

Barriers to and facilitators of return to work after sick leave in workers with common mental disorders:

Perspectives of workers, mental health professionals, occupational health professionals, general physicians and managers

Report submitted to the IOSH Research Committee

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Published in 2017



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Acknowledgement: IOSH would like to express thanks to the peer reviewers of this report.

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ACKNOWLEDGEMENTS

The project team would firstly like to thank the Institution of Occupational Safety and Health (IOSH) for financially supporting this project, in particular Mary Ogungbeje for her help and guidance throughout the project, as well as the reviewers for their feedback and advice.

We would also like to thank all occupational health professionals, mental health professionals, general physicians and managers who kindly agreed to take part in the stakeholder study. We are also grateful to the workers who volunteered to participate in the interview study. Our thanks also go to the all the occupational physicians, mental health providers, and other (health) professionals for their help and assistance during recruitment and other enthusiastically support.

The project team would also like to thank the advisory board members for their helpful input at the various stages of the project. Special thanks to Dr. Joanne Yarker for her valuable input throughout the project.

Finally, we would like to thank Lian Snoeijsen for her help with the layout and editing of the report.

ABSTRACT

Common mental disorders (CMDs) are among the leading causes of disability worldwide and have a major impact in terms of lost productivity and sickness absence. Returning to work is a complex process in which different stakeholders are involved and have to co-operate.

The aim of this study is to gain an understanding of the return-to-work (RTW) process of workers on sick leave with CMDs, and of the RTW barriers and facilitators from a multi-stakeholder perspective.

The perspective of important stakeholder groups on barriers and facilitators and their own role in the RTW process were explored in four focus groups, i.e. with mental health professionals, occupational health professionals, general physicians and managers (PART A). Workers' own perspectives on what had led to sickness absence, as well as on RTW barriers and facilitators, were explored using face-to-face interviews with three sub-groups of workers: workers with CMDs on short-, medium- and long-term sickness absence. All workers were interviewed twice to fully capture the nature of the RTW process (PART B).

PART A: focus groups on stakeholders' perspectives

Five themes were identified as central to a successful RTW process according to the four stakeholder groups: 1) workers' motivation to return versus workers' emotions, cognitions and coping; 2) type of work one returns to, fulfilling and motivating activities; 3) a safe, welcoming and stigma-free work environment; 4) personalised RTW support; and 5) collaboration between (health care) professionals. Beside similarities, differences between perspectives were also found, especially between managers and the other groups. For instance, managers did not speak about conflict between worker and manager, and did not talk about providing psycho-education to the worker.

PART B: interviews with workers with CMDs

From the interviews with 34 workers with CMDs, three important conclusions emerged in what workers saw as causes of sickness absence: 1) a perceived excessive workload/work pressure; 2) mental health conditions were *not* seen as the origin of sickness absence; and 3) the importance of valuing ones' work content. Regarding barriers and facilitators, workers with CMDs reported a number of factors influencing the RTW process. According to workers, central to a successful RTW was 1) gaining self-awareness and learning to set limits, 2) a supportive and understanding manager, 3) regain control by engaging in recovery enhancing behaviour, and 4) doing work one values. A difference between workers on short- versus long-term sick leave was that the latter often indicated they did not enjoy their work content and work tasks any more and were less satisfied with their jobs. In contrast, workers on short-term sickness absence often valued their work content and had a pleasant working environment with an understanding manager. A second difference between short- and long-term absentees was that the former seemed to engage more in recovery enhancing behaviour. Workers on long-term sick leave generally seemed to be more reactive as opposed to proactive and to be more in need of professional support, especially to help them in gaining self-awareness about their own wishes and needs regarding work-related choices.

In conclusion, the results from the stakeholder and interview study reveal a wide range of factors that, according to four stakeholder groups and workers, have an impact on the onset of sickness absence and influence on RTW in workers with CMDs. The study findings suggest that the lack of self-evaluation plays a key role in these workers and that more focus on supporting these workers in gaining self-awareness and regaining control, discussing the value of work and reducing work pressure, may not only speed up RTW but also can be important for the prevention of sick leave. In these themes especially, the manager plays a key role and further research should therefore focus on how managers can be supported in these tasks. A list of recommendations is included on how to incorporate the findings of this study into practice.

INTRODUCTION

Common mental disorders (CMDs), such as depression, anxiety, adjustment disorders and stress-related complaints, are among the leading causes of disability worldwide (1). Despite differences in methodology, several studies have all reached the same broad conclusions that overall costs are high and that a high proportion of costs are due to disrupted work patterns (2). At any moment, 20% of the working-age population suffer from mental health problems (3, 4), which have a major impact in terms of lost productivity. Indeed, 60 to 80% of the societal costs of CMDs are due to sickness absence, presenteeism (i.e. reduced productivity at work), work disability and unemployment, not health care utilisation (2, 3, 5). Given that it has been estimated that CMDs (specifically, anxiety disorders and mood disorders) cost Europe approximately 253 billion euros per year (6), this is a pressing issue for society. CMDs belong to the most prevalent causes of sickness absence and work disability, making it a highly relevant problem for employers (7-11). Furthermore, CMDs negatively affect the quality of life of the worker, and prolonged absenteeism may put them at risk of becoming unemployed. For instance, studies have shown that employment is beneficial for health, particularly for depression and general mental health, and that unemployment is associated with poorer mental health (12, 13).

To reduce long-term sickness absence due to CMDs, research has looked into the determinants of return to work (RTW) and evaluated interventions to improve RTW in this population; but results remain inconclusive. Predictors of RTW in people with CMDs vary between studies, and systematic reviews on this topic have not been able to draw strong conclusions based on the current evidence (14, 15). As for evidence on interventions, it has become clear that pure psychotherapeutic interventions aimed at reducing CMD symptoms, like cognitive behavioural or problem solving therapy, do not affect RTW (16). Extending such interventions with a work-focused component has shown to be effective in some studies, but other studies have not been able to replicate this finding (16-18).

Another limitation of current RTW research is the almost exclusive focus on the act of RTW itself (e.g. the work status or first day of RTW) with little knowledge available on the RTW process, including what happens during the process of sick leave and after initial work resumption (19). The question arises as to which factors act as barriers or facilitators in this process and whether certain factors are more relevant at certain moments or circumstances during the RTW process.

A qualitative research approach could fill the knowledge gap on what happens during the RTW process of people with CMDs, as it enables an in-depth exploration of the phenomenon from the perspective of relevant stakeholders (20). A focus on different perspectives can provide valuable insights from practice that will help tailor interventions to the needs of the workers involved (21). Indeed, Hees and colleagues (2012) (22) showed the added value of having a multi-stakeholder perspective in investigating RTW of workers with CMDs, as they found that different stakeholders strived for different outcomes in a worker's RTW process and defined successful RTW in different ways (22). Furthermore, getting better insight into workers' perspectives is of special importance, since previous research has shown that the worker's attitude towards RTW (e.g. expectations on the duration until RTW, readiness and self-efficacy to RTW) has a great impact on actual RTW (23-27).

While some qualitative studies have investigated RTW barriers and facilitators among workers on sick leave with CMDs, these studies have not: 1) tapped into the full process of RTW (i.e. experiences during sick leave and after work resumption), 2) discerned experiences of those who have been able to RTW quickly and those who have not, and 3) involved multiple key stakeholders. In addition, Andersen and colleagues (2012) (28) draw attention to the need for more high-quality qualitative research on RTW for workers with CMDs. Specifically, Andersen and colleagues (2012) (28) stress the importance of research that focuses on RTW barriers and facilitators in different sub-groups, such as short- versus long-term sick leave. Also, they call for research including relevant stakeholders' view on the RTW process. Therefore, to gain an in-depth understanding of the dynamics of the RTW process, this project consisted of a longitudinal, qualitative study on the experiences of workers on short-, medium- and long-term sick leave. In addition, to ensure a multi-stakeholder perspective, the research explored the viewpoints of mental health professionals, occupational health professionals, general practitioners and managers on RTW.

Study aim and objectives

This study aimed to gain an understanding of the RTW process of workers on sick leave due to CMDs, and the RTW barriers and facilitators from a multi-stakeholder perspective. As such, the objectives of the study were to investigate:

1. What do mental health professionals, occupational health professionals, general practitioners and managers perceive as barriers to and facilitators of the RTW process of workers on sick leave with CMDs?
2. What are the factors that lead to sickness absence according to workers on sick leave with CMDs and how do these differ between workers on short-, medium- and long-term sickness absence?
3. What do workers on sick leave with CMDs perceive as RTW barriers and facilitators, and how do these differ between workers on short-, medium- and long-term sickness absence?

Study context

This study was conducted in the Netherlands and a note of context is included here in recognition that national systems differ in the monitoring and management of employees on sick leave.

Organisation of the Dutch occupational health care system

In the Netherlands, according to the Dutch Gatekeeper Improvement Act (29), the employer is responsible for the RTW of workers on sick leave during the first two years of their sickness absence. During this period the employer compensates sickness absence by paying at least 70% of the worker's income before absence. The employer compensates sickness absence irrespective of cause and work-relatedness and during this two-year period, the worker on sick leave cannot be fired.

The occupational physician (OP) has a central role in the Dutch social security system, and is the link between workers' health and the work situation. An OP is a qualified medical doctor with a specialism in occupational health who assists employers and workers in occupational health issues, safety and sickness absence management by providing occupational health care to the working population (30). Most Dutch employers have contracts with independently operating Organisational Health Services (OHSs), which provide occupational health care and may also employ other occupational health professionals. OPs can also be part of an in-house company service or can work as self-employed physicians.

In case of sickness absence of a worker, the employer is obligated by law to provide access to an OP for certification of the sickness absence within six weeks of the worker calling in sick. The OP also provides RTW support to the worker on sick leave and provides advice to the employer regarding RTW activities and work adaptations if necessary. After no more than eight weeks of sickness absence, the worker and employer must agree an action plan for RTW. The RTW activities are evaluated by the National Social Security Institute (UWV) after two years' sickness absence. Both employer and worker risk high financial fines if they do not co-operate in the RTW.

Structure of the report

This report is divided into two parts: PART A describes the focus group study in which the perspectives from the stakeholders on the RTW process of workers with CMDs are outlined. PART B describes the interview study. This part focuses on the causes of sickness absence from the perspective of different types of worker and their thoughts on RTW barriers and facilitators.

PART A. FOCUS GROUP STUDY

METHODS

Study design

A qualitative, exploratory study was performed as this suits the collection of explanatory information on a complex issue as the RTW process of workers with CMDs (31). We investigated the perceptions of general practitioners (GPs), occupational health professionals (OHPs), mental health professionals and managers on RTW barriers and facilitators among workers with CMDs. It was decided to conduct focus groups, as this is a useful method to collect the views and experiences of a selected group and for generating a broad understanding of the phenomenon of interest (32, 33). Furthermore, focus groups allow the sharing of a range of perspectives, which can enrich the collected data through group reflections and interactions. Four focus groups were conducted, each heterogeneous in gender and work experience and homogenous in professional discipline, i.e. one with GPs, OHPs, mental health professionals and managers.

Ethics

Ethical approval for this study was obtained from the Ethics Review Board (ERB) of the School of Social and Behavioral Sciences of Tilburg University.

Participants and recruitment

Participants were recruited through advertisements in electronic newsletters and websites of (occupational) health care providers, work organisations, and relevant field parties and institutions. Two large OHSs, which employ occupational physicians, psychologists, employment experts and other occupational health professionals helped with the recruitment. Also participants were recruited via mental health care providers, the NHG (The Dutch College of General Practitioners), Stichting KOEL (a foundation responsible for continuing medical education for GPs in the South-Western part of the Netherlands), a network of retired general physicians, and a national network of nurse practitioners. Also, the researchers contacted a variety of health care and work organisations and professionals from their professional network via telephone or email. The aim was to recruit between 6-12 participants per stakeholder group.

Data collection

One senior researcher (HvG) with extensive experience in conducting qualitative research facilitated the focus groups supported by a second researcher (BS, IA or MJ) who wrote down the key messages and provided short summaries to facilitate the discussion.

At the beginning of each focus group, the researchers and the participants introduced themselves and provided information on their professional background. The interview guide focused on the RTW barriers

and facilitators for workers on sickness absence with CMDs and on what the stakeholders perceived as their own role in the RTW process.

Data analysis

The focus groups were audio recorded and transcribed verbatim to enable content analysis. All transcripts were anonymised before analyses were performed. The four transcripts were read and coded independently by two researchers (IA, EB or MJ) using the software package ATLAS.ti, version 7.5.16. Codes were developed following the main goal of this focus group study, i.e. the identification of RTW barriers and facilitators from the perspective of the different stakeholders and their perspective on the role they have in RTW. As such, three major categories were pre-defined to which codes were assigned: 1) RTW barriers, 2) RTW facilitating factors, and 3) the role of the stakeholder. Themes and sub-themes within these three categories were created by the method of constant comparison in which different codes were compared and the relationship between codes was explored to detect emerging themes. This process was executed by one researcher (IA), who clustered the codes and defined emergent themes. Next, these results were discussed in a group of three researchers (IA, EB, MJ) until consensus was derived on interpretations and the themes' titles. Separate code lists and emergent themes were created for each focus group to be able to identify differences and similarities between the four stakeholder groups. In case comparable themes emerged in the different focus groups, the same theme titles were used to enhance visibility of similarities and differences between the focus groups.

RESULTS

Participants' characteristics

In each focus group, six to 11 representatives from the same discipline participated. Participating OHPs were OPs, case managers, employment experts, and occupational health nurses. The group of mental health professionals consisted of work and organisational psychologists, clinical psychologists, and social workers in occupational health care. Despite considerable efforts to enlist GPs, too few were willing to participate because of work pressures. Instead, six GPs who had recently retired agreed to participate. Managers were team leaders or line/cluster managers in health care institutions, or directors in educational institutions.

Across the four focus groups, the content analysis revealed similar core themes: seven themes for RTW barriers, four themes for RTW facilitators, and five themes for the stakeholders' own role in RTW. The findings are described in detail below.

RTW barriers according to stakeholders

Table 1 shows the results of the content analysis of RTW barriers. Across the four stakeholder groups, barriers were mentioned that could be classified in the following core themes: 1) the worker's motivation, 2) the worker's emotions, cognitions and coping, 3) the worker's private life, 4) types of problem, 5) the work context, 6) support from professionals, and 7) the societal context.

Barriers in the worker's motivation

The mental health professionals, OHPs and GPs talked about the hindering effect of a worker's negative attitude towards the RTW. Specifically, they mentioned that a worker could experience benefits of being ill and on sickness absence. For example, one OHP, when talking about the current trend of attaching medical diagnoses to different kinds of problems, said:

"[...] and there are all kinds of compensations attached to it [to medical diagnoses], all kinds of privileges [...] underneath that there is so much secondary gain from illness [...] and people will make use of that ..."

Similarly, two mental health professionals discussed this as follows:

"A: [...] profiting from illness, [...] there are of course truly people who, yes, profit from not going to work.

B: And you immediately feel that in the consultation room, someone who would actually like to be declared unfit for work. You quickly see through that."

In the focus group with the managers, a negative attitude towards RTW was not mentioned, but this group spoke about the worker's unwillingness to take responsibility for their own recovery (including RTW). For instance, one manager said:

"What I think is playing a role is whether someone is willing to take his own responsibility and thus also to collaborate in recovery and thus make choices consciously about 'How will I manage this now? Will I get someone to support me? Who will help me to become more stable?' Or is it the employer who needs to take care of all this? [...]"

Barriers in the worker's emotions, cognitions and coping

All four stakeholder groups talked about the hindering effect of a worker's feelings of anxiety, guilt and shame. The groups varied in their views on the reasons for workers to feel anxious, guilty or ashamed. For example, mental health professionals talked about the fear of returning to work, as workers sometimes increasingly perceive that before the sick leave period they had suffered from high work pressure when they were working. On another note, OHPs mentioned that workers could become fearful about taking steps in their recovery process, because they are afraid that things could go wrong. Feelings of guilt and shame pertained to the perception of abandoning colleagues due to one's sickness absence or undertaking health-enhancing activities during sickness absence, which could be perceived by the work environment as preferring to 'enjoy' one's sickness episode instead of returning to work.

Mental health professionals and OHPs described how RTW could be hindered by the worker's own negative perception on sickness absence and mental health problems. For example, one mental health professional thought that some workers feel that going on sickness absence is just something you do not do, and one OHP mentioned that workers could themselves be stigmatising mental health problems. Such negative perceptions could induce feelings of shame and guilt, which may delay recovery and make it more difficult to take the step to RTW.

Across three focus groups (OHPs, mental health professionals and GPs), the topic of a worker's limited self-reflection was discussed. For instance, OHPs said that workers are sometimes unable to learn from their illness process, as shown in the following discussion:

"A: [...] strain, depression has a high relapse percentage, in my view it is then insufficiently treated and insufficiently learned from.

B: Learned from, primarily [...]"

C: I think that many have it after one time, but we of course see those who relapse and it is just like it never helped [...]"

Comparable to this, the GPs mentioned that when someone has no self-insight it is difficult to realise changes because the person does not see what needs to be changed. The lack of self-reflection was also discussed among the managers, who pointed out that some workers are stuck in feeling a victim and are incapable of moving beyond problems and towards solutions.

Barriers in the worker's private life

Not many aspects were addressed under this theme, but three topics clearly emerged. First, the mental health professionals mentioned that a worker's partner could disempower the worker by trying to control the situation, often with good intentions. An example that was given was a situation in which the partner comes along with the worker to a meeting with the employer and takes over the conversation. This could harm the employer's impression of the worker, and not enable the worker to find their own solutions.

Second, in the focus group with GPs, having responsibilities as the main carer of children or a sick family member was seen as an important barrier to returning to work:

"Interviewer: [...] what could play a role in the duration of sickness absence?"

A: Well, a double role, I still think that women have a double role much more than men because they often have the responsibility for raising the children, more responsibility for care at home and I don't try to be old fashioned...

B: It still is.

A: ... but I think that today it still is quite common that those women generally, I feel, are carrying a heavier burden."

Third, the managers discussed that the opinion of close others (e.g. the partner, friends) on returning to work could impede a successful RTW. Others could voice the opinion that it is better to stay at home, for example because they feel that the worker has been through a lot and that they have the right to stay at home. Alternatively, others could push the worker into returning to work too quickly, for example if they perceive that the worker is not suffering greatly or that the worker is letting the employer down.

Type of problems

When workers are having problems in multiple life areas, this was seen as an RTW barrier by all stakeholder groups. Furthermore, the OHPs, GPs and managers all mentioned the severity of the complaints as a barrier. To this, the managers also added the duration (i.e. a longer history) of complaints. Finally, both in the focus group with GPs and the focus group with managers the problem of the invisibility of mental health problems was discussed. One GP thoroughly formulated this problem:

"Also, another problem, in my opinion, with sickness absence due to mental health problems is its invisibility [...] distrust develops among those who remain at work. And it is also my experience that, for example, someone who had a skiing accident, with his plastered leg [...] received a fruit basket more quickly than someone who had mental health problems and was standing doing nothing in the supermarket [...] that [the invisibility] was clearly a very important barrier for that person who was at home with mental health problems."

Barriers in the work context

There were multiple topics under the theme 'barriers in the work context' that recurred in three or four focus groups. First, all four stakeholder groups addressed that unhelpful behaviour or attitudes of the manager could act as a barrier to returning to work. For example, the manager could be pushing the worker too much to RTW (mentioned by the GPs) or could be breathing down the worker's neck by trying to get in contact too often (mentioned by managers). The mental health professionals mentioned that a

manager's unrealistic expectations about when and how a worker could RTW could act as a barrier. Furthermore, the OHPs discussed that a manager could experience difficulties with a worker returning to work who has become more assertive and learned to protect limits by saying 'no' more often.

A second barrier in the work context mentioned by the mental health professionals, OHPs and GPs was that the work environment is sometimes not motivated to have the worker RTW, as clearly shown from a discussion among the mental health professionals:

"A: And is work waiting for you? I often ask this question: 'Do you miss this worker?'

B: Are you being missed?

C: Not at all."

Reasons mentioned for unwillingness of the work environment to have a worker return were: 1) conflicts at work, 2) having someone who has been replacing the sick worker and who is doing a better job, or 3) performance problems existing before the worker's sickness absence episode.

Third, the mental health professionals, OHPs and GPs mentioned that the type of work a worker returns to can act as an RTW barrier. Examples of hindering work conditions were high job strain or, the opposite, unchallenging work, insecurity about one's position (especially in case of large reorganisations), or unsafe/poor work conditions.

Two topics that emerged in both the focus group with mental health professionals and GPs were stigma in the work context and a distance between the worker and work. Mental health professionals indicated that there is stigma related to being on sickness absence, and GPs specifically addressed stigma related to distrust or disbelief of colleagues towards mental health problems. According to mental health professionals, an increasing distance between the worker and work could be caused when the workplace is waiting until the worker has recovered and taking up little contact. In this regard, GPs indicated that the workplace sometimes provides the worker with rest for too long.

Finally, some unique barriers in the work context were addressed among the OHPs, GPs and managers. The OHPs mentioned that disturbed relationships with colleagues prior to the sickness absence can make it difficult for the worker to RTW. The GPs extensively mentioned that an important reason for a delayed or failed RTW is the lack of structural changes or solutions for work-related problems in the work context. The focus group with managers provided some more detail on why structural changes are sometimes not implemented, as the managers mentioned that sometimes there are no means to realise changes in the work context or that it is impossible to have the worker return to a different job position. For example, the managers discussed the following:

"A. What is difficult is that following the legislation ['The Dutch Gatekeeper Improvement Act that regulates return-to-work responsibilities of the employer and employee] you are working too long on returning to the own job position, while you actually already know like, gosh, that position is actually too heavy. What is already mentioned, you would actually want to go on to another track. And you actually stay too long ... yes, just hoping that he returns.

B: That's a bit like what you just said, sometimes legislation is very protective towards the worker, but because of that also debilitating [...]

C: We move on too late, we keep holding on too long."

Barriers in support from stakeholders

In all four focus groups, difficult collaboration between (health care) professionals was described as an RTW barrier. The main problems that emerged were the involvement of too many professionals, which could delay RTW because of multiple treatment trajectories, contradictory advice of different professionals and, related to this, poor contact and alignment between professionals. Mental health professionals mentioned that the mental health care system is insufficiently aware of the importance of (return to) work and not focused on this aspect in their treatment, of which the following quote is exemplary:

“[...] That counts especially and above all for clinical psychologists who only work from that position. They see a worker isolated from his work. That psychologist also does not always have the knowledge about processes in work situations or processes around recovery or legislation around sickness absence et cetera. But specifically the combination of knowledge about as well illness, the complaints as well as the work situation where the worker should return to, that according to me is indeed crucial [...]”

The OHPs, GPs and managers discussed problems related to the professional support provided in the RTW trajectory. Both OHPs and GPs mentioned that RTW protocols could result in impersonal guidance unfitted to a worker's unique situation. Similarly, the managers mentioned that occupational physicians are sometimes not flexible in adjusting the RTW plan. Finally, both the OHPs and managers indicated that long waiting lists for psychological treatments can delay the recovery process, including RTW.

Societal barriers

In the focus group with OHPs and GPs, a few barriers were addressed that pertained to the level of the societal system. Both groups reported on legal arrangements that could hinder RTW. For example, in the focus group with the OHPs it was mentioned that in the education system, public funds are available for employers to quickly hire a replacement for a teacher on sickness absence, which reduces the urgency for employers to ensure a quick RTW of the sick teacher. Next to this, the OHPs mentioned societal stigma and taboo regarding mental health problems as a barrier to returning to work because this can deter people (including the workplace) from getting into contact with someone on sickness absence due to mental health problems. The GPs talked about financial incentives for taking long-term sickness absence (e.g. in the Netherlands, employers continue paying 70 to 100% of the worker's salary during sickness absence) and also brought up the current economic climate as a barrier. Specifically, the economic crisis and, as a result, the limited availability of jobs and the increase in flexible jobs was seen as problematic. It was mentioned that this could cause people to RTW too rapidly, followed quickly by a relapse of sickness absence, as shown from the following discussion:

“A: But that also directly shows that when it is going bad with the economy and there are limited opportunities to find another job that this will be a barrier to return to work. So, there are...”

Interviewer: Thus you will then return to your old job position earlier?

A: Yes, you then return to your job position with, as a result, you quickly relapse.”

Table 1. RTW barriers, according to stakeholders

	Stakeholders			
	<i>Mental health professionals</i>	<i>Occupational health professionals</i>	<i>General practitioners</i>	<i>Managers</i>
Barriers in worker's motivation	- Negative attitude towards RTW - Enjoy being at home more than at work	- Negative attitude towards RTW - Apathy	Negative attitude towards RTW	Not willing to take responsibility
Barriers in worker's emotions, cognitions and coping	- Fear of returning - Feeling guilty towards colleagues - Negative perception of sickness absence - Not able to ensure work-life balance	- Fear of taking steps in recovery - Fear of having contact with the manager - Feeling guilty about undertaking health-enhancing activities during sickness absence - Idea that work is harmful to health - Experiencing loss of control when returning to work - Negative perception of mental health problems - Playing down problems - Not able to learn from the experiences of the illness process	- Fear of repetition of traumas - No self-insight - Unassertiveness - Feeling ashamed about abandoning colleagues	- Feeling ashamed about undertaking health-enhancing activities during sickness absence - Uncertainty about ability to cope with RTW - Not able to move beyond problems and look at solutions
Barriers in worker's private life	Partner is disempowering the worker		(Informal) caregiver responsibilities in private life	Opinion of close others to 'stay at home' or 'RTW quickly'
Types of problem	Multiple problems	- Multiple problems - Severity of complaints	- Multiple problems - Severity of complaints - Invisibility of mental health problems	- Multiple problems - Severity of complaints - Invisibility of mental health problems - Duration of complaints
Barriers in the work context	- Unhelpful behaviour or attitude of manager: too caring; too focused on complaints; unrealistic expectations - Work environment is not sympathetic to the worker's return; conflicts;	- Unhelpful behaviour or attitude of manager: having difficulty with a worker who has become more assertive; no compassion for the worker - Work environment is not sympathetic to the	- Unhelpful behaviour or attitude of manager: pushing the worker; manager is the cause of sickness absence - Work environment is not sympathetic to the worker's return - Type of work to which the	- Unhelpful behaviour or attitude of manager: breathing down the worker's neck - Stigma in the work context: incomprehension by colleagues - No opportunities to realise

	having a better replacement • Type of work to which the worker returns: high job strain; work not challenging at all; no control over workload volume • Stigma in the work context: stigma about sickness absence • Distance between the worker and work: waiting until the worker has recovered; little contact	worker's return; conflicts; having a better replacement; performance problems • Type of work to which the worker returns: insecurity about the worker's job role; work accommodations are difficult to implement; unsafe working conditions • Relationships with colleagues are disturbed	worker returns; job insecurity; small company with limited possibilities; difficult manager; poor work conditions • Stigma in the work context: distrust of colleagues towards mental health problems • Distance between the worker and work: provided with rest for a long period • Nothing has changed in the work context: no structural solutions	changes at work: no means; no space for creative solutions • Worker is unable to return to a different job role: trying too long to have the worker return to their own job position; not educated to return to a different job position
Barriers in support from professionals	• Difficult collaboration between professionals: no time to adapt advice to each other; too many (health) care professionals are involved; psychologist is involved too late • No focus on (return to) work that takes account of mental health care	• Difficult collaboration between professionals: poor alignment between professionals; too many (health) care professionals are involved • Bottlenecks in the RTW trajectory; impersonal protocols • Delay in recovery due to the (health) care system: long waiting lists and treatment paths	• Difficult collaboration between professionals: contradictory advice from different professionals; difficult to get in contact with the occupational physician • Bottlenecks in the RTW trajectory; impersonal protocols; no guidance in the sickness process; worker does not experience support from the occupational physician	• Difficulties in collaboration between professionals: contradictory advice from different professionals • Bottlenecks in the RTW trajectory: occupational physician is not flexible in planning gradual RTW • Delay in recovery due to the (health) care system: long waiting lists
Societal barriers		• Legal arrangements: employer can use public money to hire a replacement • Stigma and taboo about mental health problems	• Legal arrangements: financial incentives for long-term sickness absence • Economic context: few jobs; flexible contracts	

Facilitators of RTW according to stakeholders

Table 2 shows the results of the content analysis of RTW facilitators. All four stakeholder groups mentioned facilitators that could be classified in the following core themes: 1) ways to support the worker, 2) what the worker can do, 3) what the work environment can do, and 4) collaboration between professionals.

Ways to support the worker

Activities that were specifically seen as the stakeholders' own role or responsibility are not described here but under the third topic on the stakeholders' own role in RTW (presented from page 21).

All four stakeholder groups discussed the importance of paying attention to the worker. Examples of how this could be done were by sincerely listening to the worker and taking them seriously and by providing appreciation, recognition and support. Both in the focus group with OHPs and GPs, it was mentioned that it could be helpful to have a caseworker or coach for the worker who could provide support in the RTW process. OHPs addressed the positive effect of providing perspective to the worker:

A: [...] that is why I just said that if you provide people with trust and confidence in the future, you see them almost instantly...

B: Instantly.

A: ...you see them improve."

Similarly, both GPs and managers addressed the significance of providing structure and clarity so that workers know where they stand and what steps will be taken. A specific topic that frequently reappeared in the focus group with mental health professionals was the importance of attention for both the recovery of the worker's (mental) health and the role of work:

"Thus, you almost cannot see it differently than as an integrated approach and cannot say like yes, I [only] focus on the person. That is also the consequence of a societal development that, as it were, it is always important to see when it goes about health, functional recovery, yes, that is about the integration also of work in your life."

What the worker can do

Several similar topics about what the worker could do to facilitate RTW emerged in the different stakeholder groups. Mental health professionals, OHPs and GPs all mentioned that a worker should explore what motivates them to work: what aspects of work are valued, satisfying, enjoyable or suiting the workers' needs. As described by a mental health professional:

"[...] What is most satisfying to you? That of course always has the aspect of positive energy and value in it, thus it is more an approach that it in fact always works to look at where is the energy source and satisfaction for someone to, yes, pick up work again."

Mental health professionals and OHPs also saw it as beneficial when a worker takes up responsibility for keeping in contact with the work environment. Examples of how this could be done were by making agreements with the manager on when contact could take place, and by preparing what to tell to the manager and colleagues about the sickness absence process. OHPs and GPs mentioned that being able to learn from the crisis is essential, as explained by a GP in the following quote:

"[...] a crisis makes you often also wiser and riper. Thus they [patients with CMDs] give a positive spin to it, but you do have to go through it. You have to put up with a lot, but eventually if you get through that process, even though it is difficult, you indeed become stronger because of it."

Another facilitating factor that was seen as the task of the worker by mental health professionals, GPs and managers was building self-confidence. For example, mental health professionals and managers mentioned that it is important for a worker to actively work towards acquiring successes and feeling useful. Furthermore, aspects were mentioned like improving resilience, losing feelings of powerlessness and developing perspective. In line with this, managers mentioned that it is beneficial when workers take responsibility for their recovery process by making their own choices in recovery and arranging the necessary support. Managers also felt it important that workers are able to recognise signals that things might be going wrong (again) and that they possess self-reflection to get insight into the problems related to sickness absence and which steps need to be taken.

What the work environment can do

In all four stakeholder groups there was agreement that the manager can have a facilitating role in RTW. The mental health professionals mentioned that the manager should show their involvement, get in touch early in the sick leave period, keep the focus on work and possibilities and ensure a safe work culture. Several of these aspects were also mentioned in the other groups, e.g. managers mentioned the importance of keeping in contact with the worker and creating a safe culture, and GPs agreed that managers should engage workers on sick leave in work.

A second key topic related to the work environment that arose within multiple focus groups was providing a worker with decision authority in the RTW process. This included, for example, to offer the worker room to experiment with what they are still able to do (mentioned by the managers) or the opportunity to self-arrange working times (mentioned by the GPs), or to ensure an RTW plan that is supported by the worker (mentioned by the OHPs).

A third key topic that emerged in three focus groups (OHPs, GPs and the managers) was the importance of no pressure from the work environment on the worker to RTW.

Both mental health professionals and managers indicated that arranging other work activities (other than the normal activities of a worker's job) could facilitate an earlier RTW, which clearly showed from a discussion among managers:

"A: But I strongly recognise providing an alternative, so that people also achieve successes again. And with successes they can return again, they need the security again ... We just talked about failing. Afterwards you often see an insecurity arising and that they don't dare to make a start from that insecurity. Well, you can get people back into that position following successes in an alternative workplace.

B: That is what I meant with quickly going back to work.

A: Yes.

C: But not at the same place and if you postpone that too long it becomes a big problem. The threshold becomes too high, if you can do something in another place you feel useful again. Thus then it doesn't need to take weeks [...]"

Within the focus group with mental health professionals several facilitating factors were addressed that did not emerge in the focus groups with the other stakeholders. Specifically, the mental health professionals pointed out there should be focus on a worker's ability in their professional role, and not on their limitations due to a mental health disorder. Furthermore, the mental health professionals mentioned that the employer or manager should have more regard for the person behind the worker:

"A: ... thus, the balance is completely lost. The person, I think, the person in society needs to become more and more productive, and if you are not productive any more then you are taken out. So I think there needs to be a new balance between productivity and humane..."

B: Humane, or something like that.

C: The human behind the worker.[...] Humanity.

A: Because if that gets back in balance, people will also be happier to return to work."

Finally, across the different stakeholder groups, varying topics emerged in relation to the facilitating role of the work environment in RTW, such as: supportive relationships with colleagues and the manager, professional support in the RTW process and managing RTW expectations.

Collaboration between professionals

The four stakeholder groups all mentioned good collaboration between different (health care) professionals as an important facilitator of returning to work. The mental health professionals and OHPs stressed that adjusting activities to each other can speed up recovery and RTW, as more time is spent by sorting out different advice provided by different professionals. The GPs indicated that it could be helpful when the GP and occupational physician support the worker together and provide a shared advice, which can create a feeling of trust and set the worker into motion. Finally, the managers discussed that a good relationship between the occupational physician and the manager can increase creativity in developing work accommodations. Additionally, they said that the RTW process could be facilitated when the worker provides permission for contact between treatment providers and the occupational physician and/or manager.

Table 2. RTW facilitating factors, according to stakeholders

	Stakeholders			
	<i>Mental health professionals</i>	<i>Occupational health professionals</i>	<i>General practitioners</i>	<i>Managers</i>
Ways to support the worker	• Pay attention to the worker: show appreciation of their condition • Attention to both recovery of health and work • Early involvement of a psychologist • Medication in case of severe problems	• Pay attention to the worker: listen; show support; take their condition seriously • A caseworker/coach in the recovery and RTW process • Provide perspective: take away fear; provide confidence in the future	• Pay attention to the worker: listen; show appreciation of their condition • A caseworker/coach in the recovery and RTW process • Provide structure and clarity • Courses: assertiveness; development skills for the job • Support from home • Legal regulations, such as financial incentive to work	• Pay attention to the worker: listen; show recognition of their condition • Provide structure and clarity
What the worker can do	• Explore motivation for work: what is satisfying?; sources of energy; value of work • Keep in contact with work; know what to tell colleagues • Build self-confidence; perspective; realise successes; resilience • Keep a daily structure	• Explore motivation for work: what suits you? • Keep in contact with work • Learn from the crisis • Undertake activities for daily structure and relaxation • Guard limits and regain/remain in control	• Explore motivation for work: what is enjoyable?; what do you want? • Learn from the crisis • Build self-confidence	• Keep being active • Build self-confidence; realise successes; feel useful • Recognise signals • Take responsibility for recovery: arrange support; make choices • Self-reflection
What the work environment can do	• Role of manager: be involved; create a safe culture; be proactive; focus on work • Manage expectations about what the worker	• Role of manager: recognise barriers • Provide worker with authority in making RTW decisions • No pressure on the RTW	• Role of manager: understanding; focus on work; positive approach • Provide worker with decision authority in the RTW process	• Role of the manager: keep in contact; be open about signals; create a safe culture • Provide worker with decision authority in the

	- can and cannot do • Substitute work activities: creativity in work accommodations; discuss which tasks are still possible • Occupational physician supports the worker • Focus on the worker's professional role • Support relationships with colleagues: involvement; team stability • Pay attention to the person behind the worker	• Possibility to return without much job strain	• No pressure on the return • An active RTW policy • Evaluate the RTW process with the worker • Positive contact between the worker, manager and colleagues: show interest; regular contact	- RTW process • No pressure on the return • Manage expectations about what the worker can and cannot do • Early opportunity to do other work activities • Develop a personalised RTW plan with the worker • Professional support in the RTW for the worker and manager, such as an occupational psychologist
Collaboration between professionals	• Good collaboration	• Good collaboration	• General practitioner and occupational physician work together to support the worker	• Good relationship between occupational physician and manager • Worker provides permission for contact with treatment provider

The stakeholder's own role in RTW

Table 3 shows the results of the content analysis for the stakeholders' own role in RTW. The topics discussed by the four stakeholder groups could be classified in the following core themes: 1) fundamental responsibilities, 2) psycho-education, 3) interventions, 4) activities aimed at work, and 5) collaboration with other professionals.

Fundamental responsibilities

In all four stakeholder groups there was discussion about aspects experienced as crucial to the own role in RTW. These aspects could be seen as fundamental responsibilities that the stakeholder had to live up to. For example, the GPs said that they are there to support the patient's interests.

An aspect all four stakeholder groups experienced as central to their role was empowering the worker. This could imply supporting the worker in finding their own solutions or self-managing conflicts, stimulating the worker to make use of available resources or providing the worker with the opportunity to take the lead and experiment with returning to work. For OHPs, an important part of empowering the worker also implied refraining from telling the worker what they should do. They felt that this is a weak spot for professionals with a medical background who are used to diagnosing problems and prescribing solutions, while workers should be empowered to find their own solutions.

Both OHPs and GPs felt that getting the diagnosis right is an important part of their role. However, for OHPs this was especially focused on distinguishing between mental health complaints and complaints that are purely related to work problems, while for GPs it was more about establishing the cause of problems and making sure that there were no primary physical problems explaining the mental health problems. Furthermore, GPs felt it as their responsibility to signal problems early on as they are often the first health care provider to whom people (with health problems) turn.

Managers felt it as their responsibility to ensure a safe culture at work, for example by facilitating open communication. They also mentioned the importance of keeping contact with the worker without putting pressure on returning to work and ensuring an RTW plan tailored to the individual worker. Moreover, they addressed it as their role to recognise signals that a worker might not be feeling well and support them in setting and keeping limits, as shown from the following two quotes:

Quote 1: "[...] Yes, as employer you may have failed if you did not see it in time, that could.... I think that, that ... that for a part you can... if you know your workers then you also recognise the signals, then you can raise the alarm."

Quote 2: "It is our task to guard it [a worker's limits] because you then see them [the workers] like 'That is being expected from me and then they [colleagues, the manager] like me again.' It's such a pitfall."

The managers were the only group in which a clear statement was made on what did not belong to their core responsibilities. They addressed that they are not responsible for problems in a worker's private life that might put them in a difficult position at work. An example of this were workers who had taken a high mortgage that required a full-time job, but whose health and wellbeing would benefit from permanently reducing their contract hours.

Psycho-education

Providing psycho-education was mainly discussed by the GPs and OHPs and to a lesser degree by the mental health professionals. All these stakeholders saw it as their role to provide an explanation about how sickness absence could have occurred. They did this, for example, by structuring the causes of sickness absence, drawing a picture of how the worker ended in this situation or discussing what had happened and the choices the worker had made. Next to this, both GPs and OHPs found it their

responsibility to provide information on a proper daily structure, i.e. ensuring a balance between exercising, doing daily activities and taking rest, as shown from the following discussion among GPs:

"A: I think that I do mention in the first week like, forget everything for a moment and next week we will talk again or within 14 days we will talk again, but now just go and have a walk and physical activity.

B: Yes I have that indeed, cycling. Go cycling and walking.

C: No, I think that too, about two weeks to recover physically [...] from all troubles and then indeed at least walk one hour a day, exercise, cycle and daily structure I had in my repertoire, thus getting up on time, going to bed on time. Not that you get in a pattern with which you have difficulty later on to get into that rhythm again [...]"

Other examples of psycho-education were providing perspective by explaining that sickness absence is a phase that will pass and sketching a picture of improvement (mentioned by OHPs), clarifying the treatment trajectory and linking this to RTW and comforting the worker that they are not the only one and that it can happen to anybody (mentioned by GPs). Managers did not talk about psycho-education during the focus group meeting.

Interventions

In all four focus groups, stakeholders talked about activities they would undertake to stimulate a worker's RTW. Within this topic, relatively more variation between the stakeholders was observed compared to previous topics. There was one overlap between mental health professionals and OHPs who both discussed recovery tasks with the worker. For example, one mental health professional said:

"[...] I actually always start, even if it is the first week, with having someone indeed operationalise [i.e. define] rest to call it that way. And I often work, you then talk about recovery and recovery tasks. [...] recovery tasks could be all kinds of passive activities and also that you do something active, [...] because actually often no one is feeling satisfied when he says yes, now I am at home and what shall I do now?"

The other overlap was between OHPs and GPs in that they both addressed it as their task to discuss the worker's choices. However, while GPs primarily mentioned that, together with the patient, they had to look at the choices made, OHPs also discussed that they had to stimulate the worker to take responsibility for making choices and provide insight that the worker has the ability to make choices.

Other activities mental health professionals mentioned, next to discussing recovery tasks, was having the worker think about what 'taking rest' implies (which also shows from the quote above), discussing RTW barriers and drawing up a gradual RTW plan together with the worker, and looking at the value of work. As one mental health professional said:

"[...] depending on the client and the conversation level, you call it the value, or what you enjoy in work, or what is a reason later on [to return]... What is most satisfying? [...]"

OHPs discussed that they try to clarify a worker's cognitions to discuss the validity of these cognitions, and they structure feelings to clarify what caused these feelings. Furthermore, OHPs mentioned responsibilities in setting up an RTW plan, but this differed from the role mental health professionals experienced in this. The OHPs saw it as their responsibility to decide which steps should be taken in RTW, encourage a worker to make their own RTW plan and reduce the threshold for the first step in RTW:

"You have to get over that threshold and then you also know how it is at your work [...] if it doesn't work then we'll quit, then it just doesn't work and it [the return to work] needs to be done differently. So I always give them an alternative and in my advice to the workplace I always state 'it is very important that [...] this worker guards her limits well' because you have to learn that [to protect your limits]. [...] So I do support and stimulate them, actually just like a nurse when someone has been operated on, approximately that attitude."

The core activity discussed by GPs was keeping regular contact and monitoring progression. GPs indicated that they should see a patient with mental health-related sickness absence approximately every two weeks to ascertain that the period in which the worker is at home taking rest is not taking too long, check whether things are changing and address whether a patient is able to apply the things that have been learned during recovery. Besides this, some GPs also mentioned that they had therapeutic conversations with patients and provided written information related to mental health problems.

The managers reported other ways of positively intervening in a worker's RTW process. For example, it was seen as important to acknowledge it when the employer also played a role in the events that led up to sickness absence, as shown in the following two quotes:

Quote 1: *"Maybe it could be an important conclusion that you have failed as employer by not having signalled sooner what was going on with such a worker. Very personally. But I think that some recognition, as said by respondent Y, is extremely important."*

Quote 2: *"And that also the employer's part... the shared responsibility, that we shouldn't keep that out of sight and that we shouldn't only look at the worker."*

Managers also talked about their role in the RTW plan, but described different responsibilities compared to the mental health professionals and OHPs did. Managers said that they have to make clear that the RTW will be built up in an appropriate way and discuss whether the situation at work has changed for the worker. Furthermore, they could decide to work closer with the worker at the start of the RTW, or send a worker home if the worker is showing signs that things are not going well but is not picking up these signals. Another task that managers saw for themselves was offering work accommodations such as alternative work or working part-time. Lastly, they mentioned that they played a role in discussing the signals that indicate that the worker is having troubles, but also the things a worker is interested in and is able to realise, as one manager explained:

"I believe that when you notice that someone is experiencing stress due to the type of work they are in, you can help people by starting a conversation about this, like what do you need to be able to keep going? But maybe also the conclusion that the work stress is getting so heavy that this is not my type of work any more. And then you can go and help people, like what is then... and what are your interests? Where can you realise a second chance? I hear from my team leaders that they are zooming in on this, what the remaining possibilities are."

Activities aimed at work

Next to supporting the individual worker on sickness absence due to CMDs, all stakeholders discussed activities that were specifically directed at work, working or the work environment. Of course, all manager activities mentioned above are also embedded in the work environment (as this is the context in which the manager operates). However, under the current sub-theme, specifically those manager activities are described that were aimed at the work environment surrounding the worker.

A comparable finding between mental health professionals and OHPs was that they both felt responsible for connecting with the worker's manager. For example, the mental health professionals mentioned that they provided advice to the manager about how they could approach the worker, quite similar to OHPs who discussed with the manager how they could deal with a worker's mental health problems and informed them that the majority of workers experience difficult periods at some point in their working life (i.e. in Table 3, this was framed as psycho-education to the manager.) Mental health professionals additionally talked about quickly involving the manager and the possibility of organising a meeting with both the worker and manager. Having a tripartite meeting was also mentioned by the OHPs as an example of how to facilitate the collaboration between the worker and manager. Furthermore, in the focus group with OHPs it was discussed that they have the responsibility to make clear to the manager that they can influence the RTW process:

“A: I believe that getting someone back is the most important criterion. If you want to do something, [i.e.] getting someone back, and that is educating the manager on how you [the manager] need to do that. The manager is the key player.

B: I say to the manager: ‘You have more influence than you are aware of yourself.’ I say: ‘That could go two ways: could be positive and it could be negative.’ I say: ‘You have the most influence on that.’ Then I explain a part ...”

A similarity found between GPs and managers was that they both talked with the worker about potential negative reactions or incomprehension from colleagues at work. Managers also indicated that they could play a role in this by communicating with colleagues about the worker’s recovery process and discussing with the worker what to exactly say to colleagues.

Mental health professionals and GPs both frequently discussed that it was important that they talked about work and returning to work. Mental health professionals tried to lower the threshold to work by focusing on the positive aspects of work, advising about the disclosure of health problems (related to the sick leave period) at work and stimulating quick contact with work. GPs, however, were reserved in advising contact with the workplace in case there were work-related conflicts. They did find it important to stimulate the worker to discuss work-related problems and RTW, but they thought this could also go through human resource services instead of the direct manager. In the GP group it was additionally brought up that a GP could do very little if the employer (or manager) is the main problem hindering RTW.

Collaboration with other professionals

Collaboration was also a topic that appeared from discussions about the stakeholder’s own role in RTW. As shown in Table 3, mental health professionals, GPs and managers specifically talked about their responsibilities in collaborating with the occupational physician. Mental health professionals said they need to seek collaboration with occupational physicians and that it is important that they bring in an occupational physician as quickly as possible. GPs suggested that they should invite an occupational physician to get into contact with them (through the worker) and get to an agreement about the treatment and RTW process. They also found it important that neither the GP nor the occupational physician would interfere with the core responsibilities of the other’s profession (i.e. deciding on the treatment process versus deciding about work disability, respectively). Managers mentioned that collaborating with the occupational physician is mainly important to get advice, if necessary, in decisions about RTW. For example, one manager mentioned that in case a worker requests to speed up the RTW process it would be checked with the occupational physician if that would not be harmful. The OHPs discussed more generally that they would sometimes contact another care professional to align treatment and RTW plans. Finally, the GPs frequently mentioned their responsibility to not talk about the patient’s personal and intimate information with any other (care) professional, and to protect the patient’s privacy towards the employer and occupational physician specifically.

Table 3. Stakeholders' perceptions of their roles in RTW

	Stakeholders			
	<i>Mental health professionals</i>	<i>Occupational health professionals</i>	<i>General practitioners</i>	<i>Managers</i>
Fundamental responsibilities	• Empower the worker: help the worker to self-manage conflicts, clarify preferences and make use of available resources • Help the worker focus on their recovery • Provide solution-focused and process-focused guidance	• Empower the worker: stimulate; don't tell the worker what to do; prevent victimisation • Diagnostics: distinguish mental health complaints from work problems • Be supportive • Focus on opportunities • Protect the worker from a negative work environment • Explain one's own role as a professional in the RTW process	• Empower the worker: support the worker in finding their own solutions and taking steps to implement them • Diagnostics: early recognition of symptoms; establish the cause • Support the patient's interests • Be supportive • Adjust advice to each individual worker	• Empower the worker: provide space to take the lead and experiment with RTW • Ensure a safe workplace culture • Keep in contact without putting pressure on the worker • Recognise and watch over a worker's signals, limits and pitfalls • Adjust advice to each individual worker • Not responsible for worker's decisions in their private life
Psycho-education	• Explain how sickness absence could have occurred	• Explain how sickness absence could have occurred • Provide information on taking rest, exercise and activities • Provide perspective for the future	• Explain how sickness absence could have occurred • Provide information on taking rest, exercise and activities • Provide information on the treatment trajectory and RTW • Provide reassurance that this can happen to anyone	
Interventions	• Stimulate the worker to think about what 'taking rest' implies • Discuss recovery tasks • Discuss barriers • Sketch a gradual RTW plan with the worker	• Discuss recovery tasks • Discuss choices to enable RTW • Discuss expectations • Clarify cognitions and structure feelings • Provide support in setting	• Discuss choices • Keep regular contact and monitor progress • Therapeutic conversations/exercises	• Acknowledge the employer's role in occurrence of sickness absence • Design a proper RTW plan and support during RTW

	Discuss the value of work for the worker	up an RTW plan		- Provide work accommodations - Discuss what the worker wants: what are the worker's interests and possibilities? - Discuss signals
Activities aimed at work	- Involve and advise the manager - Lower the threshold to work: early contact; focus on the positive side of work; provide advice about disclosure of health problems at work - Point out the worker's contractual obligations towards the employer - Point out structural problems in the organisation and provide support	- Provide psycho-education to the manager - Point out the manager's influence on the RTW process - Facilitate collaboration between the manager and worker in the RTW process	- Advise on how to keep in contact with the workplace: discuss work-related problems and RTW; bring someone to a meeting with the manager; reserved about giving advice in case of conflict - Explain potential negative reactions from the work environment - GP has no influence on RTW if employer is the problem	- Discuss with the worker what to communicate to colleagues about the worker's recovery process - Discuss colleagues' incomprehension about the worker being socially active during sick leave
Collaboration with other professionals	Early and good collaboration with the occupational physician	Align activities with other care professionals	- Collaborate with the occupational physician - General physician should not make judgments about work disability - Occupational physician should not make decisions about therapy - Protect worker's privacy	- Occupational physician has an advisory role - Discuss with the worker diverging advice from different professionals

DISCUSSION

The objective of the focus group study was to investigate what mental health professionals, occupational health professionals, general practitioners and managers perceive as barriers to and facilitators of the RTW process of workers on sick leave with CMDs. Here, the conclusions that can be drawn from the analyses have been summarised and interpreted against the background of previous research.

Main findings

For each of the three main themes (RTW barriers, RTW facilitating factors and the stakeholders' role in RTW), different sub-themes emerged, of which the large majority were covered by each stakeholder group. When considering all sub-themes, five cross-cutting themes stand out that are central to successful RTW of workers on sick leave with CMDs: 1) a worker's motivation versus a worker's emotions, cognitions and coping; 2) the type of work one returns to; 3) a safe, welcoming and stigma-free work environment; 4) personalised RTW support; and 5) collaboration between (health care) professionals.

A worker's motivation versus a worker's emotions, cognitions and coping

The worker's motivation is a key factor in RTW and can, in the view of the participants, be distinguished from emotions, cognitions and coping, both in terms of impact on RTW and potential interventions to deal with it. Especially, fear and anxiety of not being able to cope with work demands or losing control can be associated with negative attitudes towards work resumption. This in turn may affect coping behaviour. Previous studies have illustrated the importance of such cognitions and emotions for the RTW process of workers with CMDs, such as self-efficacy (27, 34). All stakeholder groups mentioned that a worker needs to be motivated, i.e. willing, to RTW, and if a worker does not want to RTW because work is not rewarding or activities at home are more rewarding, this is a major barrier. Various stakeholders indicated that it is therefore important to talk with the worker about what is valuable and fulfilling in work to try to enable a RTW that incorporates these aspects (35). However, this could also imply that a worker needs to rethink the current job position and job choice. Next to the workers' motivation, their emotions, cognitions and coping related to sickness absence with CMDs and RTW are important for RTW. Previous research has also addressed the importance of workers' motivation, emotions, cognitions and coping. For example, Corbiere et al. (2016) (36) found that union representatives also reported that emotions like denial, shame and fear are hindering factors for RTW in workers on sick leave due to depression. And an interview study with managers on factors influencing RTW in workers with mental health problems showed that managers indicated that a worker's job dissatisfaction (which relates to a lack of motivation) impedes RTW (37). However, the present focus group study adds to this existing knowledge because, as said, it shows that a clear differentiation can be made between a worker's motivation on the one side and a worker's emotions, cognitions and coping on the other side. A lack of motivation may imply that a worker is not enjoying the type of work they are doing. This calls for a discussion of what is exactly motivating in work and how/if this can be realised in the current work context. Working on RTW may be fruitless if there is a motivational problem. Barriers in emotions, cognitions and coping, however, seem to undermine a worker's ability to take steps in RTW and request that one empowers the worker to regain control which can reduce negative emotions and cognitions and improve active coping strategies.

The type of work one returns to

The results indicated that it is essential for a successful RTW to focus on the *type* of work one returns to, not only on enabling RTW *per se*. For example, the necessity of adequate work adaptations was stressed by all stakeholder groups as paramount to enable RTW. The importance of work adjustments as a means of reducing sick leave has been underlined before (38). Work contexts in which no substantial actions have been taken to support the returning worker were deemed as a major barrier to RTW. Managers specifically stressed that RTW is facilitated when a worker can start with a return to alternative work instead of their own work. One's own work may come with expectations and pressure to perform as before the sick leave period, while alternative work could be more quickly realised (in the managers' experience) and may provide a context to quickly achieve small successes and re-establish self-confidence. In deciding on the type of work a worker returns to, the worker's motivation is again important to take into account. Several stakeholders mentioned that returning to activities that are fulfilling and motivating is a great RTW facilitator.

A safe, welcoming and stigma-free work environment

A safe, welcoming and stigma-free work environment is experienced as essential for a successful RTW by the stakeholder groups in this study. This is in line with previous studies that have shown similar results; for example that conflicts at work, prejudice at the workplace towards mental health problems and difficult communication with the manager are debilitating for RTW (36, 37, 39, 40). The focus group data also provided indications for why a safe, welcoming work environment is sometimes hampered. Several stakeholders mentioned that the workplace is not always motivated to have the sick worker RTW, for example because a substitute was hired who is doing a good job. Furthermore, relationships between the sick worker and colleagues may have been damaged in the period before the sick leave episode if the worker was already experiencing work functioning problems or could have been more difficult to communicate with. Stakeholders also addressed the incomprehension colleagues often experience towards workers on sickness absence with mental health problems. According to the stakeholders, colleagues have limited knowledge of the recovery process of mental health problems and seem to misunderstand activities that a worker undertakes in private life (e.g. cycling, going shopping) as enjoying one's sick leave episode instead of working for recovery. The stakeholders mentioned that sick workers do feel guilty towards colleagues for undertaking such activities.

A personalised approach to RTW support

One of the complexities of the RTW process that clearly stood out in the focus group data is that there is no standard in RTW support and that a personalised approach is essential. This clearly showed from the views expressed by all stakeholders on several sub-themes. For example, with regards to the manager's role, all stakeholders agreed that it is important that the manager stays in regular contact with the worker. However, they also all agreed that it is sometimes better that the manager does not get into contact too soon or too frequent, especially in case of (rising) conflicts at work. As another example, on the one hand, it was stressed that all stakeholders involved in the RTW process should take an activating approach (i.e. stimulating the worker to RTW quickly), while on the other hand, it was said that some workers may feel pressured if a quick RTW is discussed, which can work as a barrier. This shows that RTW facilitators for one worker may act as a barrier to RTW for the other worker and underscores the importance of adjusting RTW support to each individual worker.

Collaboration between (health care) professionals

Another complexity of the RTW process that showed to be an important cross-cutting theme in this study is the collaboration between various (health care) professionals in supporting a worker with CMDs back to work. Independent of what the topic being discussed was (barriers, facilitators or the stakeholders' own roles) the issue of collaboration arose in all stakeholder groups. The stakeholders agreed that communication between professionals and aligning each other's interventions and activities with the sick worker greatly facilitates RTW. They also acknowledged that they themselves play a role in ensuring collaboration; GPs, mental health professionals and managers specifically addressed the importance of collaborating with OHPs. However, at the same time, all stakeholder groups addressed the difficulty of realising collaboration and acknowledged that it rarely occurs. These findings corroborate conclusions from previous research – the problem of collaboration between professionals in supporting workers on sick leave with CMDs has been well-documented (28, 41, 42).

The roles of the different stakeholder groups

The present study is, to the authors' knowledge, the first to report on the views of four different stakeholder groups on their own roles in RTW of workers on sick leave with CMDs. Several conclusions can be drawn from this input.

First, all four stakeholder groups readily acknowledged that they have a responsibility in supporting RTW. The fact that managers and OHPs acknowledged this might be typical of the Dutch context, in which employers are legally responsible for RTW and are required to consult OHPs. The existence of RTW guidelines for OHPs, GPs and mental health professionals in the Netherlands may have also contributed to the stakeholders' knowledge on how they can contribute in RTW. It is especially encouraging that the GPs discussed the importance of work for the recovery process of people with CMDs, and that they talk about work issues with their clients who have a CMD. GPs are often the first treatment provider people with CMDs get into contact with and is therefore ideally placed to spot and address work-related issues early on. In line with this, the OECD recently recommended that countries should invest in GPs' knowledge of the importance of work for people with CMDs (43).

Second, there were some clear differences between the health care professionals on the one hand (i.e. the GPs, OHPs and mental health professionals) and the managers on the other hand. In each focus group with the health professionals, it was mentioned that a barrier to RTW could be a lack of motivation of the workplace (mainly represented by the manager) to have the worker return. An important reason given for this was conflicts between the worker and the manager. In contrast, the managers did not once talk about the hindering effect of conflicts or that they sometimes lacked the motivation to have a worker return. Another distinction between the health care professionals and the managers could be perceived in their knowledge of CMDs and the related recovery process. Specifically, managers reported little about what a worker needs who is on sickness absence with CMDs, while the health care professionals gave ample illustrations (e.g. providing perspective, assertiveness training, a coach, support from home). This difference was also reflected in the stakeholders' perspective on their own role in the recovery process. While all health care providers talked about providing psycho-education to the worker, the managers did not mention any activities that would fall in this category (e.g. providing explanations about sickness absence, information on how the RTW process will look like and perspective for the future). Although it might not seem surprising that the health care professionals reported more knowledge about CMDs and how this affects RTW and are better able to provide psycho-education – it is also known from previous literature that workers with mental health problems are not always well supported by their managers (44) – it pinpoints a missed opportunity to comfort and support workers on sick leave for CMDs early on. A manager is most likely one of the first to know that a worker has gone on sick leave because they cannot cope with work any longer. If the manager would take up the role of providing reassurance that this can happen to anybody and provide perspective (i.e. the majority of people get through this process well), i.e.

providing psycho-education, this may reduce several barriers at the level of the workers' emotions, cognitions and coping early on. Of course, this would request some mental health education for the manager, which has also been concluded and recommended by the OECD (45).

Finally, overall, the stakeholder groups were able to report on a large amount of RTW barriers and facilitators for workers with CMDs and seemed to be quite knowledgeable about what is needed to ensure a sustainable RTW. This however seems somewhat in contrast with the reality that mental disorders are associated with long periods of sickness absence. In the Netherlands, the median duration of sickness absence of people with mental disorders has increased from 87 days in 2005 to 118 days in 2013 (46). This finding therefore raises the question whether the participants in the focus groups were more knowledgeable than peers who would *not* volunteer to participate in scientific research on the topic of mental health and work. Alternatively, the finding that stakeholders were quite knowledgeable may indicate there is an implementation gap between what stakeholders know and how they act. A factor that may play a role in such a gap is the issue of ownership when problems arise in the RTW process. Knowing the barriers does not necessarily mean that one is able to tackle them all, and when problems arise in tackling barriers, it could be that a lack of urgency or ownership for addressing these problems causes stagnation. There are some indications from the focus groups that may support this explanation. For example, GPs mentioned that if the true problem for RTW lies at the workplace, the GP could play no role. Similarly, managers indicated that if there is little opportunity to change anything in the type of work being done or the work environment, they cannot really do anything. Another example is the collaboration between the different professionals which was addressed as essential in all stakeholder groups, but at the same time none of the participants showed to be very proactive in collaborating with other professionals and doing this on a regular basis. Thus, in case all stakeholders feel that their hands are bound to overcome certain barriers and have the initial reaction to take their hands off the problem, it would be essential to ensure that one stakeholder still keeps ownership of supporting the worker (which might imply, for example, discussing with the worker the impossibility of making certain changes and how to cope with them).

Strengths and limitations

Previously, the need for good qualitative research investigating relevant stakeholders' views on the RTW process, for example through the lens of managers, case managers or personnel in the mental health care system, was stressed in the literature (28). One of the strengths of this study therefore is that in this study, the RTW process for workers with common mental disorders was indeed examined from a multi-stakeholder perspective. RTW by workers with CMDs is a complex process in which different stakeholders have to co-operate. Most qualitative studies that investigated the RTW of workers with mental health problems have focused on one or two perspectives only (37, 41, 47). As such, investigating the RTW process from different perspectives, including taking into account the different roles of the stakeholders, is of added value to understand its complexity. A second strength is that by exploring different perspectives we were able to identify patterns of similarities and differences between the perspectives. This provides the opportunity to see potential gaps in co-operation and communication between stakeholders. A third strength of the study is that the reliability of the themes was strengthened by the use of researcher triangulation.

A limitation of the study is that it is not clear how far the findings can be generalised, as results may be subject to sampling or response bias. As was stated above, our recruitment process may have led to a selection of stakeholders who were above average interested in evidence based methods in addressing RTW issues. Indeed clinical psychologists, who do generally not focus on client's work context and RTW, were less well represented in the focus group with mental health professionals. Also, within the managers focus group participants had various work experiences, but there was greater representation of the education and health care sector. Hence, the experiences of the participants may not necessarily be representative for all OHP, mental health professionals, GPs and managers. This may particularly be the

case for the GPs, as most had recently retired. However, all stakeholder participants were highly experienced in the guidance of workers on sick leave with CMDs. A second limitation is that we did not conduct a focus group study with people with CMDs. Because of the extensive interview study that was part of the present project, where a large variety of workers with CMDs were interviewed individually, an additional focus group was not carried out. However, this difference in research methods disables a proper comparison of one of the most important stakeholder groups with the other groups. Finally, a limitation of this study is that we conducted only one focus group per stakeholder group; for this reason it is not clear if we reached data saturation for each stakeholder group.

Implications for research and practice

To investigate the aims of this study, qualitative research was chosen as it is the appropriate technique when a subject matter is complex and not well understood (31), such as in the RTW process of workers with CMDs. Qualitative research aims at exploring complex issues and providing answers to subject matters that are not well understood (31). Indeed, the present multi-stakeholder focus group study helped to provide better understanding of the perspective of important stakeholders in the RTW process of workers with CMDs. However, many questions for future research remain. For instance, this study underlines the need for research on the possible implementation gap, i.e. the difference between knowledge and behaviour of stakeholders involved in the RTW process. Previous research has shown that many factors may affect occupational physicians' behaviour in their guidance of workers on sick leave with CMDs, and that external barriers beyond physicians' control are strong barriers to adequate professional guidance (48). Especially the topic of limitations of 'ownership' (the extent to which one feels responsible) by the stakeholders as a flaw in RTW process seems of interest for future research. A second recommendation for further research stems from the finding that despite similarities, stakeholders also saw different barriers to RTW and had different views on their own role in the RTW process. As they are all closely involved in the RTW process, combining their complementing perspectives as was done in provided a broader view that could be investigated further with quantitative research. Furthermore, future research could extend this work by investigating if it is feasible and effective to better educate managers, e.g. in dealing with conflict and communication, in providing psycho-education to workers with CMDs on sick leave, and in creating the right circumstances and type of work to return to. Finally, the list of barriers and facilitators that was found can be useful in designing questionnaires for further quantitative research.

Also for practice, several recommendations can be made based on the findings of this focus group study. First, the list of barriers and facilitators can provide input for developing checklists of topics to take into account when guiding RTW. It can be used for the development of tools for the different stakeholders. Second, the findings suggest that stakeholders are quite knowledgeable of how workers with CMDs should properly be guided back to work, but that despite this, implementation is possibly lacking. As such, the findings provide input for discussions within and between different stakeholder groups about ownership/responsibility for managing various aspects of the RTW process, and on how implementation can be improved. Finally, all three groups of health care professionals agreed on the importance of manager behaviour, such as in situations where there is a conflict between worker and manager. In contrast, managers did not discuss any negative effects they may have on the RTW process. This finding suggests that managers may underestimate the negative consequences their behaviour and communication may have in the process. As such, creating awareness concerning manager behaviour seems important. In fact, education for managers on how to support workers with mental health problems in the workplace is not only recommended *after* sick leave but also before, as previous research stresses the importance of manager behaviour and communication in people with mental health problems, even prior to sick leave (36).

PART B. INTERVIEW STUDY

METHODS

Study design

A qualitative design using interviews was chosen as it enabled us to obtain information about behaviour, underlying motivation, needs and preferences of the target group (31). Moreover, the longitudinal design offered us the opportunity to explore all factors that hamper or facilitate the RTW process for different types of worker, as well as possible changes over time.

Semi-structured face-to-face interviews were held with workers at two moments during their process from sick leave towards returning to work: 1) at the start of their sick leave period (first-wave interviews) and (2) when they resumed work or when they still were at sickness absence 6 months after they first called in sick (second-wave interviews). Based on their pace of returning to work three groups of workers were distinguished: 1) Workers who had resumed work within 3 months (short-term sick leave workers); 2) Workers who had resumed work after 3 to 6 months (medium-term sick leave workers); and 3) Workers who had still not resumed work after 6 months (long-term sick leave workers).

Ethics

Prior to the start, ethical approval for this study was obtained from the Ethics Review Board (ERB) of the School of Social and Behavioral Sciences of Tilburg University.

Participants and recruitment

Recruitment of workers was organised in collaboration with several occupational health professionals, psychologists, and general physicians. Workers were eligible for inclusion if:

- 1) the worker was on sick leave for a maximum of 6 weeks at the start of recruitment, of which at least 1 week was full time on sick leave;
- 2) the worker was aged between 18 and 65 years;
- 3) the worker had an adequate command of the Dutch language;
- 4) mental health problems were the primary reason for the worker's sick leave according to the (occupational) health professional.

Workers who were suicidal or for whom a physical problem was the primary reason for sick leave were excluded.

Workers were recruited by the participating (occupational) health professionals in this study who first screened the inclusion and exclusion criteria. If the worker was interested in participating, the (occupational) health professional asked whether contact information of the worker could be given to the researcher (HvG) and handed over written information about the study (see additional file 1). If the worker approved, the (occupational) health professional gave the email address or telephone number to the researcher. The researcher contacted the worker by telephone, explained the purpose of the study,

checked the inclusion and exclusion criteria and asked if the worker wanted to participate. Workers were offered a gift voucher (10 euros) for each interview they participated in.

If workers who were willing to participate, an appointment was made for a brief psychiatric interview (i.e. Primary Care Evaluation of Mental Disorders (PRIME-MD) (49) by telephone to obtain diagnostic information (and fully check the inclusion criteria concerning mental health problems) and to collect socio-demographic information (e.g. age, gender, education level, occupation). At the end of this conversation an appointment was made for the first interview at a time and location that was most convenient to the participant.

After the first interview, the researcher emailed the participating workers every two weeks to monitor their sickness and work status. Workers were invited for the second-wave interviews if they had fully returned to work or if they were still on sick leave after 6 months. Potential workers for the second interview were invited by email and an appointment for the interview was made.

Data collection

The semi-structured face-to-face interviews (n=116) were held by one of three researchers (HvG, BS, EB), at the respondent's home or other preferred place. Prior to the start of the interview participants were asked to give permission to audio-tape the interview. A semi-structured topic guide was used for both waves of interviews. The first wave of interviews focused on workers' views on what had caused their sickness absence and expectations concerning barriers to and facilitators of work resumption. The second wave of interviews focused on how the workers had experienced their sick leave and RTW process and which factors they perceived as hindering or facilitating the RTW process. All participating workers gave their written informed consent prior to the interviews.

Because three sufficiently large groups were needed for the second interview (reaching situation) and because of the fact that at the first interview it was unknown who would be on sick leave for how long, a relative high number of workers had to be interviewed for the first wave. Because qualitative data analysis is very time consuming and further analysis is beyond the point where saturation is reached, not all respondents from the first wave were also interviewed in the second wave. Instead, a selection of workers was made for the second wave, primarily on diversity of professions within the groups.

Data analysis

A total of seventy-two interviews (first and second wave) were transcribed verbatim. Next, all identifying characteristics were removed from the transcripts and they were entered into a qualitative software program AtlasTi, a professional tool designed for qualitative data analysis.

A general grounded theory perspective was used for analysis. This perspective is particularly suited to situations about which is little known, as it provides a better understanding of how and why things happen (31). It assures that the meaning of a concept is discovered in the words and actions of participants from the ground up – rather than from the application of an *a priori* theory or concept (31).

Transcripts were coded by four researchers in total (HvG, BS, ML and MJ):

- The first three transcripts were independently (openly) coded by HvG and BS. The codes were compared and discussed and a preliminary coding scheme was generated.
- Next, seven more transcripts were independently coded by HvG and BS using this preliminary coding scheme. After comparing and discussing the new codes, a more structured coding scheme emerged.

- The remaining 58 transcripts were coded by one researcher (HvG, ML, MJ or BS) using this structured coding scheme and checked by a second researcher (BS or ML). Code agreements and disagreements were discussed until consensus was reached.

After the initial coding process the analyses proceeded by the iterative and interpretive process of constant comparison. Data relating to each code were retrieved, described and compared across individuals, and across different groups of workers. The overall analysis process resulted in the identification of core categories of factors contributing to the onset of sick leave in workers with CMDs and to core RTW barriers and facilitators.

Inter-observer reliability was tested on several occasions, through coding of the first ten transcripts by more than one coder and by group discussions (on meaning) of codes and relationships between codes.

The first wave included an overrepresentation of workers in health care and education. As saturation was quickly reached with these workers we specifically also included workers from other work experiences, to obtain a more diverse sample of representative experiences, which is in line with the tradition of qualitative research (31). New participants for each group were selected based on relevant patient sociodemographic and/or clinical characteristics until saturation (of concepts) was achieved.

RESULTS

Participants' characteristics

Table 4 presents the main characteristics of the 34 participating workers on sick leave with mental health problems. Each worker was interviewed twice: initially at the start of their sickness absence period (first-wave interview) and then after returning to work or after 6 months of sickness absence (second-wave interview). Based on their pace of returning to work, three groups were distinguished: 1. Workers who had resumed work within 3 months (short-term sick leave workers) (n=12); 2. Workers who had resumed work within 3 to 6 months (n=11) (medium-term sick leave workers) (n=11) and 3. Workers who had still not resumed work after 6 months (long-term sick leavers) (n=11). Workers had various mental health problems, most prevalent were major depressive disorder (n=19), somatoform disorder (n=13), and generalised anxiety disorder (n=11).

Table 4. Characteristics of participating workers with CMDs

	Participants			
	Group 1 Short-term sick leave workers	Group 2 Medium- term sick leave workers	Group 3 Long-term sick leave workers	Total
Number of participants	12	11	11	34 (100%)
Sex				
Male	5	2	1	8 (23.5%)
Female	7	9	10	26 (76.5%)
Mean age in years (range)	48 (29-59)	48 (37-60)	52 (40-62)	49 (29-62)
Educational level				
Low	2	1	0	3
Middle	4	6	2	12
High	6	4	9	19
Disorders (number of participants)*				
<i>Any psychiatric disorder</i>	12	9	9	30
<i>Any mood disorder</i>	11	8	7	26
Minor depressive disorder	1	0	1	2
Major depressive disorder	7	6	6	19
Partial remission or recurrence of major depressive disorder	2	2	1	5
Dysthymia	3	2	3	8
R/O bipolar disorder	2	2	0	4
<i>Any anxiety disorder</i>	7	7	6	20
Panic disorder	0	0	1	1
Anxiety disorder NOS**	3	3	3	9
Generalised anxiety disorder	5	4	2	11
<i>Probable alcohol abuse/dependence</i>	0	0	0	0
<i>Any eating disorder</i>	1	0	0	1
Bulimia nervosa, 'purging type'	0	0	0	0
Bulimia nervosa, 'nonpurging' type 2	0	0	0	0
Binge eating disorder	1	0	0	1
<i>Any somatoform disorder</i>	7	8	6	21
Multi-somatoform disorder	3	2	3	8
Somatoform disorder NOS*	4	6	3	13

* Measured with the PRIME-MD (49)

**NOS= not otherwise specified

Results from the interview study

Within the interview study we focused on three main themes to answer our research questions: 1) Factors leading to sickness absence from the perspective of workers, including associated complaints, last straw

and (the experience of) calling in sick, 2) Barriers to returning to work from the perspective of workers and 3) Facilitating factors for returning to work from the perspective of workers. It should be stressed that interestingly there were far more similarities between the personal stories of the workers of the different sub-groups than differences. For each theme the findings for the total group and subsequently for the three sub-groups of workers (i.e. short-term sick leave workers, medium-term sick leave workers and long-term sick leave workers) are described below.

Factors leading to sickness absence from the perspective of workers with CMDs

Total group of workers

Figure 1 presents an overview of analysis of factors that according to the workers on sick leave had led to their absenteeism. Seven main domains of factors were perceived to have caused the sickness absence. The factors leading to sickness absence as perceived by the total group of workers varied across all seven domains, but particularly factors within four domains were mentioned: The first was non-fitting type of work (domain A), such as *a changes in type of work (more tasks, different content, no match), high workload, working overtime, travel time and irregular working hours*, and having *difficulties in adapting to technology* were work-related factors that were mentioned. The second dominant domain was related to a poor/bad relationship with manager and/or colleagues (domain C), factors such as *lack of support by manager*, as well as *lack of support and interaction with colleagues* were identified. Third, ineffective cognition and attitudes (domain D) was highly prevalent in workers' own view of what had led to their sick leave. The final domain that dominated the interviews was domain E, ineffective coping and behaviour. Here, often workers reported a high sense of responsibility and not being able to define limits or listening to signals.

Interestingly, workers did not mention their mental health condition, such as burnout or depression, as the cause of their sickness absence. Another remarkable finding was that no clear differences emerged between the first and second interview, regarding workers' views of what had caused the sickness absence.

Short-term sick leave workers

A predominant theme in these workers' interviews was that over a period of time they had experienced a workload that had been too high, and that they had dealt with it too long, often ignoring signs that it was too much (e.g. physical symptoms). The high work pressure was either clearly a characteristic of the work environment, or was perceived as such by workers who put the pressure on themselves, e.g. by perfectionism or by being a workaholic. Either way, they felt they had come up to a point where they could not keep up with the high work pressure any more. This ineffective coping and behaviour (domain E), in particular *not being able to set limits/not listening to signals (E2)* was an important factor that contributed to worker's sickness absence:

R: Now, [...] a lot of people say: "Well..., that had to happen one day, right?" [...]

I: They actually saw it coming?

R: Yes. Some. Yes.

I: And did they warn you too or something?

R: Some people did [warn the worker]. Others have the image of me – and that is also the image that I always portray to everyone – that I can manage everything and everyone. That I never, that I don't fall over and you can always knock on my door." [woman, 44 years, manager in youth health care, first-wave interview]

Figure 1: Factors leading to sickness absence, from the perspective of workers with CMDs

A Non-fitting type of work

- A1. Changes in type of work (more tasks, different content, no match)
- A2. Lack of clarity of the work content (e.g. tasks) or role at work
- A3. High workload, working overtime, travel time and irregular working hours
- A4. Lack of control opportunities/lack of opportunities to realise modifications at work
- A5. Difficulties in adapting to technology

B Inadequate management and/or policy

- B1. Insufficient communication with management, inadequate policy
- B2. Insufficient opportunities for training and education
- B3. Experienced injustice/not feeling heard
- B4. Non-fitting workplace culture

C Poor/bad relationship with manager and/or colleagues

- C1. Lack of support by manager, insufficient supervision
- C2. Lack of support and interaction with colleagues
- C3. Bullying
- C4. Experienced injustice/not feeling heard

D Intrapersonal: ineffective cognitions and attitudes of worker

- D1. High sense of responsibility
- D2. Lack of self-insight/not able to see limits
- D3. Not willing to give up control
- D4. Lack of self-confidence
- D5. Negative perception on mental health problems
- D6. Opinion and expectations of close others
- D7. Situation conflicts with own values and norms

E Intrapersonal: ineffective coping and behaviour of worker

- E1. Avoidant coping
- E2. Not being able to set limits/not listening to signals

F Complaints

G Home/work interference

- G1. (Informal) care giver responsibilities in private life
- G2. Tensions/stress in private life
- G3. Work–home imbalance

Workers mentioned that having a high sense of responsibility and setting the bar too high played a role in experiencing a high workload. They also believed that having mental health problems is not a valid reason for calling in sick and did not feel comfortable in telling their work environment that they were not doing well. This was identified/labelled as ineffective cognitions and attitudes (domain D), particularly a *high sense of responsibility (D1)* of the worker:

“R: It has started with, [...], I have always been hyperactive, even since I was a child, hyperactive. I have always tried, everywhere, to do my best, everywhere. In this case with working.

I: Set the bar too high, or?

R: Yes, no, but also because I, [...] I like everything to run smoothly. So at my job I don't give 100%, but I think 118% for my job. So I really live with my job. Even that far that my job was my hobby. So in other words: I don't have hobbies” [man, 51 years, helpdesk employee, first-wave interview]

Work-related factors were less often mentioned as causes for sickness absences in workers on short-term sick leave. Also, workers did not mention their mental health condition as a reason for their sickness absence.

Medium-term sick leave workers

For medium-term sick leave workers the self-perceived cause of their sickness absence seemed to be primarily in the domain of non-fitting type of work (domain A), poor/bad relationship with manager and/or colleagues (domain C), and intrapersonal domains (domains D and E).

With respect to a non-fitting type of work (domain A), a *high workload, working overtime, travel time and irregular working hours (A3)* were commonly perceived as factors that had contributed to the worker's sickness absence:

“R: [...] we must do a lot of production. We have too much personnel, even though every month there are shifts open. Then I think: how is it possible? [...] We have to fill them ourselves, that too.

I: So that's extra workload then? Or are those extra hours on top of...?

R: That's all overtime. [...] And they weren't paid hours for a long time, I don't know why, probably also because of savings. [...] Before it was, if they asked: 'can you do an evening shift?' If I didn't have anything else to do, I thought it was fine, but then usually it was: 'you can have the day off'. But that is not up for discussion any more.” [woman, 51 years, home health nurse, first-wave interview]

As for poor/bad relationship with manager and/or colleagues (domain C), both a *lack of support by manager (C1)* and a *lack of support and interaction with colleagues (C2)* were reported as factors contributing to workers' sickness absence. In addition, *experienced injustice and not feeling heard (C4)* by manager and colleagues were identified as relevant factors:

“R: In a meeting you are not being heard and not that... I think nothing is as bad [...], as when they downplay things. Because the [circumstances] are really bad. [...] How we experience it on the work floor, that is really bad.

I: Yes, a lot of pressure?

R: Yes, so then you indicate something, it is always being downplayed than it is and I think that's a very unpleasant [...], I think it is really unpleasant if they don't listen.” [woman, 51 years, home health nurse, second-wave interview]

Regarding intrapersonal factors (domains D and E), like the short-term sick leave workers relevant ineffective cognitions and attitudes were related to a *high sense of responsibility (D1)*, *not willing to give up control (D3)*, but also to a *lack of self-confidence (D4)* and *lack of self-insight (D2)*:

“R: [...] I also think that that has been the reason that I fell through on this, because I wanted to do it all too good, the feeling of responsibility. And despite the fact that I just didn't have the time and I couldn't get it all together, I still wanted it and felt responsible. Also, for those employees... All those things, and that... I fell through [...] just because I wanted to do it so good.” [woman, 44 years, team leader finance, second-wave interview]

Long-term sick leave workers

For long-term sick leave workers the perceived factors that have caused their sickness absence seemed to be primarily in the domain of non-fitting work content and/or context (domain A) and in the intrapersonal domains (D and E).

Remarkably dominant in the interviews with long-term sick leave workers was the view that a non-fitting type of work contributed to their sickness absence. Workers often wondered whether their job was the right job for them. They mentioned that they realised that their work had changed (A1) over the years and that they had to do more tasks they didn't like to do (and weren't part of their original job), such as administrative tasks, the use of ICT, refresher courses, leaving less time for the core tasks of their profession, such as dealing with students or patients. This made them realise that they felt they could not dedicate themselves to the work they had originally liked, performing tasks they valued. This had clearly a negative effect on their job satisfaction. Together with experiencing a high workload they couldn't cope any more:

"R: But I think that it is, you know, that education that becomes of course... when you look, when I started twelve years ago and now everything is being noted, you have to meet a lot of requirements and [...] Everything you had to note, all the further training, all the extra things. Well, I think that that ruined me. [...] And partly the society, how the youth is now, the commotion, the additional things with apps, with Facebook and for me the endless flow of ICT and when I understood the ICT then one year later it was different again. And I couldn't keep up, so that is also partly age-related..." [woman, 62 years, teacher secondary education, second-wave interview]

As with workers on short-term and medium-term sick leave, long-term sick leavers mentioned experiencing a high workload. They indicated to have worked too hard for a longer time period and had not set their limits or had not listened to (warning) signs. This can be seen as ineffective coping and behaviour (domain E) and within the sub-group of long-term sick leave workers both *avoidant coping* (E1) and *not being able to define limits/listen to signals* (E2) were mentioned.

Also, workers mentioned they had a *high sense of responsibility* (D1) and wanting to do the right thing and at the same time had a *lack of self-confidence* and self-insight (D4). The combination of 'not listening to signals' and 'having a high sense of responsibility' is illustrated here:

"R: Yes, I always went to school tired, during the holidays I was sick a lot and still I always continued. But yes, somehow I really like it to go to school. I get a lot in return from students and.... Look, just before you arrived, a mother came by and she brought a card from the boys, yes the boy misses you so, yes that is..." [man, 51 years, teacher in higher education, first-wave interview]

"I: If you look back at the whole process or at the cause, do you look at it differently now? [...] because back then you said that there was actually just too much work for too few people and that you also didn't get support from your manager?

R: Yes, that is right. Well yes it still is like that but... yes what I did learn in the meantime is that... yes of course there is a reason though that I got burned-out and my colleague didn't. And um... there just is an underlying cause why I am susceptible to burn-out.

I: Yes. And how would you describe that?

R: Um... Primarily I think that I am very insecure and that I, because I am that insecure, for example can't guard my limits.

I: Yes, I can also remember that last time you said you wanted to do everything yourself or that you felt really responsible?

R: Yes, also that, I have a terribly misplaced sense of responsibility and I am a real perfectionist. So even if I think stuff for my work is not really interesting or nice to do then still, then I want to do it.

I: Do it well.

R: ...do it as good as possible and preferably perfect.” [woman, 48 years, co-ordinator complaints department, second-wave interview]

Associated complaints, last straw and (the experience of) calling in sick

Total group of workers

Physical, cognitive and mental/emotional complaints

Workers reported three main types of complaint. First of all *physical complaints* such as fatigue/exhaustion, headaches, hyperventilation, and intestinal and stomach problems were mentioned. Second, *cognitive complaints* such as concentration problems/difficulties with focusing/concentrating, forgetting things and not being able to remember things were reported. The third group consisted of *mental/emotional complaints* such as feelings of anxiety and panic, depressive symptoms, not being able to cope with much, not being able to recognise oneself and having crying spells.

Last straw

Workers commonly reported that they had experienced an emotional and physical collapse which was seen as the last straw that broke the camel's back. They indicated that all of a sudden they were not able to cope any more and that as a result they were unable to do their work. Often they were caught off guard by it.

Usually no assignable cause could be attributed to the emotional and physical collapse according to the workers. In some cases however, it was preceded by a specific event at work or at home. The collapse was often accompanied by physical and/or cognitive and/or emotional complaints:

I: And what was the straw that broke the camel's back? What was the moment you thought: now it's done?

R: Well yes, a bad feeling inside, and the telephone that rang and um...I was thinking: I am going to throw that thing against the wall and... I am normally not like that.

I: You didn't recognise this response?

R: No exactly. And then you really despise the whole situation.” [man, 52 years, team manager safety and service, first-wave interview]

Calling in sick

Workers reported that the actual sickness notice often took place at the initiative of the manager or was pushed by close others. They commonly experienced it as difficult and shameful and experienced a high threshold for calling in sick.

Calling in sick was often associated with negative emotions as experienced by the workers such as feeling guilty, feeling like a failure, feelings of powerlessness/incapacity, but also feelings of anger and feeling shocked. They also reported having difficulties with accepting their own sickness absence.

In addition, positive emotions such as feelings of relief and feeling one has made the right decision by reporting sick were also identified among all three groups of workers.

I: [...] how was it to have to decide to stay at home?

R: In the beginning really difficult because I see it as a bit of betrayal of my team. Because I abandoned my team and looking back I also feel like [...] He [the general physician] says yes you should also think of yourself. And I have to mention that I am really forgetting things. It is like you are being reset. Yes that is a bit strange to say it like this, but it is like...

[...]

R: I forget things so I really have to do everything myself, I never used the agenda of my phone and now I am putting everything, when I make appointments, I am putting it in. Yes. So I did have a fair dent and eventually, in the beginning I thought it was if I would abandon my team and now I feel like yes, no it is okay.” [man, 42 years, team leader, first-wave interview]

Short-term, medium-term and long-term sickness absence workers

For the group of workers with short-term sickness absence the *last straw* seemed to be more often an event at work, whereas they less often reported to experience a collapse as distinct onset for the sickness absence period. In contrast, according to the interviews both medium- and long-term sick leavers commonly had experienced a collapse as a last straw, which was often followed by an event at work and/or accompanied by physical complaints. With respect to *calling in sick* it was found that for short-term sick leavers the calling in sick often took place at the initiative of the manager. All types of worker reported negative emotions, such as feeling guilty or feeling like a failure after calling in sick, as well as having difficulties with accepting the sickness absence.

Among workers on medium- and long-term sick leave, positive emotions such as feelings of relief and feeling one has made the right decision were relatively more often identified.

Barriers to returning to work from the perspective of workers with CMDs

Total group of workers

Figure 2 provides an overview of the perceived barriers to returning to work from the perspective of workers. Nine main types of barrier were identified. For the total group particularly, barriers related to the type of work, management and relationships at work seemed to be relevant. Within the domain non-fitting type of work (domain A), *non-fitting work content (tasks not challenging, non-fitting, no match)* and *non-fitting work context (workload, working hours and other obligations)*, and the fact that *‘nothing has changed in the work context: no structural solutions’* was mentioned. Related to inadequate management and/or policy (domain B), workers mentioned barriers such as *having to start-up too fast, no accommodations arranged, higher workload than agreed on, extra work, being pushed and insufficient guidance/supervision: lack of clarity of RTW process, insufficient guidance/supervision*. Thirdly, a poor relationship with managers and/or colleagues (domain C) seemed to be relevant, such as *lack of support and lack of understanding from manager and lack of support and sympathy of colleagues*.

Short-term sick leave workers

When looking at the three sub-groups we found that short-term sick leave workers primarily mentioned barriers related to the relationship with managers and/or colleagues (domain C) and intrapersonal barriers related to motivation and emotions of the worker (domain D). Factors related to type of work were less often mentioned as barriers to returning to work.

With respect to the relationship with managers and/or colleagues (domain C), the barriers mentioned were *lack of support and inadequate communication (C1)*, *lack of support and understanding of colleagues (C2)*, *bullying (C3)* and *experienced injustice/no appreciation (C4)*. Workers mentioned that they were angry with their manager and/or the organisation (including human resource department) and that this was not helpful to RTW. They felt they were treated unfairly and feelings of distrust were often mentioned. Especially, workers saw their manager as being incapable and unsuitable managers. When there was no communication about the worker's needs and views upon RTW, this was perceived as an important barrier for work resumption. In the second-wave interview, workers mentioned that they expected the manager to show understanding and interest in the worker's situation. If they didn't, workers felt disappointed and angry. This was seen as a barrier to returning to work swiftly:

Figure 2: RTW barriers, from the perspective of workers with CMDs

A Non-fitting type of work

- A1. Non-fitting work content (tasks not challenging, non-fitting, no match)
- A2. Non-fitting work context (workload, working hours and other obligations)
- A3. Nothing has changed in the work context: no structural solutions

B Inadequate management and/or policy

- B1. Having to start-up too fast, no accommodations arranged
- B2. Higher workload than agreed on, extra work, being pushed
- B3. Insufficient guidance/supervision: lack of clarity of RTW process, insufficient guidance/supervision
- B4. Experienced injustice/no appreciation/lack of trust
- B5. Non-fitting work culture

C Poor/bad relationship with managers and/or colleagues

- C1. Lack of support, lack of understanding, inadequate communication, not approachable manager
- C2. Lack of support and interest/sympathy/understanding of colleagues
- C3. Pressure from manager, bullying
- C4. Experienced injustice/no appreciation

D Intrapersonal: motivation and emotions of worker

- D1. Lack of motivation to return to work
- D2. Feeling insecure, fear of returning, fear of negative responses at work
- D3. Feelings of shame or guilt

E Intrapersonal: cognitions and behaviour of worker

- E1. Not able to set limits
- E2. High sense of responsibility
- E3. Lack of self-insight
- E4. Unassertiveness

F Complaints

- F1. Physical complaints
- F2. Emotional complaints

G Private life context

- G1. Tensions/stress in private life
- G2. Lack of understanding from close others

H Professional guidance

- H1. Long waiting lists in treatment paths and setting diagnosis

I Societal factors

- I1. Legal arrangements: accommodations only possible after sickness notice

“R: [...] for example my manager, [...] a manager is also someone who, if he calls you asks: When are you returning to work? But that is someone who never asks: person A how are you? Do you need

support? So really a pat on the shoulder.

I: He doesn't do that?

R: They don't know it.

I: He only asks when will you return to work again?

R: Yes, [...]" [man, 51 years, helpdesk employee, first-wave interview]

As for interpersonal barriers (domain D), *lack of motivation to return to work (D1)* is one of the main barriers according to workers. This lack of motivation is often related to feelings of anger and being treated unfairly:

"R: So again, being motivated to go to work. No. The only motivation is, well not motivation either, to go to work and to get paid. So that's my right. And again, in the past it was like: I am going there and I was happy [...] If I could help in Italy, I did it too. If I could help in France, then I did. But, in the end I said: No, I do what has been asked and nothing more." [man, 51 years, helpdesk employee, first-wave interview]

Also, workers mentioned that having *fear of negative responses at work (D2)* was an important barrier to RTW:

"R: Yes, of course, you do have the worries like can I still do it and um... um... what do others think about it and um..."

I: Oh yes, how they react.

R: Yes..." [woman, 32 years, teacher primary education, second-wave interview]

Medium-term sick leave workers

For workers on medium-term sick leave, barriers to returning to work seemed to be primarily in the domain of inadequate management and/or policy (domain B) and relationship with managers and/or colleagues (domain C). Also, intrapersonal barriers (domains D and E) were often mentioned.

Regarding inadequate management and/or policy (domain B), workers mentioned that *having to start-up too fast (B1)* and *working more hours and perceiving higher workload than agreed on (B2)* were barriers for them to RTW. Also mentioned were insufficient guidance such as *lack of clarity of the RTW process (B3)*, and a *not-fitting work culture (B5)* in terms of the norms and values of the worker.

Within the domain of relationship with managers and/or colleagues (domain C), in particular a *lack of support, lack of understanding manager (C1)* and *lack of support and interest of colleagues (C2)* were mentioned:

"R: [...] What I do think is a real pity is that, I think I have been home for six weeks, and that nobody ever..."

I: Showed interest?

R: Well my manager called particularly to ask when I would come back to work. That was a bit the tone, yes, but never somebody came by or... I did get some flowers from the staff association, but yes I live a half hour drive from work, but never somebody really um..."

I: Showed interest?

R: No, no.

I: Neither the manager, nor the colleagues.

R: No, never seen anyone." [woman, 44 years, team leader finance, second-wave interview]

As for the intrapersonal barriers, within the domain of motivation and emotions of worker (domain D), *fear of returning (D2)* was mentioned as a barrier. Within the domain of cognitions and behaviour of worker (domain E), *lack of self-insight (E3)*, *not able to set limits (E1)* and *unassertiveness (E4)* were barriers mentioned by workers on medium-term sick leave:

"R: [...] I thought: what do they expect from me, shortly they will demand more. And it was like that for a moment. Two days later the occupational physician said: but we are not going to do that. But the colleagues were really warm, so I felt like yes..."

I: But what do you mean with: shortly they will pull me? If you wanted to come more often?

R: Yes, for more hours or half days or. I thought: I can't judge it right now.

I: But was that you were you were most afraid of?

R: Yes, that they would pull me, that was the most difficult, that first time." [woman, 37, co-ordinator in health care, second-wave interview]

Long-term sick leave workers

Long-term sick leave workers mentioned primarily barriers related to non-fitting type of work (domain A), inadequate management and/or policy (domain B) and intrapersonal barriers (domain D and E).

Interestingly, workers frequently mentioned that they didn't enjoy their work any more. They felt the work content didn't fit any more and/or they weren't happy in their job and this hindered them from returning to that job. An example of this non-fitting type of work (domain A) is shown here:

"I: I already asked how you could be supported to return to work. So yes, you mentioned that the job should be better fitting.

R: Yes, for the work part. And look, I could return to where I am now, but then dissatisfaction would come up again and that is of course one of the factors that leads to that you... that this happens, that it's not going well.

I: But could you be supported in that? Imagine you would come back in the same job...

R: I don't have to be supported so much. Yes there would be someone who will take you over partly, but it is not so much about the support. It is about that you don't like it [the job]. I don't have to be supported in that.

I: Yes or how could it become more fun?

R: That is not possible, it is just like it is. [...]" [woman, 44 years, co-ordinator complaints department, first-wave interview]

As with short- and medium-term sick leave workers, long-term sick leavers mentioned a lack of support from their work environment as a barrier to RTW. They had feelings of distrust because they thought the employer wanted to get rid of them. Also, a manager who is not empathetic, shows no appreciation for the worker and/or pushes the worker to return is seen as a barrier. Workers also mentioned that there was a lack support from the occupational physician, such as having to change physician, few contact moments and/or insufficient guidance. This was labelled as inadequate management and/or policy (domain B), workers mentioned that *having to start-up too fast (B1)*, *insufficient guidance (B3)* and *lack of trust (B4)* hindered them from returning to work:

"I: Since last time you went to the occupational physician and to the psychologist. Any others?

R: No, I went only... yes that is something else, because of the merger there has been a switch of occupational physicians. And I would be called in the middle of January, but I just didn't get called. Yes, so in the end I asked my manager, I even called once myself, but then had to run via the manager. [...] And then I got a meeting in the middle of February I think. So then I asked, why didn't I get called? Um, it was a new system, if you are in the Sickness Benefits Act then you don't get called any more, then you should contact the occupational physician yourself. I say: But you have to know that. Yes, but nobody knew it. [...] Yes, so that's why it took some longer, yes.

I: [...] I already emailed a few times and like, and I kept hearing nothing.

R: Yes, but that is because at first I was waiting dutifully and then I thought like: yes, I just start to build up [work] slowly, because it has to be done. So I managed all that a bit myself, but yes... And the crazy thing was, then I went to the occupational physician, which was very bad, the data weren't transferred. I had to sign a letter for that again. [...] [I had to explain] everything from the start again

[...] I also said that it wasn't pleasant and I didn't agree. Yes, for all we know, I would still be in a really dark place [...]." [woman, 53 years, operating room assistant, second-wave interview]

With respect to intrapersonal barriers (domain D) long-term sick leave workers mentioned they were fearful of returning to work, mainly because of *fear of negative responses (D2)* and fear of feeling too much pressure to perform. Also, *feelings of shame (D3)* because they collapsed were mentioned as barriers:

"I: Do you think that there are some things that would make it difficult to return again?

R: Yes, because I feel ashamed, yes.

I: Yes, is it hard to get past it?

R: Yes.

I: Why exactly are you ashamed?

R: Well yes, because I have collapsed. I have always been someone who solved her own problems and especially don't bother others. And I wasn't able to do it now, so that was really hard for me.

I: That someone else had to solve it or had to help you?

R: That I needed help." [woman, 53 years, operating room assistant, first-wave interview]

Facilitating factors for returning to work from the perspective of workers with CMDs

Total group of workers

Figure 3 presents an overview of the facilitating factors for returning to work that were identified among workers. Seven domains of facilitating factors for returning to work were perceived by the workers. For the total group, four domains were mentioned in particular. First, fitting/matching type of work (domain A), such as *structural or temporary work accommodations* and *structural changes in the work context (less job strain, fewer working hours)* were mentioned. Within the domain of adequate management, policy and supervision/guidance (domain B), factors such as *feeling no pressure on the return and enable work accommodations* and *getting the opportunity to get decision authority* were mentioned as helpful for returning to work. Within the domain of fulfilling relationship with manager and/or colleagues (domain C), workers mentioned that *support from manager* and *support from colleagues* and *being accepted/feeling safe at work* were enabling factors. Within the fourth domain, intrapersonal factors: effective behaviour: what the worker can do (domain E), *disclosure and explaining the situation to the work environment*, *take time to recover: taking rest and keeping distance from work*, and *actively focus on recovery: keep a daily structure and keep on being active* were factors that helped workers' RTW.

There were no clear differences in opinion about RTW facilitating factors between the first- and second-wave interviews.

Short-term sick leave workers

Short-term sick leave workers mentioned primarily facilitating factors related to fulfilling relationships with manager and/or colleagues (domain C), adequate management, policy and supervision/guidance (domain B), and both interpersonal facilitating factors (domains D and E).

Workers mentioned that most of all they needed rest and *take time to recover (E2)*. They needed a distance from work for a while and rest at home. Other facilitating factors were *actively focus on recovery (E3)* and taking better care of themselves by keeping a daily structure, exercising, undertaking nice/pleasant things, and meeting friends:

Figure 3: RTW facilitating factors, from the perspective of workers with CMDs

A Fitting/matching type of work

- A1. Structural or temporary work accommodations
- A2. Structural changes in the work context (less job strain, fewer working hours, fewer stimuli)

B Adequate management, policy and supervision/guidance

- B1. No pressure on the return, enable work accommodations
- B2. An active reintegration policy, policy on the elderly
- B3. Supervision/guidance and communication: providing structure and clarity, managing expectations
- B4. Management level providing appreciation
- B5. Opportunity to get decision authority

C Fulfilling relationship with manager and/or colleagues

- C1. Support from manager
- C2. Interest/sympathy and support from colleagues
- C3. Being accepted/feeling safe at work
- C4. Sharing responsibilities with co-workers

D Intrapersonal: effective cognitions and motivation of worker

- D1. Acceptance and self-reflection
- D2. High sense of responsibility
- D3. Exploring the value of work, having perspective (other job)

E Intrapersonal: effective behaviour: what the worker can do

- E1. Disclosure and explain situation to work environment
- E2. Take time to recover: taking rest and keeping distance from work
- E3. Actively focus on recovery: keep a daily structure and keep on being active
- E4. Keep in contact with work
- E5. Guard limits and regain/remain in control

F Private life context

- F1. Work-home balance
- F2. Accommodations in private life
- F3. Support from home

G Professional guidance

- G1. Professional support, guidance from a coach

“R: [...] because I was just, really, just physically exhausted. In the period that I was at home I didn’t do that much. Actually nothing, especially, um, taking rest and um, at a certain moment I forced myself to start exercising, just starting getting exercise. I was occupied with that then, to add structure, to just, add structure to my day. Because otherwise it would start getting stuck. Yes then I would, um, really have done nothing, laid on the couch, in my bed, because it would be really starting to get stuck. I

thought [...] this isn't the way back. So physically I took rest." [woman, 57 years, mentor, second-wave interview]

Other intrapersonal factors workers mentioned as RTW facilitating factors were accepting the situation and *self-reflection (D1)*, for example knowing your limits. Also, *exploring the value of work (D3)* helped workers returning to work:

I: What made the return to work easier?

R: Um, because I felt connected with my job, I like my job, I have affinity with my job, with the people on my job, I get respected as a person, yes." [man, 42 years, engineer, second-wave interview]

Workers mentioned that *feeling safe at work (C3)* and having a good relationship with the people at work was helpful to return, especially *support from manager (C1)* who is understanding and helps to guide the worker in setting their limits. Also, workers mentioned that *interest/sympathy and support from colleagues (C2)* was helpful:

"R: Yes, yes that they don't put pressure on you and that they also hold your hand for a while like, like, um, don't jump too hard. [...] I felt like... it is a busy time, I will get started soon and she just, um... hit the brakes, the occupational physician. My manager is also doing that, but there are also managers who are really easy like, um... Are you sick? When can we start again? And immediately put pressure on it. [...] Well I got [...] all the space to sort it out myself. Even the things that I [...] I thought of, it can be done sooner. That they said like, um... just take it easy. And I think that that's good." [man, 56 years, head of finance, second-wave interview]

Concerning adequate management, policy and supervision/guidance (domain B), workers felt it was important that *no pressure in the return (B1)* was given, that workers could work according to their own pace, and doing tasks they liked to do. Also, getting the *opportunity* from the work environment to *get decision authority (B5)* helped them to RTW swiftly. Short-term sick leave workers often took the initiative in arranging the things they needed, such as appointments with psychologists and occupational physicians, or even looking for another job:

"R: Yes. Well, you know, everything that has been arranged, I organised that myself. I mean, I organised all – the psychotherapist the registration etc. – myself. I suggested the occupational physician to make a preventive appointment. I made the appointment myself. So when you say like: Gee, what did come from the employer?

I: Nothing.

R: Yes, I did this all on my own initiative. You can't have a more exemplary patient.

I: Yes, so actually the employer just didn't take action, after you reported sick?

R: No. Because of course I already set [things] in motion." [woman, 44 years, manager in youth health care, first-wave interview]

Medium-term sick leave workers

The group of medium-term sick leave workers mentioned primarily facilitating factors regarding fitting/matching type of work (domain A) and adequate management, policy and supervision/guidance (domain B). Also, a fulfilling relationship with manager and/or colleagues (domain C) and intrapersonal factors: effective behaviour: what the worker can do (domain E) were mentioned as helpful for returning to work.

Within fitting/matching type of work (domain A), workers mentioned *structural or temporary work accommodations (A1)* as helpful. Also, *structural changes in the work context (less job strain, fewer working hours and fewer stimuli) (A2)* were mentioned as facilitating returning to work:

"R: ... Well yes, I thought rest was also really important.

I: In the beginning or always?

R: Yes, actually always [...]
 I: What do you exactly mean?
 R: [...] also rest at the workplace and at home and...
 I: Then what do you mean with rest at the workplace?
 R: Well, we always had the radio turned on at Endoscopy, but I can't... it is too much. [...]
 I: Yes, so you especially mean the sounds with rest?
 R: Yes, yes." [woman, 57 years, department secretary, first-wave interview]

Regarding adequate management, policy and supervision/guidance (domain B), facilitating factors such as *enabling work accommodations (B1)*, *an active reintegration policy (B2)*, and *providing structure and clarity and managing expectations (B3)* were identified. Also, workers mentioned that a *management level providing appreciation (B4)* was helpful.

As for a fulfilling relationship with manager and/or colleagues (domain C), medium-term sick leave workers mentioned that especially *support from managers (C1)* and *support from colleagues (C2)* was helpful in returning to work:

"R: Um, and L [manager], just was really happy that I returned, but said like: yes, what are we going to do? How do you want to start? Um, do you only want to do trainings? That you only start with those. Or do you want a combination? So, it was really from everyone, also my colleagues, like: Yes, what can you do? What do you want to do for now?
 I: Yes, it was asked what you wanted yourself.
 R: Yes.
 I: And what did you think about that?
 R: Well yes, I liked it. Yes." [woman, 44 years, administrative assistant, first-wave interview]

Medium-term sick leave workers also mentioned intrapersonal factors: effective behaviour: what the worker can do (domain E) as facilitating factors. The main factors mentioned were those regarding *disclosure and explaining the situation to the work environment (E1)*, *take time to recover: taking rest and keeping distance from work (E2)*, and *actively focus on recovery: keep a daily structure and keep on being active (E3)*.

Long-term sick leave workers

Long-term sick leave workers perceive facilitating factors primarily on the domains: adequate management, policy and supervision/guidance (domain B), fulfilling relationship with manager and/or colleagues (domain C), intrapersonal factors: effective behaviour: what the worker can do (domain E), and professional guidance (domain G).

As with short- and medium-term sick leavers, *take time to recover (E2)* was considered helpful for returning to work. Workers mentioned they need some time away from work and need rest. This is mostly mentioned in the first-wave interviews.

Also, workers mentioned that talking about their struggles in general and *explaining their situation to the work environment (E1)* helped them in the RTW process. Some workers had disclosed their problems to colleagues and felt supported by them. Also, talking to close others was found helpful in getting insight into their situation and to get perspective:

"R: And what I also told the psychologist: just talking to someone who is not involved, who actually has nothing to do with it, but that you just can talk once, just talking, talking a lot, yes. Just getting everything off your chest and that somebody is just listening...
 I: And does it help you to put things in order or is it more just telling your story?"

R: Telling the story yes. And then you start thinking a bit about it too and then yes, [...] then you feel like: yes, it is all not that bad, and it is all less [bad] than expected. But yes, just the talking and listening has really helped a lot." [woman, 53 years, operating room assistant, second-wave interview]

With regard to adequate management, policy and supervision/guidance (domain B), workers mentioned that it was helpful if they were not pushed to return (*No pressure on the return (B1)*) and stayed at home for a while. Also, being allowed to get *decision authority (B5)* in the RTW process was mentioned by workers. Such as, deciding when to return and to start working at their own pace.

Like the short- and medium-term sick leave workers, long-term sick leavers mentioned fulfilling relationship with manager and/or colleagues (domain C), such as *support from their managers (C1)* and *support from colleagues (C2)*, as important facilitating factors. They mentioned that it is important that the manager listens to the worker, accepts the person for who they are and shows understanding. Also, the feeling of being taken seriously was mentioned, and that work accommodations can be arranged, such as less workload:

"R: Well, what will make it difficult...if I would return and nothing has changed, that wouldn't make it difficult, I think that would make it impossible. But what would make it easier is if once they would be listening to what I say, yes.

I: So if your manager listens?

R: For example, yes. And then not only listens, but also does something with it.

I: Yes. Maybe any other things that could make it easy?

R: Well yes... Maybe if... um... that they [...] would make more use of the talents of people. Everyone is good at something different and yes, if you let people do things which they are good at, then they actually will have more fun in doing that." [woman, 48 years, order manager, first-wave interview]

Workers on long-term sick leave often mentioned that getting support from professionals was important for returning to work. Especially, guidance from the occupational physician, specialist mental health nurse, psychologist, coach and alternative treatment was mentioned. Professionals helped workers with mirroring, making thoughtful choices and getting insight into what costs energy and what are energisers:

"R: Well, I do think like something of guidance that talks you through the steps, but who is also your safety net or a big stick. Of course you were part of it and that means that you of course also did not arrange this well. I think that that's really good that you are accountable [...], but that you consciously working on it, because otherwise I think you will keep hanging in it.

I: Yes, someone who disciplines you?

R: Yes. And who can hold up a mirror, because at that moment you probably don't exactly have a right image of yourself and haven't made the right choices." [woman, 42, team manager facilities, first-wave interview]

DISCUSSION

The objective of the interview study was to investigate which factors had led to sickness absence according to workers on sick leave with common mental disorders (CMDs), and to investigate what these workers perceived as barriers to and facilitators of the RTW process. The second aim was to investigate if specific patterns could be distinguished within sub-groups of workers on short-, medium- and long-term sick leave using qualitative research methods, and if these patterns differed or rather appeared to be similar. Short-term sick leave was defined as a RTW within 3 months following the first day of sick leave; medium-term as 3-6 months; and the group of workers on long-term sick leave were absent from work for over 6 months. All participants were interviewed twice during the sick leave and RTW process, in order to capture a comprehensive view of their perspectives on what led to sickness absence, and what are RTW barriers and facilitators.

Main findings

According to workers, a wide range of factors had led to their sickness absence, including work-related psychosocial factors, intrapersonal factors, and home/work interference. Workers with CMDs also identified a variety of RTW barriers and facilitators, indicating that RTW is affected by multiple factors related to work environment and work content, relationships at work and in private life, professional guidance, and intrapersonal factors.

When considering all domains and sub-themes, six themes appeared to be central to the origin of sickness absence and/or a successful RTW according to workers with CMDs: 1) perceived high workload/high work pressure as the origin of sick leave, 2) workers on sick leave with CMDs did not see a mental health disorder as the origin of their sickness absence, 3) the importance of valuing ones' work content prior to sickness absence and during the RTW process, 4) the crucial role of self-evaluation, 5) the importance of a supportive manager for successful RTW, and 6) the ability to regain control. These themes will be discussed in more detail below. Overall, mostly similarities were found between the three sub-groups. Across the interviews, highly similar views and experiences of workers occurred and themes emerged across the three groups. However, we did find some differences between sub-groups. Most contrast was found between the short-term and long-term sick leave workers, which is why these groups receive most attention in this discussion.

Perceived high workload/high work pressure as the origin of sick leave

Clearly, the key factor causing sickness absence was, in workers' own view, a high workload/work pressure. Often, over an extended period of time prior to the sick leave period they had perceived a workload or work pressure that had been too high, causing them to finally have a physical and emotional collapse. The reason for perceiving a high workload was two-fold: on the one hand work pressure was clearly a characteristic of a too demanding work environment, e.g. working extra (often unpaid) hours, tight deadlines. On the other hand, high workload was often reported to be self-imposed. Very frequently workers reported working harder than strictly necessary, out of perfectionism, the inability to be assertive and a high sense of responsibility. The theme of an excessive workload/work pressure was present in nearly all interviews, and there often seemed to be a combination of both a demanding work environment *and* self-imposed work pressure. Ineffective cognitions and coping behaviour also played a part in experiencing high workload, particularly a lack of self-awareness regarding work- and health-related preferences, the inability to set limits, and setting the bar too high. Often combined, self-imposed and

actual work pressure caused workers to feel they had come to a point where they could not deal with the work situation any more.

Workers on sick leave with CMDs do not see a mental health disorder as the origin of their sickness absence

Although many causal factors were mentioned by workers with CMDs, they did not view a mental health disorder as the main *cause* for their sickness absence. Workers did experience physical, cognitive and mental/emotional complaints, however these were often viewed as consequences rather than causes of their problems. These symptoms were often regarded as signs of being worn out rather than as being the core origin of their absenteeism.

The reason for workers not to mention their mental health condition might lay in the nature of the sample of workers. This study focused on workers with common mental health problems, rather than workers with chronic severe mental health disorders. Having ‘mild’ mental health complaints, the workers in this group might not have been diagnosed by a clinician before or were under treatment of a psychiatrist. However, the PRIME-MD diagnosis of the workers (Table 4) indicates that the workers in this study had various mental health problems. Most prevalent were major depressive disorder, somatoform disorder and generalised anxiety disorder. Also, between the three groups of workers no large differences were found in the severity of the disorders. This suggests that the severity of the complaints is not of great influence on the duration of sick leave.

These findings would suggest that not the condition itself but other non-disease-related factors play a part in the origin and duration of sickness absence. Very little research is available on conditions prior to the sick leave of workers with CMDs (28, 36, 50). There is a need for further research to focus on the conditions under which workers leave work, especially in the causes of sickness absence regardless of the nature of the disease.

The importance of valuing one’s work content prior to sickness absence and in the RTW process

One of the most remarkable differences between the self-perceived causes of sick leave between workers on short- versus long-term sick leave was that they seemed to value their work content differently. Whereas many workers from the short-term sick leave group indicated to like many aspects of their work (e.g. work content or social contacts at work), workers on long-term sick leave seemed to have more fundamental problems with the type of work they were doing. A recurrent theme in their interviews was that they felt that their work content and tasks had changed over the years and it had become less fulfilling for them. For instance, complementary administrative and computer tasks that had accumulated over the years were often reported as a nuisance by workers in health care or education. The value of their work had diminished as such. In contrast, workers on short-term sick leave seemed to have fewer problems with the content of their work. Overall, they had a pleasant working environment, with nice colleagues and an understanding manager, and had work they often enjoyed. Workaholism, for instance, did occur in the short-term sick leave group, but was not identified in accounts of the long-term group. The importance of valuing one’s work is addressed by other researchers as well and receives increasing attention with regard to the topic of improving sustainable employability in healthy workers (35).

In addition, workers on long-term sick leave stressed that job dissatisfaction hindered them from returning to work. At the same time, short-term workers mentioned that exploring and seeing the value of their work helped them returning to work swiftly. Having affinity with the job, feeling connected with the job and being respected as a person by others at work seemed important values that facilitated RTW. These findings are in line with previous research (51), and this topic merits more investigation. Ultimately, returning to work in a job that one values would result in feelings of work engagement, which is defined by a positive, fulfilling work-related state of mind, which has been found to be associated with better health

and wellbeing (52). In addition, there are indications that investing in work engagement is associated with lower sickness absence (53). Therefore, directing work interventions at the positive aspects of mental health seems promising. However, the implementation of these positive health interventions by companies has been found to be difficult (53) and its causal effect on sickness absence and RTW needs to be further researched.

The crucial role of self-evaluation

A recurrent theme across the groups was that workers indicated to lack self-evaluation skills. Better self-reflection and awareness can help setting limits and making choices at work, such as learning to prioritise, to be assertive, to ask for help and being open about their problems. Indeed, workers saw improvements in this area as essential for their recovery and work resumption. In fact, this raises the question whether the lack of self-evaluation is not only a barrier to RTW but also an important origin for sick leave in workers with CMDs. This could be an interesting and new focus for research. Previous studies have illustrated that there is a need to study the relevance of *non-disorder-related* factors for RTW of workers with CMDs, as they seem to be of particular importance (54-56). If confirmed in future research, interventions aiming at enhancing self-evaluation skills in workers who are inclined to perceive high work pressure (e.g. due to a high sense of responsibility or perfection) may be successful in preventing sick leave. More high quality research is urgently needed on how to improve RTW and especially prevent sick leave in workers with mental health problems (16).

Across the groups, the relevance of being able to discuss work-related problems with others outside the work environment (e.g. friends, family, health care professionals and coaches) was frequently mentioned as helpful in regaining insight and control and facilitating work resumption. In the group of workers with long-term sick leave, it was repeatedly mentioned that workers first wanted to feel mentally and physically recovered before returning to work. This is in line with previous research indicating that workers' own illness perceptions and expectations regarding workability are predictive of actual sick leave duration (26, 57, 58).

A supportive manager is essential for successful RTW according to workers

In our study, a recurrent theme was that workers did not feel heard by their managers. Having an immediate manager who is supportive and understanding was experienced as essential for facilitating RTW according to workers across the groups. This is in line with previous research that has shown similar results; in qualitative studies with workers on sick leave (28, 36, 59) and when investigating predictor factors for RTW, support from the employer/manager has shown to be important for successful RTW (60, 61). According to workers, supportive manager behaviour was characterised by listening to the worker, showing understanding, accepting the person for who they are and by guiding the worker in setting limits. Also, workers mentioned that feeling pressured to and/or to return to activities they did not like to do was perceived as a barrier to RTW.

This shows there is a thin line between what workers perceive as a barrier or as a facilitator. A manager who believes they are showing interest by calling a worker on sick leave, can be perceived as pressure to RTW, which can have adverse effects. Clearly, no straightforward recommendations can be given on the time and frequency of contacting the worker on sick leave. This underscores the importance of a personalised RTW support by the manager to each individual.

The ability to regain control: differences in behaviour of workers on short- and long-term sick leave

A highly dominant theme in virtually all interviews was fatigue, feeling worn out and being in need of rest. Not surprisingly, therefore, workers across all groups indicated to feel a need to receive time and support to recover, without any pressure from the work environment. However, workers on short-term sick leave seemed to be more proactive and were able to regain control more easily. They often engaged in physical exercise and seemed to be consciously working on recovery supporting behaviour, such as forcing themselves to go out, undertaking activities, e.g. spending time with friends. They often tried to structure their day into moments of resting and of activities, as opposed to being inactive all the time, and when discussing what they saw as facilitating factors for RTW, this behaviour was often mentioned as helpful. In contrast, a recurrent theme in the accounts of workers on long-term sick leave was that they often did not know what they wanted concerning work-related choices, expressed a need for professional help in gaining more self-evaluation and awareness in this area and preferred to be left alone by the work environment.

There is some evidence that work-directed intervention, such as self-scheduling of shifts, increases employee control and reduces mental health symptoms (62). However, there is a need for a better understanding of the impact of employee ability to regain control of sickness absence, as well as to how the recovery-enhancing behaviour of workers can be influenced.

Strengths and limitations

This study has several strengths and limitations. One of its strengths is that each worker was interviewed twice, which allowed the researchers to capture a comprehensive view of the perspective of workers shortly after they called in sick and after their RTW or after 6 months. By conducting multiple interviews and following workers over an extended period, we were able to identify sub-groups of workers: workers who returned to work swiftly and workers who are still on sick leave after 3 or 6 months. The need for qualitative research investigating why some workers with CMDs RTW swiftly and others stay on long-term sick leave has been stressed in the literature (28). To the authors' knowledge, this is the first study to have used a longitudinal qualitative design for the aim of investigating differences in sub-groups of workers with CMDs, and therefore doing justice to the fact that RTW should be seen as a process. Using this design it was possible to gain insight in whether the RTW process and the views of these sub-groups on barriers and facilitators differed or were not so different at all. Another strength of this study is its strong methodology. To enhance validity of findings and reliability, researcher triangulation was used in collecting data and the analysis process. Multiple researchers have interviewed workers and were part of the analysis process and discussions about the interpretation of the data. Also, part of the interviews were independently analysed by two researchers. Additionally, it was a strength that workers' first interviews were conducted shortly after their initial sick leave date. Due to the Dutch occupational health system it was possible to find and invite eligible respondents during an early stage of their sick leave period.

The study also has limitations that should be taken into account. First, as a qualitative study, the main limitation of this research relates to generalisability. For example, in our study, more female workers (26 out of 34) and more (moderately) highly educated workers participated (31 out of 34 workers). Also, the study was conducted in the context of the Dutch social security system, which is different from that in other countries. However, generalisability was not the purpose of the study. As with other qualitative studies, the aim here was to generate insight into a complex condition where little current evidence exists, and where more knowledge is urgently needed. The interview study approach, and diversity of our sampling, ensured inclusion of perspectives and experiences from a wide range of participants with different characteristics. This provides a multifaceted picture that would not have been available using survey or other observational methods.

Although the purpose of the study was to investigate workers' own perspective on things, and as such it is not a limitation that only *one* perspective was explored, adding the perspective of other relevant stakeholders could have enriched the findings. Especially, including workers with their own managers and health care professionals could have provided an even broader understanding of the complex process of RTW. However, the perspectives of stakeholders were investigated in focus groups, although the differences in research methods hindered a proper comparison between workers' views and those of the other stakeholders.

Meeting with stakeholders

To validate the findings from the study and discuss its implications for practice, a meeting was organised with stakeholders in the field of occupational health and safety. During this meeting the results from the focus group study and the interview study were presented by the researchers and discussed with the audience. Twenty-one stakeholders attended the meeting with different backgrounds and professions: occupational physicians, psychologists and psychiatrists, insurance physicians, employability coaches/advisors, HR managers, managers/team leaders/supervisors, and business controllers/project leaders.

Overall, the stakeholders indicated the findings of the study provided valuable and new insights. When discussing the finding that all focus groups shared the same knowledge of what was needed for a swift RTW, the researchers raised the question: if everyone involved knows what is necessary, then why are so many workers with CMDs on long term sick leave? Could this imply there is an implementation problem when putting this knowledge into practice? The stakeholders recognised and confirmed there is an implementation problem with respect to putting knowledge into practice and collaboration between different health care professionals and employers/managers. The stakeholders also recognised that experienced work pressure and a mismatch between the worker and the job are important issues that can impact on sickness absence and RTW. Moreover, they recognised that each workers perceives concepts like 'work pressure', and 'rest' differently and has different work-related needs. Furthermore, they mentioned there is a need for prevention of sickness absence. According to the stakeholders, drawing more attention to the positive aspects of sustainable employability would make employers keener to invest in prevention. Finally, the stakeholders noted that a personalised guidance in returning to work is necessary and that managers and (occupational) health care professionals should focus more on what is important for the worker him/herself.

The experiences and opinion of the stakeholders who attended the meeting generally were in line with the main findings of the research project and confirmed the researchers' new insights.

Implications for research

In conclusion, several implications for research and practice can be pointed out. For research, the present study has found new insights that can be explored further and confirmed using quantitative research methods. For instance, the importance of lacking self-evaluation skills that was found to be so common among workers on sick leave with CMDs is an area that requires further research. Future studies could investigate further how workers can be supported in gaining self-awareness and self-evaluation skills, and how this affects their work participation. A similarly interesting area is the importance of liking one's work content, not only for its connection to the RTW process but perhaps also for the prevention of sick leave. Another focus for future research could be on developing screening tools for predicting absenteeism in workers, or on developing existing tools further by adding new knowledge. Finally, given the fact that workers did not see mental *illness* as the origin of sick leave, future research should focus on the question if this is also the case in workers on sick leave with other health conditions. Hence, replicating our study in a sample with workers on sick leave with a physical illness might result in new insights.

Perhaps illness in general creates a vulnerability to absenteeism, but sickness absence can well be prevented when considering factors such as work pressure, job satisfaction, adequate self-evaluation and manager support.

Implications for practice

Support workers in gaining self-awareness

For practice, a first implication is that as an RTW intervention and possibly also for the prevention of sickness absence, it seems of crucial importance that workers are supported in gaining more self-awareness and gain more insight into their own personal needs and wishes. They need to become more aware of what parts of their work they do and do not value and enjoy. Or how they can make adequate work-related choices that enable them to deal with high work demands without exceeding their own limits. This support should first open their eyes to the fact that their way of dealing with their work situation is not helpful to themselves, then make them aware of their own work-related needs, and finally to empower and support them in being more assertive and influential in adapting their work tasks where possible. As we have learned from our study, workers who are most in need for such support are those who have a high sense of responsibility, who are perfectionists and who have difficulty being assertive.

Support recovery enhancing behaviour

A second implication for practice is the importance to keep in touch with workers who seem to engage less in recovery enhancing behaviour. Workers on long-term sick leave seemed to be more passive and reactive in their behaviour. As facilitating factors for RTW they often mentioned that being left alone (i.e. being given much freedom in their decisions on work resumption) was helpful. However, as they were still on sick leave after 6 months, the helpfulness of this freedom for a successful and rapid RTW needs to be questioned. Especially with long-term sick workers, a personalised approach – consisting of good communication and an assessment of what the worker's values, views and needs are – seems important. And although no-one-size-fits-all advice can be given, based on this study it seems very important that occupational health professionals such as OPs are able to identify stagnation in an early stage so that they can intervene.

Focus on what people value in their work

A third implication for practice is that the topic of value of work should be addressed more often in the work context, for example during periodic performance interviews that managers have with their employees and also during RTW interventions. Especially for long-term absentees, the way in which workers valued their work content was found to be very important. Not feeling connected to the job and being dissatisfied with the job content was one of the self-perceived causes of sick leave and also wasn't helpful when returning to work. In contrast, workers on short-term sickness absence often indicated that they valued their work, which helped returning to work.

To prevent sick leave and improve RTW, employers should try to improve the fit between one's job and personal strengths and interests. A suitable method for this is job crafting, which involves changing work task, changing interpersonal relationship at work, and changing cognitions about work to redesign the job so that it better suits the worker (63, 64).

Take signals of work pressure serious and personalise support in RTW

The final implication for practice is that the adverse effects of high work pressure and high workload should be taken seriously by employers and managers, as this was the main cause for sickness absence

of almost all respondents. Managers and employees need to understand that there are individual differences and that not every employee can deal with the same work pressure, as it is mainly the *experienced work pressure* that negatively affects employees' health. In case of perceived high workload, signs from the employee should be taken seriously, and good communication and personalised support from the manager are advised.

APPENDIX 1: INTERVIEW QUESTIONS – FIRST-WAVE INTERVIEWS

PART 1: Introduction

Comfort participant. For example: 'We have already talked on the phone, and you told me that you have been on sick-leave since [date]. Then, we also talked about your complaints. I would like to know more about your sickness absence.'

1. Can you tell me how you are doing and what is going on?
2. How did you function at work when the problems started? What were difficulties? How did you experience this?
3. At this moment, what makes it difficult for you to do your job? How do you experience this?

PART 2: Cause and onset

4. When did the problems start and how did they develop?
5. What was the straw that broke the camel's back?
6. When you weren't doing well, did your manager know? And your colleagues? What were your reasons to (not) tell your manager or colleagues? Were you able to discuss this? How did you experience this?
7. How did you feel about deciding to stay home/call in sick? Could this have been prevented? What does this mean to you? What does this mean to your environment? What do you miss now that you aren't working?

PART 3: Return

Now we will talk about how you feel about the return to work.

8. At the moment, are you working on the return to work? Do you think about returning?
9. At the moment, which steps are undertaken concerning the return to work? How do you experience the procedure? With whom do you have contact/who are involved? How do you experience the contact? How do you experience the involvement of others?
10. What do you think of all those involved and their mutual co-operation?
11. How important is it to you to return to work? Who do you think plays an important part? What influence do family/friends/partner have? And the physician? The occupational physician? Colleagues and the manager? Practitioners like the psychologist? Do goals/values/ambitions that you want to achieve play a role?
12. When do you think you will return to work? Why not longer or shorter?
13. How easy or difficult do you think it will be to return to work? What makes it easy/difficult to return to work? Who could help to facilitate this?
14. If you would be able to return to work in a week, and you could decide yourself what tasks you would do and how you would start, what would you be able/like to do? What do you need to return to work? Who needs to be involved?

15. In your opinion, what do people in your situation mostly need to be able to recover?
16. How can you be supported to return to work? And in what way?
17. What would your ideal way of returning to work look like?
18. Can you tell if you can discuss your situation at work right now?
19. Did I forget to ask something or do you have remarks/supplements?

PART 4: Closure

Thank you for talking to me. How did you feel about doing this interview?

APPENDIX 2: INTERVIEW QUESTIONS – SECOND-WAVE INTERVIEWS

PART 1: Period until return to work

1. How are you doing? When did you return to work?
2. Do you experience the cause of your absence differently now? Could it have been prevented? How?
3. What did help in the return to work; what went well in this period/what did make the return easy?
4. What didn't help in the return to work; what went wrong in this period/what did make the return difficult? What would have been needed to return sooner? When in the process should that have happened?
5. Since last interview, what did exactly happen? Did your problems get solved? How? With whom did you have contact? Interventions/actions?
 - a. Occupational physician
 - b. Psychologist
 - c. Physician
 - d. Other practitioners
 - e. Private environment (partner, family, friends)
6. Did those actions suffice your needs?
7. Did the actions fit your needs in resolving problems that you experienced at work?
8. Did you receive information (brochures/websites)?
9. How was the contact with your manager?
10. How was the contact with your colleagues? Did you often have contact?
11. Were you able to talk with your manager/colleagues about your situation? Did they show understanding? Did you feel supported?
12. Did you discuss what you think is important in work? Goals/values/ambitions? What do you miss from work now that you did not (fully) return?
13. Did the employer, occupational physician and the practitioners – such as psychologist and GP – work together?

PART 2: Return to work; moment of the return

14. How has your return been established? Did you succeed in returning?

15. How did you start working? How has that been established? Who took the initiative? What role did the occupational physician, GP, other practitioners or family and friends play?
16. Has your work content and/or work tasks been adjusted? Did it help?
17. What did your manager (director, team supervisor) mean/do for you?
18. What did your colleagues mean/do for you?
19. What did you do yourself? To what extent could you provide input in the process? Did you reveal your wishes/worries?
20. What went well; what made it easy to return to work/what made it difficult to be back at work?
21. When you returned to work, did you exactly tell what was going on?
22. Were you able to talk about your situation at work with your manager/colleagues? Did they show understanding? Were you worried about certain things? Did you discuss that?

PART 3: Period after the moment of return

23. What did help when you were already working? What made it difficult to work?
24. Which tasks or work situations are difficult or not possible yet?
25. To what extent can you provide input? Did you discuss your wishes/worries?
26. To what extent do you have decision authority in matters that are important for you at work?
27. Who is supporting you during this period? Occupational physician, GP, manager, colleagues? How does that happen?
28. Do they show understanding? Are you able to discuss your situation with your manager/colleagues?
29. What do you think of the total return-to-work process, from the moment you were on sickness absence?
30. How do you see your job in the future (same job, other job)?
31. What would you advise others who are on sickness absence?
32. What have you learned from the total process?

PART 4: Closure

Thank you for talking to me. How did you feel about doing this interview?

APPENDIX 3: INTERVIEW QUESTIONS – FOCUS GROUPS

1. What do you think are important causes of sickness absence due to common mental disorders?
2. What do you think are the needs of workers on sick leave?
3. What are the barriers for workers to returning to work? What can you do about it?
4. What are the facilitating factors for workers to returning to work? What can you do about it?
5. What are the causes of long-term sick leave due to common mental disorders? What can you do about it?
6. Why do some workers return to work swiftly and others don't?
7. What do you think is needed to prevent sickness absence due to common mental disorders?

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