Returning to work

The role of depression

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Mental Health Foundation

Foreword

Hundreds of businesses up and down the country are losing employees every month because they have not been able to return to work after depression. This is a tragedy for the individual and their family, but it is also bad business. Negative consequences for business include loss of skills, recruitment costs, lower staff morale and even successful legal claims or increased insurance costs. Yet there is plenty of good practice out there that employers can learn from, and at the Mental Health Foundation we know of many employers, that have shown a commitment to improving their performance in this area.

This ground-breaking study brings together data from a variety of sources and I would like to commend the authors on their commitment and skill. It also looks at the important issue of return to work after physical illness where there is concurrent mild to moderate depression. It is sad that many employers can deal better with life threatening and frightening illnesses like cancer than mild to moderate depression, presumably because of stigma and lack of information. A number of key lessons flow from the research as well as pointers to further research. It is not that many managers are unwilling to help or wish to let depressed colleagues go, often they simply lack the knowledge or skills required to help. Similarly employees themselves may lack the confidence to seek help or explain the problem.

Whilst the need for change is clear, this report is not about knocking employers or expecting them to become psychiatric nurses. But it does provide a timely stimulus to better training for managers and clear and consistent policies and procedures from HR. A manager who can deal with a staff member's return to work after depression is likely to be good at many other management tasks as well – depression is sadly part of life and generally has clearly explicable causes such as relationship problems and bereavement which are part of the lives of every workforce and community. With hundreds of thousands of people on incapacity benefit with depression, many of them unnecessarily condemned to long term unemployment, the social and economic benefits of managing this issue better are immense.

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Contents

1. Background

The purpose of this study was to examine the role of depression in returning to work after a period of sickness absence. There is now strong evidence to suggest that the presence of depressive symptoms plays a significant role in return to work outcomes for a range of illnesses.[1] However, a limited number of studies have examined the effects of depression upon returning to work. These suggest that those with depression and anxiety returning to work still present with levels of depressive symptoms that may affect work and well-being. There is also growing evidence to suggest that those with physical illnesses such as heart disease, back pain or cancer may present with mild to moderate symptoms of depression.[2, 3] This can also affect their work and well-being upon returning to work after long term sickness absence.

Sickness absence

Sickness absence is a major public health and economic problem. Evidence suggests that 28.4 million working days per annum are lost due to ill-health and most long term sickness absence is due to mental health problems such as stress, depression and anxiety.[4] It is well documented that depression and anxiety are associated with work stress and are one of the most prevalent causes of work-related ill-health and of working days lost through work-related injury or ill-health.[4] However, depression and anxiety are also important features associated with absence in combination with medical complaints such as back pain, heart disease and cancer.[5, 6] The consequences of depression, both as a primary illness and in association with chronic illnesses, are well-documented for sickness absence. These can include psychological distress, poor self-esteem, poor self-management (e.g. not adhering to prescribed medication), fear of returning to work, disturbed relations with colleagues and superiors and possible job loss.

There are numerous organisational, health, rehabilitation and other initiatives designed to improve workers' health and attendance at work. These include the identification of physical and psychological processes for return to work, interventions to improve absenteeism and the identification of barriers and facilitators for successful return to work. The outcome of these studies has not only advanced knowledge and understanding of sickness absence, but also improved return to work outcomes. However, a number of studies have highlighted the poor knowledge that exists concerning the effects of depression and depressive symptoms following return to work.[7] There are currently no accurate return to work figures following long term sickness absence for depression and anxiety, although statistics suggest that 13% are in employment, compared with 33% of people with other chronic illnesses.[8] Furthermore, for those returning to work little is known about the effectiveness of intervention strategies put in place to facilitate adjustment to work and work performance. These can range from measures to reduce workplace stressors and provision of support aimed at helping employees recover from illness.[9]

The extent to which employees successfully adapt back into their job roles and manage their symptoms following return to work remains unclear. Those with depression and anxiety may not only return with levels of depressive symptoms but with poor coping skills, low self-esteem, a reliance on medication, poor self-management (e.g. not utilising available workplace support such as occupational health service and counselling), poor working relationships, low motivation and low job satisfaction.[7, 1] If appropriate intervention strategies are not offered upon returning to work, such individuals' ability to work effectively may continue to be impaired leading to a 'relapse' in sickness absence, early retirement or unemployment.

For those with chronic illnesses, the concerns following return to work are not dissimilar for those experiencing depression and anxiety. For physical illnesses such as heart disease, back pain and cancer, over half of workers go back to work and it is estimated that about 20% of these may take early retirement within 12 months.[10, 11] Regaining work after a period of sickness absence is not always followed by full work recovery and a significant proportion report being moved to a different job, earning less, having less responsibility and control over their work or reporting that their illness has damaged their work capacity.[10, 2] However, the psychological and social consequences following return to work within these illness groups have not been fully examined.

Depression, chronic illness and returning back to work

In order to understand the role and risk of depression in the workplace upon returning to work some of the modifiable and non-modifiable risks associated with depression are reviewed in this section. In addition, a distinction between work-related and non work-related risks is also discussed.

Non-work-related risk factors

Depression and anxiety are reported to be the most common mental health problems affecting 20 per cent of the UK working population.[12] Approximately half of those reporting depression also report symptoms of lifetime anxiety.[13] According to the Work Life Balance Centre survey, more than a quarter of employees report experiencing anxiety or panic attacks during any one year.[14] Non-modifiable risk factors for depression include genetics, female gender, poor parenting, history of abuse or trauma, certain personality traits, early onset anxiety and previous episodes of major depression.[15] Modifiable risk factors are largely psychosocial and include poverty, education and access to healthcare,[16] as well as substance misuse, low self-esteem, low self-efficacy, social stigma and low social support.[17]

A number of studies suggest that individuals developing or managing a chronic illness are at relatively more risk of depression than physically healthy people. In particular, the odds for developing depression are increased for patients with cancer,[18] back pain[19] and heart disease.[20] Below, a brief overview of the illness, symptoms and the link to depression are presented:

- **Cancer** is one of the fastest growing illnesses affecting the UK working population. Approximately 1 in 3 people in the UK receive a new cancer diagnosis each year [Cancer Research UK]. Advances in cancer treatments have led to an increase in the number of people surviving the disease, and many continue or resume their everyday lives, including their working lives. Therefore cancer is increasingly seen as a chronic, rather than terminal illness that requires lifestyle management. The most common cancers for men include lung, prostate, and bowel cancer. For women, common cancers include breast, bowel, lung and ovarian. Cancer treatments range from surgery, radiotherapy, chemotherapy and hormone therapy and will depend on the type of cancer, its location and size. Depression is a common experience among cancer patients and studies report that major depression affects approximately 25% of cancer patients. Factors associated with depression are physical disability, changes in body image, physical symptoms, treatment and the long-term effects of treatment such as fatigue. It has been estimated that 40% to 60% of patient's emotional distress is directly related to the cancer treatment itself.[21] Psychosocial factors such as poor coping skills have also been associated with depression.[22] At the time of writing, the authors are unaware of any studies that explore the link between cancer, depression and return to work outcomes.
- **Back pain** is one of the leading causes of musculoskeletal disorders and occurs in a substantial proportion of the working population. The risk factors for back pain include male gender, older age and manual work. Although a clear relationship between physical jobs and reports of back pain has been shown over the years, research suggests that for approximately 85% of all back pain cases, particularly low back pain, there is no specific evidence of injury.[23] Most back symptoms are of spontaneous and gradual onset, without a specific accident or unusual activity. For this reason, work-related causes of back pain have been largely attributed to psychosocial work factors. Individual factors also play a significant role in prolonging back pain or injury. For example, perceived pain and pain-related fears; incorrect belief about the nature of back pain, poor coping strategies; low expectancies about recovery and low confidence in carrying out physical activities such as sports, exercise and work due to back pain[24]. This leads to a downward physical and emotional spiral and as the spiral continues, the person with chronic back pain feels an increasing loss of control over his or her life. Under these circumstances, depression can occur.[19] Depression is by far the most common condition associated with chronic back pain, yet only a handful of studies have investigated the relationship between these conditions in the general population.[24]
- **Coronary heart disease (CHD)** is a preventable disease that kills more than 110,000 people in the UK every year. More than 1.4 million people suffer from angina and 275,000 people have a heart attack annually [Department of Health]. Non-modifiable risk factors for CHD are increasing age, male gender and heredity. Modifiable risk factors include smoking, high blood pressure, physical inactivity, obesity, being overweight and stress.[25] Depression is a major risk factor for the development and progression of CHD.[25] However, depression can also occur after heart disease and/or heart surgery. Studies of heart disease and depression have found that people with heart disease were more likely to suffer from depression than otherwise healthy people.[26] The interrelationship between heart disease and depression is complex and much further research is required in this area.

Evidence suggests that co-morbidity of depression can exaggerate reactions to illness symptoms and decrease motivation to care for, and reduce the capacities to cope with the symptoms of, chronic illness.[27] For example, patients who are depressed are less likely to adhere to their medication and other illness-related self-managing regimes, and show an increase in negative health behaviours.[28] Studies from the health literature emphasise that early intervention for depression among those with chronic illness is important so as not to contribute to the aetiology of chronic disease. Intervention is also important as depression affects many areas of an individual's life, including their overall health and functional ability.

Work-related risk factors

For work-related factors, certain occupations are at greater risk for stress, depression and anxiety than others. People in non-manual jobs are more likely to report depression and anxiety than those in manual jobs.[4] Teachers, nurses, police officers, the armed forces and medical practitioners have a higher incidence of work-related stress, depression and anxiety. It is well-documented that depression and anxiety is associated with work stress, and a wide range of factors contribute to this: too much or too little work, having to make too many decisions, having very little control over decisions; time pressures and deadlines to meet; excessive and inconvenient working hours; highly repetitive work and lack of job variety; the necessity to work fast; job insecurity and the prospect of redundancy or being forced into premature retirement have all been reported to contribute to stress, depression and anxiety.[29, 30] Work stress can also exacerbate an employees' chronic illness and, in effect, be counter-productive. Employees managing chronic illnesses in this type of work environment are most likely to go into work but perform beneath their optimum and show signs and symptoms of stress including depression.[31] There is strong evidence that supervisor support, as one of the dimensions of workplace support, has a beneficial effect on health outcomes among employees, particularly for depression[32, 33]. Studies have found that social support at work is directly related to high job control, low depression and high job performance.[34] High social support at work is also associated with lower sickness absence related to depression.[35] However lack of awareness and understanding of depression and anxiety is one of most common reasons given by managers and supervisors as to why support for such employees is inadequate.[36] In addition, managers and supervisors lack confidence in their abilities to support individuals with mental health problems[37].

Despite research and intervention into reducing work-related stress, the prevalence of work-related depression and anxiety continues to rise as indicated by national surveys. Overall, there has been a marked increase in the contribution of depression and anxiety to long-term sick leave and evidence suggests that longer absences are associated with a reduced probability of eventual return to work and subsequent economic and social deprivation.

Return to work

Research on return to work in those with depression and anxiety, back pain, cancer and heart disease has led to significant advances in understanding of the predictors for long-term sick leave, the return to work process and its associated outcomes.[24, 5, 38] The most popular intervention adopted by many workplaces in getting people back into work are phased or gradual return to work programmes, in combination with psychological rehabilitation such as confidence building, counselling or cognitive behavioural therapy where appropriate. The understanding of the return to work process is no longer restricted to a medically-determined model, but also incorporates a deeper understanding of individual, workplace, medical, economic and social factors.[39] Despite these advances, in practice return to work or rehabilitation programmes are largely designed to cater for and support the presentation of a single illness, rather than returning employees presenting a co-morbidity of illnesses (e.g. a cancer survivor returning with depression).

Overall there are a number of factors that are common to all four illnesses in predicting return to work outcomes. For example, illness severity, old age, limited education and low wages are factors that play against return to work for most people with chronic illnesses,[40] and it is likely that an ageing workforce will increase the numbers exiting the labour market as a result of impairment and long-term absence.[41] Studies have also shown that return to work is low in jobs with poor working conditions, in sectors with physically demanding jobs or in organisations that do not have a formal rehabilitation policy or do not have good workplace practices to encourage rehabilitation through formal processes.[42, 43] In addition, there are a number of factors specific to each illness group which are summarised below.

- Not all individuals with depression and anxiety take long-term sick leave. For those who do, the few studies that have focused on the return to work outcomes for those with major depression, report much longer durations of sickness absences for older workers (aged above 50 years), those with expectations of not returning to work early, those with higher educational level and those who perceive that exposure to employers, colleagues or other aspects of work will lead to a relapse.[44] In addition, evidence suggests that regaining health does not necessarily result in return to work.[45, 46] In terms of psychosocial work factors, high job demands, few opportunities to make work adjustments, low supervisory support and poor communication between the supervisor and employee has been associated with longer sickness absence duration and low return to work outcomes.[44, 47, 48]
- For individuals with cancer, a recent study has shown that approximately 30 per cent of employees in the UK continue to work, in some capacity, during their cancer treatment[38]. For those on long-term sick leave, return to work figures range from 44% to 100% depending on the type of cancer, its treatment and stage of disease[49]. For most individuals, returning to work is important as it gives a sense of returning to normality in terms of recovery, regaining perceived control over the illness and in social and financial support[50]. Factors that impede return to work include fatigue, pain, concentration problems, physical demands at work, difficult relationships with colleagues and superiors and lack of discussion with health professionals about work and return to work issues[49, 51].

- For back pain, many factors have been linked to a failure to return to work. These include high pain levels, persistent pain, pain radiating to extremities, previous injury, more than 6 months sick leave, poor self-reported health status and functional limitations, own low recovery expectation and increasing fear-avoidance beliefs toward work and activity.[52, 53] Depression has also been found to impede return to work. For example, individuals with musculoskeletal conditions who are depressed have sick leave duration that is twice as long as individuals with musculoskeletal conditions who are not depressed.[24]
- Return to work after a heart-related illness has been extensively studied,[54] although the factors emerging as predictors vary over different studies. Most individuals diagnosed with CHD return to productive and effective employment. A recent study indicates that approximately 80 per cent of people treated for CHD returned to work 12-13 months following hospital admission, of which 64 per cent were working full-time and 37 per cent were working part-time.[55] Factors that influence an employee's ability to return to work include type of heart condition, illness severity, functional ability, and how much control (decision latitude) they have over their work.[54] The most commonly reported factors resulting in the likelihood of delayed or no return to work are low social support, social isolation, Type A behaviour, poor perception of health status and most importantly, depression.[56, 57] A number of studies have shown contradictory results as to whether CHD individuals with depression are likely to return to work. For example, some studies report that those with major depression are less likely to return to work compared with those who have mild or no depression;[58] while others report that those with major depression were more likely to return to work than those with mild depression.[5] These studies suggest more research is needed to explore the role of depression in predicting return to work.

Post return to work and workplace interventions.

In comparison to the literature on return to work outcomes, information on outcomes following return to work is limited. Studies that do exist, largely report the type and prevalence of work adjustments made and the level of work ability. For example, many individuals returning to work report undesired changes to their work, earning less, having less responsibility and control over their work, problems with co-workers or reporting that their illness has damaged their work capacity.[2, 10, 51, 59] After returning to work an individual can be effected in different ways and the impact on their work will vary depending upon the severity of the disease and the treatment received. For example, both heart disease and cancer can lead to a temporary reduction in an employee's ability to work, permanent changes to their ability to work, or a permanent incapacity to work. For this reason, there is perhaps more information available on outcomes post return to work for these illness groups. For example, Pryce and colleagues[38] found that many employees who have long since finished their cancer treatment still require adaptations to their work or additional support from colleagues due to the late (side) effects of cancer treatment such as fatigue.

Rehabilitation of employees returning to work should be undertaken by organisations either through occupational health (where available) or human resources. Currently, the majority of research has focused on workplace rehabilitation for those with depression and anxiety who have continued to work without taking substantial long-term sick leave, or on rehabilitation to improve return to work outcomes. Individual-level interventions have typically focused on protective factors that can help to reduce the symptoms of depression such as encouraging positive health behaviours in terms of a better diet and exercising[60] and improving an individual's internal and external psychosocial

resources within the workplace by reducing perceived stress, promoting coping and problem-solving skills, improving self-esteem and self-efficacy. These can help to develop resilience in employees and to cope with adversity related to both workplace stressors and illness.[60, 61] Employer-level interventions have typically focused on policies and opportunities for employees to have control and decision-making latitude, clear workplace roles, good job fit, fair performance appraisals, attention to work-life balance, the full use of worker skills and capacities, employee involvement in the workplace, supportive work environment including interpersonal contacts and valued social positions.[62, 63] Kawakami et al (2005) suggest that in addition to strategies, such as increased communication through team meetings and greater opportunities for worker participation, a supervisor education/training programme on recognising symptoms of depression and anxiety and understanding their effects on overall employee well-being and work performance, would ultimately increase supervisor support and reduce poor mental health outcomes. This would also help to reduce the stigma toward depression.

Currently, few employees returning to work following sick leave are assessed on symptoms of depression or adjusting back to work, so many of the interventions outlined above are not offered or tailored to individual needs. Many employers assume that employees returning to work are usually returning because they are physically and mentally fit to do so. However, evidence from the return to work literature suggests that this is not always the case and many employees are most likely returning to work with mild to moderate depression and with perhaps poor perception of their health status and functional ability. Symptoms of depression associated with these conditions often go unrecognised by healthcare professionals, employers and employees themselves. A better understanding of these factors, and the extent to which depression impacts on return to work success, is needed if we are to develop more comprehensive return to work interventions, and increase the likelihood of those returning following chronic illness staying in employment.

Post-return to work: the current study

There is limited information on how depression affects an individual's psychological and social well-being upon returning to work following long-term sickness absence; and how the design and management of return to work contributes to the individual's well-being. A recent study by Munir et al (2005), suggests that the availability of support and intervention is reported to be better for those with a physical chronic illness such as heart disease and musculoskeletal pain, than for those with depression and anxiety. This may be due to employers' low awareness of the symptoms and consequences of depression and anxiety and the possible stereotypes or stigma associated with the illness.[36, 64] By comparing the return to work experiences of individuals with depression and anxiety to individuals with heart disease, back pain and cancer, this study looked at the extent to which symptoms of depression affect return to work and vice versa; and the extent to which workplace illness perceptions, attitudes and behaviour affect the individual (see Figure 1).

This study examined the role of depression in returning to work after a period of sickness absence. The main objectives of the study were to:

1. Examine the presence of depression symptoms in a range of illnesses among employees returning to work following long term sickness absence. This includes depression and anxiety as a primary illness [depression often co-exists with anxiety], and illnesses commonly associated with symptoms of depression: heart disease, back pain and cancer. These illnesses are also associated with long term sickness absence.

2. Investigate the relationship between depression, capacity to function at work and the overall quality of working life.

3. Assess the degree to which the design and management of return to work impacts on the individual's return to work experience and symptoms of depression.

4. Build a schematic model of the relationship between depression and the work environment following return to work.

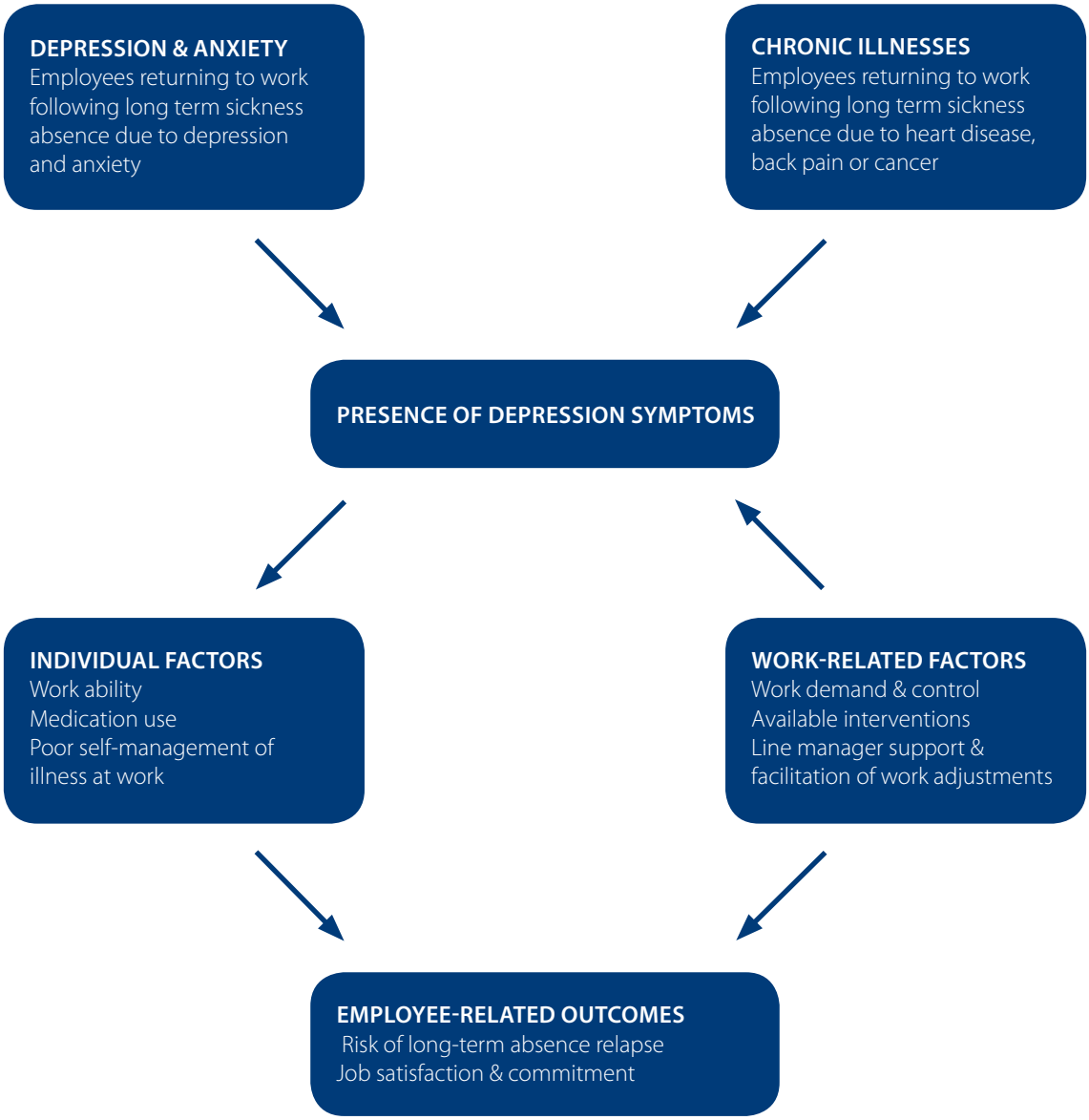

Figure 1: Role of depression following return to work

2. Research methods

The study used a combined quantitative and qualitative approach. Semi-structured interviews were used to collect qualitative data from key stakeholders involved in managing return to work. Questionnaires were used to examine the role of depression in returning to work after a period of sickness absence from the employees' perspective. Further data was collected from a small sample of employees. Individual structured interviews were carried out with this group to obtain in-depth information on the role of depression following return to work.

The design of the study, the sample participating, the interviews, questionnaires and procedures are described below.

Research approach

This study was carried out in five phases over a one year period.

- **Phase 1** involved recruiting organisations to participate in the research.
- **Phase 2** consisted of conducting qualitative interviews with key organisational stakeholders. The participating staff from each organisation worked within human resources, line management and occupational health roles.
- **Phase 3** involved the distribution and return of a questionnaire by employees who had returned to work following long-term sick leave from each organisation.
- **Phase 4** concerned an online survey sent to relevant charities and support groups. The online survey was the same questionnaire sent to employees across the organisations. The purpose of the online survey was to increase and support questionnaire data obtained through organisations as the number of employees who fitted the criteria for this research were low.
- **Phase 5** consisted of in-depth interviews with 30 employees showing symptoms of depression as identified from the questionnaire.

Phase 1: Recruiting organisations

Fifty-four organisations in the UK were invited to participate in the study by the research team (Table 1). The organisations were selected from the Thomson Business Search Pro CD Rom Directory (2003) and from existing organisational contacts. Recruitment techniques included telephone calls and emails to organisations between September 2006 and April 2007.
The criteria for targeted organisations were:

- Size: a minimum of 3,000 employees. This lower limit was applied in order to generate a large enough sample size of employees who had been on sick leave and had returned to work due to either depression and anxiety, back pain, cancer and heart disease.

- Sector: manufacturing, transportation, local government and healthcare. These sectors were chosen because they are most at risk of high long-term absence levels[4].

- Organisations with an occupational health service and with adequate databases of employees who had returned to work following long-term sick leave.

Sector	Number Approached	No further contact or declined	Expressed an interest	Recruited
Manufacturing	20	15	5	1
Transport	15	6	9	1
Local Government	15	13	2	1
Healthcare	4	3	1	1
Totals	**54**	**37**	**17**	**4**

Table 1: Organisational recruitment strategy

Table 1 shows 17 organisations expressed an interest and four participated. The recruitment of organisations for this particular research project proved to be difficult for the following reasons:

- The research required identifying employees who had returned to work following sick leave due to one of four types of chronic illnesses. Many organisations did not record sufficient data on the type of illness to allow the research to take place.

- Some organisations conveyed that their staffing levels and resources were at a low level which meant they were unable to allocate time and resources to identify and recruit participants on the research teams' behalf.

- When looking through adequate databases, a number of stakeholders found few employees had returned to work following cancer or heart disease. In addition, for heart disease, most had either taken less than 4 weeks sick leave, or had taken early retirement rather than returning back to work.

- One major consideration of this project was the research topic being mental health. Some organisations felt this was too sensitive to take forward within their organisation and were concerned about confidentiality, accountability and responsibility of the outcomes of the research.

Participating organisations: Four organisations met the criteria for the study and agreed to fully participate. These were from one of each of following sectors: healthcare (Acute NHS Trust), manufacturing, local Government and transportation. All organisations had an employee base of at least 3,000 located on either one site or across multiple sites within the United Kingdom and/or Internationally. For each participating organisation, a key contact person was established from the organisation's Occupational Health Service (Human Resources for the NHS Trust) to help co-ordinate the research.

Phase 2: Interviews with stakeholders

The research team recruited approximately five stakeholders per organisation to participate in individual, face-to-face or telephone interviews.[2] A total of 19 interviews were conducted across the organisations. A key contact person, established from each organisation's occupational health service (human resources for the NHS Trust) identified organisational representatives from their organisation. These were line managers, occupational health professionals and human resource managers involved in the management and rehabilitation of employees returning to work (see Appendix, Table 1).

Interview schedule

Semi-structured interviews were used to collect detailed information on how organisations support employees with depression and anxiety, back pain, cancer and heart disease returning to work following long-term sick leave. All organisational representatives received the same interview schedule with some questions rephrased according to their job role. Each interview consisted of a standard set of questions which covered:

- Interviewees' role in reference to absence and return to work management
- Familiarity and experience of managing employees returning to work following long-term sick leave
- Awareness and management of potential co-morbidity of depression in employees returning to work
- Awareness, communication and implementation of relevant return to work and rehabilitation policies
- Knowledge and delivery of rehabilitation tailored to different chronic illness needs
- Employees' view on the effectiveness of current organisational policies and practices in rehabilitating and supporting employees returning to work

Interviews were carried out either on site or by telephone during working hours. Each interview lasted approximately 50 minutes and was recorded on tape, with the agreement of employees. Each participant was assured their responses to these questions would be anonymous and that they were able to withdraw from the interviews at any time. The recorded interviews were fully transcribed and analysed using content analysis. The reliability of the analysis was ensured through systematic review of the data by three members of the research team. The findings are summarised under the themes along with illustrative quotes in Section Four.

2 The original research proposal stated focus groups would be carried out with 6-8 stakeholders involved in the management and rehabilitation of employees returning to work in each organisation. However, due to the sensitive nature of the research, all organisations strongly expressed the wish for individual interviews.

Phase 3: Questionnaire survey via organisations

In Phase 3 of the study, the research team aimed to send between 300 - 600 questionnaires to employees in each organisation who have returned to work in the last 24 months following long-term sick leave due to either coronary heart disease, cancer, back pain or depression and anxiety. The exact number of questionnaires sent would be dependent on the number of employees who retuned to work in the last two years.

Each organisation identified participants meeting the above criteria on the basis of their absence records i.e. had been absent for a periods of four weeks or more within the last 24 months. Internal stakeholders completed this process to ensure confidentiality. Unfortunately, the number of employees identified by each organisation was lower than expected for the following reasons:

- There were fewer cases of employees with back pain, heart disease and cancer returning to work following long-term sick leave (4 weeks+) than either anticipated or recorded by the organisations.
- Exclusion criteria were applied by organisations where participants with a complex or sensitive medical or return to work history were excluded. For example, the NHS Trust cut the number of potential participants by half from 120 identified to 60 actually approached.
- A high number of employees were still absent at the time of recruitment.

While the questionnaire was designed to minimise the cognitive load on employees, taking into account that returning employees may find additional tasks difficult to manage, it is reasonable to suggest that those employees who did receive the questionnaire may have been struggling to meet the requirements of their work and may not have had any additional capacity to complete and return the questionnaire.

Each organisation distributed a postal questionnaire and a letter outlining the nature and general objectives of the study, to employees on behalf of the research team. Where possible, employees also received notification of an on-line version of the questionnaire via their work email address. Consenting participants were required to complete the questionnaire and return directly to the research team (for the on-line survey responses were submitted directly to the research team via an internet facility).

Questionnaire

The questionnaire comprised of four sections asking respondents questions on i) their chronic illness, ii) their current work ability and post return to work support, iii) the psychosocial demands of their work, and iv) demographics.

(i) Chronic Illness

- *Return to work:* Respondents were asked to indicate details of their illness and duration of absence from work. This section also asked respondents if they had a phased return to work with the same or different tasks than before their absence.
- *Depression:* The Beck Depression Inventory-II[66] was used to measure the severity of depressive symptoms. The BDI-II consists of 21 items describing various symptoms of depression. Respondents were asked to rate phases that best described how they had been feeling during the past 2 weeks. The BDI-II has been shown to a reliable and valid index of depressive symptoms in those with depression, back pain, heart disease and cancer.
- *Confidence in self-management of illness at work:* This was assessed with established scales. Respondents were asked how confident they were in following their doctor's advice on diet, exercise, medication and monitoring symptoms at work. These questions were asked because Individuals with low confidence in managing their health are more likely to report adverse symptoms of their illness and difficulties in carrying out job tasks.

ii) Current Work Ability and Post Return to Work Support

- *The Work Ability Index (WAI):* The WAI[67] was used to assess respondents' work ability in reference to job requirements, illness-related impairment of work ability and own prognosis of work ability in the next two years. WAI scores range from 7 to 49 points and results indicate the following: poor work ability (up to 27 points), moderate (28-36 points), good (37-43 points), or excellent work ability (44-49 points).

- *Workplace support:* Respondents were asked about receiving two types of workplace support in relation to their health: practical (giving information, help and advice) and emotional support (sympathy and understanding). These were measured with three items each, representing support received from colleagues, line manager and occupational health. Items were measured on a five-point Likert scale (no support to a great deal of support).

iii) Psychosocial Work Demands

- *Job demands, control & stress:* The Job Content Questionnaire[30] was used to determine participants' job content and job demands. This measure gives an indication of job strain (i.e. whether respondents have little control over their work to meet their job demands) and iso-strain (whether participants under high job strain have little workplace support). Questions were asked on skill discretion and decisional authority (i.e. job control), psychological workload and physical exertion (i.e. job demands), supervisor support and co-worker support. All items were measured on a five-point Likert scale (strongly disagree to strongly agree). Job strain is defined by the demands score divided by the control score, hence higher demands and lower control scores imply more job strain. Iso-strain is defined by job strain divided by the support score, and thus higher strain and lower support results in higher levels of iso-strain.
- *Work adjustments:* Respondents were asked to indicate (yes or no) what adjustments had been made to their work since returning to work, and whether these adjustments were still in place. Questions included fewer working hours, flexible working hours, different job tasks and stress management.
- *Job satisfaction:* This was measured using a three-item measure of Overall Job Satisfaction[68]. In addition to job satisfaction, intention to leave work was also measured using an established scale. Both work attitudes were measured by means of a seven-point Likert scale (strongly disagree to strongly agree).
- *Absence:* Respondents were asked to estimate the number of times they had been absent from work over the past 12 months (spells of one to four days or five days or more).

(iv) Demographics

- Information on gender, age, ethnic background, education, occupation, salary and tenure (length of service) was collected from respondents.

Analyses

Three types of analyses are used in this study and reported in Section Five: Chi Square analysis, Odds Ratios and Analysis of Variance. A short description of these analyses are described below:

- Chi square analysis is a statistical test for determining whether two variables are independent of one another by comparing differences between observed and expected frequencies for various cells in a table.
- Odds ratio analysis calculates the ratio of the odds of an event occurring in one group to the odds of it occurring in another group, or to a sample-based estimate of that ratio.
- Analysis of variance is a statistical test used to determine if differences among three or more means are statistically significant.

Phase 4: Online survey via charities & support groups

Due to low number of employees identified by each organisation that met the criteria for the questionnaire survey (see survey results), it was agreed with the Mental Health Foundation to widen the sampling strategy to increase response rates. Between July-October 2007, an online version of the questionnaire was placed on the Mental Health Foundation's website and sent to a range of national charities and support groups for those with either depression, back pain/injuries, heart disease or cancer. A range of support groups and charities were targeted of which the majority were affiliated with NHS Trusts or clinics. These agreed to place the link on their website or newsletter (see Appendix two for examples).

The online survey was identical to the survey sent to employees through the organisations. Minor amendments were made to the demographics to collect information on the type and size of sector the respondent worked in. The findings from these are presented in Section Five of the report.

Phase 5: Employee interviews

Phase 5 of the research study recruited a total of 30 employees for in-depth semi-structured interviews. Recruiting these participants was done via the questionnaire. The questionnaire and online survey contained information for further participation in confidential interviews. Respondents were invited to participate by completing their contact details at the end of the questionnaire (confidentiality of personal information was ensured). Participation was entirely voluntary and those not wishing to participate left this section blank.

From those respondents willing to participate, 15 with depression and anxiety only, and 15 with a physical chronic illness reporting depression were selected for interview. The interviews were conducted by telephone and all participants received the same interview schedule with some questions rephrased according to their illness and return to work experience. Each interview consisted of a standard set of questions which covered:

- Experiences of returning to work with either depression or a chronic illness; or the combination of both
- The extent to which employees feel supported at work through workplace interventions
- Perceptions on work ability and possible long-term sickness absence relapse, in relation to illness or depression

Each interview lasted approximately 40 minutes and was recorded on tape, with the agreement of participants. Each participant was assured their responses to these questions would be anonymous and that they were able to withdraw from the interviews at any time. The recorded interviews were fully transcribed and analysed using content analysis. The reliability of the analysis was ensured through systematic review of the data by three members of the research team. The findings are summarised under the themes along with illustrative quotes in Section Six.

Ethical approval

The study received ethical approval from Loughborough University's Ethics Committee and from Leicestershire NHS for the local NHS Trust. Written consent was obtained from each participating organisation, and for the interviews, consent was obtained from all participants before interviews took place. Consent for the questionnaire survey was obtained by participants consenting to complete and return the questionnaire.

3. Review of employer return to work initiatives

This section provides a brief outline of each participating organisation, followed by a review of their policies and services for managing return to work.

Organisation 1: Transportation

This large commercial company provides services which include postal, communication, retail and money transmission. It employs around 9,000 employees and the majority are employed in manual occupations. The organisation keeps absence records for those diagnosed with a medical illness. The company's annual short-term sickness absence rate is 7.6% and in July 2007, there were 130 employees on long-term sick-leave. The company has specific rehabilitation and redeployment programmes which assist employees in return to work over a specified period of time. All decisions are made with the agreement of the employee involved and by referral from Occupational Health Service or a GP.

Organisation 2: Local Government

This public administration organisation delivers a wide range of services (e.g. education, leisure, social, environmental services). It employs around 25,000 full-time and part-time employees. Approximately 7,000 employees are employed in manual service or trade occupations; and 5,000 work in professional or associate professional occupations. The remainder work in an administrative/clerical role, operate at Senior Management level or are based in school locations (the latter group were excluded from this study). The organisation has an attendance management and return to work policy. At the time of research, annual sickness absence figures were not available. The organisation has a formal referral system to personnel services or occupational health to facilitate a successful return to work.

Organisation 3: Manufacturing

This manufacturing company produces metal and plastic packaging/containers. The organisation employs around 24,000 people across 42 countries and has two sites in the UK; the Midlands and the North of England. Over half of employees work in operational roles and a quarter are quality auditors and engineers. The remaining workforce are administrative and management employees. The company has an annual short-term sickness absence rate of 2.8%. Long-term sick leave figures were not available. The organisation has no long-term sickness return to work programme. However, special arrangements apply for employees who are unable to work but who the company wishes to retain in employment, when fit to return.

Organisation 4: Healthcare

This NHS healthcare organisation is based in the Midlands region of the UK and employs around 4,000 staff. The Trust has an attendance management policy. For long-term absences, there is a formal referral process to the Occupational Health Service, which operates a 'Therapeutic' returns policy (phased return) and work adjustments. However, there is no formal record of illnesses and work adjustments for those who have successfully returned to work.

Policies / Services	Manufacturing	Transport	Local Government	Healthcare
Return to work	No formal policy	Rehabilitation/ phased return to work	Rehabilitation/ phased return to work	Gradual/ Therapeutic return to work
Occupational Health services	Access to OH available	Access to OH available. OH take part in case conference with Area manager & other relevant stakeholders	Access to OH by referral through Personnel Services using information received from the manager	Access to OH by referral - through line manager only (referral must be discussed with the employee)
Work adjustments	YES- reasonable adjustments as required by the DDA	YES - rehabilitation programme can be agreed between the manager and the Occupational Health Service	YES – reasonable adjustments as required by the DDA	YES - adjustments e.g. reduced hours of work - alternative approaches will depend on individual circumstances
Redeployment	Yes	Yes	Yes	Yes
Job retention	Yes	Yes	Yes	Yes
Stress management	YES – policy, assessment & stress management programme	No formal policy	YES – policy, assessment & stress management programme	No formal policy
Counselling	Yes	Yes	Yes	No
Diversity management	No	No	Disability Discrimination Code of Practice	Employees treated in accordance with the provisions of the Disability Discrimination Act 1995

Table 2: Policies and services for managing return to work

4. Managing return to work - Findings from employers

A total of 19 interviews with organisational representatives were undertaken for this study. Participants were those from Occupational Health, Human Resources and managerial backgrounds (see Appendix, Table one). The average number of years participants had worked for each organisation was 11.5 years (Ranging from less than 1 year to 26 years). Table 3 shows the themes and sub themes relating to discussions with the organisational representatives.

Themes	Summary of Themes
Knowledge & awareness of chronic illness	- Recognition of problems with depression among employees with back pain, cancer & heart disease - Stigma associated with depression and back pain - Limited medical knowledge of illnesses
Long-term sickness absence management	- Facilitators: phased and case management return to work - Internal barriers: management competencies & lack of training - External barriers: access to healthcare & waiting lists - Employee barriers: attitude, anxiety & competencies
Post return-to-work management	- Differences in return to work strategies and rehabilitation services - Variation in RTW outcomes between different illness groups - Employer difficulties in providing adjustments for those with depression/anxiety - Employee difficulties in self-adjustment to RTW
Future directions	- Improving internal communication between staff and stakeholders. - Training in illness knowledge and return to work management. - Over-coming communication barriers with external stakeholders such as GPs

Table 3: Stakeholder interviews - key emergent themes and summaries

Knowledge and awareness of chronic illness

All participants reported experience in dealing with an employee who had either depression and anxiety, back pain, heart disease or cancer. However, their knowledge and understanding of these illnesses varied according to the type of illness, its prevalence within the organisation and its possible cause. The findings are reported below.

Depression and anxiety

Mental-health was a major concern for all organisations. All participants were very aware that work-related stress was a significant contributor to depression among employees which often resulted in long-term sickness absence for such employees:

> *A lot of our cases are related to stress and depression arising around that interface between work and domestic kinds of pressures.*
>
> *Human resources staff*

> *The whole area of psychological, stress, anxiety, depression and all that certainly is featuring very prominently. We've seen over time that as a feature in terms of our absence levels. Our absence statistics has taken significant increase.*
>
> *Human resources staff*

Some participants had good a understanding of depression, including the psychosocial factors that affect an individual prior and post return to work. However, there was consensus between the majority of participants that people generally find it difficult to understand the causes of depression, its symptoms and its serious effects upon the individual. It was far easier to understand, and occasionally empathise with, a physical illness than mental ill-health.

> *Employers tend to accept physical far more than mental health... I think people still look upon an individual who has some form of mental health illness as a stigma.*
>
> *Occupational health staff*

> *But the rumours seem to start with things like depression, anxiety, things that you get a lot of people who talk about it. I saw them and they look fine. Why aren't they at work? We get that one a lot, even from managers.*
>
> *Human resources staff*

> *One thing I feel very, very passionate about because as I say, if I've got a broken leg, they're very sympathetic, when I've got cancer they're very sympathetic, but when they've got mental health problems it simply tends to wind them up.*
>
> *Occupational health staff*

This uncertainty made the return to work of an individual difficult. Managers were often uncertain what action or adjustments to take:

> *When it's a colleague, people sometimes get unclear how to handle the problem. It's difficult to separate your relationship with them as a colleague as well as their mental health problems.*
>
> *Human resources staff*

> *It tends to follow a long path because depression can be very difficult to get under. It's very difficult to find even adjustments for them to come back to.*
>
> *Human resources staff*

Back pain

The majority of participants recognised that many employees with back pain develop depression and anxiety as a secondary illness, largely to the difficulties in managing back pain. Stigma attached to back pain itself may also result in depression as a number of workers remain unsympathetic toward those with back pain as one line manager summarises:

> *Cancer, heart disease, remember I'm a layman where medical procedures are concerned, they are things that are treated. If I was a cynical person, 'you've got back pain? are you really or are you just idle and don't want to come to work today? How can I prove that you have back pain? How can I prove that you've got depression?' Yeah, the ones I can see, I can trust, because I know they're real. The ones that I can't see then, you could be sceptical about them.*
>
> *Line manager*

Cancer and heart disease

Both cancer and heart disease affected a smaller proportion of employees across the organisations, compared with depression, back pain and other physical illnesses such as diabetes. However, both illnesses appeared to be a significant cause for concern due to the impact they have upon the individual and upon the workforce – both in terms of long-term sick leave and staff morale. These illnesses generated the most sympathy and leniency in the return-to-work process as one occupational health staff discussed:

> *We do have a few cancer cases, terminal cases which are incredibly sad, and an organisation this size, we will treat them a lot differently to how we treat other people... We've had a year mark. If it goes to a year, go to re-employ, just finish it. Whereas your cancer people, we will waive that because sometimes they get better.*
>
> *Human resources staff*

Most participants were aware that those returning to work following long-term sick leave due to cancer or heart disease, were more likely to return with some level of depression or anxiety. Although not formally assessed by the organisations, occupational health staff did look for symptoms typically associated with depression:

You actually can get quite a lot of secondary depression after a cardiac incident and this is something that you really have to be aware of because sometimes people don't seem to be doing as well as you think they should be doing, and you want to be asking the right sort of questions to see if they're showing signs of actual depression, they're fatigued, they've got sleep disturbances, diminished libido, feeling low, that sort of thing and send them back to a doctor with a note.

Occupational health staff

He's got an irregular heartbeat. So then, they went to give him an operation to stop his heart and restart it back in sequence, and they couldn't do that because he's got a blood condition. He's now taking tablets trying to get his blood right before he can have his op... So from that, he's then got depression.

Line manager

Long-term sickness absence management: Return to work

Each organisation collected some kind of long-term sickness-absence data but these were often incomplete, not organised by illness type or length of sick-leave; or problems with the database meant they were not easily accessible.

The aim and objective of the long-term absence management system was discussed by the participants. Most felt long term sickness absence was a complex issue. Although there were commonalities or patterns that pertained to the majority of long-term sick-leave cases, each case still varied significantly from the next. A Human Resource manager described how the process should ideally be managed within their organisation:

The long term sickness absence should be when an individual hits a four week period. The manager is then supposed to take the lead together with HR to do welfare visits to contact the individual to try and establish exactly what's wrong with the individual in layman terms... if at that time it is decided that they can cope with that themselves then they're referred to occupational health. So a formal referral paperwork system... That's how the system is meant to work!

Human resources staff

All participants highlighted similar issues where return to work policies are successfully implemented, and where barriers are perceived to successful return to work. These are discussed below.

Successful return to work management

The majority of participants felt a key facilitator for a timely and successful return to work was the involvement of the occupational health team. By assessing employee requirements, co-ordinating employee-line manager communications, collating medical reports, holding case conferences and planning return to work packages for each individual on a case by case basis:

> *There could be a whole range of factors that will make that case different and you have to be aware to the fact that not one size fits. You have to approach every case differently and you have to get to know the individual and what their concerns and their worries are.*
>
> *Human resources staff*

> *I think every case is individual. You might get somebody back over four weeks; you might need to take eight weeks. You know, if you're doing a maintenance plan you can do that, but when you're looking at humans, you can't. So that's the way I normally do it.*
>
> *Line manager*

> *We've started a process where if managers know or HR staff know a member of staff is going into surgery such as hip replacement, knee, or bypass then they can come to us to discuss any issues they've got pre-surgery, what can you expect, and post-surgery as to what can we do to get them back to work.*
>
> *Occupational health staff*

Additional factors that facilitated a timely return to work were identified as good communication between line manager, occupational health and the employee and the additional measures that were taken to help an employee feel less anxious about returning:

> *In terms of long term absences, continuing to build the relationships with occupational health to make sure the advice we're given is sound and helps us as employers.*
>
> *Human resources staff*

> *We're dealing with that which is why we go down and break the ice routes. We try the therapeutic route initially sometimes, just try coming to work, drop your mates off, and then go home. There are plenty of cases of people driving to work and they sit in the car thinking I can't get out, back in the car, drive off again. You see, I'm just trying to break that ice, make them re-connect again with work.*
>
> *Occupational health staff*

Most participants recognised that a positive employee perspective of the workplace significantly contributed to a timely and successful return to work outcome. For example, prior job satisfaction, commitment to the organisation and high motivation to return, were discussed as key predictors of a successful return to work.

I think a lot of it is down to the individual, and then what they want to engage with in the process, and wanting to get back to work.

Occupational health staff

Barriers to successful return to work

Each organisation that encountered problems with their return to work policy implementation noted that this was due to either a lack of resources, internal and external communication problems, lack of training in the return to work process, or managerial skill/competence in conducting the return to work process. One of the main problems in getting employees back to work quickly were healthcare barriers. Many employees had to wait for NHS surgical procedures and interventions before they were considered fit enough to return to work. For the transport organisation just outside of the United Kingdom, the issue was access to private healthcare:

Well, the private health care system, in itself, can be a barrier and it can create a difficulty. People are not easily able to access health care. They can't get their health problem fixed, so that they can return to work.

Occupational health staff

In response to healthcare barriers, one organisation introduced a fast track health service to encourage a speedy return to work. This includes a physiotherapy service for problems such as injuries and back pain; and a mental health in-house service for easy access to cognitive behavioural therapy for those with depression and anxiety:

We have recently launched a pilot, which was a fast track referral for physiotherapy. There's quite a long waiting list for NHS physiotherapy and, potentially, if an individual can be referred quicker, then it's possible that they may be able to come back to work sooner.

Occupational health staff

If you could have dedicated clinics for people with basic anxiety disorders, a dedicated psychotherapist, you could fast track people to work within the first one to two months, which would by pass the GP and the employer could turn in-house; training mechanisms, spot mechanisms, whatever it was, early on. That may help to solve the problems, rather than waiting six months or a year for the waiting list. If we could get them preferentially treated, that would be a big difference.

Occupational health staff

Line manager competency was a strong subject matter for human resources managers and occupational health staff. The concern was that managers did not have adequate training in managing the return to work process despite being one of the key persons in that process:

In my opinion, its management training, lack of management training, lack of management expertise, convoluted process, and lack of employment law training.

Occupational health staff

A lot of it is their own workload, they say themselves they've got a heavy workload, they're working with reduced staff, they've got budget constraints and things have just slipped. I don't think it's done intentionally, I just think it's done with the everyday pressures of life and work, but it happens.

Human resources staff

Line managers raised the issue of receiving little training and support in the return to work process. For example, many managers did not know when to contact the employee on sick leave, and what to say to them without being perceived as overly harassing. As a result, participants felt that many line managers did not provide any positive support or guidance to facilitate an individuals' possible return to work:

When a manager picks up an attendance procedure, many of them aren't experienced... They won't pick-up the phone because they don't know what they're going to say... we're their support and they should involve us...

Human resources staff

The answer is to be involved on a not too often basis because that seems a bit too much, and not too far removed because then they go off the rails. So it's a wobbly path you take... but if you harass people then there's a grievance put in within days and you are involved in hearings and tribunals as a manager.

Line manager

Even if I could be satisfied that the return to work interview was happening when it should happen and the forms were being completed, I might have a concern about the quality of the engagement with employees generally on that front... The longer an individual is out before that engagement takes place, the longer absence is likely to be.

Human resources staff

Some participants considered their main weakness was a lack of medical knowledge of an employees' illness prior and post return to work. This made some managers reluctant to offer rehabilitation for such work adjustments and would only consider allowing an employee to return to work if they were considered fully fit to return to work as one manager described:

There's a strong emphasis within our operational areas that individuals should only be returned to work when they're 100% fit to return to work. There is a resistance to notions of rehabilitation, redeployment to alternative duties.

Human resources staff

Managers in some areas believe that people need to be 100% able to return to work, they are not open to alternatives or to meeting people half way as they could be... Often its not until the person is in the scenario themselves that they realise how much a person can do even if they are not 100%.

Occupational health staff

I'd say my biggest barrier is lack of medical knowledge, I have to speak to the nurse a lot, have a good working relationship with her. So, she can trust me, that if she does say things, they won't go any further. And, at the same time, she's open and honest with me.

Line manager

With back pain, you don't get much medical advice on it. The reports we get tend to be, this person has back pain. We don't know how long its going to last... and its difficult.

Human resources manager

Employee-related barriers to successful return to work

All participants acknowledged that although some of the return to work barriers lay with line managers' competencies, some employees had issues of their own which may prevent a timely return to work. These included financial issues, low self-esteem, low confidence, feeling unsupported and not valued by the organisation.

> *I can imagine people would be very very nervous. 'Is the reason I've been off going to affect my job security?' Its got to be a very major, major concern. Whether you can still do the job, has the job changed? It's a different anxiety of starting a new job.*
>
> *Line manager*

> *The factor that has a significant bearing is the sense that the individual has of their value to the organisation. In the sense that, if they're been out on long term absence and no one has spoken to them, or they perceive that they have been treated badly in the periods that they've were out on long term absence. Even if they do return to work, that kind of experience influences their application when they come back.*
>
> *Human resources staff*

The majority of participants felt that those who were on sick leave primarily due to depression and anxiety, were the most difficult to return to work. This was because most of the problems were inter-twined with work-related stress, perceptions of bullying and harassment or poor working relations. Under these circumstances, many employees are reluctant to interact with their organisations making return-to-work interventions difficult to apply:

> *I've got one guy who's been off since last September, he's been very reluctant to maintain contact, he's got acute stress and anxiety disorder. Relations with that particular individual have been difficult, he's gone AWOL, in the last six weeks he's not returned any calls. His sick pay runs out in three weeks' time, and we've tried to contact him to say, look, we need to talk to you, and now I'm being forced into writing to him because he won't answer his phone.*
>
> *Human resources staff*

> *We had one long-term absence case and he kept coming back with stress and depression. But in fact he'd had a big argument at his workplace... Every time he went to see Occ. Health, it came back saying, until his grievance is resolved, he's not going to come back to work.*
>
> *Human resources manager*

Participants recognised that a number of employees with a serious physical illness also experience anxiety or depression during sick leave, which prevents their timely return to work. Many of the issues for these employees were the same as for those on sick leave primarily for depression, in that they felt unable to cope:

They've been off sick for a long time [heart disease]. Maybe they're apprehensive of coming back. They're frightened they can't cope, they're anxious, they may have a secondary depression.

Occupational health staff

There's one guy off at the moment and is exceptionally emotional about his cancer. We generally avoid talking about his illness because he just can't cope with it.

Human resources staff

I've got a chap at the moment who has been off about eight months, who was all ready to come back with timetables sorted out. His GP and occupational health said he was fine. He was absolutely raring to go. He had been in to see his manager, everything was great. Two days before he was due to come back in, he just absolutely lost it. Said he'd let everybody down, couldn't come back after that much time, and he just put himself under so much stress, he has not returned.

Human resources manager

The most notable occurrence of depression was among those with back pain and it was recognised this may be due to work itself contributing to back pain, the level of pain experienced and the uncertainty around the recovery period for employees.

Somebody who's gone off with a back problem may have prolonged absence because its turned into stress and depression... I think its quite complex. I think they're often interrelated...

Human resources manager

I think a lot of people with back pain, I think sometimes they withdrew, because they felt that people didn't understand, because you can't see it and its such a difficult one to diagnose.

Human resources manager

Because of the waiting list of trying to get the cause of the back pain solved is long... I think the pain is so debilitating they go down a spiral of depression...

Occupational health staff

Post return to work management

All four organisations had implemented some kind of monitoring scheme that followed employees past the point of their initial return to work, if required. In most cases, returning employees back to work is relatively straight-forward with successful outcomes. However, for those returning to work following an episode of depression or back pain; or recovering from cancer or heart disease, returning to work was more complicated and organisations were more likely to offer phased returns, temporary or permanent work adjustments and redeployment into new or similar roles:

We only do the phased return to work where there's a significant issue, in an injury, bypass surgery, hip replacements, significant depression, long term absence with complicated things I use the functional element of what they can or can't do.

Occupational health staff

"If you're dealing with a broken leg, obviously it's a process that leads to return to work and it's very defined and clear... But when it comes to issues relating to back, particularly in an environment where we have an element of manual labour... the issue of back pain can be very difficult to deal with. And assimilating an individual back into the organisation can be very difficult."

Human resources manager

"I think I've done two depression returns and we're still monitoring. It's probably about a year since she was off with depression, but we still monitor her and meet with her every three months just to check that she's okay."

Occupational health staff

Work adjustments and support

The majority of participants discussed problems with making appropriate work adjustments for those returning to work with any one of the four illnesses, without it costing additional resources. Redeploying staff who were unable to return back to their previous job roles, was also an area for concern. Participants felt most of this pressure was placed on human resources and line managers to find suitable adjustments or alternative job roles that utilised the employees' skills and knowledge.

Its difficult, you can make more adjustments for someone with back problems coming into an office than you can for somebody who's supposed to be out with their tools, or standing up... there aren't too many adjustments you can make.

Human resources manager

The problem we have is when an occupational health advisor says they're fit to return with adjustments over the next six to eight weeks. And we say no... its got to be with adjustments within two to four weeks... Because in practice, you can't really manage the adjustments, its going to cost extra money, extra help, or reduced hours or whatever.

Human resources manager

We often try and redeploy someone with musculoskeletal problems into admin roles. It can be very difficult to redeploy some staff because they've only got [specific] skills, they haven't got admin skills, they haven't got other skills to rely on and quite often it does mean that we've got to come to a hearing [capability] process.

Human resources manager

Line managers were expected to monitor the health and well-being of those who had returned to work for a period of time, usually up to a year. Participants felt this was often a difficult task for line managers as most already had high work demands and work pressures to meet. Most line managers felt untrained in this area and heavily relied on human resources and occupational health staff for support, as one human resource manager commented:

It's really down to the team and the manager. I'm sure they forget. And then an employee that's feeling they're not being noticed and they get sick again. If you're not careful, that's going to be a trend. Its all down to the managers to be aware of what is going on. Even if they don't know what to do they can at least ring personnel and say, I think this is happening again, what shall we do?

Human resources manager

Overall, participants found organisations were more prepared to provide adjustments and support for employees returning to work following cancer, than for those returning to work following an episode of depression or anxiety. This was mainly due to the sympathy associated with the illness of cancer, and the problems of understanding the needs of those returning with depression and anxiety.

Got a guy who's been off with cancer. The first time he was off, when he came back they offered him a totally different job role, offered, not implored, he was offered. So he had the option of learning more skills... its more of a chance to take your mind off what you've had preying on your mind and in his case, cancer... The mental ones are the hard ones because you don't know where to tread, from a personal point of view... how do you tread that way?

Line manager

We do have a few cancer cases which are incredibly sad; we will treat them a lot differently to how we treat other people. We have a year's [absence] mark, we'll waive that for them... With depression, that's where I start to struggle. I don't always know how to deal with it.

Human resources manager

Stress, depression and anxiety, they're the most difficult cases to deal with. There's no plaster cast, there's no sort of stitches you're dealing with something that is very difficult to assess and very difficult to talk to people about.

Human resources staff

In most heart disease cases, employees were less likely to return to work due to the impact the illness had on work ability, as one occupational health staff discussed:

One guy had a [heart disease] and he never made it back to work in two years and was medically retired.

Occupational health staff

Employee-related post return to work barriers to adjustment

Some of the problems associated with post return to work for the employee included difficulties in adjusting back to into a demanding job role or redeployed role, and interacting with colleagues and the work environment. For those employees who had been on sick leave for at least a few months, managers noted that it was difficult for them returning to a work environment where familiar colleagues had either left the organisation or the job tasks had changed somewhat during their absence.

Yeah, if you've been away a long time from work, the work environment may have completely changed. Normal mechanisms of support, like friends or other people, may have moved on. The manager may have moved on, the unit may have moved from one ward to another ward, a physical change may have happened since you've been away from work. The caseload may have changed. Lots of things may have changed while they have been away so they may not be going back to exactly the same job because people have just moved on. That could be a barrier.

Line manager

It depends on the unit itself. If you're somebody who works in a very difficult, challenging unit where the patients or the clientele are very challenging, very disturbed and you happen to have been off work for, say, eight to twelve months, you've totally lost your self-esteem, you've yet to go through your psychologist, your CBT and everything else, then you may not ever be able to come back to that job. So it depends on the environment you're going back to. That can be a restriction...

Occupational health staff

Again, most participants agreed that those returning to work following a primary episode of depression and/or anxiety, found it more difficult to adjust back to work than those returning with other types of illnesses. Line manager and colleague attitude towards depression and anxiety was raised as potential barriers to adjustment, but most participants recognised that some level of depression may still be present when an employee returns. Most employees struggle to manage coping their emotions, their work and their relations with their colleagues or line manager. Frequent relapse of illness and long-term sickness absence was a common outcome:

There was one young man who had quite significant emotional problems... who we tried to get back to work after a period of months. He was not able to sleep, he wasn't eating, he'd lost loads of weight, he eventually came back to work and it proved to be too early, and he went back off again... he couldn't cope.

Human resources manager

After two months or more [of absence] it's a daunting prospect. They're not going to hit the deck running, they need support and a bit of tolerance for people to realise they are not going to be back up to 100% efficiency. Sometimes they can be fine for the first six months and then have problems again.

Human resources manager

Such a lot of our cases are related to stress and depression... I think you can recognise where adjustments could be useful and we try to do it, but ultimately... the individual came back to work for a very short time span and then went off again. Its lack of sustainability.

Human resources manager

Many participants recognised communication was a problem for those returning to back to work with depression and anxiety. There was is a general reluctance to talk about the illness by colleagues, line managers and by the employee managing depression:

Its getting over that first barrier to start with, coming back and people asking all those questions. Especially if its depression. I think people don't know what to ask. It's a difficult conversation to have with someone... I suppose it's difficult for the person who had it.

Line manager

She kept dissolving into tears and saying she didn't want to discuss it... She was like, 'I can't talk about it, I can't talk about it'...

Human resources manager

Future directions: Post return to work management

Improving post return to work management

Participants discussed that much more work and attention was required to improving each organisations' return to work systems, particularly in tailoring existing policies to account for the different knowledge and management needs for different types of chronic illnesses. In particular, they discussed the need for:

- Better health information and training for line managers and team leaders in recognising depression and anxiety among employees returning to work. In particular, to recognise symptoms of secondary depression in those returning to work following a physical illness.
- Offer refresher courses for managers to help facilitate a consistent approach to returning and maintaining employees at work.
- Adopt a more case management approach for employees returning to work.

Participants felt some of these recommendations could be achieved through improved collaborative working, communication and general workplace culture:

> *The key is properly trained line managers, clear defined policy that is known to everybody, not hidden away somewhere, so people can follow it, open channels of communication between all the main stakeholders, be it us, the unions, the patients, their employer, be it HR and ready preparedness by the employer to use techniques and rehabilitation in the workplace, which, I have to say, our organisation does do.*
>
> *Occupational health staff*

> *A better working relationship with HR, access to the managers, being able to have the time to go out and do more case management, individual case management.*
>
> *Occupational health staff*

Bridging the gap between stakeholders and healthcare

One area noteworthy for major improvement was in bridging the gap between General Practitioners (GPs), occupational health services and human resources. Many participants felt frustrated at the level of information they receive from GPs, particularly in the cases of employees with stress, depression and/or anxiety. For example, whether an employee with depression can continue working or when they can return to work; and what impact their health may have upon work and vice versa:

> *With depression... its difficult to find them adjustments to come back to... occupational health could ask them to work two or three days [to help] recover from the effects of this kind of work, and then they go and see their GP, and the GP says, no, you can't.*
>
> *Human resources staff*

> *These individuals should see occupational health and be assessed whether they're fit to engage with management or not. It should not be the individual's decision which is often the case its reported by the GP.*
>
> *Occupational health*

> *Because there is a willingness for GPs to issue certificates of sickness to attribute what they're being told is stress, and quite readily to sign a certificate to that effect. But its not them who ought to ask, well why are you stressed?... That sort of, doesn't enter the medical process until such times we get our own doctor to review them, and he will tell us, they have been depressed or stressed, but can now handle whatever process you need to go through with them.*
>
> *Human resources staff*

All participants agreed that in order to improve return to work and post return to work outcomes, information about an employees' health could be better communicated and shared between organisational stakeholders such as occupational health professionals and GPs; to help understand and successfully support employees back into work, as one occupational health staff summarised:

> *It's a question of the company working across disciplines. When I say across disciplines I mean HR, Occupational Health, Line Management, healthcare and insurance services, all working together.*
>
> *Occupational health*

5. Role of depression following return to work - Survey findings

A total of 600 questionnaires were sent across the four participating organisations based on the number of participants identified: 300 were sent to those working in Transport, 120 each to those working in Local Government and Manufacturing, 60 to those working in Healthcare (although 150 participants were identified, the Trust only selected 60 of those they deemed appropriate to contact).

Overall, 198 questionnaires were received back from the organisations (yielding a 33% response rate), of which 151 were fully completed questionnaires. To boost the number of questionnaires, national support groups and charities were targeted of which the majority were affiliated with NHS Trusts or clinics (see appendix two). These agreed to place the link on their website which generated a further 113 questionnaires that met the study criteria, bringing the total number of questionnaires to 264 (see Tables 3 and 4).

Organisational Type	Participating Organisation		Charities		Total	
	n	%	n	%	n	%
Transport	60	40	0	0	60	23
Government	30	20	21	18	51	19
Manufacturing	27	18	3	3	30	11
Healthcare	34	22	11	9	45	17
Education	-	-	26	23	26	10
Other	-	-	29	27	29	11
Did not specify	-	-	23	20	23	9
	151	**100**	**113**	**100**	**264**	**100**

Table 3: Number of participants in particular industry sectors

Table 4 shows the number of participants who returned from long-term sick leave following an illness. Those with depression & anxiety were the largest sample, followed by back pain, cancer and finally, heart disease, which generated the least number of responses. Discussions with various occupational health professional and support groups revealed that most employees with heart conditions are older, and therefore most likely to take early retirement than return to work (see method section).

In one organisation, identifying employees by illness group was not always possible as the detail of information recorded varied considerably. Therefore a small number of questionnaires were inevitably sent by the occupational health team to employees who did not meet the study criteria in terms of illness group (n=27). In addition, several online questionnaires (n=3) were also completed by those who did not meet the study criteria for illness group. These questionnaires were completed by participants who had taken long term sick leave either due to a fractured bone, or an acute (short-term) illness. Where relevant, these questionnaires are included in the analyses as a comparison group of non-chronically ill employees (see Table 4).

Except for the comparison group and those with heart disease, the majority of participants were female. On average, those with depression and anxiety were younger and those with cancer or heart disease were older.

Group	Total		Female (n=)		Age		Length of sick leave (months)		Time since returning to work (months)	
	n	%	n	%	Mean	(SD)	Mean	(SD)	Mean	(SD)
Depression & anxiety	106	40	64	60	39.6	11.2	4.74	(4.67)	7.13	(6.5)
Back pain	54	21	29	54	43.3	9.6	4.63	(4.22)	9.48	(7.66)
Cancer	50	19	35	70	51.2	9.6	7.29	(5.35)	9.42	(6.96)
Heart disease	24	9	5	21	51.2	7.2	4.89	(3.13)	7.86	(6.27)
Comparison group	30	11	9	30	42.	9.0	3.15	(2.32)	5.69	(4.02)
Total	**264**	**100**								

Table 4: Demographic and return to work details by chronic illness group

Sick leave and return to work

From Table 4, those with cancer had on average, longer periods of sick leave compared with other groups (excluding comparison group), but had also been back at work longer than most groups. For analysis purposes, 'time since returning to work' was categorised into those who had returned to work 6 months or less, and those who had returned more than 6 months ago. Table 5 shows that except for cancer, the majority of participants had been back at work for 6 months or less following sick leave.

Group	Returned ≤ 6 months		Returned ≥ 7 months	
	n	%	n	%
Depression & anxiety	62	59	44	41
Back pain	26	48	28	52
Cancer	21	42	29	58
Heart disease	12	50	12	50
Comparison group	20	67	10	33

Table 5: Percentage of participants who returned to work ≤ 6 months ago Vs ≥ 7 months ago

Presence and severity of depression

Participants were asked to report if they had been diagnosed with depression by a physician. Table 6 shows that from the depression and anxiety group, 39% of participants also had anxiety. None of the participants reported anxiety alone. About a quarter of those with back pain or cancer reported a diagnosis of depression. Only one with heart disease reported depression and none of the comparison group had a diagnosis of depression.

Group	Yes		No	
	n	%	n	%
Anxiety	41	100	-	-
Back pain	13	24	41	76
Cancer	14	28	36	72
Heart disease	1	4	23	96
Reference group	0	0	30	10

Table 6: Percentage of participants reporting co-morbidity of depression

In addition to reporting depression as diagnosed by a physician, an independent measure of depression was also used in this study. This was for two reasons: first, differences in presence and severity could be studied and second, as noted in the introduction, individuals suffering from other chronic illnesses (e.g. cancer) may not have been diagnosed with, or sought help for, their depression and therefore the co-morbidity of depression may be underestimated when using physician diagnosis alone.

The Beck Depression Inventory (BDI-II) was used to assess the presence and severity of depression among participants. The total score ranges from 0-63 and categorised into minimal (scores 0-13), mild (14-19), moderate (20-28) and severe (29-63) depression using cut-off points suggested by Beck (1996).

Statistical analyses (Analyses of Variance) showed that those with depression and anxiety reported significantly higher mean score of depression than other groups (average depression score 25.0 Vs 16.7 for back pain, 13.6 for cancer, 13.3 for heart disease and 4.8 for the comparison group) [$F(4,259) = 21.35, p<.0001$].

As the majority of participants (except for those returning after depression & anxiety), reported minimal to moderate levels of depression on return to work, with few participants reporting severe levels of depression (4 -15% of participants in other illness groups vs. 38% of those with depression & anxiety reported severe levels of depression on return to work); the scores were categorised into two for analyses purposes: those with scores of 0-13 were classified as having no depression and those with a score of 14 and above, were classified as having at least mild to moderate symptoms of depression (elevated depression symptoms) (see Table 7).

Chronic Illness	No Depression		Mild-Moderate Depression	
	n	%	n	%
Depression & anxiety	26	25	80	75
Back pain	31	57	23	43
Cancer	28	56	22	44
Heart disease	13	54	11	46

Table 7: Depression on return to work by Chronic Illness Group (measured by the BDI-II questionnaire)

- As all participants with depression and anxiety had a diagnosis of depression, chi-square analyses was carried out to examine the association between depression diagnosis and the BDI-II score for those with a physical illness. This showed that a significant proportion of participants who were not diagnosed with depression reported symptoms of depression on the BDI-II (62% not diagnosed but reporting symptoms Vs 38% diagnosed and reporting symptoms on return to work; $x^2 = 19.07$, df=1, $p<.05$).
- When looking at each illness group individually, this finding was most significant for those with back pain (57% Vs 43%; $x^2 = 7.51$, df=1, $p<.05$).
- There was no association between gender, age and symptoms of depression.

Depression and time since return to work

- Odds ratio analyses showed that participants who had returned to work recently (0-6 months ago) were more likely to have mild to moderate depression than participants who had returned to work more than 6 months ago (59% Vs 41%; odds ratio 1.98); regardless of illness type.
- Looking only at those who had recently returned to work, a significant proportion of participants who were not diagnosed with depression reported symptoms of depression on the BDI-II (63% not diagnosed but reporting symptoms Vs 37% diagnosed and reporting symptoms; $x^2 = 6.87$, df=1, $p<.05$).

Depression and current treatment

- Eleven percent of all participants were having counselling, six percent were having cognitive behavioural therapy (CBT).
- Eighteen percent were receiving some form of rehabilitation provided by their healthcare.
- There were no significant difference between those reporting symptoms of depression and those not reporting depression in receiving any of the treatment.
- There was also no difference between those who had returned 0-6 months ago Vs more than 6 months ago and the treatments they were receiving.

Confidence in managing health condition at work

Participants were asked several questions on how confident they were in managing aspects of their health condition at work. Responses were combined into one scale reflecting confidence at work.

- Statistical analyses (Analyses of Variance) showed that those with depression and anxiety and back pain reported lower levels of confidence at work compared with cancer and heart disease [F (3,221)=12.68, $p<.01$].
- Odds ratios calculated for each illness group showed that low confidence in managing the health condition at work was associated with symptoms of depression in those with depression and anxiety (odds ratio 0.39), back pain (odds ratio 0.75) and cancer (odds ratio 0.69), but not in those with heart disease.
- For each illness group, level of confidence was not associated with time since return to work (0-6 months or more than 6 months ago).
- Confidence in managing health at work was not associated with gender or age.

Illness, depression and work adjustments

In terms of work adjustments, participants were asked if they received gradual or phased returns and/or work adjustments when they first returned to work. Participants were also asked whether they were offered workplace counselling or stress management upon returning to work (See Table 8).

- Participants with cancer or heart disease were more likely than those with depression and back pain to return to work gradually with short working hours.
- In contrast, over half the participants with depression or back pain returned to work initially with either reduced or different job tasks. Over half of those with heart disease and other health problems were also offered reduced job tasks.
- For those with depression or heart disease, nearly half of participants were offered counselling and about a quarter with heart disease were offered stress management.
- Odds ratios calculated for each illness group showed that for those reporting depression, not being offered a stress management course was associated with symptoms of depression (odds ratio 0.17).
- The association between no stress management and depression symptoms was most significant for the depression group who had returned to work more than 6 months ago than for those who had returned 0-6 months ago (odds ratio 0.11).
- There were no other associations between early return to work adjustments and current symptoms of depression for the illness groups.
- Less than a quarter of all participants still had a work adjustment in place. This was not specific to any illness.

Work adjustments	Work adjustments		Back pain		Cancer		Heart disease		Comparison group	
	n	%	n	%	n	%	n	%	n	%
Short working hours	40	38	20	37	38	76	19	79	6	20
Reduced job tasks	66	63	32	59	25	50	16	66	17	57
Different job tasks	58	55	31	57	25	50	11	46	17	57
Counselling	43	40	7	13	17	34	11	46	6	20
Stress management	15	14	4	8	6	12	6	25	1	3

Table 8: Percentage of participants by group who received work adjustments following return to work

Workplace support

Participants were asked how much contact they had with their line manager about their health since returning to work (Table 8).

- The majority of participants had minimal contact with their line manager about their health since returning to work.
- Odds ratio calculated for each group showed no association between line manager contact and symptoms of depression.
- Those with cancer who had returned to work more than 6 months ago were less likely to have contact with their line manager about their health condition than those who had returned 0-6 months ago.

Line manager contact	Depression & anxiety		Back pain		Cancer		Heart disease	
	n	%	n	%	n	%	n	%
Never	47	44	37	69	29	58	12	50
Few times a year	40	38	13	24	13	26	9	38
About once a month	19	18	4	7	8	16	3	12

Table 9: Percentage of participants in contact with line manager about their health condition

- Over 70% of participants in each illness group had regular contact with their GP about their health condition since returning to work.
- Nearly half of those with depression and anxiety had contact with occupational health compared to a quarter of participants in other illness groups.
- Odds ratio calculated for each group showed no association between GP or occupational health contact and symptoms of depression.

With regard to workplace support, participants were asked to rate on a scale of 1-5 how much practical support they received from their colleagues, line manager and occupational health since returning to work due their health condition (1= no support at all to 5 = a lot of support).

- Statistical analysis (non-parametric tests) showed that on average, the level of support received from colleagues, line manager and occupational health did not vary between the illness groups, though there was a trend for those with cancer receiving slightly more support from line managers than other groups (Table 10).
- Low levels of line manager support was associated with symptoms of depression in those with depression and anxiety (odds ratio 0.53) and in those with cancer (odds ratio 0.61).
- Low levels of colleague support was associated with symptoms of depression in those with depression and anxiety (odds ratio 0.62) and for those with back pain (odds ratio 0.52).
- For each illness group, level of support was not associated with time since return to work (0-6 months or more than 6 months ago).
- For those with back pain, high levels of line manager support was associated with being female (odds ratio 1.76). No other association between gender and support were found across the illness groups

Workplace support	Depression & anxiety		Back pain		Cancer		Heart disease	
	Mean	(SD)	Mean	(SD)	Mean	(SD)	Mean	(SD)
Colleagues	2.79	1.32)	2.64	(1.41)	3.17	(1.38)	2.74	(1.21)
Line manager	2.65	(1.28)	2.51	(1.51)	3.28	(1.47)	2.57	(1.30)
Occupational Health	2.40	(1.41)	2.04	(1.14)	2.35	(1.57)	2.43	(1.56)

Table 10: Average level of workplace support received by group

Current work ability

The Work Ability Index (WAI) was used to assess participants work ability. WAI scores range from 7 to 49 points and results indicate the following: poor work ability (up to 27 points), moderate (28-36 points), good (37-43 points), or excellent work ability (44-49 points).

Except for those the comparison group, the majority of participants reported either poor or moderate levels of work ability (see Table 11).

Work ability	Depression & anxiety		Back pain		Cancer		Heart disease		Comparison group	
	n	%	n	%	n	%	n	%	n	%
Poor	67	63	18	33	13	26	3	13	4	13
Moderate	39	37	36	67	37	74	21	87	15	50
Good	-	-	-	-	-	-	-	-	11	37

Table 11: Work ability by group

- Those with depression and anxiety were more likely to report poor levels of work ability (odds ratio 0.22).
- Those with cancer (odds ratio 4.63), heart disease (odds ratio 11.59) and back pain (odds ratio 3.07) were more likely to report moderate levels of work ability.
- However, poor work ability was associated with symptoms of depression in those with back pain (odds ratio 0.57) and cancer (odds ratio 0.24), as well as in those with depression and anxiety (odds ratio 0.15).
- Moderate work ability was more likely to be associated with those with depression and anxiety who had returned to work more than 6 months ago (odds ratio 2.64). No other pattern of work ability and return to work were found for the other illness groups.
- Higher levels of confidence in managing health condition at work was associated with moderate work ability for those with depression and anxiety (odds ratio 1.73), back pain (odds ratio 2.14) and cancer (odds ratio 1.36).
- None of the work adjustments were associated with work ability. This might be because less than a quarter of participants have a work adjustment currently in place.
- Those with back pain were more likely to report moderate work ability if they received support from their colleagues (odds ratio 2.58), line manager (odds ratio 2.15) and occupational health (odds ratio 1.92).
- Those with depression and anxiety were more likely to report moderate work ability if they were receiving support from their line manager (odds ratio 1.63).
- There was no association between gender and work ability. However, older workers were more likely to report moderate work ability than younger workers (odds ratio 1.03).

Psychosocial demands of work

The job content questionnaire was used to assess whether participants with high work demands and low job control at work were experiencing job strain; and whether those experiencing high strain were receiving low workplace support (iso-strain), all of which may in turn affect their health and well-being at work. Job strain was assessed as the ratio of job demand and job control; iso-strain was assessed as the ratio of job strain and support (see methods section).

- Those with depression were more likely to report high job strain (odds ratio 3.06) than other illness groups.
- There was no association between job strain and symptoms of depression for those with cancer, heart disease or back pain.
- There was no pattern of association between job strain and return to work (0-6 months ago or more than 6 months ago).
- Moderate work ability was associated with lower job strain (odds ratio 0.52) and this was not specific to any illness.
- None of the work adjustments were associated with job strain. As previously mentioned, this might be because less than a quarter of participants have a work adjustment currently in place.
- Those who had received stress management reported lower job strain (odds ratio 0.20).
- There was no association between gender and job strain, or age and job strain.
- There were no significant findings between iso-strain and any other variable.

Sickness absence, job satisfaction & intention to leave

Participants were asked if they had taken any sick leave over the past 12 months (or since returning to work, if they had been back at work less than 12 months). The information is presented as the percentage of participants taking spells of 1-4 days sick leave (non-certified absence), and spells of 5 days or more (certified absence).

	Non-certified absence (≤4 days)		Certified absence (≥5 days)	
	n	%	n	%
Depression & anxiety	50	47	60	57
Back pain	26	48	25	46
Cancer	14	28	27	54
Heart disease	5	21	12	50
Reference group	15	50	12	40

Table 12: Percentage of participants taking non-certified and certified absence over past 12 months (or since returning to work)

- Except for those with back pain and the reference group, over half the participants had taken certified sick leave.
- Symptoms of depression were associated with both non-certified (odds ratio 1.92) and certified (odds ratio 1.88) sickness absence. These were not specific to any illness group.
- For those with depression and anxiety, certified sickness absence was associated with high job strain (odds ratio 3.14).
- Neither type of absence were associated with return to work (0-6 months ago or more than 6 months ago), confidence in managing health condition at work or line manager support.
- Women were more likely to report taking certified absence than men (odds ratio 2.94). Younger workers were more likely to take non-certified sickness absence (odds ratio 0.96).

Participants were asked to what extent they were satisfied with their job and had thoughts about leaving their job.

- Lower job satisfaction was associated with depression symptoms in those with depression and anxiety (odds ratio 0.38) and back pain (odds ratio 0.39).
- For those with depression and anxiety, higher job satisfaction was associated with those who had returned to work more than 6 months ago (odds ratio 1.66).
- Overall, moderate work ability was associated with higher job satisfaction (odds ratio 1.63) and lower intentions to leave (odds ratio 0.63).
- Overall, higher levels of job satisfaction and lower intention to leave were correlated with increasing levels of line manager support, and higher confidence in managing health condition at work.
- Neither job satisfaction or intention to leave were associated with gender or age

Summary of findings

- Three-quarters of those with depression and forty-five percent of those with a physical illness (back pain, cancer and heart disease) reported mild to moderate symptoms of depression (measured by the BDI-II).
- Over sixty percent of participants with a physical illness had not received a diagnosis of depression despite reporting symptoms.
- Those who had returned to work less than six months ago were more likely to have depression than those who returned more than six months ago.
- Mild to moderate depression was associated with poor work ability, low confidence in managing health condition at work, low workplace support, short-term sickness absence and additional long-term sickness absence since returning to work. For those with depression as their primary illness, high job strain and no stress management training were also a contributing factor.

6. Employee perspectives on depression and return to work

Phase five of the study recruited a total of 30 employees from the questionnaire survey for in-depth semi-structured interviews. The purpose of the interviews were to discuss in detail, the effects of both depression and chronic illness on work performance; adjusting to work; the extent to which employees feel supported at work through workplace interventions; and perceptions on possible long-term sickness absence relapse. Table 13 shows the themes and sub themes relating to discussions with participants. The findings are presented separately for each illness group for ease of reading.

Themes	Summary of Themes
Episodes of illness, treatment and self-management	- Current use of medication, counselling and therapy for depression - Self-managing behaviours to manage symptoms of illness, pain or treatment side effects.
Return to work decisions	- Facilitators for returning to work - Line manager contact and communication during sick leave - Role of GP in return to work - Role of occupational health in return to work
Post return-to-work support/adjustments	- Benefits of phased returns - Minimal implementation of work adjustments - Variations in line manager support and understanding of illness and its impact on work
Workplace attitude toward sick leave and illness	- Variation in colleagues' attitude and understanding toward illness and sick leave - Perceptions of stigma attached to depression and anxiety
Effects of illness upon work	- Short term difficulties with adjusting back to work due to fatigue, line manager/colleague relationships and minimal work adjustments. - Symptoms of depression and low support interfering with work tasks - Feelings of low confidence, frustrations & guilt due to early problems with psychosocial work adjustments and work performance
Re-occurring sick leave	- Re-occurring sick leave due to symptoms of depression, illness associated fatigue or pain and returning to work too soon.
Improving post return to work management	- Improving knowledge and understanding of illnesses and co-morbidity of depression - Improving communication and contact with line manager, employee and other stakeholders - More information and assessments on phased returns and work adjustments

Table 13: Employee interviews - key emergent themes and summaries

Employees with depression and anxiety

A total of 11 interviews were conducted with employees with depression and anxiety. Eight were male and six participants were manual workers. Most participants were currently on medication and receiving counselling. Nearly all of the participants had been on long-term sick leave several times over the past two years. Bibliographic details of participants can be found in Appendix three.

Episodes of depression, treatment and self-management

All participants reported managing long-term depression and/or anxiety with the onset ranging from two to seven years ago. The majority felt the cause of their depression was work-related, and while the initial workplace trigger for their illness may have resolved, the effects of depression and anxiety are long lasting, reoccurring, and impacting participants, their family, their work and work relationships.

> *I was never like this; I was always happy go lucky chap, until all this blew up. It changed my life dramatically, the way I feel and everything. Its really changed my life.*
>
> *Male, manual occupation*

Most participants were on long-term medication for depression. Some were also receiving counselling either through their GP, their workplace or privately. For most participants, counselling started during their sick leave and continued post return to work. All such participants felt the benefits of counselling, but had mixed responses toward their medication.

> *I went down to the bottom of despair... after I met that GP it helped me along. The counselling helped. It was a different thing. It was good because it was a plus.*
>
> *Male, manual occupation*

> *I'm hoping to go off medication... I'm not working at the level I used to work. Yesterday, I actually forgot a meeting. That's never happened to me before in my life.*
>
> *Male, skilled manual occupation*

In addition to medication, the majority of participants attempted to manage symptoms of their depression either through exercise, taking weekend breaks away, or other activities to take their mind off feeling low or focusing on problems at work.

Things are always going through my mind... I don't want to go to work and fall out with the lads and then go home and take it out on my wife... so if things start to get out of hand a little bit at home, I'll go out in the garage and get the punch bag or my weights.

Male, manual occupation

For my own sanity and well-being, I started yoga which has helped tremendously. Helped me with my breathing because I wasn't breathing properly, hold my breath a lot and getting very wound up about everything.

Female, non-manual occupation

I am constantly trying to, even change the way I walk to work or where I go to eat and what I eat. I'm very aware I have to keep fresh and stimulated, I can't get in a rut

Male, non-manual occupation

Sick leave and return to work decisions

Most participants felt in control of their return to work decisions regardless of any pressure from their employers. Largely, participants' decisions to return to work were based on how well they felt, the need to return to normality, and for financial reasons.

It was a matter of life or death money-wise. I've got four children, I have a mortgage and I have a car, as well as bills that people usually have to pay.

Male, manual occupation

I wanted to get back to work. I felt a lot better, a lot more human, I wanted to go back.

Female, non-manual occupation

Some participants felt nervous about returning to work and dealing with their colleagues' reaction toward their absence as one participant discussed:

I think the biggest barrier was that I was very wary about the response I would have got with the lads. Going back in and hearing 'where the hell have you been? I'd been out for six months...

Male, manual occupation

A high proportion of participants did not have any contact with their line manager while they were on sick leave. This made it difficult to return as participants were uncertain whether their line manager would prove to be understanding or supportive upon returning to work. For the few participants who had contact with their line manager, the support and understanding they received was considerable. In these cases, the line managers had regular contact with the participant.

She was very understanding. She phoned me a few days later, when I was able to talk a bit more, she wasn't pushing me, she said that's fine, I'll sign your form, sign you off sick. And she's been fantastic during the times I have been off.

Female, non-manual occupation

Role of GP in long-term sick leave

GPs played a large and important role in the return to work decision-making process. As GPs were the first port of call for participants in their illness, they were signed off on sick leave by their GP, and received treatment, self-management advice and rehabilitation advice. Participants therefore perceived their GPs as the most supportive during their sick leave and returned to work when their GP agreed they were fit enough to do so. In some cases, this caused friction with employers who were keen to return the employee back to work sooner, but were prevented by participants who would only follow the advice of their GPs, as one participant discussed.

When I first went off with depression, I got a phone call from one of my bosses saying you don't want to be at home stewing, you want to be at work. I said I'll comeback when doctor feels I'm fit enough to come back to work.

Male, manual occupation

Role of occupational health in long-term sick leave

The majority of participants made contact with their occupational health department themselves, during their sick leave, upon the recommendation of their GP. They discussed being surprised to learn that there was an occupational health service within their organisation, and were pleased with how supportive occupational health were during their sick leave. In some cases, this helped participants in returning to work more quickly:

I found them a great help because they said, any problem; go home. Just don't take stress, you go in, if you can't handle it, just walk out, give me a ring, and we'll talk about it...

Male, Manual occupation

I found occupational health really helpful. She gave me a lot of advice about depression and helped me get back to work.

Male, non-manual occupation

Post return to work support and adjustments

Mixed responses were received as to how participants returned to work (i.e. phased in or fully returned) and whether work adjustments were offered. A small number of participants received phased return to work for each episode of long-term sick leave related to depression. Few participants also received temporary work adjustments such as job share, reduced work load or reduced working hours. These were usually implemented by occupational health.

> *One of the occupational health nurses I saw, she wrote a report and worked out a plan for a phased return to work. It was certainly a reasonable approach to things.*
>
> *Male, skilled manual occupation*

> *They wrote a report saying that it was okay for me to go back and gave me advise on my duties when I went back to work to make sure they didn't overload me and put too much pressure on me.*
>
> *Female, non-manual occupation*

> *I came back two days then three days. So I did that a few weeks... I found it very helpful because I wouldn't have been able to handle it if I had been dropped in a five-day week.*
>
> *Male, non-manual occupation*

However, most participants returned to work without being phased back in, or being offered any kind of adjustment despite repeatedly asking their line managers or occupational health for it. In most cases, no reason was given as to why they could not be phased back in or have adjustments. This subsequently affected a number of participants' feelings toward their workplace:

> *I said I wanted to get into it gradually, but there was no gradually, it was straight into it, like I was doing before... there were [no adjustments], I mean nobody, honestly and truly in the workplace where I work, nobody seems to bother.*
>
> *Male, manual occupation*

> *I got phased back in but on [the organisation's] conditions. There wasn't what I would call work rehabilitation. I suggested it but they said once you're back, you're back and that's it. I just couldn't cope at all. I found it so difficult.*
>
> *Male, manual occupation*

In other cases, extreme work adjustments were made when a participant returned to work to minimise work-related stress. This kind of approach negatively affected participants' recovery from illness and their confidence in their work competence.

> *They changed the work totally. I had a reasonable amount of responsibility and a reasonable amount of authority to carry out that responsibility. I'm a man of no consequence now, that's how I view myself by the position they've given me.*
>
> *Male, skilled manual occupation*

> *I didn't feel I got any support until I went back to work... When I went back, they moved me to another area and changed my work shifts. Its not actually helped me, its made it worse for me. I was among a lot of strangers and I found myself nearly in tears. It would have been better to have stayed in the same area and worked with a colleague for a couple of weeks.*
>
> *Female, manual occupation*

Line manager and colleague support

Workplace support post return to work affected how participants felt about their work, their health and well-being. Where line managers were supportive in phased returns and work adjustments, participants felt positive about their workplace.

> *I had regular supervision, phone calls from my line manager making sure everything was alright. Phone calls from the service manager as well, to make sure I was okay. I couldn't have wished for better support from my managers.*
>
> *Female, non-manual occupation*

Some line managers provided informal, short-term work adjustments but no long-term support and participants were left feeling isolated in dealing with their illness and their work.

> *When I went back, I saw her two or three weeks after that and she didn't do anything ongoing, which I was quite surprised at. I did think she would see me in like, three months after. I just sort of felt I was on my own.*
>
> *Female, manual occupation*

Minimal support and understanding from line managers or colleagues had a huge affect on participants ability to recover or manage symptoms of depression at work, especially feelings of low self-esteem and low confidence in their work competence. Many of these feelings arose because line managers simply didn't talk to participants about their health and well-being. For some participants, the lack of communication made it difficult for them to access support most needed.

> *[After returning to work] the communication with the manager did not change really and I don't think there's a will there. After 25 years of service, I feel quite disappointed really. We all like to feel that we're of some use. We don't like to feel we're not of value and that's the way I feel.*
>
> *Male, skilled manual occupation*

> *I couldn't get my balance and I could hardly get my breath. I had to [stop] for two hours because I knew if I rang my line manager, what was he going to do? Nothing. As one says, get on with it, they don't want to hear about it. Who do you ring? Who do you get onto? Nobody, there's no-one who cares.*
>
> *Male, manual occupation*

For one particular participant, the lack of support and understanding toward his illness from his line manager and colleagues made him feel worthless and often suicidal:

> *It would be nice if somebody that knows there are people like myself , and go around every so often and have a talk with them and say how are you coping?. I think management should look at this sort of thing and be more aware of how we are. Because sometimes I get so wound up I could just walk in front of a car... I've felt like doing myself in a few times, I've jumped in the river.*
>
> *Male, manual occupation*

Support from occupational health

Although the majority of participants were satisfied with the level of support and involvement they received from occupational health during their sick leave, most felt this support tailed off shortly after they returned to work. Participants felt let down with the disappearance of occupational health support, particularly if support was not being received from elsewhere.

> *I have been disappointed in that there was no follow-up from occupational health or personnel... it's a serious situation when someone is reduced to tears, especially somebody at my age. I'm a 60 year old man.*
>
> *Male, skilled manual*

> *There was no follow-up from occupational health. What could I do? Because there was no support there...*
>
> *Male, manual occupation*

The occupational health involvement was more of a formality when I returned. I've always perceived occupational health to be the people who are supposed to be there to support you. I don't know whether it was because how I was at that time, like I say, I felt it was more of a formality. If my manager hadn't been doing it, I'd felt a bit let down.

Female, non-manual occupation

Workplace attitude toward depression and anxiety

Most line managers and colleagues discovered an employee had depression when they were signed off on long-term sick leave. The sharing of such information was often informal, and passed to colleagues either from the participants' friends or from the line manager when the participants' workload had to be re-allocated. Participants felt this process could be handled better, as often, no-one explained to their work colleagues what depression was, and how debilitating it can be, and how it could continue to affect the participant once they returned to work. Due to the lack of information, many held misconceptions about depression and this was often picked up by employees when they returned to work as one participant described:

The stigma attached to depression in any job is very, very strong, I decided to deal with it in a different way in that I'd be quite open about it and say I got depression. The simple way I describe it to people is its like being a diabetic; its just a simple imbalance in my body of a chemical that I have no control over and I take a tablet which balances it out and I'm not nuts. They don't have to creep around me because there's a lot of that that happens, 'oh, he's depressed, don't say anything bad.

Male, non-manual occupation

There appeared to be a strong correlation between lack of workplace support and negative workplace attitude. Participants felt support was less likely to be received where line managers and colleagues had little understanding or a negative attitude toward depression. This often hindered a participant's recovery and adjustment to return to work, and in some cases, also caused a relapse into long-term sick leave again.

People laugh at me sometimes. They say its all in your head. But they don't understand until they've been through it they haven't got a clue. Last year, they kept winding me up and winding me up... and I just broke down and I went off with depression again.

Male, manual occupation

They antagonised situations. I've learnt this new job, I've done this to the best of my ability and then I've had it picked to pieces by a colleague, and that didn't help my situation.

Female, non-manual occupation

Some participants discussed how positive understanding was only received from line managers and colleagues who had experienced depression themselves or within their family:

My line manager related to my depression and anxiety and she helped me through that from her own experience, and helped me rationalise things.

Female, non-manual occupation

One of the guys that I work with I found more supportive than any of the others at the (time) I was ill, and I only found out when I got back to work , his daughter had been going out with a chap who suffered from anxiety.

Male, manual occupation

Several participants acknowledged that upon returning to work, they found it difficult to talk to their colleagues about their illness or their sick leave. This affected both their social and work relationship with colleagues.

I found it quite hard having those conversations with colleagues, and when you're feeling down, you don't want to offload on other people. You tend to isolate yourself quite a bit.

Female, non-manual occupation

Other participants made an effort to maintain good relationships with their colleagues. They found this significantly helped to return to work after each episode of long-term sick leave, to enjoy work and maintain good work productivity:

Social acceptance – the stigma attached to being depressed... I took it on the chin and now have support from all my colleagues in here, they knew the position because I've never been afraid of saying I have depression. It hasn't been great all the time, there's been ups and downs, its natural but I'm coping. I'm doing great, I'm very, very happy in my job... I can sit down with any of them, have lunch or go for a drink, I don't feel ostracised in any form or fashion.

Male, non-manual occupation

Effect of illness upon work

All participants struggled to adjust back to work and found it difficult to explain to their superiors why they were struggling and why it was taking such a long time to settle back into their job. Management's minimal knowledge and understanding of depression and its symptoms often added to the participants' difficulty in adjusting back to work as one participant described:

> *I struggled for months when I came back. It took me a good eight to ten months to get where I needed to be, after I came back because there was an awful lot of adjustments involved... but they made no allowance for the fact I'd been through a tough time and I was trying to figure things out. It was like, you're back, you're at work and you better be perfect.*
>
> *Male, non-manual occupation*

Participants discussed that when they returned to work they felt physically and mentally fit. However, they had not anticipated symptoms of depression reoccurring. Most participants felt their attitude toward their work, their ability to cope with it and their work ability fluctuated according to whether they felt depressed or stressed at the time. In some cases, this was triggered by the workplace and in other cases, they arose without any warning:

> *I'm handling it quite well at the moment... Sometimes I enjoy it and other times I just feel like getting another job or packing it in.*
>
> *Male, manual occupation*

> *I still have bad days. I still have days where I get panicky. Rather than putting myself into a position of making it worse, I won't go into work that day and will go in a couple of days later.*
>
> *Female, non-manual occupation*

> *I took a dive [sick leave] for a few days and went to see my GP and said I'm really worried. He said, why, you've had a couple of bad days, that's life... you're not falling back in; you're not slipping back to being ill again. That was one of the hardest things to understand that if I have a bad day, I have a bad day because you're paranoid that you're slipping back.*
>
> *Male, non-manual occupation*

Re-occurring sick leave

Nearly all participants had re-occurring episodes of long-term sick leave due to depression and/or anxiety. The reasons were largely due to either prematurely returning to work and not coping, struggling to adjust back to work or not feeling supported at work. In almost all cases, participants took their second leave of long-term sickness absence almost as soon as they returned to work following the first episode:

> *I went back to work and sort of, broke down at work. I'd had no sleep all night and when it was time for getting up, I dropped off to sleep... I went to work late and rang my senior and I didn't find her very helpful... I got very upset but she passed it on to my manager and so I went to the doctor that afternoon and he put me back off sick again. So I'd only been back at work a short time before I actually had to go back off sick again.*
>
> *Female, manual occupation*

> *I was just going into the office for a couple of hours, just really familiarising myself, because I'd been off four months. At that point, I can't say I actually got back into it again. My mind wasn't in the right place. So I said, 'I can't do this' ... and was signed off again.*
>
> *Female, non-manual occupation*

Rather than addressing the problem of re-occurring depression and anxiety through primary or tertiary prevention, some participants received warnings for their repeated long-term sickness absence from their employers:

> *I saw occupational health and he said I needed to be careful how much time I had off work because of them finishing me off. And also my manager said they were monitoring my sickness. So it worried me that I don't feel that I can have sickness now because I feel like I might lose my job.*
>
> *Female, manual occupation*

Employees with back pain

A total of four interviews were undertaken with participants with back pain. Two were male and all four were manual workers. They were all currently on medication for pain. Three of the participants reported symptoms of depression following the onset of their back pain/injury. Nearly all of the participants had been on long-term sick leave several times over the past two years due to reoccurring back pain. Bibliographic details of participants can be found in Appendix three.

Backpain , treatment and self-management

All participants reported managing back pain with the onset ranging from one to six years ago. In most cases, the onset of chronic back pain was due to injury either at the workplace or outside of it. Most participants managed their back pain not only with pain killers, but by active management by attending regular physiotherapy, carrying out exercises and seeking alternative therapies:

I am dealing with it by acupuncture, exercise, and medicine.

Male, manual occupation

I walk, I do the exercises, the press-ups. I walk a lot and I even bought a bike so I cycle a good bit too. I try to keep myself fit so it doesn't bother me again.

Female, manual occupation

I went to see a guy who does manipulating massage locally, I paid for that myself and he helped me a lot.

Male, manual

Sickleave and return to work decisions

Most participants made their own decisions about returning to work without the influence of their employers, GPs or physiotherapist. Feeling both physically and mentally well was the most common reason for returning to work, rather than financial constraints.

> *I decided to go back myself. It was my decision and the doctor said it was entirely up to me so I felt confident enough to return.*
>
> *Female, manual occupation*

> *They [employers] were surprised when I told them I was ready to go back to work. Even my doctor said, are you sure and I said yes, I'm fine'.*
>
> *Female, manual occupation*

Role of occupational health in long term sick leave

One participant had no contact with their occupational health during sick leave. For those who did have contact, the contact varied from only one meeting during sick leave, to meeting monthly after a time lapse of a few months.

> *A nurse contacted me once when I was out sick and then when I was back in which she contacted me to see how I was. She didn't realise I was back in work.*
>
> *Female, manual occupation*

> *I didn't see anyone for the first few months. After that, the occupational nurse contacted me... she met me then every month to see if it was improving a bit.*
>
> *Male, manual occupation*

Post return to work support and adjustments

None of the participants felt supported by their line manager upon returning to work. Only one participant felt supported by occupational health when returning to work following each episode of sick leave. They were offered phased returns which they felt helped them to make a safe and timely return to work:

> *It was good. When I was sent back I was on a third of the duty for the first week, and help, somebody with you... By the fourth week, back to normalcy.*
>
> *Male, manual occupation*

The remaining participants returning to work were not offered phased returns or adequate work adjustments. This affected their ability to cope with the demands of the work, their back pain/injury, and their perceptions of their workplace.

> *I came fully back to normal duties. That was hard going, but I'm a strong person. There was no return to work kind of thing. As far as I'm concerned the company didn't really care what happened to me.*
>
> *Female, manual occupation*

> *I think they should be more supportive, when you do hurt yourself at work. They're not very accommodating.*
>
> *Female, manual occupation*

Such participants felt temporary or permanent adjustments should have been made so that participants did not have to carry out heavy manual work immediately upon returning to work. Participants also believed their employers should have offered training in manual handling upon returning to work; to prevent the re-occurrence of back pain/injury.

> *They could have been more helpful in the sense of, okay don't lift anything heavy. I mean, over the ten years I've never had any manual handling training or health and safety training.*
>
> *Female, manual occupation*

> *A refresher on something like manual handling if the company has problems where people are hurting themselves or things are becoming difficult.*
>
> *Male, manual occupation*

Work place attitude toward back pain

Participants felt adequately supported by their colleagues in relation to their sick leave and back pain. Such colleagues helped participants with carrying heavy loads and generally formed the participants' support network in the workplace.

> *It had nothing to do with management. My colleagues... they helped; they lifted the heavy load, they did that for me, for the first couple of weeks.*
>
> *Female, manual occupation*

> *Fortunately I work with a good crew, so I won't say they carry you, but they do assist you or they can assist you which they did.*
>
> *Male, manual occupation*

Effect of back pain upon work

Most participants felt they could carry out their current work tasks adequately and manage their back pain by being careful at work and by taking painkillers. However, participants were concerned about the effect their work was having upon their back and vice versa, and the dependency of using painkillers:

> *I live with pain all the time, but you can live through that, you can take a lot of tablets and survive it... You can definitely work through the pain, with tablets.*
>
> *Male, manual occupation*

> *You were straight back in after having a few months off, and my back even though I've been ill with back pain, you're straight back into lifting and carrying again, and popping pills everyday.*
>
> *Female, manual occupation*

> *I'm very careful with what I lift, what I move, how I stretch; I'm more aware of it… I monitor it constantly, if you like.*
>
> *Male, manual occupation*

Reoccuring sick leave

Nearly all participants had re-occurring episodes of long-term sick leave due to back pain. The reasons were largely due to not being able to initially cope with the pain at work or their back seizing up, causing temporary loss of mobility. In almost all cases, participants took their second leave of long-term sickness absence due to pain almost as soon as they returned to work following the first episode.

> *When I went back first, after nine months, the occupational health nurse came down to see me and she said I didn't look very well... she could see it, you can see pain in someone's face. And she booked me off for a further few weeks. After that, I felt very good, I had no medicine, no tablets, nothing at the time, and I worked for two and a half years, nearly before my injury.*
>
> *Male, manual occupation*

Back pain and depression

All participants felt despondent about their back pain, their lack of control over it, the reoccurrence of injury or pain; and its negative effects on their quality of working life and well-being. This made some participants feel disheartened over the chronicity of their back pain.

> *When you feel your back's starting to hurt again it does bring you down in your own self. I don't think I will ever physically feel free of pain again. But unfortunately, its part and parcel of getting older, as well as the job, you know.*
>
> *Female, manual occupation*

Guidelines by the Government to employers on encouraging employees to continue working whilst experiencing an episode of back pain caused additional distress and exacerbated symptoms of depression among participants:

> *The new ethos is, you fight through the pain, and you work, don't get depressed. Maybe they're right, but when you get to a stage where the pain is so bad that you just can't get out of bed in the morning... I feel in a way, that they are putting a lot of pressure on people... where do you go from there?*
>
> *Male, manual occupation*

Employees recovering from cancer

A total of nine interviews were undertaken with participants with cancer. The types of cancers were prostate, ovarian, breast and brain tumour (see Appendix three). Two were male and only one participant was in manual work. Seven participants reported symptoms of depression following their cancer diagnosis, of which four were currently on medication.

Cancer, treatment and self-management

All participants reported being diagnosed with cancer between one to three years ago. For prostate cancer, only surgery was required. For all other cancers, a combination of surgery, chemotherapy, radiotherapy or hormone therapy was required. Most participants did not really carry out any self-managing behaviours such as exercising or altering their diet once their chemotherapy had finished. With regard to symptom management, nearly all participants felt they were struggling to manage treatment related side effects. Fatigue was the principal symptom/side effect affecting participants on a daily basis at work:

> *I am finding it very tiring and I'm finding things that normally wouldn't bother you, because you're so tired, things which wouldn't normally be an issue all of a sudden become a major issue.*
>
> *Female, non-manual occupation, ovarian cancer*

Sick leave and return to work decisions

Most participants made their own decisions to return to work depending on how well they felt as well as upon the advice of their GP or consultant. The common reason behind returning to work was the need to return to normality as quickly as possible. The need for normality made one participant return to work to work halfway through chemotherapy treatment. Only one participant returned to work due to financial reasons.

> *I enjoy doing my job... It was my decision, I wanted to come back.*
>
> *Female, non-manual occupation, brain tumour*

> *I rang one day and said, right, I'll be back tomorrow and went back to it.*
>
> *Female, non-manual occupation, ovarian cancer*

A small proportion of participants did not have any contact with their line manager while they were on sick leave. These participants felt let down by management and were concerned about whether their line manager would prove to be understanding or supportive upon their return to work:

My manager never phoned me up to see how I was getting on. I never had any contact with payroll or HR or anything, although I was filling in my forms every month... This has made me think whether they couldn't handle the cancer.

Female, non-manual occupation, ovarian cancer

Not management, they don't give a monkeys of it... I used to ring my manager every so often to say I'd be off for another two weeks or whatever and that was it.

Male, manual occupation, prostate cancer

Role of occupational health in long term sick leave

Not all participants had contact with their occupational health during sick leave. Some participants felt this may have been due to their sick leave information not being passed on from their line manager. This made some participants speculate whether line managers knew of occupational health's existence. Where there was contact, this was often instigated by the participants themselves.

Occupational health never contacted me the whole time until I actually contacted them before I went back, because I understood I had to have an interview before I went back to work. My manager did apologise that she hadn't done anything about it.

Female, non-manual occupation, ovarian cancer

I picked up the phone and rang her... She wouldn't have known unless my line manager told her, which he didn't.

Male, manual occupation, prostate cancer

I've never contacted them and I don't think anybody's contacted them on my behalf.

Female, non-manual occupation, brain tumour

When I asked my line manager about occupational health, she didn't seem to know anything you see. It was only talking to a colleague that she said, go to occupational health... It was a complete accident finding out about it, and then the fact that counselling didn't know about it either.

Female, non-manual occupation, breast cancer

Once contact had been established, participants found occupational health to be supportive during sick leave and upon returning to work.

The occupational health nurse is a lovely person altogether. She told me that if I ever needed anyone to talk to her, I was to go down to her.

Male, manual occupation, prostate cancer

She was excellent. She just said, right, I want to see you anytime, any place that suits you, if you can't come into head office.

Male, manual occupation, prostate cancer

I thought that the nurse was very supportive and if things went wrong again, she would back me up. I think it's a comforting thought, that you've got somebody like that, having that support behind you.

Female, non-manual occupation, breast cancer

Post return to work support and adjustments

Most participants were phased back into work following sick leave due to cancer. However, few received any work adjustments such as reduced workload or flexibility in working hours which left them exhausted due to the fatigue associated with cancer and its treatment, as one participant described:

Apart from a shortened day, I think practical support would have been [beneficial], perhaps a break in the middle of the day... it was tiredness that was the problem.

Female, non-manual occupation, ovarian cancer

All participants discussed how much they struggled with normal working hours, after their phased return had been completed as the late effects of cancer treatment continued to affect them. None of the participants were offered any help or support to manage the late effects and this was largely due to employers not knowing how participants were affected by their cancer at work. A number of participants eventually asked for work adjustments and requested shorter working days to help them manage the effects of fatigue.

The first they knew I was in trouble is when I started saying, right, we need to adjust my working hours, and cut back on my full-time work

Female, non-manual occupation, breast cancer

I was on a van route, but it was a long day, and I asked to be put on a shorter route.

Male, manual occupation, prostate cancer

I just found I was getting more and more fatigued, so I went to personnel and asked them if I could go part time, and they were very sympathetic and said they would talk to my boss who was fine about it.

Female, non-manual occupation, breast cancer

Line manager support

Workplace support post return to work affected how participants felt about their work, their health and well-being. Most line managers were initially supportive when participants returned to work, but failed to recognise or understand the impact of late effects of treatment upon participants work and well-being. With no work adjustments being made and no long-term support provided, participants were left feeling isolated in dealing with their side effects and symptoms, and their work:

If my managers just ask me how things were, to say how I was getting on... they should be wanting to see if this person is genuinely sick and if they need different assistance.

Male, manual occupation, prostate cancer

What you don't have during the working day, really, is time to discuss things like this [impact of late effects]. You're always so busy, and if you've got some time, your manager hasn't got the time to set aside an hour or two to just sit and go through a few things.

Female, non-manual occupation, ovarian cancer

When I first came back, I had a risk assessment done on me but everything was okay at the time and it was put down on my risk assessment but everything has gradually deteriorated over time and I don't think they can do anything... that's how its going forward.

Female, non-manual occupation, brain tumour

Workplace attitude toward cancer

Less than half of the participants were contacted by their colleagues during their sick leave and most participants discussed whether they would have liked some contact. Participants understood that the lack of colleague contact was due to colleagues being unsure about the nature of the participants' illness, its treatment and its visible side effects (e.g. loss of hair), and whether such participants would have welcomed contact. However, upon returning to work, nearly all participants discussed how supportive colleagues were toward them and their illness which helped toward emotionally adjusting to work and feeling emotionally supported at work:

When I walked in, of course everyone was delighted to see me, I was welcomed back, and I was only there for two hours or so, and they joked, and things slowly built up.

Male, manual occupation, prostate cancer

Effect of cancer and treatment upon work

Participants felt their illness and its treatment had affected their ability to carry out their work tasks to the same standard prior to being diagnosed with cancer. For most participants, adjusting back to work took a very long time due to the side effects of cancer treatment such as fatigue. This negatively affected their confidence in their work ability and also caused anxiety, frustration and guilt:

I had lost my confidence... I wanted to get back and do exactly what I was doing with my colleagues , feeling as though I could do it all, do all the strands of my job, but I wasn't doing that, I was feeling guilty that I wasn't able to do what everybody else was doing.

Female, non-manual occupation, ovarian cancer

I'm just losing my confidence because when this buzzing starts in my head I'm not very sure of where I'm walking, I trip over things [at work] and that's how its been going for a few weeks now

Female, non-manual, brain tumour

I've had anxieties, in the respect that by the nature of my illness, how shall I say, the waterworks aren't as reliable as they used to be. And when you're out somewhere [at work] where there's no facility, you kind of wonder how you are going to manage that.

Male, manual occupation, prostate cancer

Cancer, depression and re-occuring sick leave

Upon returning to work, three quarters of the participants interviewed developed symptoms of depression and anxiety which they believed was related to their both cancer and adjusting back to work. For some, this was because they had underestimated the effects of cancer treatment upon their well-being and returned to work too soon. For others, the effects of treatment led to fatigue, difficulties coping with work and subsequently depression. This inevitably led to re-occurring sick leave:

I thought I would just have the chemo and everything would be dealt with, so I planned to go back in March this year, which I tried to do, and I did for four weeks. I became quite tired and quite anxious and depressed. So I was off again until July... I managed five weeks that time and then I became quite anxious and depressed again, and basically went off on sick again.

Female, non-manual occupation, ovarian cancer

I went to the doctor and said look, I'm cracking up here... so he immediately gave me a cert, and said there you are, take a week off and if you come back and are not well, I will give you another one.'

Male, manual-occupation, prostate cancer

I've had three episodes of depression since being treated for cancer. I came back to work 14 months later [after breast cancer treatment] and I was fine. Unfortunately I became quite depressed and was put on anti-depressants, but I didn't have any time off work during that time... but then last year, I started experiencing sort of, anxiety attacks, and then became depressed and then I was off work.

Female, non-manual occupation, breast cancer

Participants were more worried about telling their employers about their depression than they were about disclosing their diagnosis of cancer. In particular, those who had been on sick leave due to depression, discussed how they found it more difficult to return to work following an episode of depression than an episode of cancer due to the stigma attached to depression.

Because after the cancer, it wasn't so bad... but I think I was much more frightened going back after last year's bout of depression, than I was after the cancer. I think at the back of my mind... that maybe my overall boss wouldn't be very sympathetic if I took time off

Female, non-manual occupation

Participants receiving ongoing medical treatment for their depression, reported coping better with their illness recovery, illness side effects and their job. However, all participants felt that if they had someone at work, to talk to about how their cancer made them feel both physically and emotionally, it could have helped them manage both work and symptoms of depression more effectively.

If you asked three weeks ago, I would probably say that I am struggling, but because I am on medication [antidepressants], at the moment things are looking up. I am having counselling with cognitive behaviour therapy as well... so that has been really helpful.

Female, non-manual occupation, ovarian cancer

Just somebody to talk to. Its very difficult because people have no concept of how you're feeling, other than health professionals... its just being able to go and talk and say, well actually, I'm really feeling not too good, and getting advice as well.

Female, non-manual occupation, ovarian cancer

Employees with heart disease

A total of four interviews were undertaken with participants with heart disease (see Appendix three). All were male and three of the participants were manual workers. All were currently on medication for their heart condition.

Heart disease, treatment and self-treatmant

All participants reported the onset of cardiovascular heart problems between one to ten years ago. For all participants, surgery was required. One participant also required a pacemaker. Most participants carried self-managing behaviours such as exercising, taking medication, altering their diet, monitoring their blood pressure and attending rehabilitation programmes upon the advice of their GP or consultant.

I do several walks every day... I used to attend the cardiac recovery programme twice a week which was voluntary

Male, non-manual occupation, heart attack

I like being active. I'm fairly active at home in that I do a lot of carpentry, a lot of gardening, physical activity around the house and things like that. You're not supposed to drink any alcohol whatsoever. Obviously you're not supposed to smoke. I do smoke but I don't drink as much as I used to. I've lost two and a half stone

Male, non-manual occupation, heart failure

Sick leave and return to work decisions

Participants made their own decisions about returning to work depending on how well they felt and the need to return to normality, rather than financial constraints. Most persuaded their consultant and GP that they were fit enough to return to work.

> *I went to the hospital and explained to the consultant that I wanted to get back to work. he said, yes, I would need a letter but knowing that would take two months, I went to my GP and asked if he would write me a note to say I could come back to work, I'm fit enough to go back to work.*
>
> *Male, non-manual occupation, heart failure*

> *The biggest influence [to return] was just to relieve the boredom of being off work and feeling well enough to do work.*
>
> *Male, non-manual occupation, heart attack*

Participants had minimal contact with their line manager while they were on sick leave. Contact by line managers were initially made to check on well-being and confirm length of sick leave. The minimal contact caused some participants' concern about their job security and relationships with their line manager as one participant discussed:

> *Here I am, at home sick, and no one has really bothered contacting me. But then I thought maybe I'm imagining it, you know? And then I was thinking more, no, no, they should be in contact with me a bit more than this. It upsets me in one sense, because I felt I've given 35 years here, I know some of these people both professionally and on a personal basis.*
>
> *Male, non-manual occupation, heart failure*

Role of occupational health in long term sick leave

Except for one participant (with an occupational health service), all others had contact with their occupational health service during their sick leave. They found them to be supportive during their sick leave and in helping them return to work gradually. One participant felt they received good advice from occupational health about not returning to work too soon.

> *I told her I was anxious to come back sooner rather than later and she advised me it would be better to take as long as possible because she had experience of people returning too soon from such a condition and then they had to take more time off.*
>
> *Male, non-manual occupation, heart attack*

Post return to work suport and adjustments

All participants were phased gradually back into work. However, none received any long-term work adjustments such as reduced working hours, reduced workload or flexible working and this affected their work ability and subsequently, their well-being in the first few months of returning to work as one participant described:

> *I think it would have been more beneficial if they had come down and said, look, we'll take a little bit of work away from you, we'll have a look at this. We may not know it, but we'll do some of the groundwork and where we're stuck, we'll come back and ask you. That would have helped a lot instead of the official line taken, welcome back, put him on a few hours work a day, don't give him too much and then next week, we'll see how it goes. It seemed welcome back with a manual, as opposed to welcome him back and let's seriously talk to the person.*
>
> *Male, non-manual occupation, heart failure*

Line manager support

Although participants did not receive any formal work adjustments, nearly all participants found their line manager to be initially very supportive about work tasks and work loads whilst participants were on a phased return to work programme. However, participants found managers did not offer emotional support especially when participants wanted to talk about their illness and how it was initially affecting them at work.

> *He wouldn't be exactly overloading me with work. He wouldn't be expecting too much of me when I did come back. You know, he would take me easy for a while...*
>
> *Male, non-manual occupation, heart attack*

> *I'd speak to my line manager, and that would be about work. There would have been no more said about it [the illness]. He would say I've another job here, but I don't want to give you too much, just take it nice and easy, but that would last for about 30, 40 seconds and they would be gone.*
>
> *Male, non-manual occupation, heart failure*

Work place attitude toward heart disease

Participants felt colleagues showed some interest in their illness, by visiting them in hospital during their sick leave and showing some support when they returned to work. This helped them emotionally adjust back to work.

> *It sort of gives you a lift each time anybody rang or gave any sort of communication, whether by phone, by card or a visit.*
>
> *Male, non-manual occupation, heart attack*

For one participant, minimal interest from colleagues affected their well-being at work and added to the pressures of their job:

> *Well I was putting added pressure on myself, because these people worked to me. Now, if this is how they would treat me when I'm sick what are they thinking or doing or saying when I am in work? Am I now inadequate in work?*
>
> *Male, non-manual occupation, heart attack*

Effect of heart disease upon work

All participants discussed feeling tired upon returning to work and this initially affected their work performance. Participants were surprised by the presence of fatigue and the impact it had on their work ability, despite some being forewarned by health professionals. Participants discussed that the feeling of fatigue made them feel that they had returned to work too early and should have taken longer sick leave. However, once the feeling of fatigue gradually subsided, participants felt their work ability to be fairly good. Nearly all participants had self-implemented some kind of strategy to manage both their illness and work.

> *I had reduced hours [during the phased return process] but I had a stressful day every day I went back, and I used to come home really tired and I thought now I think I've come back too early.*
>
> *Male, non-manual occupation, heart failure*

> *I was also advised by the occupational health nurse, that regardless of the type of work I was doing, I would experience a lot of tiredness which I didn't agree with her... Yeah, I was very tired and I didn't do an awful lot of work... now, I feel I am contributing as much as I did before I had the sick leave.*
>
> *Male, non-manual occupation, heart attack*

> *I carried on in the same role, but found myself looking at things differently, trying to adapt myself differently and people around me differently... just try and bring it all back to some sort of normality.*
>
> *Male, manual occupation, heart failure*

Heart disease and depression

All participants experienced symptoms of depression after surgery and upon returning to work. The feelings of anxiety and depression were largely episodic and beyond the participants' control. Participants discussed the effects this had on their well-being and ability to function at work. Those who had support from their colleagues found it easier to admit to having bouts of depression and were grateful for the support, but still felt alone in their illness and struggled with feelings of having let their team down.

> *I really felt alone. I felt I was the only person in the world who had this condition. When you've got heart failure, you look normal, but inside you are falling apart. I drove to work one day, I drove into the car park and I phoned up the guys and said, I can't get out of the car. And they came and brought me a cup of tea, we had a chat and I went home... I was disappointed that I felt I was letting them down... but they were very good*
>
> *Male, manual occupation, heart failure*

One participant struggled to cope with the feeling of depression at work and felt unable to talk about it or access much needed support at work. This prompted thoughts of exiting the workforce early.

> *I don't think anyone knows how I am feeling. I was feeling so bad that up to recently, I've looked into retiring early... But then I'm saying to myself, what do I do afterwards? But I am at that stage, and I am losing a lot of motivation I had before... I feel very alone, very much alone in my own world.*
>
> *Male, non-manual occupation, heart failure*

Two of the participants, receiving either therapy or information from healthcare about the occurrence of depression and how to manage it discussed how it helped them to recognise and cope with the symptoms without it adversely affecting their working life.

> *We were advised that we would have what we call down days. When you will be depressed or whatever. That does happen, and does still happen on occasion ... you know, while everything is going swimmingly well, and then for no reason at all you just have a very blue day... When I was told about it, that was a huge help, knowing that it could happen. And when it did happen, then I'd just say work your way through it.*
>
> *Male, non-manual occupation, heart attack*

> *Cognitive therapy really helped. You can see how it changed you, your thoughts at the time. I couldn't fault it really... I can honestly say now that I use some of those tools everyday unconsciously, and I feel it's a very, very strong and powerful tool.*
>
> *Male, manual occupation, heart failure*

Improving post return to work managment

One of the most important concerns all participants raised related to management's knowledge and understanding of their illness, and in particular, of depression and its symptoms. All participants discussed the need for better training for senior and lower management, supervisors and team leaders in not only understanding the late effects of certain illnesses and depression better, but also in supporting participants returning to work following sick leave so that both illness and sick-leave relapses are minimised:

> *I think it should be an integral part of a manager's learning and development, because they're under so much pressure. A lot of people, if they've never suffered depression, don't understand how debilitating it can be. If a manager don't understand the effect that has on your whole life, then you are never going to feel in a situation where, yes, I'm okay to go back to work, because I'm supported at work, and they are going to help me through the rough times as well as the good times.*
>
> *Female, non-manual occupation, depression*

> *The level of ignorance at management level is shocking. The lack of education with regards to depression and its various forms and various telltale signs, is very low in this company. They totally couldn't understand depression causes insomnia. Its not just staying awake, its night terrors, night sweats, nightmares, hallucinations and all the things that go with insomnia and depression.*
>
> *Male, non-manual occupation, depression*

Participants also discussed the issue of improving line manager communication and the amount of contact in post return to work management. This would significantly help reduce feelings of isolation and low self-esteem and help participants focus on their work and well-being. Participants also discussed improving communication between internal stakeholders and with primary and secondary healthcare and making the role of line managers in managing return to work more transparent both during and following sick leave.

> *I think more support throughout the illness and not just in going back, not just the actual return to work interview. I think it would have helped if I saw the manager every two or three months to make sure I'm alright, or any problems, they could just sort of help me through it.*
>
> *Female, manual occupation, depression*

> *Communication rather than a letter from my manager to occupational health, an actual discussion, and maybe a three-way discussion, you know, the sort of getting together and having a meeting about it. I don't know what their role is, I don't see their role as what I thought it should be.*
>
> *Female, non-manual occupation, ovarian cancer*

Some participants felt that phased returns should include explicit work adjustments such as temporarily reducing work load, so that both the manager and the employee were clearer on employee's work expectations when returning to work. All participants also discussed the need for further optional post return to work assessments at regular intervals once the phased return to work period has finished, so that individual differences in health and well-being, as well as in work tasks, team culture and climate could be taken into account to ensure employees had the optimal chance to stay in work and be productive.

From my experience, making sure that the return to work programme, that you work it out more, you know, the phased return, that you make sure that everyone understands exactly what you're supposed to be doing.

Female, non-manual occupation, breast cancer

Everybody's job is different and everybody's situation is different, so there's not really a one size fits all approach to this. It very much depends on your organisation, your job whether you're working full-time, part-time, whatever...

Female, non-manual occupation, ovarian cancer

7. Key findings

This section summarises the key findings from the study and will form the basis of discussions in the next section.

Sick leave, return to work and depression

- Evidence from the questionnaire data showed that three-quarters of responding employees who had returned to work with depression and forty-five percent of those with a physical illness (back pain, cancer and heart disease) reported mild to moderate symptoms of depression (measured by the BDI-II).
- Over sixty percent of participants with a physical illness had not received a diagnosis of depression despite reporting symptoms.
- Those who had returned to work less than six months ago were more likely to have depression than those who returned more than six months ago.

Impact of return to work processes on general health, well-being and depression

- Organisations had poor long-term sickness absence recording systems, where data was not organised by illness type or length of sick leave, making records difficult to access and monitor.
- Cancer and heart disease were thought of as illnesses that generated most sympathy and leniency in the return to work process. Those with depression and anxiety were difficult to adjust back to work, from the organisations' perspective because problems were inter-twined with work-related stress, perceptions of bullying or poor working relations.
- Additional difficulties with all illnesses lay with insufficient information from GPs and healthcare services on the effects of health on work and work on health.
- Return to work procedures were not always consistent within the same organisation. There was evidence of both good and poor return to work management throughout our study.
- Good return to work management was facilitated by good communication between line managers, occupational health and the employee, holding case conferences, planning individual return to work packages; and a positive employee attitude towards the workplace. The organisation who provided fast-track health services to their employees (physiotherapy and cognitive behaviour therapy) noted an increase in early return to work.
- Poor return to work management were due to inadequate implementation of return to work policies, minimal resources, lack of communication between stakeholders, inadequate tailored training and lack of skill/competence of line managers in return to work process (despite being key in this process).
- Unclear and inconsistent absence referral and management procedures meant there was a lack of ownership over employees on long-term sick leave. Evidence from stakeholder and employee interviews suggests both line managers and employees were often unaware of the support occupational health and human resources can provide to employees on sick leave.
- Delayed diagnosis, treatment and difficulties in accessing healthcare services were also barriers to a timely and successful return to work, as were poor communication between healthcare providers (e.g. GP) and employers.

- Despite Government advice, sources of information and support for line managers in managing return to work process, managers with little medical and legal knowledge were unsure of how to establish contact and provide support for employees on sick leave due to perception of harassment and litigation. However, lack of line manager contact left employees feeling unsupported and not valued by their organisation.

Post-return to work adjustments and support: impact on general health, well-being and depression

- There was a consistent lack of follow-up by occupational health, line managers and human resources on employees' general health and psychological well-being after returning to work (interview and questionnaire data). Evidence from this study suggests that although there is awareness and understanding of depression, neither occupational health, human resources or line managers are adequately trained in dealing with psychological issues.
- Standard phased returns and work adjustments were offered to many employees. These consisted of either short working hours, reduced job tasks or reduced workload for those with major illnesses. While these were beneficial to those who received adjustments, those who did not receive any adjustments or were offered unsuitable adjustment without prior involvement in discussions, felt this was detrimental to their psychological health and well-being.
- Reasons for lack of work adjustments were due to cost implications and lack of clarity and discussion over what constitutes a 'reasonable adjustment' from a legal perspective.
- Preferences were shown in implementing return to work processes and work adjustments for those with cancer and heart disease over those with depression, despite the latter group reporting high job strain (questionnaire data) and the cause of their illness to be work-related (stakeholder and employee interviews).
- For those receiving adjustments, these often did not last beyond the phased return period which meant that for most participants the first six months back at work were difficult and impacted negatively on their well-being.
- A combination of untailored work adjustments and lack of early tertiary psychological intervention appeared to have a significant impact with employees reporting mild to moderate depression and poor work ability (questionnaire data). Employees were left with low self-esteem and confidence, feeling unable to cope with the workplace and with negative attitude towards their organisation and their job (qualitative data).
- For those returning with depression and anxiety, less than a quarter were offered stress management. For those who received stress management training, evidence suggests this was beneficial in reducing symptoms of depression in the long-term.
- Evidence also showed that those with depression and anxiety and those with back pain who received some support from their line managers were more likely to report moderate work ability (in contrast to poor work ability). For most participants interviewed, support from colleagues was instrumental in improving low psychological well-being.
- Nearly all participants had re-occurring episodes of sick-leave associated with symptoms of depression (questionnaire data). Interviews with participants revealed this was largely due to either prematurely returning to work, inappropriate work adjustments, struggling to adjust back to work or lack of line management support.

Return to work, depression and stigma

- Participants returning to work following an episode of depression, found it more difficult to adjust back to work than other illness groups (interviews and questionnaire data). From the interviews, it was evident that there was negative support from line managers and colleagues. Both line managers and colleagues had little understanding about depression, often stigmatising and over generalising as a result.
- Upon returning to work, three quarters of participants recovering from cancer developed symptoms of depression which they believed was related to both their cancer and adjusting back to work (interview data). Most line managers were initially supportive when participants returned to work, but failed to recognise or understand the impact of late effects of treatment upon participants work and well-being. With minimal work adjustments being made and no long-term support provided, participants were left feeling isolated in dealing with their side effect symptoms and their work.
- Most participants recovering from cancer were more worried about telling their employer about their depression than they were about telling their employer about their cancer.
- Participants with heart problems experienced symptoms of depression and fatigue after surgery and upon returning to work. Both depression and fatigue impacted on their well-being and ability to function at work but most felt unable to tell their line managers about their depression. Those who had support from their colleagues found it easier to admit to having bouts of depression.

8. Discussion

This section provides a brief discussion of the main findings centred around the key objectives of this study:

1. To examine the presence of depression symptoms in a range of illnesses among employees returning to work following long term sickness absence.
2. Investigate the relationship between depression, capacity to function at work and the overall quality of working life.
3. Assess the degree to which the design and management of work impacts on the individual's return to work experience and symptoms of depression.
4. Build a schematic model of the relationship between depression and the psychosocial work environment following return to work.

1. Presence of depression in those returning to work

Evidence from the questionnaire data showed that three-quarters of those with depression and forty-five percent of those with a physical illness (back pain, cancer and heart disease) reported mild to moderate levels of depression (measured by the BDI-II) compared with the non-chronic illness comparison group, who reported no depression. In particular, sixty percent of employees who had returned to work recently (0-6 months ago) reported symptoms of depression and of these, the majority were not diagnosed by a medical practitioner. This demonstrates a high incidence of depression across the sample returning to work due to a chronic health condition. The lack of diagnosis of depression suggests the need for clearer guidelines for medical practitioners in making a risk assessment for depression in individuals prior to, and upon returning to work.

Overall, there appeared to be a lack of effective structure in the management of employees whilst on sick-leave, despite the legal duty of care extending to those who are out of work through illness and particularly if depression was considered to be work-related. Loss of contact with managers/co-workers, a perceptible lack of line management skills in managing the return to work process, lack of occupational health contact or follow-up, the loss of exposure to work, the loss of confidence in adjusting back to work and difficulties in managing illness-related symptoms back at work were all associated with depression regardless of primary illness. Poor contact with occupational health suggests that some services might be either under-resourced and/or not well-established or given ownership on return to work policies and processes. Occupational health services may also lack adequate training in identifying and managing both primary and secondary depression in those returning to work following long-term sick leave. Moreover, nearly all employees interviewed revealed difficulties in telling or talking to their line managers about their depression due to the stigma attached to mental health problems. In particular, those recovering from cancer discussed concerns over disclosing depression to their line managers in contrast to disclosing a diagnosis of cancer. For those who had disclosed both cancer and depression to their managers, they believed a more negative reaction was received from managers when presented with a depression diagnosis in contrast to a cancer diagnosis. A lack of risk assessment for depression, a reluctance in disclosing depression and poor management of employees both during sick leave and upon returning to work may all contribute to increasing or maintaining symptoms of depression for returning employees.

2. Relationship between depression and health, capacity to work and the overall quality of working life

This study found mild to moderate depression was associated with poor work ability, fatigue, pain, low confidence in managing health condition at work, short-term sickness absence and additional long-term sickness absence since returning to work. For those with depression as their primary illness, high job strain and no stress management training were also a contributing factor.

As sixty percent of recent returnees reported mild-moderate levels of depression, compared with forty percent who returned more than 6 months ago, this suggests that depression may improve over time at work (as this was cross-sectional data, this finding must be interpreted with caution). There are a number of reasons as to why depression is more prevalent in recent returnees. First, it could be that returning to work is beneficial to health , and therefore symptoms of depression are perhaps more likely to become less prevalent with time. There was evidence in this study that although work ability was poor across all illness groups reporting mild-moderate depression, it was moderately better for those with depression and anxiety who had been at work for more than six months compared to recent returnees. Enhanced work ability was also associated with those who had higher levels of confidence in managing their health at work and in those who were receiving support from either colleagues or their line manager.

Second, evidence suggests that the longer people are on sick leave, the more difficult it is for them to return due to a number of psychosocial factors outlined on pages 4 and 5 of this report. Thus, employees returning to work often do so with a number of these factors either unaddressed or not fully resolved and requiring ongoing support and/or counselling. In addition, there was some evidence in this study that a number of participants particularly those with cancer, might have experienced a type of post traumatic stress disorder (PTSD) upon returning to work. Although many cancer patients in this study were keen to return to work and to 'normality' following cancer treatment, the experience of both surviving cancer and returning to work; and employer expectations of being 'fully fit' by the end of the standard (six weeks) phased return period may have contributed to their depression and feelings of distress. Cancer survivors who were interviewed reported feelings of emotional distress, high anxiety, poor concentration as well as depression; these symptoms are associated with PTSD. Although there is evidence of PTSD in breast cancer survivors , awareness and understanding of PTSD among cancer patients is not widespread and therefore no specific therapies for PTSD in the cancer setting have been developed.

Another possibility is that elements of the return to work process may have contributed to maintaining or increasing symptoms of depression in recent returnees (see discussion under first objective above). Adjusting back to work was a problem reported by most of the participants interviewed in this study. In theory, phased return to work should help alleviate some of the adjustment problems experienced by employees. However, as poor work ability was associated with depression in recent returnees, offering traditional phased return with temporary changes to working hours, work load and tasks or redeployment may not necessarily address (or perhaps even contribute to) employees' difficulties with adjusting back to work, and this may heighten the perception of poor work ability. This suggests that either work adjustments are not adequately tailored to the needs of employees, need to be in place longer (beyond the usual six weeks) or specific work retraining needs to be introduced to help employees adjust back to work and recover their work ability more quickly.

3. Degree to which the design and management of work impacts on the individual's depression and subsequent return to work experience

Three core areas were identified which affect the health and well-being and return to work experience for employees. These were: lack of strategic planning for return to work; employer knowledge and understanding of depression; and line manager competency

Overall, findings from this study suggest there is currently little strategic planning for return to work that involves discussion and involvement with the employee about how their return to work is to be effectively managed prior to, and upon returning to work. The findings also indicate a lack of collaboration across all key stakeholders and a lack of clarity about who was responsible for managing key aspects of the return to work process. Addressing the specific responsibilities and ownership of managing employees on sick leave is crucial to developing an effective return to work process. There was also little evidence of any specific policy for the re-entry of employees suffering from depression into the workplace. For those organisations with stress management policies, there was some evidence from a small number of employees of the benefits of such policies in reducing symptoms of depression (through stress management training). Overall, the absence of specific return to work policies for those with stress, depression and anxiety may reflect a lack of commitment from senior management or inadequate information and training in managing common mental health problems. Organisations need to move beyond their minimum legal requirements regarding duty of care, and employ good practice in line with non-statutory guidelines in relation to disability management and inclusion. Failure to do so could result in greater absence, higher staff turnover and adverse impacts on staff morale, productivity, commitment and job retention, which result in direct and indirect costs to the organisation, and do not encourage social inclusion or equality of opportunity.

There was significant evidence of a lack of understanding about depression from the employer perspective, or about how employees returning to work are still recovering from, or managing an illness. Despite the prevalence of common mental health problems, employers still have far less knowledge about mental health than physical illnesses; having more sympathy and concern for those suffering from heart disease and cancer than for those suffering from depression and anxiety. Support and understanding of depression appeared to be restricted to those managers who had personal exposure/experience of depression. Line managers play a pivotal role in returning and managing employees back to work. However, this study found that the majority of line managers indicated they felt less than competent to deal with both mental health problems and return to work processes. The findings point to the need for managers to be provided with both the tools and the confidence to effectively manage return to work and post return to work support. Due to the pressures caused by time restrictions and the conflicting work demands such as the need to balance productivity with employee health and wellbeing, managers may themselves require emotional support and extra resources in order for them to meet their goals, and to provide consistent return to work support to all employees who require it. The wider organisational context also needs to be taken into account; managers need to be aware of the potential for perceived stigma and discrimination to be felt by employees returning to work with symptoms of depression.

4. Build a schematic model of the relationship between depression and the psychosocial work environment following return to work

The various findings from this study provide support for Figure 1 (page 8) and highlight three things: first, the need to develop a more integrated multidisciplinary approach to pre and post return to work management involving improved understanding and communication between the many stakeholders and the returning employee (Figure 2); second, the need to lengthen the period of monitoring, communication and support available to a returning employee, particularly in the first six months of their return; and third, a better understanding of depression as a primary and secondary illness among employers. Employees are returning to work with symptoms of depression modulated by unregulated return to work practices, limited work adjustments and poor interactions with line managers and occupational health. Both depression and the design and management of return to work impact on work ability and overall quality of working life. The risks of failing to address these issues may impact on employees, organisations and healthcare providers, and wider implications exist with reference to governmental policy and social inclusion. The research findings have highlighted key areas for improvement and recommendations are presented overleaf.

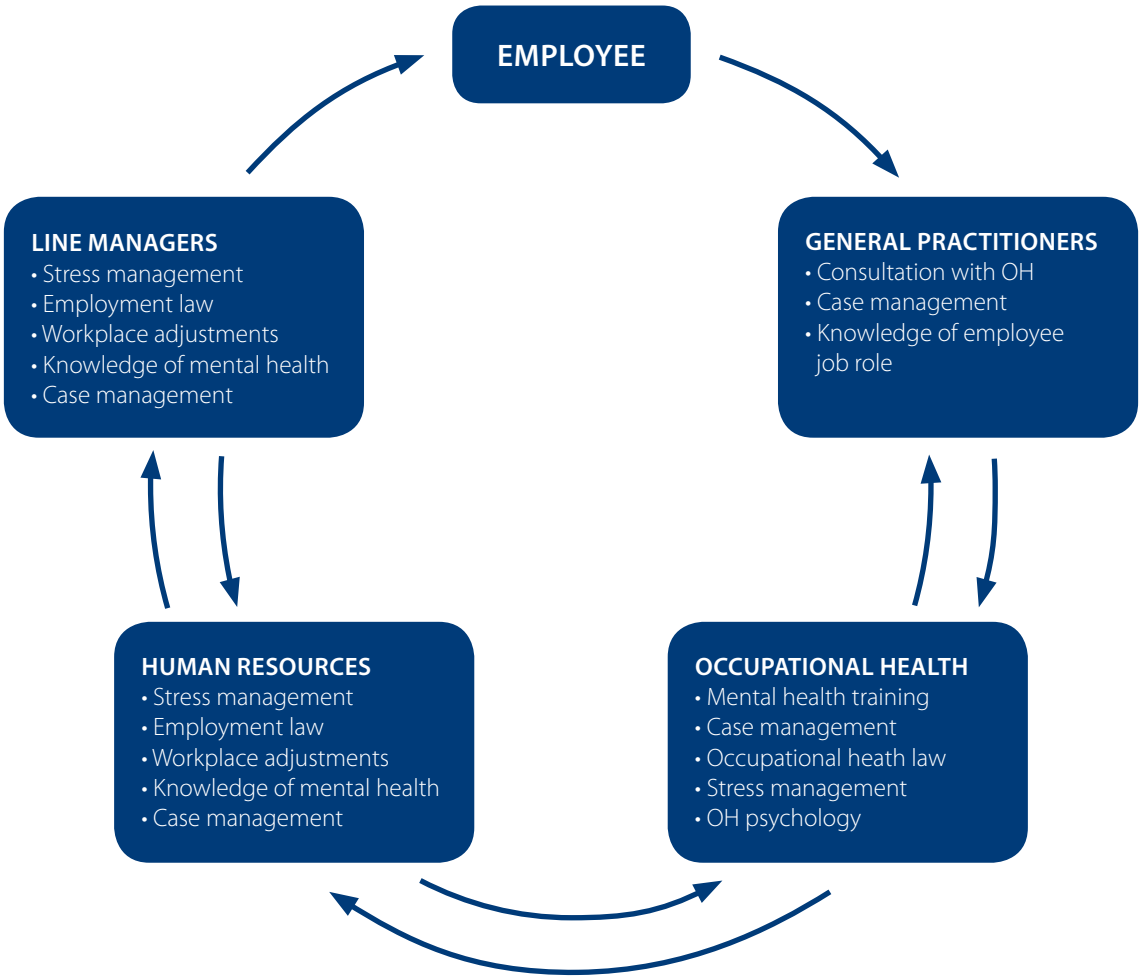

Figure 2: Schematic model of relationship between depression and the work environment following return to work: a stakeholder collaborative model

This schematic model demonstrates the necessary collaboration between the key stakeholders pivotal to empowering the employee (suffering from depression) to participate in the recovery process. The employee, occupational health practitioner (OHP) and general medical practitioner (GP) should jointly discuss the employee's work tasks, current work ability and any necessary adjustments to help manage their return to work. The occupational health practitioner communicates the outcome of these discussions to Human Resources and/or line Managers to implement. A confidential IT system could be designed and developed that would help to bridge communication between all the stakeholders. Training in understanding the impact of mental health on work ability and delivering stress management will be necessary for key parties along with case management and employment law for line managers

9. Recommendations

The implications of the research were explored. Key areas for improvement and recommendations for best practice are presented by the different levels of implementation.

AT NATIONAL LEVEL

- **Align healthcare services with organisations:** Occupational health professionals and GPs need to work collaboratively using a bio-psychosocial approach to include mental health services and healthcare specialists (such as oncologists). This can be achieved by improving communication, sharing information and removing barriers whilst safeguarding confidentiality.
- **Legislate for return to work rehabilitation:** At present, employers are not legally required to provide return to work rehabilitation, but have a duty of care toward employees. By legislating for return to work rehabilitation, employers will be required to provide designed re-entry rehabilitation programmes.
- **Lobby for guidelines, practices and qualifications in case management:** Case management appears to unify all key stakeholders but there is no current recognised accreditation. This should be addressed with lobbying for UK case management accreditation and research to establish a baseline for case management provision. Guidelines could form the basis of a white paper.
- **Raise the profile of a multidisciplinary Occupational Health:** Occupational health services underpinned with an evidence-based academic foundation would raise the occupational health profile and allow OH practitioners to take a lead role in the management of employee health and well-being.
- **Continue campaigns to raise awareness of depression and raise the profile of its impact on work-ability:** National campaigns do much to raise public awareness of depression. Taking the step to link this to work-ability will help to improve widespread understanding within workplaces, encouraging further support for those returning to work.

EMPLOYERS

- **Raise the importance of conducting a cost-benefit analysis:** Research suggests that when employers are provided with evidence to support the benefits of tailored work adjustments, they are more likely to provide funding interventions. Tools and guidance regarding approaches to cost-benefit analysis could be made available to organisations.
- **Promote mandatory risk assessment of depression:** Given the relationships between depression, sickness absence and intention to leave, it is important to identify those employees returning to work who are at risk for depression. This should be made a key policy by organisations and a part of the risk assessment framework already in place with regards to UK legislation on general health and safety at work, and the HSE Management Standards for Work-related Stress.
- **Introduce mandatory stress management:** In complement to the risk assessment for depression, employers should provide employees returning to work following depression with stress management training to help reduce the risk of depression.
- **Train mental health first aiders:** Mental-health first aiders are colleagues with a genuine interest in common health problems. They are trained to monitor and identify those at risk of depression in partnership with line managers. This assists line managers, and shares the responsibilities of identifying common mental health problems before they result in long-term sick leave.
- **Colleague buddy-system:** As colleague support is important in the promotion of psychological well-being of employees returning from long-term sick leave, mental health first aiders can also be trained to act as 'buddies' to provide support and identify any decline in recovery post return to work.
- **Multidisciplinary OH/HR team:** Investment in occupational health psychology professionals ensures early and appropriate psychological interventions and provides support for occupational health and human resources who require additional training to adequately deal with common mental health problems. Investment is required in terms of recruiting staff with specialist training in this area and in supporting their continuing professional development.

LINE MANAGERS

- **Tailored line management training:** Evidence from this study suggests that current training and information to line manager in managing return to work and in identifying common health problems may not be effective. Line management training should be tailored and embedded within evidence-based psychological models of intervention such as the Stage of Change model.
- **Factoring in time for line management to manage depression and return to work processes:** By encouraging employers to invest in 'time windows' where line managers consult with employees who have workplace/domestic stressors which makes them vulnerable to absence. This could be co-ordinated with Mental Health First Aiders.
- **Reinforcing legal duty of care:** Line managers require additional training and information in employment law since fear of litigation over harassment appears to prevent contact with sick employees. This could include advice on appropriate interventions in partnership with occupational health.

FURTHER RESEARCH

Findings from this research suggest that there are several important issues that need clarification and further evidence through research:

- There is a need for longitudinal studies into the role of depression following return to work. Importantly, the presence of depression in recent returnees and reasons as to how and why symptoms of depression dissipate over time, needs to be carefully examined.
- More research is required to systematically evaluate the effectiveness of existing guidelines, information and training available to line managers in managing common mental health problems.
- There is a need for high quality scientific studies on the benefits of case management in returning and retaining employees at work.
- There is a need for further research to establish whether current occupational health service provision is fit for purpose.

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11. Appendices

Appendix 1

Organisational Sector	Representatives	Interviews per organisation
Transportation	Chief Medical Officer	
	Human resources manager	5
	Occupational health staff x2	
	Line manager	
Local Government	Human resources manager x3	
	Occupational health staff x2	6
	Line manager	
Manufacturing	Human Resources manager	
	Occupational health staff	5
	Line manager x3	
Healthcare	Director of human resources	
	Occupational health staff x2	3

Table 14: Interviews carried out with representative from each organisation

Appendix 2: List of national support groups and charities

Depression & Anxiety

Depression Alliance & Long-term Conditions Alliance
Anxiety Care

Back Pain

Back Care
Pain Support
National Ankylosing Spondylitis Society

Cancer

Macmillan (website and support groups targeted)
Ovacome

Heart Disease

Heartcare Partnership UK (British Association for Cardiac Rehabilitation)
H.E.A.R.T UK

Appendix 3

Participant (gender and age)	Occupation	LT absence episodes in past two years	Perceived cause of illness	Medication for Depression	Other Current Treatment
1. Male	Manual supervisor	3 [3 months, 1 month, 3 weeks]	Work-related	Yes	Counselling
2. Male	Manual	3 [3 months, 4 months, 6 months]	Non work-related	Yes	Counselling
3. Male 51	Manual team leader	2 [4 weeks, 2 months]	Work-related	No	Counselling & group therapy
4. Male 60	Skilled manual	1 [4 months]	Work-related	Yes	None
5. Male	Manual	2 [10 months, 4 months]	Work-related	Yes	Counselling
6. Female	Non-manual skilled	2 [4 months, 5 months]	Non work-related	No	Counselling
7. Female	Manual	3 [2 months, 1 month, 3 months]	Work-related	No	Counselling
8. Female 41	Non-manual	2 [1 month, 3 months]	Work-related	Yes	Counselling
9. Female	Manual	1 [10 months]	Non work-related	Yes	Counselling
10. Female	Non-manual	2 [3 months, 3 months]	Work-related	Yes	Counselling
11. Female	Non-manual	1 [3 months]	Non work-related	Yes	Counselling

Table 15: Bibliographic Details of Participants Interviewed with Depression & Anxiety

Participant (gender and age)	Occupation	LT absence episodes in past two years	Location of injury/pain	Medication	Other Current Treatment
1. Female	Manual	1 [4 months]	Lower back pain	Painkillers & muscle relaxant	None
2. Male	Manual	3 [9 months, 1 month, 6 months]	Back & neck pain	Painkillers	Acupuncture, Physiotherapy
3. Female	Manual	1 [2 months]	Back pain	Painkillers	None
4. Male	Manual	1 [2 months]	Back pain	Painkillers	None

Table 16: Bibliographic Details of Participants Interviewed with Back Pain

Participant (gender and age)	Occupation	LT absence episodes in past two years	Type of Cancer	Surgery	Other Treatment
1. Male	Non-manual	1 [4 months]	Prostate	Yes	Medication for depression
2. Female	Non-manual	1 [2 months]	Brain Tumour Non-malignant	No	Radiotherapy
3. Male	Manual	1 [3 months]	Prostate	Yes	None
4. Female	Non-manual	3 [2 months for cancer; & 1 month & 6 months for depression	Ovarian	Yes	Chemotherapy, medication & counselling for depression
5. Female	Manual	1 [10 months]	Breast	Yes	Chemotherapy, Radiotherapy & medication for depression
6. Female	Non-manual	2 [14 months for cancer, & 3 months for depression)	Breast	Yes	Chemotherapy, Radiotherapy
7. Female	Non-manual	1 [1 month]	Ovarian	No	Chemotherapy
8. Female	Non-manual	1 [3 months]	Ovarian	Yes	Chemotherapy
9.		2 [2 months, 2 months both cancer]	Breast	Yes	Chemotherapy, Radiotherapy, & medication for depression

Table 17: Bibliographic Details of Participants Interviewed Recovering from Cancer

Participant (gender and age)	Occupation	LT absence episodes in past two years	Location of injury/pain	Medication	Other Current Treatment
1. Female	Non-manual	1 [3 months]	Heart failure	Blood pressure, cholesterol & arrhythmia	Surgery, Pacemaker
2. Male	Non-manual	1 [6 months]	Heart attack	Blood pressure, Pain	By-pass surgery
3. Male	Manual	1 [4 months]	Heart failure	Cardiomyopathy, depression	Cognitive behavioural therapy
4. Male	Manual	1 [6 months]	Aortic valve replacement	depression	Surgery

Table 16: Bibliographic Details of Participants Interviewed with Back Pain

Mental Health Foundation

Founded in 1949, the Mental Health Foundation is the leading UK charity working in mental health and learning disabilities.

We are unique in the way we work. We bring together teams that undertake research, develop services, design training, influence policy and raise public awareness within one organisation. We are keen to tackle difficult issues and try different approaches, many of them led by service users themselves. We use our findings to promote survival, recovery and prevention. We do this by working with statutory and voluntary organisations, from GP practices to primary schools. We enable them to provide better help for people with mental health problems or learning disabilities, and promote mental well-being.

We also work to influence policy, including Government at the highest levels. We use our knowledge to raise awareness and to help tackle stigma attached to mental illness and learning disabilities. We reach millions of people every year through our media work, information booklets and online services. We can only continue our work with the support of many individuals, charitable trusts and companies. If you would like to make a donation, please call us on 020 7803 1121.

Visit www.mentalhealth.org.uk for free information on a range of mental health issues for policy, professional and public audiences, and free materials to raise awareness about how people can look after their mental health.

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