



Best practice in rehabilitating employees following absence due to work-related stress

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Best practice in rehabilitating employees following absence due to work-related stress

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The emphasis of this research project is on identifying specific examples of best practice following absence due to stress-related illness, and various factors which influence its effectiveness. This will provide employers not only with information on different types of practices, and the evidence of their effectiveness, but also any specific elements that contribute to this effectiveness.

Secondly, the research aims to highlight any costs and benefits of rehabilitation practices that are identified. It will also consider the historical development of rehabilitation practices within the case study organisations, and describe the key factors influencing the development of procedures. It is envisaged that this type of information will be important in encouraging other employers to develop their own rehabilitation practices.

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IES aims to help bring about sustainable improvements in employment policy and human resource management. IES achieves this by increasing the understanding and improving the practice of key decision makers in policy bodies and employing organisations.

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Louise Thomson at IES designed and managed this project from its inception last year to near its delivery this year, at which point she went on maternity leave to deal with a delivery of her own. As a result the report was completed by her co-authors, so any omissions or errors are ours rather than hers.

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1. Introduction

1.1 Background

It has become increasingly clear in recent years that stress is a major contributor to employee absence in UK organisations. The 2001/02 Self-reported Work-related Illness (SWI, 2001/02) survey, found that stress was the second largest category of work-related illness, estimating that over 560,000 people were affected (HSE, 2002). Similarly, research by IRSR for the CIPD has indicated that stress is the second most important cause of absence for non-manual employees, and is the leading cause of absences of five days or longer for this group (CIPD, 2001). The revised economic impact figures from the 1995 SWI survey estimate that 6.5 million working days were lost in Britain due to stress, depression, anxiety, or a physical condition ascribed to stress (HSE, 1999).

One of the targets of the Government initiative, Revitalising Health and Safety (DETR, 2000), is to reduce the working days lost due to work-related injury and ill-health by 30 per cent by 2010. It is widely accepted that there are various approaches to reducing and managing work-related stress. Although prevention is often seen as the priority, it is essential that preventative approaches are accompanied by, rather than seen as an alternative to, rehabilitation. This is especially necessary whilst preventative actions and standards are being researched and developed. To address this need, one of the key aspects of the HSC's programme of work is to identify best practice examples of retention and rehabilitation practices after a period of ill-health stemming from work-related stress.

Historically, the UK has had one of the worst records in Europe for the return of employees to work after long-term illness. In their review of employers' approaches to rehabilitation after long-term absence, James *et al.*, (2000) concluded that few employers appear to provide comprehensive and integrated rehabilitative services and are able to draw on the advice and expertise of occupational health professionals when considering action to assist an employee to return to work. However, the issue has recently risen up the policy agenda, not least in the form of the job retention and rehabilitation pilot schemes being conducted by the DfES. Rehabilitation has also become an increasingly important

issue for many employers. A recent survey of large employers (IRS, 2001) indicated the reasons for employers giving more attention to the issue of rehabilitation, which include:

- increasing concern for the general well-being of employees
- part of the process of improvement of general management
- growing concern over both the number of long-term absences and number of ill-health early retirements
- part of their policy on the treatment of disabled workers
- concerns about rising employment liability insurance claims and premia.

Despite the level of information about rehabilitation practices in general, the picture regarding current practice in rehabilitation for stress-related illness is less clear. There is a need to identify best practice in this specific area in order to support employers in tackling stress at work, and to assist employees in returning to work. This information will provide employers with examples and details concerning the kind of rehabilitation practices that are possible. It will also have a number of other benefits.

Firstly, it will identify and describe the most effective forms and aspects of rehabilitation practices in relation to stress-related ill-health. Generally, rehabilitation can be successful in helping people to retain their jobs or to return to work in some capacity with their employer. However, various factors may influence the effectiveness of attempts to rehabilitate workers following a period of ill-health, such as:

- the nature of the work-related stress and subsequent ill-health
- the point at which intervention takes place
- the extent of line management involvement and commitment
- the nature of the work situation on returning from absence.

The emphasis of this research project is on identifying specific examples of best practice following absence due to stress-related illness, and various factors which influence its effectiveness. This will provide employers not only with information on different types of practices, and the evidence of their effectiveness, but also any specific elements that contribute to this effectiveness.

Secondly, the research aims to highlight any costs and benefits of rehabilitation practices that are identified. It will also consider the historical development of rehabilitation practices within the case study organisations, and describe the key factors influencing the development of procedures. It is envisaged that this type of information will be important in encouraging other employers to develop their own rehabilitation practices.

1.2 Aims and scope of the research

The research specification set out two main aims for the study:

- to identify current organisational practices of job retention and vocational rehabilitation after a period of ill-health stemming from work-related stress, and to review the evidence of their effectiveness
- to select and describe approximately 12 examples of best current practice in job retention and vocational rehabilitation that match the evidence-based practices identified.

1.3 Research approach

1.3.1 Case study methodology

There is no single model of best practice in rehabilitation that is adopted by all organisations. Indeed, the definition of rehabilitation practices may vary quite widely between different organisations. The effectiveness of any approach is, in part, determined by organisational context. Factors likely to influence both the approach used by a particular organisation, and the effectiveness of that approach, include:

- the perceived size of the problem (*ie* the number of cases of stress-related ill-health)
- the type of stress problems typically identified
- the workforce size and composition
- the nature of the work undertaken
- the location and distribution of workplaces
- the other occupational health and stress management procedures adopted.

Given these variations with organisational context, we used detailed organisational case studies to obtain best practice examples.

Best practice examples are typically of an organisation's general approach to rehabilitation of those with stress-related illness. However, organisations have more than one approach that meet best practice criteria, for different groups of employees and different kinds of workplace, for example. To handle this level of specificity, we have treated each practice as a separate example where appropriate.

1.3.2 Assessing best practice

No single source of information enabled us to identify best practice. From the employers' perspective, effectiveness depends

on the objectives which were set for the rehabilitation practices, and this largely reflects their historical context. Naturally, the objectives of rehabilitation practices and the associated assessments of effectiveness, vary between organisations. In addition, other perspectives on these practices and their effectiveness are relevant, such as those of the service providers and key professionals involved in rehabilitation, as well as the recipients of those practices.

Our approach in determining what constitutes best practice in the rehabilitation of individuals with stress-related ill-health was, therefore, based on a combination of the following assessments:

- a review of existing evidence from academics and practitioners concerning the effectiveness of different rehabilitation practices
- the views of experts and specialists with a wide range of experience in the field
- the views of the key professionals in the organisation concerned
- any data they have to support those views
- the views of line managers and employees with direct and indirect experience of rehabilitation practices in organisations.

Specific criteria for best practice were to be drawn up, based on a review of the academic and practitioner literature on effective rehabilitation and the views of experts and specialists. These criteria then provided a consistent framework for the selection and assessment of organisational rehabilitation practices. The views of key professionals, line managers and employees from the case study organisations were also taken into account in the final assessment of best practice.

1.3.3 Research stages

Overall, the research followed the seven key stages summarised below (for full details of each stage, see Appendix 1):

- a review of the literature to identify the range of existing rehabilitation practices and the evidence for their effectiveness
- telephone interviews with occupational health practitioners within organisations, to identify potential examples of best practice within large organisations
- telephone interviews with experts and specialists in the areas of stress and rehabilitation, to identify best practice criteria and examples of best practice within organisations (large, small and medium sized enterprises (SMEs))
- interviews with occupational health service providers to identify examples of best practice in SMEs
- developing and agreeing a list of criteria for best practice in stress rehabilitation and return to work, based on the review

of existing evidence and the views of the experts and specialists

- using the best practice criteria to select organisations for case studies, based on their responses to the telephone interviews
- conducting detailed case studies in the selected organisations, including:
 - a review of relevant policy documentation or organisational data collected from each case study organisation
 - a series of interviews within each case study organisation to provide a detailed description of the organisation's policies and practices, and actual examples of how these work.

1.4 Definitions

1.4.1 Defining stress

The term 'stress' is used to describe a wide range of psychological and physical ill-health. This has two major implications for this type of research:

As stress can be linked to a wide range of complex physical and psychological symptoms, the nature and effectiveness of any rehabilitation will be, to some extent, dependant on the way in which an individual is experiencing stress. For example, rehabilitation for someone who has suffered a severe psychological reaction to bullying, will be different from rehabilitation for someone who has suffered severe migraines due to workload stress. More perhaps than in any other area of rehabilitation, the nature of the stress-related problem will vary, and the research must be sensitive to the wide range of different conditions with which successful rehabilitation will need to contend. The implication for the research was that each case study had to be sensitive to the extent to which organisational practices are generically applicable, or are tailored, to the specific demands faced by employees of that organisation.

Organisations also have varying operational definitions of stress, with some forms of work-related stress being far more easily identifiable or culturally acceptable in some organisations than in others. This is fundamentally a labelling issue, with one organisation's stress not necessarily being another's. Whilst the research adopted the accepted HSE definition of stress, we had to be open to the possibility that what is recognised or labelled as stress in one organisation, is not necessarily recognised in another. The implications for the research were that each case study had to explore the organisations understanding or conceptualisation of stress as it affects their workforce.

1.4.2 Defining ill-health due to work-related stress

The focus of the research was on rehabilitation after ill-health stemming from work-related stress. It is important that such ill-health refers to both psychological and/or physical symptoms. For those who experience purely symptoms as a result of stress (eg see 1.4.1) there will be psychological elements that need to be dealt with. The majority of practices reported here will be relevant to both physical and psychological symptoms. However, there are various parties involved in the long-term absence of an employee, all of whom could attribute the employee's ill-health to different factors. For example, whilst the employee may describe his or her ill-health as stemming from work-related stress, the employer or occupational health professional may attribute it to an underlying chronic health problem that is not work related.

While acknowledging these considerations, it was outside the scope of this project to establish the accuracy of diagnoses. Therefore, we set out to work with the existing diagnoses provided by organisations – either supplied by their own occupational health professional or by the employee's GP. In other words, where organisations talked of an individual being diagnosed with stress-related depression, for example, then this diagnosis was accepted in the context of the project. However, details of the specific diagnosis was recorded as part of the case study as the nature of the diagnosis may have had an impact on the success of any intervention.

1.5 Structure of the report

The remaining chapters of this report describe the detail of the research that was carried out.

Chapters 2 to 4 describe the main findings from the research, presenting different elements of best practice in job retention and vocational rehabilitation after a period of ill-health stemming from work-related stress. For each of these elements of best practice, two separate accounts are provided where available:

- a general account of the organisational practice, and a summary of any existing research evidence concerning its effectiveness, where such evidence is available
- specific examples of how this practice is used within the case study organisations, and any evidence concerning its effectiveness within the organisations.

Chapter 2 describes best practice in the actual stages of the rehabilitation process. It is based on specific 'cases' from the participating organisations, and relates their actions at each stage. These elements of best practice follow the sequence of events and actions that typically take place.

Chapter 3 discusses best practice relating to the broader aspects of the management of rehabilitation after a stress-related illness, *ie* it is concerned with the broader structures in place that enable specific instances of rehabilitation to occur.

Chapter 4 considers some of the wider issues concerning the development and implementation of best practice and the evaluation of rehabilitation practices, *ie* those factors which appear important in creating a work context that is supportive of rehabilitation.

Chapter 5 summarises the findings, drawing a number of conclusions and making a series of recommendations.

Appendix 1 provides a full account of the methodology used in this research.

Appendix 2 contains brief summaries of the case study findings from each of the organisations participating in the research.

2. Best Practice in the Stages of Rehabilitation

This chapter describes best current practice in each of the stages of an employee's rehabilitation and return to work following illness due to work-related stress. The rehabilitation process typically starts with some form of contact between the employee and the organisation at the beginning of the employee's absence, and ends with the employee's full return to their job. For each stage, we provide a summary of what is known from the literature, followed by examples of practice from the case study organisations. The best practices associated with the various stages of rehabilitation are described below in the chronological order in which they usually occur.

2.1 Early contact with the employee

Based on the available literature on rehabilitation, communication with the employee at various stages of their stress-related absence is thought to be vital to successful rehabilitation and return to work. To be effective, the nature of the communication will need to be appropriate for the stage of rehabilitation that the employee is at. Nowhere is this more crucial than at the initial stage of a stress-related illness or absence.

It is widely accepted that when an employee is first absent with illness due to work-related stress, they should be contacted by someone from the organisation within a week. This person should offer general support to the employee and demonstrate the organisation's concern for them as an individual, but they should not start to discuss interventions and treatments at this stage. However, there appears to be no specific research evidence concerning the most effective timing and nature of the initial contact between organisation and employee.

In practice, contact with the employee varied enormously across the case study organisations, with some organisations advocating procedures for contacting employees at quite lengthy stages into the absence (*eg* initial contact made after two or more weeks). However, the majority of organisations studied engaged in some form of early contact with the individual, be it on a formal or informal basis. A range of these procedures and practices is described below.

2.2 Evidence from the case studies

The original invitation to tender specified 12 case studies as the final output of the research. To ensure this target was met we originally aimed to work on case studies with 15 organisations. In fact, 14 organisation case studies were completed for inclusion in this research. Full details of how they were selected can be found in the research methodology (Appendix one). Appendix two also provides detailed summaries of each case study organisation. The participating organisations were:

- Agilent Technologies
- AstraZeneca
- a chemical company
- Devonport Dockyards
- Doncaster Metropolitan Borough Council
- Flintshire County Council
- a frozen food manufacturer
- an insurance company
- Lancashire Constabulary Central Division
- MTM Products
- North Tees and Hartlepool NHS Trust
- Sandwell Healthcare NHS Trust
- Sheffield City Council
- a supermarket.

2.2.1 Case study examples of early contact with employees

A variety of approaches to early contact were adopted by the case study organisations that took part in the research. Some of the organisations made early contact with the employee through the line manager, whilst for others it was the occupational health (OH) department who contacted the employee.

Contact via the line manager

In the majority of cases where the line manager established early contact with the employee, this was done in line with the organisation's absence or attendance policy that related to early contact for employees with any illness, rather than stress-related illness specifically. A number of examples of best practice emerged from the case studies relating to the line manager contacting the employee. These are described in more detail below, and highlight the following best practice points:

- provide advice to line managers on appropriate contact
- consider who is the most appropriate person to make contact
- do not rush employees who do not want to be contacted.

At Flintshire County Council, managers are expected to remain in regular contact with employees who are sick by telephone, letter and visit. The ill-health policy gives line managers guidance on how to be 'sensitive' to the wishes of the employee, and suggests that the trade union should be told of an employer visit, if the employee requests this.

At North Tees and Hartlepool NHS Trust, in the example case that was examined, the line manager involved in the case felt that the line manager may not necessarily always be the right person to make contact with the employee initially. Although it should be someone 'senior', each individual case should be considered separately, and the right person chosen to keep in touch with the employee. For example, this might be a manager or colleague who has closer day to day contact with the individual.

The policy recognises that line managers may be nervous about contacting an employee who is off sick with stress-related illness, especially if the manager has not previously dealt with employees experiencing work-related stress. For example, they may not know what to expect, or may be worried about exacerbating the problem. Therefore, appropriate advice and assistance from elsewhere in the organisation (OH, Human Resources, or a colleague who has experience in dealing with work-related stress) is made available.

In some cases, the employee may not be ready to talk to someone in the organisation. This scenario occurred in the example case at MTM Products, when the employee wouldn't take any calls from the organisation. The company wrote to the employee instead, saying that they did not want to rush her, but they would like to help in finding out what the problem was, and provide appropriate support to aid recovery. After about six weeks, the employee responded to the letter, and a meeting was arranged to start the rehabilitation and return-to-work process.

At AstraZeneca, it was the line manager who first identified the problem and advised the employee to go to his GP. The manager then contacted the employee the day after he was sent home. The manager then stayed in regular phone contact over the next two months.

At The Chemical Company, initial contact varies according to each case. In this individuals case, initial contact was made by the line manager at the time, who was also an old personal friend. HR also made contact with him at home on a regular basis, and he felt that 'they handled me very well, the people involved were supportive and just wanted me to get well.'

At The Supermarket, the store and personnel manager visited the employee at home during the first week of absence. They told him to try not to worry and to focus on getting better. The employee reported that he found this very reassuring, and felt he could talk to the store and personnel managers about what the problems were.

The Supermarket personnel manager echoed comments made elsewhere in the case studies about which person is best placed to make initial contact with the individual. In this case, the personnel manager says that if a medical certificate says stress, she will not necessarily call straightaway herself. This is to avoid causing concern for the individual if the store personnel officer phones. Early contact is seen as very important, so a colleague or the personnel assistant will phone instead. If appropriate, the personnel manager will encourage the employee to come into the store for a coffee so that they don't feel isolated from work or feel that they can't come in to see their friends and colleagues.

The policy at Doncaster Metropolitan Borough Council encourages managers to make contact at an early stage if an individual employee is off with stress, anxiety, or depression, although managers ought to seek the advice of OH in this regard. The managers role is to offer help if needed, and a referral to OH. They also encourage the employee to keep in periodic touch with the department. There is recognition that some managers are unconfident about contacting an employee who is off work with stress. As a result, managers are given guidance about the types of questions to ask about stress, to try and determine which are the relevant work factors so that they can be tackled.

At Sandwell Healthcare Trust, the individual employee was contacted on a regular basis by her line manager, but didn't want to accept the calls, and used the answerphone to screen them. The Trust also contacted her by letter, and at first she felt this was better, but appreciates now that her line manager was trying to help her.

At The Insurance Company, early contact was seen as vital, and normally formed part of the line manager's duties. However, it was recognised that some managers might shy away from this contact, or find it a difficult situation to deal with if the employee was upset. Guidance was offered to managers, and the emphasis was placed on trying to ascertain if work was contributing to the situation, and establishing when it was the best time for the individual to talk.

Where contact via the line manager seems unproductive, or the individual is unwilling/unready to talk directly to a work colleague, then OH can provide an important opportunity for early contact.

Contact via OH

At The Frozen Food Manufacturer, the OH department currently contacts employees as soon as a medical certificate has been received that indicates stress. Medical certificates are received after seven days of absence. However, the company is planning to change this procedure to being line-manager led. It wants line managers to take more responsibility for absence management, and one way of achieving this is for the onus of contacting the employee to be on the line manager.

At The Supermarket, the first OH visit is a 'welfare' visit. The aim is to talk to the employee and find out how they are feeling, to offer reassurance, and to start to gain an understanding of the cause of the problem. In the current case, the OH advisor recommended that the individual also sought advice from his own GP about counselling. The OH advisor will then make a recommendation to the store regarding the employee's likely return to work, she will offer help to the employee and, when ready, draw up a rehabilitation plan.

2.3 Early health assessment

There is no clear evidence that indicates an optimal time for a health assessment for ill-health due to work-related stress. However, the consensus amongst the experts that we consulted during our research, was that it should be possible to identify whether the employee will recover spontaneously at around two weeks of illness, and at four weeks, the intervention or treatment should start with a referral to occupational health services (or equivalent) for assessment. However, a specific request from the employee may determine an earlier assessment.

2.3.1 Case study examples of early health assessment

The case study organisations had a variety of different approaches to the timing of a health assessment.

Set timings

Some organisations referred employees for assessment after a set period of time, usually four weeks. For example, at The Frozen Food Manufacturer, an employee who is off work for four weeks is automatically sent a letter from OH, asking them to attend the department for an initial assessment of their condition.

Immediate referral

Other organisations had a 'set timings' approach for all other ill-health problems, but initiated an OH assessment immediately for

stress-related illnesses. For example, at Flintshire County Council, ill-health referrals to OH normally take place after an absence of eight weeks. However, if a medical certificate states 'stress, anxiety or depression', then the employee would be referred to OH straightaway. In the example case from Flintshire County Council, the employee was referred to the OH department by her line manager immediately, and was seen within ten days of first going off sick. She had already visited her GP, who had signed off from work with stress and depression for one month and prescribed her Prozac. The OH department then referred her to a counsellor immediately.

Similarly, all absences relating to conditions associated with depression, stress and anxiety at the central division of the Lancashire Constabulary, must be reported in writing by line managers to the OH department as soon as they are notified. Any referral to OH is also notified to the trade union and Human Resources (HR). The OH department will then contact the employee, and they are invited to the department for a medical assessment.

In both AstraZeneca and The Chemical Company, managers were quick to suggest that individuals went to their GP and occupational health once they were aware of the problem, although in neither organisation is there a set time limit for referral to OH.

At Devonport Dockyards, HR intervene on receipt of a medical certificate that identifies stress. Employees may be assessed at the outset by their own GP or by the organisation's OH doctor. However the OH doctor always conducts his own assessment (referring to information from the GP where relevant).

Doncaster Metropolitan Borough Council is explicit in its stress policy. Where an employee is off work for anxiety or nervous/depressive states (*ie* stress related reasons), referrals to OH should take place as early as possible. Managers would be able to identify employees with stress either at the four-day stage (through self-certification), or the eight-day stage, when a medical certificate is required.

The central division of the Lancashire Constabulary adopts a similar approach of early referral to OH. In cases of occupational health referral could be on day one if that is what is stated on the certificate.

At The Insurance Company, return-to-work assessments tend to happen at around the four-week stage. When a person is referred with stress related problems, he or she has an individual assessment with a psychologist.

Flexible approach

A more flexible approach to the timing of health assessments is taken by other organisations. For example, Sheffield City Council has no set point at which the employee is referred to OH for an assessment, and it does not happen automatically. When there were set timings, they found that managers used these in a mechanistic way, and only referred an employee when a trigger point was hit, even though it was clear that they should have been referred earlier or they might not refer at all. The approach taken now, therefore, requires more active management by the line manager, and OH becomes involved when it is clear that they are needed. Individual employees can also refer themselves to OH for an assessment.

A flexible approach is also advocated by North Tees and Hartlepool NHS Trust. Where recovery looks likely, and it is probable that the employee will return to work relatively quickly, the manager should review the situation at regular intervals, in this instance every four weeks. Where recovery time is less certain, then medical guidance about contact is sought on a case by case basis.

2.4 Quality of the health assessment

It is not just the timing of the first health assessment that is important, but the manner in which it is conducted and what happens after this. The key factors are that:

- the assessment and diagnosis must be accurate
- the physician doing the assessment must be sympathetic and supportive
- the referral for treatment or intervention after this must be appropriate, and based on the identified need of the employee
- where both a GP and OH are involved in assessing the employee's health, there should be communication and information sharing between both parties.

However, existing evidence suggests that the inaccurate diagnosis and inappropriate treatment of mental health conditions is relatively common, especially among general health practitioners (Boland *et al.*, 1996; Gjerris, 1997). Ineffective treatment is expensive both in terms of the costs of treatment and the time to recovery (Goodman, 2000).

2.4.1 Case study examples of quality health assessments

One comment frequently made by case study organisations, was that a medical certificate for stress told them very little about the

nature of the problem and appropriate interventions. A more specific assessment was necessary in order to design and facilitate appropriate rehabilitation plans. Despite this, examples of good practice were also in evidence.

Either the employer's OH professional or the employee's GP can make the assessment and subsequent referral for appropriate treatment. In the case study organisations, we saw examples of good practice from both parties.

OH assessments

In the example case examined at The Frozen Food Manufacturer, the OH assessment was both accurate and supportive towards the employee. The individual met with the head of OH and the OH doctor. The aim of this meeting was to give the employee the chance to talk about his problems, and to offer support. It also allowed the doctor to ask about medication from the GP and gauge the employee's overall physical condition. At this meeting, it was agreed that the employee was not ready to return to work and another review meeting was arranged. In the meantime, the employee gave his permission for OH to contact his line manager to discuss the case. OH would also ask for the employee's consent if it were necessary to speak to their GP directly.

At The Insurance Company, a specialist psychologist is available to provide an assessment in longer term or more complex cases. Such an assessment will cover all aspects including exercise, diet, social functioning, symptom levels as well as work issues. This way, a highly individual rehabilitation plan is drawn up for the individual.

In one of the case examples we looked at, we found that it was the approach of the physician conducting the OH assessment that had a negative impact on the employee. At the initial assessment, the physician was a temporary cover for the usual occupational health physician. He indicated that there was a long-term illness and that the employee was unfit to work, but during the assessment, the doctor told the employee that he wouldn't get ill-health retirement as a result of his illness. The employee was quite distressed and insulted by the Doctor's attitude, and felt more demotivated after it. Fortunately, the case was reviewed by the new OH nurse one month later, and she was able to rectify the situation through her supportive approach.

GP assessments

The employee's GP is often the first port of call for the employee, and for most SMEs, the GP will be the sole source of the health assessment, treatment and referral. For example, MTM Products must rely on the employees' GP for a quality health assessment. In the example case from this SME, the employee appears to have

received good treatment from the GP, and was referred to a counsellor via the GP.

In some cases, the initial assessment by a GP when an employee first goes off sick can prove crucial in effective rehabilitation. For example, in an example case from Sheffield City Council, it was the employee's GP who referred the employee to a local hospital's psychiatric department for specialist outpatient care. The occupational health nurse felt that the GP's quick and appropriate referral was a key factor in the employee's successful rehabilitation.

Other case study organisations agreed that appropriate diagnosis and treatment from the employee's GP was an important factor. If an employee's GP does not recognise or 'believe in' work-related stress, then the whole rehabilitation process can be stalled.

Communication between OH and GP

A number of examples from the case study organisations demonstrated the benefits, where possible, of OH and GPs working closely together. At North Tees and Hartlepool NHS Trust, for example, the occupational health department will contact the employee's GP, with the employee's consent. When the GP's report is received, the OH department will arrange an interview with the employee and their representative to discuss the options available.

The case from Sandwell Healthcare Trust also demonstrated close liaison between occupational health and the individual's GP, and this practice was mirrored in the policies of many of the case study organisations.

In fact, the case study organisations provided plenty of examples of OH or HR liaising with GPs during the rehabilitation phase. However, at this, the assessment phase, there was also some evidence that information from GPs was of limited use, and that communication between OH and GPs was not always all it could be.

2.5 Developing an agreed rehabilitation plan

A number of aspects of the development of the rehabilitation plan may be important for effective rehabilitation:

- The rehabilitation plan for any individual employee should be agreed by all stakeholders, but particularly by the employee.
- The plan should be developed and initiated at the appropriate time for the employee, regular reviews and have built into it.
- Both the employee and the manager must be committed to the rehabilitation plan and the aim of a successful return.

A number of rehabilitation practices emphasise the importance of employee involvement in the planning and execution of their own rehabilitation. Opportunities for the individual to influence their own rehabilitation process may be crucial as dependency on the rehabilitation provider may be detrimental (Ekberg, 1995). Participation and self-management in rehabilitation emphasise the intrinsic motivation of the individual rather than the extrinsic steering of the rehabilitation process, which may encourage the development of the 'sick role'.

The timing of the development of the rehabilitation plan is also important. It should be done neither too soon, nor too late. Too soon and it may make the employee feel under pressure and put back their recovery from their stress-related illness. Too late and the employee may lose their confidence in their ability to return to work, as the barriers to work appear insurmountable. So when is the right time to start talking about return to work? A flexible approach appears to be needed as the appropriate timing will be dependent on the employee and the nature of his or her illness. It requires a series of judgements to be made concerning when the employee is ready to start thinking about it returning to work, when they are ready to start planning their return, and when they are ready to actually do it. By breaking the return process down into these smaller stages, it may help to reduce the apparent size of the undertaking.

Commitment to the aims of the rehabilitation process was seen as a crucial factor for effectiveness by the case study organisations. It was felt that all parties must agree and support the return-to-work plan, but that agreement from line managers and employees was particularly key. For the line manager, commitment and a willingness to change the working environment was highlighted as important. Some interviewees reported that a key barrier was resistance from managers to make changes to their department or ways of working. For the employee, the motivation to return to work and gradually redeveloping their commitment to the job was seen as important.

2.5.1 Case study examples of developing the rehabilitation plan

The importance of timing and the flexible approach was illustrated well by one of the example cases from Sheffield City Council. The employee described how initially he thought that he would never be able to return to work because of the anxiety that he felt. He was also worried about how things would be when he returned – *ie* it would be in a worse mess, and all his systems and procedures would have been thrown out. But when he started to get treatment at the hospital and discuss his experience with others there, he realised that he could eventually go back to work. Clearly, approaching the subject of return to work would not have been appropriate at the early stages of the employee's treatment.

So when and how did these discussions start? The OH nurse said that at their review sessions, she would assess whether he was ready to start discussing return to work by asking him whether he ever thought about work at all, and how he felt about it. These questions were fairly indirect, but she could tell from his reactions when he was not ready to start discussing a gradual return and when he was.

The employee said that he had needed a nudge to get him thinking about returning, and the OH nurse gave him that nudge in a gentle way by asking him about work. The OH nurse also consulted with the psychiatrist he was receiving treatment from to see when it was appropriate to start discussing a return to work.

A case conference was held after 12 months absence as the first formal discussion of a return-to-work plan. This involved the employee, his line manager, a TU representative, a personnel representative and the OH nurse. At this stage they discussed reasonable adjustments for the future, and the OH nurse advised a long-phased return to work over 12 weeks starting at a time when it was appropriate for the employee. She did set an approximate timescale, but the dates were a long way off. The employee said that he found this useful as it gave him something to aim for, but he had also had plenty of time to get there, and clear options for altering the timescale if he was not ready. A proposed plan was agreed and the employee was asked to discuss it with his psychiatrist at his next meeting in a month's time. The psychiatrist then wrote to OH agreeing that the employee could resume work at the time when he felt it was appropriate.

At Agilent Technologies, every rehabilitation plan is developed by occupational health in conjunction with the employee and the line manager. Generally, the internal occupational health specialist meets with the line manager to determine the scope that they can work within, how the business needs can be met, what are the key tasks of the job, how work is organised and the timing of work. The occupational health advisor also meets with the employee to discuss approaches and find out what is acceptable to the employee. All these people have input to the work restrictions listed on the form, but the occupational health doctor ultimately signs and issues the form. If relevant, other people may become involved in the process. For example, in the case we examined, the health and safety manager was involved because it was a dangerous department and there were concerns about the effect of possible lapses in concentration.

The example case at MTM Products highlighted the importance of commitment in developing a successful rehabilitation plan. The interviewee felt that the acceptance by the employee that the company wanted her back, and that she wanted to return, was an important step in the successful rehabilitation.

At North Tees and Hartlepool NHS Trust, the rehabilitation plan can take a number of different forms. A typical rehabilitation plan will involve (where appropriate) offering specialist treatments, review and adjustment of the individual's previous job role, provision of additional training, flexible return-to-work patterns and agreement on how the rehabilitation plan is managed.

In the individual case, the rehabilitation plan consisted of a reduced workload as part of the Therapeutic Work Activity Scheme for those on incapacity benefit (this allows employees to return to work without losing benefits). The Trust's formal rehabilitation plan started five months later. Initially, the employee returned to work for four hours a day, three days a week. She agreed with her line manager about the area of work she would return to (the 'recovery area' of theatre work, where the employee could be offered more support), additionally a 'link' person was assigned to her specifically to provide support. This phase of the rehabilitation lasted for a six-week period and the individual then returned to her normal thirty-hour week. During this phase, the employee reports that her line manager was very supportive and helped her to feel calmer.

Despite a successful return to work, the employee again became ill six months later. This time she discussed different return-to-work options with the HR department, including alternative employment. The HR department helped her to choose the best option, which for her was a phased return to her original job. The employee received full pay during this phased return to work.

The case provided by The Supermarket exemplified the way all parties are usually involved in the agreement of the rehabilitation plan. In this instance a psychiatrist, an NHS counsellor, OH and the employee's GP were all involved in working out the rehabilitation plan. Over a two-month period the employee discussed return to work with all parties, OH then liaised with the managers involved to discuss and agree the rehabilitation plan. When he felt ready to return, both the personnel manager and the store manager discussed with him the type of job he would return to. The employee then had a phased return to work.

At Doncaster Metropolitan Borough Council, two rehabilitation plans were used. The first was developed by OH and the individual. It had to be agreed with the line manager, but he was not involved in the preparation of it. The plan involved a phased return to work. Following a second period of absence, the employee was asked to come into the office to discuss her absence and the rehabilitation plan. The meeting involved the employee, her new line manager and a representative from HR. The HR representative had already liaised with OH to check that OH felt confident the individual was ready to return to work. The second plan included a phased return to a permanent part-time position (at the individual's request).

In general, line managers are encouraged to meet with individual employees and someone from OH to discuss the rehabilitation plan. As a rule, OH expects employees to be able to work for half a week before they return, and this is usually confirmed with the individuals GP. The OH department seeks to ensure wide agreement to the return-to-work plan and ensure someone is available to meet the employee on their first day back.

At The Insurance Company, a thorough analysis by the psychologist is used as the basis for the rehabilitation plan. This results in a highly individual rehabilitation plan. The plan starts from whatever the most immediately achievable targets are for the individual and, these are not necessarily work related. As an illustration, one plan given as an example had targets of getting up by a certain time, preparing and eating breakfast, conducting specific household chores and planning and preparing an evening meal. Other examples from this organisation involved the individuals getting involved in charity work as well as a phased return to work. The approach was truly flexible and, starting from wherever the individual was at, tried to provide structure and goals, and support in achieving them.

2.6 Availability of therapeutic interventions

There are a variety of individual-level therapies that organisations commonly refer employees to as part of their rehabilitation following stress-related illnesses. These include counselling, psychotherapy, and cognitive-behavioural therapy.

Cognitive behavioural therapy (CBT) has been increasingly recognised as the most effective treatment for a variety of psychological problems, especially those relating to anxiety and depression (Clark *et al.*, 1999, cited in Kendall *et al.*, 2000; NICE, 2002). Although the majority of evaluation studies have demonstrated the efficacy of CBT in clinical settings, a recent meta-analysis suggests that CBT approaches to work-related stress are more effective than other treatments in improving perceived quality of life and psychological resources, and reducing complaints (van der Klink *et al.*, 2001).

Evidence from the psychotherapy research literature suggests that psychotherapy and counselling for work-related difficulties may also be effective (Reynolds and Briner, 1993). Meta-analytic reviews (eg Shapiro and Shapiro, 1982; Smith *et al.*, 1980) conclude that psychotherapy has clear benefits when compared to no treatment, and that the outcomes of all different forms of therapy are broadly equivalent. Allison *et al.*, (1989) demonstrated reduced levels of depression, anxiety, and absenteeism in Post Office workers following workplace counselling. Reductions in depression and anxiety, which were sustained at two-year follow-up, were also found for professional and managerial employees following psychotherapy (Firth and Shapiro, 1986; Shapiro and

Firth, 1990). In a review of the effects of treatment for depression on work outcomes, Mintz *et al.*, (1992) found that unemployment, absenteeism, and self-reported work problems also appeared to improve after treatment, but that these effects lagged behind psychological improvements.

Whilst there is growing evidence concerning the effectiveness of these therapies, it is important for organisations to know how best to implement and manage their use (*eg* when they should be used, how long they should last, who should provide the therapy, how they should be combined with other aspects of vocational rehabilitation). Although the appropriate management of therapeutic interventions is seen as crucial to their effective use in vocational rehabilitation, there is little evidence on these aspects of their use. However, some logical principles are generally acknowledged. For example, the referral of an employee to any form of counselling or therapy must be based on an assessment of what the employee actually needs, and the take-up of the therapy by an employee must be done voluntarily.

2.6.1 Case study examples of therapeutic interventions

The case study organisations offered a wide variety of different interventions to employees. By far the most common was counselling (in-house or outsourced). The ways in which these were managed by the organisations also varied. Some examples are described below, and highlight the following points:

- ensuring access to appropriate types of counselling and counsellors
- promoting the long-term use of strategies learnt through counselling
- the effectiveness of multiple forms of specialist treatment
- the importance of accessibility to therapeutic interventions
- awareness of the appropriate number of counselling sessions for each employee
- awareness of any preference for internal or external counselling from the employee.

Sheffield City Council offers up to six sessions of a variety of different types of counselling from vetted local providers. This is arranged via OH and funded by an employee's manager. If the employee approaches OH directly for counselling, they have to agree to OH contacting the manager for funding. The Council is currently looking to increase the diversity of the counsellors that it uses to ensure that the whole workforce feels able to use the service. At the moment, the majority of counsellors are white women. In one of the example cases from Sheffield City Council, the employee described how the counselling that he had received

was very useful and had remained so. It had helped him to understand his feelings, to recognise the causes of those feelings and to use various strategies to deal with them. He described how the problems he had encountered focused on change and how he needed to feel control over it, so he learned to set small targets for himself to give him a sense of achievement and to reinforce his sense of control. He has since used the strategies which he learnt through counselling to help him to deal with other changes at work. He has also been able to advise other colleagues on some of the strategies.

Another employee at Sheffield City Council had been referred to the local hospital's psychiatric department for outpatient treatment for anxiety. He received a variety of complimentary treatments through the specialist health services, including medication, instruction in relaxation techniques, and an anxiety management course. This setting also provided him with the opportunity to share his experiences and feelings with others who were going through similar things, which helped him to rebuild his confidence. He has continued to see the psychiatrist for check-ups since returning to work.

One of the case study organisations highlighted the importance of accessibility to the therapeutic treatments. The Frozen Food Manufacturer has access to a cognitive behavioural therapist who is provided by the parent company. However, this form of treatment is very rarely used by employees because of the geographical distance between the site and the counsellor.

It seems to be important for the employee to receive continued therapy when appropriate. The employee in the example case that we looked at from Flintshire County Council had regular sessions with the specialist psychological counselling service during her absence. Although it is normal to have up to six sessions, OH suggested that she have more than this. The employee reported that the counselling enabled her to feel that she can cope with her situation at work. Similarly, the employee in the example case from the central division of Lancashire Constabulary continued seeing a counsellor after he had returned to work full-time. He reported that this continuation was very useful.

Both internal and external counselling services are provided at the central division of Lancashire Constabulary. Although both are confidential, the HR department reported that staff often prefer the external counselling service. In contrast, interviewees from other case study organisations felt that internal counselling might be more appropriate, as the counsellor would have a greater appreciation of the organisational context of the problem and of the possible organisational solutions. If both forms are available, it may be useful to ask the employee whether they would prefer internal or external counselling.

Sandwell Healthcare Trust staff have access to the clinical psychology service. Individuals can self-refer or can be referred by their line manager, HR or OH. In addition to counselling, the clinical psychologists offer a range of interventions such as mediation in dysfunctional teams, monitoring the workplace for particular types of hazard and coaching managers in dealing with employees with mental health problems.

North Tees and Hartlepool NHS Trust now offers a variety of options in the rehabilitation plan alongside a phased return to work. A counselling service is available to all staff, as well as training in time management and assertiveness.

Another approach is that of formal employee assistance programmes (EAP). The Insurance Company provides access to an employee assistance programme for staff for all types of problems, not just stress. The EAP allows for up to eight face-to-face sessions for employees and their families.

2.7 Flexible return-to-work options

It is widely recognised that an employee rehabilitating should not be returned directly back into their job after a long period of ill-health. A variety of options for a flexible return to work should be offered as part of the rehabilitation process. The most common of these is a phased return to work, with the gradual increasing of hours and duties over a period of time. However, there is little direct evidence concerning the effectiveness of flexible return-to-work plans, especially following ill-health due to work-related stress.

It is commonly reported that most workers who have been absent from work due to illness or injury will achieve their former functional level more quickly if they are allowed to return on a gradual basis (eg Thurgood, 2000). However, there are also various aspects of a phased return that may influence its effectiveness (IRS, 2001), including:

- the length of the gradual return-to-work period: this is typically four to six weeks but may be longer if required
- the work conditions that are returned to: medical and ergonomic assessments of the individual and their duties are often carried out to ensure their suitability
- payment: usually full payment is given for a period of time, or employees are required to use their remaining leave and flexi-time to cover their 'time off'
- timing of return to work: when should the employee begin their return?

Young and Russell's (1995) study of the rehabilitation of Australian teachers with stress-related illness, examined how

various factors predicted their return-to-work outcomes. While severity of injury was found to be predictive of the return to work of those people who *did* return to work, it was suggested that other factors, such as the length of time away from the workplace, influence the return-to-work outcome of those who *did not* return. People who did not return to work within 505 days of their first absence were more likely to not return at all. It was suggested that these individuals may succumb to a 'disability syndrome', taking on the 'sick role' and giving up the notion of ever returning to work.

2.7.1 Case study examples of flexible returns

The case study organisations provided a number of examples of best practice in flexible return-to-work options. The vast majority supported some form of phased or gradual return, which highlighted the following points:

- The plan should be designed to allow a gradual increase of tasks and hours as appropriate to the case.
- Sufficient resources and support should be available to ensure that the reduced tasks and hours actually occur.
- There should be monitoring throughout the return to work to ensure that the tasks and hours remain appropriate.
- The plan should be flexible and adjusted plan if necessary.
- The return should occur over a sufficient time period for the employee to recover (this time period may not be obvious at the start).
- Other options, such as homeworking, are considered where appropriate.

An appropriate gradual return

At Sheffield City Council, a period of 6 weeks phased return is typically offered for returns from ill-health, but it can be longer if agreed. There is no set programme for the phased return because so many contextual factors are involved, but the return-to-work plan will be discussed and agreed by the manager, the employee and the OH nurse. The OH department has a document that describes the phased return-to-work scheme, providing details of how it works and some suggested programmes for full-time, part-time and shift-work staff. The document states that the scheme aims to successfully rehabilitate an employee in their return to work and gain permanency in that return, and to enable and/or support a return to the employees usual working pattern, whilst incorporating any aspects of job redesign, adaptation or adjustment.

In one of the example cases from Sheffield City Council, we saw an excellent example of a well-designed and well-supported flexible return to work. The employee, who had been absent from his job as a technician in a secondary school for 15 months, was given a 12-week phased return programme designed under this scheme. The programme involved the following time schedule:

- Week 1 and 2: employee worked for two half days
- Week 3 and 4: employee worked for three half days
- Week 5 and 6: employee worked one full day and two half days
- Review with OH nurse and manager
- Week 7 and 8: employee worked for two full days and two half days
- Week 9: employee worked for three full days and two half days
- Week 10: employee worked for four full days and one half day
- Week 11: employee worked five full days
- Review with OH nurse and manager
- Week 12: employee worked five full days.

During this phased return, the employee's tasks and duties were also adjusted. The first week back was seen as a settling-in week. The employee was just asked to do some minimal tasks such as setting up the 'prep room', stocking up on solutions and stationary, and photocopying worksheets for future needs. The rest of the time he was encouraged to catch up with other colleagues. The line manager said that this was aimed at giving him the opportunity to feel comfortable with colleagues again, and it gave them a chance to reassure him and make him feel good. Also, lots of his work practices had changed while he had been away, so they wanted him to have time to come to terms with that.

From week two to week 12 of the phased return programme, his duties remained reduced. Although he was not engaged in any of his previous team leader responsibilities, he was included in the usual work rota for the times and days when he was in the school. However, throughout the period of his phased return there was additional technical support within the science area, as the full-time temporary cover for his post was intentionally kept on for this period. This meant that the normal workload that the employee would be expected to do was reduced, and he had support in doing the usual tasks. Any spare time that the employee had during this period was to be spent backing books, tidying labs and topping up solutions and stationary. The employee's job role was reviewed again after he had returned full-time, and his previous team leader role was discussed. With the agreement of the employee, the OH nurse wrote to the employee's consultant psychiatrist asking him to confirm whether it would be

acceptable for the employee to resume the team leader role. The employee and consultant psychiatrist discussed this at their next consultation. At the beginning of the next academic year (five months later), these duties were commenced with the approval of the employee and his psychiatrist. The employee felt that this phased return plan was one of the most important factors in his successful return to work.

Examples from the central division of Lancashire Constabulary also illustrate flexible and gradual returns. In one case the individual in question had a new work role devised for him, as he felt unable to return to patrolling the streets. In another example, an officer came back to work on reduced hours (9.30-3.00) to accommodate childcare issues which were contributing to the pressure the individual felt under.

At The Insurance Company we saw an innovative approach to returning to work. Rehabilitation plans could start well before the individual returns to work (see section 2.4), the aim being to create the structure and routine that work provides. Once an individual is ready to begin a phased return to work, a typical plan might start with two hours per day on two days per week. This is monitored and reviewed with the individual, and built up gradually as they feel able to take on more. There is no 'average' length of a phased return to work, it is all managed on a wholly individual basis.

At Sandwell Healthcare Trust, the employee wanted to return to work, but couldn't face going back to the floor of the building where she had been working prior to going off sick. OH suggested a gradual return, starting with coming into the hospital for coffee, then a visit to friends working on the floor below hers, and finally returning on a part-time basis for a couple of weeks before returning full time. Even once she was back full time, the employee felt that 'they didn't throw everything at me at once'. She had a monitored workload and regular line manager meetings to check on how she was coping.

Sufficient resources and support

The example from Sheffield City Council above also highlights the importance of having sufficient resources and support to ensure that the tasks and hours can be reduced as intended. By keeping on the employee's temporary replacement during his phased return, he was given additional support that helped his return. Similarly, at Agilent Technologies, one of the interviewees mentioned the importance of having cover for the employee during the rehabilitation and return-to-work period. Rehabilitation can take a long time, and requiring colleagues to share extra work during this period may put a strain on the team, which would have been counter-productive. It would be possible to manage the workload without the cover, but the comfort zone that extra cover

provided helped the recovery of the employee and prevented additional stressors for other team members. At the same time, it is important that the person being rehabilitated is given valuable work and that they can see that they are contributing.

Monitoring and adjusting the plan

Many of the case study interviewees mentioned the importance of monitoring and flexibility, *ie* the need to keep reviewing and adjusting the return-to-work plan as necessary. As a person recovers, they may react differently and unexpectedly to aspects of their work, so there is no benefit to having a rigid plan and a fixed date for being back full-time.

The case study at Agilent Technologies demonstrated the importance of a long-term approach which is monitored throughout. The typical rehabilitation at Agilent involves a phased return to work. During this time, work restriction forms are issued to the line manager, detailing the suggested daily working hours, days of work and other general restrictions (*eg* rotate job tasks). The work restrictions are adjusted frequently and a new form is issued whenever an adjustment is made. The approach is very flexible, and work restrictions tend to be reviewed every couple of weeks. In the example case from Agilent Technologies, the employee initially came back on four to five hours each day for a full five-day week. However, after a couple of weeks this was found to be unsatisfactory for two reasons. Firstly, the employee was doing a long drive to get to work for a very short day, and secondly it didn't suit the team because most of their tasks took more than four hours. Therefore, this schedule was changed to an eight-hour day, but only for four days a week. After a while, this seemed to be too much for the employee, who had noticeable lapses in concentration. So the hours were reduced back down again, to six hours a day for four days per week. This seemed to work, and the hours were gradually built up to full-time hours over a period of five months.

The example case from North Tees and Hartlepool NHS Trust is another example of monitoring and providing flexibility. The employee, who was a nurse, was given longer to return to work given her ongoing ill-health. The first time she returned to work, it was as part of the Therapeutic Work Activity Scheme for those on Incapacity Benefit. Employees can return to work part-time and not lose benefits. The Trust's formal rehabilitation plan started five months later, and consisted of a reduced workload. The employee returned to work for four hours a day and for three days a week to begin with. She worked alongside others and had a 'link' person assigned to her. In discussion with her line manager, she returned to the 'recovery area' of theatre work. More people work in this part of theatre, and the individual felt more supported here. The phased return lasted for six weeks and then she returned to her normal 30 hours a week. Her line

manager was very supportive of this phased return, and it made her 'feel calmer'. She continued to have discussions with her line manager about permanently reducing her hours. She was paid full pay during the phased return to work, which she said was very helpful.

Another example demonstrated what can happen when a flexible return is not monitored effectively. In the example case from The Frozen Food Manufacturer, the flexible return just involved a reduction of duties and not hours. The employee was in the process of being redeployed but because it took time to arrange his new job, he had to return to his old one temporarily. The employee found his return to work difficult under these circumstances. He said that there was no one in the department on his return, and that it was a very busy time within which to return. The job was exactly the same on his return, although the line manager did her best to 'protect him' by keeping some jobs from him. OH told him not to 'overdo it' and not to work any extra hours, but it was very difficult not to. He felt that his return to work could have been more structured, with a phased return to work on shorter hours. When he returned to work, he did go off sick again quite early on, and this was because nothing had changed.

At Doncaster Metropolitan Borough Council, a phased return usually lasts for anything up to eight weeks. However, this is monitored during the rehabilitation period and can be adapted if the employee wants to speed up or slow down the process.

At the central division of Lancashire Constabulary, the individual had regular checks with the Chief Inspector to see how he was getting on. The job he returned to was initially a short-term position, but after 12 months was made permanent, and the individual was gradually re-introduced to outside work (which he had previously dreaded). In addition, training was provided, because the individual felt de-skilled after working in the same job for 16 years. The individual felt that the colleagues in his new department were 'brilliant', and has now been back at work for three years.

Sufficient time period

At MTM Products, the example case also illustrated how sufficient time needs to be given to the return-to-work process following ill-health due to work-related stress. It also shows how the monitoring and assessment must continue beyond the resumption of full-time hours. The initial return-to-work plan involved modifying the employee's role so as to remove any managerial responsibilities to begin with. A written schedule for increasing the employee's hours and managerial duties was agreed. However, on returning to work after three months absence, the employee's confidence was very low, and constant reassurance was needed from managers and colleagues. Consequently, the

vocational rehabilitation took much longer than expected. Over a period of six months, the employee's hours were built up to full-time. At this stage, the employee wanted to return to their previous management position. However, the line manager felt that the increasing management responsibilities in this role had contributed to the original illness. So, although the company needed someone back in that role, they were reluctant to put the employee back into the same position. Therefore, they found another permanent position for the employee that still involved some management tasks, but was not as intense as the previous job. The employee is happy with this new role and has taken well to it. The whole rehabilitation process took 12 months, during which the employee was paid a full-time salary.

Considering other options

Some of the interviewees reported that it was important to have a range of options to offer the employee, beyond reduced duties and hours, including training or redeployment. A wider set of flexible return options was offered by some organisations. For example, the central division of Lancashire Constabulary offer 'recuperative duties' including:

- fewer hours of work
- a limited work regime
- a change of workplace to a location nearer home
- home working
- a change of role to an OH-sanctioned job
- shadowing.

Recuperative duties are 'temporary rehabilitation duties or working conditions to assist a member of staff's ultimate return to full duty following illness or injury permitting return to or continued work in a less demanding capacity'. They are offered with defined timescales and provisions for periodic review, and there is flexibility for the plans to be extended.

According to the procedure, it is the responsibility of line managers to consider and identify opportunities for recuperative duties for their staff. HR advisers can provide assistance and must sanction any arrangements. OH can provide advice on the fitness and abilities of staff to perform recuperative duties. If recuperative duties need to be found in a different area of work, this will be the responsibility of the HR adviser. A stress risk assessment is completed by the health and safety officer before the person returns to work. This follows a standard risk-assessment format. The HR department will work with the employee and their representative to draw up the return-to-work action plan. HR will send a letter to the employee outlining any new duties and payments.

In the majority of cases, examined individuals were able to return to their original duties. However, where this wasn't the case, employees were offered a range of different options, including permanent part-time work and alternative duties.

2.8 Work adaptations and adjustment

Part of any vocational rehabilitation and return-to-work plan should include a review and subsequent adjustment of the employee's previous work role. In returning after a period of ill-health stemming from work-related stress, it is crucial that any of the stressors that had a role in the employee's stress-related illness are assessed and, if possible, removed or reduced. Not only is this a logical step to try to prevent recurrence of the illness, it is also a legal requirement under both Health and Safety and Disability Discrimination legislation.

Work adaptations are commonly used as part of vocational rehabilitation from occupational illnesses. The process generally involves conducting return-to-work assessments by looking at the employee's job and their medical assessments, and then advising on changing the job to allow the employee to return to do work that will not aggravate their illness or injury recovery. If an employee is unable to be returned to their job, he or she may be redeployed to a different job, usually with a period of retraining. Work adaptations and adjustments are made on a permanent basis, which makes these changes distinct from the temporary adjustments to duties that may be used as part of a gradual return-to-work plan (see section 2.6).

Evidence from a number of studies examining rehabilitation following physical impairments and musculoskeletal disorders suggests that adaptations to tasks, equipment and hours leads to improved health and attendance (Butler *et al.*, 1995; Ekberg *et al.*, 1994; Ekberg *et al.*, 1996; Jonsson *et al.*, 1988). However, the effectiveness of different work adaptations has not been studied specifically in relation to rehabilitation after stress-related illness.

2.8.1 Case study examples of work adaptations and adjustments

The stated rehabilitation procedures of the case study organisations involved a systematic review of employees' work as a matter of course, prior to return to work. On the basis of this review, permanent work adaptations or adjustments could be made. However, the effectiveness of these changes to successful rehabilitation is dependent on the ability to change the job or redeploy employees, which is not always possible. Line managers may lack the resources necessary to implement the changes that are required. Some examples of the type of adaptations made and

the way in which they were managed are described below. The adaptations include:

- changes to tasks or duties
- changes to the way work is managed
- additional training
- redeployment.

One of the example cases at Sheffield City Council provided a good illustration of how tasks and duties can be adjusted. The employee, OH nurse and line manager discussed the aspects of work that were involved in the employee's anxiety, and what adjustments could be made. Prior to his stress-related illness, the employee had been responsible for technical support in two subjects at a secondary school. When he returned, this was reduced to just one subject, as it had been when he first started his job. The school also agreed that there would be no pressure on him to use computers. The OH nurse and line manager also played an important role in monitoring the employee's work to ensure that these adjustments did actually happen.

Work adjustments may not always be changes to duties and tasks. They can also include changes to the ways in which employees work. In another example case from Sheffield City Council, a senior manager described how he reviewed his work with his new manager on his return. The new manager identified that the employee had not been managing himself effectively, *eg* he had not been taking his annual leave. The new manager told him that he needed to take more time off, and now monitors him to ensure that he takes most of his annual leave in a year.

Another potential intervention, but one that focuses more on adapting the employee than the work, is the provision of additional training. At Sheffield City Council, the manager and returning employee are encouraged to identify any training needs that may support the employee in their return, and help to prevent further stress-related illness. For example, when one employee returned, he signed up to take a course in Personal Effectiveness and Communication Skills with the Council's training and development department. This has helped him to cope better with his team leader responsibilities.

In some cases, it may also be possible or necessary to redeploy the employee to a different job. In the example case from a frozen food manufacturer, the employee knew that he could not return to the particular job that had caused his stress-related illness, and felt that he would rather leave the organisation than return to the same job. He reaffirmed this during the meeting to develop his rehabilitation plan. Therefore, his line manager agreed to look at the possibility of redeployment, although it was recognised that redeployment might take some time. Although the employee

returned to his original post for eight weeks while a new position was sought, he said that he felt relatively OK during this period as there was 'an end in sight'. The employee says that the line manager and OH worked out his move to a new department, and that he felt involved in this process. He felt better because the company had made it clear that they wanted to keep him and that redeployment was a positive solution. He saw the OH doctor on a regular basis and this continued when he moved to the new job. Since his move, he has not had any more health problems.

Redeployment was also used in the example case from the central division of Lancashire Constabulary. The employee was a rural police officer in a small village, who had been off work for 15 months with clinical depression. He felt that he couldn't return to his previous role in the village, but he also felt unable to work as a police officer in a city, as he had no experience of the situations he may face. Various options were considered, and it was agreed that he would return initially to a job in the Operations Planning Unit. No police officer had worked there before, but the organisation had made this option available for him. He came back to work in this new position on full hours, although he was offered a phased return to work. The job was supposed to be a short-term position, but after 12 months it was made a permanent job. He says that staff in the department were 'brilliant'. They re-introduced him to outside work (which he dreaded).

The Supermarket also offered an adapted role to the individual case we studied. Changes were made to his shift pattern and also to his job content in the first few months, to help him adjust back to the workplace.

A number of work adjustments are cited for consideration in the development of the rehabilitation plan at Doncaster Metropolitan Borough Council. In addition to a phased return to work, these include:

- reduced hours on return
- retraining
- supervisory support
- reallocation of duties
- adjustments to the job
- temporary redeployment.

A number of people in our case studies felt that it was important for employees to reflect on the nature of their work before returning to it, and to explore whether their current position was 'right' for them. Often, the best solution for an employee would be to return to a different job with the employer. If this option is not explored, the employee may return to a job that ends up making them ill again, despite best efforts to adjust it.

In our case studies, we also saw examples of failures to adequately adjust work to remove the causes of stress. For example, one employee had a phased return to work, which outwardly appeared to be successful in that it resulted in a full-time return to work. However, despite the fact that the employee now feels in control at work, 'bad days' are still experienced. This is because the original problem – bullying and harassment from a senior manager – has not been resolved by the employer. In essence, the employee feels as if she can cope with the situation since she had counselling, but that the cause of the stress has not been removed. Bullying and harassment, although relatively rare in these examples, also seemed to be the most difficult and challenging situation in removing the stressor from the workplace.

In other cases, managers might be limited in what they can offer. For example, one of the case study organisations has individuals who work in isolated technical roles. For most people this is fine, but for some it is a very stressful job. Where it causes a problem for the individual, the company might not be able to redeploy them as it may not have alternative work in the area.

2.9 Summary of best practice in the stages of rehabilitation

2.9.1 Early contact with employers

This is seen as highly important by most case study organisations, however there are variations in policy and practice:

- Organisations need to consider who is best placed to have initial contact with the individual.
- Where line managers are to have responsibility for contacting the individual, it should be recognised that this can be a difficult task, so advice or guidance should be made available to them if required.
- Finally, it is important not to rush employees who do not want to be contacted.

2.9.2 Timing of the health assessment

There is no clear evidence about the optimal time for a health assessment to be conducted. Experts generally agreed that rehabilitation should start with a referral to OH at four weeks.

Practice amongst case study organisations varied:

- Set timings were used by some organisations (usually at the four-week stage). In this way they could be certain that all stress problems were picked up reasonably early without waiting for referral from another party.

- Immediate referral was the policy adopted by some of the case study organisations. This might be an informal practice through managers spotting the problem and advising individuals to go to their GP, and referring to occupational health at the same time. Alternatively, this was policy in some organisations where, unlike a physical injury, stress was not seen as having specific prognoses, but early referral could speed up access to therapeutic interventions and rehabilitation.
- A more flexible approach is used by several of the organisations, and managers are encouraged to consider what the likely recovery time will be and whether, or when, a referral is appropriate.

2.9.3 Quality of the health assessment

The evidence suggests that inaccurate diagnosis and inappropriate treatment of mental health conditions is quite common. In line with this, several case study organisations felt that the information available on sick notes (*ie* 'stress') was not helpful in understanding the nature of the problem, the role of work, and appropriate interventions/rehabilitation.

There were many examples amongst the case study organisations of good quality health assessments. The key components were:

- accurate assessment and diagnosis
- a sympathetic and supportive assessor
- referral for treatment based on the identified needs of the employee
- information sharing between all parties involved in assessing the individual's health.

2.9.4 Developing an agreed rehabilitation plan

Evidence from the case studies identifies three key factors for the development of a rehabilitation plan:

- it should be agreed by all stakeholders, but particularly by the employee¹
- it should be developed and initiated at the appropriate time for the employee, and incorporate regular reviews
- both employee and manager must be committed to the plan.

¹ Stakeholders will vary from case to case, but might typically include: the employer; the line manager; OH; HR; the employee's GP; psychiatrists/psychologists/counsellors; TV; in some cases even insurance companies and legal services may be involved.

In addition, case study evidence highlighted the need for flexibility in approach and the need to be able to adjust the plan to the individuals changing needs during the rehabilitation process.

2.9.5 Availability of therapeutic interventions

Research evidence about the impact of different individual-level therapies for psychological problems is growing. Of the different types of counselling available, Cognitive Behavioural Therapy (CBT) is increasingly recognised as the most effective treatment for anxiety and depression-related problems. There is also recent evidence that CBT approaches to work-related stress are the most effective.

Although research on the general effectiveness of these interventions is clear, little is known about their appropriate management in a vocational rehabilitation setting. However, it is acknowledged that:

- referral of an employee to any form of therapy must be based on an assessment of what the employee needs
- take up of the therapy by the employee must be done voluntarily.

Evidence from the case studies demonstrated that counselling (either in-house or outsourced) was the most common form of therapeutic intervention on offer. Key good practice points to emerge from the case studies were:

- ensuring access to appropriate types of counselling and counsellors
- promoting the long-term use of strategies learnt through counselling
- the effectiveness of multiple forms of specialist treatment
- the importance of accessibility to therapeutic interventions
- awareness of the appropriate number of counselling sessions for each employee
- awareness of any preference for internal or external counselling from the employee.

In addition, it was noted that whilst many systems for offering counselling are based on a limited session basis, when dealing with work-related stress a longer period of counselling support can be extremely effective for some individuals.

2.9.6 Flexible return-to-work options

Good practice is clear that a variety of options for flexible return to work should be offered as part of the rehabilitation process. It is also well recognised that previously absent workers will achieve

their former levels of functioning more quickly if a graded return to work is allowed.

Evidence of both these principles was abundant in the practice of the case study organisations. These included:

- allowing for adjustment in length and flexibility of the return-to-work plan
- assessment (and if necessary adjustment) of the job to which the individual will be returning
- careful monitoring of progress
- considering other work options where appropriate.

On the current evidence from the case studies, the main best practice point is to review and adjust the work as appropriate, but where this is not possible, to consider other options such as changes to the management of work, retraining and redeployment.

2.9.7 Work adaptation and adjustment

The case for adapting work in relation to physical impairment or musculoskeletal disorder is clear. Research has yet to study the impact of work adaptation for stress-related illness. Even so, there are clear principles from physical rehabilitation which can be drawn upon here. There should be a return-to-work assessment both of the job and the individuals condition. Where potentially harmful work aspects can be identified, these should be changed or removed, enabling the employee to return to a job which will not aggravate their illness or impede their injury recovery. For work-related stress, such adjustments have to be judged on a case-by-case basis, and there was clear evidence of this approach in the case study organisations.

3. Best Practice in the Management of Rehabilitation

This chapter describes elements of best practice relating to the broader aspects of the management of rehabilitation after a stress-related illness.

First, each element of best practice is described based on what is known from previous research, then examples from the case study organisations are given.

3.1 Written policy or guidelines

A written policy or set of guidelines describing the organisation's rehabilitation practices and procedures is often seen to be a key element of best practice. It can provide information for employees and line managers on what to do, when to do it, as well as contact details of specialists involved. However, the effectiveness of a written policy or practice will vary depending on its exact content and context. Furthermore, written documentation may follow every aspect of best practice, but it is only if these practices are followed in reality that they will contribute to effective rehabilitation and return to work.

There is currently no existing evidence in the research literature that indicates which aspects of written policies are most important to rehabilitation following stress-related illness, or the overall contribution of a written policy to effective rehabilitation. However, one key aspect of the written policy or guidelines that may contribute to effectiveness is thought to be the context in which they are written, which appears to vary between organisations. A written policy relating to rehabilitation after illness due to work-related stress may take one of the following forms:

- a specific policy in relation to stress-related illness
- a general policy for occupational illnesses as a whole
- part of the organisation's stress management policy
- part of the organisation's general sickness absence or attendance policy.

If the rehabilitation and return-to-work procedures are described under the sickness absence policy, it has been suggested that it should clearly indicate that rehabilitation is not treated as a disciplinary matter. IRS (2001) described how rehabilitation practices in organisations are often triggered by absence levels reaching disciplinary levels. This approach can lead to a negative view of rehabilitation, as it becomes linked with a staged system of review, warnings and actions commonly associated with disciplinary action. With stress-related illnesses in particular, this can have a detrimental effect on the employee's confidence and well-being, potentially putting their rehabilitation further back. Instead, the trigger of the rehabilitation process should be associated with concerns for the individual's well-being, not just those of the organisation.

3.1.1 Case study examples of written policy or guidelines

A number of the case study organisations demonstrated some good examples of written policies and guidelines.

Sheffield City Council has written information and guidance to describe various aspects of its rehabilitation practice. Together, these provide guidelines for employees, line managers and occupational health nurses on their roles and expectations of any return-to-work procedures. They also clearly set out the organisation's view of stress, and how it should be dealt with in an open and constructive manner.

The main source of information is a pamphlet called 'Tackling Stress Together', which is issued to all employees and managers. It demonstrates a deliberate attempt to demystify the area, and to develop a common language and understanding of stress across the organisation. There are a number of different versions of this pamphlet, each targeting the needs of different groups. One version is for line managers, and describes in some detail the following:

- steps that managers should take to prevent stress
- example solutions for some causes of stress
- what a manager should do following a critical incident
- what a manager should do if an employee tells him or her that they are experiencing stress
- what a manager should do if an employee is off work with stress.

The pamphlet for employees encourages individuals not to keep stress-related problems to themselves, and that the best way to solve them is through constructive discussion with their manager. It sets out the following in some detail:

- what an employee should do in work if they are experiencing stress
- what an employee can do out of work if they are experiencing stress
- what an employee should do following a stress-related illness before they return to work
- other policies and practices that might be helpful to employees, such as flexible work options and advice on harassment and bullying.

The Council has also identified the need to have a separate version of the pamphlets for headteachers and staff in schools, to ensure that the message gets across to these specific groups. The majority of the information in the pamphlets for schools is the same as the other pamphlets, but there are some changes to make it more relevant to the school context.

The Council feel that the written guidelines have helped to remove the stigma of mental health and stress-related problems. Employees and managers are more open about the experience of work-related stress. This means that employees are more likely to admit to a health problem being due to work-related stress. This helps greatly in identifying the appropriate treatment and rehabilitation strategy, thus reducing the length of time they may take to recover. Employees and managers are also more likely to discuss any work-related problems before they cause a long-term health problem and absence. Finally, it provides employees directly with sources of help. This is particularly important in situations where, *eg* the line manager is perceived as part of the problem.

Flintshire County Council has three policies that relate to rehabilitation following illness due to work-related stress:

- employee ill-health policy and procedure
- sickness absence monitoring and management policy and procedure
- policy for the prevention and management of stress.

The stress policy outlines the organisation's general approach to stress. It adopts a risk assessment approach backed up by education, training, instruction and support systems. The ill-health policy outlines standard procedures for management contact and discussion with the employee, referral for occupational health advice, ill-health rehabilitation, re-deployment and ill-health retirement. The Council also operates a return-to-work interview procedure as part of its sickness absence policy. It states that one of the reasons line managers are expected to do return-to-work interviews is to identify any work-related problems that can be resolved before an employee is absent long-term.

The central division of the Lancashire Constabulary has two main policies relating to rehabilitation following ill-health due to work-related stress. These are:

- the attendance policy
- the work-related stress policy.

The attendance policy details the role of line managers in reporting absence to HR; the role of OH; recuperative and restricted duties and returning to work. The stress policy 'establishes procedures to enable staff to return to work following an absence due to work-related stress'. It states that all managers and supervisors are responsible for identifying individuals or groups at risk of stress-related illnesses as a result of their particular work activities, within the general risk assessment process. They should then introduce positive stress-reduction measures, including the provision of support and advice to those affected.

The central division of Lancashire Constabulary has had an attendance policy and a stress policy in place since the mid to late 1990s. According to the stress policy, there is 'a great deal of evidence to suggest that police work is inherently stressful. Few occupations require staff to face the kinds of dangerous situations that police officers may encounter as part of their daily routines'. The policy adopts a risk assessment approach to stress, and responsibility for risk assessment lies with line managers. The overall aim of the policies is to ensure that employees return to work as quickly and effectively as possible.

Lancashire Constabulary also has a stress advisory group which looks at force-level stress statistics. It has representatives from all six geographical areas, different ranks, and from the unions. It looks at legislative changes and monitors trends. It is planning to review the stress policy in the light of the development of new work-life balance policies.

There is also a force-wide 'internal critical incident management process'. This adopts a case-management approach. It looks at all individual sickness cases (including stress cases). It identifies critical-incident cases and tracks to see if line managers are doing what they should be doing according to procedures. It aims to ensure that the force is complying with the duty of care it has for its employees.

The head of HR at central division also chairs a monthly meeting, called the resource committee, within his division, which is attended by UNISON, the Police Staff Federation, health and safety personnel and senior managers. The attendance policy is a standing item on the agenda, and this has increased the understanding of the policy amongst chief inspectors. Statistics are collected on stress cases and sickness generally. Data are kept

by HR and cases are tracked to ensure that the employee is being offered the help necessary to enable them to return to work. Good industrial relations and union support of the attendance policy was thought to be an important factor in the successful rehabilitation process.

It is not just the larger organisations that have written policies and guidelines. The SME case study organisation, MTM Products, had a written mental health policy that was detailed in the employees' handbook. The handbook states that this policy aims to increase the effectiveness of the company by improving the quality of the working life of its employees, by supporting and encouraging them to achieve their potential and reducing the personal and organisational costs of mental ill-health. In order to do this, the policy states that the company will:

- increase employee understanding of mental health problems and assist managers in early recognition and handling of mental health problems
- set out to identify workplace hazards to mental health, assessing risks and developing practicable strategies to control them
- wherever possible allow flexibility in individual working patterns, including reduced hours, to enable employees to achieve an acceptable balance between work and home life
- take a constructive approach to helping individual employees overcome stressful situations arising outside work that have an impact at work
- act sympathetically in rehabilitating employees into work after a period of absence due to mental health problems by facilitating a smooth return back to full employment, with a phased return to work where appropriate.

However, just having a written policy or guidelines does not ensure that these are followed. It is more important for the practice to be right than it is to have perfect documentation. Some of the case study organisations did not have written policies at the time of the research, although many of these were in the process of writing a policy document. Some of the organisations described how they felt that it was more important to get the practice right before attempting to formalise it in a written document. Others had very well-established practices, but these just weren't written down in a formal policy document.

The Supermarket participating in this research had three main policies that cover absence due to work-related stress. These are:

- the absence management policy
- the sickness policy
- the rehabilitation policy.

The absence policy includes a return-to-work interview conducted by the departmental manager. This includes assessing whether there is anything the store can do to assist the individual's return to work. As a retail company, The Supermarket is used to staff working a wide range of different hours, so it is quite straightforward if an individual wants to change their working patterns or reduce their hours.

At Doncaster Metropolitan Borough Council there is a Managing Attendance guide. This gives practical guidance to managers on monitoring and handling attendance at work. The policy was introduced in 2000 and stress was added as a separate section in 2001.

The policy distinguishes between long- and short-term absence and focuses on the responsibilities of line managers. Guidance is provided about conducting return-to-work interviews, including examples of the type of question to ask. The responsibility of the manager to identify and tackle any relevant work factors is underlined.

In addition to the above policy, Doncaster Metropolitan Borough Council also has a Stress Management at Work and Employee Well-being Scheme. The scheme incorporates a number of initiatives to manage stress and improve the well-being of the workforce. The document spells out the roles of OH, the safety department, line managers and employees. It also informs staff of the availability of counselling and training for managers and employees.

At AstraZeneca, procedures relating to sickness and absence are part of the overarching attendance policy. The philosophy is a positive one of managing attendance not absence. Sickness and absence are not therefore considered under disciplinary procedures.

There is no specific policy for dealing with stress because it is felt that this might isolate stressed employees and possibly create stigma. Each case is dealt with individually, and the flexibility of a non-specific policy is thought to enable this process. An important backdrop to this approach is that AstraZeneca emphasises the psychological and emotional symptoms are features so all illnesses and the organisation will take into account all symptoms when considering the health needs of employees.

The Chemical Company visited has a number of policies which relate to work stress and rehabilitation:

- company booklet: *Health, Safety & Environment* (HSE), this includes areas of responsibility and the management framework
- written sickness policy

- occupational health policy code of practice
- flow chart of rehabilitation process
- notes on musculoskeletal discomfort and mental health issues/stress-related illness.

It is recognised within the organisation that it can be a very stressful place to work, and for this reason there are well established procedures to prevent, recognise and/or deal with stress.

In support of the written policies, the occupational health department has an open door policy. There, nurses, a doctor, a counsellor, a psychiatrist, a dentist and a physiotherapist are available.

In addition to this, there is information for staff on the intranet covering health, education, promotion and events. The service and the issue are both high profile, so it would be difficult for staff not to be aware of what is on offer. There is also an Employee Assistance Program, but in some respects this is seen as a last resort.

Actual levels of absence are very low, especially given the size of the workforce. In the year 2000, eight people were classified as having stress-related illness, but only two of these actually took time off sick. In 2001, only two people had stress, with only one of these taking time off.

At Devonport Dockyards, the procedures relating to sickness and absence are contained within a Sickness Absence and Inefficiency Procedure. Although the organisation does have a disciplinary procedure, it is felt that sickness and inefficiency due to ill-health should be treated separately.

Work-related stress is dealt with under this procedure. There is not a specific policy which relates to stress because, as with The Chemical Company example, there is a fear that such a move might increase stigma and separate stressed employees from staff with other kinds of problems.

'We don't want to tell people 'well you're a special case because you happen to have this.' We deal with it under the same policy because it is an illness as any other, it just needs different handling.'

(HR representative)

For absences of less than seven days, employees self-certificate. Normally, for these shorter absences, employees simply ring their immediate line manager during the day/week of their absence and report the problems without the need for a medical certificate. HR may not always be able to act on these smaller instances of stress as they tend to find out after the event, if at all.

For longer-term stress cases, *ie* greater than seven days, organisational checks and procedures come into action. A medical certificate must be registered with HR to justify the absence, the line manager is made aware of the problem, and a dedicated senior personnel officer takes up regular contact with the employee. If the medical certificate details the problem as related to stress at work, HR will log it as such in their records. However, there is concern that due to the stigma attached to stress, GPs will sometimes ask their patients whether they want the problem to be recorded as something unrelated to work, as something which does not throw their mental health into doubt. If true, this obviously has implications for the ability of all organisations to assess the size of the problem accurately and deal with it effectively.

At North Tees and Hartlepool NHS Trust, policies are currently being harmonised following the merger of two existing hospitals. There are three working draft, new or legacy policies that relate to rehabilitation:

- sickness and absence policy (general)
- return-to-work and rehabilitation policy
- promotion of good mental health and well-being.

The HR department is currently bringing all policies together under a 'Health at Work Framework', which will encompass initiatives and policies to proactively address health issues.

The Trust has had a 'Promotion of Good Mental Health and Wellbeing of Staff' policy since January 2002. It sets out the Trust's philosophy, which is described as aiming to 'promote a climate of work which de-stigmatises mental ill-health and promotes positive mental well being'. It will achieve this in the following ways:

- the provision of suitable and sufficient training to all those with responsibility for managing staff
- the provision to all staff of information on mental well being at work and sources of support
- the implementation of suitable two-way channels of communication throughout the Trust
- the implementation and review of all human resources policies
- demonstrating continuing commitment to Investors in People
- support and review the staff appraisal process
- support the provision of a comprehensive occupational health service; and
- provide a confidential staff counselling service.

The policy then defines the responsibilities of key personnel such as directors, heads of departments, HR *etc.* It lists the types of information that will be collected and presented to the Trust Health, Safety and Welfare Committee at least twice a year. It also includes the Trust's definitions of mental health and stress.

This is underpinned by the existing sickness and absence policy and the return-to-work and rehabilitation policy. Further specific guidance is also available on capability procedures and bullying and harassment.

Sandwell and Dudley NHS Trust is also going through a period of harmonising policies following a very recent merger. HR are currently implementing procedures through training programmes in sickness absence and rehabilitation.

The current procedures differentiate between short- and longer-term absence. In the short-term, issues are dealt with via the managing attendance policy:

- robust reporting of absence is encouraged
- a return-to-work interview is conducted
- decisions are made on a case-by-case basis. If attendance issues are identified, the manager will seek to establish if there is a particular problem and make appropriate changes.
- if there is no improvement, then formal counselling is used (this is pre-disciplinary) to:
 - set standards
 - agree targets
 - set a review period
- a decision is then made on whether there is a capability issue or a conduct problem, and appropriate action is taken.

The long-term absence procedure is somewhat different:

- absence is reported
- an occupational health referral takes place at four weeks
- occupational health then offer advice and discussion around supporting return to work
- phased work re-entry then takes place (at the appropriate time), which can include re-deployment or retraining.

For either long- or short-term absence, if stress is identified then a referral to occupational health is automatic. Where stress is the issue, the emphasis is very much on rehabilitation. These policies are supported by workshops on prevention and managing change, and a register of placements to use in rehabilitation as and when appropriate.

3.2 Overseeing the rehabilitation process

Given the complex nature of the rehabilitation process and the large number of stakeholders involved (often up to 30 practitioners, [IRS, 2002]), it is important that it is managed and monitored effectively. This involves ensuring that the rehabilitation starts at an appropriate time, a suitable plan is developed, the agreed rehabilitation plan actually happens, the proper cover, support and adjustments are in place for return to work, and the employee has follow-up assessments during and after their return to work as necessary. One of the key factors that is central to this whole process is effective communication between the parties throughout rehabilitation and return to work.

One overall approach to rehabilitation management has been called 'case management'. It is a generic service-delivery model which is used as a method of co-ordinating a range of social, health and rehabilitation services, and which is designed to improve the quality of care and conserve costs (Akabas *et al.*, 1992, cited in Kendall *et al.*, 2000). It is an approach that has been developed for use in the occupational rehabilitation of employees with illness or injury, but has only recently been discussed specifically in relation to stress-related illness.

In several national studies of rehabilitation counsellors, the case-management approach has been rated as a vital component of their work (Puckett, 1984; Roessler and Rubin, 1992; Wright, Leahy and Shapson, 1997). Although the approach is well established in the USA and Australia, it has only recently been applied in the UK and may take a different approach because of the different legal and employee-relations situation in the UK (IRS, 2002).

The core functions of case management generally include the following (Austin and McClelland, 1996; Rothman, 1991; IRS, 2002):

- assessment of the individual's unmet needs
- development of a realistic and relevant plan to meet those needs, presenting the costs and benefits of alternative approaches
- co-ordinated access to rehabilitation services in a timely and logical manner
- implementation of the case management plan
- formal and informal monitoring of the plan and evaluation against outcomes.

Although the evidence on the effectiveness of case-management in occupational rehabilitation generally shows some encouraging results, empirical evidence remains inconclusive (Kendall *et al.*, 2000). This may in part be due to difficulties comparing case

management programmes which are necessarily situationally specific. Nevertheless, case management is generally seen as a cost-effective and logical approach to managing rehabilitation and return to work.

There is very little literature examining the use of case management in relation to work-related stress. It has been suggested that potential conflicts between stakeholders may make it difficult to use case management for work-related stress. One possible reason for these conflicts is the increased likelihood of different interpretations of the nature and cause of symptoms in stress-related illnesses than there is in other occupational illnesses. In addition, interactions with work colleagues and managers are more likely to be a cause of stress-related illnesses, and some of these people may be stakeholders in the rehabilitation process. In addressing this, Nowland (1997, cited in Kendall *et al.*, 2000) recommended a systematic approach to case management of occupational stress injury, including the following steps:

- The case manager identifies all the stakeholders involved.
- The key people among those stakeholders are clarified.
- The case manager finds out the rules governing the behaviour of the stakeholders and the relationships that exist between them and the worker.
- The issues causing stress for the worker are identified.
- The case manager and worker establish which of the stakeholders can assist in overcoming these issues and any other return-to-work barriers.
- The case manager develops a rehabilitation plan with clear goals.

This systematic approach is yet to be tested empirically (Kenny, 2000, cited in Kendall *et al.*, 2000).

3.2.1 Case study examples of overseeing the rehabilitation process

Some of the case study organisations had formally adopted a case-management approach, whilst others used elements of it on a more informal basis, such as ongoing communication and monitoring.

Case management

Only three of the case study organisations appeared to have a formal case-management structure in place. In the others, overall responsibility varied from case to case.

The Frozen Food Manufacturer's long-term absence policy indicates that the employee is allocated a 'case management team'

as soon as the company receives a medical certificate. This team consists of an OH nurse, line manager and personnel officer. The team works together with the employee throughout their absence to ensure that 'appropriate actions take place at appropriate times to enable you (the employee) to return to work at the earliest opportunity into a suitable environment, in a structured way'. The OH representative who was interviewed felt that the case management approach works well, and that involving the employee and getting them to 'sign up' for the rehabilitation plan is important for effective rehabilitation.

At The Insurance Company a similar approach to case management is used, with the specialist psychologist and the HR manager jointly reviewing all cases on a regular basis and making assessments of what should happen next.

At Devonport Dockyards there is an HR casework system. Individual personnel staff will be assigned specific cases and will carry out all the HR duties associated with that individual.

Ongoing contact with the employee during their absence

Line managers at Sheffield City Council are encouraged to keep lines of communication open throughout an employee's absence with stress-related illness. In one of the example cases, an employee described how his line manager would phone him regularly to see how he was, and also visit him at home during his 15-month period of absence. When she contacted him it was to find out how he was and if there was anything she or the organisation could do for him, but she never asked him directly about coming back to work. The employee felt that the regular contact and visits from his line manager and the occupational health nurse were key factors in his successful return to work. In another example case from the Council, the employee felt that regular contact was crucial, and that it would have been very difficult for him to get back if he'd been off work for a while without contact.

Similarly, at the central division of Lancashire Constabulary, the line manager is responsible for maintaining contact. The attendance policy states that it is 'essential that effective contact is maintained with all members of the Constabulary who are absent from duty'. A personal visit is the 'most effective method'. It states that it is good practice to keep the absentee informed of developments at work unless there is medical advice to the contrary. Colleagues should also be encouraged to maintain contact, and any significant events or developments should be communicated. Contact should be seen as an opportunity to both 'support the individual's needs' and 'address the issue of an early return to work'. Although the line manager is responsible for contacting employees who are absent, the HR adviser felt that it can be better if the line manager does not conduct a home visit if

the cause of the illness is work-related stress. Any home visit has to be notified to HR so it is possible to intervene so that the home visit is conducted by the HR adviser with the Staff Federation representative or UNISON representative. The representatives will reassure the employee about the role of HR in the home visit.

At AstraZeneca, the immediate manager of the absent employee will conduct attendance reviews. The purpose of attendance reviews is to ensure that the employee is receiving appropriate support and ensure that an up-to-date understanding of the latest medical situation and prognosis is available. The reviews will normally involve the employee visiting the site, although the review may be contacted at the employee's home. The attendance review should not be less than once a month, will normally be contacted by the immediate manager, and may involve a human resources representative.

At Devonport Dockyards, a long-term absent employee will normally be contacted initially by the HR department in the form of a letter offering support. This letter is usually sent two weeks into the absence. During the following month, HR will ring the employee to find out how they are. After this, home visits are set up, during which problems are discussed and solutions broached. HR tends to be quite assertive about setting up these visits so that employees do not become too caught up in, and demotivated by, their absence. Under the organisation's casework set-up, an HR liaison is assigned to the case, and it is hoped that confidence and a personal 'first name terms' closeness may be built up between the employee and their HR contact.

At Doncaster Metropolitan Borough Council, the stress policy states that 'if an employee is off sick due to anxiety/ nervous/ depressive (stress) related illness, contact should be made by the manager in the early stages, although managers ought to seek the advice of OH in this regard'. It goes on to say that the manager should make contact offering help if needed. It also says that the employee should be contacted periodically, and should be encouraged to keep in regular contact with the directorate.

In other organisations, the ongoing contact is via the OH department. For example, at Agilent Technologies, the employee is asked to come into the OH department every couple of weeks. Sometimes, and depending on the circumstances, the OH nurse will let a line manager or colleague know that the employee is due in so that they can come by to say hello. Managers are not encouraged to call employees direct.

In the example case from North Tees and Hartlepool NHS Trust, OH saw the employee at regular intervals of six to eight weeks. During these visits, the OH doctor asked the employee about medication and ongoing treatment with the consultant psychiatrist. The employee reported that this was very supportive.

Monitoring the rehabilitation and return to work

At Sheffield City Council, the OH nurse would typically see the employee during their phased return and before their full return to work. These may not necessarily be formal meetings. The employee is encouraged to contact OH if they experience any problems. The manager would monitor the return-to-work process day to day.

In one of the example cases from Sheffield City Council, both the line manager and the OH nurse played a central and important role in the monitoring of return to work. The line manager asked the employee to come and see her first thing in the morning and last thing in the afternoon every day. She also told the employee that he could also see her at any time of the day when he needed to. As the employee settled back and felt more confident, some of these 'reviews' became just a matter of the employee putting his head round the door at the end of the day to say he was off and everything was fine. Eventually, and under the employee's control, they stopped entirely. The line manager is still monitoring the situation on a regular basis, with the employee and providing him with support at his request. Meanwhile, the OH nurse reviewed the case every two to three months during the absence to see how the employee was. During the phased return, she reviewed the situation with him twice, and has done so once again since he returned full-time, at which point they decided that no further OH input was required.

At The Frozen Food Manufacturer, there is an emphasis on monitoring the effectiveness of the return-to-work programme. As part of the long-term absence management strategy, the company undertakes formal reviews of the employee's ongoing medical condition. Reviews take place at regular intervals, normally at four, 12 and 26 weeks. It states that the employee 'may be required to attend these reviews' and that in all cases the employee will receive formal communication from the OH department or HR department on the outcome. Under the recovery programme, there will be regular appointments with the lead nurse and/or manager to review the employee's ongoing progress. In the example case we examined, the employee saw the OH nurse on his first day back at work, and saw the Doctor the following day. The OH role is to check that the rehabilitation plan is going well and to support the line manager.

At Flintshire County Council, OH contacts the employee during the fourth week of the return-to-work programme to ensure that there are no problems before the employee returns to normal duties. The line manager is expected to monitor the return to work. The HR department can also get involved if it is a particularly difficult case.

At the central division of Lancashire Constabulary, the line manager is responsible for monitoring the return-to-work action

plan. HR says this too, but adds that HR will also keep an eye on them, especially if they are undertaking recuperative duties. In the individual case, the employee had regular interviews with the chief inspector to see how he was doing in the job.

At The Supermarket, formal monitoring of the rehabilitation plan is the role of the personnel manager. They have a written copy of the plan from OH. OH will only get involved again if the plan does not work or needs changing. In this case, the store manager also took on an informal monitoring role. The manager met with the employee on day one, and thereafter had weekly meeting to discuss how things were both in and out of work. The manager also made sure that the employee did not work late and encouraged him to, *eg* sit with colleagues during lunch rather than on his own in the car.

On the current evidence from the case studies, the main best practice points are that: there should be ongoing and sympathetic (*ie* non-pressurising) contact between employee and employer throughout the absence; there should be formal and informal monitoring of the employee's return to work.

3.3 Integrated roles and responsibilities

Integration between different organisational policies and functions is also thought to be an important element contributing to the effectiveness of rehabilitation. It has been suggested that the integration of management policies, human resource management practices, and effective rehabilitation strategies, will provide a win-win situation for all parties (Ellis, 1995, cited in Kendall *et al.*, 2000). This will involve having clear policies and practices, defined roles and responsibilities, and effective communication between the various parties involved in rehabilitation.

There are numerous stakeholders who may be involved in stress management, which can complicate the rehabilitation process (*eg* the employee, the organisation, medical services, psychiatrists and psychologists, insurance companies, and legal services). The process also may be hampered by conflicting agendas amongst these stakeholders, which may mean that the needs of employees are not met at the most appropriate time for their recovery (Kendall, 2000). Therefore, it is important that there is a clear rehabilitation policy which sets out the roles and responsibilities of these different stakeholders.

In large organisations, occupational health teams appear to generally lead rehabilitation, with line managers, GPs and physicians playing a supportive role (IRS, 2001). Other potentially important players such as disability advisers, health and safety specialists, and employers liability insurers, do not appear to play a role for many organisations (IRS, 2001). Occupational health specialists' role usually includes assessing the individual and

making a prognosis for the successful return to work. The communication channels between OH and line managers are clearly crucial both in terms of the original referral and for negotiating any adjustments and adaptations for return to work.

In many organisations, line managers appear to have primary responsibility for maintaining contact with absent employee, and exploring whether anything can be done to facilitate their return to work (James *et al.*, 2002). The literature stresses that the employee's line manager should be involved throughout the rehabilitation process, but particularly in the work-role review and adjustments, and the phased return options. If the line manager is usually the central person during rehabilitation, there needs to be an alternative approach if the line manager is part of the cause of the stress-related illness.

The involvement of the employee's GP is also considered to be important. The organisation should be engaged in a dialogue with the employee's GP to ensure that he or she is aware of what treatment or intervention is being offered by the organisation and vice versa. In organisations where there is no internal OH department, then the GP will play the key role in providing health assessment, treatment and referral, and return-to-work advice.

3.3.1 Case study examples of roles and responsibilities

Different models of organisational roles and responsibilities emerged from the case study organisations. In some cases, OH played the central role, in others this role was devolved to the line manager. Despite these variations, the case study organisations were agreed that a joint venture with support from all sides (HR, OH, line managers, GPs, Trade Unions) was a key factor in effective return to work. They also highlighted the importance of good communication between these parties.

Occupational health

At Sheffield City Council, OH will typically assess the individual's health, obtain information from their GP, and look at the work-related issues. The employee and manager are then encouraged to discuss the results and recommendations. OH will offer advice to both parties, but their level of involvement varies.

At Flintshire County Council, the head of OH states that he will write to the line manager immediately after his first meeting with an employee. He will tell the manager what issues have been raised if they are work-related or organisational issues. This, he says, is an 'early warning system' as it gives managers time, while the employee is absent, to resolve the problems before they return. His role is sometimes to be 'a thorn in their side', and get managers to address the work-related issues that are causing ill-

health. This report is also copied to HR. This acts as a 'prompt' for HR to offer support and chase up the line manager to ensure that he or she is trying to resolve the problem.

One of the interviewees at The Frozen Food Manufacturer felt that the role of OH was crucial to effective rehabilitation. In particular, it was important to have skilled OH staff who can facilitate meetings between the line manager and the employee, and who can co-ordinate the case-management approach.

At AstraZeneca, OH has an advisory function and provides information and guidance to the line manager. They will normally meet with the line manager prior to the managers initial meeting with the employee. They will also check the rehabilitation plan is feasible according to the medical information about the employee's condition.

At Devonport Dockyards, the role of OH is to confirm the condition cited on the medical certificate. The outcomes of any meetings between the employee, the line manager and HR are then forwarded to the occupational health physician for his or her approval. The OH physician may well suggest amendments or changes in line with their own views or recommendations, however these are made from a medical perspective, and the OH physician is concerned with psychological well-being in that context.

At North Tees and Hartlepool NHS Trust, OH will act in a liaison capacity, contacting the employee's GP and arranging a meeting to discuss options with the employee. Any planned return to work is agreed between the employee, the line manager, OH and the employee's GP, to ascertain whether the proposed plan is in the best interests of the employee.

The OH advisor at The Supermarket will normally keep in touch with the employee, advise on the likely return to work of the employee, and contribute to the rehabilitation plan. In the example case, OH liaised with the employee's psychiatrist, his NHS counsellor and his GP to discuss rehabilitation. The OH adviser then discussed plans with the line manager and personnel. OH will then only get involved again if the plan doesn't work or needs to be changed.

At The Insurance Company, rehabilitation planning can start at a very early stage – prior to return to work. At this stage, responsibility for monitoring rehabilitation is with the HR director and the specialist psychologist. Plans now specify the roles and responsibilities of the individual, HR and the line manager.

The line manager

The support of the line manager was considered key to a successful rehabilitation by all of the interviewees at Agilent Technologies. Only the line manager can really control the type

and amount of work being given to an individual, so his or her support and involvement in the process is very important.

The guiding principle of Sheffield City Council's approach is that good management is the foundation of stress management. Therefore, they emphasise the central role of the line manager throughout all of their policies, practices and guidance. It has been a deliberate decision to focus the rehabilitation process on the manager and the employee, with support from the organisation as required. After setting up the rehabilitation approach, OH has stepped back from its day-to-day practice to ensure that the key figures are in control. OH will provide support and guidance, and step in to champion a case if there are difficulties. But they prefer to leave the manager and employee to work through the details, as this encourages them to take responsibility for the issues.

With an approach that focuses on the manager and employee to such a degree, the system can break down if the manager is one of the causes of work-related stress. If these circumstances occur at Sheffield City Council, counselling is often used to analyse the way that the employee sees the manager's behaviour to see if there is anything that lies behind the problem, *eg* one thing that the manager does, or a misconstruing of the manager's behaviour, by the employee. The manager will be approached too. HR will also be involved in this as they may be aware of a problem with that manager already. They would try to get people together for a round-table discussion. It is often the case that this occurs with a new manager who has a different style to the old manager. There can be a clash of expectations that needs to be discussed in the open. This is quite common in schools where a new head has been brought in to turn around a failing school, and part of their role is to change the style and be more confrontational and target-focused.

At AstraZeneca, the line manager develops and implements the rehabilitation plan in agreement with the individual employee and HR. OH provide advice and guidance. It is felt that this works best as the line manager approaches the problem from a work point of view, and will be better placed to ensure that recommendations are realistic and achievable within team dynamics, roles and budgets. The involvement of so many different parties meant that the employee perceived support from every quarter, and it took the pressure off individuals to provide a solution on their own – they could rely on each other. From the organisation's perspective, good communications between all parties was seen as an important aspect of the successful rehabilitation.

At Devonport Dockyards, as with AstraZeneca, it is the role of the line manager and HR to discuss the situation with the employee and devise a rehabilitation plan with a realistic understanding of the work context and what is achievable. This will be done with information and approval from OH.

At The Supermarket, the line manager has responsibility for monitoring the rehabilitation following advice from personnel and OH. If need be, the line manager will call OH back in for further advice (*eg* on changing or adapting the rehabilitation plan).

The GP

The OH nurses at Sheffield City Council routinely approach the employee's GP as part of the rehabilitation planning process. In one example case, it was the GP who referred the employee for the necessary outpatient care, in what was seen as an important factor in the employee's successful rehabilitation.

The employee's GP is routinely contacted by North Tees and Hartlepool NHS Trust (with the employees permission), and provides advice on the suitability of any proposed return-to-work plans.

3.4 Stress awareness in line managers

Awareness, from all parties, of the issues surrounding work-related stress is thought to be important for effective stress management. In particular, it is critical that line managers are able to recognise stress-related symptoms, and know how to manage employees with these symptoms. Providing line managers with stress awareness training is seen to be one way of ensuring this. Although other methods, such as policy documents and guidelines, may be used which may make additional stress awareness training sessions redundant.

3.4.1 Case study examples of stress awareness

A number of examples from the case study organisations demonstrated the importance of stress awareness in line managers for effective rehabilitation. Stress awareness training had been given to line managers in some of these organisations, but not in all of them.

The importance of stress awareness

One of the example cases from Sheffield City Council illustrated the importance of stress awareness for effective rehabilitation following stress-related illness. Here, the line manager offered tremendous amounts of support to the employee both whilst he was absent and on his return. She was heavily involved in designing his phased return-to-work programme and ensuring that he had enough time to adjust back into his work role after a long absence. The OH nurse felt that the manager's own awareness of stress and mental health issues and appreciation of the employee's needs, made an important contribution to the successful rehabilitation.

Similarly, in the example case at Flintshire County Council, a line manager who had previous experience of stress-related symptoms was able to identify work-related stress in an employee early on.

A number of interviewees mentioned line managers' lack of awareness and understanding of stress, and an unwillingness to take responsibility for long-term sickness as a potential barrier to effective rehabilitation. In one of the example cases, we saw how a lack of stress awareness can lead to a less effective rehabilitation. In this case, although the final outcome was successful, both the employee and the OH representative felt that the line manager should have spotted some of the signs before the employee went off sick. The line manager says that she noticed that the employee was unable to do the job, but because she was new to her post she was unsure whether it was a competency issue or whether this was how he always behaved/worked. The employee's situation got worse, as the line manager did not spot the signs and try to help at the early stages. A more proactive and preventative approach would have been better, but it was recognised that this relies on the competency of managers in this area, and the support provided to them by their organisations.

At AstraZeneca, there is a strong healthcare philosophy. As a healthcare company they want to be the best in healthcare both internally and externally. Historically, there has been good awareness of the psychological aspects of work and health. The OH departments have always functioned on the basis that stress should not be treated differently from any other health risk. The company has always promoted the view that physical ailments will have an emotional impact, so even if stress is not the cause, or an issue, illnesses will have stressful characteristics, and these should be taken into account by occupational health departments. For that reason, awareness of stress has always been high. In addition, specific information and training is provided (which is described below).

At Doncaster Metropolitan Borough Council, the stress policy states that 'the management of stress and the promotion of employee well-being should be seen as an integrated approach and managers should be encouraged to use other policies where appropriate'. The stress policy also refers to other sources of guidance available in the policies on personal harassment, job share and redeployment.

The Council also has a 'working together group' made up of employees, managers and union representatives. One of the sub-groups focuses on employee health, and has been awarded money under the government's partnership fund to look at ways of moving forward together on employee health issues.

The Council is also participating in the HSE pilot exercise to look at the deployment of management standards for dealing with work-related stress.

The central division of Lancashire Constabulary provides an excellent example of how understanding about stress is changing. Traditionally, stress was seen as negative, says the head of HR. Today, in central division it is seen as a concern to be dealt with quickly. It is important to find out the causes and stop it happening to others. It is clearly considered a 'medical condition'. He says that understanding of stress has changed within this division over the past five or six years.

The change has been brought about by the changing nature of policing in the UK. Stress is now seen as an occupational hazard. Line managers are taking more responsibility for their staff and therefore have to have an understanding of absence management, stress and rehabilitation. While there is a good understanding of stress amongst most managers and supervisors, there are still pockets, at supervisor and line manager level, where this cultural change has not been accepted.

The stress policy has been in place since 1997, although it has been reviewed since then. According to the stress policy, there is 'a great deal of evidence to suggest that police work is inherently stressful. Few occupations require staff to face the kinds of dangerous situations that police officers may encounter as part of their daily routines'. The policy adopts a risk assessment approach to stress, and responsibility for risk assessment lies with line managers.

The head of HR at central division also chairs a monthly meeting called the resource committee within his division which is attended by UNISON, the Police Staff Federation, health and safety personnel and senior managers. The attendance policy is a standing item on the agenda, and this has increased the understanding of the policy amongst chief inspectors.

The policies discussed above are very prescriptive, and line managers have been briefed on the importance of adhering to these policies. Statistics are collected on stress cases and sickness generally. Data are kept by HR and cases are tracked to ensure that the employee is being offered the help necessary to enable them to return to work.

North Tees and Hartlepool NHS Trust provides leaflets for all employees on stress. The definition used in the leaflets was devised by the OH department. It says that:

'Stress is part of life. It is a normal response to challenging circumstances. It can be caused by good, as well as bad events. A bit of stress is not always a bad thing; it mobilises our body and energises us during the coping process. But being overstressed may result in a range of health problems.'

The leaflet goes on to talk about:

- how to recognise stress responses
- signs to be aware of
- managing stress
- some ways which might help
- what support is available
- staff counselling service.

The Insurance Company visited, uses leaflets to promote recognition and awareness of stress and sources of help. The leaflets detail responsibilities for management and HR, as well as providing practical advice and guidance for employees.

Sandwell Healthcare Trust have recently established a virtual health club which undertakes much promotion activity throughout the Trust. Stress has been the subject of promotion and awareness-raising in this way. In addition, there are more established stress counselling sessions and psychological services available to staff. Stress awareness is also raised through the wider policy of staff.

Stress awareness training

To increase line managers' awareness of work-related stress, some organisations run stress awareness training sessions. For example, during European Stress Week in 2002, MTM Products ran workshops on work-related stress for all managers and employees. These covered the definition of stress, work-related causes of stress, symptoms and signs of stress, what to do if you are experiencing stress, MTM's mental health policy, and how the company is trying to prevent work-related stress.

Flintshire County Council offers a number of training courses on stress. There is a basic three-hour training module on assessing and controlling organisational stress risks for managers, employees and work teams. Training is also provided on 'managing sickness absence', 'managing stress – a one day seminar for managers' and 'managing personal stress'. Information on the training courses makes it clear that while training in personal stress management (coping skills) may be helpful, it should not be seen as an alternative to the effective control of organisation stress risks.

AstraZeneca places a strong emphasis on the well-being of its employees, and historically has invested in ideas to support employees as best as possible. The Counselling and Life Management (CALM) project was established in 1995/6, and was designed to inform managers and employees about work-related mental health. It consists of stress management and stress training

programmes, and was considered a novel project in the UK at its inception. At a broader level, health and safety has always been integrated into management procedures, and lots of materials exist for employees and managers to raise awareness and promote well-being.

At Doncaster Metropolitan Borough Council, the policies and procedures on stress are backed up by mandatory training. All line managers must attend the 'Managing Attendance' training course, which includes a session on dealing with stress. Additionally, there are separate training courses on stress for both managers and employees.

Training is provided for managers and employees at North Tees and Hartlepool NHS Trust. The HR department runs training courses on managing sickness absence. There is now a specific section on stress, which gives managers guidance on how to identify the factors that cause stress.

Staff (including managers) are all required to attend health and safety training, and the OH department has a session on this course which includes stress awareness and the counselling service.

At The Insurance Company, training focuses on helping managers to recognise the warning signs and catch problems early. In addition, the EAP provides coaching to managers on how to handle stressed employees. Both these approaches mean that stress awareness and good practice is growing within the organisation.

Sandwell Healthcare Trust provide workshops for staff on stress prevention and on managing change. In addition, there are mandatory training courses for employees which include sessions on managing violence and aggression and which are based on the specific risks associated with hospital work

3.5 Good awareness of return-to-work or rehabilitation policy

As described in section 3.1, an organisation may have excellent written policies on return to work and rehabilitation, but if line managers and employees are not aware of these policies they will fail to be of use. Therefore, it is important that both line managers and employees are aware of the organisation's policy and procedures.

3.5.1 Case study examples of awareness of policies

One of the interviewees at The Frozen Food Manufacturer reported that having a consistent approach and making employees aware of the policy was a key factor in successful rehabilitation.

This was illustrated in one of the case examples from Sheffield City Council. The employee was a manager who described himself as having good awareness of the Council's policies and procedures and of his own rights. He felt that one of the key factors in his successful return was his knowledge of the systems and procedures, which enabled him to be more assertive during the rehabilitation planning.

Stress has been on the agenda for some time within AstraZeneca. Both the HR manager and occupational health physician felt that stress levels are recognised within the company, and employees are aware that stress is a serious health risk. Stress is taken very seriously by the company as a whole, and current staff focus studies show that staff feel AstraZeneca is a safe environment where an employee can talk about stress and how to deal with it. In addition, the CALM project is available to all employees. It runs regular workshops and numerous leaflets on the subject.

3.6 Monitoring sickness absence patterns

One element of best practice that does not relate directly to rehabilitation practices concerns the monitoring of sickness absence patterns. This activity is something that should go alongside effective rehabilitation to help identify and prevent problem areas or cases. It involves the organisation monitoring absences to identify early intervention opportunities where there are high incidences of stress-related absence. At a more local level, the line manager can also monitor and identify any possible work-related causes of individuals' short-term absence, and address these before the employee goes off work with long-term ill-health.

3.6.1 Case study examples of monitoring absence

Sheffield City Council's policy on attendance describes how work-related causes of short-term absence should be identified early on to prevent more long-term absence. Managers should discuss any work-related factors during the attendance review with employees following each absence.

At AstraZeneca, for absences of less than seven days, employees may 'self-certificate'. Normally, for these shorter absences, employees simply ring their immediate line manager during the day/week of their absence and report the problems without the need for a medical certificate. HR may not always be able to act on these smaller instances of stress as they tend to find out after the event, if at all.

For longer-term stress cases, *ie* eight days or more, organisational checks and procedures come into action. A medical certificate must be registered with manager/occupational health, and will be forwarded by the line manager to HR to justify the absence.

In the interest of effective case management, an absent employee and his immediate manager must make every effort to maintain regular contacts during a period of absence. If it is clear to a manager that there is stress involved, he will notify occupational health as soon as possible. Normally, the occupational health physician will assess an employee after four weeks of absence. When the case is urgent, either the line manager or the employee has the possibility to request a quicker assessment.

At Doncaster Metropolitan Borough Council, employees are expected to contact their line manager directly when reporting sick. The line manager is required to establish the nature of the illness and the anticipated length of the employee's unavailability for work. By the fourth day of absence, the line manager should receive the self-certification form. The employee is also expected to call in again on this day. On the eighth day of absence, the line manager must receive a medical certificate from a doctor. Managers should also ensure that medical certificates are sent in to cover the total period of absence.

The central division of Lancashire Constabulary has clear guidance on absence reporting. All employees should report their sickness absence to their line manager. Line managers are responsible for reporting all absence to the HR department, where it is recorded on the HR system. The HR adviser is responsible for checking these statistics weekly, and she looks particularly for stress cases. If the employee is absent for four days, they must call in on the fourth day to provide an update on the absence. The line manager should remind the employee that a certificate is required for any absence beyond seven days.

All absences beyond 28 days are monitored by HR and notified to the OH department. The OH department will then ensure that all appropriate support is being given to the employee. All absence related to depression, stress and anxiety must be reported in writing by line managers to OH, via HR, immediately.

The central division collects data on stress cases, and currently there are seven employees off work with work-related stress out of 500. The head of HR says that although the number is small, the cases can take a long time to deal with. The main causes of work-related stress are:

- operational issues
- the officer having to deal with a particularly traumatic case
- poor management
- a formal employee grievance
- the officer being disciplined.

Lancashire Constabulary also has a stress advisory group which looks at force-level stress statistics. It has representatives from all

six geographical areas, different ranks and from the unions. It looks at legislative changes and monitors trends. It is planning to review the stress policy in the light of the development of new work-life balance policies.

As well as these two policies, there are force-wide targets for absence. The aim overall of the policies is to ensure that employees return to work as quickly and effectively as possible. The central division has been very successful so far in meeting its targets. While it has reduced sickness absence to four per cent over a sustained period, the division has also, as a result of this, reduced overtime costs.

At North Tees and Hartlepool NHS Trust, there is a staff counselling service provided by independent, qualified counsellors. Staff can contact this themselves or can be referred by the OH department. The counsellors can also provide mediation between managers and employees to resolve difficulties (with the employee's consent). The head of the counselling service sees counselling as 'part of the package' provided for the Trust. She conducts a quarterly audit of the cases and gives recommendations to the Trust. A yearly report is also provided. These highlight any 'hot spots', departmental trends and recommendations to HR.

Sandwell Healthcare Trust have a year-on-year sickness reduction target. This means that they regularly review sources of absence and the controls and preventions that are in place.

Practical procedures also exist of, for example, notifying occupational health if an individual is suspended, as this is recognised as a potentially stressful occurrence. Other specific triggers have also been identified based on the organisations previous experience (eg midwives having to attend court), and HR managers have a checklist of these so they can be quick to intervene and offer support if they spot a potential difficulty arising.

3.7 Summary of best practice in the management of rehabilitation

3.7.1 Written policy or guidelines

There is currently no evidence in the research literature about written policies and their contribution to rehabilitation following work-related stress, although a written policy is often seen to be a key element of best practice.

Written policies relating to rehabilitation after illness due to work-related stress tended to take one of the following forms:

- a specific policy in relation to stress-related illness
- a general policy for occupational illnesses as a whole
- part of the organisation's stress management policy
- part of the organisation's general sickness absence or attendance policy.

Practice amongst our case study organisations was varied. Some organisations had explicit guidance for managers in relation to stress, in the form of a dedicated stress management policy. Other organisations had a number of more general policies (*eg* on occupational health or rehabilitation) which applied to stress as they would to any other illness.

Clearly there are a number of approaches which successfully deal with written policy in this area. To some extent, the approach adopted will reflect the needs of individual organisations. For example, in organisations with an historically altruistic approach, stress awareness and manager skills are more likely to be well established. A more general policy might be more appropriate in these settings. However, in situations where organisations are amending or amalgamating old policies, or where they are attempting to change culture, a far more prescriptive and detailed policy could be more appropriate to clarify and underpin new procedures in relation to work-related stress. Organisations need to consider how good they are at understanding individual problems, how clear they are about procedures and possibilities available under rehabilitation, and how consistent they are in applying these practices across the organisation.

3.7.2 Overseeing the rehabilitation process

Rehabilitation processes can often be complex and involve input from a number of different stakeholders. For this reason, it is important that they are carefully monitored and managed.

Only a few of the case study organisations visited felt the need for, or had developed, a formal 'case management' approach to rehabilitation.

Other case study organisations had a number of different approaches to maintaining contact with the employee, which varied from line managers having this responsibility to it resting with HR, or in some cases OH.

Monitoring the rehabilitation and return to work was also an important aspect of overseeing the process. On the whole, monitoring the process involved some form of regular contact between the employee, line manager and either HR or OH.

Current best practice from the case studies is that there is a need for ongoing (and unpressured) contact with the employee during

the absence, and that there is a role for both formal and informal monitoring of the individual when they return to work.

3.7.3 Integrated roles and responsibilities

It is suggested that having clear policies and practices, defined roles and responsibilities, and effective communications between all groups involved in the rehabilitation process, will provide a win-win situation for all parties.

On the whole, it appears to be occupational health providers who lead rehabilitation, with line managers, GPs and HR all contributing to the process.

In most of the organisations visited, it was the line manager who was responsible for keeping in contact with the individual during any spell of absence.

The case study organisations had examples of many different models of organisational roles and responsibilities. Despite these variations, all organisations agreed that a joint venture with support from all sides (HR, OH, line managers, GPs, Trades Unions) was a key factor in successful return to work.

3.7.4 Stress awareness in line managers

Having line managers who are aware of stress and able to recognise stress-related symptoms was seen as critical by many case study organisations. Line managers' awareness was addressed through a number of mechanisms:

- mandatory training on policies and practices
- stress awareness training
- policy documents and guidance
- manager coaching (when dealing with stress-related cases)
- establishing working groups
- standing agenda items on manager meetings.

3.7.5 Good awareness of return-to-work or rehabilitation policy

Awareness of policies is crucial if they are to become practice and to be used effectively and appropriately within the organisation. As with awareness of stress, there were examples of a number of different ways in which organisations sought to promote awareness of rehabilitation policies. Often such approaches were tied into general awareness of stress and absence management.

3.7.6 Monitoring sickness absence patterns

Although not directly related to rehabilitation, there is evidence that monitoring sickness absence patterns can help identify or prevent problem areas or cases. It involves the organisation monitoring absences to identify early intervention opportunities where there are high incidences of stress-related absence.

Amongst our case study organisations, there were many examples of monitoring sickness absence for a variety of reasons:

- to intervene early in a case of 'stress'
- to intervene early following a high-risk incident
- to identify causes of stress across the organisation
- to monitor any particular problem areas/departments.

4. Implementing and Evaluating Best Practice

This chapter describes some of the contextual factors that appear to be important to the successful implementation of best practice. It examines the historical development of best practice in the case study organisations, and discusses some important factors such as culture change and policy integration. It also considers the evaluation of best practices, describing the assessment of both their overall effectiveness in reducing stress-related absence, and of their successful implementation and management.

4.1 The development of best practice

One of the important contextual aspects of best practice that was of interest was how, and why, a certain policy or approach was adopted or developed by the organisation. What is the history and the motivation behind the approach to rehabilitation following illness due to work-related stress? What factors were involved in persuading the organisation that they had to do something? What arguments or evidence was used, and how was the relevant information or evidence gathered and presented to persuade the organisation to adopt the approach?

Historically altruistic approach

The approach to rehabilitation at Sheffield City Council was first formed 15 to 20 years ago. There have been slight changes since then, but the basic approach has remained the same. However, the philosophy and motivation behind the policies then were very different to what they would be now. When the practices were first formed, they were done that way for the good of the employee. Now, the motivating factors would be more to do with ensuring the benefits for the organisation rather than the employee. Nevertheless, there is a feeling that the approach taken by the Council has proved to be good for the business too. So although the philosophy behind organisational practices has become more service-oriented, the policies have remained similar.

At the time of the merger between Astra and Zeneca three and a half years ago, there were legacy policies (such as the CALM project) which were taken on by the newly formed company.

Sandwell Healthcare Trust also underwent a recent merger, which left them with a number of different policies and approaches to staff welfare. The work of the HR team over the last year has been to harmonise these two different sets of processes, and arrive at one procedure that works across the whole trust.

In both instances, the organisations have commented on the advantages of building on historically altruistic approaches to staff welfare, and on how much existing practice has shaped the future practice for the newly merged organisations.

To some extent, organisations felt that, where an historically altruistic approach existed, the argument was already won in the sense that the appreciation of the value of rehabilitation already existed. As a result, efforts focused on the best ways of delivering the rehabilitation itself. However, this factor alone was rarely the sole motivation for the organisations' policies and practices. Commitment to an altruistic approach was maintained through evidence of its successful impact.

Targets for reducing sickness absence

The central division of Lancashire Constabulary described how costs associated with absence are the main motivation from above. The police force is being encouraged by central government to tackle absence. This is demonstrated by national targets for sickness levels, and in the occupational health strategy for the police service. The central division has been very successful in meeting its targets so far. While it has reduced sickness absence to four per cent over a sustained period, the division has also, as a result of this, reduced overtime costs.

The OH physician at North Tees and Hartlepool NHS Trust felt that the increased number of stress cases, following the merger of the two hospitals in 1999, was the main factor that triggered the policy. The hospitals did not recognise this increase immediately, as the senior managers and line managers were all too busy with the merger. But as the numbers increased, it became obvious that it needed to be dealt with. In 2002, a new 'Promotion of good mental health and wellbeing of staff' policy was introduced for the newly merged Trust, in an attempt to reduce the number of cases and the sickness absence associated with them.

At Doncaster Metropolitan Borough Council, target setting was a part of the motivation to raise the profile and practices around work stress. The nationally-set standards for corporate health, and the performance indicators in best value, acted as prompts alongside other business related benefits.

Targets have also played a role in driving the development of policies at Sandwell Healthcare Trust, where there are year on year sickness absence reduction targets. In achieving these targets, the Trust places emphasis on the wider issue of staff management

and management style – ensuring the Trust is a good place to work.

At a broader level it can be seen that targets for reducing stress-related absence, whether locally or nationally set, were a clear driver of recognition of the need for rehabilitation programmes within organisations.

The associated business benefits

The motivation for the SME, MTM Products, concerned the business benefits that are associated with tackling work-related stress. This organisation also illustrated the importance of having a senior manager to drive the approach through. When the current director joined six years ago, he wanted to introduce multi-skilling, which provides a variety of work and assists the company in accommodating requests for a change of work pattern. He then got interested in other positive aspects of work such as increasing motivation, flexible working and work-life balance. Talking to other SME's, it seemed that most were not addressing work-related stress, but he realised that it was better to be proactive in this area too. So he started to develop a policy and approach to how they would deal with it. The company's owners were happy to let him get on with it, and it was presented as one of the ongoing business improvements they were undertaking.

The perceived business benefits were also an important driver for developing policies at Doncaster Metropolitan Borough Council. The executive board was persuaded of the need to act, in part because of the costs of stress in the UK and in the Council. The HR representative felt that this buy-in by the senior managers was critical in raising the profile and understanding of stress within the organisation, and in making the implementation of such policies effective.

The Insurance Company also felt that business benefits were a strong factor in supporting an innovative and highly individual rehabilitation process. Although not yet formally evaluated, the feeling was that the rehabilitation programme was at worst cost neutral, and at best, saved the organisation considerable amounts of money in terms of reduced sickness absence, and an earlier resolution of the situation.

Perceived business benefits were a considerable influence in many case study organisations.

Obtaining advice on rehabilitation practices

The approach to rehabilitation used by MTM Products was also based on advice received from the local Primary Care Trust. The director felt that it was important for SMEs to know where to go

to get some advice on how they should be helping employees back to work after stress-related illness.

In virtually all the other case study organisations, obtaining advice, and access to advice, were seen as critical to enabling successful rehabilitation. Ensuring that specialist support, advice or guidance was available to line managers in particular, was felt to be essential if policies and practices were to be developed and implemented within the organisation.

4.2 Encouraging culture change

In most case study organisations, the organisational culture and attitude towards work-related stress was seen as an important factor in the effectiveness of their rehabilitation practices. The interviewees generally described a diverse set of views on stress within their organisations, but felt that they were going through a culture change that was encouraging a more open and constructive approach to tackling work-related stress. This change in attitude was also important for providing a sympathetic and supportive working environment for employees to return to. This in turn meant that employees were more open about discussing and reporting stress-related problems. Many of the organisations mentioned the role of increased awareness and understanding in encouraging this culture change. Beyond this, developing trust between employer and employee as part of this culture change was highlighted as a crucial factor by a number of the organisations.

Changes in attitudes to stress

The importance of understanding and awareness about stress was thought to be important for developing openness about stress-related problems, but also for ensuring a supportive environment for rehabilitating employees to return to.

At Sheffield City Council, the representatives from the OH department felt that there was an active process of culture change going on. This was being led by the provision of information aimed at demystifying stress and developing a shared understanding of what it is, and what can be done to tackle it. The importance of people's attitudes to stress was seen in one of the example cases from the Council. The employee who returned to work after 15 months off with anxiety, felt that the supportive and understanding working environment that he returned to was a key factor in his successful return. His colleagues show tremendous appreciation for him and this, in turn, has raised his self-esteem.

Similarly, at MTM Products, the employee in the example case had very low confidence on returning, and was helped by the

reassurances, patience and support given by her colleagues and managers.

According to the HR representative in The Frozen Food Manufacturer, stress is seen as something that could affect everyone in the organisation. It is not seen as a sign of weakness. However, the head of OH believes that the perception of stress amongst managers and staff varies depending on the individual who is suffering from stress, and whether they are seen as being genuinely stressed.

At Flintshire County Council, it was reported that both managers and employees have an increasing understanding of stress. The level of understanding has changed over the last ten years for a number of reasons, including case law and heavier workloads within the Council. The Council has been running stress awareness training for many years, and there is still demand for the courses.

At the central division of Lancashire Constabulary, stress had traditionally been seen as negative, but this has changed over the last five or six years. Today it is seen as a concern to be dealt with quickly, and it is clearly considered a 'medical condition'. The change has been brought about by the changing nature of policing in the UK. Stress is now seen as an occupational hazard. Line managers are taking more responsibility for their staff, and therefore have to have an understanding of absence management, stress and rehabilitation. While there is a good understanding of stress amongst most managers and supervisors, there are still pockets, at supervisor and line manager level, where this cultural change has not been accepted. The HR representative felt that an organisational culture that supports attendance and understands stress at work, was key to effective rehabilitation.

At The Supermarket, there was recognition that some managers and employees still hold the view that if you are off work with stress, you should not come into the store, see friends or go shopping, but that you should stay at home. Both HR and OH are working hard to change this perception where it exists, and as demonstrated by their practice in this case, encourage individuals to come into the store for a coffee and to see colleagues. Isolation from work and colleagues is seen as a negative factor in the rehabilitation process.

The executive board at Doncaster Metropolitan Borough Council are strongly committed to the development of more proactive policies and procedures on work-related stress. This senior management buy-in is seen as critical to raising the profile and understanding of stress within the organisation. Two further activities have helped to change the culture within the organisation with regard to stress. These include a 'Managers for Change' programme (which got managers to look at individual

responses to stress and responsibilities for employee stress), and an employee relations conference, which included a session on stress. Council members, managers, union representatives and staff attended the conference. One of the outcomes was the establishment of a stress task-group, made up of a similar range of stakeholders.

The reporting of stress-related absence

Most organisations reported that employees are more open about saying they are absent due to stress or depression than they were a few years ago. They felt that this reflected a wider societal change, rather than just a specific organisational one. Some reported an increase in figures that may, in part, be due to more acceptance in reporting absence as being stress-related. The importance of openness and the ability to discuss the matters involved in effective rehabilitation was highlighted in a number of the case studies.

Developing trust

A trusting and supportive relationship between the employee and the other parties involved in his or her rehabilitation, are thought to contribute to its effectiveness. For example, in one of the cases from Sheffield City Council, the employee felt that he would have had a complete breakdown if he had not had such a good relationship with the OH nurse and the counsellor.

At MTM Products, openness and trust was seen as a crucial factor in successful rehabilitation. It would be far more difficult to rehabilitate effectively someone if they did not believe that the employers were really concerned. The director at MTM Products highlighted specific actions or approaches that they felt had helped to develop the trust necessary to encourage culture change in the case study organisations. He felt that everyone in the company had a good understanding of what stress is and what the employees and the organisation need to do if there is a problem. They have tried to make sure that employees and managers know what the early signs of stress are, so that it can be addressed before it becomes serious depression. This means that people must feel free to say something to their manager if they are experiencing stress-related problems, and this in turn requires openness and trust. They have, therefore, worked hard at building up mutual trust. For example, they have encouraged increased delegation, participation in decision-making and the development of a 'no blame' culture. This has meant that people are now more willing to admit to having problems. The director felt that this culture change was key to the effectiveness of any practices. He also thought it was something that was easier to do in SMEs because of the smaller number of people involved.

Another important factor in developing and maintaining trust is the sensitive management of information. This was highlighted by one of the interviewees at Agilent Technologies. They felt that for successful rehabilitation, the manager needs information about the employee's ill-health and the causes of it, but at the same time the confidentiality of the employee has to be preserved. It is important to establish what information the manager needs to know, and then ask permission from the employee before passing any confidential information on to the manager.

4.3 Integrating rehabilitation and prevention

Whilst the case study organisations were selected for their approach to rehabilitation following ill-health due to stress, some of them were also actively combining this with a preventative approach to work-related stress.

Sheffield City Council are currently collecting information on the causes of stress in the Council, and plan to use this information to inform preventative practice. They do not just look at individual causes of stress in isolation, as they feel that employees can often cope with stress from one of these areas, but that it is when they combine that illness often occurs. A preventative approach is also encouraged at a more local level. In the normal course of their management/supervision of staff, line managers will be expected to identify where a problem exists, or may arise that impacts on an employee's performance or attendance. They should take responsibility for managing and providing support, in order to resolve the matter in the appropriate way. Employees are encouraged to communicate with their manager about difficulties and problems, so that efforts to resolve these can be made. Employees are encouraged to co-operate fully in resolving difficulties, by taking advantage of support offered, referral to other agencies, *etc.*

The Council will also be one of the organisations piloting the HSE's Management Standards for work-related stress.

At Flintshire County Council, the stress policy describes a risk-assessment approach to preventing stress. Managers are expected to identify the factors that have the potential for causing stress to employees, and undertake a risk assessment. This assessment should be conducted with members of the staff team, and training is provided to managers and employees. Assessments must be undertaken for any new activity, and when there has been any alteration in a risk that may have introduced new hazards. However, the head of OH does not believe that this approach is currently being implemented across the Council. He would like all managers to be more proactive in 'spotting the signs' of stress, and to treat stress as any other hazard.

MTM Products has been very proactive in the area of mental health and stress over the last few years. They have completed three stress and satisfaction surveys over the last five years (one based on interviews, and two based on questionnaires). The survey results are used to address areas for improvement (*eg* pressure felt during 'rushed jobs').

The Central Division at Lancashire Constabulary believes that, as a result of introducing stress management policies, the organisation has started to manage all long-term absence more rigorously. In addition, it feels that the 'managing stress' policy has influenced the development of a more holistic approach, through influencing policies on work-life balance and the Working Time Directive.

4.4 Evaluating organisational rehabilitation practices

Some organisations do not appear to evaluate the overall effectiveness of their rehabilitation and return-to-work practices, *ie* a summative or outcome evaluation. Although they may not collect data on overall success rates, there is a perception that they are increasingly successful. However, they do appear to conduct more formative, or process evaluations, *eg* collect and act on feedback on the rehabilitation practices from OH nurses or HR.

4.4.1 Outcome evaluation

The supermarket chain involved in the research, does not hold data on the effectiveness of the rehabilitation policies and practices at a store level. The individual employee felt strongly that the policies were effective in enabling him to return to work. The company contacted him regularly and he felt that they demonstrated genuine concern for his well-being. He did not feel as though he was placed under undue pressure at any time to return to work. He also found that the practical help offered by OH was very useful.

Both anecdotal and quantitative evidence helps to measure the success of the rehabilitation policies and practices at Doncaster Metropolitan Borough Council. There is good feedback from both managers and unions on the 'managing attendance' policy, and the way it is being implemented. Additionally, the number of sick days has been reduced, and has resulted in financial savings for the Council. The rehabilitation policy, however, is only viewed by the Council as one strand in its strategy for dealing with stress.

At the Central Division of Lancashire Constabulary the head of HR reports that the stress-management and attendance policies have had a direct impact in reducing absence, and that there have been cost savings as a result.

Sandwell Healthcare Trust feel that where rehabilitation is handled and managed appropriately, it results in a successful return to work in nine out of ten cases.

4.4.2 Process evaluation

All case study organisations had thoughts about what helped and hindered the process of good rehabilitation. Many similar and consistent themes emerged in the course of these discussions. The main themes are summarised below for each case study organisation, and any less common factors highlighted.

Factors promoting the effectiveness of policies

At The Supermarket there is clear consensus about the factors that constitute good implementation and management of their procedures:

- Make sure that everyone involved is clear of the return-to-work-plan, and agrees to it. Employee input is vital here and the employee should always be consulted as to what they feel they can do.
- Respond to the needs of the individual, do not rush people back to work if they are not ready for it, but help them to get ready to return.
- Keep regular contact with the employee during their absence.

There is a further factor that is seen as important. In this organisation, OH advisers are not store-based, and this is seen to give them a slight independence that is valued by all parties.

The employee in this case also had clear views about what parts of the practice had contributed to his return to work. These were: making sure it was the right time to come back to work (not too pressured and not too late), and being able to return to a job with reduced hours and tasks (*ie* to an adjusted job with less pressure).

Doncaster Metropolitan Borough Council has identified a number of key factors that they believe help or hinder the effective implementation of their policies. Factors that help include:

- The timing of the rehabilitation plan – not getting the person back before they are ready is important, as is not leaving it too late.
- Monitoring of the rehabilitation plan should be done by OH, but also by someone within the department.
- The plan should be kept flexible.
- Contact with the employee should be maintained through any period of absence, and should be both from their colleagues and their manager (if appropriate).

- Promoting a clear understanding of stress within the organisation is essential to getting policies implemented appropriately.

At Agilent Technologies, the support of the line manager is considered key to a successful rehabilitation – only the line manager can really control the type and amount of work being given to an individual. Every interview emphasised the importance of the line manager’s support and involvement in the process.

Interviewees also mentioned flexibility – the need to keep reviewing and adjusting the return-to-work plan. As a person recovers, different things may come up. Every employee is different, so there is no benefit to having a rigid plan and a fixed date for being back full-time.

The line manager interviewed at Agilent Technologies, mentioned that it was useful to have cover for the employee during the rehabilitation period. Rehabilitation can take a long time, six months of colleagues sharing extra work may have put a strain on the team, which would have been counter-productive. It would have been possible to do it without the cover, but that comfort zone helped the recovery.

Sensitive management of information is also considered very important. The manager needs information, but the confidentiality of the employee has to be preserved. It is important to sort out what information the manager needs to know, and then ask permission from the employee before passing any confidential information on to the manager.

At AstraZeneca, there was a high degree of consensus amongst the employee, line manager, HR representative and the OH adviser, as to what contributed to successful rehabilitation: a good relationship between manager and employee, expressed in a regular contact between them from day one of the absence.

- The manager needs to own the rehabilitation ownership is very important. One person needs to manage the case and secure all the inputs of different parties. The line manager is the most appropriate person for this task.
- A good relationship between HR and line manager: managing expectations of line managers. The line manager will be, most of the time, focused on organisational targets and perspectives. The HR manager will make sure that the well-being of the individual won’t be overlooked.
- Good communication between the line manager, SHE department and the HR department: regular contacts so everyone knows what is going on. The rehabilitation case is managed without gaps.

- The competence of the manager: the more experienced a line manager is, the less he or she will need the support of the HR department, and the better a rehabilitation will work.
- The willingness of the individual: if an individual is unwilling to participate, then rehabilitation won't work. Such unwillingness may stem from many things: genuinely low self esteem undermining confidence; fear of failure; lack of trust; lack of belief that the source of the problem will be tackled *etc.* Where unwillingness is apparent, it is important to understand what lies behind it.
- Consistent support for line manager and employee: Occupational health and HR should bring a flexible framework, that fits with the reality of the workplace, so line manager and employee feel supported in a sensible way.
- Managing expectations: occupational health needs to be as honest as possible with employees and line managers. If everyone is talking the same language, it will give a firm foundation for a good rehabilitation.

At Devonport Dockyards, a number of issues in addition to those above were cited. In particular, being part of a large organisation they can offer a range of different work settings if someone needs to move job. The role of trust in successful rehabilitation. The key supporting factors they identified are given below.

- line management understanding of, and support for, employees returning to work after stress-related absence.
- the adoption by the HR and OH departments, of an approach which is flexible to the needs of individual cases.
- having supportive and informed trade union representatives who can help the employee to ensure that a rehabilitation plan is agreed and implemented.
- being a large organisation that can offer a range of job roles to individuals who need to move jobs.
- having a dedicated OH function which is trusted by employees, and is able to provide input into the rehabilitation plan.

Flintshire County Council also indicated similar themes of good communications, flexibility, and opportunities to use redeployment if necessary.

- good communication between all the parties concerned
- a policy flexible enough to enable the rehabilitation plan to be changed if it is not working
- management commitment and willingness to change
- ability to change the job, or redeploy employees (this is not always possible).

The Frozen Food Manufacturer indicated that, amongst other factors, making sure employees know about the policy is critical to it's success:

- having a consistent approach and making employees aware of the policy
- publicising the wide-ranging role of the OH department (the department in this company has a range of leaflets for employees)
- having skilled OH staff who can facilitate meetings between the line manager and the employee, and who can co-ordinate the case management approach
- having a range of options to offer the employee, such as reduced hours, training, or redeployment.

Lancashire Constabulary emphasised the importance of an understanding and supportive culture and, in particular, support for line managers.

- The return-to-work plan must be flexible and allow for changes/readjustments.
- All parties must agree and support the return-to-work plan.
- An organisational culture is required that supports attendance and understands stress at work.
- Professionally trained HR staff are needed to support and assist line managers.
- Good industrial relations and union support of the attendance policy.

At MTM products, many similar themes emerged with regard to what helps effective rehabilitation, although the perspective was slightly different, as might be expected with an SME:

- constant reassurances and confidence building
- having a detailed discussion between the employee and manager
- from the employees perspective, accepting that the company wanted her back, and that she wanted to return
- being patient and supportive (both employees and managers)
- accepting that there was a problem and not dodging it
- knowing where to go for advice (Chesterfield Primary Care Trust).

Discussions at MTM also allowed us to understand some more of the difficulties that could be faced by SMEs in particular, when providing rehabilitation for work-related stress. The feeling at

MTM was that the following factors were key to SMEs having effective stress-rehabilitation practices:

- Be proactive, not reactive — you need to have thought it through beforehand. If you haven't got a rough idea of what to do if someone is absent with stress-related ill-health, then it will be far more difficult to help them back effectively. SMEs need to give it some prior thought, but it doesn't need to be too complicated.
- Education and awareness about stress amongst senior managers/owners — there is a lack of acceptance among owner-managed business that employees can become stressed (especially at the middle and lower levels). They need to recognise that even boredom can cause stress, not just high-powered decision-making. It can hit anyone, and there are lots of things you can do about it.
- Selling it in the right way — the impression at the moment is that stress is a negative thing, that legislation is involved, and this makes many managers avoid the whole issue. If you sell stress management in a more positive way, then people will see the benefits of addressing it. See it as a business improvement opportunity, a way of increasing people's job satisfaction and motivation.

One factor that is felt to assist in positive rehabilitation at North Tees is the commitment of senior management to the rehabilitation process. Other factors highlighted by the Trust are as follows:

- Organisational, departmental and team support for the employee is important.
- The organisation must also be committed to rehabilitation.
- The individual needs to be seen very early on, as this sends a positive message to the employee that the organisation and line manager are prepared to help.
- There needs to be team effort between HR, OH, employee, counsellor and line managers. All need to be involved in developing the rehabilitation plan.

Sandwell Healthcare Trust placed emphasis on the broad context in which rehabilitation takes place, as well as specific behaviours or practices:

- a supportive and nurturing culture
- a good industrial relations climate
- standardised procedures
- senior management support for the process
- early referral for stress-related cases.

At Sheffield City Council, one of the key success factors mentioned, was to reflect on the nature of the work being undertaken by an individual, to try and recognise if a job was unsuitable for a person, and to discuss possible solutions.

- commitment from the employee and the manager – both have to want a successful return
- appropriate care from the National Health Service – some employees say that their GP doesn't believe in stress
- a joint venture, with support from all sides (HR, unions, OH)
- an openness and ability to discuss the matters involved
- reflecting on the nature of the work – getting the employee to recognise when the work is not 'right' for them, and that the best solution would be to look for a different job. This could well be internally and about finding a better individual/demands fit.

Factors hindering the implementation of successful rehabilitation

In addition to the positive factors identified above, many organisations were able to identify particular obstacles to the rehabilitation process. These were often based on previous experience, and were issues that participating organisations had sought to address with current practices and procedures.

The barriers to effective implementation of rehabilitation fell broadly into the following categories:

Process barriers

- diagnosis
- timing
- communications
- consistency of approach
- resources.

Cultural barriers

- trust
- managers
- employees
- staff.

Each of these is discussed in turn.

4.4.3 Diagnosis

Several issues emerged around diagnosis, the primary one being failure to identify the real problem, particularly when personal relationships between colleagues were concerned. Where difficult issues were fudged over or brushed under the carpet, the chances of successful rehabilitation could be extremely limited.

A second issue around diagnosis, was the failure of managers or colleagues, or the individual in question, to catch the problem in time. An early diagnosis and assessment would have made the rehabilitation a lot easier, but in several examples interviewees spoke of ignoring the early indications of ill-health, 'we made excuses for the behaviour' or 'we hoped it was a glitch'.

4.4.4 Timing

Once a diagnosis had been made, it was recognised that poor timing could prove a very strong barrier to successful rehabilitation in two ways. Firstly, and obviously, poor timing could cause delays directly to the rehabilitation process. Secondly, the knock-on effects could be very damaging in terms of undermining trust and confidence in the process.

Poor timing could affect the rehabilitation process at any stage, and specific examples are discussed in more detail below. However, it was clear from the case study examples that what would happen when, and who was responsible for ensuring it happened, were important in terms of maintaining momentum and making the process as smooth as possible.

4.4.5 Communications

Poor communication between any of the stakeholders in the rehabilitation process was a serious threat to successful rehabilitation. Examples were given where lack of communication between any combination of OH, HR, the line manager, the employee, or the employees GP, had the potential to run the process aground.

Clear and consistent communication was highlighted as a critical success factor by many of the case study organisations.

4.4.6 Consistency of approach

Several case studies do not have a specific written strategy for stress rehabilitation. This in itself is not necessarily a problem, however, several organisations pointed to the difficulty in maintaining a consistent approach across the business, particularly in large organisations with many different functions/departments, or where new policies and practices were being introduced.

Many organisations had found that a written policy was particularly effective in ensuring that all parts of the organisation were aware of the rehabilitation process, and able to enact it effectively.

4.4.7 Resources

A key issue was around resources. It was clear that a lack of resources to implement changes needed for rehabilitation, could mean that the rehabilitation plan cannot be implemented in effect.

A comment made by several case study organisations was that managers are already very busy, and often, dealing with an employee who is going through a rehabilitation can require extra time and support from the manager. This needs to be recognised and taken into account when planning the rehabilitation process.

Other resource issues included ensuring adequate cover to complete the work normally done by the employee whilst they are on a graded return to work. This is important, both in ensuring the employee doesn't see work going undone and feel under pressure as a result, but equally to ensure that colleagues are not overburdened during the rehabilitation period.

4.4.8 Trust

A lack of mutual trust was seen to make rehabilitation far more difficult. The employee needs to believe that the employer is really concerned, and believe in the process.

Lack of trust or cynicism was particularly a threat to successful rehabilitation in organisations with a more 'macho' culture, where the culture mitigated against the legitimisation of stress as a work-related issue.

4.4.9 Managers

The role of managers in the rehabilitation process was mentioned by several of the organisations. As such key players in the rehabilitation process, managers often have a number of additional challenges to deal with when implementing the rehabilitation plan. However, it was also recognised that they themselves could be a threat to successful rehabilitation in certain circumstances.

Managers' (particularly senior managers) lack of commitment to the principles of rehabilitation would be likely to undermine the process.

Managers' fear and ignorance of mental health and what it means was one potential area of risk. Some managers don't want the individual back to work until they are 'fully fit', and don't understand that getting them back to work will help them to get fit.

At a lesser level, failing to get line managers 'on board' was seen as a threat to the rehabilitation process, as was persuading managers to make changes to their department or ways of working, and their resistance to this.

Finally, it was also recognised that managers have a key role in understanding stress, or taking the time to address organisational stressors. If the organisation does not acknowledge and support this in managers, then the success of rehabilitation is likely to be limited.

4.4.10 Employees

In some instances, it was recognised that the position of employees could be a threat to successful rehabilitation, and that this needed to be addressed through the rehabilitation process. In situations where the employee was unwilling to 'give up their history and start again' rehabilitation was unlikely to succeed.

Litigation was also a major stumbling block. Where there was a pending legal case, the interests of the employee and the organisation were likely to be at odds, meaning that successful rehabilitation was unlikely.

4.4.11 Staff

Managing other staff who might resent a colleague for their reduced hours or phased return, was seen to be a challenge for managers, and a potential threat to rehabilitation. This was particularly felt to be the case in situations where colleagues had to take on extra work.

4.5 Summary of implementing and evaluating best practice

4.5.1 The development of best practice

Several drivers were identified as key in the development of best practice. Historically, altruistic approaches were common amongst the case study organisations, and facilitated the development of practice that both met business needs and supported the employee.

Targets for reducing sickness absence were often a trigger for focussing attention on stress and developing or improving guidance on its management and on rehabilitation.

Business benefits were cited by most organisations as an important aspect of developing and focussing effective rehabilitation strategies.

Finally, knowing where to go, and having access to advice at an organisational or at an individual level was critical in terms of making policies happen.

4.5.2 Encouraging culture change

Providing the right cultural context for rehabilitation was a regular theme of our discussions with organisations. Many organisations spoke about the need to create a good awareness and understanding about stress amongst managers and employees. This could involve challenging existing perceptions about what stress was, and effective ways of dealing with it.

Accurate reporting of stress, and encouraging employees to feel secure about admitting to feeling unable to cope, were also seen to be an important part of creating the right culture. Initially, this could often lead to an increase in reporting, but it also meant that issues could be identified and dealt with more effectively.

Part of creating the right culture also involved developing trust between all parties, and the careful handling of sensitive information.

4.5.3 Integrating rehabilitation and prevention

Several of the case study organisations emphasised that prevention was also an important part of the whole process. These organisations were actively combining rehabilitation with prevention in their approach to managing stress.

In some instances, this involved piloting the HSE's Management Standards for Work-related Stress. Other organisations talked about using risk-assessment approaches or stress and satisfaction surveys, to help them understand potential psychosocial hazards.

4.5.4 Evaluating rehabilitation practices

Very little existed in the way of formal outcome evaluation in the organisational case studies visited. To a great extent it was felt that this information was already known in terms of seeing the majority of cases successfully rehabilitated, seeing a reduction in sickness days, and seeing financial benefits, without the need to formally monitor this.

Qualitative and anecdotal feedback was very positive in virtually all case studies from both the policy makers and the policy implementers. Additionally, most individual employees we spoke to were categorical about the specific ways in which their rehabilitation had enabled them to return to work.

All case study organisations were clear about the factors in the process that contributed to successful rehabilitation. These varied from organisation to organisation, but can be summarised as:

Specific factors

- early referral for stress-related cases
- regular contact with the employee during their absence
- timing – not getting the person back to work before they are ready
- consultation with the individual in the development of the plan
- agreement to the plan between all the parties involved
- clarity about individual roles
- good communication between all parties involved in the process
- manager ownership of the rehabilitation process
- manager competency, and support where they are less experienced or confident in dealing with cases of stress
- monitoring of the plan
- flexibility in the process.

Generic factors

- promoting a clear understanding of stress and the rehabilitation policy
- sensitive management of information
- resources to cover the absent individual's work, maintained through the period of rehabilitation
- option to change jobs, or to redeploy the individual
- having a consistent approach
- commitment to rehabilitation at the most senior level in the organisation
- a positive industrial relations climate.

Equally, a number of practical threats to successful rehabilitation were identified. In many organisations, these had been learning points in the development of good practice in rehabilitation, and are summarised as follows:

Process barriers

- diagnosis – *ie* failing to get a clear understanding of the nature of the stress problem

- timing — trying to get people back too early or failing to respond when adjustments to a rehabilitation plan are needed
- communications — information not reaching all relevant stakeholders
- consistency of approach — practice ranging across the organisation
- resources — lack of appropriate backing to implement rehabilitation plans.

Cultural barriers

- trust — suspicion in the individual, manager or organisation as to the other's motives
- managers — reluctance in managers to tackle 'mental health' issues/lack of support or guidance for managers in this area
- employees — conflict between employee and organisational goals (*eg* where there is litigation)
- staff — resentment and lack of support from staff, particularly where a colleague's absence has implications for them.

5. Conclusions

This chapter summarises the general principles and approaches underlying the examples from the case studies. For each section, key questions for organisations are listed.

5.1 Summary of elements of best current practice

5.1.1 Early contact with the employee

When an employee first goes off sick, early contact is important both in terms of the evidence from literature, and practice in case study organisations. The principle that when an employee goes off with work-related stress they should be contacted within the first week of absence was applied in several of the organisations visited.

The purpose of this initial contact should be to offer general support and communicate the organisation's concern. It should not be to discuss interventions and treatments.

Questions for organisations:

- When is early? (day 1/week 1)
- Who should make contact? (line manager/HR/OH/ colleague)
 - Is this already covered by a general managing attendance policy?
 - Is the general policy appropriate for stress related cases?
- What guidance is available on the purpose and content of the initial contact?
- What support is available to the person making contact?
- What happens if the employee is not yet ready to talk to the organisation?

5.1.2 Early health assessment

Although there is no clear research evidence about the optimal timing of a health assessment for work-related stress, there was clear guidance from the experts contacted during the course of the

research. They concluded that by two weeks, it should be possible to tell if the individual will recover spontaneously, and by four weeks, the intervention or treatment should start with a referral to occupational health (or the equivalent) for a health assessment.

In practice, the organisations visited for the research showed considerable variation in their policies regarding referral for health assessment. In some instances, referral happened immediately, in others it happened when the individual reached a trigger-point level of absence. In one case, the organisation had reverted from a trigger-point referral (of three months) to a case by case decision, as it felt that having a trigger meant no referrals were made until the trigger point was reached. However, in certain cases it would clearly have been beneficial to refer an individual much earlier in the absence.

Questions for organisations:

- What is the current organisational practice regarding referral for health assessment in cases of work-related stress?
- Is immediate referral an option?
- If a trigger point is used, what is an appropriate length of time before referral?
 - Is timing covered by a general policy?
 - Is the timing of the general policy appropriate for work-related stress?
- If no trigger point is used, how should managers be advised on when to refer for a health assessment?

5.1.3 Quality of the health assessment

Evidence highlights the following points as key aspects of a quality health assessment:

- The assessment and diagnosis are accurate.
- The physician doing the assessment must be sympathetic and supportive.
- The referral for treatment or intervention after this must be appropriate and based on the identified need of the employee.
- Where both a GP and OH are involved in the assessment, there should be communication and information sharing between both parties.

Evidence from the case study organisations also highlighted other key elements to a quality health assessment. The main issue for organisations was the specificity of the diagnosis or assessment. Often, a medical certificate is received for 'stress' or 'work-related stress'. This provides organisations with little or no information as

to the cause of the problem, the nature of the problem, the likely duration, and appropriate interventions. Whilst these might be aspects of illness which are more difficult to determine in relation to mental rather than physical health, they are important pieces of information for any organisation trying to respond appropriately and supportively towards an employee. This is particularly the case when there is an indication that the illness is work-related.

Questions for organisations:

- Who is best placed to conduct the health assessment?
- Who is responsible for communicating with the GP or OH?
- What information is typically available from such an assessment?
 - Could an assessment for work-related stress be made more detailed?
- How will sensitive information about an employee be handled?

5.1.4 Developing an agreed rehabilitation plan

The central theme to emerge from this part of the research was the importance of employee involvement in a successful rehabilitation plan. This was clear from the research evidence and echoed very strongly by the case study organisations.

Research on effective rehabilitation highlighted the following points:

- The rehabilitation plan should be agreed by all stakeholders, but particularly the employee.
- The plan should be developed and initiated at the appropriate time for the employee, with regular reviews built in.
- Both employee and line manager must be committed to the plan and to a successful return.

Amongst the case study organisations, there were many variations in the way a rehabilitation plan was developed. Dependent on the individual, the nature of their problem, the job they normally do and their health, there was a lot of scope for the development of innovative and tailored rehabilitation plans.

Questions for organisations:

- Who has overall responsibility for initiating rehabilitation plans?
- Who has responsibility for discussing and agreeing the plan with the employee?

- If it's the line manager, what guidance or support is available to them in terms of options/scope/ideas *etc.*?
- Aside from the line manager and the employee, who else should/could be referred to?
- What preparation can be done in advance? (availability of different work options, specialist treatments *etc.*)
- How are reviews managed, and by whom?

5.1.5 Therapeutic interventions

There is growing evidence about the efficacy of a variety of therapeutic interventions. Virtually all organisations visited offered some form of therapy as part of their rehabilitation following stress-related illness.

Current evidence suggests that approaches based on cognitive behavioural therapy (CBT) are most effective in relation to work-related stress. However, the evidence also shows that other forms of therapy, such as counselling and psychotherapy, are more effective than no intervention.

Whilst there is growing evidence about the efficacy of therapy it is important for organisations to understand how best to implement and manage their use.

Questions for organisations:

- Is any form of psychological therapy currently offered? If so, in what circumstances and format?
- When should therapies be used?
- How long for?
- Who should be the provider?
- How will access to the appropriate types of counselling and counsellors be assured?
- How will the organisation promote the long-term use of strategies learnt through counselling?
- How will the organisation manage multiple forms of specialist treatment (if appropriate)?

5.1.6 Flexible return-to-work options

Flexibility about the return to work is a key factor in rehabilitation. It is generally recognised that workers who have been absent from work through illness will achieve their former functional level more quickly if they are allowed to return on a gradual basis.

Research has identified aspects of a phased return that can influence its effectiveness:

- the length of the gradual return (typically four to six weeks, but longer if required)
- the work conditions that are returned to (medical and ergonomic assessments of the individual and their duties are often carried out to ensure their suitability)
- payment (usually either full payment for a period of time, or individuals using remaining leave and flexi-time to cover their 'time off')
- the timing of the return to work (identifying the appropriate time for the individual to begin their return).

In addition to these points, a number of effective practices were highlighted by case study organisations:

- The plan should be designed to allow a gradual increase of tasks and hours as appropriate to the case.
- Sufficient resources and support need to be in place to ensure that the reduced tasks and hours actually occur.
- The plan needs constant monitoring to ensure that tasks and hours remain appropriate.
- The plan must be flexible and adjustable as necessary.
- The plan should run over a sufficient time period to allow the employee to recover (the length in question is not always apparent at the start).
- A wide range of options including for example, homeworking, should be considered when appropriate.

Questions for organisations:

- How flexible are current return-to-work plans?
- How is the decision about starting a return to work made?
- Who monitors the plan?
- How, and how often, is progress monitored?
- How are reviews or amendments decided?
- How does the organisation react to plans that are not working?

5.1.7 Work adaptations and adjustments

In principle, work adjustments are seen as a constructive and positive way of assisting an individual back to work. They regularly feature in the rehabilitation of individuals from occupational illness. However, in practice, such work adjustments have not been studied in relation to work-related stress.

There were clear examples of work adaptations in the actions of the case study organisations, and the organisations were clear about the success of these approaches. The adaptations included:

- changes to tasks or duties
- changes to the way work is managed
- additional training
- redeployment.

Questions for organisations:

- How, and at what stage, are work adaptations considered for an employee?
- What range of work adaptations is available?

5.2 Summary of elements of best practice in the management of rehabilitation

5.2.1 Written policy or guidelines

A written policy or set of guidelines describing organisational policies and procedures is often seen as a key element of best practice.

Such written documentation can come in a variety of formats, such as policies on rehabilitation in general, or specifically for stress, or as part of the sickness absence or managing attendance policy.

Most organisations researched here had several different policies which, in combination, covered aspects of rehabilitation following work-related stress.

The exact citing or presentation of a policy in this area will vary dependent on what is most appropriate for the organisation in which it is set. However, it is clear that in management terms, rehabilitation should not be treated as a disciplinary matter.

Questions for organisations:

- What policies currently cover rehabilitation following absence due to (work-related) stress?
- Based on practice in the case study organisations, are there gaps in current policies or guidance?
- Are management roles and responsibilities clearly defined?
- How are practices promoted and embedded within the organisation?

5.2.2 Overseeing the rehabilitation process

It quickly became apparent from the case study organisations, that rehabilitation following absence due to work-related stress can often be a complex business, involving a number of different stakeholders.

One overall approach to managing stakeholders and ensuring their appropriate involvement in the rehabilitation process, has been the development of the case-management approach. Although common in the co-ordination and delivery of a range of social health and rehabilitation services, it has only recently been considered in relation to rehabilitation following a period of absence due to work-related stress.

Only three case study organisations used what could be formally identified as a case-management approach. They found it to be effective in ensuring consistency of approach, bringing together expertise about options, strategies, and treatments in the rehabilitation plan, and providing support to those delivering the rehabilitation policy.

Questions for organisations:

- What are the procedures for managing the rehabilitation process?
- How are stakeholders identified?
- How are their roles clarified?
- What are the procedures for monitoring rehabilitation, and who should be involved?
- How are decisions made about adapting the plan as necessary, and calling again on input from stakeholders as appropriate?
- How are all the various roles and responsibilities integrated?

5.3 Stress and rehabilitation awareness in line managers

Effective stress management and rehabilitation were seen to depend heavily on managers being able to recognise problems in their staff, and take action accordingly. The importance of manager awareness was reiterated time and again by the case study organisations. Both manager awareness of the signs and symptoms of stress, and awareness of rehabilitation policies and the range of options available to help them manage those situations, was seen as critical. This was achieved in a number of ways:

- mandatory training on, for example, absence procedures
- stress awareness training

- policy documents and guidance
- employee information leaflets
- manager coaching (when dealing with stress-related cases)
- establishing working groups
- standing agenda items in manager meetings.

Questions for organisations:

- How is strategy on stress and rehabilitation promoted throughout the organisation?
- How is support made available to line managers to ensure that they are able to implement policies?

5.3.1 Monitoring sickness absence patterns

Monitoring sickness absence is not directly related to rehabilitation practice or its management. However, research evidence and case study practice alike, suggest that this is something that can sit alongside effective rehabilitation as a method of identifying and preventing other problems or cases. It has been proposed that this can be done both for long-term illness, and at a local level for patterns of short-term absence.

A variety of different methods for monitoring sickness absence were evident in the case study organisations. These practices allowed the case study organisations to achieve the following actions, believed to be important in minimising sick leave and supporting effective rehabilitation:

- early intervention when a case of 'stress' is identified
- early intervention following a high-risk or traumatic incident
- identification of causes of stress at an organisational or departmental level
- identification of causes of stress at an individual level
- monitoring of any particular problem areas or departments.

5.4 Generalisability of best practices

No single model of rehabilitation emerges from this research. It is clear that organisations use a wide range of strategies and techniques to effectively rehabilitate an employee following a period of absence due to work-related stress. These practices have developed on the basis of historical approaches within the organisation, analysis of particular needs, problems and priorities, and the culture of the organisation itself.

Having said that, two important findings from the research are that:

- Firstly, the majority of approaches outlined here are not organisationally specific. They can be applied in many different organisational contexts, and to many different groups of employees. They therefore offer scope for organisations to develop realistic and manageable rehabilitation practices to meet their own needs.
- Secondly, the experience of the organisations studied here shows that such approaches can be successfully developed in organisations using the techniques identified in this report in the section on the best practice of rehabilitation management.

The range of organisational settings studied and the wide variety of practices used, offer huge scope for organisations wanting to develop, or that are currently developing, their strategies for rehabilitation following absence due to work-related stress.

5.5 Specificity of best practice for work-related stress

The practices and policies used by the organisations are the same general approaches used for any occupational illness, *ie* organisations feel that these should be flexible enough to deal with work-related stress. Only one of the case study organisations (The Insurance Company) had specific practices that were intentionally different for rehabilitation following illness caused by work-related stress. However, there appear to be some ways in which the practices were actually implemented and managed that may be important factors in effective rehabilitation following stress-related illness, but which are not as important in rehabilitation from other occupational illnesses. These include:

- Recognising the symptoms of work-related stress (*ie* employees and managers can recognise other occupational injuries and illnesses more easily than the signs of stress).
- Early intervention where a stress case is identified. Unlike certain other occupational injuries or illnesses, there is no general period of recovery or prognosis for work-related stress. It is an area where the organisation's reaction to the situation can, in some cases, influence the prognosis and recovery time.
- The importance of an accurate assessment of the problem, the situation, and the individual's needs. Again, there is likely to be far more variety here than for some other areas of occupational illness where symptoms follow a more uniform pattern.
- The importance of providing a non-stressful environment on returning to work, *ie* supportive, with demands that the employee can cope with (underload may be as harmful as

overload), and allowing the employee to participate/have control over the situation.

- Recognising that the causes of stress can change over time. What caused the stress-related illness the first time may be addressed, but replaced by other stressors. Therefore, the return-to-work process probably needs more reviewing than for other occupational illnesses.
- More flexibility. The recovery from stress-related illness is likely to be less predictable and the certain than from other occupational illnesses. Therefore, timescales and possible duties may need to be more flexible, and should be reviewed regularly.

5.6 What SMEs can do

Clearly, SMEs will not have the access to the resources and support systems for rehabilitation and return to work that larger organisations do. However, the SME case study organisation included in our research, showed how they could still effectively rehabilitate an employee following stress-related illness without these resources. Some of the key factors included:

- openness and trust between the employee and employer
- flexibility, patience and support in the return-to-work plan
- providing the employee with reassurances and confidence building
- the employer knowing where to go for advice on what to do.

The SME case study also described some of the common barriers amongst SMEs to tackling stress-related issues. These are described below.

Most employers only think about how to manage the rehabilitation and return to work of an employee following absence due to work-related stress when it actually happens. The employer should be proactive, not reactive, in their approach to work-related stress. They need to think through how they would manage the situation in advance. If you haven't got a rough idea of what to do if someone goes off with stress-related ill-health, then it will be far more difficult to help them back effectively. SMEs need to give it some prior thought, but it doesn't need to be too complicated.

There needs to be sufficient understanding and awareness about stress amongst senior managers and owners of SMEs. There may be a lack of acceptance among SMEs that employees can become stressed (especially at the middle and lower levels). They need to recognise that even boredom can cause stress, not just high-powered decision making. It can hit anyone, and there are lots of things you can do about it.

The reasons for being proactive in this area need to be sold to SMEs in the right way. At the moment, there is an impression that stress is a negative thing, and that legislation is involved. This makes many managers want to avoid the whole issue. It was suggested that if stress management were sold in a more positive way, then people would see the benefits of addressing it. They will see it as a business improvement opportunity, a way of increasing people's job satisfaction and motivation.

5.7 Promoting rehabilitation for work-related stress

Rehabilitation for work-related stress has yet to enjoy the thorough research attention devoted to other areas of stress. It is clear that we cannot yet be definitive about certain aspects of rehabilitation as it relates to stress. Despite this, there is much that can be learnt from more general research on rehabilitation, and applied to cases of work-related stress.

In addition, it is clear from the evidence presented by the case study organisations, that a wide range of approaches and techniques are believed to be effective in combating work-related stress. The organisations studied here found that their practice resulted in:

- reducing the length of absence following a period of work-related stress
- getting the individual fit, healthy, and back to work
- preventing unnecessary or unwanted turnover
- identifying and tackling potential problems or issues on an organisational or departmental scale.

Overall, the findings offer a lot of scope for organisations wanting to develop or improve rehabilitation practices. Many different approaches have been identified, as have the policies underlying their effective implementation.

More important is the fact that many of these practices and approaches can be used in a wide range of organisational contexts, and with virtually all employees/jobs.

The exact configuration of practices and policies that will best suit organisations will depend on the culture of the organisation and its current level of activity in relation to rehabilitation. The range of activity documented here offers scope for most organisations, whether they wish to develop and initiate rehabilitation practice, or merely refine existing policies and procedures.

The overall message is that there is a lot that organisations can do to promote the effective rehabilitation of employees following absence due to work-related stress.

Appendix 1: Methodology

A1.1 Review of existing evidence

The first stage in the research process was to draw together existing information on practices for rehabilitating employees with ill-health stemming from work-related stress. The purpose of this review was to identify the range of existing rehabilitation practices, and the evidence for their effectiveness.

Three types of literature were examined in the review:

- literature published in academic journals
- articles in practitioner journals
- guidance and information from advisory bodies and rehabilitation practitioners.

Methods for searching the literature included: databases such as PsycINFO, BIDS, Ingenta, and Medline; a Web search for relevant national and international information; a search for literature and advice published by advisory bodies and rehabilitation practitioners such as the Employee Assistance Professionals Association, TUC, NHS Plus, and Rehab UK.

The full results of the review were written as an interim report. The results were used to inform the structure and content of the initial telephone interviews (Section A1.2.1) and the criteria for identifying examples of best practice in organisation (Section A1.3.1). Summaries of the existing evidence on aspects of best practice identified in the review are also described in Chapters 2 and 3 of this report.

A1.2 Identifying organisations with retention and rehabilitation practices

Three methods were used to identify examples of best practice within organisations:

- telephone interviews with occupational health practitioners within organisations, obtained from an established database

- interviews with experts and specialists to identify examples of best practice within organisations (both large and SMEs)
- interviews with occupational health service providers to identify examples of best practice in SMEs.

A1.2.1 Telephone interviews

Telephone interviews allowed a wide range of organisations to be sampled for possible inclusion in the case study stage of the research.

Interview sample

The interview sample was based on an existing database of 200 organisations. This database contained the names of occupational health nurses and doctors, working in organisations who have already been identified as having some form of rehabilitation policy. They all responded to a survey on rehabilitation practices conducted by IRS Research in 2002.

All of these organisations were sent a letter to inform them of the research, and to advise them that they may receive a telephone call asking for some more details about their organisation's retention and rehabilitation practices for employees following a period of ill-health stemming from work-related stress. They were given the option to opt-out of the research at this stage.

Following the removal of duplicates, and those who replied to say that they did not want to participate in the research, a sample of 140 organisations was obtained.

Semi-structured telephone interviews were then conducted with representatives of 75 organisations from the database. Interviews with the remaining organisations were not conducted, for a number of different reasons (including, the contact names and numbers on the database being incorrect, the organisational representatives being on leave or unable to be contacted on the telephone, or the representatives declining to participate).

The results of the telephone interview, were entered into a database to allow for the results to be compared effectively, so the examples of best practice could be selected for the case studies.

Interview content

The aim of these interviews was to obtain initial information about organisations' practices regarding rehabilitation for stress-related absence, including:

- organisational details, such as sector, workforce size and location

- aspects of the rehabilitation approach to stress-related illness, such as whether they have a written policy, when the employee is contacted about rehabilitation, what interventions and treatments are available
- which personnel are involved in the rehabilitation process (line managers, internal or external OH professionals, HR professionals, employee representatives, others), what are their respective roles, and at which stage do they become involved
- what return-to-work procedures the organisation offers
- the perceived effectiveness of the rehabilitation approach used, and basis for this perception
- the number of cases of stress-related ill-health in the last 12 months, the number of cases where an attempt was made to rehabilitate the employee concerned, and the number of cases where this was successful (subject to the availability of this data)
- an example of a specific case, including the nature of the ill-health suffered, the perceived cause, the rehabilitation received, and the outcome of the case.

A1.2.2 Interviews with experts and specialists

The aim of this stage of the methodology was twofold:

- to provide an additional opportunity to identify potential case study organisations
- to identify best practice criteria in retention and rehabilitation practices following stress-related illness.

Although the telephone interviews (section A1.2.1) allowed a wide range of organisations to be included within the initial sample, relying solely on this method may have excluded some important examples of current best practice. Therefore, we used an additional approach to identify best practice in rehabilitation after ill-health stemming from work-related stress, to compliment the telephone interviews from the database. This involved holding discussions with experts and specialists in the field of vocational rehabilitation and stress management, to identify organisations with examples of best practice.

The project's external advisors acted as a starting point for suggesting known experts, and the final list was agreed with the HSE. The experts were selected to include a range of representatives from rehabilitation practice, professional and employee organisations, and stress management practice. The following people participated in this stage of the research:

Table A1.1: Expert interviews conducted with:

Name	Organisation	Description
Christine Hunter	Parkside NHS Trust	Head of Occupational Health Services
Doreen Miller		Independent consultant
Dr Claire Welsh	Equilibrium Consulting	Chartered Consultant Psychologist
Dr Mike Orton	Independent consultant	Occupational Physician
Dr Noreen Tihrani	Independent consultant	Occupational psychiatrist
Dr Paul Litchfield	Currently at BT	Occupational Physician
Dr Sayed Khan	Currently at Rolls Royce; just appointed to EEF	Occupational Physician
Hugh Robertson	Unison	Head of Bargaining Support & Health & Safety
Jane Thomas	DWP	
Martin Jarrod	Organisational stress Audit	Consultant
Mike Waters	Whitmuir Management Consultants	Consultant
Owen Tudor	TUC	Senior policy officer
Pauline Crawford	Corporate Heart	Consultant
Pauline Henderson	DTI	

The experts and specialists were interviewed over the telephone and asked to:

- list those organisations that they believe demonstrate best practice in rehabilitation from ill-health stemming from work-related stress, and a description of their rehabilitation practices
- describe the criteria with which they would define best practice in this area.

A1.2.3 Interviews with OH service providers

The IRS database, used as the basis for the telephone interview sample, is mostly limited to large organisations. Therefore, in order to ensure the inclusion of some SME's, NHS Plus Suppliers and other suppliers of occupational health services to small business were also contacted. The following service providers were contacted:

Table A1.2: Supplier interviews were conducted with:

Judith Howard Rees	Gipping OH Management
Karen Shay	Corporate Health
Nick Nickson	Audio Medical Services

These service providers were asked to:

- list those organisations that they believe demonstrate best practice in rehabilitation from ill-health stemming from work-related stress, and, a description of their rehabilitation practices

- describe the criteria with which they would define best practice in this area.

A1.3 Selecting case study organisations

The key end product of this research was 12 best practice examples, as specified in the invitation to tender. It is our experience that, however extensive the preliminary screening process, not all the case studies will live up to expectations when subject to the scrutiny of detailed qualitative research. For this reason, we planned to conduct case studies in 15 organisations, with the objective of being able to report on at least 12 examples that we are confident represent best practice.

A1.3.1 Criteria for best practice

A set of criteria were developed to identify organisational best practice in job retention and vocational rehabilitation after a period of ill-health stemming from work-related stress. These criteria were based on information from:

- the review of existing rehabilitation practices, and the evidence for their effectiveness
- the interviews with experts and specialists on what constitutes best practice.

The best practice criteria from these two sources were refined and agreed by the project team and external advisors. The criteria were divided into core criteria (which had to be present for an organisation to be selected), and non-core criteria (which were seen as contributing to best practice, but not of central importance). They are described in more detail below.

Core criteria

Written return-to-work or rehabilitation policy: this policy can relate specifically to stress-related illness, or more generally to occupational illnesses as a whole. If it is part of the organisation's general sickness absence policy, it must indicate that rehabilitation is not treated as a disciplinary matter. This criterion should not be seen as core for SMEs.

Early contact with the employee: someone from the organisation should contact the employee within a week of them going off work, to offer general support, but they should not start to discuss interventions and treatments at this stage.

Early assessment for intervention: at around two weeks of illness, it should be possible to identify whether the employee will recover spontaneously, and at four weeks, the intervention should

start with a referral to occupational health services (or equivalent) for assessment.

Referral for treatment and intervention on the basis of the employee's needs: a qualified professional assesses the health and rehabilitation needs of the employee, and refers them for treatment or other interventions as appropriate.

Availability of counselling/therapy: take-up of this must be voluntary and based on an assessment of what the employee actually needs.

Review and adjustment of the employee's previous work role: the removal or reduction of any of the stressors that had a role in the employee's stress-related illness, should automatically be part of the rehabilitation process.

Flexible return-to-work options: the employee should be offered options such as a phased return, or a gradual reintroduction to duties or shifts.

Follow-up monitoring and assessment: someone should have the role of monitoring that the agreed rehabilitation plan happens, checking that the proper cover, support and adjustments are in place, and that the employee has follow-up assessments during and after their return to work as necessary.

GP involvement: the organisation should be engaged in a dialogue with the employee's GP, to ensure that the GP is aware of what treatment or intervention is being offered by the organisation, and vice versa.

Line manager involvement: the employee's line manager should be involved throughout the rehabilitation process, but particularly in the work-role review and adjustments, and the phased return options. There also needs to be an alternative approach to managing this, in case the line manager is part of the cause of the stress-related illness

Stress awareness training for line managers: so that line managers are able to recognise stress-related symptoms, and know how to manage employees with these symptoms.

Non-core criteria

Good awareness of return-to-work or rehabilitation policy: both line managers and employees need to be aware of the organisation's policy and procedures.

Monitoring sickness absence patterns: organisations should monitor absences to identify early intervention opportunities, where there are high incidences of stress-related absence, for example.

Developing an agreed rehabilitation plan: all stakeholders should meet to agree an action plan for a return to work.

A1.3.2 Choosing the case study organisations

The ITT required 12 case studies to be completed. It was decided to attempt 15 case studies to ensure this target was met. In the end a total of 14 case studies were used in preparation of the report.

The criteria described above were used to select organisations for the case studies that provided examples of best practice in retention and rehabilitation practices. The main approach to using these criteria was to identify those organisations that meet the highest number of criteria, based on their responses to the telephone interviews. However, by solely taking this approach, we felt that some interesting issues and innovative practices may be missed out. Therefore, we agreed to select ten organisations that clearly achieved the highest number of best practice criteria, and another five organisations that may not meet as many of the criteria, but which either have innovative approaches or that show some aspects of best practice in challenging contexts.

The aim was also to ensure diversity in the case studies identified. To this end, case studies were chosen to cover the following categories:

- public and private sector organisations
- some examples from SMEs
- some examples of organisations that employ people in occupations where there is a high incidence of work-related stress (*eg* teaching, social work, nursing)
- organisations from a range of geographical areas (including organisations from England, Scotland and Wales)
- both local authority-enforced organisations and HSE-enforced organisations.

Using these selection criteria and approaches, the project team and external advisors identified 15 organisations to be invited to participate in the detailed case study research. A further 13 organisations were identified as reserves, to be approached if any of the organisations declined to participate.

A1.4 Case study methods

In each of the case study organisations, the following methods were used to explore the organisational practices in job retention and vocational rehabilitation after a period of ill-health stemming from work-related stress.

A1.4.1 Policy and data review

Any policy documentation or organisational data relating to work-related stress, sickness absence, and rehabilitation, was collected from the organisation. This policy and data information helped us further appreciate the practices offered by the organisation, the extent of their use, and their effectiveness. As much of the following information as possible was collected:

- copies of written policies and guidelines relevant to rehabilitation and return to work following stress-related illness (*eg* policies on sickness absence, stress management, return to work, or health and safety)
- data on the number of spells or days of absence due to ill-health stemming from work-related stress, during 2000-2001 and 2001-2002
- data on the number of referrals of stress-related cases to occupational health services during 2000-2001 and 2001-2002
- data on the number of cases entering the rehabilitation/return-to-work programme during 2000-2001 and 2001-2002, and the outcomes of each case. Also, where possible, any of the following information for each case:
 - the employee's gender, age, ethnicity and grade
 - the nature of the employee's ill-health, and the length of absence prior to referral
 - the nature of the rehabilitation practices or interventions used with the employee (*eg* counselling, training, adjustments to work, changes to work schedule)
 - the length of the rehabilitation period (*ie* the time spent off work, and also engaged in different gradual return-to-work options)
 - where applicable, the length of time since the employee's successful return, and the length of any follow-up support and monitoring given to them.

A1.4.2 Interview on the organisational practices

In each case study, an interview was conducted with the senior occupational health or human resources professional who was most central to the organisation's practices. The aim of this interview was to discuss the overall approach and the detailed practices involved. The topics discussed included:

- why the policies or approaches were adopted and developed by the organisation
- the organisation's conceptualisation and understanding of stress

- how the formal policies are applied
- whether they fit into a wider context of OH practice
- the effectiveness of the attempts by the organisation to rehabilitate employees suffering from stress-related illness
- factors which influence that effectiveness, their assessments of the cost benefits.

A1.4.3 Case-related interviews

Each case study organisation was asked to identify at least one case of an employee who had been diagnosed with ill-health stemming from work-related stress, and who had successfully been through the rehabilitation process and subsequently returned to work. For each case, we sought to interview the employee concerned, to determine in detail their experience of how the organisation has dealt with their case. We also interviewed those involved in the individual employee's rehabilitation, for their experience of the rehabilitation process (*eg* OH professional, HR manager, line manager, trade union representative). Each case-related interview covered the following topics:

- the nature of the health problem and its perceived cause
- how it was originally assessed and by whom
- how a rehabilitation plan was agreed and put into practice
- the short and long-term outcomes of the rehabilitation, *ie* did they return to work, what work did they return to, how was the work altered to ensure that the health problems did not recur, how is their health and work now, what is the prognosis?

Appendix 2: Case Studies

In this Appendix, details of the case study organisations are summarised.

Table A2.1: Best practice in Stages and Management of Rehabilitation

	Agilent	AstraZeneca	Chemical Company	Devonport Dockyards	Doncaster Metropolitan Borough Council	Flintshire County Council	Frozen Food Manufacturer
Early contact with employee		✓	✓		✓	✓	✓
Who is responsible for initial contact?		Line manager took responsibility proactively	Regular contact Flexible system of responsibility		Line manager with OH support	Responsibility of line manager for regular contact	Within 3 weeks Moving from OH to line management
Early Health Ass		✓	✓	✓	✓	✓	✓
Timing of Health Ass		Line managers encourage early visit to OH	Line managers encourage early visit to OH	Assessment upon receipt of medical certificate	Referral to OH encouraged immediately	Immediate referral to OH	Referral to OH after 4 weeks of absence
Quality of health assessment							✓ OH found to be very accurate in assessment and supportive
Developing an agreed action plan	✓ All rehab plans developed by OH, employee & line manager Good communication with other departments				✓ Involvement of employee, OH, HR, line managers and GP		
Availability of therapeutic intervention						✓ Counselling	✓ Access to Cognitive Behavioural Therapist
Flexible RTW options	✓ Flexible RTW Cover provided during phased RTW				✓ Approx. 8 week phased return. Closely monitored and adapted		
Work adaptation and adjustment					✓ Varied work adjustments		✓ Redeployment

Table A2.1 (cont.): Best practice in Stages and Management of Rehabilitation

	Agilent	AstraZeneca	Chemical Company	Devonport Dockyards	Doncaster Metropolitan Borough Council	Flintshire County Council	Frozen Food Manufacturer
Written policy and guidelines			Established procedures for dealing with stress ✓		Stress Management at work and Employee well-being Scheme ✓	Stress policy ✓	
Overseeing the Rehab process	OH maintains contact (approx. every 2 weeks) ✓	Line managers conduct regular attendance reviews ✓		HR case work system ✓	Employee contacted periodically ✓	Line manager monitors RTW with support from OH and HR ✓	Case Management ✓
Integrating roles and responsibilities	Line Managers' role considered key ✓	Line manager takes lead ✓ OH acts in advisory capacity		OH acts in an advisory capacity ✓ HR and Line Manager take lead		OH leads ✓	OH facilities and case manages ✓
Stress awareness and line managers		Counselling and Life Management (CALM) Project ✓			Mandatory training ✓	Stress awareness training ✓	
Good awareness of RTW or rehab policy							Seen as key factor in successful rehabilitation ✓
Monitoring SA patterns							

Source: IES, 2003

Table A2.2: Best practice in Stages and Management of Rehabilitation

	Insurance Company	Lancashire Constabulary Central Division	MTM Products	North Tees & Hartlepool NHS Trust	Sandwell Healthcare NHS Trust	Sheffield City Council	Supermarket
Early contact with employee Who is responsible for initial contact?	Line manager with OH support ✓			Interview after 4 weeks Line manager & HR ✓			Store and Personnel Manager visited employee in first week ✓ Flexible System of responsibility
Early Health Ass Timing of Health Ass	Assessment with a Psychologist at 4 weeks ✓	OH notified immediately and mentioned to the Union and HR ✓		Flexible system dependant on individual needs ✓		Flexible approach taken dependant on individual needs ✓	
Quality of health assessment	Specialist psychologist available for longer or complex cases ✓		Depends on quality assessment and referral by GP ✓	Good communication between OH and GPs ✓	Good communication between OH and GPs ✓	Quick and appropriate referral by GP key factor in success of case study ✓	
Developing an agreed action plan			Good employer committed to employee ✓	Flexible rehab plans with variety of RTW options ✓		Graduated return Employee led Flexible approach Support from OH, HR, line manager, Union, Psychiatrist, individual ✓	Thorough & ongoing consultation with employee, OH, GP, line manager, HR, psychiatrist & counsellor ✓
Availability of therapeutic intervention	8 sessions with EAP ✓	Counselling ✓		Counselling ✓	Access to NHS Clinical Psychology Services ✓	6 counselling sessions ✓	
Flexible RTW options	Individually designed RTW plans ✓	Flexible and gradual RTW encouraged Range of options with RTW plan ✓	Support and monitoring given over an extended time period (12 months) ✓	Flexible RTW with monitoring and adaptations ✓		Approx. 6 week phased return Guidelines or phased return available ✓	

Table A2.2 (cont.): Best practice in Stages and Management of Rehabilitation

	Insurance Company	Lancashire Constabulary Central Division	MTM Products	North Tees & Hartlepool NHS Trust	Sandwell Healthcare NHS Trust	Sheffield City Council	Supermarket
Work adaptation and adjustment		Redeployment ✓				Variety of adaptations and support considered ✓	Adapted role ✓
Written policy and guidelines		Work-related Stress Policy Internal Stress Advisory Group ✓	Mental Health Policy ✓	RTW & rehab. policy Promotion of mental health and well-being ✓		Policies and guidelines available for managers and staff ✓	Rehabilitation Policy ✓
Overseeing the Rehab process	Case management ✓	Regular contact by line managers ✓		OH maintains contact (every 6 to 8 weeks) ✓		Regular contact by Line managers Ongoing support from OH ✓	OH produces RTW plan and HR monitors RTW ✓
Integrating roles and responsibilities	HR and Psychologist take lead ✓			OH acts as a liaison between stakeholders ✓		OH takes lead, but involves all stakeholders Line manager's role is key ✓	OH takes lead to develop RTW plan with Stakeholders Hands over to line manager ✓
Stress awareness and line managers	Information & training EAP coaches & manages ✓	Stress seen as an occupational hazard ✓	Stress awareness training ✓	Training and information for staff and managers ✓	Training Virtual Health Club ✓		
Good awareness of RTW or rehab policy						Seen as key factor in successful rehabilitation ✓	
Monitoring SA patterns		Stress Advisory Group to look at force level Stress statistics ✓			Sickness reduction target ✓		

Source: IES, 2003

Agilent Technologies — South Queensferry site

Sector: private, electronics and telecommunications

Size: 1,250 employees

Location: Scotland

Department/person responsible for practices: occupational health

Number of stress-related referrals: 29 employees have been absent for depression or stress during the last year, with a total absence of 772 days.

Main causes of stress: Research and development is quite a demanding type of work, and a major source of stress is a mismatch between personal resources (including skill level) and the demands of the job.

Organisational view of stress: Stress is seen as something that can affect all staff, not just senior management or high flyers but people doing lower-level jobs, with what would appear to be low pressure. Generally, there is a feeling that stress or depression is caused by a combination of work, personal factors and domestic circumstances. However, work may be key to recovery.

The rehabilitation and return-to-work policies

Absence reporting. Employees are required to telephone their line manager and the OH department.

Contacting the employee during absence. All contact is through the OH department, and employees are asked to come into OH every couple of weeks. Managers are not encouraged to call employees direct.

Establishing the cause of the ill-health. They concentrate on what can be done to get the person back to work, rather than establishing the cause.

Developing and agreeing a rehabilitation plan. Every plan is developed by occupational health, in discussion with the employee and the line manager.

The typical rehabilitation plan. This involves a phased return to work, for which work restriction forms are issued by OH to the line a manager. These detail suggested daily working hours, days of work, and other general restrictions. The work restrictions are reviewed and adjusted every couple of week, and a new form issued whenever an adjustment is made.

Monitoring the rehabilitation and return to work: The employee continues to meet up with the OH specialist (every couple of

weeks) and doctor (at longer intervals) throughout the rehabilitation and return-to-work period.

The policies and practices in context

The history and motivation behind the policies. The phased return to work was an informal approach used by some managers, and became an official policy to ensure that it was available to all staff. The approach has become established over the last ten years, although there is no written policy.

The approach's relationship to other rehabilitation policies. The rehabilitation process is the same for all causes of absence.

Other stress management policies:

- external EAP (provides counselling, financial advice *etc.*)
- time management courses, and a 'Dealing with Pressure' course
- health promotion (*eg* on-site gym, healthy options in the canteen).

The effectiveness of the rehabilitation policies and practices

Summary of outcome effectiveness. All 29 employees absent with depression or stress over the last year, have returned to work.

Example cases and outcomes. The employee worked in a technical laboratory. He became depressed, withdrawn, and lacking in confidence. He saw OH and his GP, started medication, but had continued to work. A couple of months later he had a panic attack on the way to work, and was signed off for three months by his GP. He started to return to work on a phased return over four months, but was not able to regain his confidence and was still not performing well. He was offered a transfer to another job. He recovered well after the transfer, and was back to full-time hours within a month.

Organisational factors influencing effectiveness:

- the support of the line manager and their involvement in the process
- flexible return-to-work plans that are regularly reviewed and adjusted
- having cover for the employee during the rehabilitation period
- sensitive management of information — asking permission from the employee before passing any confidential information on to the manager
- taking action at early stages, *ie* at the first indications of depression.

AstraZeneca

Sector: private, pharmaceuticals

Size: 10,000

Location: UK

Department/person responsible for practices: human resources

Number of stress-related referrals: It is estimated that 70 per cent of employees are experiencing stress.

Main causes of stress: Pressure to perform, and reduced autonomy.

Organisational view of stress: Recognised across the company as a problem. Official statements acknowledge the impact of work on employees' well-being. The culture is seen as very supportive of those suffering from stress, and the matter does not carry any stigma in the company, partly because all illness is seen to have a psychological and emotional component.

The rehabilitation and return-to-work policies

Absence reporting. Initially by telephone to the line manager.

Contacting the employee during absence. Line managers are expected to conduct 'attendance reviews' with the employee at least once a month. The purpose of these reviews, which take place either at work or in the employee's home, is to ensure that the employee is receiving adequate support, and that there is an up to date medical prognosis. HR may also be involved in these reviews.

Establishing the cause of the ill-health. Employees are assessed by their own GP and then, after four weeks, by the company's OH doctor. OH staff provide reports to line management.

Developing and agreeing a rehabilitation plan. HR co-ordinates discussion that involves line management and the employee. The discussion is usually by telephone, due to geographical distances. It is the line manager and the employee who must agree the rehabilitation plan, which is checked by OH. However, the OH role is an advisory one.

The typical rehabilitation plan. Solutions considered include: relocation, additional training, adjusting responsibilities/role, and reducing hours via a phased return if necessary. The normal procedure within the company is to rehabilitate the employee within 12 weeks.

Monitoring the rehabilitation and return to work. The monitoring of employees once they have returned is undertaken by the line manager. The line manager will have regular reviews

with the employee to assess how the rehabilitation is progressing, and will feedback to the HR manager.

The policies and practices in context

The history and motivation behind the policies. As a company whose business is health, AstraZeneca places high priority on having a healthy workforce, and so has for a long time integrated the management of health and safety into core management.

The approach's relationship to other rehabilitation policies. Stress is treated as part of the attendance policy. There is no separate policy on stress, since the company does not wish to isolate this problem from others. Instead, the approach is to be flexible to each individual case. An illness and rehabilitation policy had recently been finalised to cover all illness.

Other stress management policies:

- The main element is the Counselling and Life Management (CALM) programme; which provides literature and workshops on managing and handling stress.

The effectiveness of the rehabilitation policies and practices

Summary of outcome effectiveness. Figures are not kept on the number of successful cases.

Example cases and outcomes. The employee began to suffer from stress when family problems combined with a physical illness, came at a point at which work was being reorganised, and there was a temporary change in his line management. He went home after a breakdown at work. The GP prescribed medication and counselling. He also received support from his permanent line manager, the SHE department, and occupational health. His return to work involved a phased return to full duties, and regular meetings with the line manager and the SHE department. His rehabilitation is seen as successful.

Organisational factors influencing effectiveness:

- a good relationship between manager and employee, with regular contact between them from day one of the absence
- line management ownership of the rehabilitation. One person needs to manage the case, and needs to secure all the inputs of different parties. The line manager is the most appropriate person for this task
- a good relationship and regular contact between HR, line manager, and SHE department
- competent and experienced management
- the good faith of the individual.

The Chemical Company

Sector: private, chemicals

Size: 3,000

Location: Southeast England

Department/person responsible for practices: human resources

Number of stress-related referrals: In 2000, only eight cases, with only two of these actually taking sick leave; in 2001 there were only two cases, and only one of these resulted in sickness absence.

Main causes of stress: The nature of the work, and long working hours.

Organisational view of stress: The company is recognised as a potentially very stressful place to work, and so there are well-established procedures aimed particularly at prevention and early detection. The culture is 'not to be afraid of going to your line managers and reporting a problem with stress.' In addition, staff can choose to be allocated a mentor, who is an alternative port of call in the case of such problems.

The rehabilitation and return-to-work policies

Absence reporting. Individual notifies line manager.

Contacting the employee during absence. The process of who makes the first contact varies with each case. Contact is by telephone on a regular basis and may be undertaken by the HR department or line manager.

Developing and agreeing a rehabilitation plan. Agreement on the content of such plans may involve the individual, line management, HR, and advice from the OH team.

The typical rehabilitation plan. Plans vary according to the individual case. They may include a phased return to work, in-house or external counselling, and changed duties. Staff are generally on full pay throughout the rehabilitation period.

Monitoring the rehabilitation and return to work. This is undertaken by the OH doctor.

The policies and practices in context

The history and motivation behind the policies. The company sees its low levels of stress-related absence as resulting from early detection and prevention.

The approach's relationship to other rehabilitation policies. All staff have regular health assessments, and managers receive training in the detection of stress. The company also employs the services of an external advice and counselling company provides an EAP, counselling and training.

The company's approach to managing stress should also be set in the context of its work-life balance policies, which include access to flexible working arrangements.

The effectiveness of the rehabilitation policies and practices

Summary of outcome effectiveness. Data was not supplied on the number of staff successfully rehabilitated.

Summary of process effectiveness. There are very low rates of absence resulting from stress, which is seen as indicating the success of the preventative approach.

Example cases and outcomes. A member of staff whose job location and management arrangements were changed, resulting in separation from family, and reduced job satisfaction. He was diagnosed with depression and mental breakdown, and was absent for around six months. Initial contact was with the line manager, but HR took a lead in the case, maintaining regular contact with the absent employee. He was given the opportunity of independent counselling, which he took up, although he had to negotiate to have more sessions than the pre-determined minimum. His return to work involved a phased return and a change of job. The individual returned to work with full health and normal working conditions, and generally felt that he was treated well, apart from being left with the responsibility of arranging his own counselling.

Organisational factors influencing effectiveness:

- regular contact with the employee during absence
- medical advice on the return-to-work process.

Devonport Dockyards

Sector: private, engineering

Size: 4,500

Location: Southwest England

Department/person responsible for practices: occupational health and HR

Number of stress-related referrals: Around five cases were ongoing at the time of the research.

Main causes of stress: Pressures of a changing work environment.

Organisational view of stress: Seen as a problem that has only recently come out into the open in a traditionally 'macho' culture. Company growth and sense of job security over recent years is seen to have helped that change. However, it was unclear what impact more recent insecurity would have.

The rehabilitation and return-to-work policies

Absence reporting. The employee should contact their manager/supervisor within an hour of their normal start time on the day of absence.

Contacting the employee during absence. Initial contact, by letter from the HR department, is made two weeks into the absence. For the subsequent month, contact is made via telephone; after which a programme of home visits is established. A single member of the HR department is given responsibility for seeing the case through.

Establishing the cause of the ill-health. Initial assessment is by either a GP or OH doctor. For all long-term sickness, the OH doctor conducts own his assessment, which is supplied to the HR department and in some cases, the line manager.

Developing and agreeing a rehabilitation plan. These are agreed between HR, line or more senior management, and the employee. This may be in a single meeting, or if not appropriate, HR will liaise with the parties to reach a solution. Proposed solutions are passed to OH for comment.

The typical rehabilitation plan. This normally involves a phased return to work, starting from a minimum of 15 hours a week. Phased return may last between two weeks and six months. As long as the period of absence is shorter than six months, employees are paid throughout this period. Plans may also involve additional training, adjusted roles/responsibilities, and relocation.

Monitoring the rehabilitation and return to work. Monitoring of the return-to-work/rehabilitation process is undertaken by the HR professional who has been given responsibility for the case.

The policies and practices in context

The history and motivation behind the policies. Stress at work is seen as an emerging problem, with responses developing over time.

The approach's relationship to other rehabilitation policies. The approach is basically the same as for any long-term absence, in that solutions are adapted to the circumstances of the case.

Other stress management policies:

- The company has a welfare and counselling service provided by an external supplier.
- The supplier has conducted half-day training for line managers, in recognising and dealing with stress.

The effectiveness of the rehabilitation policies and practices

Summary of outcome effectiveness. Figures are not kept.

Summary of process effectiveness. This is felt to be 'generally successful'.

Example cases and outcomes. Problems started when the employee was moved to a new position. Pressures in the new post, combined with ongoing domestic problems, led to an initial period of absence of around three months. He was diagnosed as having 'anxiety and depression'. Rehabilitation involving plans for further induction and training was unsuccessful. A further period of absence followed. A second rehabilitation plan, developed with trade union involvement, involved a change of role and of line management, and has proved successful.

Organisational factors influencing effectiveness:

- line management understanding of, and support for, employees returning to work after stress-related absence
- the adoption by the HR and OH departments of an approach that is flexible to the needs of individual cases
- supportive and informed trade union representatives, who can help the employee to ensure that a rehabilitation plan is agreed and implemented
- being a large organisation that can offer a range of job roles to individuals who need to move jobs
- a dedicated OH function that is trusted by employees, and able to provide input into the rehabilitation plan.

Doncaster Metropolitan Borough Council

Sector: public sector, local authority

Size: 14,500

Location: North England

Department/person responsible for practices: Policy is determined by HR; individual cases are handled initially by line managers and by OH.

Number of stress-related referrals: 139 referrals to OH over a 12-month period.

Main causes of stress: Work was underway to determine this at the time of the research.

Organisational view of stress: Seen as a growing issue, with managers faced with an increasing number of cases. Policy refers to 'anxiety/nervous/depressive (stress)- related illness.

The rehabilitation and return-to-work policies

Absence reporting. The employee should contact their line manager who is expected to establish nature of illness and expected length of absence.

Contacting the employee during absence. The line manager should make contact 'in the early stages', but should seek the advice of OH. OH also contact the employee to arrange to see the individual.

Establishing the cause of the ill-health. Where stress is the stated reason for absence there should be a referral to OH no later than eight weeks after the first day of absence. The OH nurse may contact The GP for further information. A report is supplied to the line manager.

Developing and agreeing a rehabilitation plan. This is undertaken by the employee and OH, and may also include the involvement of line management and HR. The GP may also be consulted about the return to work.

The typical rehabilitation plan can include:

- a phased return to work (which may last up to eight weeks). Employees take leave to cover this period
- reduced hours on return
- retraining
- supervisory support

- reallocation of duties
- adjustments to the job
- temporary redeployment.

Monitoring the rehabilitation and return to work. This is a joint responsibility of the line manager and the OH department. There is an emphasis on flexibility to adjust to changing circumstances.

The policies and practices in context

The history and motivation behind the policies. Stress is one of the top five causes of sickness absence in the organisation. There are nationally-set standards for corporate health, and incidence of stress-related absence are included amongst best-value performance indicators. There is a long-standing rehabilitation strategy, but the organisation is now working towards a more proactive approach to dealing with work-related stress. This will involve use of a diagnostic tool to identify causes, in areas where stress is a particular problem. A stress task group, involving key stakeholders including trade union representatives, has been established.

The approach's relationship to other rehabilitation policies:

Other stress management policies include:

- stress policy as part of attendance policy
- stress management at work, and employee well-being scheme
- mandatory management training on managing attendance, includes session on stress
- other training for managers and employees on stress.

The effectiveness of the rehabilitation policies and practices

Summary of effectiveness. The managing attendance policy, of which the stress policy is part, is seen as having contributed to a reduction in the number of sickness absence days. No figures are available on the effectiveness of rehabilitation after stress-related absence.

Example cases and outcomes. Reorganisation led to changes in the employee's job and support structure, and the resulting pressure led to a stress-related absence of nine months. She received counselling during this period. Return (which was phased) was to a new post with fewer workload pressures. A second period of absence followed, when work stress was exacerbated by personal problems. The second rehabilitation phase included counselling and a move to part-time hours, following a phased return, and has been successful.

Organisational factors influencing effectiveness:

- ensuring appropriate timing of rehabilitation
- having an individual case manager
- having a flexible rehabilitation plan
- regular contact with the employee during the period of absence
- line management understanding of stress.

Flintshire County Council

Sector: public sector, local authority

Size: 7,000

Location: North Wales

Department/person responsible for practices: occupational health

Number of stress-related referrals: data not available.

Main causes of stress: bullying and harassment, interpersonal relationships, management style and workload.

Organisational view of stress: recognises that stress at work can cause anxiety, depression and other forms of psychological ill-health, and will take all reasonable steps to safeguard its employees against stress risks to health. It adopts a risk-assessment approach backed up by education, training, instruction and support systems.

The rehabilitation and return-to-work policies

Absence reporting. The employee contacts the supervisor/line manager within the first hour of the normal working pattern.

Contacting the employee during absence. Managers should make every effort to remain in regular contact with employees who are sick by telephone, letter and visit. The first contact should be made within the first three weeks of the absence.

Establishing the cause of the ill-health. Referrals to OH should occur straightaway if stress, anxiety or depression are on the medical certificate.

Developing and agreeing a rehabilitation plan. OH and the employee will consider a phased return to work, and this will be notified to the line manager.

The typical rehabilitation plan. This consists of a phased return to work with restrictions in work activities and/or reductions in working hours, normally over a four-week period. During this period, the employee is paid their normal wages. This can be extended with the agreement of the manager and the occupational physician. However, this will normally be achieved by the use of leave days, or by a negotiated temporary reduction in contracted hours.

Monitoring the rehabilitation and return to work. OH contacts the employee during the fourth week of the programme to ensure that there are no problems before the employee returns to normal duties. The line manager is expected to monitor the return to

work. The HR department can also get involved if it is a particularly difficult case.

The policies and practices in context

The history and motivation behind the policies. The current focus on the preventative approach aims to manage absence better by identifying and tackling problems early on.

Other stress management policies:

- risk assessments for stress.
- training courses: assessing and controlling organisational stress risks; managing stress; managing personal stress.
- psychological counselling service.

The effectiveness of the rehabilitation policies and practices

Summary of outcome effectiveness. No data available.

Summary of process effectiveness. The Council was unaware of cases where employees were not successfully rehabilitated or redeployed after work-related stress.

Example cases and outcomes. The employee was off sick with stress and depression for six months. OH referred her to a counsellor, and developed a phased return plan with the employee. The employee now feels 'in control' at work, although she still has 'bad days', as the original problem – bullying and harassment from a senior manager – has not been resolved.

Organisational factors influencing effectiveness:

- communication between all parties concerned (OH, line manager and employee)
- management commitment and a willingness to change
- the ability and resources to change the employee's job or offer redeployment options
- flexible approach, so the rehabilitation plan can be changed if it is not working
- managers understanding of stress.

Frozen Food Manufacturer

Sector: private, food manufacturing

Size: 500 on the site examined

Location: Southwest England

Department/person responsible for practices: occupational health

Number of stress-related referrals: 12 cases over the last two years, accounting for 242 days absence. A recent increase associated with redundancies.

Main causes of stress: Communication between managers and staff; management style; lack of control for those working on the production line.

Organisational view of stress: It is seen as something that could affect everyone in the organisation. Stress purely caused by work is thought to be quite rare in the organisation. More commonly, work aggravates someone who is already suffering from stress because of personal circumstances.

The rehabilitation and return-to-work policies

Absence reporting. Employees telephone an absence phone line on day one.

Contacting the employee during absence. OH write to the employee.

Establishing the cause of the ill-health. An OH health assessment is conducted. OH will provide a report to the line manager and the personnel representative identifying the employee's fitness for work. OH will ask for the employee's consent if it is necessary to speak to their GP.

Developing and agreeing a rehabilitation plan. A flexible plan is developed for the employee by the OH department, in conjunction with the line manager. The plan focuses on returning the employee to the highest level of fitness possible within an identified time plan, usually up to 12 weeks.

The typical rehabilitation plan. The recovery programme usually includes some or all of the following: reduced working hours; avoidance of certain tasks; avoidance of certain movements; training; or redeployment.

Monitoring the rehabilitation and return to work. Formal reviews take place at regular intervals, normally at four, 12 and 26 weeks.

The policies and practices in context

The history and motivation behind the policies. The current policies have been in place for many years. The absence management policies are likely to change in the near future as the company puts more onus on the line manager for absence management.

The approach's relationship to other rehabilitation policies. The same policy is used to deal with employees suffering from stress and other long-term absences. The policies are designed to be flexible, so that individual problems can be resolved within the policy framework.

Other stress management policies:

- welfare support
- cognitive behavioural therapist.

The effectiveness of the rehabilitation policies and practices

Summary of outcome effectiveness. Of the 12 cases, five employees were made redundant during phase one of the redundancy programme, two returned to work following a one week phased return, and five returned to work 'fit'.

Example cases and outcomes. The employee was originally signed off sick by his GP with 'malaise'. At his OH assessment, it was agreed that he was not ready to return to work, and another review meeting was arranged. A rehabilitation plan was developed that involved a return to limited duties, but focused on gaining redeployment as soon as possible. The employee was happy with the overall outcome, and the redeployment strategy worked. He was happy that the company was prepared to look at options for keeping him in employment. However, he does feel that some aspects of the rehabilitation plan could have been handled better, eg his return to work could have been more structured, and he would have preferred to return to his new job rather than the old job. OH felt that, although the outcome was successful, the line manager ideally should have spotted some of the signs before the employee went off sick.

Organisational factors influencing effectiveness:

- a proactive line manager taking responsibility for absence management
- a consistent approach that employees are aware of
- publicising the role of OH
- skilled OH staff co-ordinating the process and facilitating meetings
- a range of options to offer the employee for their return to work.

The Insurance Company

Sector: Private, finance

Size: 20,000 in the UK

Location: Spread across the UK with major offices in the Southeast and Northwest

Department/person responsible for practices: central HR team (developing a new initiative)

Number of stress-related referrals: very low, but this initiative deals with more difficult, longer-term cases. Referral tends to be prompted by a cry for help from local HR departments.

Main causes of stress: Varied, more often than not external to work.

Organisational view of stress: You cannot segregate work and non-work stress, therefore this approach deals with the whole person, regardless of the source of stress.

The rehabilitation and return-to-work policies

Absence reporting. No formal procedures at this level, the central team picks up longer-term cases (*eg* four weeks plus) where local initiatives haven't been able to deal with the stress problem. They also pick up some cases earlier when there is a specific request for help.

Contacting the employee during absence. This will be done initially at a local level by line managers. Once the absence has become long-term, or in instances where a case is recognised as likely to be serious from an early stage, the rehabilitation process will start with an assessment.

Establishing the cause of the ill-health. An initial assessment takes place with an external specialist psychologist. This includes identifying the perceived and potential causes of stress, psychological symptoms (measured using standardised tools such as the General Health Questionnaire (GHQ) and the Hospital Anxiety and Depression Scales (HADS) amongst others). The assessment will also include lifestyle issues such as diet, exercise, social support *etc.* The assessment will also consider job likes and dislikes and try to identify what would enable the person to feel able to go back to work. The approach used in assessment is very much one of the company being able to help if the individual wants to move forward.

Developing and agreeing a rehabilitation plan. As part of the assessment, a rehabilitation plan is discussed.

The typical rehabilitation plan. There is no typical rehabilitation plan. A plan is developed based entirely on where that individual is at the time. Where an individual is not ready to contemplate returning to work, the plan could consist of the following:

- get up at 8.30
- have a breakfast of 'X'
- do some form of exercise
- plan and prepare an evening meal.

The aim is to provide someone with the structure and discipline that going to work creates. In other cases a plan might be about a staged return to work, or it might cover going to the local library to investigate voluntary work as a stepping stone back to employment. The point is that whatever stage an individual is at, the rehabilitation plan will help them to structure their time and set achievable goals.

Monitoring the rehabilitation and return to work. Each plan specifies the roles of the individual, the manager and HR, and gives review dates. The central HR team and specialist psychologist also operate a form of case management where they will regularly meet to discuss cases and progress.

The policies and practices in context

The history and motivation behind the policies: Traditionally, this organisation has offered help via an EAP and employee counselling. This is a new approach to rehabilitation, designed to help provide support and resolution for the more difficult/longer-term cases.

The approach's relationship to other rehabilitation policies:

Other stress management policies:

- well-being policy
- training for managers in how to recognise the early warning signs for stress and what to do if they think an employee is suffering from stress.

The effectiveness of the rehabilitation policies and practices

Summary of outcome effectiveness. This is a new initiative and the effectiveness is currently being reviewed in terms of outcomes. Most rehabilitation provided under this programme co-ordinates existing resources, so is at no additional cost. The review of outcome effectiveness will take into account cost benefits and availability of resources to support the rehabilitation approach.

Summary of process effectiveness. Ongoing review of the processes has enabled a number of developments to the rehabilitation programme. This has included making responsibilities on rehabilitation plans more specific and recognising the difficulties managers sometimes face in dealing with stressed staff, and providing appropriate support and training.

Example cases and outcomes:

Organisational factors influencing effectiveness:

- proactive organisation which encourages individuals in following their rehabilitation plan.
- a wide range of return-to-work options (*eg* short days, short weeks, part-time, term-time).
- manager training in recognising the warning signs.
- manager coaching from the EAP on how to communicate or deal with distressed staff.
- unique, individually focused rehabilitation plans.
- flexibility over amending or adapting a plan as needs be.

Lancashire Constabulary Central Division

Sector: public, police

Size: 500

Location: Northwest England

Department/person responsible for practices: human resources

Number of stress-related referrals: Seven cases of stress-related absence at the time of the research.

Main causes of stress: Operational issues; traumatic nature of some of the work; poor management; employee grievance/discipline.

Organisational view of stress: Stress was traditionally viewed negatively. However, in the division concerned it is now seen as an issue which should be addressed quickly, to identify causes and prevent further cases. It is seen as a medical condition.

The rehabilitation and return-to-work policies

Absence reporting. The employee reports absence to their line manager, who then reports it to HR for recording on the HR system. HR monitors all cases of 28 days or longer. All absence relating to depression, stress or anxiety, must be reported to HR in writing by line managers immediately. HR then passes this information to the OH department.

Contacting the employee during absence. The attendance policy gives line managers responsibility for maintaining 'effective contact' with absent employees. A personal visit is the recommended method. However, in cases of stress, the appropriateness of this approach is monitored by the HR Adviser who may make home visits together with a union representative.

Establishing the cause of the ill-health. In cases of stress, referral to the OH department is as early as the first day of absence if stress is on the medical certificate. The OH department conducts a medical assessment.

Developing and agreeing a rehabilitation plan:

The typical rehabilitation plan. This includes temporary 'recuperative duties', which may include reduced hours, limited duties, change of work location, home working, or change of role. Alternatively, there may be a permanent move to 'restricted duties'. Both internal and external counselling is available. The return-to-work plan is drawn up by the HR adviser and employee, with their representative. Line management should identify recuperative opportunities. In some cases, line management takes the lead in drawing up plans.

Monitoring the rehabilitation and return to work. This is the responsibility of the line manager.

The policies and practices in context

The history and motivation behind the policies. There are nationally set targets for sickness absence in police forces. The stress policy was introduced in 1997, in recognition of the stressful nature of police work. The focus is on a risk-assessment approach to stress.

The approach's relationship to other rehabilitation policies. The approach is similar, but intervention is earlier in the case of absence resulting from stress.

Other stress management policies:

- the attendance policy
- the work-related stress policy
- internal and external counselling services.

In addition, there is a stress advisory panel and a case management approach to individual sickness cases, based on finding critical incident cases and tracking management responses.

The effectiveness of the rehabilitation policies and practices

Summary of outcome effectiveness. No data was provided on cases of successful rehabilitation.

Summary of process effectiveness. The range of policies and practices in relation to stress are seen as very effective, in that they have resulted in reductions in sickness absence levels.

Example cases and outcomes. An employee, after many years service, found the pressures of his role difficult to cope with. He was signed off work with clinical depression, returned to work for 12 months, and then was ill again. After the second period of absence, it was agreed that the return to work should involve a permanent change in duties. He also received counselling while absent and after his return to work. He successfully returned to work, but has had occasional recurrences in his illness.

Organisational factors influencing effectiveness:

- flexibility of return-to-work plan
- agreement of, and support from all parties to the plan
- an organisational culture that is understanding of work-related stress
- professional HR support to line managers
- union support for attendance policy.

MTM Products

Sector: private, light engineering

Size: 38

Location: Derbyshire

Department/person responsible for practices: director

Number of stress-related referrals: one

Organisational view of stress: being proactive about work-related stress is good business. It is part of the employer's commitment to its employees. The company's mental health policy aims to increase the effectiveness of the company by improving the quality of the working life of its employees, by supporting and encouraging them to achieve their potential and reducing the personal and organisational costs of mental ill-health.

The rehabilitation and return-to-work policies

Absence reporting. The employee contacts the line manager.

Contacting the employee during absence. This is done by the manager, by telephone or letter.

Establishing the cause of the ill-health. The employee's GP assesses their health. The manager and employee discuss work-related factors that may be involved.

Developing and agreeing a rehabilitation plan. This is done with the manager and employee, and a colleague if necessary.

The typical rehabilitation plan. A flexible approach is used with changes to hours and duties, which are reviewed and adjusted as necessary. External counselling is paid for if required.

Monitoring the rehabilitation and return to work. This involves regular monitoring by the manager.

The policies and practices in context

The history and motivation behind the policies. The policies developed from the director's interest in positive aspects of work, such as increasing motivation, flexible working and work-life balance. He felt it would be better to be proactive in this area rather than waiting for something to happen, and then having to deal with it in an unplanned way. The mental health policy is seen as one of a number of business improvements which attempt to balance the needs and aspirations of its employees with the needs of the business.

The effectiveness of the rehabilitation policies and practices

Summary of outcome effectiveness. The one case that the company has had, ended with a successful return to work.

Summary of process effectiveness. When they actually had to put the policy into practice, it did go to plan, and he believes the approach (*ie* a sympathetic/flexible one) was right. However, it did take considerably longer than they expected.

Example cases and outcomes. The employee went off work for three months with depression, which was partly due to work-related stress. The initial return-to-work plan involved modifying the employee's role to remove managerial responsibilities. A schedule for increasing the employee's hours and managerial duties was agreed. On returning, the employee had very low confidence, so the increase in hours and duties took much longer than originally planned. Eventually, the employee was redeployed to a less intense management role to assist with the ongoing rehabilitation. The employee is now happy in this new role. The whole rehabilitation process will have taken 12 months, during which the employee was paid a full-time salary.

Organisational factors influencing effectiveness:

- having a detailed discussion between the employee and manager
- accepting that the company wanted the employee back, and the employee wanted to return
- both the employee and employer being patient and supportive
- providing the employee with reassurances and confidence building
- both employee and employer accepting that there was a problem and not dodging it
- the employer knowing where to go for advice on what to do.

North Tees and Hartlepool NHS Trust

Sector: public

Size: 4,800

Location: Northeast England

Department/person responsible for practices: occupational health

Number of stress-related referrals: (based on data applying to 60 per cent of the workforce) there were 245 mental health case referrals to OH in 2000/01, and 287 in 2001/02.

Main causes of stress: change and pressure at work; personal circumstances.

Organisational view of stress: This has been changing in recent years, and is now seen as an issue which needs to be dealt with. A 'promotion of good mental health and well-being of staff' policy was introduced in 2002.

The rehabilitation and return-to-work policies

Absence reporting. Stress-related absence is treated in the same way as other absences, which must be reported to the line manager and certified if eight days or longer.

Contacting the employee during absence. An interview should be arranged with the employee after four weeks of absence. This is conducted by line management, with HR support. There should also be 'regular' reviews of the situation.

Establishing the cause of the ill-health. Following referral by a line manager, the OH department contacts the employee's GP, subject to the employee's consent. Following this, the OH department interviews the individual. A pilot scheme was providing for automatic OH referral after four weeks.

Developing and agreeing a rehabilitation plan. This must be agreed by the employee, their line manager, occupational health, and the employee's doctor.

The typical rehabilitation plan. The plan may include flexible return-to-work options, a review of the employee's previous role and duties, and additional training. Phased return to work is normally over a four week period, and is on full pay.

Monitoring the rehabilitation and return to work. This is the responsibility of line management. If this does not work, the employee has redress to OH.

The policies and practices in context

The history and motivation behind the policies. The organisation has been subject to a merger in recent years. The sickness absence and rehabilitation policies in place had been developed for one of the organisations, which were merged to produce the current Trust. At the time of the research, the policies were being brought together under a 'Health at Work Framework'. There was also a Promotion of Good Mental Health and Staff well-being policy, which sets out the principles of the Trust's approach.

The approach's relationship to other rehabilitation policies. The broad approach is the same for all long-term absence.

Other stress management policies:

- staff leaflets on stress
- management training on managing sickness absence, which includes guidance on how to identify factors that cause stress
- staff counselling service.

The effectiveness of the rehabilitation policies and practices

Summary of outcome effectiveness. No data was supplied.

Summary of process effectiveness. Processes and practices were seen as effective by all those interviewed, but no data was available.

Example cases and outcomes. An employee with long service in the NHS. She was off work for two years, and was diagnosed with depression resulting from a combination of work and domestic factors. Her initial return to work involved a phased return to a more supportive environment, with a 'link' person providing specific help. She became ill again after six months. After a further period of absence, medical advice was that she was fit to return, and a return-to-work plan was agreed, however she never returned.

Organisational factors influencing effectiveness:

- senior line management support for procedures
- organisational, departmental and team support for the employee
- organisational commitment to rehabilitation
- line management workload and ability to accommodate the employee's needs
- line management understanding of the issue
- early contact and diagnosis
- partnership approach to the development of a return-to-work plan.

The Supermarket

Sector: retail

Size: 300, in the store studied

Location: Southeast England

Department/person responsible for practices: occupational health.

Number of stress-related referrals: Few in the past. Eight cases in the six months prior to the research.

Main causes of stress: Combination of work and domestic factors.

Organisational view of stress: Stress is seen as a 'genuine illness'.

The rehabilitation and return-to-work policies

Absence reporting. Absent employees call the store, and their absence is reported to the store manager. Any absences of four weeks or longer are reported to the company OH department, which decides on the action to be taken.

Contacting the employee during absence. In cases of stress-related absence, the personnel officer prefers a colleague to make initial contact and encourage the employee to come to the store for an informal meeting. However, line managers, personnel and OH may all make home visits.

Establishing the cause of ill-health. This is done by the OH adviser.

Developing and agreeing a rehabilitation plan. The OH Adviser draws up the rehabilitation plan in discussion with medical advisers, including the GP and any counsellor, and the individual. OH also liaises with line management and personnel.

The typical rehabilitation plan. This includes reduced hours, flexible working and changed duties.

Monitoring the rehabilitation and return to work. This is formally the role of the personnel manager and is based on the written plan supplied by OH. OH become involved if the plan does not work, or requires change.

The policies and practices in context

The history and motivation behind the policies.

The approach's relationship to other rehabilitation policies. There is no separate stress policy and in procedural terms, stress-related absence is treated in the same way as absence due to any

other illness or injury. The main policies that apply are the absence management policy, the sickness policy, and the rehabilitation policy. The company OH department plays an important role in supporting both employee and manager, and providing in-store training.

The effectiveness of the rehabilitation policies and practices

Summary of outcome effectiveness. No data was supplied.

Summary of process effectiveness. No data was supplied.

Example cases and outcomes. An employee who was diagnosed with depression following personal problems. He remained in work, but work problems exacerbated his condition and he was then absent for six months. He received counselling which he paid for himself, and was regularly contacted by his line manager, the personnel officer and the OH adviser. His rehabilitation plan involved an end to shift work, and different duties for a limited period. His return to work was phased over three weeks and was successful.

Organisational factors influencing effectiveness:

- awareness and agreement of the parties to the return-to-work plan
- timing of the return to work
- independence of the OH department
- contact with the employee during absence
- line management and other employee understanding of the nature of stress.

Sandwell Healthcare Trust

Sector: public, health

Size: 7,000

Location: West Midlands

Department/Person Responsible for Practices: occupational health and HR

Number of stress-related referrals: Referrals to the psychology and counselling service to occupational health for 2001/02 was 121.

Main causes of stress: Of the counselling service referrals, 73 provided data on causes of stress. Approximately half of these referrals to the counselling service were work related, the main category being work and professional support problems.

Organisational view of stress: Stress is seen as one of the biggest factors in sickness absence and is treated very seriously. There are clear procedures in place for referral to occupational health whether absence is short or long-term. This Trust was recently formed through the merger of two smaller Trusts. Procedures in both Trusts had been in place over a number of years and are currently being harmonised across the new organisation.

The rehabilitation and return-to-work policies

Absence reporting. There is a robust absence reporting procedure. In the case of short-term absence, this is followed by a return-to-work interview with the line manager and depending on the case, a referral to OH if appropriate. For longer-term absences (*ie* four weeks or more) the rehabilitation procedure is followed. This is described below.

Contacting the employee during absence. Initial contact is via the line manager with a referral to OH at four weeks. OH will then invite the individual in for an assessment.

Establishing the cause of the ill-health. The OH assessment focuses on identifying the causes of the problem. This can involve the use of standardised psychological measures of symptoms, and counselling.

Developing and agreeing a rehabilitation plan. The rehabilitation plan is agreed between the individual, the line manager and OH. In some cases the union rep can be involved as well.

The typical rehabilitation plan: Individuals are assessed on a case by case basis and plans are developed to suit the individual's needs. Common features include the use of placements where

appropriate, and a register of placements is kept. Placements vary in length, but in general last between four and eight weeks. In addition, staged returns to work are used and there is scope for re-training where appropriate. In addition to the counselling service, there is a virtual health and fitness club which runs health promotions. This can contribute to rehabilitation by offering lifestyle advice and developing individual fitness programmes.

Monitoring the rehabilitation and return to work. The Trust operates a case management system with roles clearly defined for the line manager, divisional HR managers and OH in each rehabilitation plan. The HR director is responsible for the overall sickness absence management procedure and its monitoring. Each rehabilitation plan will involve regular review dates and can be changed or adapted as required.

The policies and practices in context

The history and motivation behind the policies: The Trust has a long history of stress management and rehabilitation, although these varied across the two hospitals making up the new Trust. These are now being harmonised with elements of best practice drawn from each Trust. Emphasis on stress and rehabilitation has grown over the last few years, and the Trust has year on year sickness reduction targets.

The approach's relationship to other rehabilitation policies:

- in addition to the rehabilitation policy the Trust has robust absence reporting practices.
- there is also clear guidance on competency procedures.
- mandatory training is offered in handling violence and aggression in the workplace.
- training for managers is available in managing change.

The effectiveness of the rehabilitation policies and practices

Summary of outcome effectiveness. Generally speaking, the procedure works well, and if the process has been well handled and properly managed then nine times out of ten there will be a successful outcome. If the rehabilitation process does not result in a successful return to work then the process is reviewed and any lessons identified.

Summary of process effectiveness. Given the recent merger of two smaller Trusts, the rehabilitation processes are currently being harmonised. This is an opportunity to review and improve upon practice and also to establish practice more firmly through promotion of the new policies.

Example cases and outcomes:

Organisational factors influencing effectiveness:

- robust sickness reporting.
- rapid referral to occupational health if stress related problems identified.
- good liaison between OH, HR, the individual and the line manager in developing and monitoring the plan.
- flexibility to amend the plan as required.
- support for managers in dealing with staff who are experiencing stress.

Sheffield City Council

Sector: public sector, local authority

Size: 19,000 employees

Location: South Yorkshire

Department/person responsible for practices: corporate occupational health and safety service and a network of occupational health nurses.

Number of stress-related referrals: During the period April to December 2002 (incl.) of the 760 employees that were referred to occupational health by a Manager 271 people had psychological health problems. These problems included stress, anxiety, depression, substance misuse issues and other mental health conditions.

Main causes of stress: workload, change, management style, type of work and higher-pressure characteristics for specific groups (*eg* social workers)

Organisational view of stress: guiding principle is that good management is the foundation of stress management. They emphasise the central role of the line manager throughout all of their policies, practices and guidance.

The rehabilitation and return-to-work policies

Absence reporting. The employee should notify their manager that they are ill. If work-related stress is involved, it should be identified by the line manager through their contact with the employee or through the medical certificate.

Contacting the employee during absence. The line managers will contact the employee during their absence. The OH nurse will also contact them if appropriate.

Establishing the cause of the ill-health. There is no set trigger point for an OH referral, the line manager must actively decide when OH are needed. Health assessments are conducted by an OH nurse or physician, they will also get information from the GP.

Developing and agreeing a rehabilitation plan. This is focused on the manager and the employee, with support from OH as required.

The typical rehabilitation plan. Counselling can be arranged via the OH department. A phased return to work is always discussed, and tends to involve the gradual return of duties and hours over a period of six weeks, but possibly longer. There is no set

programme because so many factors are involved, but it will be discussed and agreed by the manager, employee and OH nurse. The manager and employee are encouraged to identify any training needs.

Monitoring the rehabilitation and return to work. OH see the employee during their phased return, and before their full return to work. The employee is encouraged to contact OH if they experience any problems. The manager monitors the return-to-work process day-to-day.

The policies and practices in context

The history and motivation behind the policies. The current approach was first formed 15-20 years ago. The philosophy and motivation behind the policies then was to do things for the good of the employee. Now, the focus would be more to do things for the benefit of the organisation than the employee. However, over time, the approach has proved to be good for the business too, so although the philosophy behind organisational practices has become more service-oriented, the policies have remained similar.

The approach's relationship to other rehabilitation policies. The approach to rehabilitation following work-related stress illness is the same as that for other illnesses. The general procedures are the same, but the flexibility is built into them to allow the detailed practices to be based on the need for each case.

Other management policies that support the stress strategy:

- work-life balance and flexible work options
- employee development
- policy on harassment, discrimination, victimisation and bullying
- critical incident stress debriefing
- counselling via occupational health
- management development programme to address the importance of good management.

The effectiveness of the rehabilitation policies and practices

Summary of outcome effectiveness. No data available on success rates, but the perception is that they are increasingly successful.

Summary of process effectiveness. It would be difficult to assess the effectiveness of the manager-driven aspect of the process, as this would not show up in the figures, but anecdotally and logically they feel this is the best way to go. There has been no negative feedback on the rehabilitation practices from OH nurses

or HR. They feel that they have tackled the stigma of mental health and stress-related problems.

Example cases and outcomes:

1. A member of staff in a secondary school was absent for 15 months, diagnosed with anxiety. He was referred to a psychiatrist for treatment at the local hospital. After a 12 week flexible return-to-work programme, he successfully returned to his original role. He has now been back for nine months, five of these on a full-time basis, with his team leader responsibilities restored. The employee and line manager both feel that the rehabilitation was very successful. Since his return, the line manager feels that he has contributed more than ever to the school.
2. A manager from the housing directorate. He was absent for three months with stress and anxiety. He successfully returned to a different job, which he applied for internally. The employee has been back in a new post for eight months and feels fine. He enjoys what he is doing, has a good team and a supportive manager. The OH agreed that he sounded very positive when she spoke to him after his return.
3. Manager from the housing directorate. He took leave from work for three weeks with acute anxiety and depression. Successfully returned to his original role. He feels that the support he received was very good at getting him back to work. The OH nurse said that there had been a tremendous turn around. He had used the skills he'd learnt in the counselling to help him through various periods of change. He also advises other people now, through his work with his trade union.

Organisational factors influencing effectiveness:

- commitment from the employee and the manager
- a joint venture, with support from all sides (HR, TU, OH)
- appropriate care from the health service and quick referral
- an openness and ability to discuss the matters involved
- reflecting on the nature of the work – recognising when the work is not 'right' for them, and that the best solution would be to look for a different job
- regular contact and home visits with the line manager and OH nurse
- a well-designed phased return plan
- the supportive working environment to return to
- the manager's awareness of mental health issues, and appreciation of the issues and how much time was needed
- a good relationship between the employee and the OH nurse.

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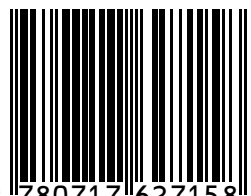
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