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ORIGINAL ARTICLE

Return-to-work: Exploring professionals' experiences of support for persons with spinal cord injury

Lisa Holmlund[a,b], Susanne Guidetti[a], Gunilla Eriksson[a,c] and Eric Asaba[a,d,e]

[a]Department of Neurobiology, Care Science and Society, Division of Occupational Therapy, Karolinska Institutet, Huddinge, Sweden; [b]Spinalis SCI Unit, Rehab Station Stockholm, Stockholm, Sweden; [c]Department of Neuroscience, Rehabilitation Medicine, Uppsala University, Uppsala, Sweden; [d]Research, Education, and Development Unit, Stockholms Sjukhem Foundation, Stockholm, Sweden; [e]Department of Occupational Therapy, Graduate School of Human Health Sciences, Tokyo Metropolitan University, Tokyo, Japan

ABSTRACT

Purpose: To generate knowledge about how professional stakeholders organise and experience the support of the return-to-work (RTW) process for persons with spinal cord injury (SCI).

Methods: Constructivist grounded theory approach. Professional stakeholders ($n = 34$) involved in the RTW process and representing three Swedish Regions were recruited into seven focus groups. Analysis followed initial, focussed, and theoretical coding.

Findings: The core category – mediating intentions to support work and possibilities of working through social, labour market, and societal context – illustrates complexities of when and how to support a person with SCI in the RTW process, and a risk of delayed, unequal, or absent RTW processes. Analysis outlines: (1) Assessment of ability to work – uncertainty of how and when; (2) Planning RTW – divide between dynamic and rule-based perspectives; (3) Work re-entry – unequal paths towards viable solutions.

Conclusions: In RTW after SCI, it is critical to acknowledge how the RTW process is situated in relation to the person and context. A possible direction – grounded in an occupational perspective – through early identification of needs and resources and coordination derived from the SCI rehabilitation setting within healthcare is suggested. This can facilitate a time-sensitive and equal RTW process.

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Introduction

Participation in everyday life occupations, including meaningful work, is instrumental for a person's health and well-being [1,2]. Persons with disabilities [3], including those with spinal cord injury (SCI) [4–6], experience work as an integral part of their everyday life. Therefore, full and productive employment and decent work for all is part of the sustainable development goals [7]; and the convention on the rights of persons with disabilities [8]. Yet, the employment rates for persons with disabilities in 2017 were 62%, compared to 78% for the entire population in Sweden [9]. There is no recent research on employment rates for persons with SCI, but evidence point to about 47% [10,11] compared to about 35% internationally [12]. For the person with SCI, the return-to-work (RTW) process involves negotiations of uncertain everyday life situations and opportunities, due to physical, social [4,13–15], and societal circumstances [5,14]. Interventions for improving employment outcomes after SCI are scarce [16,17]. Research in the United States show evidence for Individual Placement and Support (IPS), an evidence-based supported employment programme [18]. In Australia, early RTW through the support of a vocational professional is developed [19,20]. More research from various settings is necessary to build an evidence base for RTW after SCI [16,21,22]. Therefore, the present study is part of a project aiming to explore and generate knowledge about RTW for adults with SCI to develop and evaluate the design and feasibility of an intervention in a Swedish rehabilitation setting.

RTW in this study is seen as a phenomena including a process that follows sick leave and an eventual outcome of resuming employment, or not [23]. RTW reflects a complex negotiation of employers,

CONTACT Lisa Holmlund lisa.holmlund@ki.se Institute of Environmental Medicine, Unit of Intervention and Implementation Research for Worker Health, Karolinska Institutet, Nobels väg 13, 171 77 Solna, Sweden

organisational structures, and individual situations, as well as socio-political discourses [22,24,25]. Therefore, supporting RTW rests on knowledge grounded in experiences representing multiple stakeholders involved in the RTW process. Stakeholders are defined as 'any person, organisation or agency that stands to gain or lose based on the results of the RTW process' [26, p. 544]. In this study, professional stakeholders refer to healthcare professionals within the SCI rehabilitation team, employers, and representatives from the Swedish Social Insurance Agency (SSIA) and the Swedish Public Employment Service (SPES). The SSIA oversees monitoring and coordinating measures for individuals on sick leave [27]. The employer is responsible for actively engaging in a rehabilitation plan and making accommodations at the workplace [28]. For those lacking employment, the SPES carries the corresponding responsibilities. Traditionally, healthcare manages medical care and rehabilitation [29]. However, an increased responsibility for healthcare to coordinate RTW is legally required in Sweden from February 2020 [30].

In Sweden, persons with SCI experience fragmented support from professional stakeholders [5,13,14] and unclear allocation of responsibilities [5]. This implies a risk that the person needs to find their own solutions for RTW [5]. In line with this, research demonstrates challenges in how professional stakeholders act and interact in the RTW process. These are: challenges to coordination [31]; divergent perspectives on work ability assessments [32,33]; fragmentation of the RTW process due to lack of routines [31,32]; and lack of knowledge about others' expertise and capacity for actions [31,34]. As a response to poor coordination of RTW, integration of services using a coordinator is being increasingly reported internationally [35–39] and is also described in Sweden [40]. The evidence for such services is still uncertain [41,42] and implementation strategies vary [41]. In Sweden, coordination of RTW is mainly implemented within the primary health care for persons with musculoskeletal and common mental disorders [40]. Coordination of RTW within rehabilitation settings is less developed. Due to the multiple systems involved in RTW [24], interventions for RTW will depend on the local insurance, healthcare, and labour market systems [22]. Therefore, in the development of interventions for RTW, it is necessary to build on what is already known, and to understand the context and setting in which the implementation of interventions are intended [21,22]. To our knowledge, professional stakeholders' organisation and interactions to support RTW within SCI rehabilitation have not been explored. Therefore, the aim of this study was to generate knowledge about how professional stakeholders organise and experience the support of the RTW process for persons with SCI.

Methods

This qualitative explorative study used a constructivist grounded theory approach. This approach is sensitive to context, and focusses on actions, interactions, and process, and acknowledges the involvement of researchers in the interpretation and construction of data [43]. The authors have clinical and research experience of RTW and SCI rehabilitation.

Setting

SCI services in Sweden are provided on a Regional level. The first acute care episode is provided in a SCI unit at a hospital and subsequent in-patient care and rehabilitation are carried out in a rehabilitation setting. For some, life-long outpatient care and follow-up are provided in a SCI rehabilitation setting. However, access to such services can vary between regions.

After sickness or injury, eligibility for sick leave benefits is decided by the SSIA based on a work ability assessment issued in a sickness certificate by the physician in healthcare. This assessment needs to be grounded on a causal link between diagnosis–disability–activity limitations, and follows certain time limits: (1) the first day of sick leave is a waiting day, and up to 14 days, the employer is the cost bearer; (2) after 14 days, assessment of work ability is for ordinary duties at work, and the SSIA is the cost bearer; (3) after 90 days, assessment is for any duties at the place of employment; and (4) after 180 days, if the person is not likely to return to the employer within 364 days of sick leave, assessment is for any job in the regular labour market. If the person is unemployed, assessment for any job in the regular labour market starts from the first day of sick leave. A person who lacks employment after injury can be involved in increased cooperation between the SSIA and the SPES with retained sick leave allowance. Another measure offered by the SPES is a special introduction and follow-up support [Swedish SIUS] that builds on Supported Employment – however, SIUS is not a fully implemented IPS service. Measures offered by SPES for persons on sick leave are initiated by the SSIA, and this, in turn, often requires cues from healthcare.

If the person is permanently unable to work, s/he can be granted disability pension. Both sick leave and disability pension can be granted on fixed levels, i.e. 25%, 50%, or 75% of previous working hours.

Participants

Participants ($n = 34$) represented stakeholders who assisted the persons with SCI in their RTW process: employers, with at least one employee living with SCI; representatives from the SSIA and the SPES; and the SCI rehabilitation team in healthcare, e.g. physician, nurse, occupational therapist, social worker, and physiotherapist (Table 1). Recruitment into seven focus groups followed purposive [44] and theoretical sampling [43] and took place in three Swedish Regions (Table 2). Purposive sampling was initially relevant to facilitate a broad understanding in relation to the aim [44], while theoretical sampling was used to refine and develop emerging categories, which is in keeping with strategies in grounded theory [43]. The representatives from the SSIA were all caseworkers, while representatives from the SPES were both caseworkers or worked as consultants, such as occupational therapists or psychologists. In this study, representatives from governmental agencies will be referred to as officers. Officers at the SSIA and the SPES are not specialised in different conditions, such as SCI. Therefore, the inclusion criterion for officers at the SSIA and the SPES was officers with a wide experience of working with rehabilitation aiming at RTW.

Table 1. Overview of participants ($n = 34$).

Participants	Number of participants ($n = 34$)
SCI rehabilitation team	14
Physicians	4
Occupational therapists	3
Physiotherapists	2
Social workers	4
Nurse	1
Swedish Social Insurance Agency	5
Swedish Public Employment Office	10
Caseworkers	6
Special consultants	4
Employers	5
Private sector	3
Municipality	1
County Council	1

Data generation and analysis

Focus group interviews were utilised to explore experiences of RTW from multiple perspectives as well as to enable group dynamics to shed light on nuanced differences and tensions in how different stakeholders experienced supporting RTW [45]. Each focus group interview was digitally recorded and transcribed verbatim. Data were analysed continuously during data collection by listening to recordings and writing memos [43]. The focus group interviews were semi-structured with questions divided into four conceptual areas: the RTW process after SCI; coordination of stakeholders involved; communication between professional stakeholders; and paths to work for those lacking employment after SCI, e.g. persons who were unemployed at the time of injury or persons who could not return to their previous work due to consequences of injury. The focus group interviews were conducted in five interview phases and the interview guide was reviewed between each phase (Table 2). The first two interviews sought to collect data related to a broad understanding of governmental officer experience of the RTW process. This guided further exploration and adaptation of the interview guide. The third and fourth interviews included participants representing all professional stakeholders and focussed on questions such as coordination of the RTW process and communication between stakeholders. In addition, findings generated in a previous photovoice study [5] were used as triggers for discussion to include a perspective of those living with SCI. These triggers related to experiences such as fragmented support in the RTW process after SCI [5]. The following three interviews were guided by theoretical sampling (Table 2). The focus group interview with the SCI rehabilitation team contributed to data to deepen

Table 2. Interview phases, sampling, focus groups ($n = 7$) and participants ($n = 34$).

Interview phase	Sampling	Focus group	Participants[a]	Participants representing
1	Purposive	1	6	SPES
		2	3	SSIA
2	Purposive	3	7	All professional stakeholders
		4[a]	7	All professional stakeholders
3	Theoretical	5	5	SCI rehabilitation team
4	Theoretical	6[a]	3	Increased cooperation between SSIA and SPES[b]
5	Theoretical	7	4	Employers to persons with SCI

[a]One officer from the SSIA participated in both groups 4 and 6.
[b]SSIA = Swedish Social Insurance Agency, SPES = Swedish Public Employment Office.

the knowledge on RTW organisation in early SCI rehabilitation. The last two focus groups (Table 2) generated data on RTW organisation for those in work and those lacking employment to return to.

Analysis followed initial, focussed, and theoretical coding [43]. Initial coding started with the first author reading transcripts and subsequently coding the data. Initial coding helped with defining meaning and actions and gave direction to explore and make constant comparisons of data. When initial coding advanced, analytically important codes were re-coded or summed up in focussed codes to advance the conceptual understanding of the data. Theoretical coding was used to conceptualise how focussed codes were related, and to make the findings comprehensible and coherent. This process resulted in a temporal ordering of main categories and a core category that was connected to theoretical concepts. The analysis was supported by memo writing and continuous discussions among the authors [43], and the software ATLAS.ti was used when coding the data [46]. Swedish language was used throughout the focus group interviews, transcription, and analysis. For the purpose of publication, quotations have been translated independently by the first and last author and compared for accuracy. Where there were discrepancies, the authors discussed and proceeded until consensus could be reached.

Findings

The findings are presented in three main categories: (1) assessment of ability to work – uncertainty of how and when; (2) planning RTW – divide between dynamic and rule-based perspectives; and (3) work re-entry – unequal paths towards viable solutions. From these categories, the core category – mediating intentions to support work and possibilities of working through social, labour market, and societal context – was developed (Table 3). The categories follow the initial phases of the RTW process, e.g. off work and work-re-entry [36].

Assessment of ability to work – uncertainty of how and when

Assessing the person's ability to work was part of the RTW process, although ambiguity lingered among participants in relation to how and when a more comprehensive assessment of the persons situation should be implemented. The category is divided into subcategories: lacking a comprehensive picture and the paradox of acting early.

Lacking a comprehensive picture

Early work ability assessment represented a one-dimensional medical picture through a sickness certificate, while comprehensive identification of the person's needs and resources was lacking. The sickness certificate was an important communication tool between healthcare professionals and the SSIA officers, and officers at the SSIA emphasised the importance of a sickness certificate – grounded in a medical assessment – as a starting point for their actions. However, the healthcare professionals and officers at the SPES questioned if the sickness certificate reflected a fair assessment of the person's work ability. One physician explained,

> Then I need to know where the person is working, what it is they do at work, how much support they get, if they must do everything on their own. There are so many factors that impact on whether the person can work 58% or 60%. I don't have any scientific methods to measure it.

The physician's frustration was grounded in a feeling of unrealistic expectations from the SSIA. Six months after the first day of sick leave, sickness certificates needed to be completed in relation to non-specific work assignments and workplace environments, i.e. any job in the labour market. At this point, the person was often still readjusting to the consequences of the SCI. Participants from healthcare and the SPES stressed that work ability was related to everyday life situations after SCI and opportunities in the regular labour market. This tension between what was a possible or unrealistic expectation implicated a wider, multidimensional perspective on work ability. One physician said,

> There are visible hindrances and measurable barriers in relation to RTW that are likely directly related to disability. But then there are all these less visible hindrances that are very difficult to measure … / … if a person has worked in manual labour earlier, then

Table 3. Core category and categories.

Core category	Mediating intentions to support work and possibilities of working through social, labour market, and societal context
Category 1	Assessment of ability to work – uncertainty of how and when
	Lacking a comprehensive picture
	The paradox of acting early
Category 2	Planning RTW – divide between dynamic and rule-based perspectives
	Arguing for the dynamic or the explicit
	Acting for the person or by regulations
Category 3	Work Re-entry – unequal paths towards viable solutions

> returning to a completely different job. Or return … find another job. And that alone is something that needs to be taken into consideration in the assessment.

Writing a 'good' sickness certificate was built on tacit knowledge about how to balance medical assessments, matching the legal framework, with the assessment of work ability/inability relating to everyday life situations and context. How a person's needs and resources could be identified as part of a RTW process after SCI was however ambiguous. A structured use of outcome measures relating to work ability was lacking in healthcare, despite competencies of a multi-professional team. The officers at the SPES expressed being skilled at work ability assessment but lacked awareness of the persons with SCI, if contact were not initiated by the SSIA. Both the SSIA officers and the employer expressed lack of knowledge in relation to SCI. Overall, it was a risk of a one-dimensional medical picture of work ability communicated *via* the sickness certificate as the starting point of the RTW process and therefore unclarity about the person's needs and resources in early RTW.

The paradox of acting early

All participants emphasised the importance of acting early in the RTW process. A clear definition of early was not provided, and early needed to be balanced to medical rehabilitation. The SCI rehabilitation team talked in terms of initiating a dialogue about work and motivating the person to visit the workplace during primary rehabilitation – or early secondary (outpatient) rehabilitation – while the SSIA promoted return to the workplace preferably before 180 days. Benefits of early dialogue were to set direction and prevent a distance between the individuals with SCI and the workplace; yet, returning too early could pose risks for secondary complications and physical weariness. One physician said: 'One needs to talk quite a lot about how you are working full-time with your [medical] rehabilitation. You cannot think about work right now.' Therefore, finding a balance between an early dialogue and initiating work re-entry was important for healthcare professionals. For the officers at the SSIA, early dialogue had a purpose of sharing information about the RTW process and related legal frameworks. One officer said,

> What's important is to think that the SSIA has a legal framework to follow, what can we do, based on what the framework looks like today … / … That it is important to share, early in the process …

Deviations from time limitations needed to be motivated in a sickness certificate. A challenge was therefore that the person with SCI was expected to proceed rapidly, but preferably after medical recovery. To manage this paradox, the physicians described that exceptions in sickness certificates were the norm after SCI. The complex situation after SCI also meant that the SSIA officers and the employers found it challenging to determine when to initiate RTW measures. One officer reflected on her experience of awaiting medical recovery: 'I shouldn't disturb, that is the typical approach, so like, now we wait until the person gets better and comes back.' The initial period after SCI could therefore be characterised by insecurity, pending medical recovery, and exceptions to the time limits of the rehabilitation chain. A possible option of parallel processes of medical rehabilitation and early dialogue about work was purposed by some of the participants as an alternative to the current situation.

Planning RTW – divide between dynamic and rule-based perspectives

Design of a plan for RTW set the direction in the RTW process, and integration of services was essential to accomplish this; yet, divided perspectives meant breaches to seamless coordination for the person with SCI. The category is divided into subcategories: arguing for the dynamic or explicit and acting for the person or by regulations.

Arguing for the dynamic or the explicit

Navigating RTW often required integration of stakeholder competencies and incentives. Communication between stakeholders could include written or telephone contact; however, face-to-face meetings were often seen as important to design a plan for RTW. Meetings created a platform to share expertise, and could reduce the risk of the person with SCI being forgotten or lost to follow up. One occupational therapist explained,

> I think these meetings with the patient, the employer, the SSIA and the team from here [the SCI unit] are extremely good meetings. When everyone hears the same thing, [people agree].

Meetings were therefore experienced as a success factor in the RTW process; however, the structuring of meetings involved tensions. Participants from several stakeholder groups argued that RTW after SCI was complex and therefore the planning needed to include a dynamic approach to follow the person's rehabilitation process. Early, 'open-ended' meetings could contribute to maintaining the persons with SCI's positive expectations for work and moving the

RTW process forward. This was found to be particularly important to those lacking employment after SCI. One social worker said,

> It has been so positive to come and be part of these meetings. Even if it doesn't mean that the patient is going to start working next month; more like getting things started, and what is the situation like now, how close to returning are we, what can the plan look like and when? Even if it's a few months ahead, it's ok.

The social worker reflected on a supportive process where paths, hard-to-see for separate stakeholders, could be explored with common expertise. Furthermore, she reflected on how possibilities for more open-ended meetings had been limited. Officers at the SSIA were directed to avoid unnecessary meetings, one officer said, 'if there is no need, one doesn't have meetings for the sake of meetings.' This perspective meant that open-ended meetings was not arranged. Arguing for an explicit purpose of meetings was grounded in a concern of meetings ending up in no or unrealistic plans. Yet, upholding a demand on an explicit purpose, together with lack of clarity about responsibility to initiate meetings, seemed to imply delayed RTW processes.

Acting for the person or by regulations

Focussing on the person with SCI throughout the RTW process was taken for granted for all participants. Despite the clarity about what to focus on, a legal framework for sickness absence controlled the RTW process. This category thus juxtaposes the tensions between a focus on the person or the regulations. One doctor said: 'Illness has its … its course that cannot be controlled by artificial limits,' in referring to the individual process for recovery and rehabilitation after SCI. While an officer at the SSIA stated, 'What's important is that one thinks the SSIA has a legal framework to follow, and what we can do based on the framework today.' The officer pointed to the insurance policy that was based on a legal framework that applied equally to all persons on sick leave, and she expressed frustration in trying to find solutions within this framework. The linearity in this reasoning led to frustration among the other participants. These frustrations were exemplified in a dialogue between an occupational therapist and an officer at the SSIA,

> [OT] 'We often see that flexibility in the system doesn't exist, it is a very rigid system, one should work 25%, or 50% or 75% … in between there isn't much … there are actually very few jobs in which one can work 25%.' [SSIA officer] 'I agree. The biggest challenge for me working in the SSIA is to find a plan that fits all, based on the legal framework we have, and grounded in the assessments we have.'

Tensions between focussing on the person or regulations were present in discussions about time limitations to sick leave, the demand to evenly distribute part-time work over the week, and the fixed sick leave grades. Legal frameworks were not experienced as suitable for a person with SCI, considering their adverse effects and the extended rehabilitation following SCI. Instead a certain amount of flexibility was highlighted, especially by employers, healthcare professionals, and officers at the SPES. Comprehensive identification of needs and resources and concerted actions could potentially bridge discrepancies and open for flexibility in planning RTW. One officer said: 'If healthcare, the physician, has provided a medical justification that we accept … then it's ok with an alternative setup.' Thus, well-functioning integration of services was critical to the practice of negotiating both individual needs and structural conditions.

Work re-entry – unequal paths towards viable solutions

Finding paths towards work for those lacking employment was challenging in the RTW process. Due to the consequences of SCI, such as changed physical ability, employers and officers at the SPES found that RTW often required time to be spent at a workplace to assess their work ability. Paths towards work thus differed depending on whether the person had a workplace to return to. For those with a workplace to return to, work ability assessment at the workplace was possible with economic support from the SSIA. Through on-going dialogue with the employee with SCI, the employers could gain an awareness of how work interacted with everyday life after SCI. This awareness contributed to the person being able to focus on work tasks and acquired knowledge for the employer in how the employee with SCI preferred being met at the workplace. One employer gave an example,

> We are out with customers all the time, and then we need, the first time at least, to find out, how does he gain access to the customer workplace? And typically, it works out very well, and exactly, he is also like that, 'no, I don't want to be pampered, but when there is a need, then you have to carry me'.

For those lacking employment after injury, a workplace could be appointed by the SPES This required

an assessment that the person had ≥ 25% work ability and for the person to register as a job seeker in the regular labour market. Opportunities to find employment with support from the SPES were problematised among healthcare professionals. The physicians expressed difficulties to assess ≥ 25% work ability without a specific job to relate to, and uncertainty of employability in the regular labour market for a person with SCI in need of accommodations at work. One physician exemplified this,

> She could work 25–50% with lighter duties. The problem is that it isn't available at the person's workplace, so the question is whether she should resign 50%. And what should she do then? Go to the [Swedish Public] Employment Service that has a responsibility to provide support. What are the chances of that happening? Zero, according to my experience.

The physician described a situation with no opportunities after SCI for reassignment or accommodation at the previous workplace. The uncertainty felt was related to the lack of opportunities of finding less demanding, part-time employment in the regular labour market, and a risk of the person losing sickness benefits without solutions for work being found. Officers at the SPES shared this concern. Although they had means of physical adaptations and support for the person, they struggled with finding suitable placements. Healthcare professionals lacked in-depth knowledge about SPES and experienced resistance from the officers at the SSIA when advocating for economically safer paths *via* the Increased Cooperation between the SPES and the SSIA. Officers at the SPES stated that they rarely received referrals about persons with SCI. Paths towards work *via* employment services were thus obscure and necessary referrals seemed uncommon. Consequently, paths towards work were unequal, and depended on whether the person had employment to return to after injury.

Core category: mediating intentions to support work and possibilities of working through social, labour market, and societal context

The core category relates to the influence of context, e.g. social, labour market, and societal context, when aiming to co-construct viable paths towards work after SCI. The participants wished to include the person with SCI in finding paths towards work, thus supporting a sense of belonging and becoming through future meaningful work [1]. Yet, occupational possibilities [47,48], e.g. opportunities for future work, were shaped by everyday life situations after SCI in relation to the labour market and the societal context. A well-functioning RTW process was hindered by the uncertainty of when and how to initiate and proceed in supporting the person living with SCI in the RTW process. Uncertainties were grounded in a lack of structure, lack of tools to identify the person's needs and resources in the process, unclear allocation of responsibilities, and tensions among professional stakeholders. The promoted and intended support for RTW was therefore contrasted to potential risks of unequal or economically unsafe paths towards work. This implied that the RTW process could be delayed or absent for the persons with SCI, and negatively affected the stakeholder's actions and interactions in the RTW process. The analysis points to the potentiality of a structured but non-linear process emerging from an understanding of how everyday life situations, labour market, and societal context affect occupational possibilities, such as opportunities for paid work [47,48].

Discussion

This study illustrates situations of complexity in relation to when and how to support a person with SCI along paths towards work after injury. The core category – mediating intentions to support work and possibilities of working through social, labour market, and societal context – highlights contextual barriers to the ambitions to support persons with SCI in the RTW process. The potentiality of early but time-sensitive initiation of RTW, and direction through coordination of RTW deriving from the SCI rehabilitation team will be discussed. Moreover, how the facilitation of RTW relates to occupational possibilities [47,48].

The findings illustrate early assessment and time-sensitive initiation as critical in RTW after SCI. A time-sensitive initiation is relevant because research shows that RTW for many persons with SCI involves a substantial delay of about five years on average due to the need for readjustment and retraining [49,50]. Evidence suggests that early and multidisciplinary interventions are effective [51]. Yet, if work re-entry is too early, there is a risk that the person returns to the workplace before being sufficiently recovered [52]. Defining early is therefore challenging and difficult to standardise across populations. In initiating a RTW process, this study highlights the urgency of early and comprehensive identification of needs and resources to guide planning and timeliness for RTW after a complex condition such as SCI. To better design a

plan for RTW, 'focussing on the person and situation as a whole' [53, p. 7] is needed, i.e. a structured identification of needs and resources in relation to the person's everyday-life, work situation, and societal context. Based on viewing work as one of the several occupations in a repertoire of everyday situations [54,55], the occupational therapist has an important role in the team responsible for RTW rehabilitation. The occupational therapist's role and competencies in carrying out assessments complementary to the medical assessment, and to support the person in finding strategies for a new everyday life is previously highlighted [33,54,56]. In addition, the occupational therapist's training in establishing partnership with the person is relevant for a shared responsibility and trust in the rehabilitation process [57,58], and for goalsetting and planning [57]. Utilising the occupational therapist's competencies thus have the potential to facilitate a time-sensitive initiation of RTW.

Based on the findings, coordination of RTW derived from the SCI rehabilitation setting within the healthcare is suggested. This study pointed to a lack of structure, unclear allocation of responsibilities, and different approaches among professionals in the RTW process for the person with SCI. Similar challenges has previously been shown in other settings and for other populations [24,26,31–34]. This study especially demonstrated how a lack of structure and unclear responsibilities implied a risk of delayed or absent support through RTW for the person with SCI. A majority of those with a traumatic SCI in Sweden are in working age [59], and coordination of RTW derived from the SCI rehabilitation setting has the potential of organising the early RTW process for them. The use of coordinators is increasingly reported [35–40], and coordination of RTW within healthcare is legally required in Sweden [30]. Yet, persons with SCI in Sweden typically lack coordinator availability, and the evidence for coordination of RTW is still uncertain [41,42]. Continued development and evaluation are therefore relevant. For the effectiveness of coordination, it is possible that the work-place based component in coordination needs to be further developed. A combination of health-focussed, service coordination, and work modification interventions is shown to decrease duration away from work [60], and persons with SCI highlight that dialogue with the employer is imperative for a well-functioning RTW after injury [5]. Further, research show that occupational therapists trained in following a person-centred programme in a rehabilitation setting can support communication between stakeholders in the RTW process [56,61], and in this way clarify paths towards work [61]. Integrated services deriving from the SCI rehabilitation setting is thus probably important to guide the early RTW process. Through knowledge transfer about the SCI and initiating a dialogue between stakeholders, it might be possible to combine a focus on the person with SCI with considerations of legal frameworks.

The uncertain paths towards work after SCI, especially for those lacking employment to return to, indicate a need to address possibilities for work after SCI. The participants pointed to complex barriers due to economically unsafe paths towards meaningful work, time needed for readjustment after SCI, potential difficulties to find an adjusted part-time job, and a poor fit between regulations and recovery after SCI. Rudman [47,48] argues that occupational possibilities are shaped by political, cultural, and social influences, and that by using the concept 'occupational possibilities,' we can conceptually understand certain occupations as ideal, possible, and promoted within a certain socio-historical context. Occupational possibilities are also connected to experiences of meaning, i.e. that persons respond to how possibilities arise and are recognised by themselves and others [62]. Occupational possibilities in this study relates that employment is highly valued in the Swedish socio-political system, yet support for those lacking a workplace to return to after injury was difficult to organise. This aligns with experiences of those living with SCI who express uncertainty about finding a viable working situation contributing to meaningful engagement, identity construction, and self-sufficiency [13,14]. Therefore, there is a need to consider how RTW can improve after SCI for those with less opportunities to return to work. In this endeavour, it is important to support the person to find integrated solutions for everyday life with work [5]. The occupational therapist and the SCI rehabilitation team is important in enabling this. It is also relevant to review paths between stakeholders and the opportunities at the labour market for the person with SCI that lack employment after injury. Increased cooperation between the SSIA and the SPES can be a suitable measure since it can offer economically safer paths to assess work ability and options for work. Moreover, special introduction and follow-up support [Swedish SIUS] can be suitable. Exploring paths through SPES and the relevancy of measures building on supported employment are relevant for future studies among those lacking employment after SCI. This is important from the evidence for IPS shown for this group in the United States [18].

This study contributes with a multiple stakeholder perspective to how the RTW process is organised for the person with SCI. This is instrumental to critically exploring routines and legal frameworks for RTW after disability and to the future development of interventions. The systematic back and forward process in data collection and analysis, triangulation of participants and researchers, and a move towards theoretical sampling and theoretical coding contributed to sufficient data to merit the claims presented in the findings [63]. The core category does not present a final theory construction. However, attending to actions and interactions through a process of initial, focussed, and theoretical coding enabled situating the analysis in relation to a temporal understanding of the RTW process and a theoretical concept [43,63]. To advance theory construction, this can be further developed in future research. Limitations to this study was that the follow-up of RTW was not explored in depth. Moreover, officers at governmental agencies in Sweden are not specialised in different medical conditions and it was therefore not possible to recruit officers who were specialised in RTW after SCI. It was, however, relevant to recruit officers with a wide experience of working with rehabilitation for RTW. This enabled contrasting the employers and healthcare professionals' experiences of SCI rehabilitation to implementation of legal frameworks, and thus understanding the RTW process from different perspectives. In addition, the study was carried out in urban settings and related to a specific population with substantial physical disability. This was important in generating knowledge in the local context. Findings might be applicable across settings and to other populations within medical rehabilitation.

In conclusion, despite ambitions of inclusive RTW, the participants illustrated an ambiguous situation and a process that lacked the structure to support the person with SCI. This imposed uncertainty and tensions among stakeholders and a risk of unequal, delayed, or absent processes. The potentiality of early but time-sensitive actions and coordination based in healthcare is highlighted. In this endeavour, the competencies of occupational therapists are useful. Moreover, consideration of how everyday life situations are related to context and how they are shaped by possibilities is critical in preventing disparities among persons with SCI.

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ORCID

Lisa Holmlund http://orcid.org/0000-0001-8321-0174
Susanne Guidetti http://orcid.org/0000-0001-6878-6394
Gunilla Eriksson http://orcid.org/0000-0002-5308-4821
Eric Asaba http://orcid.org/0000-0002-6910-3468

References

[1] Wilcock AA, Hocking C. An occupational perspective of health. Thorofare (NJ): Slack; 2015.
[2] Waddell G, Burton AK. Is work good for your health and well-being? London: TSO (The Stationery Office); 2006.
[3] Saunders SL, Nedelec B. What work means to people with work disability: a scoping review. J Occup Rehabil. 2014;24(1):100–110.
[4] Hay-Smith EJ, Dickson B, Nunnerley J, et al. "The final piece of the puzzle to fit in": an interpretative phenomenological analysis of the return to employment in New Zealand after spinal cord injury. Disabil Rehabil. 2013;35(17):1436–1446.
[5] Holmlund L, Hultling C, Asaba E. Mapping out one's own paths toward work: focus on experiences of return to work after spinal cord injury. Qual Health Res. 2018;28(13):2020–2032.
[6] Meade MA, Reed KS, Saunders LL, et al. It's all of the above: benefits of working for individuals with spinal cord injury. Top Spinal Cord Inj Rehabil. 2015;21(1):1–9.
[7] Sustainable development goals knowledge platform [Internet]. New York: United Nations; 2015 [cited 2019 Nov 1]. Available from: https://sustainabledevelopment.un.org/sdg8
[8] Convention on the rights of persons with disabilities-optional protocol [Internet]. New York: United Nations; 2006 [cited 2019 Nov 1]. Available from: https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-withdisabilities.html
[9] Statistics Sweden. Situationen på arbetsmarknaden för personer med funktionsnedsättning 2017 (Eng.The labour market situation for people with

disabilities 2017). Stockholm: Statistics Sweden; 2017.
[10] Levi R, Hultling C, Seiger A. The Stockholm spinal cord injury study: 4. Psychosocial and financial issues of the Swedish annual level-of-living survey in SCI subjects and controls. Paraplegia. 1996;34(3): 152–157.
[11] Valtonen K, Karlsson A, Alaranta H, et al. Work participation among persons with traumatic spinal cord injury and meningomyelocele1. J Rehabil Med. 2006;38(3):192–200.
[12] Ottomanelli L, Lind L. Review of critical factors related to employment after spinal cord injury: implications for research and vocational services. J Spinal Cord Med. 2009;32(5):503–531.
[13] Bergmark L, Westgren N, Asaba E. Returning to work after spinal cord injury: exploring young adults' early expectations and experience. Disabil Rehabil. 2011;33(25-26):2553–2558.
[14] Holmlund L, Guidetti S, Eriksson G, et al. Return to work in the context of everyday life 7–11 years after spinal cord injury – a follow-up study. Disabil Rehabil. 2018;40(24):2875–2883.
[15] Fadyl JK, McPherson KM. Understanding decisions about work after spinal cord injury. J Occup Rehabil. 2010;20(1):69–80.
[16] Roels EH, Aertgeerts B, Ramaekers D, et al. Hospital- and community-based interventions enhancing (re)employment for people with spinal cord injury: a systematic review. Spinal Cord. 2016; 54(1):2–7.
[17] Trenaman LM, Miller WC, Escorpizo R, SCIRE Research TeamInterventions for improving employment outcomes among individuals with spinal cord injury: a systematic review. Spinal Cord. 2014; 52(11):788–794.
[18] Ottomanelli L, Goetz LL, Suris A, et al. Effectiveness of supported employment for veterans with spinal cord injuries: results from a randomized multisite study. Arch Phys Med Rehabil. 2012;93(5):740–747.
[19] Middleton JW, Johnston D, Murphy G, et al. Early access to vocational rehabilitation for spinal cord injury inpatients. J Rehabil Med. 2015;47(7): 626–631.
[20] Hilton G, Unsworth CA, Murphy GC, et al. Longitudinal employment outcomes of an early intervention vocational rehabilitation service for people admitted to rehabilitation with a traumatic spinal cord injury. Spinal Cord. 2017;55(8):743–752.
[21] Craig P, Dieppe P, Macintyre S, et al. Developing and evaluating complex interventions: the new Medical Research Council guidance. BMJ. 2008;337: a1655.
[22] Stahl C, Costa-Black K, Loisel P. Applying theories to better understand socio-political challenges in implementing evidence-based work disability prevention strategies. Disabil Rehabil. 2018;40(8): 952–959.
[23] Young AE, Roessler RT, Wasiak R, et al. A developmental conceptualization of return to work. J Occup Rehabil. 2005;15(4):557–568.
[24] 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.
[25] Lederer V, Loisel P, Rivard M, et al. Exploring the diversity of conceptualizations of work (dis)ability: a scoping review of published definitions. J Occup Rehabil. 2014;24(2):242–267.
[26] 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.
[27] Socialförsäkringsbalk (eng: Social Insurance Code) (SFS 2010:110). Stockholm: Socialdepartementet.
[28] Arbetsmiljölag (eng: Work Environment Act) (SFS 1977:1160). Stockholm: Arbetsmarknadsdeparte mentet. Stockholm: Arbetsmarknadsdepartementet.
[29] Hälso- och Sjukvårdslag (eng: Health and Medical Services Act) (SFS 2017:30). Stockholm: Socialdepart ementet.
[30] Lag om koordineringsinsatser för sjukskrivna patienter (SFS:2019:1297). Stockholm: Socialdepart ementet.
[31] Russell E, Kosny A. Communication and collaboration among return-to-work stakeholders. Disabil Rehabil. 2019;41(22):2630–2639.
[32] 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.
[33] Sturesson M, Edlund C, Fjellman-Wiklund A, et al. Work ability as obscure, complex and unique: views of Swedish occupational therapists and physicians. Work. 2013;45(1):117–128.
[34] Hellman T, Bergstrom A, Eriksson G, et al. Return to work after stroke: Important aspects shared and contrasted by five stakeholder groups. Work. 2016; 55(4):901–911.
[35] 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.
[36] 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
[37] Karkkainen R, Saaranen T, Rasanen K. Return-to-work coordinators' practices for workers with burnout. J Occup Rehabil. 2019;29(3):493–502.
[38] 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.
[39] 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.
[40] Hälsooch sjukvårdsförvaltningen. 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.
[41] 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(3): CD011618.
[42] 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.
[43] Charmaz K. Constructing grounded theory. Thousand Oaks (CA): Sage Publications; 2014.
[44] Bogdan R, Biklen SK. Qualitative research for education: an introduction to theory and methods. Boston, MA: Pearson A & B; 2007.
[45] Ivanoff SD, Hultberg J. Understanding the multiple realities of everyday life: basic assumptions in focus-group methodology. Scand J Occup Ther. 2006; 13(2):125–132.
[46] Friese S. Qualitative data analysis with ATLAS.ti. London: Sage; 2014.
[47] Rudman DL. Occupational terminology. J Occup Sci. 2010;17(1):55–59.
[48] Rudman DL. Understanding political influences on occupational possibilities: an analysis of newspaper constructions of retirement. J Occup Sci. 2005;12(3): 149–160.
[49] Ramakrishnan K, Mazlan M, Julia PE, et al. Return to work after spinal cord injury: factors related to time to first job. Spinal Cord. 2011;49(8):924–927.
[50] Krause JS. Years to employment after spinal cord injury. Arch Phys Med Rehabil. 2003;84(9): 1282–1289.
[51] Hoefsmit N, Houkes I, Nijhuis FJ. Intervention characteristics that facilitate return to work after sickness absence: a systematic literature review. J Occup Rehabil. 2012;22(4):462–477.
[52] Seing I, MacEachen E, Stahl C, et al. Early-return-to-work in the context of an intensification of working life and changing employment relationships. J Occup Rehabil. 2015;25(1):74–85.
[53] Fritz H, Cutchin MP. The transactional perspective on occupation: a way to transcend the individual in health promotion interventions and research. J Occup Sci. 2017;24(4):446–457.
[54] Hasselkus BR. The meaning of everyday occupation. Thorofare (NJ): SLACK; 2011.
[55] Townsend EA. Enabling occupation: an occupational therapy perspective. Ottawa: Canadian Association of Occupational Therapists; 2002.
[56] Ost Nilsson A, Eriksson G, Asaba E, et al. Being a co-worker or a manager of a colleague returning to work after stroke: A challenge facilitated by cooperation and flexibility. Scand J Occup Ther. 2020; 27(3):2013–2222.
[57] Ranner M, von Koch L, Guidetti S, et al. Client-centred ADL intervention after stroke: occupational therapists' experiences. Scand J Occup Ther. 2016; 23(2):81–90.
[58] Ranner M, Guidetti S, von Koch L, et al. Experiences of participating in a client-centred ADL intervention after stroke. Disabil Rehabil. 2019; 41(25):3025–3033.
[59] Joseph C, Andersson N, Bjelak S, et al. Incidence, aetiology and injury characteristics of traumatic spinal cord injury in Stockholm, Sweden: a prospective, population-based update. J Rehabil Med. 2017;49(5): 431–436.
[60] Cullen KL, Irvin E, Collie A, et al. Effectiveness of workplace interventions in return-to-work for musculoskeletal, pain-related and mental health conditions: an update of the evidence and messages for practitioners. J Occup Rehabil. 2018;28(1):1–15.
[61] Ost Nilsson A, Eriksson G, Johansson U, et al. Experiences of the return to work process after stroke while participating in a person-centred rehabilitation programme. Scand J Occup Ther. 2017;24(5):349–356.
[62] Reed K, Hocking C, Smythe L. The interconnected meanings of occupation: the call, being-with, possibilities. J Occup Sci. 2010;17(3):140–149.
[63] Charmaz K. Constructivist grounded theory. J Posit Psychol. 2017;12(3):299–300.