formalising it through policies – so each case, in the rare event we have a case, is dealt with according to its own merits.’ (GM/CD 5)

On the whole companies with absence policies were documented in employees hand books; most admitted to not being aware of the contents. Most sickness policies focused on sick pay contingencies and policies. The policies seem to be discretionary dependent upon the seniority of the employee, job function and circumstances surrounding the absence.

A few GM/CDs commented on an employee’s contractual obligation to be at work:

‘It is the culture of our company to pay people to come to work; **people are paid to work**. So unless the absence is due to a real illness, then we do not nurture the length of the absence. Basically, any stress related absence boils down to ineffective or effective management.’ (GM/CD 3)

In sum, the contents of most absence policies refer to sick pay, procedures to manage and monitor the sickness absence, refer the member of staff to occupational health or other medical specialists, recommendations for return to work programmes and details of employment contracts and legal obligations. The absence policies and procedures were on the whole deemed effective as long as they were sensitively implemented. The absence policies are designed to deter frequent short term absences.

Three of the GM/CD commented that the law seems to favour the employee not the employer in cases of long term absence, Many feel their hands are tied, they are not legally allowed to employ anyone else to the job during the official sickness absence, as one GM/CD commented:

‘[] it becomes a legal mine field when someone goes long term sick for what ever reason. As employers what are we meant to do? It is not practically possible to keep that job open indefinitely, we have to move on.’ (GM/CD 4)

Onward Referral

Two GM/CD reported that they have never had to refer an employee to anyone for stress related problems because they have never had a stress related problem in their company. However if a stress related problem does occur the employee is referred within the company to their line manager, HR or occupational health. Often this is in conjunction with advice to be referred to an appropriate medical specialist outside of the company.

Return to Work

Two GM/CD commented that they have never had to assist anyone who has been absent in their organisation back to work:

‘Apart from one man who had a car accident, we have never had to worry about getting anyone back to work. If someone has been off sick we know that they will come back when they are fit and they do. Absenteeism is not a problem here.’
(GM/CD 1)

However if necessary the GM/CD would do anything within reason to facilitate work resumption for an employee who has gone off sick for genuine reasons and is wanting to return.

‘We will make any reasonable, positive changes, such as flexible hours; make arrangement to work from home, change of job role and/or a graduated return. It all comes down to having a flexible attitude, trust and good communication.’
(GM/CD 5)

The following is a summary of the responses:

1. Involve Occupational Health
2. Return to work interviews.
3. Graduated return.
4. Open lines of communication
5. Identify source of problem and deal with issues
6. Do not return person to same situation
7. Make any reasonable changes to promote and facilitate work resumption and retention.
8. Prevent absence in the first place.

GM/CD commented that the employee and the employer have a joint responsibility to promote a quick and efficient return to work.

Work place adaptations/arrangements

Work Place Adaptation/arrangement	Yes	No
Changed Work Organisation e.g. Decreasing Work Load	7	0
Changed Employment Conditions e.g. Flexible Time	7	0
Changed Work Environment e.g. Improved Ergonomics	7	0
Individual Intervention e.g. Training or retraining , Work or Job Assessment.	7	0
Redeployment i.e. moving to another job within the organisation	7	0
Provision of Technical Aids/Adaptations	7	0
Return to Work Measures e.g. Rehabilitation, Case Management	7	0
Stress Awareness programme for other staff	2	5

Fig. 2.5.2 Work Place Adaptations/Arrangements

The GM/CD are clear, they would consider implementing any of the above adaptations/arrangements to facilitate work resumption.

Ideal Return to Work Process

1. Early identification and intervention to prevent the absence in the first place. (primary intervention)
2. Learn from experience.
3. Introduction of stress awareness and management programmes.(secondary intervention)
4. Improve quality of management. (primary intervention)
5. Acknowledgement by management that work is hard and that stress is an inherent part of the job. (secondary intervention)
6. Promote and improve team spirit – responsibility to colleague. (primary intervention)

‘In this company everyone counts, everybody relies on everybody else – if you go off sick then you know that your colleagues are absorbing your work on top of their own, this means no one goes off longer than is absolutely necessary. Everyone has to put up with a lot of stress here’ (GM/CD 1)
7. Listen to staff.(secondary intervention)
8. Being proactive not reactive to problems.(primary intervention)
9. Effective, improved selection to optimise job-person fit.(primary intervention)
10. Flexibility.
11. Problem solving approach. (secondary intervention)

Organisational Details

Collectively the common reasons for absence are:

- Personal problems

- Health issues i.e. serious medical illness and mental health problems,
- Work related issues including work load, change, feeling undervalued, long hours, commuting, targets and deadlines

Available Function Services

Functions/Services	Yes	No	Don't know
Union/Worker Representation	3	4	-
Human Resources	7	-	-
Health and Safety	7	-	-
Occupational Health Services	3	4	-
Onsite Ergonomist	1	6	-
Return to Work Co-ordinator	2	3	3
Case Manager	3	2	2

Fig 2.5.3. Functions/Services Available to Employees

Policies and Health Service Programmes

Fig 2.5.4 Organisational Policies and Health Service Programmes

Policies and Health Services/Programmes	Yes	No
Family Friendly/Work Life Balance	6	1
Return to Work/Retention	4	3
Equal Opportunities	7	-
Employment of People with Disabilities	7	-
Pre-Pension	2	5
Flexible Time and Work Arrangements	6	1
Sick Leave	7	-
Leave of Absence/Career Breaks	4	3
Health Promotion	2	5
Bullying and Harassment	4	3
Periodic health screening for all staff	3	4
Periodic health screening for 'at risk' staff (e.g. for staff who are handling chemicals)	2	5
Control Programmes e.g. Alcohol	1	6

Health Education/ Promotion Programmes	2	5
Stress Management	1	6
Employee Assistance Programme/Welfare	1	6
Income/Salary Protection	2	5
Private Health Insurance e.g.BUPA	3	4
Company Funded Pension Scheme	2	5
Other		

- In some cases the above policies were available but not to all staff e.g. private health care and income/salary protection.
- Some of the policies indicated 'yes' were implicit not explicit e.g. family friendly work life balance, flexible time and work arrangements.
- All the policies were felt to be relevant either directly or indirectly to employees on stress related or medical long term absence.

Seven out of seven GM/CDs believed that their employees knew how to access information on the above policies and health programmes; mainly listed in the employee hand book or available via the intranet or HR. However they were not convinced that staff were aware of many policy details which seemed to be acquired on a needs wants basis. These policies were constantly monitored and updated by every company. This was done either formally or as one GM/CD described:

' [] as and when we feel things need updating, this is a judgement call based on common sense having learnt from our experiences generally when things have gone wrong.'(GM/CD 2)

2.6 HRP Professionals (HRP)

Seven HRP were interviewed for this research (4 female and 3 male). The size of companies they worked for varied from a small family run business employing 55 people to a large multi national company with a total number of employees in excess of 3000. Their employers represented both private and public sectors of industry including manufacturing, education, professional and support services, leisure and finances. The majority of HRP professionals were also responsible for implementing Health and Safety management standards in the workplace. Two were HR directors, three HR officers and two were HR consultants. The HRP had an average of 12.5 years experience.

Stress Recognition

Five out of seven HRP believe that the incidence of stress has increased in the workplace over the past five years; one HRP said that it had only increased 'a little' (HRP 7). one believed that it has stayed the same.

Reasons for Increase

Overwhelmingly the common reason cited for the increase was the high profile that stress has these days. Symptoms that were previously written off as illness such as anxiety and depression have now become stress related not medically related problems. It is publicly more acceptable to use the term stress. In the opinion of these HRP stress has become the new backache; people are able to use the word stress to get away with malingering. In short stress is something that we hear more about now, employee are able to vocalise what is wrong, it has become a modern day excuse that was not available before. Nowadays it is alright to be stressed and expect someone else to sort things out.

One HRP commented:

'My worry is that this stress epidemic will not last –the term is over used and abuse and will eventually become just as stigmatising as any mental health illness – people will associate 'stress' as not being able to cope, not being able to their jobs. Employers will get fed up hearing the word stress in their workplace' (HRP 3)

One HRP referred specifically to the effect of downsizing as having had a significant role to play in the increase of stress related complaints. Downsizing means more is now being done by less and people being promoted beyond their capability.

Technology and speed of communication was also mentioned. The requirement for instant responses, 24 hours a day, 7 days of the week is believed to be a major stressor for many employees.

Untrained managers and poor management, the line manager in particular was singled out as being a great source of stress for many employees.

Reasons for Stayed the Same

One HRP believes that in his experience the introduction of an open policy of communication at work is why stress related problems have stayed the same within his organisation.

‘Those who are not coping are identified early and we can intervene quickly and sort any problems or issues before they become chronic. We manage our stress’
(HRP 4)

The popularisation of stress means in effect we hear more about stress these but in fact for some HRP the actual incidence of stress related long term illness has not increased.

‘People just talk more about things they quietly dealt with on their own in the past.’
(HR 5)

Models of Stress

Organisational Definitions of Stress

There were no organisational definitions of stress.

Personal Descriptions of Stress

The personal descriptions of stress generally focus on the notion of stress being a state of mind which has a negative impact physically and/or mentally and/or psychologically, influencing subsequent behaviour. It is described as a mismatch of resources and demands. It is not about how much work there is to be done it is all about how much there is available to cope. Stress is often the result of an accumulation of events inside and outside of work. Stress is viewed as very individual:

‘There are two sides to stress. There is the level that people thrive on, which drives them on, then there is the level where things have built up, which people cannot handle and stops them from functioning, from operating normally. Stress for one is an adrenaline rush for another.’ (HRP 7)

Stress is viewed as something unpleasant with negative associations.

Recognising Stress

All the HRP had encountered stress at work; a few explained that this encounter was often indirect, second hand via line managers. The HRP seems to deal with stress when it has become problematic and cannot be resolved by the employee and their line manager.

Signals used to recognise stress include performance issues at work, people stop delivering, fail to meet deadlines and targets, produce poor quality of work and have a negative attitude to work.

'It is obvious to me when someone is 'stressed' they race around, like headless chickens, talk about all they have to do, are always busy creating a flurry of activity wherever they go yet despite all the apparent activity achieve and finish nothing.'
(HRP2)

The HRP referred to personality and/or behaviour change highlighted by frequent short term absence, aggression, withdrawal and over reacting. Stressed people become disruptive, distracted, bad tempered and disengaged. They display a lack of clarity and inability to deal with problems.

'Someone who is stressed is not very good at taking any form of comment or criticism about their work, normally they can but if stressed they just do not get it, burst in to tears or get angry – a stressed person does not behave in their normal predictable way.'
(HRP 6)

Background and Knowledge of Stress

Five were confident in their ability to deal with most stress related situations, two (the ones with least job tenure as HRP) were not.

'Experience is the best teacher, no cases of stress are the same therefore it is no good for me to just read about it , I need experience to learn how to deal with and handle it.'
(HRP 1)

Some highlighted problems areas with stress, for example:

'Where is the dividing line between what we as employers are responsible for and how much is down to the employee. Stress is a cocktail of things, each issue has to be separated out and dealt with – but where do responsibilities begin and end?
(HRP3)

One HRP mentioned that 'stress' was a personal not a company interest. He believed that if he was to do his job well and prevent unnecessary absenteeism, then he had to introduce stress awareness and management programmes for the teams in his

company. To do this he was obliged to gain and share as much stress related information as possible. Knowledge sharing, seminars, conferences, workshops and journal were identified as informal and formal forums to learn about stress related issues.

The Case Studies

Each HRP was asked to recall and describe, if possible, two cases of stress related long term (LT) sickness absence, one where the patient successfully returned to work and one where the patient did not return to work.

Three HRP were unable to describe a case where an employee had not returned to work.

Factors aiding successful return to work

1. Employee insight and self awareness
2. Early intervention
3. Multi professional support during absence including GP, HRP, OH & management.
4. Compliance with medication and professional advice.
5. Not returning too early – being ‘fit’ for work.
6. Regular and meaningful contact with employer
7. Supportive colleagues – managed work load during absence.
8. Supportive management
9. Making changes to working environment– shorter hours, graduated return, redeployment.
10. Return to work programme - constantly monitored and reviewed.
11. Having time off work

[] When this girl went off sick so soon after joining the company, the employer suddenly realised that the way new people were introduced to the workplace was unreasonable. It was in no ones interest for a new member of staff to be left to their own devices, to find their way round, to learn the technical stuff. Team training was one of the first programmes that was introduced. She successfully returned to work – by going off she certainly did the company a favour it highlighted everything that was wrong. For her though it was quite distressing.’ (HRP 2)

Factors inhibiting successful return to work.

1. Fear of stigma, emotional distress.
2. Job insecurity
3. Excessive work load.
4. Negative attitude of employee.
5. Personality clash between employee and manager.

6. Lack of trust between employee and employer.
7. Intolerant employee and intolerant employer.
8. Problems left to become chronic and irresolvable.
9. No effective communication.
10. A culture of blame

Factors that might have prevented sickness absence

1. Adequate and appropriate training e.g. team training.
2. Support from management after illness.
3. Early identification of problems.
4. Early intervention.
5. Sensitive management – involving and addressing future company changes with the with employees
6. Management training and awareness – dignity in the workplace.
7. Good working relationships – supportive team attitude, open team spirit
8. Supportive, effective HRP department.
9. Proper complaints system.
10. Open and honest communication.
11. Good appraisal system.
12. Climate of openness – being able to talk to someone about concerns, problems.
13. Nothing – problems stemmed from personal, home life issues.

Factors relating to stress

1. Poor time management
2. Relationships – work and home e.g. marital difficulties
3. Health
4. Promotion
5. Work – including work load, bad management styles, job insecurity, inadequate training, short term work contracts, conflict between colleagues, unrealistic expectations.
6. Equipment breakdown and failure.
7. Commuting.

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Fig 2.6.1 Stress Related Issues

One HRP commented:

'Everything in life can be a source of stress it all depends on your coping levels.'

(HRP 2)

Onward Referral

The HRP were asked to whom they would refer a employee who has a stress related condition.

- Occupational health
- Line manager
- GP
- Counselling services – where available

Interventions and Absence Policies

Absence Prevention

The following is a summary of the issues the HRP discussed with regard to absence prevention:

1. Maintaining an open policy of communication to promote early identification of problems.
2. Placing an emphasis on team work collaboration and support.

'I believe the reason we do not have a problem with absenteeism is due mainly to our team spirit both within and between teams. Everyone knows their roles and responsibilities. The management is hands on and leads by example. This is a company with a culture of good team work and excellence in delivery of our services.'

(HRP 7)
3. Proactive annual development review and appraisal systems.
4. Sensible sickness policies which flag up irregularities early.
5. Prevention rather than cure.
6. Accessible and readily available access to HRP.
7. Effective change management – involve the staff, be proactive and positive
8. Onerous sickness policy which acts as a deterrent.
9. Honesty and trust at work.
10. Encourage partnership between staff and management.
11. Provision of health care, gym membership and counselling services.

Changes in the workplace

The GM/CD were asked to indicate from list any changes that they are aware have been made in their workplace to prevent employees going absent.

Changes	Yes	No
Changing Work Organisation e.g. Decreased Work Load, Job Design.	7	0

Changing Employment Conditions e.g. Changed the nature of the job pay, conditions, shorter hours, Job-Sharing, Part-Time Work, Flexible Working Times.	5	2
Changing Work Environment e.g. Addressed the structure and climate at work i.e. bullying, Stress Management Programme, Improved Ergonomics	7	0
Individual Intervention e.g. Sick leave, Training or Retraining, Work or Job Assessment.	6	1
Redeployment i.e. moving to another job within the organisation	4	3
Provision of Technical Aids /Adaptations	6	1
Other		

Fig 2.6.2 Prevention of Absence

All of these changes would be considered to prevent any type of absence; each case dealt with individually.

Absence Procedures

Most absence procedures are a mixture of informal and formal policies; five HRP admitted to having no formalised procedure for long term absence. Some attitudes toward sickness absence were cynical others were positive. Short term procedures were straightforward and similar in each company; the employee is expected to ring on the first day of their absence to explain why they are off and how long they are likely to be off. At this stage HRP are not likely to be involved; contact is with their line manager as is discretionary sick pay.

‘It is only when someone admits to their line manager that they are too stressed to work or seem to be having too many, what we call ‘duvet days’ is HRP contacted and becomes involved.’ (HRP 5)

Self or a medical sickness certificate is required upon return to work. Many companies do not pay short term sick pay – although this does seem, in many cases, to be at the discretion of the line manager.

Only when the absence becomes long term is HRP involved. When involved the HRP contact the employee to encourage and offer support and hopefully minimise feelings of isolation.

‘It is really important to keep lines of communication open. I do not want to add to their anxiety; most people are off work for genuine reasons and appreciate the contact. (HRP 7)

Any stress related work place issues would then be identified and discussed. According to availability occupational health would be contacted. In some companies absences are solely dealt with by the line manager who might contact HRP for advice.

One HRP admitted:

'This system does not work that well. I am planning to introduce a stricter monitoring system to pick up petty absenteeism as well as an absence bonus scheme – at the moment we have no way of identifying regular short term absences, we miss the alarm bells.' (HRP 1).

One HRP explained:

'We do not have a long term sickness procedure because we do not have a problem there. There is such a high degree of trust between the staff and management here that if someone does go off sick, there is no reason to suspect the worse. We have a generous sickness pay policy, private health care, occupational health and health insurance; all employees are looked after well. HRP will keep in touch, as will their line manager and colleagues. (HRP 3)

Most agreed that the aim of any absence procedure should be to get the employee back to work sooner rather than later.

Absence Policies

Six out of seven HRP worked for companies with absence policies. On the whole these referred to sick pay, terms of employment, guidance to managers and legal implications. In some organisations the policies were deemed 'not functionally practical' (HRP 7). No reference was made to any formalised return to work procedures.

One HRP was unaware of the contents of his organisational absence policy.

Return to Work

Several HRP commented that in the absence of any formalised return to work policies and procedures, anything is considered to encourage work resumption. This might include an agreed graduate return, working reduced hours in the first instance. Some organisations arrange informal return to work interviews. Those HRP working in large companies referred to return to work programmes being coordinated and monitored by occupational health.

One HRP spoke on behalf of her company:

'In our company every body knows every body else; we have a very relaxed attitude to sickness and returning to work. All of our employees are a valuable part of the company – so we will do anything to get them back to work. Mostly they cannot wait to get back, sometimes we have to encourage them to take more time off, to get properly well before they come back.' (HRP 5)

The return to work in one organisation is implemented at the discretion of the line manager; most HRP have no direct involvement in work resumption.

Problems arise when employees return to work too soon i.e. they are not fit to return. When the problems have not identified or dealt with so the employee returns to the same problems, the same situation which caused them distress in the first place.

Work place adaptations/arrangements

Work Place Adaptation/arrangement	Yes	No
Changed Work Organisation e.g. Decreasing Work Load	6	1
Changed Employment Conditions e.g. Flexible Time	7	0
Changed Work Environment e.g. Improved Ergonomics	5	2
Individual Intervention e.g. Training or retraining , Work or Job Assessment.	7	0
Redeployment i.e. moving to another job within the organisation	3	4
Provision of Technical Aids/Adaptations	5	2
Return to Work Measures e.g. Rehabilitation, Case Management	5	2
Stress awareness programmes for other staff	2	5

Fig 2.6.3 RTW Work Place Adaptations/Arrangements

Ideal Return to Work Process

1. Prevention rather than cure.(primary intervention)
2. Early intervention
3. Improved stress awareness and management.
(secondary intervention)

‘The problem is we run the risk that too much stress awareness might open up a can of worms. Suddenly we might have a rush of people who suddenly feel they are stressed.’ (HRP 3)
4. Structured appraisal systems.(primary intervention)
5. Structured guidelines and training for all managers.(secondary intervention)
6. Formalising the implicit informal return to work procedures.(primary intervention)
7. Improved structure and guidelines for best practices in managing sickness and return to work.(primary interventions)
8. Constant communication. (secondary intervention)
9. Improve management.(primary intervention)
10. Promote open climate of communication. (primary intervention)

Organisational Details

The most common reasons for long term and short term absence are:

- Stress related problems
- Medical illness – e.g. cancer (cited by 5 of the HRP)
- Depression
- Anxiety

Comment

A few HRP have had not had a case of long terms stress related sickness absence – some are also unaware whether or not they there has been any incidence of short term stress related sickness absence within their companies.

Available Function Services

Functions/Services	Yes	No	Don't know
Union/Worker Representation	4	1	2
Human Resources*	7	0	0
Health and Safety *	6	1	0
Occupational Health Services	3	4	0
Onsite Ergonomist	1	6	0
Return to Work Co-ordinator*	3	4	0
Case Manager*	3	4	0

Fig 2.6.4 Functions/Services Available to Employees

* Four of the HRP included these functions in their job role.

Policies and Health Service Programmes

Policies and Health Services/Programmes	Yes	No
Family Friendly/Work Life Balance	7	0
Return to Work/Retention	2	5
Equal Opportunities	7	0
Employment of People with Disabilities	3	4
Pre-Pension	1	6
Flexible Time and Work Arrangements	4	3
Sick Leave	6	1
Leave of Absence/Career Breaks	6	1
Health Promotion	2	5
Bullying and Harassment	5	1
Periodic health screening for all staff	1	5
Periodic health screening for 'at risk' staff (e.g. for staff who are handling chemicals)	1	6
Control Programmes e.g. Alcohol	1	6
Health Education/ Promotion Programmes	7	0
Stress Management	2	5
Employee Assistance Programme/Welfare	3	4
Income/Salary Protection	5	2
Private Health Insurance e.g.BUPA	6	1
Company Funded Pension Scheme	6	1
Other	0	7

Fig 2.6.5. Organisational Policies and Health Service Programmes

The HRP interviewed for this research all suggested that the above were a mix of formal and informal policies.

In the opinion of a couple of HRP the above policies were on the whole deemed 'probably relevant to those employees who are absent due to stress related conditions. The HRP generally believe that the staff do know how to access these policies, even though many are implicit. Three HRP felt that these policies were being properly monitored and evaluated:

They are constantly monitored at a group level and are flexible enough in that they can be altered and changed to respond to every new situation or staff need.
(HRP7)

One of these three felt that the updating and monitoring of these policies was an integral and vital part of their job role. The remaining four HRP did not feel that these policies were properly monitored and that there was definitely room for improvement:

These policies tend to be reactive not proactive to stress related work place issues. This is something we need to look at' (HRP 1)

Section 3 Description by Themes

Note Employment professionals (EP) refers to general managers/company directors and human resources professionals. Medical Professionals (MP) refers to General Practitioners and Occupational Health Practitioners

3.1 Summary of Similarities and Differences *within* Professional Groups

3.1.1. General Practitioners

Frequency of Stress

GP believe that the incidence of stress has increased or stayed the same over the past five years. There is an overriding feeling that 'stress' is an overused and abused fashionable descriptive term for old fashioned mental health problems such as depression and anxiety. Some believe that being able to talk about stress is a good thing for those patients who might not otherwise have brought their problems to the consultation room; some believe it has led to a pandemic of complaints.

Personal Descriptions of Stress

Their descriptions of stress share many similarities and generally refer to stress as an adverse reaction which can lead to physical or mental problems brought about by feelings of not being able to cope with pressures and demands of life. Stress is idiosyncratic; stress for one is adrenaline for another.

Diagnosing Stress

Diagnosing stress divides this group between those who would not use stress as a diagnosis believing it is a purely descriptive term to describe a variety of symptoms and those who, having eliminated any organic causes for the presenting complaints would make a clinical judgement that the symptoms are stress related.

Interventions

The GP agree that any stress related intervention has to be implemented and tailored according to each individual case. Effective interventions usually involve a combination of medication, talking therapy as well as a short break from work. Ineffective interventions just relieve the symptoms i.e. just use medication and do not get to the root cause of the 'stress'. The aim of any intervention is to relieve symptoms and adopt a problem solving approach to the stress related issues. Most agree that time off work was important to be able to reassess problems – however a couple of GPs insist that this time has to be monitored and not prolonged.

Return to Work

Time constraints seem to hinder the efforts of those GPs who believe should be involved in the return to work process. Some GPs believe that their contribution to RTW process can only be to get their patients 'fit for work'. One GP felt strongly that it was not his job or the job of any GP to become involved with stress related work issues; if the problem stems from work then the employers need to sort these problems out. The employer has a responsibility to provide a work environment that promotes employee mental and physical health.

The GPs generally agree that they are not often best placed to deal with work related issues as they have no inside knowledge of their patient's workplace. Furthermore they cannot compromise their role as the patients advocate.

The GPs are divided between those who become directly involved in helping their patients identify and deal with the sources of their stress, those who are willing but not able to become involved and those who refer their patients on to specialists.

3.1.2 **Occupational Health Physicians**

Frequency of Stress

OHP are divided between frequently and sometimes when asked about the frequency of stress as a complaint referred to by their patients. They are also divided between those that believe the frequency of stress related complaints have increased, stayed the same or even decreased over the past five years. They all believe in the social phenomenon of 'stress' as a new less stigmatising label for mental health problems. They believe that intrinsic job characteristics such as ineffective management, poor person-job fit are largely to blame for work related health problems.

Personal Descriptions of Stress

The OHP share common personal descriptions of stress, including its causes and manifestations with particular reference to the negative impact of stress. It is a perception that things are not right. A feeling of not being able to cope, or in control of events. Furthermore they believe that it is impossible to have an all encompassing definition of stress because it is indefinable, being a catch all phrase for a multitude of problems and complaints.

Diagnosing Stress

The OHP are unanimous that 'stress' is not a medical condition, and therefore should not be medicalised. They would never use stress as a diagnosis because it is not a medical condition with aetiology. There is no pill to cure stress. They are concerned that stress is used too readily, by their patients, employers and GPs to write off inexplicable reasons for psychosomatic complaints.

Interventions

One of the most important aspects of their job is the promotion and maintenance of a healthy work environment for all staff members. Prevention is aim of any stress related intervention. Their interventions have many common elements. OHP do not prescribe so they frequently refer their patients to medical specialists to relieve any stress related symptoms. Cognitive behavioural therapy is a popular intervention.

Return to Work

RTW indicates a successful intervention; facilitating RTW is a critical part of an OHP job.

They are all confident in their ability, based on their specialist training and years of experience to intervene and deal with stress related problems. Good communication, especially between managerial and non managerial levels, is a key issue.

Occupational health is about providing a safe and healthy workplace for company employees; for an OHP a mark of success is a safe and healthy work environment with few if any stress related problems. Several of the OHP commented that in their opinion the public sector has much to learn from the private sector about health promotion within the workplace.

Overall this is a homogenous group with no major areas of diversity

3.1.3 Mental Health Professionals (MHP)

NB Four of the participants are counsellors and may not be considered strictly as mental health professionals more mental health specialists; this is open to debate.

Frequency of Stress

The MHP frequently see clients with stress related problems. In their experience the incidence of these complaints has either increased or stayed the same, at a constantly high level, over the past five years. They mostly agree that stress is triggered by work

place issues, relationships and a lack of emotional support at home or at work; they did not refer to the 'stress phenomenon'.

Personal Descriptions of Stress

Their descriptions of stress include common references to a lack of control, inability to cope, resources outstripping demands, typified by mental disorganisation and causing internal discomfort, psychological distress and illness. Stress causes distress. The MHP see their patients as genuine victims. In their opinion stress is very much an intrinsic part of everyday life.

Interventions

The MHP generally adopt a solution based approach to problems utilising a combination of cognitive and talking therapies as well as physical exercise. Their role is to unpick, identify and deal with the root cause of the problems. They do not necessarily enquire about their clients work status – this normally becomes apparent during their first meeting. The addiction specialist deals firstly with the problems associated with addiction and might, although not routinely, become involved in the process of work resumption. MHP are used as secondary and tertiary interventions to assist individuals in coping and appraising work place stressors and to provide emotional support to those who have experienced the negative effects of excessive strain.

Ultimately the aim of the MHP is to return their patient/client to normal levels of functioning.

Return to Work

This group is divided between those who would and do actively involve themselves in the RTW process and those who believe their job is done once the client feels empowered to leave the consulting room. RTW is not the primary objective of a MH intervention.

3.1.4 Return to Work Specialists

Frequency of Stress

The RTWS have all experienced a steady increase in the rate of stress related referrals over the past five years. In their opinion this is mainly due to the popularisation of stress which means more people are picked up when they are

struggling and not left to cope on their own. The increase is also largely blamed on work place stressors. The RTWS are united in their recognition that work related stress causes multi factorial health related problems. In their opinion the fact that more people are picked up and not left to cope on their own is a good thing.

Personal Descriptions

Stress is described as an individual perception of resources, a perception of imbalance between what can and cannot be dealt with. They referred to the physical and mental manifestations of stress such as headaches and backache, anxiety and low self esteem. There was some debate i.e. does stress cause the symptoms or are the symptoms caused by stress?

Interventions

They agree that interventions and return to work programmes need to be case specific. Any interventions might include medical input to relieve physical or mental health problems. An ineffective intervention is one that does not involve a return to work specialist.

Return to Work

The basic steps taken as part of the return to work process do not differentiate between stress and non stress related absence. They see their role as pivotal in successful work resumption. Most importantly it is their job to facilitate multi professional collaboration to enable work resumption for each client. A graduated return, reduced working hours and work load and changes to the workplace are common features of return to work programmes.

Overall this is a homogenous group.

3.1.5 General Managers/Company Directors

This group were divided between those who worked for small companies with less than 100 members of staff and those who worked for larger companies, some with over 4000 employees. It seems that attitudes and belief about stress varied according to the size of the company the participant was representing.

Frequency of Stress Related Incidence in the Work place

Generally the GM/CD believe that the incidence of stress in the work place has increased over the past five years – although not necessarily though in their own

companies. A couple believe that the level has stayed the same. Common factors for the increase included pace and rate of change in the workplace, expectations of high performance, downsizing, new technology, speed of communication and work-home life imbalance. Many blamed the increase on the overuse and abuse of stress as an acceptable label to explain underperformance and not being able to cope.

Those who believed that stress has stayed the same explained that what has happened is an increase in stress **awareness** – not the rate of incidents of stress. Furthermore they are of the opinion that stress is an inherent part of any job and increased stress awareness has meant increased stress management and increased levels of coping.

The following highlights the diversity within this professional group regarding the incidence of stress in the work place:

- The reason for the increase is the readiness of GPs to sign people off sick.
- The GM/CD from the smaller companies had no experience of stress related long term absence in their companies.
- Stress is just an excuse for explaining work place tensions and lack of performance.
- Stress is something everybody has to put up with:
 ‘If you can’t cope with stress then you should not be working in this company.’
 (GM/CD 1)
- Stress is a good thing – heightens performance.

Definitions of Stress

There was no organisational definition of stress. Personal descriptions of stress were similar and referred to inability to cope with demands; recognised by visible behavioural signs. One GM/CD did not feel he had the time to spend learning more about stress – he felt his time was better spent talking and working alongside his staff to prevent stress becoming a problem.

Absence at work

Two GM/CD had no experience of LT sickness absence – medical or stress related. Three referred only to sickness related long term absence. Absence prevention split the group between the GM/CD of smaller companies who believed they had an advantage at being able to adopt a hands on style of management, open doors of communication and to lead by example and those, representing the larger companies,

who relied on deterrents such as onerous sickness absence policies and return to work interviews.

'Being the director of a small company means I know all my staff, daily we work alongside each other. I lead by example, set the standard and expect my staff to follow this lead, to be responsible. I would be personally offended if someone went off 'sick' for stress because that would mean they felt unable to come and talk to me about their problems; that they felt I was unapproachable. This is not the case.' (GM/CD 3)

Most absences are dealt with informally for the first few days. Any absence that is going to be long term is dealt with at the discretion of the line manager, including sick pay and procedure for work resumption. Some larger companies had formalised long term absence policies; the smaller companies did not.

'People are paid to work; not to be off sick.' (GM/CD 3)

- Reference was made to the legal system favouring the employee not the employer.
- GPs were accused of prolonging unnecessary sickness absence.

Return to Work

There were no formal return to work policies. All GM/CD would do anything within reason to facilitate work resumption but they believe this is a two way process between the employee and employer, each has to be flexible, willing and reasonable.

3.1.6 HR Professionals

Frequency of Stress

HR mostly agree that the rate stress related incidences has increased; only a couple believe it has stayed the same. Overwhelmingly the common reason cited for the increase was the high profile that stress has these days. Symptoms that were previously written off as illness such as anxiety and depression have now become stress related not medically related problems – we hear more about stress, this does not necessarily mean that stress related incidences have genuinely increased. The role of the GP in signing people off with stress was referred to. The individuality of stress was highlighted. The common factors for stress were mainly organisational such as poor management and downsizing and job specific sources such as work overload, deadlines. One HR referred to a new company policy of open communication as having contributed to a stop in the rise of stress related incidence at work.

Definitions of Stress

There were no organisational definitions of stress. The personal descriptions of stress are similar; stress is a state of mind which has a negative impact physically, mentally or psychologically. High absenteeism and turnover, low productivity and team conflict both within and between teams are organisational signs that HRP seem to use as indicators that there are problems.

Not all the HRP had first hand experience of 'stress'; some saw their role in dealing with long term absenteeism as purely advisory, others believed in a more active involvement. In many companies the line manager was directly responsible for absence and stress management.

Interventions

The primary function of any HRP involvement with an employee on long term absence is to open up and maintain lines of communication, to avoid feelings of isolation on the part of the absentee, to facilitate work resumption. Communication is the key to their intervention.

There was a difference of opinion with regard to stress management; how much responsibility do employers accept, how much is down to the employee. Some HRP believe it is their job to reduce absenteeism by dealing with job-specific and organisational sources of strain, others do not see this as part of the job role.

Their attitudes to stress and stress management differed according to the size of the company they worked for. Only 2 companies had stress awareness and stress management policies; some believe that too much stress awareness can be a bad thing. Smaller companies do not to have 'stress' related sickness absence.

Absence

All the companies had absence policies. Absence procedures were a mix of informal and formal policies. HRP only became involved in long term absences; short term absences were the responsibility of line managers. There were no formal return to work policies; only in smaller companies did HR have direct involvement in work resumption. However most commented that any long term absence needs to be monitored. Some felt that their absence policies needed to become more stringent in order to flag up problems earlier.

The HRP were divided in their attitudes to absence prevention – proactive and reactive. Smaller companies dealt with stress and absence in an informal manner utilising their open door policy of communication. Larger companies relied on strict absence monitoring, return to work interviews and non payment of sick pay to deter people from taking long term sickness absence. Some used bonus schemes to discourage people from taking unnecessary absence.

Some remarked upon the fine balance between genuine concern for the health and wellbeing of the employee and concern for the implications on the company.

Medical illness was the only reason for long term absence in smaller companies.

Return to Work

There were no formalised return to work policies. It seems anything would be considered within reason to encourage work resumption. If available occupational health is directly involved in work resumption in the case of long term absence.

Organisational policies and health service programmes were constantly monitored by HRP in larger companies. Smaller companies seemed to do this on a needs want basis.

3.2 **General differences/similarities between categories of professionals**

3.2.1 **Frequency of Stress Related complaints and incidence**

The majority of interviewees believe that stress related complaints and incidents of stress have increased over the past five years. A few professionals within each category feel that in fact the level has stayed at the same high level; individuals might indeed be experiencing an increase in perceptions of stress

Reasons for increase

- Work related stressors – work overload, long hours, unrealistic demands, poor management, lack of control, relationships, conflict, commuting
- Organisational stressors – downsizing, change, redundancy, job insecurity, ineffective management, poor communication between management and non management, poor person-job fit.
- The Stress Phenomena –awareness and acceptability of the stress phenomenon.

Differences

- Reference by EP to readiness of GPs to write sick notes for stress related problems
- Reference by MP to individual differences in reaction to stress.
- HRP talked about the effects of increased stress awareness. They believe that too much information about stress not a good thing because it can act like self-fulfilling prophecy leading to an increase in self diagnosis

Reasons for Stayed the Same

- The 'Stress Phenomena' means that only stress awareness has increased not the rate of stress related incidents or complaints.
- Stress has remained at a constantly high level for more than five years

3.2.2 **Models of Stress**

- There were no organisational definitions of stress.
- There are wide meanings of the term 'stress'.

Personal Descriptions of Stress

The professional categories share many common elements in their personal descriptions of stress. Stress is generally viewed as the difference between coping and not coping, a mismatch of resources to demands. A few MP made specific reference to stress being a perception. Stress is acknowledged to have negative mental, psychological and physical symptoms.

- EP specifically referred to the organisational impact of stress e.g. high absenteeism and turnover.
- MHP were the only professional group to refer to secondary behavioural reactions to work-related stressors – such as self damaging behaviours e.g, substance abuse.

Problems and Reservations in Diagnosing Stress

- The GPs and OHP were divided. Some GP and all the OHP would never diagnose stress. In their opinion 'stress' is a purely descriptive term; stress should not be medicalised.
- Concerns were raised by GP, OHP and MHP about the usefulness of stress as a diagnosis. The use of the word stress is thought by some to be too easy and have too many implications and meanings to render it of any clinical use. Stress does not reveal anything about the root cause of the problems.

Problems and Reservations in Identifying Stress

- The EP believe that stress is easily recognisable.
- Two levels at which stress is recognised:
 - i. personal level – recognised by visible out ward signs such as negative changes in personality and behaviour, anything out of the ordinary, anything unexpected
 - ii. organisational level – low productivity, high levels of short term absenteeism, high turnover and low investment.
- RTWS believe stress is a serious work place problem.
- EP concern that stress is overused and open to abuse.
- CD/GM commented that there is no job without stress. Stress is an inherent part of all our working lives.
- EP working in smaller companies (less than 100 employees) had no experience in stress related sickness absence.
- EP concern that 'stress' might be interpreted as another way of saying 'I am not up to my job'.

Factors Causing Stress

The most common factors identified as causing stress were downsizing at work, heavier work loads, relationships both at work and at home, work family conflict, illness, unrealistic pressures to succeed, line manager and poor job-person fit resulting from promotion.

- MHP were the only professional group to refer specifically to personal stressors.

Knowledge of Stress

- Overall based, on their experience, the professionals felt they had sufficient knowledge of stress to deal with all stress related complaints and problems.
- Knowledge sharing was a popular method of keeping up to date with and increasing stress related information.

3.2.3. Issues raised in Relation to Stress and Absence by the Professionals

- EP attitudes towards stress and absence varied according to the size of their company. Companies with less than 100 employees claimed that they had never had an absence from work due to stress related problems. They believe that this is due directly to the size of their company because they are able to adopt an open, hands on style of management with an open door policy of communication and lead by example. Absence is not part of the company culture.

Factors facilitating successful work resumption

From the case studies there were many common factors identified as facilitating successful work resumption:

- Early Intervention
- Communication between absentee and employer, directly or through third person acting as spokesperson and negotiator on behalf of employee.
- Agreed, tailored made return to work programme – which might include and graduated return, reduced hours, retraining, redeployment, work place changes and adaptations.
- Timeliness of return – absentee is fit for work, not returning too soon.
- Access to OH.
- Access to RTW specialist.
- Multi professional collaborative approach.
- Positive attitude of employee.
- Positive attitude and willingness of employer to facilitate work resumption.
- Stress awareness and stress management skills for employee and employer.
- Emotional support from family and colleagues

Factors inhibiting work resumption

From the case studies there were common factors identified as inhibiting work resumption:

- Personality of Employee
- Attitude of employer – intolerant and unwilling to make reasonable workplace changes.
- Unresolved conflict
- Unresolved issues at work.
- Absence that has not been monitored.
- Relationship with colleagues – characterised by mistrust, conflict, ignorance and unsupportive.
- Generous financial compensation – takes away motivation to return to work.
- Intervention was too little too late
- No communication between workplace and employee – leading to feelings of isolation.
- Stigma attached to stress related sickness absence.

Factors Preventing Stress Related Sickness Absence

From the case studies the following are common factors that might have prevented the stress related sickness absence:

- Prevention rather than cure
- Increased stress awareness and management.
- Shared responsibility for stress management.
- Communication between non management and management.
- Improved management and leadership styles.
- Improved job-person fit.
- Improved individual coping skills and appraisal of their situation.

Note

- GP reference to organisations failing to provide a healthy work environment for their staff.
- Some EP suggest that GP be less hasty in writing sick notes because this would prevent a number of unnecessary sickness absences.

Absence Policies & Procedures

- All the companies had absence policies – not all the GM/CD were aware of their contents. Absences were dealt with informally if short term and sick pay, unless otherwise specified, was generally at the discretion of the line manager.
- Larger companies rely on onerous absence policies to act as absence deterrents.
- Concern about 'stress' as a **genuine** diagnosis on sick notes.
- There were no formal guidelines for dealing with long terms absence – sickness or stress related, such absences were dealt with according to implicit rules.
- Any absence procedure needs open and ongoing communication and should not be prolonged unnecessarily.
- There was concern expressed with regard to the fine line between company contact being viewed as supportive or as a mild form of harassment.
- Sometimes employees are too generously compensated during their absence
- The law seems to be on the side of the employee not the employer in cases of long term absence.

3.2.3 Interventions

- The professionals agree that any intervention needs to be case specific. There is no off the shelf intervention.
- Prevention is the best form of intervention.
- Interventions described are secondary or tertiary interventions. In the whole designed to deal with the outcomes of stress rather than the cause.
- MP agree that interventions should involve a combination of medication, talking therapy or CBT in conjunction with time off from work.
- The aim of any intervention should be to get to the root cause of the problems.
- OHP firmly committed to promoting healthy working environment for staff.
- Are many GM/CD in denial about 'stress' within their organisations?

Comment

The professionals are divided between those who believe that believe the answer to stress related problems lies in increased stress awareness and those who believe that this might prove to increase the reporting of it. Those who might not have considered themselves 'stressed' in the past, might well become to believe they indeed are – a form of self fulfilling prophecy.

The EP see intervention as the responsibility of the MP however the MP believe successful intervention lies with the EP. Some EP feel that if GP have signed

someone off sick, then it is up to them to get their patient fit and back to work. So whose responsibility is intervention?

The OHP and RTWS are the two professional categories actively promoting multi disciplinary intervention.

3.2.4 Return to Work

- All the professionals see return to work as a 'win win' situation for all. However the main barriers to work resumption were the attitudes of the absentee and the intransigent nature of the employer. Work resumption is ultimately the joint responsibility of the employee and employer.
- The medical professionals were divided between those who believe they should be actively involved in the return to work process and those who believe it is only their job to get their patients fit for work. It is the responsibility of the EP to facilitate work resumption particularly if the stress is worked related. The GPs refer to time constraints, so even if they were willing to help in the return to work process, it was often not practically viable. The MHP did not feel best placed to help in the return to work process.
- Successful RTW involves change – change to the working environment. It is imperative that LT absentees do not return to the same working situation that prompted the stress related absence in the first place.
- The ideal return to work procedure should be a multi professional collaboration.

Section 4

Discussion

The essence of this research is the development of a theory of action for best return to work practices, promoting and ultimately dependent upon, inter professional collaboration.

Mental Models of Stress

A mental model is a concrete inner representation of objects or events, a 'psychological representation of the environment and its expected behaviour' (Holyoak 1984 p.193), which can vary from person to person. A model is not the same as a mental image because a model contains abstract elements that cannot be visualised (Johnson-Laird & Byrne 1991). Individuals run their own mental models to form expectations and explanations, to make inferences and to understand the meaning of events and ultimately to decide upon the appropriate course of action to adopt in the circumstances (Millward & Jeffries 2001). Rydstedt, Devereux & Furnham (2004) write that an individual's beliefs and attitudes about stress e.g. what causes stress both for themselves and others, will affect their subsequent response to stress. So the outcome of any stress process is affected not only by the 'stressed' individual but also by the attitudes and beliefs of those around them i.e. their mental models. Hence having reviewed individual mental models of stress, between and within these professionals it is possible to establish the degree of overlap or discrepancy with regard to a shared understanding or not of the 'stress' phenomenon.

There is good agreement on the key feature of stress. The professionals acknowledge that stress causes adverse reaction. It is presented as a multi factorial concept which only appears when it is causing problems and affecting normal functioning. It is described as being out of control, when abilities to cope outstrip resources available to deal with demands. In this way it is different from pressure because pressure is something that can be handled over which there is control; stress is an imbalance of normal functioning. Stress is described as being idiosyncratic so the potential stressfulness of a situation depends on a subjective individual appraisal of the stressors. Interactive models of stress, depict stress as the consequence of the 'lack of fit' between the needs and the demands of the individual and their environment.(Cooper & Cartwright 1997). Every individual has their own personal stress threshold, this is why some people thrive in certain setting and others suffer (Cooper & Cartwright, 1997); stress does not always mean distress. This notion of a

mismatch between demands and resources is central to the majority of stress conceptualisations (Furnham 2002)

The professionals describe stress as almost an inevitable part of modern life with huge individual differences in perceptions of, reactions to and range of stress outcomes. Their descriptions of stress tie in with the HSE's (the body responsible for occupational safety and health in the UK) 'the adverse reaction people have to excessive pressure of the other types of demand placed on them. Much has been written in the psychological literature about the vagueness of the term 'stress' leading to a proliferation of definitions which have not necessarily helped to clarify its meaning (Jones & Bright 2001). Mostly there is agreement that stress is a process which starts with an 'emotional reaction to a negative event, involving a stress response, a cognitive appraisal, an experience of distress and a coping effort' (Millward, 2005 p.392)

Stress is something the professionals easily relate to and recognise but they are divided between those who believe it is only *awareness* about stress that has increased and those who believe that it is indeed *true* levels of stress that have increased over the past five years. They all agree that the workplace has changed. For some stress is no worse now than it has ever been. For others the stress problem is getting worse and needs to be taken seriously. Those who truly believe that work related stress has increased largely blame the changing nature of work, with poor working relationships, managerial styles, ineffective communication, behaviour of line manager, long working hours and increased work load cited as a key stress triggers. Many professionals feel that the real cause for concern is the constant popularisation of stress by the media raising the profile of stress, in turn increasing the incidence of stress related issues. Although most descriptions of stress are at the individual level, causes of stress are mainly levelled at the organisation.

The medical professionals (i.e. GPs and OHPs) are divided between those who believe that stress should not be medicalised and only used as a descriptive term on patient's records and those who treat stress as a serious medical complaint. The employment professionals (GM/CD and HRP) are also divided over the stress phenomenon. Some are clearly sceptical. There are those who believe that stress is a normal part of our everyday working lives. For them questions need to be raised concerning claims that stress is the genuine cause of absence. In conjunction with this is a degree of expressed cynicism on the part of EPs with regard to the role of the GPs

in long term absence and the reliability of their 'stress' diagnosis. Employment professionals do not deny that stress exists but many adopt the view that stress is an integral part of our daily working lives 'there is no job without stress' (GM/CD 3). Some suggest that being 'stressed' can be and often is interpreted as another way of saying I can't cope, as a weakness.

The size of the company seems to influence perceptions of stress. Representatives of the smaller companies generally claimed that stress is not a problem within their organisations. They clearly understand the potential of stress to be problematic but more importantly they believe in their climate of openness and the quality of their working relationships acting as a buffer against the negative effects of stress. Larger companies acknowledge the existence of stress but are confident in their ability to identify and tackle work related stress. In their opinion caring and responsible employers do not seem to have work related stress problems.

So far there is a general consensus on the prevalence of stress and many commonalities in these professional's awareness and mental models of stress. However, there is discrepancy between and within these groups with reference to levels of cynicism about the stress phenomenon. Different professional groups seem to have varying beliefs about stress peculiar to their occupation. They all agree that 'stress' is presently highly fashionable and in vogue; for some it is an overused and abused word.

Interventions

Many companies had no written policies covering long term absence or work resumption. Their employees had no access to any form of occupational health or support. A cocktail of individual stress interventions which can be loosely divided into 3 types were described:

1. Cognitive, changing attitudes and beliefs either towards the stressor or about ones self. This might involve encouraging positive thinking, enhancing coping skills and normalising the situation.
2. Affective, dealing with mood and emotional responses. This might involve medical treatment in conjunction with counselling, or even assertiveness training.
3. Behavioural, dealing with the behavioural, physical response to the stressor i.e. the symptoms of the stress related illness. This may well involve medical treatment as well as assisting people to change lifestyles or work styles in order to withstand the

pressures they face.

Despite the fact that they agree that the experience of stress is mostly tied up with the workplace, interventions are rarely directed at the organisation; stress interventions mentioned deal with the individual. Most interventions described are reactive and tend to deal with the consequences not the source of the stress i.e. they are secondary or tertiary interventions. This is probably because the majority of EPs believe that the major barrier to successful work resumption is the health, attitude and personality of the absentee. Secondary interventions give people coping skills and include health promotion activities and lifestyle change programmes. Tertiary interventions are concerned with the treatment, rehabilitation and recovery of individuals experiencing stress related ill health. Murphy (1988) suggests that targeting interventions at the individual level can be viewed as somehow blaming the victim. Secondary or tertiary interventions tend to separate the individual from the source of the stress and are described by Cooper & Cartwright (1997) as 'essentially damage limitation' (p.9). This equates to relief for the individual of the symptoms of stress as opposed to tackling the root cause of the problem.

Prevention is considered as the ideal stress management policy; this is a primary intervention. A primary intervention involves changing the very nature of the job such as improving communication and reducing job demands and is often considered as a vehicle for culture change (Cooper & Cartwright, 1997). The professionals generally refer specifically to such factors as good communication, stress awareness programmes, work load and management, which are not primary interventions. With one exception, there is no reference to the implementation of primary interventions. Evidence suggests that individual interventions only temporarily reduce the experience of stress (Murphy, 1988) whereas prevention has been described as an oversimplification in thinking about interventions (Briner & Reynolds, 1999).

Most reasoning for the use of organisational interventions is based on the assumption that prevention is better than cure and superior to treatment (Briner & Reynolds, 1999) yet clear supportive evidence for the effectiveness of organisational interventions does not exist (Briner & Reynolds, 1999). Kompier, Cooper & Geurts (2000) believe that one of the significant barriers to progress in reducing work place stress is the lack of evaluation research. So while there are good reasons to support the concept that the ideal is to prevent stress before it occurs, findings suggest that their effects are mixed. Coupled with this it has also been suggested that organisational interventions are

either too costly, practically not viable or advice to companies on how to effectively intervene is simply not there. Bond (2004) writes that in addressing occupational stress 'organisational and individual-directed interventions would be useful' (p.147) but there seems to be no clear common standard or understanding of good management practice to tackle work-related stress.

Whereas knowledge sharing is one common method of maintaining and enhancing stress awareness, the dynamic nature of stress means that advice from one company to another on tackling work related stress needs to be interpreted broadly and adopted with caution because there is no single intervention that can be used successfully to tackle stress.

Work Resumption

According to a recent report for the Health & Safety Executive (HSE 2003) any rehabilitation and return to work process following work related stress absence can be complex and involves input and collaboration from a number of different stakeholders (HSE 2003). 'Effective communications between all those involved in the return to work should provide a 'win-win' situation for all parties' (HSE 2003 p. 64). However inter-professional collaboration presumes an understanding of each other's roles, communication through a common language and mutual respect for each other's professional point of view. The more 'shared knowledge' the better is the potential for effective interdisciplinary teamwork (Millward & Jeffries 2001). The development of a shared understanding of a phenomenon has been identified as an essential group process (Bettenhausen, 1991).

Occupational Health Physicians and Return to Work Specialists are the only professionals that view work resumption as an integral part of their job, involving the facilitation of multi professional collaboration. Although the other professionals view work resumption as ideal, they are divided over the question of responsibility. Consequently no common RTW model appears from the interviews. The professionals pin point many common factors as facilitating successful return to work; such as a phased return but there is little suggestion of collaboration between GPs and the EPs. For example, many GP's view their contribution to the RTW process as being solely to get their patients fit for work; their emphasis is on treating the individual. This clinical approach means that often the root cause of the problem is not targeted.

'If the absence is due to work related stress then work needs to sort out the problems. Furthermore it is the employer's responsibility to have systems in place to monitor the welfare of their employees [] GP should only be used to sign people off, to get them fit for work not get them back to work' (GP 3)

Furthermore many GPs feel that they are not best placed to actively facilitate work resumption because mostly they have no knowledge about their patient's job.

Although there might be some contact between EPs and GPs this is described as cautious. GPs acting on behalf of their patient are not convinced of the true motive behind the employers contact. EPs feel that GPs are generally guarded and on the whole not willing or able to enter into discourse concerning their patient's prognosis for a full recovery and work resumption. Relationships between employers and GPs are strained. The role of the GPs as gatekeepers to long term sickness absence and the benefit system is a cause for concern for everyone including the GPs.

EPs commented that they have to draw a fine line between contact with their employee during their absence which is viewed as supportive and that which is viewed as harassment. Mostly work resumption is regarded as something initiated by the employee and facilitated by the employer. The EPs are unanimous, any work place adaptations will be considered in order to support a return to work. Furthermore many EPs comment that their employees are paid to work and have an obligation to be fit for work in order to fulfil their contractual obligations. Many of the EPs were not trained in absence management so in their experience, unless there was access to occupational health or a return to work specialist via an income protection insurance company, work resumption was an isolated, idiosyncratic discretionary process undertaken by the absentee in collaboration with the employer. Inter-professional collaboration is the exception not the rule in the return to work process.

To conclude, these professionals share much common ground regarding the stress absence phenomena but the question of role responsibility divides them. This might help to explain why interventions and return to work policies are mainly at the individual level addressing the outcomes of work related stress rather than its sources. At the risk of repetition there are as many differences within as there are between the groups of professionals

SECTION 5

Conclusions

- ❖ The stress phenomenon is viewed as salient.
- ❖ Stigma of being 'stressed' i.e. could be interpreted as not being able to cope with job.
- ❖ The media plays a significant role in the stress phenomenon.
- ❖ Work is the most likely common causal factor of long term stress related absence.
- ❖ Opinion is divided over whether or not stress as a problem has increased over the past five years.
- ❖ Workplace had changed but not necessarily for the worse.
- ❖ There is cynicism surrounding stress as a genuine medical condition.
- ❖ Stress interventions focus mainly on the individual outcomes rather than the causes of stress i.e. they are at the secondary or tertiary level not primary level.
- ❖ Prevention is seen as the ideal stress intervention.
- ❖ Due to the dynamic nature of stress it is not possible to have a generic stress intervention.
- ❖ The role of the GPs in long term absence is a source of contention between employers and GPs.
- ❖ There were no company policies to deal with long term absence and work resumption.

Recommendations

- ❖ Increase in research and evidence to support the value of **primary** stress management interventions.
- ❖ Revision of the role of GPs in long term sickness absence.
- ❖ Advice to companies on managing long term sickness absence.
- ❖ Encouragement of inter professional collaboration for work resumption after long term stress related prevention.
- ❖ Increased access for employers to occupational health facilities and return to work specialists.
- ❖ Increased knowledge sharing and collaboration between stakeholders involved in long term absence and work resumption.

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Appendices

Samples of Case Studies

Successful Return to work

Study Box 1.1 – Case 1	1
Study Box 1.2 – Case 2	2-3
Study Box 1.3 – Case 3	4

Unsuccessful Return to Work

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CASE STUDIES

The following is a selection of case studies as described by the professionals.

SUCCESSFUL RETURN TO WORK

Study Box 1.1 – Case 1

New female employee joined an established sales team. This team was very busy, under a great deal of pressure and thus has no time to facilitate her arrival. This sales job required substantial technical knowledge. There was no training system in place and no one available to act as her mentor. In spite of her lack of product knowledge and inexperience with this product, pressure was put on her from the start to perform, to help the sales team realise its targets; she was expected to be an active and productive team member from day one. Although she was a competent and confident person she felt isolated and out of her depth. Her colleagues were not being intentionally unreasonable, they were all under such pressure themselves they had no time to stop and help. There was no support and her relationships with her team strained. Understandably she became stressed because she could not cope, she started to take the odd day off here and there; being a small company this was flagged up. One day after she had returned to work after a couple of days off, one of the company directors spoke to her and the whole situation came to light.

The company realised that it had no proper, organised training or support scheme in place for new employees. No allowances were made for new staff, there was no space allowed for them to learn the ropes. There was no team training, awareness or interaction and no staff support network. This was a very poor state of affairs; the company assumed full responsibility. She was given two weeks off to recoup and recover during this time the company addressed matters at work.

They have now introduced official induction policies and training schemes for new staff. There are regular team training days; a healthy team spirit is now encouraged. The company felt fortunate that she did not resign because now she is a valued and respected member of staff.

Study Box 1.2 – Case 2

Married man, early 40's with young children worked as a charge nurse on an intensive care ward. This man had a great deal of pressure in his life; he was a man who could be described as vulnerable to life events. He suffered a serious road accident where he nearly lost an arm. He ended up in the hospital where he worked, with post traumatic stress disorder. During his time in hospital his friends would come and visit him, as soon as he was able to sit up they are talking to him about returning to work. This man left hospital and went home to convalesce.

During this time he became increasingly anxious about his finances. He had not received any form of psychological help. His GP was no help. He returned to work with the approval of OH; in hindsight he returned to work too early. He returned to the same job with the same physical demands i.e. lifting and moving patients which he was not up to (remember he nearly lost his arm in the car accident), his colleagues were too occupied with the demands of their jobs to give this man any leeway back into his job or to provide him with the opportunity to talk, to offload about his concerns. He had not dealt with the trauma of his accident and was reticent to talk to anyone for fear of the stigma attached to mental health problems. He returned home at the end of each shift, tired, anxious and increasingly depressed and takes this out on his wife and his children by shouting at them and eventually pushing his wife while she is holding the toddler. Social services become involved and they want to place the child in care. He made the decision to leave home; his marriage was now on the rocks. He had no where to go and ended up sleeping on empty beds in empty wards at the hospital where he worked.

At this point he went back to the Dr and saw a different GP who recognised immediately that this man was in crisis with serious mental health problems; he was signed off work. He was referred to a psychiatrist, a psychologist. Once he started to receive treatment his wife allowed him back home. Work started to put pressure on him to return as they were short staffed anyway. He had an ongoing compensation claim as a result of the accident which meant constant contact from solicitors and other medical experts representing either side of the case. He was not well enough or strong enough to deal with any of this so his wife tried to handle everything but did not really know how. They were both disempowered, out of control and not coping and in conflict. Finally they were both referred to a case management vocational expert.

They now had someone to share the burden of their responsibilities, to liaise with all the various parties, to support them and to facilitate his eventual return to work. The case manager dealt with all queries regarding his employment, accident and recovery. The case manager has full authority to act on behalf of this man in all matters. This gave the man space to recover and regain his health. He was given cognitive behavioural therapy. He was empowered and began to take control of his life including his marriage and his job. His return to work was negotiated and coordinated via the case manager involving a graduated return and redeployment to a job with less physical demands. Long term plans were to place him on a management training scheme. A couple of his long term close colleague acted as his ambassadors at work to de-stigmatise his mental health problems. The case manager monitored his return to work and met with him once a month.

This was a win-win situation for all – this man regained his strength and dignity, got his life back on track. His employers retained the expert skills, knowledge and experience of their employee. Social support at work was a key factor that enhanced this successful work resumption. A lack of social support at work was a main reason for his initial abortive return to work coupled with his lack of fitness for work. This was a solution based approach to return to work.

Study Box 1.3 – Case 3

A man late 20's who had been employed with the company for 4 years. He had problems both at home and work. He took time off work because he was unwell. He returned several times but each time he went off again. Basically he returned each time before he was fit and having not dealt with either his work or home life problems. The work place issues stemmed from his recent promotion. He had recently been promoted to a job more high profile than before. Outwardly there were no signs that there were problems. He was a very driven man, with an excellent work ethic, a perfectionist. He was a valued employee. Once he started to take regular days off 'sick' it was apparent that things were not as they seemed. It was then that the company realised that much of his unhappiness stemmed from the fact that he could not cope with his new job; he had been promoted beyond his ability.

As soon as there was open, honest and effective communication between the management and the employee, it was possible to facilitate successful permanent work resumption. In order to become physically and mentally well. he was given a month off work with full pay. Seeing a counsellor enabled him to re-establish control over his personal and work life. His work load was reduced and his job role changed. The company felt they had failed him as much as he felt he had failed the company; the situation at work boiled down to a break down in communication.

UNSUCCESSFUL RETURN TO WORK

Study Box 2.1 – Case 4

50 year old man worked for years as a builder, he then retrained and for the next 15 years he worked in personnel management. He then went to university and qualified as a teacher. He soon realised that he hated classroom teaching; this was not something for which he had a vocational calling. He decided to become a university lecturer. To be near his new job he relocated his family to a larger house with a larger mortgage. It was not long before he realised that he had made a mistake, teaching in any form was not for him but he had to carry on because he was now committed to the larger house. He did not know how to tell his family that he had made a mistake. He worked in this job for another 5 years. He did not talk to anyone about his anxieties and worries; the pressures and stress built up. Eventually he collapsed and left work, never to return.

The key issues here were firstly poor selection procedures. The college did not have in place any formal selection processes so they were not able to make an objective prediction about his suitability for the job or forecast his future job performance. Furthermore the college had no performance appraisal system. This might well have flagged up the issues surrounding this man's employment. Secondly this man found himself in a situation where he could see no way out. He was trapped in the circumstances of his employment and did not have the strength of character to admit he had made a mistake. He was not open or honest with himself, his family or with his employer.

This man identified the root cause of his problem i.e. his unsuitability to teach. His way of dealing with the problem was to remove himself from the source of his stress, his work. By the time he left work he was chronically ill. There was no support network for this man. He lost confidence in himself, had low self esteem and poor mental health.

Study Box 2.2.- Case 5

Young man mid twenties, worked as an engineer where he was a senior bench manager. He was relocated to a different office within the country. His job remained unchanged but his status dropped, he was no longer in a senior position. The first that the company knew that anything was wrong was when a formal complaint for race discrimination bullying and harassment was filed by this man against the company.

There were several system failures. In the first instance his relocation was not managed. This man was left to cope with his move on his own; he was offered no support. There was bad communication, poor working relationships, role ambiguity, conflict, no leadership, no management, no interventions, or team training. He felt an outsider and decided that being Asian was the cause of his problems. The implications of racial discrimination were serious. He did not speak to HR until it was too late. He blamed his colleagues for his eventual resignation; he believed that nothing could be done to change their attitudes towards him. He had no confidence in the management whom he felt had ignored his claims of harassment. His line manager was particularly singled out as a perpetrator of the bullying; he believed he had no one in the company to support him. It became clear that once he was signed off sick with stress, he had no intention of returning to work; hence his resignation.

The culture and climate of the company, the personality of the employee were equally to blame for this no win situation. The company failed this employee but this man's antagonistic manner made a bad situation worse. He did nothing to ingratiate himself with his new colleagues; their working relationship was characterised by conflict and jealousy. Needless to say the company had no policy in place to formally or informally deal with workplace bullying and harassment. This company have now introduced a policy called 'dignity in the workplace' which requires training for all staff to inform them about what they can and can't say to their colleagues, their personal liabilities and responsibilities. Basically the aim of the course is to instil an atmosphere of mutual respect inherent in the company culture; too little too late for this employee.

Study Box 2.3 – Case 6

A lady in a senior level of management went off with stress related ill health. The company are prepared to accommodate any changes in order to facilitate her work resumption. The main issue hindering her return to work is her generous insurance policy which meant that she was being financially compensated for not being at work. The insurance company paying her benefit do so without any referral to the employer, they assess whether or not she is fit for work. She has been off work for about 3 years. There is no incentive for her to return.