# Coordination of return-to-work for employees on sick leave due to common mental disorders: facilitators and barriers

Lisa Holmlund , Therese Hellman , Monika Engblom , Lydia Kwak , Lars Sandman , Lena Törnkvist & Elisabeth Björk Brämberg

Published online: 05 Dec 2020.

Submit your article to this journal

Article views: 776

View related articles

View Crossmark data

Taylor & Francis
Taylor & Francis Group

ORIGINAL ARTICLE

🔓 OPEN ACCESS    Check for updates

# Coordination of return-to-work for employees on sick leave due to common mental disorders: facilitators and barriers

Lisa Holmlund[a] (ID), Therese Hellman[a,b], Monika Engblom[c], Lydia Kwak[a] (ID), Lars Sandman[d], Lena Törnkvist[c] and Elisabeth Björk Brämberg[a,e] (ID)

[a]Institute of Environmental Medicine, Unit of Intervention and Implementation Research for Worker Health, Karolinska Institutet, Stockholm, Sweden; [b]Department of Medical Sciences, Occupational and Environmental Medicine, Uppsala University, Uppsala, Sweden; [c]Department of Neurobiology, Care Sciences and Society, Karolinska Institutet and Academic Primary Health Care Centre, Region Stockholm, Sweden; [d]Department of Health, Medicine and Caring Sciences, National Centre for Priorities in Health, Linköping university, Linköping, Sweden; [e]Department of Public Health and Community Medicine, Sahlgrenska Academy, University of Gothenburg, Gothenburg, Sweden

**ABSTRACT**

**Purpose:** To identify facilitators of and barriers to the coordination of return-to-work between the primary care services, the employee, and the employers from the perspective of coordinators and employees on sick leave due to common mental disorders (CMDs).

**Material and methods:** Descriptive qualitative study. Semi-structured interviews were conducted with eighteen coordinators and nine employees on sick leave due to CMDs. The Consolidated Framework for Implementation Research (CFIR) was used as a starting point for the interview guides and in the thematic analysis of data.

**Results:** The results show facilitators and barriers related to the CFIR domains "intervention characteristics," "outer setting," "inner setting," and "characteristics of individuals." Positive attitudes, an open dialogue in a three-party meeting, and a common ground for the sick leave process at the primary care centre facilitated coordination, while an unclear packaging, conflicts at the employee's workplace, and a lack of team-based work were examples of barriers.

**Conclusion:** The results indicate a need for the detailed packaging of coordination; formalization of coordinators' qualifications and levels of training; and acknowledgement of the role of organizational factors in the implementation of coordination. This is important to further develop and evaluate the efficacy of coordination.

➤ **IMPLICATIONS FOR REHABILITATION**

- Positive attitudes to coordination, an open dialogue in a three-party meeting, leadership engagement, routines for the return to work (RTW) process at the primary care centre, and collegial alliances were identified as facilitators.
- An unclear packaging of the intervention, conflicts at the employee's workplace, lack of team-based work, and lack of coordinator training were identified as barriers.
- A detailed intervention packaging adapted for the specific setting and formalization of coordinators' qualifications and training is necessary for coordination of RTW.
- Recognizing organizational factors were identified as being important for the implementation of coordination of RTW for persons on sick leave due to CMDs.

## Introduction

In the Organization for Economic Co-operation and Development Countries (OECD) countries, diagnoses related to common mental disorders (CMDs) such as anxiety, depression, adjustment disorders and stress-related disorders are one of the leading causes of long-term sick leave [1]. In Sweden CMDs caused about 45% of all sick leave among women and 32% of all sick leave among men in 2016. Moreover, periods of sick leave due to CMDs tend to be longer and are more likely to reoccur than other diagnoses [2]. Sick leave because of CMDs poses the risk of social isolation,

stigmatization, negative effects on the private economy [3], and future receipt of disability pension [4]. The total costs of health care, social security, and labour market impact due to mental health problems is estimated at some €600 billion in the European Union (EU) countries [5]. Given the magnitude of individual suffering and societal costs related to sick leave, the Swedish government launched the Work first principle in 2008, i.e., measures to increase return-to-work (RTW) among employees on sick leave and to prevent long-term sick leave [6]. One of these measures is the coordination of RTW for employees on sick leave.

---

**Table 1.** Coordinators (*n* = 18), demographic characteristics and type of interview.

| Coordinator[a] | Formal education | Time in profession *(years)* | Formal coordinator training[b] *(yes /no)* | Coordinator involvement *(part-time/full-time)* | Patients listed at PCC *(n)* | Face-to-face interview *(yes/no)* |
|---|---|---|---|---|---|---|
| C.1 | Human resource specialist | 10–20 | Yes | Full-time | 10 000–15 000 | N |
| C.2 | Single-subject courses | MD | MD | Part-time | 10 000–15 000 | N |
| C.3 | Nurse | 10–20 | Yes | Part-time | <10 000 | Y |
| C.4 | Occupational therapist | 20–30 | No | Part-time | <10 000 | Y |
| C.5 | Single-subject courses | <5 | Yes | Full-time | <10 000 | Y |
| C.6 | Physiotherapist | 10–20 | No | Part-time | 10 000–15 000 | Y |
| C.7 | Single-subject courses | MD | MD | Part-time | 10 000–15 000 | Y |
| C.8 | Physiotherapist | <5 | No | Part-time | 10 000–15 000 | Y |
| C.9 | Nurse | MD | MD | Part-time | <10 000 | Y |
| C.10 | Physiotherapist | 20–30 | Yes | Part-time | 25 000–30 000 | Y |
| C.11 | Social worker | 10–20 | Yes | Part-time | 10 000–15 000 | Y |
| C.12 | Occupational therapist | 10–20 | Yes | Part-time | MD | Y |
| C.13 | Occupational therapist[c] | 20–30 | Yes | Part-time | 10 000–15 000 and < 10 000 | Y |
| C.14 | Nurse | 5–10 | No | Part-time | 10 000–15 000 | Y |
| C.15 | Social Worker[c] | MD | MD | Full-time | 10 000–15 000 and 10-15000 | N |
| C.16 | Physiotherapist | 20–30 | Yes | Full-time | 10 000–15 000 | Y |
| C.17 | Physiotherapist | <5 | No | Part-time | 10 000–15 000 | Y |
| C.18 | Social worker | 20–30 | No | Part-time | 10 000–15 000 | Y |

PCC: primary care centre; MD: missing data.
[a]Coordinator number.
[b]Formal coordinator training applies to training for coordination of RTW (7,5 credits).
[c] Assigned to two PCCs.

Sickness absence and RTW are situated within multiple levels of systems. These include personal, legislative, insurance, workplace and health care systems [7]. Challenges to the integration of RTW services between stakeholders are well documented in international [8,9] and Swedish research [10,11]. As a response to this, coordination of RTW is increasingly recognised and included in private initiatives or policy changes [12–18]. Coordination of RTW vary greatly in terms of the type of setting in which the coordinators are employed [12,15], the level of coordination (e.g. across levels of systems and organizations, or within one level of a system or organization) [14,15]. Coordinators are employed by health care organisations, insurance companies, large organisations, or are self-employed [15,16,18] and the professional background and training of individuals employed as coordinators varies [15–18].

The implementation of coordinator services in Scandinavia is at an early stage of development, but is increasingly being implemented alongside policy changes [14,19,20]. In Sweden, coordinators are employed mainly in the primary care services. No minimal qualifications are provided, however having a health professional background is common (e.g., registered nurse, occupational therapist or physiotherapist). The main thrust of their work is giving personal support for employees as well as managing internal and external coordination [21]. In implementing coordination, the coordinator is expected to provide information about sickness absence and RTW to the primary care centre (PCC) [22]. Thus, the expertise of the coordinator can positively influence the overall organization of sick leave and the RTW process. In other words, the introduction of a coordination function can be part of an organizational learning process in which routines for sick leave and RTW are critically reviewed, and potentially bring about an incremental change in practice [23].

To date, evidence of the positive effects of RTW coordination programmes is uncertain [24,25]. While one review found a relatively small but probably important benefit [24], a recent Cochrane review of RTW coordination programmes identified no significant difference in RTW outcomes compared to usual practice [25]. However, for persons with CMDs work-directed interventions in addition to clinical interventions [26] and psychological interventions such as problem-solving therapy [27,28], do have a positive effect on number of days on sick leave [26,28], and partial RTW [27]. Based on the Cochrane review by Vogel et al. [25] the uncertain evidence of the benefits of RTW coordination programmes might be due to low quality of research and the variation in the way in which these programmes are organized and practiced. It might also be explained by the lack of a workplace component in coordination services [29]. To the best of our knowledge there is no previous research into barriers to and facilitators of the coordination of RTW between the primary care services, the employee on sick leave due to a CMD, and the employer. A better understanding of what works and the present challenges is vital for our ability to further develop and evaluate coordination services and to be able to effectively translate knowledge into practice [30]. The aim of this study was, therefore, to identify facilitators of and barriers to the coordination of RTW between the primary care services, the employee, and the employers from the perspective of coordinators and employees on sick leave due to CMDs. In this study, coordination is defined as RTW support received by the employee and cooperation with his or her employer by means of a three-party meeting, in line with implementation of psychiatric guidelines in the primary care sector [31].

## Materials and methods

This study used a qualitative approach involving semi-structured interviews with coordinators working in the primary care services in Sweden and employees on sick leave due to CMDs (Tables 1 and 2). Ethical approval was obtained from the Regional Ethical Review Board in Stockholm, D-nr 2018/677-31/2; 2018/2119-32. The study follows the consolidated criteria for reporting qualitative research [32]. Details of the method and the overall project are also described in a study protocol [33].

Table 2. Employees on sick leave due to CMDs ($n = 9$), demographic characteristics and type of interview.

| Employee[a] | Age (years) | Gender | Work sector (private/municipal) | Sick leave (part-time/full-time) | Face to face interview (yes/no) |
|---|---|---|---|---|---|
| E.1 | 34 | Female | Private | Part-time | N |
| E.2 | MD | Female | Municipal | Full-time | Y |
| E.3 | 61 | Female | Municipal | Part-time | N |
| E.4 | 46 | Female | Private | Part-time | N |
| E.5 | 31 | Female | Municipal | Part-time | N |
| E.6 | 43 | Female | Private | Part-time | N |
| E.7 | 25 | Female | Private | Part-time | N |
| E.8 | 33 | Female | Private | Part-time | Y |
| E.9 | 61 | Male | Private | Full-time | N |

MD: missing data.
[a]Employee number.

## Setting

In Sweden, the health care and the social insurance systems are mainly tax funded. The Swedish Social Insurance Agency (SSIA) has overall responsibility for monitoring and coordinating the RTW process. The SSIA decides on eligibility for sick leave benefits based on a certificate issued by a physician. The first 14 days of sick leave are paid by the employer and thereafter sick leave benefits can be granted by the SSIA if applicable. The employer's responsibilities include to provide an efficient RTW process and to accommodate the employee. The employer should design a plan for RTW for the employee on sick leave within 30 days if it is assumed that the person will be absent for more than 60 days. Health care in Sweden is organized mainly on a regional level. People's initial contact with the health care system typically occurs *via* the primary care services, which is tasked with providing evidence-based care characterized by easy and equal access for everyone. The coordination of RTW, organized by an on-site coordinator, has been broadly implemented at PCCs across Sweden [19]. The implementation has been supported by regional-level process leaders who are often coordinators themselves (Table 1). The role of the process leaders is to provide operational support to the coordinators in their daily work, and to provide strategic support to the health care services regarding the social insurance system and RTW process. The present study was conducted in three Swedish regions. At the time of inclusion, Region Västra Götaland had coordinators employed in 180 out of 200 PCCs. The equivalent figures for Region Uppsala were 30/40 and for Region Stockholm 75/210.

## Participants

A strategic sampling was used to find a broad range of employees with regard to type of profession, gender, and educational background. The following inclusion criteria applied to all participants: (1) participated in a three-party meeting attended by at least one employee on sick leave due to CMDs, the employer, and a coordinator. It should have been initiated by the PCC and conducted at the PCC, the workplace, or as a telephone conference; (2) be able to speak and understand Swedish. For the employees there were some additional inclusion criteria: (a) aged between 25 and 65; (b) they should be on sick leave currently or on sick leave for a maximum of 12 weeks in the previous six months due to CMDs (i.e., mild to moderate depression, anxiety, or adjustment disorder); (c) examined by a general practitioner or physician at the PCC.

At recruitment, all participants received oral and written information about the study prior to consent. Recruitment started with managers at PCCs or process leaders in the regions, who were informed about the study and the criteria for the inclusion of

coordinators. They, in turn, informed eligible coordinators assigned to the PCC. Coordinators who agreed to participate were given information about the inclusion criteria for employees and asked to inform eligible patients. Employees were also recruited by means of an announcement in a free newspaper distributed in the public transport system. In total, 18 coordinators and 15 employees were recruited. After recruitment, three employees declined to participate because of their CMDs or because they were reluctant to share sensitive information about RTW, while three did not reply to the researchers to schedule interviews. The employees had been employed at their current workplace for $\geq 4$ years. The coordinators had been employed as coordinators for between $>1$ and 8 years. Those who worked in a part-time capacity combined the coordinator role with being a process leader ($n = 4$), clinician ($n = 7$), other ($n = 1$), or a managerial position ($n = 4$). Two of the coordinators combined three roles. The demographic characteristics are described in tables one and two.

## Data collection

Semi-structured interviews were held between June 2018 and May 2019 and were conducted by the second and the last author [33]. The interviews were held face-to-face at a location chosen by the participant, or by telephone. They lasted 20–60 min (Tables 1 and 2). Two interview guides were used for coordinators and employees respectively. The interview questions were open ended, and prompts or follow-up questions were used to clarify the answers. The Consolidated Framework for Implementation Research (CFIR) was used as a starting point for the interview guides [30] and questions linked to the CFIR's domains intervention characteristics, outer setting, inner setting, and characteristics of individuals were used. The process domain was not applied in data collection or analysis. A detailed description of the interview guides is provided elsewhere [33]. Before the interview, participants were informed about the definition of coordination used in the study. All interviews were conducted in Swedish and recorded on a digital recorder. All participants were given the opportunity to review their transcripts.

## Data analysis

All interviews were transcribed verbatim, after which identifying information was removed. Thematic analysis was used to interpret the data [34] and the software program N-Vivo 11 was used to organize the data. The analyses were performed in a six-step process according to Braun and Clark [34]. The initial steps, (1) familiarization with the data; (2) generating initial codes, and (3) searching for themes, were data driven, meaning that analysis depended on the data. When the preliminary themes had been identified a theoretical perspective of CFIR [30] was applied in

**Table 3.** Overview of themes, and facilitators of and barriers to coordination from the perspective of coordinatorsand employees on sick leave due to common mental disorders (CMDs).

| CFIR dimension | Theme | Facilitators | Barriers |
|---|---|---|---|
| Intervention characteristics | Perceived advantage despite the description of how to accomplish coordination being vague | Perception of coordination as an advantage in organizing the return-to-work (RTW) process for the person with a CMD[a,b] Adaptation of coordination to meet local needs[a] Use of a general set of coordination components[a] | Lack of detailed work description for implementing coordination into daily practice[a] |
| Outer setting | Facilitate a dialogue to reach consensus about the RTW process | Open dialogue in a three-party meeting to mediate employee needs with external demands[a,b] Open dialogue in a three-party meeting to provide structure and clarity to the RTW process[a,b] Open dialogue in a three-party meeting to provide consensus and knowledge transfer to design a plan for RTW[a,b] | Lack of conditions for accommodation at the workplace[a] Conflicts between employee and employer[a,b] Lack of time due to stakeholders' other engagements and coordinator resources[a] Lack of existing lines of communication between stakeholders[a,b] |
| Inner setting | Establish a common ground for the sick leave process at the primary care centre (PCC) | Communication about values and policies around sick leave[a] Routines for the RTW process at the PCCs[a] Leadership engagement[a] The coordinator's ability to provide the PCC with expert knowledge about the RTW process [a] | Lack of a managerial mandate[a] Insufficient introduction to and/or supervision of the coordinator role[a] Lack of time to reflect upon and develop coordination[a] Lack of suitable physical work environment[a] |
| | Create and foster collegial alliances to improve coordination | Network with process leader and other coordinators[a] Team-based approach to the RTW process at the PCC[a,b] | Lack of peers[a] Lack of knowledge and appreciation of the coordinator role[a] Lack of time at the PCCs to engage in team-based work[a] Staff turnover at the PCCs[a] |
| Characteristics of individuals | Return-to-work as a common objective of employees and employers | Stakeholders' positive attitude and cooperation throughout the RTW process[a,b] Fulfillment of stakeholder responsibilities in the RTW-process[a,b] | The employee's lack of motivation or hesitance to participate in coordination or RTW[a,b] Perceived unwillingness among employers to accommodate the employee's needs[a,b] |
| | Coordination dependent on the coordinator's professional engagement | The coordinators' positive attitude to coordination[a] The coordinators' professional background[a] Formal coordinator training and skills development[a] Competence in general practice and insurance medicine[a] | Lack of formal coordinator training[a] Lack of confidence in how to carry out the coordinator role[a] Lack of professional boundaries between the therapeutic and the coordinator role[a] |

CFIR: consolidated framework for implementation research.
[a] Facilitators of and barriers to coordination from the perspective of coordinators.
[b]Facilitators of and barriers to coordination from the perspective of employees on sick leave due to CMD.

steps (4) reviewing themes, (5) defining and naming themes; and (6) producing the report. This approach was used to clarify barriers to and facilitators of implementation of coordination in the local context of primary care as well as across levels of systems [30]. The analysis process moved back and forth between the data set, the coded extracts and the report, and continuous discussions took place between the co-authors. This meant that initial codes were merged and rephrased, and themes were collapsed, expanded, or rewritten [30]. To support the analysis, memo-writings were used during all steps. Quotes were translated into English according to the following procedure: (1) independent translation by the first author; (2) review of the translation by the last author; (3) final editing by a language editor. In analysis, the intervention refers to the coordination between the primary care services, the employee, and the employer; the outer-setting refers to the legal framework for RTW, the employee, and the employer; the inner setting refers to the PCCs; and analysis of characteristics of individuals refers to the employee, the employer and the coordinators.

## Results

Six themes were identified from the analysis and linked to CFIR dimension. See Table 3 for an overview of the themes and facilitators of and barriers to the coordination of RTW between the primary care services, the employee, and the employers.

### *Intervention characteristics*

#### *Perceived advantage despite the description of how to accomplish coordination being vague*

Coordination was seen as facilitating the organization of the RTW process for the person with a CMD. It implied that there was

cohesive support and a continuity which participants had previously found to be lacking. Some of the employees had experienced previous episodes of sick leave and they emphasized the benefits of coordination. One employee said (E.9): "Well, yes it's amazing to be able to see this coordinator. Last time [referring to a previous sick leave episode], I really hit the wall then … and I was completely at the mercy of the system." However, it was felt that the coordination was vaguely presented. How coordination was to be achieved was therefore unclear, which was a barrier. The coordinators lacked a detailed description of how to implement the coordination into their daily work practice. This lack of clarity gave rise to a gradual process of interpretation and development which was necessary to adapt the coordination to the work of the PCC. This inevitably led to a variation in how coordination was practised and the risk of drift from the original purpose of the coordination. One coordinator explained (C.8):

> I was given a work description; it was very broad, and I tried to work out a plan for how to do the work so as to fit in the parts that had to be included … / … But there were no concrete or clear guidelines about how I was to do it. Suggestions, but no actual decisions about how I was to go about it, no.

Despite the variation in how coordination was practiced, a set of general components of coordination was evident in the coordinators' descriptions, namely structured inclusion; identification of work-related needs and resources; coordination with the employer; planning for RTW; and follow-up. The specific content of these components thus needed to be refined or developed by the coordinator. A detailed work description was seen as important for establishing a structure for the coordination and organizing the different actors involved, thereby setting boundaries for the coordination and dealing with any insecurity related to the assignment.

### Outer setting

#### *Facilitate a dialogue to reach consensus about the RTW process*
Taking the employee's needs and resources into consideration alongside external demands such as workplace demands and legal frameworks was integral to the purpose of coordination. An open dialogue between the primary care services, the employee and the employer, preferably in a three-party meeting was therefore a facilitator for coordination. And open dialogue was providing knowledge transfer among stakeholders and structure to the RTW process, and therefore clarity and consensus about the RTW process. This could help to meet the needs of the employee in terms of giving a sense of security and direction in the RTW process by arriving at a common plan together. One employee said (E.7): " … before I had contact with the coordinator, I was the only one to keep track of my situation at work … /I felt there was no plan for me at all. I barely knew what hours I was supposed to work." The citation highlights the need of a supported dialogue because the employee and their employer often lacked the necessary knowledge to organize RTW. This was also important because of the employees health status. The coordinators spoke of a sort of diplomacy and a positive spirit to facilitate a dialogue and arrive at solutions for RTW, one coordinator said (C.16):

> So, my role, it's kind of being the link between, I think, to get the employer to understand what needs the employee has in order to be able to get back to work. That's what we talk about. Get them to understand the difficulties and be able to explain the needs and also see what possibilities there are to meet them.

A barrier to meeting the needs of the employee was that the conditions for being able to accommodate him or her varied from one workplace to another. For example, small companies might find it difficult to offer the employee alternative work tasks. A further barrier was that conflicts between employee and employer might hinder the ability to reach a consensus. Difficulty in organizing three-party meetings, which meant that meetings were delayed or avoided, was yet another barrier. This difficulty might arise because of other commitments on the part of the employer or the coordinator, a lack of existing lines of communication between the PCCs and the workplace, and the time needed to travel to meetings held at the employee's workplace. The resources allocated for coordination were often limited, with some coordinators only having one day per week to devote to it, which meant they had to prioritize.

### Inner setting

#### *Establish a common ground for the sick leave process at the PCC*
Sick leave and RTW for persons with CMDs were complex tasks at the PCCs involving several professions. It was therefore important to establish a common ground around sick leave and RTW among the professionals at the PCC. Implementing coordination meant a paradigm shift from professionals managing sick leave and the RTW process separately, to a common focus on involving the employee's workplace. Communication across the PCC about values, policies, and the formalization of routines for the RTW process, such as for sickness certification and coordination of RTW, facilitated this. However, there was a great deal of variation in the extent to which such discussions were held and documented. Some coordinators felt that the they had got quite far, while others felt that they were alone in determining the direction of coordination. Leadership was central to achieving overall change at the PCC. One coordinator emphasised (C.6): " … that's absolutely key to it, if you have a senior manager who, how should I put it, makes decisions and supports the implementation." The coordinator could act as an expert and provide the PCC with expertise about the RTW process. The process seemed to be facilitated further if the coordinator role was, in addition, combined with that of process leader or manager. For those lacking a managerial mandate it was difficult to have influence on overall change at the PCCs. A lack of leadership support in such cases could give rise to feelings of loneliness and insecurity, one coordinator said (C.2):

> …I can also feel a lot of loneliness in the role, that it's me, sort of, who decides what to do, and I don't really know if I'm actually doing, am I doing the right things? Even if I get a positive answer to that question, I can feel that I'm very alone.

While most coordinators described feelings of freedom and of being a pioneer in connection with developing the coordination of RTW, several of them also felt alone in trying to achieve change. In addition, some experienced a lack of introduction and supervision related to the coordination assignment, and a few pointed to the lack of necessary conditions in the physical work environment, such as an office space or telephone. Several felt they had insufficient time to reflect upon and develop the coordination at their specific PCC. This was important since the vagueness of the coordination meant that they lacked detailed descriptions of what their coordinator role entailed. For some of the coordinators, these were obstacles to being able to develop a well-functioning coordination.

#### *Create and foster collegial alliances to improve coordination*
It was usually the case that one coordinator was assigned to one or two PCCs. Creating and fostering formal and informal alliances

with a network of process leaders and coordinators located at other PCCs, and with colleagues at the PCC, therefore facilitated the coordination. A network of process leaders and coordinators created a context in which to disseminate an understanding of the coordination process. Network meetings enabled knowledge transfer to take place and discussions about how to interpret the coordinator role. Networks accordingly enabled participants to upgrade their skills and functioned as a sounding board for implementation and improvement. One coordinator explained (C.1): "…the network with other peers, 'how do you do this?', 'what works for you?' We have a great network, and everybody are very generous, sharing what works and what doesn't." Creating alliances with colleagues at the PCC, especially with the physicians, was important for developing routines (such as referrals to the coordinator) and creating an awareness about the coordinating role. A team-based approach within the PCC gave opportunities to discuss specific cases and take advantage of each other's expertise. It also helped to prevent feelings of uncertainty and of being alone among the coordinators. Employees also underlined the benefit of consensus and collaboration between professionals at the PCC; it gave them a feeling of stability in their RTW process. One employee said (E.6): "until I started seeing her, I was just kind of thrown around." Here too, the degree of collaboration at the PCC varied; while some had a well-established structure for collaboration, at others the coordinators were alone in their role. Lack of knowledge and appreciation of the coordinator role, lack of time for a team-based approach, and turn-over among professionals at the PCCs were obstacles to successfully applying a team-based approach.

### Characteristics of individuals

#### Return-to-work as a common objective of employees and employers

Because of the nature of coordination, a positive attitude among stakeholders, fulfilment of responsibilities in the RTW-process, and all stakeholders sharing the common objective of RTW for the employee, were all factors which facilitated coordination. In contrast, characteristics of individuals, such as employee's attitudes and motivation could also constitute barriers to coordination. One employee described her lack of motivation to return to her current workplace (E.3): It's just that I dont want to stay there… that I want to be somewhere else, so I sort of apply [for job positions] at other workplaces. This citation exemplified situations when the employee did not want to return to the workplace or had hesitance about their capacity to work. This could be related to their health status, the situation at work, or their overall life-situation, and could imply challenging thresholds in coordination of RTW.

Individual engagement and openness to change on the part of the employer were seen as facilitating coordination. One coordinator said (C.13):"…my experience is that the contacts you have with your employer, when they're willing to cooperate with the health care services and with their employee, then it works really well." The coordinators and employees found most employers to be positive and collaborative, although sometimes it proved not possible to adjust the employee's work tasks or work environment. In some cases, the coordinators came across an unwillingness to carry out changes for the sake of the employee. When coordinators encountered unwillingness on the part of stakeholders, they lacked a mandate to exert pressure other than through information and motivation. The RTW-process might come to a halt if this was unsuccessful.

#### Coordination dependent on the coordinator's professional engagement

A positive attitude on the part of the coordinators, as well as their professional background and coordinator training, were factors which facilitated coordination. Factors which could impede coordination were if coordinators had too little training or did not regard themselves as skilled in the role. Those who were process leaders and had helped to develop the coordination process at national or regional level or had longer work experience seemed more self-confident than those relatively new to the assignment. Nearly half had gone through a short formal training course (Table 1), which was felt to facilitate coordination. One coordinator said (C.10): "How I been thinking? I have understood, or learnt, when I have taken those coordinator courses." Others lacked this type of training but had participated in regional skills-development training. Despite coordinator training, many seemed instinctively to base their work on skills and knowledge acquired through their professional background and work experience. The variety of occupational backgrounds among the coordinators (Table 1) thus meant there was a broad variation in how coordination was conducted. One coordinator reflected about this (C.7):

> …It's both a challenge and an asset, because yes, there are different professions and we think differently because of that. There's nothing wrong with that and it's good to be able to look at things in different ways, or how should I put it, you have different views on things when it comes to sick leave…

Each different professional background also brought with it certain theoretical perspectives and skills which, in turn, determined how coordinators approached employees and the strategies they used in the coordination. In addition, some had dual roles at the PCC, for example working both in their professional role as a coordinator and in their health care profession (Table 1). This meant they had to draw boundaries between the two roles and shift between a more consultative coordinating role and a more therapeutic one. Apart from establishing clear role boundaries, a good knowledge of medical practice and insurance medicine was seen as important for developing the necessary skills and self-confidence for the role of coordinator.

## Discussion

This study contributes to the previous literature on coordination of RTW [12–18] by exploring facilitators and barriers across multiple levels of systems and organizations. Examples of facilitators were: a perceived advantage and positive attitudes toward coordination; an open dialogue between health care, the employee and the employer; leadership engagement and routines for the RTW process at the PCC; and collegial alliances. Examples of barriers were: an unclear packaging of the intervention; conflicts at the employee's workplace; lack of existing lines of communication between health care and employer; lack of team-based work; and the quality of coordination being dependent on the coordinator's professional background and training. This study specifically identified the need for the coordination to be packaged in a sufficiently detailed way to facilitate implementation and effectiveness testing. It also identified the need for there to be an organizational perspective to the implementation of coordination. In addition, this study adds to previous discussions about coordinator training [12,16] and point to the need to formalize qualification criteria for coordination implemented as part of a national policy.

The coordinator's and employee's perception of coordination as advantageous to their experience of previous solutions for RTW for persons with CMDs conforms with the CFIR construct "relative

advantage" [30] and is important for facilitating implementation. Despite recognizing the benefits of coordination, the coordinators felt that role was unclearly described. This was a barrier to coordination, and related to the CFIR constructs "design quality" and "packaging and adaptability" [30]. An unclear description of the assignment indicates a risk of large variations in practice and drift from the original purpose of coordination. Despite the variation in coordinator practices described in this and other studies [12,15], a set of general coordination activities can be identified on which the core components for coordination can be built. The intervention components identified in this study followed the early phases of the RTW process [35]. They were: identification of work-related needs and resources; coordination with the employer; planning RTW; and follow-up. This is also in line with previous research [12,13,15]. In further development it is important to be clear about the content of components. In addition, certain elements of an intervention need to be adaptable to the specific setting or organization in which the intervention is being implemented, and to the specific target group [30]. For example, the employees in this study highlighted the benefit of an open dialogue in a three-party meeting to reach consensus and a plan for RTW after sick leave due to CMDs. This is in line with the existing evidence base for RTW for this population [26–28] and the purpose of coordination of RTW in Sweden – to coordinate the RTW process in health care, and across levels of systems, such as the workplace system [21]. It is therefore important to include a clear focus on workplace-based activities in further development of coordination of RTW.

This study found that having professional experience, participation in formal coordinator training, and having a knowledge of general practice and insurance medicine all facilitated coordination. The need for relevant knowledge is included in the domain "characteristics of individuals" and the construct "knowledge and beliefs about the intervention" in CFIR [30]. The diversity of professional backgrounds and training among coordinators in this study are previously demonstrated [12,15–18]. This study indicates that the coordinators based their approach on experience from their professional background. While basing the approach on previous experience could be beneficial, it also gave rise to a variation in how coordination was carried out. Bohatko-Naismith [18] and Durand [15] argue that coordinators should be health care professionals, while the study by Kärkkäinen et al. [13] found that many coordinators had a background in human resources. Moreover, a large number of skills and personal characteristics that are important for coordinators are identified in research [16–18]. However, to the best of our knowledge there is a lack of research evaluating coordinator competencies in relation to improvements in sick leave and RTW outcome. It is probably difficult to draw general conclusions across countries and settings about which specific professional backgrounds or competencies are particularly important. Rather, in developing the coordinator role, it is necessary to consider formalizing the qualifications according to the specific setting and taking the professional background of those receiving coordinator training into account. While coordinators employed at workplaces might benefit from human resources expertise, it might be more suitable for coordinators working in health care settings to be health care professionals, at least if the assignment requires a knowledge transfer about people's health status – for example about CMDs. Whatever the individual professional background, additional coordinator training is likely to be important. Most importantly, when implementing coordination at national level it is important to formalize qualifications so that employees on sick leave receive equal coordination irrespective of PCC or coordinator.

Having a common understanding of sick leave and RTW; leadership engagement; and collegial alliances were all identified as facilitators of coordination in the inner setting in the PCCs. These factors are linked to the CFIR constructs "culture, structural characteristics, networks and communication" and "implementation climate" [30]. A collaborative approach is important in RTW after sick leave due to CMDs due to the complex RTW process for this group [36]. Our study suggests that such an approach provides stability for the employee. It is therefore necessary to recognize organizational factors for well-functioning coordination. These factors can be understood in relation to theories about organizational learning, i.e. learning processes of and within organizations [37]. Argote [23] defines organizational learning as "a change in the organization that occurs as the organization acquires experience" (p.1124). In relation to the coordination of RTW and the present study, this means that the implementation of coordination optimally occurs over time in a process where knowledge about coordination is translated into practice through an incremental change in behaviours, performance, and practice [23]; for example, by implementing routines for RTW and contact with employers. In this process, establishing networks and collegial support might be more important than personal attributes [38]. Moreover, to stimulate a positive implementation climate in PCCs it is necessary for an engaged leadership to review coordination routines and guidelines [23,30,38]. It is also important to address and evaluate the resources needed for coordination, e.g.,lines of communication between the primary care services and the employee's workplace, the amount of time needed for the coordination, and the amount of time needed for reflection and supervision when implementing coordination in health care practices. Important issues for future research are the development of structured coordinator services, evaluating coordinator competencies in relation to sick leave outcomes, and strategies for organizational learning, as factors in implementing evidence-based and equal coordination practices.

### Methodological considerations

A qualitative approach to implementation science has benefits such as eliciting stakeholder perspectives, informing implementation, and understanding contextual factors across settings [39]. In the present study the analysis of coordination across multiple levels of system was facilitated by the use of CFIR [30]. Our methodological approach facilitated an in-depth description of facilitators of and barriers to central actors, i.e., those delivering and receiving coordination, which has previously been lacking in research. The data were collected and analyzed by a research team with relevant methodological and theoretical experience [40]. The data was based on interviews with 18 coordinators with varied professional experiences and backgrounds, and representing three Swedish regions. Moreover, the data was based on interviews with nine employees, whereof one male. Limitations of this study related to the difficulties to recruit eligible employees and to achieve gender balance. There is reason to believe that employees with negative attitudes to coordination declined participation. Possible negative user experiences of coordination are therefore important to address in future research. It is possible that gender balance and data from other stakeholder perspectives could have contributed to greater variation and depth in data. However, the combination of rich data from coordinators and the voice of those most intimately involved in coordination, namely

the employees on sick leave, was seen as important to achieve a breadth of experiences in relation to the study aim [40]. Another limitation was the variation in interview methods. The methods used were adapted to the participants' private or work situation and necessary to include a sufficient number of participants. This study was conducted in Sweden and included participants residing in urban settings and the coordinators were employed in the primary care health services. Generally, transferability of research related to RTW and coordination is limited by the differences in practice and settings in which coordination is conducted. However, the detailed descriptions of the health care and insurance system provided in this study, facilitates judgements of transferability to other settings.

The CFIR domains intervention characteristics, outer setting, inner setting, and characteristics of individuals was applied in analysis. While the use of deductive coding related to detailed accounts of selected CFIR constructs is recommended [30,39,41], combining an inductive and a theoretical approach in implementation research, such as in the present study, can make detailed descriptions possible [39]. However, to gain an overall understanding of CFIR domains, especially inner and outer settings, was challenging because of the large variety of constructs included in the domains and synthesized from a variety of existing theories. It was also a challenge because of the variety of detail in which constructs are presented. For example, "external policies and incentives" and "design quality and packaging" are only described briefly, while inner and outer settings might vary for coordinators and employees. Consequently, other interpretations might be possible. When further developing CFIR it might be a good idea to consider further synthesizing domains and specifying the mentioned constructs in greater detail.

### Conclusions

This study presents facilitators of and barriers to coordination across multiple levels of systems from the perspective of the coordinators themselves and the employees who are on sick leave because of CMDs. The facilitators indicate that coordination has the potential to mediate employees' needs with external workplace and policy demands and strategies to improve coordination. The barriers indicate that insufficient packaging and organization can give rise to uncertainty about how to achieve coordination as well as variation in practice. The present study therefore point to a need to: (1) develop detailed intervention packaging of coordination, (2) formalize coordinators' qualifications and level of training, and (3) recognize the importance of organizational factors such as a team-based approach and leadership engagement as a means of establishing a common ground for RTW in PCCs. These aspects are important to further develop and evaluate the efficacy of coordination and are therefore critical avenues for future research and practice.

### ORCID

Lisa Holmlund ⓘ http://orcid.org/0000-0001-8321-0174
Lydia Kwak ⓘ http://orcid.org/0000-0003-3117-6765
Elisabeth Björk Brämberg ⓘ http://orcid.org/0000-0002-0204-5144

### References

[1] OECD. Fit mind, fit job: from evidence to practice in mental health and work. Paris: OECD Publishing; 2015.

[2] Försäkringskassan (The Swedish Social Insurance Agency). Sjukfrånvarons utveckling 2016 Social insurance report 2016:7. Försäkringskassan Analys och Prognos. 2016. (Swedish).

[3] Psychosocial risks and stress at work [Internet]. European Agency for Saffety and Health at Work. [cited 2020 Oct 01]. Available from: https://osha.europa.eu/en/themes/psychosocial-risks-and-stress

[4] Rahman S, Mittendorfer-Rutz E, Alexanderson K, et al. Disability pension due to common mental disorders and healthcare use before and after policy changes; a nationwide study. Eur J Public Health. 2017;27(1):90–96.

[5] OECD. Health at a Glance: Europe 2018: State of Health in the EU Cycle. Paris: OECD Publishing; 2018.

[6] Björk Brämberg E, Klinga C, Jensen I, et al. Implementation of evidence-based rehabilitation for non-specific back pain and common mental health problems: a process evaluation of a nationwide initiative. BMC Health Serv Res. 2015;15:79.

[7] Loisel P, Buchbinder R, Hazard R, et al. Prevention of work disability due to musculoskeletal disorders: the challenge of implementing evidence. J Occup Rehabil. 2005;15(4): 507–524.

[8] Russell E, Kosny A. Communication and collaboration among return-to-work stakeholders. Disabil Rehabil. 2018; 17:1–10.

[9] Liukko J, Kuuva N. Cooperation of return-to-work professionals: the challenges of multi-actor work disability management. Disabil Rehabil. 2017;39(15):1466–1473.

[10] Ståhl C, Svensson T, Petersson G, et al. A matter of trust? A study of coordination of Swedish stakeholders in return-to-work. J Occup Rehabil. 2010;20(3):299–310.

[11] Ståhl C, Svensson T, Petersson G, et al. Swedish rehabilitation professionals' perspectives on work ability assessments in a changing sickness insurance system. Disabil Rehabil. 2011;33(15–16):1373–1382.

[12] Shaw W, Hong QN, Pransky G, et al. A literature review describing the role of return-to-work coordinators in trial programs and interventions designed to prevent workplace disability. J Occup Rehabil. 2008;18(1):2–15.

[13] Karkkainen R, Saaranen T, Rasanen K. Return-to-work coordinators' practices for workers with burnout. J Occup Rehabil. 2019;29(3):493–502.

[14] Skarpaas LS, Haveraaen LA, Smastuen MC, et al. Horizontal return to work coordination was more common in RTW programs than the recommended vertical coordination. The Rapid-RTW cohort study. BMC Health Serv Res. 2019; 19(1):759.

[15] Durand MJ, Nastasia I, Coutu MF, et al. Practices of return-to-work coordinators working in large organizations. J Occup Rehabil. 2017;27(1):137–147.

[16] Pransky G, Shaw WS, Loisel P, et al. Development and validation of competencies for return to work coordinators. J Occup Rehabil. 2010;20(1):41–48.

[17] Gardner BT, Pransky G, Shaw WS, et al. Researcher perspectives on competencies of return-to-work coordinators. Disabil Rehabil. 2010;32(1):72–78.

[18] Bohatko-Naismith J, Guest M, James C, et al. Australian general practitioners' perspective on the role of the workplace Return-to-Work Coordinator. Aust J Prim Health. 2018;24(6):502–509.

[19] Hälso- och sjukvårdförvaltningen. Lägre sjukskrivning med rehabkoordinator: utvärdering och utveckling av rehabkoordinator för patienter med långvarig smärta och/eller lätt medelsvår psykisk ohälsa i Stockholms läns landsting. Stockholm: Stockholms läns landsting; 2018. (Swedish).

[20] Aust B, Nielsen MB, Grundtvig G, et al. Implementation of the Danish return-to-work program: process evaluation of a trial in 21 Danish municipalities. Scand J Work Environ Health. 2015;41(6):529–541.

[21] Lag om koordineringsinsatser för sjukskrivna patienter (SFS:2019:1297). Stockholm: Socialdepartementet; 2019. (Swedish).

[22] Hansen Falkdal A, Ekvall A-B, Eklund U. Metodbok för koordinering av sjukskrivning och rehabilitering för hälso- och sjukvården. Stockholm: Sveriges kommuner och landsting; 2017. (Swedish).

[23] Argote L, Miron-Spektor E. Organizational learning: from experience to knowledge. Organ Sci. 2011;22(5):1123–1137.

[24] Schandelmaier S, Ebrahim S, Burkhardt SCA, et al. Return to work coordination programmes for work disability: a meta-analysis of randomised controlled trials. PLoS One. 2012;7(11):e49760.

[25] Vogel N, Schandelmaier S, Zumbrunn T, et al. Return-to-work coordination programmes for improving return to work in workers on sick leave. Cochrane Database Syst Rev. 2017;(3):CD011618.

[26] Nieuwenhuijsen K, Faber B, Verbeek JH, et al. Interventions to improve return to work in depressed people. Cochrane Database Syst Rev. 2014;(12):CD006237.

[27] Arends I, Bruinvels DJ, Rebergen DS, et al. Interventions to facilitate return to work in adults with adjustment disorders. Cochrane Database Syst Rev. 2012;(12):CD006389.

[28] Axen I, Björk Brämberg E, Vaez M, et al. Interventions for common mental disorders in the occupational health service: a systematic review with a narrative synthesis. Int Arch Occup Environ Health. 2020;93(7):823–838.

[29] Skarpaas LS, Haveraaen LA, Smastuen MC, et al. The association between having a coordinator and return to work: the rapid-return-to-work cohort study. BMJ Open. 2019;9(2):e024597.

[30] Damschroder LJ, Aron DC, Keith RE, et al. Fostering implementation of health services research findings into practice: a consolidated framework for advancing implementation science. Implement Sci. 2009;4:50.

[31] Swedish agency for health technology assessment and assessment of social services (SBU). Implementeringsstöd för psykiatrisk evidens i primärvården: en systematisk litteraturöversikt [Implementation of psychiatric guidelines and evidence-based knowledge in the primary care sector]. Stockholm: SBU; 2012.

[32] Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. Int J Qual Health Care. 2007;19(6):349–357.

[33] Björk Brämberg E, Sandman L, Hellman T, et al. Facilitators, barriers and ethical values related to the coordination of return-to-work among employees on sick leave due to common mental disorders: a protocol for a qualitative study (the CORE-project). BMJ Open. 2019;9(9):e032463.

[34] Braun V, Clarke V. Using thematic analysis in psychology. Qual Res Psychol. 2006;3(2):77–101.

[35] Young AE, Wasiak R, Roessler RT, et al. Return-to-work outcomes following work disability: stakeholder motivations, interests and concerns. J Occup Rehabil. 2005;15(4):543–556.

[36] Corbiere M, Mazaniello-Chezol M, Bastien MF, et al. Stakeholders' role and actions in the return-to-work process of workers on sick-leave due to common mental disorders: a scoping review. J Occup Rehabil. 2020;30(3):381–419.

[37] Ellstrom P-E. Orgnisational learning. In: Learning and cognition. Oxford: Elsevier; 2011.

[38] Plsek PE, Wilson T. Complexity, leadership, and management in healthcare organisations. BMJ. 2001;323(7315):746–749.

[39] National Institute of Health. Qualitative methods in implementation science. USA: U.S Department of Health and Human Services; 2015.

[40] Morse JM. Critical analysis of strategies for determining rigor in qualitative inquiry. Qual Health Res. 2015;25(9):1212–1222.

[41] Kirk MA, Kelley C, Yankey N, et al. A systematic review of the use of the consolidated framework for implementation research. Implement Sci. 2016;11:72–72.