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# Factors of importance for return to work, experienced by patients with chronic pain that have completed a multimodal rehabilitation program – a focus group study

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**ABSTRACT**

**Background and purpose:** To reduce the individual, societal, and economic burden of the high sick leave rates due to chronic pain, it is essential to find effective strategies for increasing return to work (RTW). Although multimodal rehabilitation programs (MMRPs) may have positive effects on RTW, the results are inconsistent. This study explores the factors that contribute to decreasing sick leave and increasing RTW in patients with chronic pain who completed a MMRP.

**Method:** Four focus groups and three individual interviews were conducted. In total, 18 patients were interviewed. All patients had chronic pain and had completed a MMRP. They were either employed or unemployed, either working to some degree or fully on sick leave. The data were analysed using qualitative content analysis.

**Results:** Three main categories were identified: Knowledge and understanding–prerequisites for tailored solutions; Individual adaptations–necessary but difficult to implement; and Stakeholder collaboration–-needs improvement.

**Conclusion:** The participants described a variety of facilitating and limiting factors that created complex prerequisites for RTW. This finding makes it clear that these patients need tailored interventions and strong collaboration among all stakeholders throughout the rehabilitation process. Tailored interventions and collaborations could improve the effectiveness of MMRPs.

**➤ IMPLICATIONS FOR REHABILITATION**

- Patients with chronic pain need tailored solutions and adaptations based on their individual needs in the RTW rehabilitation process.
- To return to work, patients with chronic pain needs support to strengthen their selfconfidence and to be prepared with knowledge and strategies about their abilities and their rights and obligations in relation to the labour market.
- A well-designed and communicated RTW rehabilitation plan supports the patient in the RTW rehabilitation process.
- To improve the possibility for employees and employers to create a sustainable work situation, stakeholder reconciliation meetings should be held routinely over time to strengthen the transfer of knowledge and collaboration.

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Chronic pain; return to work; rehabilitation; qualitative method

## Introduction

Chronic non-cancer musculoskeletal pain is a major burden for individuals and societies around the world as it has a prevalence of 16–18% in the general population [1,2]. Moderate to severe chronic pain can negatively impact mental health, quality of life, social functioning, the ability to work, and performance of meaningful activities [3]. Furthermore, patients with chronic pain report that limitations of activities interfere with work [4]. In Sweden, chronic pain is the second most common reason for long-term sickness absence, representing about 25% of the total sick leave in the country [5]. Similar patterns for long-term sick leave due to chronic pain have been seen in other European countries [6]. To reduce the individual, societal, and economic burden of the high sick leave rates and the low employment rates due to chronic pain, it is essential to find effective strategies for return to work (RTW) [7]. In Sweden, many stakeholders are involved in the RTW rehabilitation process for patients with chronic pain. The Swedish Social Insurance Agency (SSIA) is responsible for the social insurance, including assessing who receives sick leave benefits. Sick leave benefits may be granted at 25, 50, 75, or 100% of full work ability. For day 1–14, the employer pays the sickness benefit. From day 15, the patient's right to continue to be granted sickness benefit is assessed by SSIA–for day 15–90 in relation to the patient's current work task; for day 90–180 in relation to all work

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This article has been corrected with minor changes. These changes do not impact the academic content of the article.

tasks that may be offered by the employer; and from day 181 in relation to any work task in the employment market. The SSIA also assesses the need of RTW interventions and coordinates the RTW rehabilitation process with other stakeholders. The employers have a work rehabilitation responsibility that includes adapting the workplace and the work tasks to the employee's limitations. Many employers have an agreement with occupational health care (OHC) to seek support for their rehabilitation responsibilities. For unemployed patients or patients who may not return to their previous work, the Swedish Public Employment Service (SPES) assesses the patient's work ability and helps the patient find new work. The health care system is responsible for medical rehabilitation such as Multimodal Rehabilitation Programs. In primary care, Rehabilitation Coordinators (RC) coordinate interventions for patients with sickness absence [8].

Many rehabilitation strategies have been used to help patients with chronic pain return to work: graded sickness-absence certificates, early ergonomic interventions, disability evaluation followed by information and advice, and coordinated and tailored RTW interventions [9]. Moreover, workplace interventions are more effective for improving RTW than interventions performed outside the workplace [10,11].

World-wide, patients with chronic pain conditions are offered Multimodal Rehabilitation Programs (MMRPs), evidence-based multidisciplinary biopsychosocial rehabilitation programs. MMRPs involve physical components, one or more psychological components, and social/work targeted components delivered by clinicians with different professional backgrounds [12]. During the last decade, the Swedish government has invested in MMRPs to strengthen rehabilitation aimed at RTW for patients with chronic pain. Indicators concerning who could benefit from this intervention and should be included have been identified [13]. Although MMRPs have been shown to reduce pain and disability, the effects of RTW are inconsistent and it seems unclear to what extent work interventions in general are included in MMRPs [12]. Hellman et al. [14] report that clinicians working with MMRPs believe rehabilitation programs are the foundation for a continuous RTW process, which continues after the MMRPs. Furthermore, the clinicians emphasised the importance of creating a coherent link with external factors such as different stakeholders (e.g., SSIA and SPES) in the RTW process. This type of collaboration should support chronic pain patients' RTW after completing MMRPs [14]. Additionally, employers need to take a more active part in the work rehabilitation process of their employees suffering from chronic pain [15]. In an interview study of employers and employees, Wynne-Jones et al. [15] highlighted the importance of a good employee-employer relationship. For example, both the quality and quantity of contact were important for employees on sick leave as well as the managers' support of their employees through the use of organisational policies. These factors were key issues for facilitating a RTW. Therefore, strategies should encourage communication and trust to help create an environment conducive to successful RTW. Furthermore, according to de Vries et al. [16], support from others, including employers and colleagues, is an important factor for staying at work. A large majority of the participants mentioned adjustment latitude as a powerful factor for success. Adjustment latitude was associated with support from colleagues and managers in modifying work and work responsibilities.

Today, evidence-based MMRPs might serve as a foundation for RTW and it seems important to offer work interventions for patients with chronic pain [9,14]. However, more specific knowledge is needed about effective components in the RTW rehabilitation process and how to plan and implement these interventions to increase the RTW. From both a patient and employer perspective, Jakobsen and Lillefjell [17] explored the experiences of returning to work for working patients with chronic pain after completed a rehabilitation program. They focused on promoting factors for employed patients, not unemployed patients. Factors the patients experienced as promoting a successful RTW were mobilising personal resources, balancing daily life, partaking in good dialogue, and receiving social support. Factors raised by the employers were managing expectations, adjusting work conditions, and being involved in the RTW process [17].

Recently, the health care system in Sweden has been expected to focus on work interventions to help patients on sick-leave return to work [18]. To improve interventions to increase RTW for patients with chronic pain, the patients may contribute with their own experiences of important factors when planning and implementing interventions to promote RTW. Here, we explore important factors that decrease sick-leave and increase RTW for both employed and unemployed patients with chronic pain who have completed a MMRP.

This study was approved by the local ethics committee (Dnr. 2016/184-31) and all procedures followed the Helsinki protocol [19]. Participants provided written consent and were informed that they could withdraw participation in the study at any time.

## Method

Focus group discussions with a structured interview guide were used to gather perceptions, experiences, and attitudes about decreased sick-leave and increased RTW from patients who had participated in a MMRP. The discussions aimed to help identify similarities and differences among the participants as well as allowed for a dynamic interaction and synergy among the participants [20]. The focus groups were conducted between October 2017 and June 2018.

### *Participants*

Participants, recruited from two pain rehabilitation clinics in south-eastern Sweden, were identified using the Swedish Quality Register for Pain Rehabilitation (SQRP) [21], a national registry established in 1998. The SQRP, a collection of data and health-related information from patients, can be used for follow-up studies, for comparing outcome studies, and for clinical practice. About 90% of the Swedish specialised pain rehabilitation units contribute to the SQRP and all patients who visit one of these units are asked to participate in the registry and complete questionnaires.

This study uses the following inclusion criteria: chronic pain; inclusion in the SQRP; between 18 and 64 years old (working age in Sweden); and completion of MMRP2 within specialist care (in Sweden labelled MMRP2 as MMRP1 is in the primary care) between 2014 and 2016 (i.e., 2–4 years before the focus groups). During this period, the content of the MMRPs within each pain rehabilitation clinic remained the same, so the participants probably had similar experiences with the MMRPs. The MMRPs at the two pain rehabilitations clinics were similar regarding their physical training and cognitive behavioural therapy. However, the MMRPs had some differences as the amount of work interventions varied and the length of the programs varied between six and ten weeks.

Participants were selected purposively [22] to ensure different work situations and sick-leave status were represented. Therefore, at the beginning of the MMRP, the patients were on full-time

**Table 1.** Overview of characteristics of participants in focus groups and individual interviews.

| | In total | FG I | FG II | FG III | FG IV | FG V | FG VI | II |
|---|---|---|---|---|---|---|---|---|
| Participants (*n*) | 18 | 5 | 3 | 0 | 2 | 5 | 1 | 2 |
| Women (*n*) | 13 | 3 | 1 | – | 1 | 5 | 1 | 2 |
| Men (*n*) | 5 | 2 | 2 | – | 1 | 0 | 0 | 0 |
| Age, *m* | 43 | 42 | 38 | – | 40 | 48[a] | 52 | 43 |
| (range) | (27–60) | (27–60) | (29–46) | | (39–41) | (44–57) | | (31–54) |
| Pain NRS, *m* (range) | | 6.8 | 7.3 | | 6.5 | 7 | 9 | 7(6–8) |
| | | (5–8) | (6–9) | | (6–7) | (5–9) | | |
| Pain duration days, *m* | | 3061 | 1025[a] | | 1045 | 2337 | [a] | 1471[a] |
| (range) | | (217–8268) | (457–1593) | | (710–1379) | (230–8958) | | |
| Pain locations, m | | 9 | 17 | | 4 | 20 | 26 | 7 |
| (range) | | (2–28) | (6–32) | | (2–6) | (8–34) | | (5–9) |
| Employed (*n*) | 13 | 4 | 2 | – | 1 | 3 | 1 | 2 |
| Unemployed (*n*) | 5 | 1 | 1 | – | 1 | 2 | 0 | 0 |
| Refunds (*n*) | 10 | 1 | 2 | 4 | 3 | 0 | 0 | 0 |
| Missing (*n*) | 11 | 0 | 2 | 3 | 1 | 1 | 4 | 0 |

FG: focus group; II: individual interview *n*: number of; *m*: average value; NRS: numeric rating scale. [a]One internal missing.

sick-leave, part-time sick-leave, or working full-time and were either employed or unemployed. In addition, participants were recruited so different ages, genders, and cultural backgrounds were represented.

A letter with information about the study was sent to 81 former patients from two pain rehabilitation clinics and one week later the first author telephoned the patients to confirm participation in the study. A total drop-out of about 50% was expected. At the telephone request, 37 patients agreed to participate; these patients were assigned to one of six focus groups. Due to late cancellations, only four focus groups (a total of 16 participants) were formed. Reasons for cancellations were chronic pain symptoms, work activities, and snowy weather making driving difficult. Each focus group included two to six participants and lasted approximately 1.5 h. One of the planned focus groups (FG VI; Table 1) was turned into an individual interview as the other four group participants dropped out. Two more individuals were interviewed to complete the data as these interviews provided more experiences from patients who had returned to work at the time of the interview.

In total, 13 women and five men (mean age 43) were interviewed. When the patients began their MMRP, they reported their pain to the SQRP. Pain intensity ranged from 5 to 9 and number of pain locations ranged from 2 to 34. Thirteen participants were employed and five participants were unemployed (Table 1).

### *Data collection*

The discussion began with an open-ended question: What did you think was valuable in the MMRP regarding decreased sick leave and return to work? That is, we used a funnel-based strategy [23]. A funnel-based strategy encourages free discussion at the beginning of each focus group and addresses the accomplished MMRP as a shared experience. An interview guide was prepared in advance to provide structure to the group discussions and to elicit different and shared experiences of participants regarding their RTW rehabilitation process. The authors formulated the questions in the interview guide in collaboration with a patient research partner–a representative from the Swedish Rheumatology Association. The interview guide comprised two themes: factors related to the MMRP that contributed to the decrease of sick leave and RTW and factors related to how stakeholders collaborated during the RTW rehabilitation process. Each theme was addressed with specific questions to provide a deeper understanding of the participants' situations and provide the opportunity to receive unanticipated answers. The formulation of the questions and when they were posed varied depending on how the discussion developed in the interviews. Two of the authors (FS and GML), one serving as the moderator, conducted the focus groups. The same interview guide was used in the individual interviews, although the interviewer had a more active role and asked more follow-up questions. The interview guide was used as a checklist at the end of the interview to guarantee that the themes had been discussed.

The focus group interviews were conducted at the hospitals where the involved pain rehabilitation clinics were located. At the beginning of the interviews, the participants sat at a round table but were told they could move and change positions as their pain conditions required. One individual interview took place at the patient's home and one at a pain rehabilitation clinic. Before starting the interview, the participants were given a written informed consent document to read and sign. The participants were also asked to provide demographic data and information about their former and present work status.

### *Analysis*

One interview was transcribed verbatim by the first author (FS) and the rest by a skilled secretary. Each transcription was read through and checked against the tape by GML and FS.

Qualitative content analysis [24] with an inductive approach [22] was used to analyse the interviews. The analysis was conducted in four steps. First, the transcribed text was read through several times to form a general impression. Second, each interview was read and meaning units–i.e., chunks of text with similar content–were identified. These meaning units, condensed and coded at the same time, consisted of one to a few words and were labelled with the participants' own words or similar words. Third, the codes were sorted into subcategories. The researchers discussed and compared the subcategories to ensure the accuracy of the similarities within and differences between the content of the subcategories. In this part of the analysis, several subcategories were condensed. Fourth, the subcategories were abstracted into categories. To facilitate the coding process in step two and step three, OpenCode 4.0 Umeå software [25] was used. The transcribed text files were transferred to OpenCode, where the coding process took place. When the material had been coded and categorised, the complete interviews were reread to verify the findings.

The analysis process was conducted by two of the authors (FS and GML), who frequently consulted the other authors (MB and ML) regarding excerpts of the primary transcript data and the

clustering of the data into subcategories and categories. To increase the trustworthiness of the analysis, a patient research partner from the Swedish Rheumatism Association participated in the preparation of the interview guide and was involved in the identification of preliminary categories. In the Results section, quotations are used so the reader can evaluate the results, and the speakers are identified as either from the focus groups (e.g., FG1) or the individual interviews (e.g., II1). In addition, brackets are used to make implicit words explicit in a quotation.

## Results

The analysis revealed three categories: Knowledge and understanding–prerequisites for tailored solutions; Individual adaptations–necessary but difficult to implement; and Stakeholder collaboration–needs improvements. All three categories suggest a need for more tailored solutions and interventions throughout the RTW rehabilitation process.

### *Knowledge and understanding–prerequisites for tailored solutions*

The participants described that mental status, motivation, and a feeling of being prepared influenced the possibility to RTW. In addition, the participants noted that the MMRP introduced them to several facilitating factors for RTW–e.g., new insights into their own abilities, finding acceptance for what is possible, learning to know one's capacities in different ways, and learning new strategies to alter and adapt one's activity performance:

> At first, you are so focused on the fact that the pain is the big problem, but then … it is the family, it is the finances, it is the psyche, it can be social life at home, in other words lots of things like that you tackle … so I think that if I only had the pain under better control, then there was still a lot left to work on before returning to work. So I think it is great that they [rehabilitation personnel in MMRP] take everything [the total life situation] into account and don't just focus on the pain, because then I don't think … certainly, I might have gone to work but probably hadn't been that ready for it. (FG4, 41 year-old woman)

Furthermore, the participants emphasised other significant factors such as feeling secure and having self-confidence (e.g., reaching a sense of security in one's knowledge of obligations and rights with respect to the labour market):

> It feels like they [SSIA, employers, SPES, and rehabilitation personnel] retain information so that you can't … that is, there are some things that you have to find out yourself … to gain a little more insight on what your rights and obligations are from all authorities, from the primary care centre, the employers, and the SSIA. So that you can avoid this anxiety and these demands. You don't know where to go in the end. I think it would be useful to have a little more information. You are terribly lost sometimes when you stand there [in that situation]. (FG2, 39 year-old man)

> Yes, and sometimes you think like this: Do I need to sit quietly here [all by myself] and read the Occupational Safety and Health Act? What is required? (FG2, 29 year-old woman)

The participants found that their ability to RTW improved when they met competent and knowledgeable professionals who had the ability to perceive and meet their needs. However, the participants often experienced that stakeholders lacked knowledge about chronic pain and rehabilitation, so they suggested that there needs to be better information and knowledge transfer from the pain rehabilitation clinic to these stakeholders. In addition, there were proposals to include the SSIA, the SPES, and the RC during the MMRP. In addition, the participants wanted more involvement from their employers. The stakeholders' involvement during the MMRP was mentioned as a way to strengthen their knowledge about pain conditions and improve their understanding of the participants' prerequisites for RTW after MMRP.

> There were many [patients in the MMRP group] who had a lot of problems with the SSIA. There were many discussions with the officers at the SSIA. Many hassles and changes in officers and … that part should probably be looked at, too … because they pull the rug out from under you so terribly much, and you need help just in dealing with the SSIA … it probably would have been good if they had been here [personnel from MMRP], if they were invited or maybe if there could be some collaboration with the SSIA in this course [MMRP] … maybe that the officers come here and meet us in these groups … have come in and listened and checked off and also received our opinion and rehab's opinion of what's important to bear in mind. (II1, 52 year-old woman)

In general, adequate attitudes and actions from involved stakeholders facilitated the RTW rehabilitation process–e.g., advocating for patients, listening and mediating understanding and support, and encouraging the patient's will power and self-perception.

> It is extremely important that you get good … , have good people around you who provide support, are knowledgeable and dare to act [sometimes with flexibility to the regulations]on behalf of the person they are helping or are going to support. (II1, 52 year-old woman)

Throughout the RTW rehabilitation process, the participants found that their managers' and colleagues' attitudes influenced their ability to stay working or RTW. The participants regarded the existing culture at the workplace–i.e., open attitudes regarding health problems and sick leave issues as well as adequate knowledge and understanding from managers–as factors that helped them stay at work or RTW.

> … but if the employer is not understanding, then things won't work out especially well anyway. Rather, it is the culture in the workplace … nobody, yes nobody looks at me differently because I am in pain, it is not a big thing at all. And I think it is extremely important that you are not placed in some pigeonhole … if the job I have today disappears, I do not feel at all sure that I would be able to perform at 100% in another workplace because many [employers] do not know what type of adaptation is needed. (II3, 31 year-old woman)

### *Individual adaptations–necessary but difficult to implement*

Limitations in performing daily activities restricted the participant's efforts to go back to paid work. The participants noted that it was difficult to adapt activities and to moderate performance to their own conditions, both at home and at work. For example, work tasks could be managed during working time, but after work they experienced more pain and needed time for recovery. It seemed important to set realistic goals and learn one's own boundaries to be able to work and reach an activity balance. In an individual interview, one participant described her boundaries and need to adapt her activities:

> I have to work a lot on finding my way … and also being able to tell that to people around me … no, now we have to stop here [in performing the activity]. I am stopping here now without needing to get into a discussion with maybe a colleague or … except then I have tried, and I feel that no, now this won't do. (II1, 52 year-old woman)

Several attempts to RTW before MMRP were described, and to fail to RTW was perceived as a limiting factor. The participants then raised questions concerning relevant amount of work and working hours, suitability of the work, whether other more appropriate work tasks were available, and the possibility to exclude inappropriate work tasks. These questions were described as worrying but could also serve as an eye opener and lead to actions:

> … for the first time [since the beginning of the personal RTW rehabilitation process], I'm saying that I do not want to work where I have tried to; the job that I have tried to come back to for several years is not made for me. I will not do this. And having said that to myself, it was then that the penny dropped. If anyone else had said it, then I would have just said, no, I will, I will. (II3, 31 year-old woman)

For the unemployed patients, questions about what kind of work might be appropriate and can be managed were central. Moreover, they found it difficult to identify concrete goals and interventions when not knowing what work or employment to return to. During the MMRPs, the participants wanted opportunities to discuss suitable jobs in relation to their specific pain condition and situation:

> Then there should be an officer from the SPES who could take part and who knows the labour market and someone who knows about pain. Being able to match them up. Work adapted to the individual. (FG1, P4 27 year-old man)

> Since I think I still should undergo retraining for something, I would of course still want to know that I was making the right investment. That this would actually be something worthwhile to work on. (FG1, P3 36 year-old woman)

The participants described feelings such as sadness and guilt because of their inability to work and inadequacy because of their inability to satisfy the demands of their families, themselves, and stakeholders. There were many demands, often perceived as unreasonable, from physicians, employers, and the SSIA. For example, some participants believed their limitations were not regarded as adequate and therefore not respected. Sometimes, the demands at work were experienced as unreasonable; in some cases, this led to a need to change work tasks and even the need for a more adapted workplace. SSIA's demand to work a certain number of hours was often experienced as difficult to achieve. The participants were able to manage at some level (e.g., 50%), but they were expected to move as fast as possible to the next level. One focus group noted that it was difficult to comply with external demands to reach a higher level of work capacity by either performing other work tasks or increasing working hours, which was often not manageable:

> I am working at 50% right now. I have worked as much as 75% and have tried to do that on two occasions since the MMRP. Once in the autumn and then once now after the summer holidays … and then my life stopped functioning, so I know myself what my limitation is, but that is not okay with the world around me. I mean that from a societal standpoint it is not okay to have a limitation. (FG2, 29 year-old woman)

A slow escalation of working hours and working time was described as facilitating, and sometimes even necessary for RTW. For example, one day off for recovery each week might be needed; however, the participants noted that such solutions could be difficult to implement at work because of the SSIA regulations or the employer's unwillingness to adapt. Different stakeholders could also have different regulations and preferences that made it hard to find solutions that were accepted by the other stakeholders, including the patient:

> They [rehabilitation personnel from MMRP and RC from primary care] thought that I should have some rest days during the week and not go away every day because that stresses me. That might suit someone else but not me. Then I had swimming exercises and yoga exercises, plus I begin working or doing work exercises … so I had the entirety there and then a day free … so I had Wednesday free during the week then, but that new officer at the SSIA tore it [the RTW rehabilitation plan] up. I was forced to go and work one hour and 38 minutes every day, and everything fell apart there. (II1, 52 year-old woman)

Participants described negative experiences with SSIA officers when solutions were made outside the regulations even if the solutions were designed to strengthen the possibility to RTW:

> … the job always has to be adapted for me, and the SSIA is very conventional in how you are allowed to work, so I have to work five days a week for shorter periods … for a while I worked several hours and was free one day a week because I couldn't work five days in a row … there was a kind of agreement between me and my manager, so we did not say anything to the SSIA because I had experienced a lot of problems if I indicate that I am working in any other way. Then she [the officer at the SSIA] becomes very prickly towards me and says how are you actually working, and you can't do it that way. (FG2, 29 year-old woman)

The labour market situation, such as high production rates increasing pressure on employees in general, were described. Some participants argued that this situation affects all employees, limits the ability to adapt work, and means that there are more people at work with different kinds of disabilities who need adaptations. The participants experienced that sometimes the money rather than the patient was the main concern for the stakeholders. This led to work situations where adaptations could be difficult to implement.

> … depending on where you work, you can be a cog in a machine, you become almost like a product in a process. Unfortunately, I think that is how things stand in today's society, and that is way too stressful for many people. This is the situation in the workplace so that you cannot get the adjustment and the requirements that you need, such as sick leave and returning to work at your workplace. There is more focus on the money than the people and that it takes too long and too much money to help this person return to work. (FG2, 39 year-old man)

The participants told of a constant exchange of officers that led to inconsistencies in the way regulations and policies were interpreted and enforced. That is, they found that different officers had different ways of applying the same regulations and guidelines, which led to differences in obtaining interventions and solutions adapted to their individual needs.

### *Stakeholder collaboration–needs improvement*

The participants described difficulty managing all the contacts with the stakeholders throughout their RTW rehabilitation process. Managing these contacts with stakeholders was described as facilitating factors that enabled an ability to be active and take control (i.e., the ability to make active choices rather than to just let things happen). However, despite active choices and control, the participants also identified limiting factors in the RTW rehabilitation process. These limiting factors were especially apparent when they attempted to link different interventions and collaborate with different stakeholders:

> I think that is the biggest problem … the collaboration among the SSIA, physicians, the SPES, and bringing this together to something that works … because it seems as if you have to start over again all the time with each stakeholder, each agency, and I also think that is a very, very big problem, the fact that they don't work together. It should be possible to have some kind of collaboration among these stakeholders … yes, okay, we have this that we can do for this patient … instead of just one stakeholder saying one thing and then they bring in a pain physician at the SSIA, and then it's the last round, it's like the final word, and then you fall between the cracks and can't do anything. It's about making this work among the stakeholders. (FG2, 39 year-old man)

The participants suggested ways to improve the different parts of their RTW rehabilitation process. For example, it was suggested that reconciliation meetings should be held more frequently, even before starting the MMRP, to ensure stakeholders share the goals and expectations of the MMRP:

> I wonder if the RC could help in some way, if one were to gather the physicians, someone from here [MMRP], or if the RC were to arrange a meeting with someone from here [MMRP], the regular physician and

> maybe the employer and the SSIA especially, since they are the ones with the money. So that everyone is speaking the same language, with the individual. To be able to go to the pain rehabilitation clinic and MMRP, it will be done this way. These are the prerequisites. (II3, 31 year-old woman)

After the MMRP, many participants experienced a period where they felt time was being wasted and where planned activities were not being performed. In addition, many participants felt they had been passed around or had been caught between stakeholders and health care providers. For example, a delayed contact with the RC after the MMRP was regarded as a limiting factor for RTW. To reduce the gap between the end of MMRP and meetings with the RC, the participants recommended that the MMRP include a plan for the next steps of their rehabilitation, including contacts with other stakeholders and activities they need to engage. That is, knowing what activities to participate in and who is responsible for the specific activities might facilitate their return to work:

> It [a RTW rehabilitation plan] would have provided the whole programme with a greater purpose, I think. So that you could go further with it. For me, it would have provided a lot more, as a matter of fact. But it is a question of being able to know where you are going. It also depends on whether you have a job to return to. A formulated plan, perhaps … in my case it was very muddled. (FG1, 36 year-old woman)

Usually, a plan for further RTW rehabilitation was established when the participants finished the MMRP. Nevertheless, the end of the MMRP was experienced as too abrupt and was associated with uncertainty and in some cases anxiety about what would happen next. The participants described having difficulties maintaining the skills and strategies they learned during the MMRP. They lacked guidance and monitoring that would help them follow through on the strategies they learned, including following their RTW rehabilitation plan. In some cases, the plan had not been accepted by all stakeholders, which made the participants reflect on the importance of communicating the plan to all the involved stakeholders. This lack of acceptance was regarded as a limiting factor, especially when the plan was not concrete, not communicated, or not accepted by all stakeholders. In some cases, these limitations led to taking steps back from work:

> … there is no money [for tailored solutions), there are no positions … and maybe it is not a matter of money or positions when you are returning to work, but a RTW rehabilitation plan is to be set up then, and that is where disputes arise … it certainly was not a good beginning to go out to job training [every weekday] when there was so very much [physical activities for improving my health to do] and then a new officer at the SSIA who tore up the whole plan that we had made here in rehabilitation [MMRP] for a RTW … so there was a lot of turbulence there. If it had gone more smoothly, then … (II1, 52 year-old woman)

A reconciliation meeting during the MMRP where the involved officers from different stakeholders meet was described as a facilitating factor for managing the activities in the RTW rehabilitation plan. In addition, the participants suggested there needed to be more standardised forms for follow-up. That is, some sort of support system should be established such as regular meetings the first year after MMRP or a one-year follow-up program. These regular meetings and follow-up activities would serve as a review of the strategies learned during the MMRP and would provide a means for forming a new RTW rehabilitation plan when needed. Overall, the participants wanted improved collaboration and support where the responsibilities of the stakeholders are clarified throughout their RTW rehabilitation process.

## Discussion

### *Multidimensional interventions to support RTW*

Our results indicate that many factors can both limit and facilitate the RTW rehabilitation process for persons with chronic pain. Facilitating factors for RTW include feeling prepared and having self-confidence, improvements that could be obtained by providing more knowledge. In addition, facilitating factors for RTW include adapting work to individual needs so workers returning to work can perform their duties, factors that De Vries et al. [16] also found as important for people with chronic pain to stay at work. To increase work capacity, De Vries et al. [16] also suggested that employers and other stakeholders should lower workload, modify work conditions, and provide support for employees returning to work after an absence due to chronic pain, factors they label as adjustment latitude. Within the adjustment latitude, the participants also mentioned aspects of work modifications such as flexible work hours and adjusted work. Compared to de Vries et al. [16], our study included a broader population regarding work status as the participants were both working and on sick leave. Perhaps the aspects related to adjustment latitude were experienced as facilitating when present but limiting when lacking. When supporting patients with chronic pain to RTW, it seems important to address these factors with a flexible approach so as to adapt to each patient's unique situation. In our study, the participants identified a variety of facilitating factors, ranging from a personal level with activity performance, motivation, and being able-bodied to a societal level with complex interplay between different stakeholders. The broad complexity of the participants' experiences suggests that facilitating decreased sick leave and increased RTW requires addressing several factors. That is, such complex problems need to be targeted in a multifaceted way from different points of view and through different intervention domains and professions such as in MMRPs.

Cullen et al. [26] concluded that there is strong evidence for the efficacy of multi domain interventions, including multiple intervention components that reduce time away from work by supporting patients with musculoskeletal disorders, pain-related issues, or mental health problems. Examples of different domains to include in workplace interventions are health-focused interventions, work modification, and service coordination [26]. The participants in our study highlighted several ways their MMRP facilitated RTW. For example, the MMRP helped them find strategies for activity performance in relation to work, boundaries, everyday life, and controlling their own situation. Some of the participants also had opportunities to meet different stakeholders and to plan for the next step in their rehabilitation. The participants viewed their MMRP as a stage of their personal RTW rehabilitation process where they were given the possibility to approach their situation from different views and from their total life situation. As described by the participants, MMRPs may include the different domains described by Cullen et al. [26] with interventions focusing on pain-related and health-related issues, work activities, and stakeholder collaboration, together helping the patient arrive at new insights, acceptance, and strategies. Hallstam et al. [27] also found that patients with chronic pain who participated in MMRPs experienced a process of change where new strategies make it possible to remain at work and participate in everyday activities. According to the participants in our study, MMRPs may also be a foundation for stakeholder meetings, knowledge transfer, and planning the next step of rehabilitation. However, the results concerning sick leave and RTW are not satisfactory for either the patient or society.

Biopsychosocial interventions such as MMRPs can positively affect the possibility of RTW, but the results are inconsistent [12,28–30]. These somewhat positive results suggest MMRPs are a possible platform for decreasing sick leave and increasing RTW. According to Hellman et al. [14], clinicians working with MMRPs view MMRPs as the foundation for a continuous RTW process. These clinicians highlighted the importance of meeting the patients' needs regarding improved psychological function, increased physical activity, and participation in household and leisure activities before moving on with RTW interventions. Sometimes the clinicians working with MMRPs initiate RTW activities such as creating a plan and establishing contact with stakeholder representatives. However, it was seldom possible to support the patients in their long-term RTW process after the MMRP. In our study, the participants gave examples of how to improve the rehabilitation before, during, and after the MMRP to improve RTW. These examples include holding reconciliation meetings with all the stakeholders before starting the MMRP.

Our participants experienced that the interventions and solutions were not accepted by all stakeholders; for example, they found it difficult to increase their work responsibilities and work hours according to the timeline set by the SSIA or the employer. For patients with chronic pain, such aspects of adjustment latitude are seen as important for staying at work [16]. The aim of a reconciliation meeting before the MMRP would be to make RTW a part of the plan and set realistic goals for the patient during the MMRP. This strategy may be a way to focus on RTW questions earlier in the personal RTW rehabilitation process and better take advantage of the MMRP's potential as a multi domain intervention with more focus on work modification and service coordination [26].

### *The importance of strengthening the weaker links–collaboration and follow-up*

The participants in our study gave examples of periods in their personal RTW rehabilitation process where nothing was happening and where the next step was unclear. The period after the MMRP was often perceived as such a period where the weaker links between different interventions and stakeholders became obvious. The interventions within MMRP and throughout the personal RTW rehabilitation process need to be strengthened to avoid these gaps and to provide more long-lasting effects. The participants argued for more standardised follow-up activities after the MMRP to help them continue with the strategies they learned and stick to the plan they had developed during the MMRP. In Germany, the need for more long-lasting effects of rehabilitation in general led to the development of an aftercare program called Intensified Rehabilitation Aftercare (IRENA). Fechtner and Bethge [31], investigating the effect of this aftercare program on RTW in terms of proportion of income from welfare benefits, did not find any significant differences between the participants with and without an aftercare program, although they noted that the interventions in the program mainly included exercise therapy and that work interventions probably need to be included to increase RTW [31]. Perhaps a more standardised follow-up program focusing on work interventions and frequent follow-ups of the RTW plan would increase RTW for patients with chronic pain after MMRP. Another way of strengthening the weaker links would be to develop the collaborations between different stakeholders during the personal RTW rehabilitation process. Earlier studies have established the importance of such collaboration [32,33]. Jacobsen and Lillefjell [17] specifically emphasise the collaboration between employer and employees. Nevertheless, the results of our study imply that in practice collaboration is still lacking according to the participants. The participants suggest more efficient stakeholder collaboration throughout their personal RTW rehabilitation process and particularly during the MMRP2. How to manage the collaboration beyond different rules and regulations is one major challenge in RTW practice [34], which also becomes clear from the experiences of the participants in our study who highlighted the need for one stakeholder to be responsible for the RTW rehabilitation plan and to ensure continual collaboration. A RC could have a central role throughout the RTW rehabilitation process [32]. In Sweden, primary care is responsible for providing RCs, but there are great variations when it comes to competence, resources, and routines for each coordinator, which results in unequal support for patients. To strengthen the weaker links between different stakeholders and interventions, there is an urgent need for better collaboration, a move that includes a better implementation of pre-established collaboration strategies. This study suggests that MMRPs could be the foundation for improving collaboration, although more research is needed that focuses on developing effective collaboration strategies.

### *How to implement more tailored RTW interventions*

The participants' descriptions of their experiences give the picture of a RTW rehabilitation process where solutions facilitating RTW are often difficult to implement. Possible barriers to RTW include laws and regulations, the labour market situation, officers coming from different stakeholders (SSIA and SPES), and employers' unwillingness to adapt. The participants noted that individualised solutions outside the present framework may facilitate RTW. Studies of sick-listed patients have focused on the importance of meeting individual needs [33,35,36] and the challenges associated with meeting these needs due to regulations such as a strict bureaucratic sickness insurance system [37]. Our study of patients with chronic pain provides examples of situations where individually tailored solutions outside the frame of the regulations have facilitated RTW. For example, allowing a patient to have one day off each week might improve a patient's ability to RTW. Of course, this adaptation must be approved by the patient and the employer and may contradict the SSIA's regulations and policies. However, there is a risk that these kinds of solutions, when not accepted by all stakeholders, are not long-term solutions. As the RTW rehabilitation process is a highly complex process involving complex personnel problems, organisational beliefs, and a myriad of players, McEachen et al. [33] argue that 'successful outcomes will require active planning and sensitivity to the complexity of the process,' which may be reached through goodwill, creativity, and good communication by all involved stakeholders.

Based on current knowledge, the results of the interventions are highly affected by the stakeholders' abilities to deliver interventions based on the individual's needs. Therefore, the RTW interventions need to be tailored, focusing on the individual's needs, not dependent on the different stakeholder representatives' knowledge (or lack of) or personal preferences. According to the participants in this study, different officers and employers seem to have different knowledge about chronic pain as well as different approaches on how to meet the individual's needs in relation to the regulations and work conditions. Presently, whether a patient receives tailored and individually adapted evidence-based RTW interventions depends on the different stakeholder representatives they encounter. Clearly, this unfair situation

needs to be changed. A tailored approach must not be the result of the knowledge, courage, and good will of each stakeholder representative.

### *Methodological considerations*

To obtain credibility, purposive sampling was used to ensure a variety of participants [20,22]. In our study, participants were collected with different work status and sick leave status such as employed and unemployed as well as working and non-working. In addition, the participants had a higher proportion of women than men and a mean age representing the greater population of patients living with chronic pain [38]. Nevertheless, the results need to be interpreted in light of the constructed situation that a focus group produces. Group dynamics may be influenced by selection bias as those who agree to participate may be more articulate [18]. Nonetheless, the participants in each focus group shared experiences of living with chronic pain, struggling to decrease sick leave or RTW, and completing a MMRP. Earlier studies have used other inclusion criteria concerning work and sick leave status. For example, Jakobsen and Lillefjell [17] only included participants who were employed and had RTW to some degree at the time of their interviews. This study brings a broader perspective with experiences from both employed and unemployed patients who had either managed to RTW or not. However, to transfer the results to the population of unemployed patients with chronic pain there should have been a greater representation of this population in the interviews.

One limitation of the study was the late cancellations and drop-outs led to small groups of participants. Five to seven participants were planned for each focus group, but only one group had the planned number of participants. All planned interviews were conducted irrespective of the number of participants who showed up as they also brought valuable information to the study. Due to the dropouts and cancellations, the youngest participant in our study was 27 years old. This makes the results of the study difficult to transfer to the youngest part of the population. Furthermore, because this study only included patients from two pain rehabilitation clinics, the ability to transfer these findings to other pain rehabilitation clinics is limited.

The focus groups and the individual interviews took place two to four years after the participants had completed the MMRP, which may have resulted in recall bias. However, the nature of the focus groups, where participants share experiences and discuss many topics [20], could have helped the participants recall their experiences. In addition, the participants in most cases were still struggling to decrease sick leave and RTW, which made the topic of the interviews relevant to their everyday experiences.

The trustworthiness of the study was strengthened by the triangulation of the four authors during the whole analysis process. In addition, the peer review by the patient research partner confirmed the validity of the categories and results of the study.

## Disclosure statement

No potential conflict of interest was reported by the author(s).

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