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Workplace Social Relations in the Return-to-Work process

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Till minne av min älskade far Göran Tjulin

In memory of my beloved father Göran Tjulin

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ABSTRACT

The overall aim of this thesis was to explore the impact of workplace social relations on the implementation of return-to-work interventions. The thesis consists of four separate papers with specific aims. In Paper I, the overall purpose of the study was to analyse how a multi-stakeholder return-to-work programme was implemented and experienced from the perspective of the stakeholders involved, i.e. supervisors, occupational health consultants and a project coordinator. The objective was to identify and analyse how these stakeholders perceived that the programme had been implemented in relation to its intentions. In Paper II, the objective was to explore how workplace actors experience social relations, and how organisational dynamics in workplace-based return-to-work start before and extend beyond the initial return of the sick-listed worker to the workplace. In Paper III, the objective was to explore the meaning of early contact in return-to-work, and how social relational actions and conditions can facilitate or impede early contact among workplace actors. In Paper IV, the objective was to explore the role of co-workers in the return-to-work process, and their contribution to the process, starting from when a colleague falls ill, continuing when he/she subsequently becomes sick-listed and finally when he/she re-enters the workgroup.

The general methodological approach to the papers in this thesis has been explorative and interpretive; qualitative methods have been used, involving interviews, group interviews and collection of employer policies on return-to-work. The data material has been analysed through back-and-forth abductive (Paper I), and inductive (Papers II-IV) content analysis.

The main findings from Paper I show that discrepancies in the interpretations of policy intentions between key stakeholders (project coordinator, occupational health consultants and supervisors) created barriers for implementing the employer-based return-to-work programme, due to lack of communication, support, coaching and training activities of key stakeholders dedicated to the biopsychosocial intentions of the programme. In Papers II-IV, the workplace actors (re-entering workers, co-workers, supervisors and/or human resources manager) experienced the return-to-work process as phases (time before the sick leave, when on sick leave, when re-entering the workplace, and future sustainability). The findings highlight the importance and relevance of the varied roles of the different workplace actors during the identified phases of the return-to-work process. In particular, the positive contribution of co-workers, and their experience of shifting demands and expectations during each phase,

is acknowledged. During the period of time before sick leave the main findings show how workplace actors experience the meaning of early contact within a social relational context, and how early contact is more than an activity that is merely carried out (or not carried out). The findings show how workplace actors experience uncertainties about how and when contact should take place, and the need to balance possible infringement that early contact might cause for the re-entering worker between pressure to return to work and their private health management.

The findings in this thesis show how the workplace is a socially complex dynamic setting, which challenges some static models of return-to-work. The biopsychosocial and ecological/case management models and policies for return-to-work have been criticised for neglecting social relations in a return-to-work process at the workplace. This thesis provides increased knowledge and explanations regarding important factors in workplace social relations that facilitate an understanding of what might “make or break” the return-to-work process.

SVENSK SAMMANFATTNING

Denna avhandling handlar om vilken betydelse sociala relationer på arbetsplatsen har under en sjukskrivning och vid återgången i arbete. Tidigare forskning om återgång i arbete har tagit upp de medicinska och psykologiska faktorer som kan hindra eller underlätta en sjukskriven persons återgång till arbete. Sociala faktorer som kan hindra eller underlätta återgång till arbetet har inte studerats i någon större utsträckning. Därför genomfördes fyra delstudier med fokus på sociala relationer och social interaktion på arbetsplatsen. Varje delstudie har sitt specifika syfte. Det övergripande syftet med avhandlingen är att studera hur arbetsplatsrelaterade sociala relationer utvecklas vid återgång. I avhandlingen har material samlats in från tre offentliga arbetsgivare i Östergötland. Materialet till studierna har samlats in under 2007 och 2008. Den övergripande metodologiska ansatsen har varit explorativ och tolkande, där kvalitativa metoder har använts för att få en förståelse för hur olika nyckelpersoner på arbetsplatserna upplevt en sjukskriven persons återgång i arbete. I de fyra delstudierna har intervjuer, gruppintervjuer och insamlande av arbetsgivarnas handlingsplaner för sjukskrivnas återgång i arbete använts som datainsamlingsmetoder.

Delstudie I behandlar hur en arbetsgivare implementerade ett multiprofessionellt rehabiliteringsprogram i organisationen och hur det upplevdes av aktörerna som var involverade (chefer, företagshälsovårds konsulter och projektledaren). Syftet var att identifiera och analysera hur aktörerna uppfattade att rehabiliteringsprogrammet hade genomförts i förhållande till dess intentioner. Studien utfördes med kvalitativ metod. Individuella intervjuer gjordes med åtta chefer och med projektledaren, och två gruppintervjuer gjordes med konsulter från de två deltagande företagsvårdsenheterna. I analysen av intervjuerna framkom att det fanns hinder för implementeringen av rehabiliteringsprogrammet, till exempel hade inte alla planerade interventioner genomförts som det var tänkt i programmet. En förklaring var att nyckelpersonerna som genomförde programmet arbetade efter en mer biomedicinsk syn på återgång i arbete och arbetsförmåga, medan rehabiliteringsprogrammet hade utformats enligt en holistisk, biopsykosocial syn. Slutsatsen från studien är att implementering av ett rehabiliteringsprogram kräver långsiktig planering och en långsiktig strategi som innefattar tid för reflektion, delaktighet från de nyckelpersoner som genomför interventionen, en öppenhet för förändringar av åtgärder i rehabiliteringsprogrammet samt konstant kommunikation bland de inblandade personerna.

Delstudie II behandlar hur arbetsplatsaktörer (den sjukskrivne, arbetskamrater, chefer och eller personalkonsulenter med rehabiliteringsansvar) upplevde sociala relationer,

och hur de agerade på arbetsplatsen utifrån ett socialt perspektiv under en sjukskrivningsprocess. Studien utfördes med kvalitativ metod och tre arbetsgivare deltog i studien. Individuella intervjuer med 33 individer gjordes vid sju olika arbetsplatser. De intervjuade var personer som återgått i arbete efter sjukskrivning, arbetskamrater till den sjukskrivne, den sjukskrivnes chef och eller personalkonsulent som hade det yttersta rehabiliteringsansvaret. De tre arbetsgivarnas rehabiliteringsplaner samlades in och analyserades. Analysen av intervjuerna visade att återgången i arbete uppfattas som en process med tre distinkta faser: 1. när individen är borta från arbetsplatsen, 2. när individen återvänder till arbetsplatsen, 3. när individen varit i arbete ett tag och hållbarhet i arbetsförmågan ska uppnås. Genomgående för alla dessa tre faser var att arbetsplatsaktörerna kände osäkerhet, speciellt ifråga om hur och när åtgärder och handlingar för att främja återgång i arbete skulle genomföras. Det visade sig även att arbetskamraterna tog på sig ett stort socialt ansvar för återgången i arbete, något som inte alltid uppmärksammades av eller var synligt för chefer och personalkonsulenter. Slutsatsen av studien visar att det är av vikt att uppmärksamma de sociala relationerna på arbetsplatsen i samband med en återgång i arbete för att kunna häva och förebygga osäkerheten bland alla involverade och för att synliggöra arbetskamraternas roll i rehabiliteringsprocessen.

Delstudie III behandlar innebörden av tidig kontakt i återgång i arbete, och hur sociala relationer och handlingar kan underlätta eller förhindra tidig kontakt mellan arbetsplatsaktörer. Studien bygger på samma material och metod som delstudie II. Analysen visade att tidig kontakt är en komplex social åtgärd vid återgång i arbete och att arbetsplatsaktörerna hade olika incitament för att ta kontakt, dels formulerat som ett organisatoriskt arbetsgivarkrav, dels som ett informellt socialt ansvar mellan människor. Tidig kontakt innebar att de involverade arbetsplats aktörerna behövde hantera balansen mellan att ta tidig kontakt och att vara följsamma för den sjukskrivnes behov av att ha en kontakt eller inte med arbetsplatsen. Slutsatsen av studien visar på betydelsen av insikten att åtgärden tidig kontakt är en socialt komplex intervention som inte bara handlar om en aktivitet som utförs eller inte utförs utav arbetsgivaren. Arbetsplatsåtgärden tidig kontakt behöver problematiseras och tydligare artikuleras som koncept i handlingsplaner och program för återgång i arbete.

Delstudie IV behandlar arbetskamraternas upplevda roll och deras erfarenheter av processen återgång i arbete. Studien bygger på samma material och metod som delstudie II och III. Analysen av intervjuerna och rehabiliteringsplanerna visade tre huvudfynd: (1) handlingsplaner och den struktur som finns inom organisationen för att underlätta återgång i arbete tar inte med arbetskamrater till den sjukskrivne som betydande aktörer, (2) sociala krav och förväntningar i arbetsgruppen visar sig ha betydelse för hur den sociala interaktionen blir och vilka attityder som formas i

relation till den person som återgår i arbete och till processen återgång i arbete, (3) om chefen är närvarande och tar ett rehabiliteringsansvar eller inte i processen har betydelse för hur kommunikationen i arbetsgruppen blir, och hur hela processen hanteras av arbetsgruppen. Slutsatsen av studien visar att återgång i arbete är något som skapas genom handlingar och social interaktion på arbetsplatsen, inte bara mellan den sjukskrivne och chefen, utan också med arbetskamrater. Arbetsgivare bör se processen återgång i arbete som ett dynamiskt socialt samspel som involverar hela arbetsgruppen.

LIST OF PAPERS

- I Åsa Tjulin, Elinor Edvardsson Stiwne, Kerstin Ekberg. Experience of the Implementation of a Multi-Stakeholder Return-to-Work Programme. *Journal of Occupational Rehabilitation 2009, volume 19, issue 4, page 409-418*
- II Åsa Tjulin, Ellen MacEachen, Kerstin Ekberg. Exploring Workplace Actors' Experiences of the Social Organization of Return-to-Work. *Journal of Occupational Rehabilitation 2010, volume 20, issue 3, page 311-321*
- III Åsa Tjulin, Ellen MacEachen, Kerstin Ekberg. Exploring the meaning of early contact in return-to-work from workplace actors' perspective. *Disability and Rehabilitation, 2010; Early online, page 1-9*
- IV Åsa Tjulin, Ellen MacEachen, Elinor Edvardsson Stiwne, Kerstin Ekberg. The Social Dynamics of Return-to-Work explored from co-workers experiences. *Submitted to Disability and Rehabilitation.*

INTRODUCTION

There are several reasons for conducting research about return-to-work – reasons that can be found at a societal level, a workplace level and at the individual level. From a welfare perspective, one of the main consequences mentioned in relation to sickness absence and return-to-work is increased compensation costs for healthcare and the social insurance system (1). For the employer, sickness absence and return-to-work leads to an increase in production costs, which in turn leads to a loss of production and skilful employees (2). From an individual perspective, a sickness absence situation could result in a potential loss of well-being and full participation in today's society, since work not only provides a regular income, but also contributes to important psychosocial needs, individual identity, social roles and social status (3). Thus, return-to-work research can contribute to decreasing the consequences of sickness absence on all different levels.

Rationale for the studies performed

Return-to-work research has primarily focused on the medical and psychological conditions which facilitate the return-to-work process. The social conditions in which the return-to-work process is embedded, and the way in which social interaction and relations between the workplace actors (supervisor and co-workers) and the sick-listed worker evolve, have only been researched to a limited extent. The contribution of this thesis is a further elaboration of how workplace social relations influence practice in the return-to-work process. As guidance to the four papers presented in this thesis, a background of return-to-work research will be described. The research describes how work disability is approached from a biomedical and social constructive perspective. The two perspectives of work disability have led to attempts to integrate biomedical and social perspectives in the return-to-work process in different models. In this thesis, the biopsychosocial- and ecological/case management models will be further discussed, as well as how the workplace and workplace-based interventions have been studied in relation to the return-to-work process. But first, a short description of sickness patterns in Sweden and of Swedish sickness benefit insurance will be given, since the studies in this thesis have been conducted in Sweden.

Patterns in Swedish sickness insurance

The pattern in sickness insurance benefits in Sweden has shifted. During 1990-1997 there was an increase in the number of days with individuals on sickness benefits; following this, there was an increase during 1997-2002 due to higher rates of long-term sickness absence. Since 2002 the average number of days on sickness benefit has decreased for each year. Women have a higher rate of days on sickness benefits than men, and the average number of days on sickness benefit rises with increased age. Approximately 2.3 million women, and 2.4 million men, aged 19-64 years in Sweden were insured for sickness benefits during 2008. Of these, 4% of women, and 2% of men were on sick leave during January 2008. The pattern of sickness compensation has followed the pattern of sickness benefits. Close to 9% of the population in Sweden aged 19-64 years have left the labour market full-time or part-time, due to decreased work ability. Two thirds of all individuals on either sickness benefit or compensation are absent due to musculoskeletal or mental health disorders (4).

Description of Swedish sickness insurance

The increase of long-term sickness benefits in the late 1990s led to an intense debate on how to decrease the rising numbers. It was suggested that the system was too generous, and that the Social Insurance Agency, who makes decisions about eligibility for sickness benefits, seemed to prefer to grant sick-listed individuals permanent disability pensions rather than taking an active approach towards a work-oriented return-to-work process and a labour market re-integration of sick-listed individuals (5-6). In 2008, the Swedish government implemented new sickness insurance legislation in relation to the return-to-work process: the so-called rehabilitation chain (7). Sickness insurance is based on the principle of the work line, which argues that as many people as possible should provide for themselves through their own work; this will increase employment and decrease alienation from the labour market (8). The rehabilitation chain is presented as an activation strategy focusing on constraining medically determined sick leave, with the underlying idea that it is "good medicine" to keep people in work and thereby minimise detachment from the labour market. The political aim of the strategy is to promote a faster return-to-work to the individual's previous workplace, or to find another suitable job on the labour market at an early stage (9). In brief, the rehabilitation chain sets time limits of work ability assessments after 90, 180 and 365 days on sick leave. After 90 days on sick leave, work ability is assessed in relation to the individual's ordinary work tasks. Between 90 and 180 days on sick leave work ability is assessed in relation to other available work tasks with the

same employer. Finally, after 180 days the sick-listed individual's work ability is assessed in relation to their ability to earn a living elsewhere on the regular labour market (10).

Sick-listed individuals' eligibility for benefits is assessed with regard to their work ability rather than their disease, and with respect to how their work ability is affected by their current medical condition. The sickness insurance system does not differentiate between work-related or non-work-related conditions. Sickness benefits can be paid for 100%, 75%, 50% or 25% loss of work ability, for a maximum of one year, and sick-listed individuals receive 80% of their previous earnings. If their work ability is permanently reduced by at least 25% after one year of sickness benefit they are eligible for sickness compensation, which is based on 64% of their previous earnings (11).

Stakeholders in the Swedish sickness insurance system

Several stakeholders are involved in the return-to-work process. The Social Insurance Agency administrates sickness insurance and compensation benefits and makes decisions regarding eligibility. The healthcare services provide the Social Insurance Agency with medical assessments upon which eligibility is based. According to the new sickness insurance legislation (12), the Public Employment service delivers vocational guidance after 6 months. Employers in Sweden have a legal responsibility for the return-to-work process, as formulated in the National Insurance Act (13) and the Work Environment Act of 1992 (14). In brief, employers are required to adapt work conditions to the capacity of the individual worker whenever possible (15). However, the demands on employers seem to have decreased due to the new sickness insurance legislation. The focus has shifted from the return-to-work process, with incentives for employers to submit a rehabilitation plan for each worker on sick leave, to a labour market reintegration where employers have minor financial incentives for bringing sick-listed workers back to the workplace. Thus, in practice employers have few obligations with respect to their sick-listed workers (9). The municipalities are responsible for social rehabilitation and social allowances for those individuals who cannot participate in any work on the labour market (12).

CONCEPTS

The concepts of return-to-work and the return-to-work process, stakeholders and actors, social relations and interaction are frequent and prominent in this thesis. An explanation of how these concepts are viewed is given below.

Return-to-work and the return-to-work process

The concept of return-to-work is a broad concept used to explain and describe the return-to-work process, as well as an outcome to describe and explain variations in pain intensity, physical function, psychological function and care utilisation (1). However, the use of return-to-work as an outcome measure collected at a single point in time has been criticised for not acknowledging the dimensions of social interaction, time, sustainability of work ability and context (16). There is emerging conceptual, clinical, and empirical consensus that return-to-work should not be considered a static employment outcome.

In this thesis, the concept is used to describe a return-to-work process. Return-to-work is considered to be something more than an outcome measure. Rather, consideration should be given to the temporal (time-based) aspects of return-to-work, patterns of work/disability, and how these factors interact with the dynamic relationship between a worker and the workplace over time, in producing return-to-work outcomes (17).

Stakeholders and actors

A return-to-work stakeholder is defined as any person, organisation or agency that stands to gain or lose, based on the results of the return-to-work process (1). Key stakeholders in the return-to-work process include the worker on sick leave and their families, employers, co-workers, labour union groups, healthcare providers, compensation insurers and/or social insurance agencies, and the societies in which the stakeholders live.

In this thesis, a difference is made between *stakeholders* (referring to employers, the social insurance- and compensation board, and the healthcare and occupational health

services in the return-to-work process) and *workplace actors* (referring to the key actors who are involved in the return-to-work process at the workplace). The workplace actors represented in this thesis include re-entering workers, supervisors, co-workers, and human resource managers.

Social relations and social interaction

Social relations and social interaction are key concepts in this thesis. The term *social relations* is used to conceptualise the way in which individuals relate to each other in a specific common workplace and refers to the work context which the workgroup have in common or share. *Social interaction* is used in relation to how, why and with whom individuals interact at the workplace in the return-to-work process (18-19).

RETURN-TO-WORK RESEARCH

Perspectives on work disability

Historically, individuals who were unable to work were viewed as having a medically determined diagnosis, and illness was connected to physical pathology (20). In this biomedical perspective, disability is viewed as an observable deviation from the structure or function directly produced by a medical condition (21). Treatment within the biomedical perspective focuses on restoration of lost work ability by attempting to overcome, adapt or compensate for this loss. Mind and body are seen as separate. It is physicians who set the diagnosis and treatment plan, regardless of contextual factors such as the social sphere of the individual (22). The use of the biomedical perspective in the return-to-work process has been criticised for neglecting the contextual factors of illness and disability, such as: personal/psychological prerequisites, environmental/social prerequisites (22), and political/economic factors (23).

The biomedical perspective of disability as a medical condition and nothing else has also been criticised by researchers with a social constructive perspective. From this perspective, disability is regarded as a social construction, created in a social and economic context, where norms and values define what is normal and deviant. Disability is not simply an individual characteristic; rather, disability is formed in relation to a context where there are conditions, activities, norms and values that define what disability comprises. Thus, the social construction perspective is suggested to explain factors in the social environment (21, 23).

In search of a more comprehensive understanding of the return-to-work process, a biopsychosocial model has been proposed which integrates the biomedical and social perspectives (21). Here, the return-to-work process is viewed as interaction between bio-, psycho-, and social prerequisites for an individual's work ability. *Bio* refers to impairments, structures and function in the body, i.e. physical or mental health conditions. *Psycho* refers to activity limitations and personal factors, i.e. illness behaviour, beliefs, coping strategies and emotions. *Social* refers to the importance of the social context and environmental factors that could impede participation in society, i.e. social interaction and the sick role (22). However, this model has been criticised for being too theoretical, and for failing to capture the subtleties of social relations and interactions in the return-to-work process, since the social factors are not specific

enough for systematic empirical validation within the field of return-to-work research (17), and fail to recognise the relation between the individual and the workplace (24).

SOCIAL	Culture Social interactions The sick role
PSYCHO-	Illness behaviour Beliefs, coping strategies Emotions, distress
BIO-	Neurophysiology Physiological dysfunction

Figure 1: The biopsychosocial model (adapted from (22))

The ecological/case management models are in line with the biopsychosocial model. A large study was conducted in Canada during the late 1990s (25) and the results from the study, which led to the Sherbrooke model, symbolise the shift from personal disease/biomedical models towards person/environment models within return-to-work, which incorporate the biopsychosocial model (24). The responsibility for outcomes shifts from the healthcare provider-patient relationship to a multi-player decision-making system influenced by different professional, legal, administrative, and cultural (societal) interactions (26). The underlying idea of the model is that the return-to-work process has multi-determinants that impact the process. It is therefore argued that the return-to-work process should be understood in a systematic context which considers the interplay between the macro-system (societal context, culture and politics), the meso-system (workplace, healthcare, legislative and insurance system) and the micro-system (the worker). The model also highlights the fact that several stakeholders are involved in the return-to-work process, and each of these stakeholders have their own understanding of return-to-work and what outcomes they expect (17).



Figure 2: The Sherbrooke model, or the ecological/ case management model (26)

Implications for the return-to-work process

Even though the biopsychosocial and ecological/ case management models of return-to-work are emphasised in the research literature (17, 22, 24), research studies show how complex it is for stakeholders and workplace actors to apply the models in everyday practice (12, 27-28). One practical implication of the return-to-work process is created between the need for objective medical assessment of work ability (the biomedical perspective) and the social context of function and support for facilitating work ability (the social constructive perspective). For instance, social insurance and compensation systems prefer an administrative definition for the return-to-work process, based on a biomedical approach where objective proof of impairment, illness or reduced work ability is stressed. Clinical definitions of work disability, and assessment of work ability, are beginning to take into account that the worker's ability to meet personal, social or occupational demands is dependent on environmental and contextual factors (29). Nevertheless, when it comes to the return-to-work process, proof of work disability is provided by physicians, and entitlement to benefits often forms the basis for sickness benefits/wage replacements for the sick-listed worker. A

recent Swedish study shows that this biomedical perspective, focusing on eligibility for benefits, fails to include the characteristics and demands of the work in assessments for eligibility (12).

The research results shown in the Sherbrooke model provide a way of structuring different systems and acknowledge stakeholders involved in the return-to-work process. However, it is important to note that there is a fundamental difference in the way in which the model is applied by different stakeholders and workplace actors, depending on the socio-political system in which the model is used (30). In research and practice, models and conceptualisation of the return-to-work process vary widely and depend upon the social insurance or compensation system, involved stakeholders and their invested interests, definitions and conceptual approaches to return-to-work and views of desired outcomes (1, 16, 31). Thus, the interplay between the different systems and stakeholders (healthcare-, legislative and insurance-, workplace- and personal systems) described in the Sherbrooke model creates consequences when applied in the everyday return-to-work process. Furthermore, the Sherbrooke model needs to be elaborated to facilitate understanding of how the interaction within and between the key system components and stakeholders hinders or facilitates the return-to-work process, especially in relation to the sick listed worker (17). A further discussion of the consequences of these applications for practice, and the implications for the return-to-work process within the legislative and insurance system, at the workplace- and for the re-entering worker, is given below. This discussion serves as a basis for identifying research gaps that are relatively unseen in the two existing models mentioned above, and is a call for a more elaborated dynamic view of the return-to-work process and return-to-work models.

The legislative and insurance system

Studies have shown that getting the return-to-work stakeholders to collaborate and communicate in return-to-work has proved to be complicated (27, 30, 32). One reason for this is that stakeholders involved in a return-to-work process have different interests, different ideas about what is at stake, and also have a certain way of communicating, depending on the system, or perspective, they represent (23).

These collaboration and communication difficulties need to be addressed in the return-to-work process (26, 30). A recent Canadian study focuses on contextual factors surrounding the stakeholders while collaborating in a return-to-work process, and on how system factors influence the process. The results show that prolonged sick leave of sick-listed workers is driven by return-to-work policies and models that do not take

into account power imbalances and conflicts between different stakeholders. The findings show recurring systematic challenges caused by inappropriate modified work, co-worker hostility, physicians who are too busy for paperwork and comprehensive assessments of work ability in relation to the actual work situation. Further difficulties may be due to compensation systems officials who communicate poorly with sick-listed workers and fail to provide guidance and information about how to progress in the return-to-work process from “a system view” (27).

In Sweden, an acknowledged system challenge is the lack of collaboration between the healthcare services, the Social Insurance Agency and employers. A recent study shows that the healthcare services and the Social Insurance Agency lack knowledge about working conditions and how to assess work ability for sick-listed workers in relation to specific work tasks and organisational prerequisites for accommodations at the workplace specified by employers. The results show that due to employers’ lack of financial incentives, and a legal framework that does not specify what the employer’s responsibility for return-to-work actually comprises, there is a decreased interest in involvement and collaboration with the healthcare services and the Social Insurance Agency (30). A comparative study, investigating if cross-country differences could explain differences in return-to-work after occupational back pain, showed that work interventions and less strict social insurance or compensation policies contributed to sustainability in return-to-work. Sweden was one of the countries that did not use workplace interventions to any great extent for promoting the return-to-work process, except for workplace training. One of the policy implications found in the study was that national policies need to encourage more workplace interventions. In order to achieve policy change, collaborative action needs to be taken by stakeholders from the social insurance or compensation system and the workplace system (33).

These examples of system divergences created by inadequate interaction between stakeholders and workplace actors throughout the return-to-work process, lead to inadequate communication that increases, the further the return-to-work process progresses. In the worst case, the link of communication failures leads to a “toxic dose” of system failures, which creates a worse situation for the sick-listed worker than was caused by the sick leave and illness in itself (27).

The workplace

It has proved outdated to view the return-to-work process as strictly a problem that concerns individual employees. Rather, there is now an increased emphasis on research into workplace and organisational factors and their influence on the return-to-

work process (34). However, the impact of the workplace in the return-to-work process has been researched to a limited extent, even though there are studies showing that the workplace plays a significant role when it comes to success in return-to-work, and that the supervisor plays a significant role in the process (25, 35-37). Several systematic reviews have been conducted on workplace-based return-to-work interventions. These reviews, of studies conducted in the United States, Canada, Australia, the United Kingdom, the Netherlands, Sweden, and Finland, are primarily based on interventions aimed at re-entering workers with musculoskeletal disorders (38-42). Here, the results show that there are several interventions that could facilitate the return-to-work process.

At the individual-workplace interface, it is suggested that the return-to-work process is facilitated by early contact between the employer and the re-entering worker (43). Early return-to-work is considered a win-win situation for the employer and the re-entering worker. The employer has invested in the worker's competence and thereby has an economic interest in getting the worker back early (44); and the re-entering worker avoids a drop in income as a result of sickness absence if the return can be managed early on (45). However, few studies have been conducted so far concerning early social contact, and there is limited research on the actual utility of early contact as a strategy (38). Little is known about the essential meaning of early contact for workplace actors, how workplace actors carry out early contact, and if early contact is health-promoting. There are studies that have shown that continuous contact between the supervisor and co-workers during absence is experienced as supportive by the re-entering worker (46-48). Whether early contact is perceived as welcoming or as harassment by the re-entering worker depends on the atmosphere at the workplace (46, 49). Early contact can be perceived as an unwelcome obligation for both the employer and the sick-listed worker if it is experienced as a pressure or a non-supportive intervention (39). To summarise, several countries emphasise early contact as a strategy, and responsibility, for employers to use in facilitating early return-to-work. However, these national guidelines(44-45, 50-51), and research conducted so far, leave knowledge gaps about how to manage the early contact and how the contact is experienced by key actors at the workplace (38-39).

Workplace-based interventions concerning work accommodations based on the work ability of the re-entering worker (36, 52) and adapted workplace training (34) are prompted in research, as well as the presence of a return-to-work coordinator (38, 53) and communication between the healthcare system and the workplace (54). However, there is no evidence of the effectiveness of the interventions when it comes to reduction in sickness absence (40). Qualitative research conducted in Canada and Sweden has shown that work accommodations and adaptations have to match the work

ability of the re-entering worker to be effective; otherwise, the work environment and work tasks contribute to a setback in the return-to-work process (49, 55). What needs to be recognised is that it is more to the return-to-work process than accommodations related to the physical work ability of the worker. The return-to-work process is considered to be a socially fragile process, where both co-workers and supervisors play a part (46-47, 49, 56).

At the organisational level, it can be supportive if the employer incorporates policy and support programmes in the return-to-work process (34, 37, 46), especially if supervisors are trained and have competence to manage a return-to-work process and show legitimacy, participation, engagement and interest in the re-entering worker's situation (38-39). However, implementation of workplace-based interventions has proved to be difficult, since the recommendations based on research are seldom precise and not always of immediate practical use (26). Several workplace actors play an important active part in a return-to-work implementation process at the workplace, and the outcome of the implementation depends on the interest of the workplace actors (57). For instance, if management neglects the participation of supervisors in the design and planning of a return-to-work intervention, then the intervention becomes difficult to adopt (58).

A review of study results shows that when considering different types of work disability disorders, it cannot be concluded that workplace interventions are more effective than usual care. This may be due to the fact that workplace interventions focus more on changing and improving the individual's prerequisites for return-to-work than making changes in the work environment and organisation (40). The mere involvement of the workplace in the return-to-work process does not facilitate re-entry for the worker (42), and the workplace actors need to actually take action in order to facilitate changes at the workplace (41). Nevertheless, the most common workplace interventions are directed towards stress management, retraining in work tasks, and accommodations made at the workplace to help the worker adjust to work task requirements (41).

To summarise, research shows that social relations and social interaction must be considered in the assessment of workplace-based return-to-work interventions. Several studies of workplace-based interventions have been conducted in relation to the return-to-work process. However, few have investigated how workplace actors (supervisors, co-workers, and re-entering workers) experience a specific return-to-work process at the workplace.

The re-entering worker

Several studies have been conducted to understand the factors behind the re-entering worker's efforts in the return-to-work process. These factors and efforts are often mentioned as personal work disability determinants, psychosocial factors or behavioural factors that impact a re-entering worker's decision whether to return to work (24, 59-60). Studies often mention fear-avoidance and pain (61-64), satisfaction with treatment and reassurance regarding diagnosis and recovery (65), involvement in decision-making and communication with the healthcare services (66) and with the workplace (54, 59), as being important for the re-entering worker's decision to return. Recovery expectations (67), motivation and intentions to return to work (60), self-efficacy (54, 59, 68), and social support (59, 69) are also considered to play a part in predicting the re-entering worker's health recovery, ability to re-enter work and sustain their ability at work.

As far as re-entering workers are concerned, motivating factors for the return-to-work process are concerned with: protection of their financial security; staying healthy and not having setbacks in their return-to-work efforts (54); preserving their dignity when re-entering the workplace as a worker; being counted on when performing the work tasks, i.e. preventing feelings of job insecurity; and being respected for the fact that they still have health problems, i.e. perceiving trust and legitimacy for their health condition (38-39, 54).

Recent studies acknowledge that individual efforts and motivation to re-enter work cannot be studied in isolation from the social insurance or compensation system, the healthcare services or the workplace (26, 32, 70). Studies related to clinical guidelines for facilitating patient satisfaction and the return-to-work process, have shown the importance of communication between the healthcare giver and the re-entering worker (65). Studies have also acknowledged the importance of communication between the healthcare services and the workplace (32, 54, 59). For the re-entering worker, communication is needed to ensure that the realistic potential for sustainability of their work ability is discussed, including identification of possible interventions for avoiding setbacks in the return-to-work process when re-entering the workplace, and providing reassurance that health problems will not increase in connection with the re-entry and sustainability phase of the return-to-work process (1, 59).

Research studies have identified knowledge gaps, such as lack of sufficient evidence to understand how the highlighted psychosocial factors in research are actually played out in the return-to-work process, especially when it comes to viewing the return-to-work process as a dynamic trajectory over time (1, 54, 59-60, 68, 71). Self-efficacy is

one factor among others that has been explored in relation to readiness to return to work. The results show that self-efficacy, i.e. the belief in one's capabilities to organise and execute the courses of action required to produce given attainments, not only relates to the re-entering worker's ability to perform a discrete physical task; it also relates to the ability to fulfil the occupational role, which is more dependent on the ability to access help, manage symptoms and meet productivity demands (59). The re-entry to work may have temporal shifts in disability in the disability-related beliefs and behaviours of the re-entering worker (54, 59).

In return-to-work legalisation, policies and practice it is stressed that successful return-to-work equals a restoration of pre-work ability and a return to the ordinary work task the re-entering worker had prior to sick leave (40-42, 72), which leaves unanswered questions about what successful return-to-work might comprise for the re-entering worker, the co-workers and the supervisor at the workplace. When an injured or ill worker re-enters the workplace, questions regarding work accommodation and a match between the worker's work ability and work task arise (1), as well as questions about how the re-entry influences social interactions and relations at the workplace. As mentioned earlier, the factors that impact a re-entering worker's decision about whether to return to work often relate to studies about psychosocial factors. In a recent study, with the aim of developing instruments for the assessment of motivational determinants for the return-to-work process, the notion of viewing motivation as a solely personal attribute is questioned; rather, motivation should be regarded as a reflection of the relationship between the re-entering worker, several key stakeholders and workplace actors in the return-to-work process. If motivation is regarded as only an individual attribute, leaving the social context unseen, this may have moral implications for the view of the sick-listed worker, resulting in a "blame the victim" mentality (60).

A few studies have been conducted about social relations in workgroups, showing that workplace conditions and social relations, attitudes and beliefs play a part in the success of the return-to-work process (46, 49, 73-74). For instance, tensions may arise if the re-entering worker cannot produce according to production quotas, or if modified work leads to an increased workload for co-workers (46, 49, 55). These results imply that the social context does matter. Studies regarding social support show however equivocal results about whether a high or low degree of co-worker and supervisor social support facilitates or hinders the return-to-work process (75-79). Due to the potential impact social support might have in promoting or hindering the success of return-to-work efforts, it is important to further investigate how social support is played out in the return-to-work process (56). Recent qualitative studies conducted in Canada and the United States have shown that re-entering workers find their co-

workers supportive in the return-to-work process (56, 69). The practical and psychosocial support experienced by the re-entering worker contributed in helping the worker stay at work (69). Emotional support, such as demonstrating caring, interest, encouragement and trust, seemed to be of special importance (56). A quantitative study from Switzerland confirms the results that social support depends on how close the relation is between the co-worker and the injured worker; and also that a close relationship with a co-worker may reinforce the re-entering worker's complaint behaviour (75).

Thus, the return-to-work process is not solely concerned with the re-entering worker's own beliefs and decisions in the process based on psychological factors; it is also related to social interaction with other stakeholders (26) and workplace actors (39, 49, 74, 80-81). However, workplace-based intervention studies described in several reviews (38, 40-42) do not take into account the temporal shifts, or phases, of the return-to-work process. Nevertheless, recurrence in the return-to-work process, or the question of sustainable work ability, is an emerging topic under discussion, since it is important to recognise that a first return-to-work does not necessarily mean that the re-entering worker manages to stay at work (1).

The call for a dynamic return-to-work process

Results from the studies referred to imply that if return-to-work models are to prove helpful for key stakeholders and workplace actors, the models need to make sense from multiple perspectives (16), and acknowledge the dynamics in the return-to-work process between the different "systems" included in the Sherbrooke model. The sick-listed worker's ability to return to work cannot be understood as a simple biomedical dichotomy: i.e. whether the worker is able to work or not able to work (21); different contextual factors, such as the workplace context, also need to be considered. The "ideal model" of return-to-work should

/---/ serve to bridge the gulf between traditional biomedical-driven practices, and empirically supported biopsychosocial models (16, page 456)

Even though the development of biopsychosocial and ecological/case management models for return-to-work are conceptualised as processes and acknowledge the importance of the interaction of biological (e.g. medical status and physical capacity), psychological (e.g. fear and distress) and social factors (e.g. work environment and family) (1, 24, 73), the models can still be considered as fairly static in relation to a dynamic workplace context. Firstly, return-to-work models are not sensitive to

changes in roles and the needs of different actors over the whole time span of the return-to-work continuum. Secondly, workplace interventions in the return-to-work process are based on the characteristics of the individual worker. The interventions side-step the social interaction that takes place when bringing back a sick-listed worker who has not fully recovered, and who thereby brings his or her health problem into the workplace and lays it before everyone. Thirdly, the models and workplace interventions are static since recurrence, or the question of sustainable work ability, in the return-to-work process, are not taken into account (17). Current models of return-to-work focus on the initial back-to-work phase and are vague about what actually happens before the return and after the initial return to the workplace (1). Fourth, there is a need to recognise that return-to-work accommodations involve more than technical changes in work tasks. Making accommodations at the workplace requires consideration of the social context in which these changes take place, which also directs the focus to how return-to-work proceeds beyond the initial return (43, 80).

Research needs to improve understanding about how the existing models of return-to-work and workplace interventions can be elaborated to better facilitate hands-on actions in the return-to-work process. This thesis adds a complementary perspective to existing models, where social relations in the workplace are in focus, and are not solely described from an individual perspective.

AIM

Overall aim

The overall aim of this thesis was to explore the impact of workplace social relations on the implementation of return-to-work interventions.

Specific aims

Paper I: The overall purpose of the study was to analyse how a multi-stakeholder return-to-work programme was implemented and experienced from the perspective of the stakeholders involved, i.e. supervisors, occupational health consultants and a project coordinator. The objective was to identify and analyse how these stakeholders perceived that the programme had been implemented in relation to its intentions.

Paper II: The objective was to explore how workplace actors experience social relations and how organisational dynamics in workplace-based return-to-work extend before and beyond the initial return of the sick-listed worker to the workplace.

Paper III: The objective was to explore the meaning of early contact in return-to-work, and how social relational actions and conditions can facilitate or impede early contact among workplace actors.

Paper IV: The objective was to explore the role of co-workers in the return-to-work process and their contribution to the process, starting from when a colleague falls ill, becomes sick-listed and finally re-enters the workgroup.

METHODS

Research perspective

This thesis focuses on workplace actors' experiences of a return-to-work process. An interpretive approach is used (82). Organisations and workplaces are viewed as a dynamic setting with changing social interactions and relations amongst workplace actors. The organisations are interactively created and recreated by the individuals, and there is an interest in seeing how, why and with whom interactions take place at the workplace (18-19). One aim of the thesis is to generate knowledge about how return-to-work functions (how things occur) given different roles and perspectives within the workplace setting, with particular consideration given to workplace actors' talk of role ambiguity during return-to-work, i.e. the possibility of interpreting the return-to-work process in more than one way. The two studies conducted in this thesis seek to understand what goes on at the workplace, focusing on social interaction and relations affected by differences and commonalities.

Individuals who work together in organisations have a variety of experience, personality, and skills, and therefore have different perceptions of the conditions at the workplace. For instance, rules, ideals and policies developed at the workplace are not important in themselves; what is important is how these enacted rules, ideals and policies are experienced in daily action. Thus, context cannot be reduced to rules or policies, since rules or organisational policies are developed informally through mastery of skills, e.g. employers learning how to implement the return-to-work process, and through external rules, e.g. governmental return-to-work policy. The way in which they are interpreted by workplace actors will shape the rules or policies every time they are encountered, thereby making the return-to-work process rule- or policy-guided rather than governed (18). Further, in this thesis it is acknowledged that the inductive interpretive research is grounded in empirical data. Therefore, in Papers II-IV in this thesis a grounded theory approach is used, based on the idea that theoretical concepts should be grounded in the inter-subjective reality of the social world (83). The process of generating theory, or models, emerges from systematic comparative analysis and is grounded in fieldwork so as to explain what has been observed (84).

Research design

This thesis is based on the results of two qualitative studies which have generated four papers. Each step during the research process (formulation of research question, sample, data collection, analysis and presentation of the study) has been critically examined in the research team by continuously asking what, why and how the research is conducted (85-86).

The first study was conducted in answer to the request of a public employer in Sweden who had initiated a multi-stakeholder return-to-work programme. The team of researchers at Linköping University were contacted by the public employer who wished to find out if their return-to-work programme worked as intended in policy. The research design and research question were developed through continuous meetings between the research team and the public employer. This is described in Paper I.

The results from the first study inspired the research questions in the second study, which were concerned with the social relational aspects of the return-to-work process at the workplace. The design and research questions were discussed between the research team at Linköping University and a researcher from the Institute for Work & Health in Canada in a joint collaboration project. The research team had no meetings with the participating employers when formulating the research design and research questions in the second study. This is described in Papers II-IV.

Research setting

The two studies were conducted at three public-sector workplaces in Sweden. The public sector in Sweden consists of the country's municipalities and county councils/regions that are responsible for providing a significant proportion of all public services. Municipalities are self-governing local authorities with decentralised autonomy to organise the public services in their geographical area. The decision-making power in these local authorities is exercised by politically elected assemblies. The municipalities are responsible for childcare and elderly care, social services, education and infrastructure (87-88). One in five employees in Sweden, or just over 800,000 individuals, works for a municipality. The majority of these employees are women (89). The three employers that participated in the studies are municipalities.

The eligibility of sick-listed individuals for benefits is assessed with regard to their work ability rather than their disease, and in terms of how the work ability is affected by their current medical condition. Sickness insurance does not differentiate between work-related or non-work-related conditions (11). Employers are required to pay sickness benefits for the first two weeks of sick leave. Since the early 1990s, employers' responsibilities for return-to-work have been regulated by the National Insurance Act (15).

Paper I

As little is known about how workplace-based return-to-work programmes are understood and implemented by employers, an exploratory study was designed and conducted.

In Paper I, the research setting is a return-to-work programme implemented by the employer, the aim of which is to shorten the time of sickness absence for workers on sick leave; to create a structure for the return-to-work process at the workplace; and to facilitate collaboration between different stakeholders (workers on sick leave, supervisors, occupational health consultants and Social Insurance Agency officers). The programme was designed to facilitate multi-level involvement in the process – on the part of the individual, the workplace as well as the organisation – in order to increase general awareness of health and return-to-work. Intermediate goals, such as increasing the sick-listed worker's health and activity level, and enabling sick-listed workers to increase their participation and take their own responsibility in the return-to-work process, were also intended to be reached in the programme.

The target group for the intended interventions comprised workers who were on full-time sick leave, were receiving benefits from the Swedish Social Insurance Agency, and agreed to participate.

Early return-to-work was emphasised in the programme, and therefore workers with less than 180 days of sickness absence were to be given the highest priority, followed by employees on sickness absence of 180-365 days, 1-2 years, and so forth. The programme also incorporated adapted gradual workplace training, which could be undertaken either at the ordinary workplace or another workplace, a so-called host unit.

Within these host units, one co-worker was trained to be an instructor who supported the employee on sick leave during the workplace training (90).

Sample

The selection of participants was intentional in order to get information-rich informants, i.e. actors who participated in the implementation process (84).

In order to map out key informants among the 200 supervisors who had access to the return-to-work programme, an inquiry form was constructed. The supervisors were asked to respond if they had referred any workers to the programme. The response rate was 53% (105 supervisors), and of these, 38 had referred at least one worker to the programme. Of these 38 supervisors, eight were included in the study. Six of the supervisors worked in the childcare and education unit; the other two worked in the handicapped and elderly care unit.

The project coordinator was a key informant for the study. The project coordinator was a human resource manager, at the employer's central office, and had the overall responsibility of coordinating the return-to-work programme.

The employer used two different occupational health services in the return-to-work programme. The five consultants working in the two participating occupational health services participated in the study. Two of them were trained in behavioural science, two in physiotherapy and one as an occupational health service nurse.

Data collection

Several meetings in the research team were held when creating the semi-structured interview guide. The interview guide was tested by first conducting a pilot interview. Based on this, the research team discussed if questions had been leading, could be misinterpreted, cause harm and if they seemed to make sense in relation to the overall research question. During the process of data collection the researcher who conducted the interviews listened to and evaluated each interview, asking questions about whether or not the questions were leading, if the questions could be misinterpreted by the interviewee or if the researcher had misinterpreted the answers given. Reflections and memos were noted after each interview, to see how the experience related by the participants, and new emerging interests and concepts, could be elaborated from one interview to the next.

Semi-structured interviews were then conducted with the project coordinator and eight supervisors, in total nine interviews. They all had key roles in referring workers to the

return-to-work programme and implementing the interventions. The focus in the interviews was the interviewed individual's personal experience in relation to their professional role and their position in the return-to-work programme.

The five consultants working in the two participating occupational health services were interviewed in two groups. The reason for conducting group interviews was to enable inter-professional discussion on issues related to the informants' experience of the return-to-work programme.

All interviews were conducted by the first author, at the workplace of the participants. The individual interviews lasted between 30 and 80 minutes, and the group interviews about 50 minutes. They were audio-recorded and transcribed verbatim.

In addition to the interviews, the organisational policy that described the return-to-work programme was collected from the central office of the employer. This was done to contextualise the interviews, in order to frame the understanding of the experience of supervisors, the project coordinator and occupational health consultants in relation to policy intentions concerning how the return-to-work programme should be implemented.

The data were collected during 2007.

Data analysis

The interviews were analysed in two abductive steps (84), using an interpretative approach (91), and involved thematic content analysis (85). During the first step, the transcripts were read and analysed by a second researcher. Themes and concepts articulated by the informants were identified, and related to the five overall phases described in the return-to-work programme policy (90).

In the second step, the first author read the transcripts again, with the aim of identifying emerging discrepancies between the intentions in the programme and the experience of the informants' three different roles (supervisor, occupational health consultant and project coordinator). The discrepancies were compared with the five pre-established themes from the first phase of analysis. The gaps between the intention in policy and perceived application by informants were interpreted as indicators of how the programme had been applied in practice. The analysis yielded four discrepancies: (1) time for referral and inclusion, (2) perspectives of health and work ability, (3) workplace support and responsibility for return-to-work, (4) the occurrence

of preparatory meetings. Descriptive statements and quotations were selected when describing the results (85, 91).

Papers II, III, IV

As little is known about social interaction within single workplaces and among different workplace actors during a return-to-work process, an exploratory qualitative study was designed and conducted. An exploratory design is particularly suited to situations about which little is known in order to provide an understanding of how and why things happen. The analysis in Papers II, III, and IV derives from the same data collection with the overall purpose of investigating different aspects of social relations in the return-to-work process.

Sample

Three employers within the public sector were selected for the study. Within these workplaces, seven work units were purposively selected (Table 1). A work unit was defined as a discrete department with a supervisor and group of workers. The main criterion for selection was that they should have direct experience of a return-to-work process (84). The criteria for inclusion were based on having experience of a recent return-to-work process, and that the sick-listed worker had been absent for at least a month. The participants were recruited within three months of the sick-listed worker's re-entry to the workplace.

An orientation of possible work units was undertaken through the human resource manager at the employer's central office, who identified work units based on the criteria for inclusion. The researchers contacted the supervisor of the unit for further information about the re-entering worker, who was then contacted by telephone. The purpose of the study was introduced to them and they were invited to participate. One re-entering worker declined because she did not want to share her experience about the return-to-work process. None of the supervisors or co-workers declined participation in the study.

In total, thirty-three individual open-ended interviews were conducted across the seven work units. At each single work unit, interviews were conducted with the re-entering worker, two to three co-workers, and the person(s) who had the delegated responsibility for return-to-work (the supervisor and/or the human resource manager).

Table 1. Sample Papers II-IV

Work unit	Diagnosis	Period on sick leave	RTW %*	Re-entered worker M/F**	Co-workers	Supervisor	HRM
Fire station	Mental health disorder	6 months	100%	1 M	2 M	1 M	1 F
Daycare	Mental health & musculoskeletal disorder	6 months	75%	1 F	2 F	1 F	
School	Mental health disorder, cancer, STROKE	5 years and 6 months	25%	1 F	2 F 1 M	1 F	
Administration	Musculoskeletal disorder	2 months	100%	1 F	2 F		1 F
Daycare/school	Mental health disorder	2 years and 7 months	100%	1 F	2 F 1 M	1 F	
Home care	Musculoskeletal disorder	1 year and 6 months	25%	1 F	3 F	1 F	
Home care	Musculoskeletal disorder	1 year and 6 months	75%	1 F	3 F	1 F	

* According to Swedish regulations, an individual can return from sick leave and work 25%, 50%, 75% or 100% , ** M = male F = female

Data collection

The first author collaborated with two other qualitative researchers in the data collection. The formulation of the open-ended interviews was discussed at several meetings to gain a common understanding of the focus of the interviews. In addition, the three researchers talked through the idea of using and filling out the sociogram as a sampling technique. The researchers conducted two pilot interviews, where one researcher performed the interview while the others observed and listened. After the pilot interviews, the three researchers discussed if questions had been leading, could be misinterpreted, cause harm and if specific questions seemed to make sense in relation to the overall research question. During the data-collection process the three researchers shared the interviews instantly, as well as short reflections and memos of the interview situation written down by the researcher after conducting the interview. Reflections and memos were taken to see how the participants' experiences, and new emerging interests and concepts, could be elaborated from one interview to the next.

The first author listened and evaluated each interview, asking whether or not the posed questions were leading, if they could be misinterpreted by the interviewee or if the researcher had misinterpreted the answers given. However, no questions or concerns came up during the period of data collection. The two researchers who collaborated took no part in the analysis or in writing up the papers.

During the open-ended interview the re-entering worker was asked to fill in a sociogram (92). The sociogram was drawn like a dart board, where the re-entering worker was in the centre. The worker was asked to fill in the dart board with names of co-workers, placing the ones with whom they worked closely nearest the centre; the co-workers who were further out on the dart board were more distant in work tasks. When completed, the sociogram provided a graphic description of the social relations between the re-entered worker and the co-workers, in terms of closeness in work tasks. The sociogram was used for purposive sampling (84) of the identification and selection of co-workers for interviews. Co-workers within a work unit were then identified and selected, based on their work relation to the re-entering worker. With the consent of the re-entering worker, co-workers and supervisors were invited to participate in the study.

If they gave their consent, a time and date was set for an interview. The interviews were open-ended; the interviewer began by asking the participants about their professional background, and then asked them to describe what they did at work during a working day. After that, questions regarding the return-to-work process were posed, beginning with questions regarding the time before the colleague got sick, during sick leave and after sick leave. Several topics were covered, such as how/if they maintained contact during sick leave, what measures were taken at the workplace during the process, and how they viewed their own role in the return-to-work process.

The interviews were conducted at the workplace, in a private room. They were audio-taped and transcribed verbatim by a professional transcriptionist.

In addition to the interviews, organisational policies regarding return-to-work were collected from the central offices of the three municipalities. This was done to contextualise the interviews, in order to frame the understanding of the experience of re-entering workers, co-workers and supervisors/or human resources managers in the different organisational settings.

The data were collected during 2008.

Data analysis

A back-and-forth inductive content analysis of the interviews and policy documents in Papers II-IV was performed, which means that the observations from the interview data contributed to the focus of the policy documents and vice versa. The inductive approach is recommended when there is no, little or fragmented knowledge about the phenomenon studied (93). Themes, patterns and concepts emerge from the participants' experiences (84), beginning by getting a sense of the data as a whole, then organising the data, followed by abstraction (93) and analytical reflexivity (94). Often the inductive approach is the opposite of the deductive approach of analysing, where the data are analysed with respect to an existing framework or hypothesis (84).

As a first step of the analysis, the interview transcripts (in Swedish) were read, condensed and translated into English by the lead author. The reason for the translation was the collaboration between the research teams in Sweden and Canada.

The first step focused on getting a sense of the data as a whole and generated descriptive categories based on initial analytical interests regarding how the workplace actors talked about return-to-work; for instance, in terms of causes and attitudes towards sickness absence and significance of diagnosis, social relations in the workgroup, and individual-, supervisor-, and workplace strategies and organisational structure in place for return-to-work, insights during the return-to-work process and what the future might be like. The analysis indicated that co-workers talked about the return-to-work process in relation to timelines or phases of the process. The next step of the analysis was interpretive constant comparison and analytic reflexivity (84, 94). At this stage, the researchers interacted regularly to systematically discuss and compare broader analytical concepts and themes. Descriptive statements and quotations were selected when describing the results (85, 91).

In Paper II, the analytical concepts and themes that were formed between the researchers yielded an explanation of the social organisation of return-to-work behaviour among workplace actors. The analysis suggested three distinct phases of return-to-work: off work, back to work, and sustainability of work ability. The analysis also suggested two crosscutting themes: invisibility (of the return-to-work efforts of different actors) and uncertainty (about how and when to carry out return-to-work).

In Paper III, the analysis focused on early contact in return-to-work among workplace actors. The analysis yielded findings which related to obligations and responsibilities, such as incentives for early contact, incentives for early contact through social

relations, and the acknowledgement and balance of individual needs in relation to early contact.

In Paper IV, the data analysis focused on themes that explained the role of co-workers in return-to-work. The analytical themes related to policies and organisational structure for return-to-work, social demands and expectations among co-workers, and supervisory management of return-to-work.

In addition to the interview analysis, the three organisational policies were read and condensed. Themes were developed and summarised to get an understanding of the content of the documents. They were analysed for how they conceptualised the return-to-work process in relation to time phases of the process, and measures such as early contact, and also for how the policies depicted roles of the different workplace actors in relation to responsibilities for return-to-work and the social interaction of workplace actors. Themes were then compared, and ordered through abstraction, i.e. by formulating a general interpreted description of the data from sub-themes to key themes (93).

Memos, notes, and diagrams were produced throughout the analysis to keep track of emerging ideas and analytical discussions.

Preconceptions as a researcher

A researcher's background and position will affect what they choose to investigate, the angle of investigation, the methods judged most adequate for this purpose, the findings considered most appropriate, and the framing and communication of conclusions (95, page 438-484)

I did not enter the research field of return-to-work as a "blank sheet". I brought with me my preconceptions, or as I prefer to express it, my earlier experience and understandings, into the academic world and my role as a PhD student and qualitative researcher. I have my own experience of being disabled in the eyes of some people, as I have a hearing impairment, and am often in need of my hearing aids to get by in day-to-day activities. I have worked as a personal assistant to individuals with severe impairments, helping them in their daily life. For several years I worked within the Swedish Social Insurance Agency as a case manager/coordinator for return-to-work. This experience has given me my understanding from practice of what it means to 'be disabled', to cooperate with stakeholders, the barriers and facilitators that can be encountered in work and the return-to-work process, and both the negative and

positive outcomes for all stakeholders involved. I have met many workers who have lost their work ability, and are struggling to find their way back into the labour market, all of them with their own life story to share.

All these experiences led me into my interest in public health issues, and to a master's degree in public health. The decision to finally take the step towards return-to-work research was not a hard one to make. Life stories and individuals' own experiences have always fascinated me; I guess qualitative research found a special place in my heart.

Ethical considerations

Throughout the two studies conducted in this thesis, the research team discussed and managed ethical issues. The research team identified what risks there could be for the participants in the studies, and how the risk could be minimised. For instance, a key ethical issue that influenced the design of Papers II-IV was how to focus on the co-workers' and supervisors' experience of a sick-listed worker's re-entry without harming the worker. In order to manage this, the study was designed to focus on all workplace actors (supervisor, co-worker and re-entering worker). To avoid scrutiny of the re-entering worker, the design considers experience across work units and across employers.

The participants were assured that their statements would be treated confidentially in all presentations and reports. When writing up the results, the researchers have considered how the statements and quotes are displayed to minimise identification of the participants. The participants were informed about the objective of the study, how it was going to be conducted, and who had access to the data that was collected. The participants were also informed that they could withdraw from the study at any time without giving any explanation. Informed consent was obtained from all participants before conducting the interview in all four studies. The information was given verbally over the telephone to several participants, and/or as a written document handed to the participants before the interview took place. Each interview situation started with a verbal description of the study by the researcher, again highlighting that the participant could choose to withdraw at any point in time.

FINDINGS

Paper I

The overall purpose of the paper was to analyse how a multi-stakeholder return-to-work programme was implemented and experienced from the perspective of the stakeholders involved, i.e. supervisors, occupational health consultants and a project coordinator. The objective was to identify and analyse how these stakeholders perceived that the programme had been implemented in relation to its intentions.

The findings revealed barriers to the implementation of return-to-work interventions at the workplace. The barriers were experienced as discrepancies between the intentions of the return-to-work programme as it was described in policy, and the interviewed stakeholders' experience of its implementation. One explanation for the occurrence of discrepancies was that the key stakeholders (occupational health consultants, project coordinator and supervisors) expressed a more biomedical, individual view of work ability, while the programme was based on a more holistic, biopsychosocial view.

There were discrepancies regarding:

(1) Time for referral and inclusion of participants, i.e. sick-listed workers on the return-to-work programme. For instance, the workers attending the programme were included after 365 days on sick leave, which was much longer than intended in policy. Moreover, there were different understandings among the key stakeholders of what the optimum timing of referral to the programme would be.

(2) Perspectives of health and work ability. For instance, the project coordinator questioned whether a multi-professional individual health assessment was always needed, whereas the occupational health consultants expressed the benefit of multi-professional individual health assessments. Moreover, the occupational health consultants acknowledged the need for workplace health assessments and evaluations, since they experienced that it was difficult to assess the individual's work ability in relation to the work tasks and the actual situation at the workplace.

(3) Workplace support and responsibility for return-to-work. The programme policy did not mention how the responsibility for return-to-work should be addressed, and different views and interpretations emerged. The project coordinator and occupational

health consultants stressed that the supervisor was responsible. The supervisors did not neglect their responsibility; however, they pointed out that return-to-work issues were a small part of their work tasks. Moreover, there was a need for a better understanding of the relation between the workload and well-being of the workgroup in relation to the return-to-work process of the sick-listed worker.

(4) The occurrence of preparatory meetings in practice versus what was stated in the return-to-work policy. The supervisors and the occupational health consultants had no experience of the intended preparatory meetings; only the project coordinator had carried out these meetings. The meetings sometimes gave rise to thoughts and reflections at the workplace that needed to be followed up and discussed on several occasions. However, the project coordinator saw this as a supervisory responsibility to start a change process at the workplace, not as something that should be incorporated in the return-to-work programme.

Paper II

The objective was to explore how workplace actors experience social relations and how organisational dynamics in workplace-based return-to-work extend before and beyond the initial return of the sick-listed worker to the workplace.

In the analysis, three distinct phases of the return-to-work process were identified: while the worker is off work, when the worker returns to work, and when he/she is back at work during the phase of sustainability of work ability. During these phases the workplace actors seemed to play more or less prominent roles, and the findings identified the positive contribution of co-workers' efforts during each phase of the return-to-work process. However, in each phase there were uncertainties about how to proceed; this referred to the workplace actors being unsure about how, in day-to-day working life, they were expected to or able to carry out certain return-to-work practices such as accommodations, or early contact with the re-entering worker. The concepts of uncertainty and invisibility showed that the characteristics of the kinds of social relations that exist during the phases shift, and how the return-to-work policies were formulated (Table 2). The uncertainty stands out most strongly among co-workers in relation to the liminal period before the person returns (early contact) and the indistinct period following the time of return (sustainability). The co-workers seem to navigate informally through these situations by relying on their personal experience of sickness or relatives'/friends' experiences of sickness. They therefore tackle return-to-work issues in an unplanned manner by trying to do what is required to 'make it work' for themselves and the re-entering worker, such as by offering strategic support

or by re-organising schedules. This relatively unrecognised contribution by co-workers to the success of the return-to-work process is an important finding of this paper.

Figure 3 illustrates how organisational policy guidance, workplace social relations and social policy shift during the three phases. The analysis indicated that supervisors are guided by policies which cover the first two phases of return-to-work. However, the return-to-work policy does not cover the sustainability phase. The results of the study show that the supervisors “let go”, and it becomes more a matter for the co-workers and the re-entering worker to make day-to-day activities work. The co-workers helped out in day-to-day practice and made schedule adjustments to accommodate the re-entering worker, an effort which was not visible in the supervisors’ account of the return-to-work process. Co-workers describe the return-to-work process by beginning with a “brotherly” perspective when a colleague falls ill, then shifting to a helping hand to coordinate the return, and finally a “goodwill” relationship once the worker is back at the workplace. Co-workers were guided through the return-to-work process by their social responsibility and workplace loyalty rather than organisational return-to-work policies.

	OFF WORK	BACK TO WORK	SUSTAINABILITY
RTW POLICY	Policy guidance	Policy guidance	Lack of policy guidance
Supervisor	Responsibility	Responsibility	Letting go
SOCIAL RELATION Co-workers	Brotherly feeling	Helping hand	Goodwill
SOCIAL POLICY & NORMS	Social responsibility	Social responsibility	Workplace loyalty

Figure 3: The social organisation of return-to-work

Paper III

The objective was to explore the meaning of early contact in return-to-work, and how social relational actions and conditions can facilitate or impede early contact among workplace actors.

The analysis indicated that early contact is a complex return-to-work intervention with shifting incentives among workplace actors for making contact. Three critical issues were identified:

(1) Obligations and responsibilities as incentives. The organisational policies stressed the importance of early contact as primarily a supervisor's responsibility, which the supervisors conducted in accordance with policy. However, one supervisor questioned whether or not it was advisable for a workplace to have a preset plan for who should initiate the contact. Co-workers had experience of different incentives for early contact; either as a 'natural' and unplanned contact on the co-workers' own initiative, or as a planned action with a calling schedule amongst co-workers.

(2) Incentives through social relations. In several workgroups the co-workers kept in contact with the re-entering worker based on the closeness of their personal relationship, as in knowing each other on a more personal level. As described by a re-entering worker, she did not feel any special need to keep in contact with her co-workers during her absence because she did not have any close relationship with any co-worker.

(3) The need to acknowledge and balance individual needs in relation to early contact. The re-entering workers emphasised that a balance was needed in the social contact with the workplace during sick leave. Several re-entering workers emphasised the significance of having early contact with the workplace, with supervisors and co-workers. However, they saw a thin line between a feeling of being welcomed back and the draining of their own energy during the contact. The appropriateness of early contact seemed to depend on the re-entering worker's social situation. For instance, some co-workers visited the re-entering worker at home. This created a situation where goodwill from the workplace crossed over into the 'personal' space of the person's health management in their home and could cause infringement, mostly for the worker, who felt embarrassed when co-workers visited or made contact.

Paper IV

The objective was to explore the role of co-workers in the return-to-work process and their contribution to the process, starting from when a colleague falls ill, becomes sick-listed and finally re-enters the workgroup. The social interaction of co-workers and supervisors was analysed within the framework of the Swedish national and employer local organisational return-to-work policies, which set the stage for workplace approaches to return-to-work.

During the analysis three main themes emerged:

(1) Policies and organisational structure for the return-to-work process, which showed that although policies for return-to-work existed in each workgroup, they appeared to provide supervisors with little practical guidance in relation to how to manage the return-to-work process while considering the entire workgroup, and in relation to how to manage workgroup social relations during the process. Co-workers were barely mentioned in policy. They were mentioned only in relation to the supervisor's responsibility to encourage co-workers to make contact with the sick-listed worker during his/her sickness absence, and to be aware that workplace accommodations might affect them when the sick-listed worker returned to work.

(2) The category "social demands and expectations" suggested that social relational demands and expectations shifted in the workgroups when illness occurred, during sickness absence and when the re-entering worker was back at the workplace. Uncertainties and anxiety concerning the re-entering worker's work ability was also present among co-workers, which led them to question their own responsibility in the return-to-work process. Some workgroups showed a work-task-oriented approach to return-to-work, whilst others had a more social relational approach to the return-to-work process.

(3) Supervisory management of return-to-work explained that the presence (active) or absence (inactive) of a formal supervisor in the return-to-work process could have consequences related to social tension in the workgroup and the way the workgroup communicated. An absent or inactive supervisor in the return-to-work process resulted in an almost "letting-go" approach to the return, where there was no one in a formal position to mediate possible conflicts in the workgroup.

DISCUSSION

The main findings from Paper I show that discrepancies in the interpretations of policy intentions between key stakeholders (project coordinator, occupational health consultants and supervisors) created barriers for implementing the employer-based return-to-work programme due to lack of communication, support, coaching and training activities of key stakeholders dedicated to the biopsychosocial intentions of the programme. In Papers II-IV, the workplace actors (re-entering workers, co-workers, supervisors and/or human resources manager) experienced the return-to-work process as phases (time before the sick leave, when on sick leave, when re-entering the workplace, and future sustainability). The findings highlight the importance and relevance of the varied roles of the different workplace actors during the identified phases of the return-to-work process; in particular, the positive contribution of co-workers is acknowledged, and how the co-workers experience shifting demands and expectations during each phase. During the period of time before sick leave the main findings show how workplace actors experience the meaning of early contact within a social relational context, and how early contact is more than an activity that is merely carried out (or not carried out). The findings show how workplace actors experience uncertainties about how and when contact should take place, and the need to balance possible infringement that early contact might cause for the re-entering worker between a pressure to return to work and their private health management.

The discussion will elaborate how key stakeholders (in Paper I) and workplace actors (in Paper II-IV) have experienced, enacted and implemented interventions at the workplace during the return-to-work process and how their experiences relate to workplace social relations.

The role of the supervisor

In Papers II, III, and IV, it is argued that the workplace actors (re-entering worker, co-workers and supervisor/human resources manager) experience the return-to-work process as phases (time before sick leave, when on sick leave, when re-entering the workplace, and future sustainability), and every phase places shifting demands and expectations upon them. These results are supported by the results in Paper I, where a supervisor acknowledged and experienced that a return-to-work process influences the entire workgroup before, during and after the sick leave. These results challenge the

earlier research conducted, where workplace-based return-to-work interventions tend to focus on treatment and management of the re-entering worker's physical function (40, 42), and the relations between the re-entering worker and the supervisor or employer during the back-to-work phase when the worker re-enters the workplace (32, 37, 39, 96).

A review of qualitative research on return-to-work showed that because of the supervisors' daily closeness to the workers, and their daily social interaction and awareness of physical conditions, they play a significant role for successful return-to-work at the workplace (39). The supervisor can lend legitimacy to a re-entering worker's condition and restrictions concerning work ability, and contribute to smoothing the social relations at the workplace (36, 47, 56). However, several studies have shown supervisory obstacles for facilitating the return-to-work process (39), such as lacking skills and training for managing return-to-work (46), lack of time for managing the process (47), and, as shown in Paper I, if they regard the responsibility for return-to-work as an unwanted burden with conflicting priorities within the supervisory assignment. The four papers in this thesis confirm that the supervisor is an important actor at the workplace. In Paper IV, the findings suggest that whether the supervisor is present (active) or absent (inactive) in the return-to-work process could have consequences for social tensions in the workgroup and how communication proceeds in the workgroup. The presence of an active supervisor, who can distribute and prioritise among return-to-work activities and work tasks, promotes a conflict-avoiding strategy. However, the supervisors display some uncertainty about their expected role as a return-to-work facilitator, which creates consequences for the return-to-work process. This will be further discussed in the light of the identified phases of the process in Paper II.

The off-work phase

Early contact with the re-entering worker during the phase when he/she is off work is emphasised in earlier research (38), national policies (45, 50-51, 97) and the organisational policies for return-to-work studied in this thesis. The findings in Papers II and III show that supervisors experience early contact as part of their supervisory responsibility for the return-to-work process. They made early contact in accordance with the organisational policy; however, one supervisor questioned whether it was advisable for a workplace to have a pre-set strategy for who should initiate the contact. In some return-to-work processes the supervisor might not be best suited for making contact, since supervisors experience early contact as depending on the type of illness the re-entering worker has had, the closeness of relationship between the re-entering

worker and the supervisor, and the personality of the re-entering worker. Instead, co-workers were mentioned as facilitating contact, since they work most closely with the re-entering worker and have a more detailed understanding of what goes on at the workplace on a daily basis, in contrast to supervisors who do not always have daily proximity to their workers as stipulated in research (39). These findings are confirmed in another qualitative study regarding absence management and presenteeism, where the results show that not all supervisors or managers appreciated the formality and the rigidity of policies, since the interpretation of the policies did not allow for a sensitive and supportive approach towards the employee. This in turn could lead to a general workplace culture of not believing that employees are ill, with underlying problems such as employees attending work despite being sick, and experience of stress and anxiety over their health. In addition, the results showed that supervisors or managers had major concerns about how to handle absence (98). The results from Paper III show that supervisors, as well as re-entering workers and co-workers, experienced concerns about balancing and acknowledging individual needs in the return-to-work process. There was a thin line between feeling welcomed back at the workplace and still being accorded privacy for recovery. This balance is acknowledged in a qualitative study conducted to understand managers' and employees' beliefs and attitudes towards musculoskeletal pain disorders. The results show that the employees tended to view the contact as intrusive of their private health management, whereas the managers thought that the contact was essential for planning and maintaining productivity. However, the managers also acknowledged the difficulties of balancing good communication and providing support, while avoiding the pressure of getting employees back to work when they needed time to recover (99). Earlier studies show that management of the return-to-work process can be an unwelcome burden for supervisors and can have a negative effect on creating a shared sense of goodwill and trust (39).

The back-to-work phase

Workplace accommodations and communication between the workplace and other key stakeholders are important in the back-to-work phase, according to earlier research (26, 32, 52). In a recent Swedish study, it becomes apparent that the healthcare services and the Social Insurance Agency assess work ability and eligibility for sickness benefits without giving any consideration to the specific work task and without consulting the specific workplace (12). In a Canadian study, it is argued that if physicians do not make workplace visits then they cannot get a full understanding of the returning worker's work ability (73). In Paper I, the occupational health consultants stress the importance of tools for making workplace assessments to

facilitate the return-to-work process, not only for making work ability assessments of the re-entering worker. At the same time the supervisors stressed the need for workplace support during the return-to-work process; and also a need for a better understanding of the relation between the work tasks and well-being of the workgroup in relation to the return-to-work process. The occupational health consultants expressed a need for earlier contact with the supervisor in the process, since conducting workplace assessments of work ability was suggested to identify individual needs regarding accommodations for the re-entering worker, leading to more target interventions at the workplace. The assumption was that closer contact with the supervisor would facilitate the occupational health consultant's understanding of the supervisor's expectations of the worker and their estimation of what kind of workplace modifications might be possible. Workplace assessments might also shift focus from seeing the re-entering worker as the subject of accommodations, and instead view the workplace as an arena for accommodations. This in turn might prevent workplaces from offering inadequate accommodations to the returning worker (49). However, the results from Paper II show that communication with occupational health consultants did not always facilitate the process, due to a discrepancy in goals for how the return-to-work process should be managed. Although two supervisors appreciated the advice given by the occupational health consultants, there were discrepancies about whether suggested workplace accommodations for the individual could fit the practical realities of the workplace. These findings about how clinicians rarely communicate with the workplace and do not assess workplace concerns, as well as the fact that employers are unwilling or unable to make workplace accommodations, has been shown in earlier research (100-102). Conclusions drawn from a study conducted during a conference workshop between clinicians and researchers show that these challenges in the back-to-work phase need to link interventions focusing on the individual worker with interventions on an organisational level (103).

The sustainability phase

The findings in Papers II-IV show that even though there are organisational return-to-work policies to guide the supervisors in the return-to-work process, the policies do not cover issues concerning the sustainability phase at the workplace. The policy guidance ends when the re-entering worker has returned to work. The findings in Paper II show that the supervisors appear to leave the sustainability phase to the co-workers and the re-entering worker to handle. The supervisors rely on the co-workers' "goodwill" for accommodations, but this shift of responsibility of the return-to-work process was not managed as a visible, delegated responsibility. Amongst some of the workgroups there were concerns that there would be setbacks for the re-entering

worker. The informal way the supervisors manage the sustainability phase leads to feelings of uncertainty about how to collectively prevent setbacks in health, and the workplace actors waited for someone else to take charge, or for the re-entering worker to manage on their own. As shown in earlier research, communication at the workplace and between the healthcare provider and the workplace is needed to ensure that the realistic potential for sustainability at work after a re-entry is discussed (1, 59). A recent study has shown that a good relationship between the re-entering worker and the supervisor has the potential to facilitate return-to-work sustainability (104).

Thus, the supervisor's role in the return-to-work process has been acknowledged in several studies, and the findings in this thesis are confirmed by earlier studies. However, the findings in this thesis also acknowledge the contribution the co-workers have in the return-to-work process, which will be discussed further, suggesting that it is not only the supervisor who is a key facilitator in the return-to-work process.

The contribution of co-workers

Return-to-work research and policies have not acknowledged or discussed the role of co-workers in the return-to-work process to any extent. There is a limited amount of research about the role of co-workers, who are often described in negative terms as selfish workers who are more concerned about having to take on a heavier workload than being someone at the workplace who can actually increase the re-entering worker's work ability (46, 55, 105). Research concerning return-to-work coordinators, and their view on what competencies they think are important for managing a return-to-work process, shows that the ability to monitor co-worker responses to returning workers is ranked as one of the lowest competencies needed (106). One reason that the co-worker role has been overlooked, and to some extent misunderstood, might be that return-to-work research and developing models have not considered social relations at the workplace in the return-to-work process, as return-to-work has not been considered an evolving process for *all* workplace actors involved. It is important to acknowledge that co-workers are not only affected and involved in the return-to-work process, when it is a question of re-entry to the workplace and undertaking workplace accommodations, which is stipulated in research (39). The findings in this thesis about co-workers' contributions in the return-to-work process will be further discussed in the light of the identified phases of the process in Paper II.

The off-work phase

As mentioned earlier, research and national policies emphasise early return-to-work as a facilitator for decreasing time away from work for the re-entering worker. However, early return-to-work seems to create a static view of the re-entering worker (43), and also, as seen in Papers II-IV, uncertainty and anxiety for the workgroup of how to encounter the re-entering worker. In the early phase of sick leave the re-entering worker may be more concerned about having access to medical treatment than having contact with the workplace (1). Results in Paper III show that social contact between co-workers and the re-entering worker is not only a question of contact or no contact; it is also important to consider how to make the re-entering worker feel valued, and at the same time balance the boundaries for work and personal space. This issue of balancing is also discussed as part of the supervisory role (99). A recent qualitative study about social support shows that re-entering workers appreciate emotional support from co-workers, as in demonstrating caring, interest, encouragement and trust (56). However, the findings in Paper III show that co-workers sometimes felt uncomfortable and uncertain about the appropriateness of the early contact, especially if the early contact was regulated by a schedule or a set workplace agreement. Instead, the findings show that co-workers had different incentives for making contact and felt that those at the workplace who already had a social relation with the re-entering worker should make the contact. This is an example of how workplace actors are governed by social relations at the workplace, and these relations cannot be reduced by policies or return-to-work models as routine acts that are performed or not. Sickness absence changes the roles of co-workers, which means that the function of the workgroup also needs to be considered.

The back-to-work phase

A cross-country comparative study shows that workplace-based interventions are absent in Swedish workplaces, with the exception of workplace training (33). The results in Papers II, III and IV show that co-workers put in a lot of effort and do a great deal “behind the scenes”, to facilitate the return-to-work process in the back-to-work phase, and these efforts are not always noticed by supervisors. Throughout the return-to-work process, co-workers take on a social responsibility, and daily social interaction, with the re-entering worker, especially in the back-to-work phase when they puzzle out schedules and work tasks for the re-entering worker and themselves in order to make the day-to-day activities work. The co-workers’ actions to manage day-to-day activities are carried out *without* any formal policy or assistance from the

supervisor. In some workgroups the supervisors “let go” of their responsibility for return-to-work, and the co-workers are the ones who facilitate the return-to-work process. In the back-to-work phase, the idea that work-task accommodation can erase the impact and presence of the disability does not acknowledge the social and psychological impact the return-to-work process has on workplace relations. This is especially true in situations when the re-entering worker is not fully recovered. Other studies have shown that workplace norms of equally sharing the workload, i.e. requiring full ability to function professionally, lead to both supervisor and co-workers discouraging workers from returning before they are fully able to resume their work tasks (43, 49).

A recent study also show that re-entering workers have feelings of guilt about the impact of their absence on co-workers, especially if they have re-entered the workplace but are unable to perform their work tasks to the full (99). Previous research studies have shown that re-entering workers have often experienced a change in body and mind function that affects their way of managing their work tasks and relations to their co-workers (72), and also the sustainability of their work ability (1, 59). Re-entering workers cannot be viewed as individuals who simply re-enter after a time away from work and are expected to “pick up where they left off” (72). In Paper IV, the results show that during the return-to-work process the co-workers struggle to balance their expectations of the re-entering worker to function socially and professionally. However, the novel finding in this thesis suggests that co-worker expectations about how re-entering workers will manage their work tasks and social interactions at the workplace could lead to either a poor or good acceptance of returning workers’ needs for personal space to re-enter the social sphere at the workplace and time to resume their work ability, which affects the workgroup’s motivation to make efforts to facilitate the re-entry. A recent study about motivational factors for returning to work proposes that motivation should not solely be regarded in relation to the re-entering worker; rather, motivation is something that reflects the relationship between workplace actors. If return-to-work motivation is viewed from a workgroup level, this promotes an inclusion of the social context of which the re-entering worker is a part, and it may prevent workgroup discouragement if the re-entering worker cannot perform socially and professionally as expected (60). Thus, the findings in Paper IV show that workplace social relations go hand-in-hand with work tasks and the social context of the workplace (how tasks are allocated and how returning workers are supported by others), which could ‘make or break’ the return-to-work situation.

The sustainability phase

What is important, however, is to acknowledge that the “goodwill” of co-worker efforts cannot go on for an extended period of time. How long the “goodwill” can continue, and how much agency the members of the workgroup have in making accommodations for managing day-to-day activities, might also be crucial for the sustainability of the re-entering worker’s work ability. The findings in Paper II show that co-workers had concerns about how the sustainability phase was managed by the supervisors. Lack of communication and planning for the re-entering worker’s sustainability made the co-workers uncertain about how to handle a situation where it was obvious that a re-entering worker could not manage the work tasks or social interactions in the same way as before the sick leave. Thus, the informal accommodations made by co-workers and their sense of “goodwill” can lose impact if they are not acknowledged and discussed with the supervisor and within the workgroup. As noted earlier, recent research shows that re-entering workers emphasise the significance of support from co-workers to enable them to stay at work (69). However, no studies have been conducted to date where workplace-based interventions are performed with the notion that support is needed after the initial re-entry to the workplace if recurrence of sick leave is to be prevented (107).

To date, workplace-based interventions for facilitating the return-to-work process have focused on changing the re-entering worker, not the work environment (40-42). Based on the findings in this thesis, it is clear that the return-to-work process is more than the performance of physical tasks. Re-entry to the workplace also concerns who is performing the work task, social relations involved with co-workers performing the work task, and the notion that work arrangements are critical for all workers. Thus, the process of return-to-work is not only a problem-solving process between the supervisor and the re-entering worker. The findings in this thesis identify co-workers as playing an important part in the return-to-work process, and identify the positive contributions of co-workers in the return-to-work process, as well as the importance of acknowledging that their roles and expectations in the return-to-work process change during the progression of the return-to-work process.

The dynamics of the return-to-work process

From the results of this thesis we argue that workplace interventions should be designed and implemented in relation to different phases in a return-to-work process, as well as in relation to specific workplace relations and work tasks. In order to

implement social interventions at the workplace, it is essential to acknowledge that the return-to-work process is a dynamic progression with temporal phases, and further investigate how the return-to-work process affects co-workers, supervisors and the re-entering worker. Previous studies have shown that the social context matters (28, 39, 46, 49, 74), and that work-related factors such as relationships at the workplace and degree of control over work tasks are important when the re-entering worker decides whether to return to work or not (108-109). Further attention is needed to the broader complexities related to work organisation and the beliefs and roles of a myriad of workplace actors. Successful outcomes will require active planning and sensitivity to the complexity of the process at the workplace (39).

Based on the findings from the four papers in this thesis, we argue that the biopsychosocial model, the ecological/case management model (the Sherbrooke model) for return-to-work (17) and the organisational policies studied in this thesis are too static, since they do not address the changes in roles, needs, and efforts of different workplace actors over a time span in the return-to-work process. Indeed, the biopsychosocial model and the Sherbrooke model have contributed to a more comprehensive understanding of the return-to-work process and have integrated the biomedical and social perspective of disability and return-to-work. However, the two models need further development when it comes to understanding the relation between the re-entering worker and the workplace, especially how workplace social relations are played out in the return-to-work process. Research has argued that it is difficult to implement return-to-work interventions, since the recommendations made in research are seldom precise and not always for immediate use (26). This notion is supported by the findings in Paper I, where an employer implemented a return-to-work programme based on research findings from the return-to-work literature. The aim of the programme was to implement a biopsychosocial approach to the return-to-work process, but instead the findings showed that a biomedical approach came to dominate the process due to discrepancies in the interpretations of policy intentions between key stakeholders (project coordinator, occupational health consultants and supervisors). These discrepancies created barriers for implementation due to lack of communication, support, coaching and training activities of key stakeholders dedicated to the biopsychosocial intentions of the programme. Thus, the findings in Paper I show failures in the implementation process of the programme, but also how difficult it can be to implement research findings into organisations. One explanation is that the suggested biopsychosocial model and the Sherbrooke model lack guidance to key stakeholders of how workplace interventions can facilitate the return-to-work process, and how the identified multi-determinants and stakeholders interact in the process, especially when it comes to the social context and social relationships. Another explanation could be that research studies build on results that focus on return-to-work

at a single point in time. If the return-to-work process is viewed as a trajectory over time and the course is followed over an extended period, this could facilitate an understanding of how the return-to-work process evolves over time (1, 39, 54). One study which describes and shows how the return-to-work models have evolved in research has pointed to the need to specify the social context and social relationships in the return-to-work process in order to improve systematic validation within the field of return-to-work research (17). This thesis, along with emerging findings from other research studies (28, 49, 56, 69, 72, 74, 99, 104, 109), is a starting point for understanding the impact of the social context and social relations at the workplace.

Through studying social relations and interactions in workgroups, the findings in this thesis suggest that the workplace is not a static environment with fixed roles for each worker. Social relations and interaction evolves during the return-to-work process. This notion of dynamic change over time poses conceptual complications to the prominent static models of return-to-work. The purpose and meaning of return-to-work in the workgroup varies, depending on the interest and motivation of the individual worker, and for making day-to-day activities and production work. Thus, the way in which a return-to-work process influences social relations in the workgroup varies, depending on the individuals involved, the quality of the social relations, the type of work and work organisation, and management strategies (110). The findings in this thesis call for dynamic return-to-work models that view the return-to-work process over time, and where consideration is given to social contextual prerequisites due to different national-, organisational- and workgroup contexts.

Conclusions and Implications

The findings in this thesis show how the workplace is a socially complex dynamic setting, which challenges some static models of return-to-work. Biopsychosocial and ecological/case management models and policies for return-to-work have been criticised for neglecting social relations in a return-to-work process at the workplace. This thesis provides increased knowledge and explanations of important factors in workplace social relations that facilitate an understanding of what might “make or break” the return-to-work process. The main conclusions that can be drawn from the four papers are that:

- ✓ The implementation of a return-to-work programme in an organisation is an on-going, long-term multi-level strategy, requiring time for reflection, stakeholder participation, openness to change of intervention activities, and continuous

communication where the key stakeholders need a common understanding of what the intentions, or goal, of the return-to-work programme are.

- ✓ The importance and relevance of the varied roles different workplace actors play during the process of return-to-work, especially during the two relatively unseen phases of the process: the off-work phase and the sustainability phase. Attention to the invisibility of return-to-work efforts of some workplace actors, and uncertainty about how and when return-to-work should be enacted between workplace actors can promote successful and sustainable work ability for the re-entering worker.
- ✓ Early contact should be viewed as a concept and intervention with a social relational context that comprises more than just an activity that is carried out or not by the employer. Attention is needed to consider the social relational balance and the uncertainty workplace actors experience as they attempt to make appropriate contact.
- ✓ Employers and workplaces should consider re-integration of re-entering workers in the light of workgroup social relations, and acknowledge social interaction and the heterogeneous experiences of returning workers, supervisors and co-workers.

It is argued that the increased understanding of how workplace social relations are played out at the workplace during a return-to-work process presented in this thesis improve implementation of workplace-based interventions, and contribute to more sensitive and sophisticated return-to-work policies and models. Implications for employers and organisational return-to-work policies can be drawn from the conclusions:

- ✓ Policies for the return-to-work process need to take into account the social relations amongst workplace actors, especially involving co-workers, in policies, when planning for return-to-work and in interventions used for facilitating the return-to-work process. Otherwise the proper attention to work arrangements, social communication and the role of co-workers in the return-to-work process might not be seen.
- ✓ Policies for the return-to-work process need to take into account the time aspects of the return-to-work process, in order to design and implement interventions that relate to the specific phases of the process, and to the social relations and work tasks at the workplace. Increased acknowledgement is

needed in the post-re-entry phase to prevent a “letting go” perspective of sustainable work ability and not leave the responsibility to “make it work” solely to the co-workers.

One main implication for further research can be drawn from the conclusions:

- ✓ Return-to-work research needs to increase understanding of social relations at the workplace in the return-to-work process for facilitating further development of existing models and workplace interventions. The findings in this thesis are seen as a starting point, where social relations at the workplace are highlighted as a necessary complement to the existing return-to-work models. Focusing on the workplace instead of solely on the individual helps elucidate the social part of the biopsychosocial and ecological/case management models.

Methodological considerations

The strengths of this thesis include the different types of data used (document review, individual interviews and group interviews), and multiple data sources through the accounts of different types of participants (occupational health consultants, project coordinator and supervisors in Paper I, and re-entering worker, co-workers and supervisors and/or human resources manager in Papers II-IV). The purposive sampling process ensured that key stakeholders and workplace actors were recruited from a range of professions and workplaces. The strengths of the sampling process in Papers II-IV were that single return-to-work processes were in focus across several workgroups. The strength of using interviews as a data-collection method is that it allows participants to use their own concepts when explaining situations.

The analysis followed systematic procedures for back-and forth data collection and analysis with an experienced team of qualitative and quantitative researchers. The emerging findings, and the manuscripts of all included studies in the thesis, have been discussed among the co-authors as continuous quality checks. Strengths of the analytical process were provided through the authors’ multi-disciplinary perspectives (public health, psychology, pedagogy, and sociology), different methodological perspectives (qualitative and quantitative), as well as different jurisdictional perspectives (Sweden and Canada). Throughout the studies the analysis has been analysed within the framework of organisational return-to-work policies (Papers II-IV) and an implementation framework (Paper I). The frameworks have provided a deeper

understanding of the findings by using them as discussion tools during the process of analysis.

The findings and conclusions drawn in this thesis are limited by their relation to the context of a specific occupational sector, the public sector, and to a specific workplace-based return-to-work programme. Other occupational sectors might handle the return-to-work process and the social relations at the workplace in different ways. Qualitative studies aim for transferability rather than statistical generalisation. The findings in this thesis offer a starting point for further quantitative research designs and analyses.

The research questions in this thesis were partly driven by a request from an employer, partly by the research findings emerging from the “research field of interest”, i.e. Paper I gave rise to research questions that were studied in Papers II-IV. Regarding pragmatic validity of the research design and findings (85), the emerging findings of both studies have been communicated to the employers involved.

The studies were conducted in Sweden and it is possible that workplace social relations in return-to-work are a cultural phenomenon. In studies of workplaces in other jurisdictions the findings might not be the same; for instance, the positive contribution and prominent role of co-workers in return-to-work, as found in this thesis. However, when it comes to application across jurisdictions, the findings play an important part in highlighting the need to consider social relations in workplace-based return-to-work.

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