Back, but not better

Ongoing mental health problems hamper return-to-work outcomes

Research commissioned by the Mental Health Foundation suggests that employees off sick with depression or anxiety may be returning to work with ongoing symptoms, and that follow-up support is often lacking. Fehmidah Munir, Catherine MacKay, Joanna Yarker, Cheryl Haslam, Aadil Kazi and Lindsey Cooper discuss their findings.

SICKNESS absence is a major public health and economic problem. Evidence suggests that most long-term sickness absence is due to mental health problems such as stress, depression and anxiety. It is well recognised that depression and anxiety are associated with work stress and are one of the most prevalent causes of work-related ill health and of working days lost through work-related ill-health[1]. However, depression and anxiety are also important characteristics associated with medical conditions such as back pain, heart disease and cancer[2,3]. The consequences of depression, both as a primary illness and in association with other health conditions, can include psychological distress, poor self esteem, poor self-management (in other words not adhering to prescribed medication), fear of returning to work, disturbed relations with colleagues and superiors, and possible job loss[2,4].

There are numerous rehabilitation initiatives designed to improve workers' health and attendance at work. These include the identification of physical and psychological processes for return to work, interventions to improve absenteeism and the identification of barriers and facilitators for successful return to work. The outcome of these studies has not only advanced knowledge and understanding of sickness absence, but also improved return-to-work outcomes for many illnesses. But what happens to employees' health, wellbeing and work ability once they have returned to work?

DEPRESSION AND WORKPLACE REHABILITATION

Although return to work is a vital indicator of recovery and rehabilitation leading to better health outcomes and quality of life, few studies have thoroughly investigated the role of occupational rehabilitation after return to work. Regaining work after a period of sickness absence is not always followed by full work recovery, and may be further hampered by ongoing or new problems with depression that may not be recognised or understood by those involved in the management of occupational rehabilitation. Nieuwenhuijsen confirms that there is only poor knowledge concerning the effects of depression and depressive symptoms following return to work[5].

So what are the implications of depression for those who have returned to work? How is it recognised – or screened – and managed in the workplace; and what are the implications for maintaining work and sustaining employment?

SICK LEAVE AND RETURN TO WORK

Recent research funded by the Mental Health Foundation examined the prevalence and severity of depressive symptoms among those who had returned to work in the past two years following long-term sick leave[6]. The study focused on those who had returned to work following depression and anxiety, back pain, heart disease or cancer. Participants were recruited either from the OH services of four organisations – from the healthcare, manufacturing, transport and public administration sectors – or from national support groups. A total of 253 individuals responded to a questionnaire on sickness absence and post-return-to-work outcomes. In addition, in-depth interviews were carried out with line managers, human resource (HR) managers and OH professionals from the four organisations. The interviews explored processes and practice of return to work and post-return occupational rehabilitation management.

RETURNING TO WORK AND DEPRESSIVE SYMPTOMS

Those reporting depression and anxiety were the largest proportion of respondents (40%), followed by back pain (21%), cancer (19%) and heart disease (9%). Seventy-five per cent of those with depression and anxiety and 45% of those with a physical illness reported mild to moderate symptoms of depression (measured by the Beck Depression Inventory II). Over 60% of those with a physical illness had not received a diagnosis of depression despite reporting symptoms. Overall, those who had returned to work less than six months previously (48%) were more likely to report depression than those who had returned between six and 24 months previously. Across all respondents, mild to moderate symptoms of depression were found to be associated with poor work ability (measured by a validated work ability questionnaire) and repeated spells of certified sick leave. A combination of poor work adjustments, minimal line manager support

Research key findings

- Organisations had poor long-term sickness absence recording systems where data was not organised by illness type or length of sick leave, making records difficult to access and monitor.
- Return-to-work procedures were not always consistent within the same organisation. There was evidence of good and poor return-to-work management in the study.
- There was consistent lack of follow up by OH professionals, line managers and HR in the study organisations, due to inadequate training in psychological issues.
- Preference was shown in implementing return-to-work processes and work adjustments to those with cancer and heart disease over those with depression, despite the latter reporting work-related job strain.
- A combination of untailored work adjustments and lack of early tertiary psychological intervention had a significant impact on work ability.
- Less than one-third of those returning to work with depression and anxiety, were offered stress management training.
- Stress management training was found to be beneficial in the long-term for those who received it.
- Those who received support from their line managers were more likely to report moderate work ability than to report poor work ability.
- Over 60% of participants with a physical illness had not received a diagnosis of depression despite reporting symptoms.
- Three-quarters of participants recovering from cancer developed symptoms of depression that they believed were related to both their cancer and adjusting back to work.
- Participants were more worried about telling their employer about their depression than they were about telling their employer about cancer.
- Most line managers were initially supportive but failed to recognise or understand the impact of the late effects of cancer treatment.
- Participants with depression found it more difficult to adjust back to work than any other group.
- Participants with heart problems experienced symptoms of depression and fatigue after surgery and upon returning to work.

and lack of early tertiary psychological intervention appeared to have a significant negative impact on employees reporting symptoms of depression and poor work ability.

OCCUPATIONAL REHABILITATION, WORK ADJUSTMENTS AND WELLBEING

Organisations revealed a mixture of good and poor return-to-work practices. Good return-to-work management was facilitated by good communication between the line manager, occupational health (OH) professionals and the employee, by holding case conferences and planning individual return-to-work practices. However, these practices were the exception rather than the rule, and unclear and inconsistent absence referral and management procedures meant there was a lack of ownership over employees on long-term sick leave. In addition, most organisations – including 24 out of the 54 initially contacted to participate – had inadequate sickness absence recording systems where data was not organised by illness type or length of sick leave, making records difficult to access and monitor.

One important finding was that most line managers were not establishing contact with employees on sick leave. Reasons included lack of training and medical knowledge, low confidence and fear of litigation in making contact with an employee on sick leave. Most were aware that this might have detrimental effects on employees' wellbeing and fuel perceptions of being undervalued by their organisation.

Regardless of good or poor management in returning an individual back to work, there was a consistent lack of follow-up by OH professionals, line managers and HR managers on employees' general health and psychological wellbeing after returning to work. Although most employees were offered standard phased returns and work adjustments, the support stopped there.

The evidence from questionnaire data supports this. Over half the respondents were initially offered a work adjustment on returning to work, which comprised either reduced job demands or different job tasks. Over 75% of those with cancer or heart disease were offered phased return to work but, in contrast, less than half of those with depression and anxiety or back pain were offered phased returns. About a quarter of those with depression and anxiety were offered stress management on returning to work and this was significantly associated with both lower depression symptoms and lower job strain.

In-depth interviews were also carried out with a random selection of 30 respondents (employees) to explore the issues of support and work adjustments more fully. These revealed that although most respondents receiving a work adjustment found them to be beneficial, others were given unsuitable adjustments without prior involvement in discussions, causing employee distress. A number of employees repeatedly made requests for an adjustment, which were eventually given. Out of the 20 participants who had received work adjustments, these did not last beyond the phased return period. This meant that for most participants, the first six months back at

work were difficult and impacted negatively on their wellbeing.

NOT UNDERSTANDING DEPRESSION CONTRIBUTES TO POOR WELLBEING

In-depth interviews with respondents showed that those returning to work following an episode of depression found it more difficult to adjust back to work compared with those returning to work with other illnesses. The interviews also revealed a pattern of negative support from line managers and colleagues who had little understanding about depression. Interviews with stakeholders confirmed this perception: although there was a general awareness and understanding of depression, OH professionals, HR and line managers were inadequately trained in dealing with psychological issues.

There was a tendency by line managers to stigmatise those with depression. Preferences were shown in providing work adjustments and line manager support for those with cancer and heart disease over those with depression, despite the latter group reporting high job strain and the cause of their illness to be work-related. Those with depression were also more likely to face barriers due to issues over perceived bullying, poor work relations and work-related stress. The lack of understanding about depression affected other illness groups – all of which are known to have co-morbidity with depression. While support and adjustments were provided to accommodate the symptoms of back pain, cancer and heart disease, OH professionals and line managers failed to recognise (or assess) depression among these employees, leaving them feeling isolated and unable to raise the issue of experiencing low psychological wellbeing.

THE ROLE OF OCCUPATIONAL HEALTH

Data from stakeholder and employee interviews suggests that both line managers and employees were often unaware of the support OH and HR professionals can provide to an employee returning to work following sick leave. Many employees and some line managers were often unaware that OH provision existed within their organisation. From the questionnaire data, nearly three-quarters of respondents with back pain, cancer or heart disease reported having little or no contact with OH departments both during sick leave and since returning to work. In contrast, over half of those reporting depression and anxiety as their primary health condition had some contact from OH professionals during their sick leave. In terms of receiving support post return to work, respondents reported receiving the least amount of support from OH professionals and the most support from colleagues; those with cancer reported receiving most support from line managers. Poor contact with OH professionals suggests that some services might be under-resourced, not well established or not given ownership of return-to-work policies and processes.

POST-RETURN STRATEGIES

This study suggests there is currently little strategic planning for return to work that involves *discussion* and *involvement* with the employee and collaboration across all key stakeholders. There was a lack of clarity about who was responsible for managing key aspects of the return-to-work process. Addressing the specific responsibilities and ownership of managing employees on sick leave is crucial to developing an effective return-to-work process. Organisations need to move beyond their minimum legal requirements regarding their duty of care, and employ good practice in line with non-statutory guidelines in relation to disability management and inclusion. Failure to do so could result in greater absence, higher staff turnover and adverse impacts on staff morale, productivity, commitment and job retention. Occupational

The employee's perspective

Julian suffered stress, anxiety and depression, which resulted in short- and long-term sickness absence. The following extracts from his narrative describe his view on the subject:

'The worst problem was that nobody in the company actually understood. The doctor and the counsellor understood, but occupational health didn't, and HR weren't interested. Probably, if you've got a broken leg you can see there's something wrong but if you haven't [got any visible symptoms] there's always the perception that you're just skiving. I think I'm a different person now – a lot quieter, a lot more introverted. I don't mix with people that I work with very much, whereas I used to beforehand.

'I don't think anybody in the workplace actually understands. I think, again, if you go back to work with a broken leg you can see what's the matter. If it's a mind thing – like depression or anxiety, or even stress – the perception is that there's nothing the matter with you and that you're putting it on.'

The line manager's perspective

Natalie is a line manager and the following are extracts from her description:

'I'd say my biggest barrier is lack of medical knowledge; I have to speak to the nurse a lot and we have a good working relationship so she can trust me that if she does say things, they won't go any further. The mental [health] cases are the hard ones because you don't know where to tread. If you've been away from the workplace for a long time, the work environment may have completely changed. Normal mechanisms of support like friends and other people have moved on. The manager may have moved on. It's getting over that first barrier to start with, coming back and people asking all those questions – especially if it's depression. I think people don't know what to ask. It's a difficult conversation to have with someone ... I suppose it's difficult for the person who had it.'

CONCLUSIONS

■ **Individuals** returning to work following long-term sick leave require ongoing adjustments and support
■ **Line** managers require better training on return-to-work management competency skills
■ **An interactive** occupational health psychology 'tool box' may help OH professionals and line managers to monitor the psychological wellbeing of those returning to work following long-term sick leave
■ **There** should be increased OH collaboration between line managers, HR and treating health practitioners
■ **More** research is required to evaluate the beneficial effects of stress management training for those returning to work

rehabilitation management should aim to address the following within organisations:

➤ raise the profile and role of occupational health across the organisation. This would allow OH practitioners to take a lead role in the management of employee health and wellbeing
➤ develop a more integrated multidisciplinary approach to pre- and post-return-to-work management involving all key stakeholders, including GPs and insurers
➤ improve communication between the many stakeholders and the returning employee
➤ lengthen the period of monitoring, communication and support available to a returning employee, particularly in the first six months of their return.

It is important to identify those employees returning to work who are at risk for depression. This should be made a key policy by organisations and a part of the risk assessment framework already in place with regards to UK legislation on general health and safety at work, and the HSE management standards for work-related stress. In addition, employers should provide employees returning to work following depression with stress management training to help reduce the risk of depression and anxiety. As the role of line managers is pivotal in making work adjustments and providing support to returning employees, OH practitioners can substantially help by providing them with the relevant knowledge and support they need. By working closely with other key stakeholders such as HR professionals and unions, the following can be achieved:

➤ *tailored line management training*: evidence from this study suggests that current training and information to line managers both in managing return to work and identifying common health problems may be ineffective. Line management training should be tailored and embedded within evidence-based psychological models of intervention such as the Stage-of-change model[7], which helps to elicit and maintain behaviour change

➤ *reinforcing legal duty of care*: line managers require additional training and information in employment law, since fear of litigation over potential harassment issues appears to prevent contact with sick employees. This could include advice on appropriate interventions in partnership with OH professionals.

OH services should invest in a multidisciplinary OH team. For example, investment in occupational health psychology professionals ensures early and appropriate psychological interventions and provides support for OH and HR professionals who require additional training to deal adequately with common mental health problems. Investment is required in terms of recruiting staff with specialist training in this area and in supporting their continuing professional development. Overall, a multidisciplinary and collaborative approach by all key stakeholders in the return-to-work process can potentially benefit employees at all stages: those who have returned to work following long-term sick leave and those at risk of repeated long-term sickness absence and social exclusion.■

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Notes

1 Health and Safety Executive. Self-reported illness and injuries in 2006–07: Results from the labour force survey. London: Health and Safety Executive, 2008.

2 Lewin R. Return to work after MI, the roles of depression, health beliefs and rehabilitation. International Journal of Cardiology 1999; 72: 49–51.

3 Hoffman BM, Papas RK et al. Meta-analysis of psychological interventions for chronic low back pain. Health Psychology 2007; 26: 1–9.

4 Henderson M, Glozier N, Elliot KH. Long-term sickness absence. British Medical Journal 2005; 330: 802–803.

5 Nieuwenhuijsen K, Verbeek J et al. Supervisory behaviour as a predictor of return to work in employees absent from work due to mental health problems. Occupational and Environmental Medicine 2004; 61: 817–823.

6 Munir F, Yarker J, Haslam C, Kazi A, Cooper L, MacKay C. The role of depression following return to work. London: The Mental Health Foundation. (In preparation).

7 Prochaska JO, DiClemente CC. Transtheoretical therapy: toward a more integrative model of change. Psychotherapy: Theory Research and Practice 1982; 19: 276–288.

The names used in this article have been changed to protect the identity of the participants.