Review

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Meta-synthesis of qualitative research on return to work among employees with common mental disorders

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Objectives The purpose of this study was to investigate which opportunities and obstacles employees with common mental disorders (CMD) experience in relation to return to work (RTW) and how they perceive the process of returning to work. In addition, the study explores what characterizes an optimal RTW intervention and points to possible ways to improve future interventions for employees with CMD.

Methods A systematic literature search was conducted, and eight qualitative studies of medium or high quality published between 1995–2011 were included in this systematic review. The eight studies were synthesized using the meta-ethnographic method.

Results This meta-synthesis found that employees with CMD identify a number of obstacles to and facilitators of returning to work related to their own personality, social support at the workplace, and the social and rehabilitation systems. The employees found it difficult to decide when they were ready to resume work and experienced difficulties implementing RTW solutions at the workplace.

Conclusions This study reveals that the RTW process should be seen as a continuous and coherent one where experiences of the past and present and anticipation of the future are dynamically interrelated and affect the success or failure of RTW. The meta-synthesis also illuminates insufficient coordination between the social and rehabilitation systems and suggests how an optimal RTW intervention could be designed.

Key terms back to work; meta-ethnography; mental health; mental illness; rehabilitation; review; RTW; sick leave; social support; work accommodation.

Long-term sick leave due to common mental disorders (CMD) such as depression, anxiety, and stress-related disorders is an increasing problem in many countries (1–5). Long-term sick leave is a major risk factor for early withdrawal from the labor market (6), and only 50% of those off work for >6 months due to poor mental health return to work (7). CMD make up an increasing percentage of claims for disability benefits (8), and a number of studies show a strong correlation between depression and disability pension (4, 8–10) and also between anxiety and disability pension (8). Not only is CMD-related sick leave and withdrawal from the labor market costly for society and workplaces due to compensation costs and lost productivity (11), being off work also frequently has negative consequences for the individual as work is socially highly valued and beneficial to self-respect, identity, health, and general well-being (12).

To reduce both the human, societal, and economic consequences related to long-term sick leave and withdrawal from the labor market due to CMD, a better understanding of the factors that facilitate or complicate return to work (RTW) for employees with CMD is warranted.

Previous research has found RTW to be a complex and multi-factorial process (13). Quantitative research shows that the medical seriousness of the disorder, work-related factors, personal factors, national compensation policies, and the structure of the healthcare system determine whether sick leave results in return to or withdrawal from the labor market (7, 13–18). While quantitative studies are useful for investigating general

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predictors for RTW and the effects of RTW interventions, they are not suitable for capturing the complex processes characterizing RTW. Qualitative research can help expand our understanding of the RTW process (19) and is particularly suited to examine the complex dimensions and practices of RTW (20).

The meta-synthesis method is an obvious research method to extract and integrate results from various qualitative studies (21–23). We therefore conducted a systematic meta-synthesis of qualitative research to investigate how people with CMD themselves experience the RTW process and which obstacles and opportunities they identify in relation to RTW. Thereby this meta-synthesis addresses the recommendation of MacEachen et al (20), who pointed to the need for a meta-synthesis on RTW for employees with mental health problems. In this meta-synthesis, we use Noblit & Hare's meta-ethnography method (21) as it is one of the most widely accepted methods of synthesizing findings from qualitative studies (24, 25).

Other examples of meta-ethnographies on related subjects are MacEachen et al's meta-ethnography on RTW after work-related injury (20) and Gewurtz & Kirsh's meta-ethnography on disability in the workplace for people with mainly somatic health problems (25). Fossey & Harvey (12) conducted a meta-synthesis on the views of people with serious psychiatric conditions (eg, psychosis, bipolar disorder, or schizophrenia) on finding and maintaining employment. They concluded that people with serious psychiatric conditions experience that the right kind of job improves their mental health in that it provides structure, social contact, and a sense of purpose. But maintaining the job requires ongoing strategies to manage the psychiatric condition and ongoing support from mental health services, employment specialists, family, and the workplace. (12). To our knowledge, a meta-synthesis on RTW of people with CMD has yet to be conducted. Such a meta-synthesis is warranted given that the prevalence of CMD is higher in the general population and contributes more to increasing sickness absence than more serious psychiatric disorders (3).

The following research questions guided this meta-ethnography: (i) Which opportunities and obstacles in relation to RTW do people with CMD experience? (ii) What characterizes the RTW process for people with CMD? (iii) What characterizes an optimal RTW intervention from the perspective of people with CMD?

Methods

Search process and inclusion criteria

A systematic search was conducted using six electronic databases to identify relevant qualitative peer-reviewed studies on RTW for people with CMD: CINAHL (Cumulative Index to Nursing & Allied Health), EMBASE, MEDLINE, PsycInfo, Sociological Abstracts, and Web of Knowledge. We searched for peer-reviewed papers published in English between 1995–2011 using the keywords and combinations of keywords set out in figure 1. The relevant keywords were mainly identified by screening articles found through a search process conducted in relation to a white paper on CMD and the labor market (11). Moreover the reference lists of relevant articles were reviewed to identify additional articles.

We used the following inclusion criteria to identify relevant qualitative studies: (i) the study used a qualitative research method; (ii) the research questions of the study addressed RTW; (iii) participants were people with CMD; and (iv) the study focused on RTW from the perspective of the person with CMD. If the study was based exclusively on interviews with supervisors, colleagues, or caseworkers, the article was excluded. The fourth criterion secured a certain level of homogeneity between the studies included as the main focus was the perspective of the person with CMD.

Quality assessment and data extraction

Studies meeting the inclusion criteria proceeded to quality assessment. The quality of the studies was assessed using 17 out of 18 criteria[1] defined in a framework developed by the UK National Centre for Social Research (26) for assessing quality in qualitative research. The 17 criteria relate to: (i) findings (eg, how credible are the findings, discussions of generalization, limitations); (ii) design and sample (eg, discussion of rationale for study design, description of participants, study location); (iii) data collection (eg, information on who conducted the data collection); (iv) analysis and reporting (eg, how the descriptive analytic categories had been generated, discussion of patterns within data); and (v) reflexivity and neutrality (eg, reflections on how theoretical ideas affected the research process and results) (26). These 17 criteria have also been applied in previous meta-ethnographies (20, 25, 27). Apart from the 17 criteria, we also applied Rocco's (28) third criterion for evaluating qualitative studies: "Are method, data collection tools, and steps adequately described and grounded in relevant literature?" This criterion was included to assess whether there was discrepancy between the method, data collection, tools, and techniques used in a study.

In their meta-ethnography, MacEachen et al (20) developed guidelines to evaluate the quality of studies as low, medium, high, or very high (table 1). In this article, we used the same guidelines to rate the studies, and those rated as "low" were excluded.

[1] One criterion that specifically addressed evaluation research was eliminated.

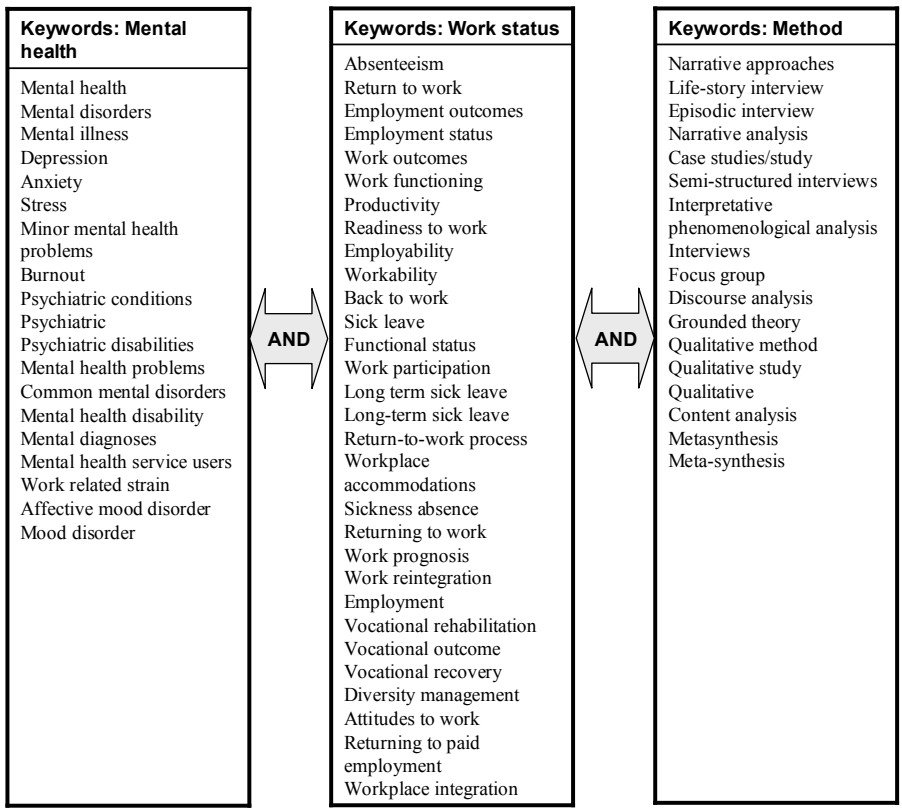

Figure 1. Search process: keywords and combinations of keywords

The first and second author of this article rated the quality of relevant studies independently and subsequently met to discuss the ratings. If a consensus could not be reached, the third author was involved. However, this turned out to be unnecessary as consensus was reached by the first and the second author for all relevant studies.

Studies rated as medium, high, or very high quality proceeded to data extraction. Data extraction is a systematic identification of information relevant to this meta-ethnography's research questions and provides information about contextual factors (20). The data extraction included the following themes: focus of the study, country, study method, recruitment strategy, and participants (table 2).

Meta-ethnography as research method

The meta-ethnography method was originally developed by Noblit & Hare (21) and is a set of techniques and principles created specifically for synthesizing qualitative studies. Meta-ethnography differs from quantitative meta-analysis by being inductive and interpretative rather than aggregative. This means that the results of the individual studies are not simply juxtaposed and reported, but a higher-order understanding is sought through synthesis of the individual findings. According to Noblit & Hare there are three major strategies for synthesizing qualitative studies: reciprocal translational analysis (RTA); refutational synthesis (RS); and lines of argument (LOA) synthesis (21, 23).

In this meta-ethnography, we mostly used RTA as the studies included are roughly about similar things: in this case, RTW from the perspective of employees with CMD. We have also used RS where apparently contradictory findings exist between the primary studies.

Table 1. Quality assessment guidelines from MacEachen et al (20).

Rating	Requirements
Low	Data too invariable, due to inadequate analysis or sampling strategy; data do not "ring true" and it appears that the authors had superimposed their own set of ideas
Medium	Analysis descriptive in nature and somewhat "thin" in describing context and detail, leading to appearance of superficiality
High	Descriptive but including a more adequate level of analysis, with consideration of context; presentation of a more nuanced picture of study participants and the complex environment in which they function
Very high	Required a theoretical focus, with consideration of the internal processes involved in creating the situation that was being described (for example, links to macro structures), and with an explanatory value that could be transferred to other research arenas

Table 2. Partial data extraction for included studies. [M=men; PTSD=post-traumatic stress disorder; RTW=return to work; W=women.]

Study	Focus of the study	Country	Study method	Recruitment strategy	Participants
Verdonk et al (39)	Women's sickness absence and RTW	The Netherlands	Individual interviews. Grounded theory	The researcher's personal contacts and health websites	13 women suffering from work-related psychological strain. On sick leave or off work: 0.5–8 years
Saint-Arnaud et al (38)	The work reintegration process among employees who were absent from work	Canada	Individual interviews. A version of grounded theory	Information flyers distributed by employee services, organizations and medical clinics	37 participants (25 W, 12 M). Sickness absence: 1–12 months.
Holmgren & Ivanoff (34)	How women perceive their possibilities for and obstacles to RTW	Sweden	Focus groups. Method not reported	Women participating in a cooperation project between a rehabilitation centre and the social insurance office	20 women with work-related strain. Average sickness absence: 93 days (shortest: 44 days, longest 180 days)
Noordik et al (36)	Barriers and solutions to full RTW	The Netherlands	Individual interviews. Grounded theory	Workers were recruited by their own occupational health practitioner	14 participants (10 W, 4 M) with stress, anxiety or depression. Average time to partial RTW: 4 months
Millward et al (40)	Attitudes to work among people diagnosed with clinical depression	UK	Individual interviews. Interpretative phenomenological theory	Local advertising in primary healthcare centres, word of mouth, and vocational trainers	19 participants (14 W, 6 M) with depression. Off work for >10 weeks.
Hillborg et al (33)	Circumstances affecting the opportunities to seek and obtain a job	Sweden	Individual interviews. Hermeneutic and content analysis	Rehabilitation professionals identified potential participants	8 participants (4 W, 4 M) with mostly depression. Sick leave: 1.5–3 years
Pittam et al (37)	What works in relation to a RTW service offered by employment advisors	UK	Individual interviews. Method not reported	Invitations were sent by letter to all clients who were referred to the service	22 participants (16 W, 6 M) with anxiety or depression. Work status: unemployed: 11, sick leave: 11 (average 11 weeks) still at work: 2
Cowls & Galloway (32)	How RTW-interventions are experienced	Canada	Individual interviews. Grounded theory	Through referral list focusing on clients who had traumatic histories and motivation for RTW	25 participants (gender not listed) with depression, anxiety or PTSD. On sick leave or off work for mostly 4–6 months.

Conducting a meta-ethnography involves three levels of analysis and organization of data: first-order concepts, second-order interpretations, and third-order syntheses (20, 21, 29). In this meta-ethnography, key concepts were developed analytically through the identification of concepts in the original studies (first-order concepts); for instance, the key concept "handling individual demands" emerged when at least two studies noted that the absence or presence of specific personal attributes affected the RTW process. The final analysis – the synthesis – consists of a re-interpretation of the key concepts in relation to the research questions guiding this meta-ethnography. The three-level analysis was conducted by all three authors. The first author developed a mind map at each step in the three-level analysis and a scheme showing the organization of the concepts. These were subsequently reviewed and adjusted by the second and third authors until consensus was reached.

Results

The search process in the six databases yielded 4136 unique articles after merging the different databases and removing duplicates (figure 2). The first author reviewed titles and abstracts to determine whether they were relevant in terms of the inclusion criteria. This led to the exclusion of 4072 articles while 64 articles proceeded to full-article screening. Furthermore, three articles identified by reference lists were also retrieved in fulltext. The first and second authors read and evaluated these independently to judge if they met the inclusion criteria. If the full article gave insufficient information about the type of mental disorder, the authors of the article were contacted for further clarification of the type of disorder (30, 31).

After the full articles were reviewed, 59 out of 67 articles were excluded, mostly due to a lack of focus on RTW or because they were about people with severe psychiatric conditions. Eight articles proceeded to quality assessment (32–39). The quality assessment concluded that all eight studies were of sufficient quality and all therefore preceded to data extraction (table 2). Of these studies, three were rated as being of high quality (33, 36, 38) and five of medium quality (32, 34, 37, 39, 40). The studies ranked as medium quality were characterized by being relatively sparse in terms of describing context and with a limited discussion of negative cases and differences within data. The studies ranked as high quality were characterized by provision of an adequate description of the method, process of analysis, and context. Moreover, the nuances in the data were accounted for in these studies.

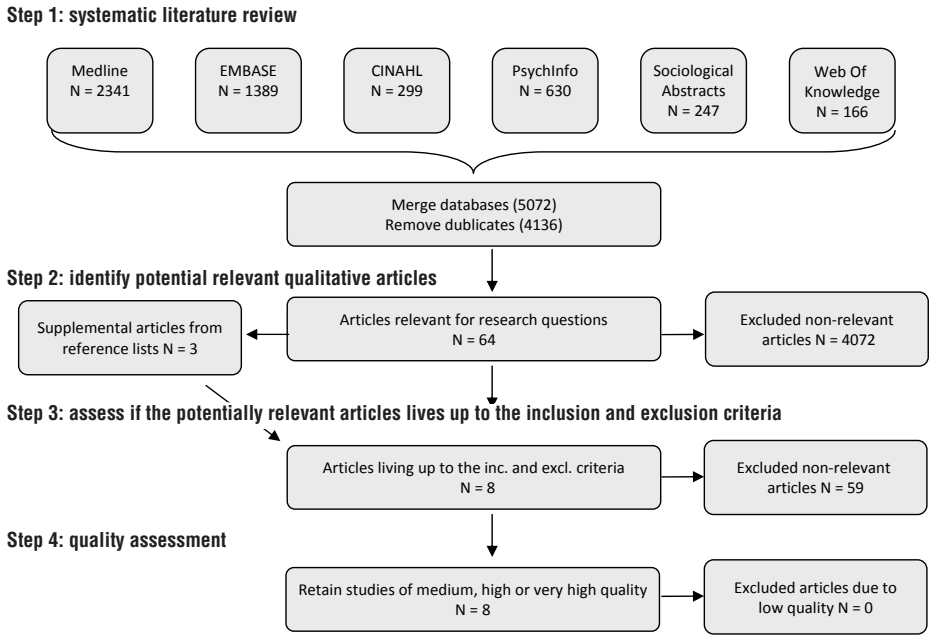

Figure 2. Flowchart of study inclusion process

Key concepts and meta-ethnography synthesis

Based on our three research questions, we identified first-order concepts in the eight studies. On the basis of this, we developed five new second-order key concepts. This section describes the five key concepts and their relevance for the RTW process (table 3).

Handling individual demands. Three studies noted that persons with CMD experienced individual psychological factors as obstacles to RTW (34, 36, 40). The employees reported reduced working capacity due to mental and physical symptoms such as exhaustion, reduced concentration, irritability, and forgetfulness (36). They found it difficult to protect themselves from exceeding their work capacity after resuming work as it was hard for them to set limits in demanding situations at work even though they considered this an important coping strategy for RTW (34, 36). A high sense of responsibility could make it difficult for the employees to set limits (34, 36). The employees reported that a high sense of responsibility could also result in a too early RTW, at too high a pace as the person on sick leave was afraid of being a burden to the employer (34). Some of the employees also reported their levels of perfectionism to be a cognitive barrier for RTW as it made it difficult for them to slow down their own work pace and accept their reduced work capability (34, 36).

Several studies showed that being on sick leave due to CMD often resulted in low self-efficacy. Many employees felt insecure about their capability to handle the work demands when returning to work and questioned their ability to change their behavior and personal attributes (34, 36, 40). The low self-efficacy affected the employees' trust in their chances of getting a new job or returning to the old job and might therefore prolong their sickness absence (34).

If the employees felt that the supervisor and colleagues attributed the sickness absence and the development of the CMD to individual factors exclusively and not to the work situation, their motivation to return to the same workplace decreased significantly as they did not believe that the employer would implement relevant workplace changes (34, 39).

Accommodations and social support at work. The reviewed studies showed that the employees' expectations and actual experiences of the social support available and the possibility for work accommodation and gradual RTW seemed to determine the employees' feelings, thoughts, and behavior in relation to RTW.

Several studies showed that employees preferred to return to work gradually as they were anxious about the impact of work on their health and felt incapable of working a full-time schedule due to mental and physical symptoms (32, 36, 38). Moreover, during the process of returning to work, the employees needed extra time to practice and utilize the RTW solutions and coping strategies they had developed and had to continuously evaluate whether they exceeded their work capacity (32, 36). The reviewed studies showed that reduced work hours alone were insufficient to secure RTW. Responsibilities and workload also needed to be increased gradually

Table 3. First-order concepts and key concepts. [RTW=return to work]

	Cowls & Galloway (32)	Hillborg et al (33)	Holmgren & Ivanoff (34)	Millward et al (40)	Noordik et al (36)	Pittam et al (37)	Saint-Arnaud et al (38)	Verdonk et al (39)
Handling individual demands								
Work capability			X		X			
Perfectionism and responsibility			X		X			
Self-efficacy			X	X	X			
Accommodations and social support								
Gradual RTW	X				X		X	
Accommodations	X		X		X		X	X
Social support			X		X		X	X
Competing interests between the systems								
Social insurance office								X
Occupational rehabilitation		X				X		
Mental healthcare	X	X			X		X	X
Communication between the systems	X			X	X			
The right time to return								
Anxious for relapse	X						X	X
Lack of control of timing		X					X	
Gap between intentions and implementation								
Factors increasing the gap					X		X	X
Factors decreasing the gap	X					X		

through relevant work accommodations (32, 36, 38, 39). Adaptation of the job content, additional manpower, improvement of communication at the workplace, job shadowing, and discontinuation of night shifts were mentioned as relevant modifications (32, 36). Even though work accommodations were seen as an important part of a successful RTW, a number of the employees feared or actually experienced that there had not been improvement or reorganization of their working conditions when they returned to work (34, 38, 39).

Most of the studies found that social support from both supervisors and colleagues played a vital part if gradual RTW and work accommodations were to result in full-time RTW (34, 36, 38, 39). Employees reported a need for social support both during the sick leave and in the process of returning to work. During sick leave, social support could consist of the workplace signaling that the employee was respected and missed and that the supervisor and colleagues showed that they believed that the mental health problem was genuine (34, 38). Several employees experienced a lack of social support during full-time sick leave. Either the employer did not contact them at all or the employee interpreted contact as the employer questioning the mental health problem (36, 38, 39). This was especially the case if the employer required the employee to submit to examination by a psychiatric expert (38). After returning to work, it was crucial that the employees were met with an understanding of their symptoms and their decreased work capacity and that supervisors and colleagues acknowledged and respected the arranged work accommodations (34, 36, 38).

One study found that the extent of the social support received by the employees depended on the cause of the CMD and sick leave: if the mental disorder was caused by stressful life events outside work such as the sudden death or serious illness of a spouse, the employees experienced that the supervisor and colleagues were quite understanding and supportive. But if the mental disorder was caused by economic problems, divorce, or the psychosocial work environment or if the mental disorder did not have a well-defined cause, the workplace was considered less supportive (38).

Different interests between the systems. The articles reported that employees often had contact with three systems during their sickness absence: the social insurance office, the mental healthcare system, and occupational rehabilitation services. The studies indicated that the three systems influenced the RTW process in different ways as the systems seemed to have conflicting interests and different perspectives concerning RTW.

Employees reported to have mainly negative experiences with the social insurance office, which they felt did not provide the necessary support as the social insurance office focused more on the employee returning to work or reporting fit for duty as soon as possible than on the mental health problem and needs of the person on sick leave (33, 39). As the insurance office often had the authority to decide whether employees were entitled to sickness benefits and relevant rehabilitation interventions, the contact with the social insurance office tended to weaken the employees' feeling of control and

thereby increased stress and anxiety (33, 38, 39). Moreover, some employees also experienced an inconvenient standstill in the RTW process as they had to wait for the social insurance office to grant relevant RTW activities, such as a course or work practice (33).

The studies showed that most of the employees evaluated their interaction with mental healthcare system positively and that they felt they benefited from the interventions offered (typically, psychotherapy and medication) (36, 39, 40). However, one study concluded that the mental healthcare system could have a negative effect on the RTW process as the interventions and health professionals could reinforce the illness identity and non-work identity of the employees by focusing narrowly on their symptoms and illness instead of their resources (40). Moreover, some of the studies found that psychotherapy and medication could contribute to an individualized interpretation of the mental health problem and sickness absence by focusing on the individual adaption strategies rather than on relevant workplace changes (38, 39).

Several of the reviewed studies found that employees felt their contact with the occupational rehabilitation services enhanced their opportunities for a successful RTW (32, 33, 37). Employees found that the occupational rehabilitation services offered interventions they could utilize and transfer directly to their workplace (32) and that the interventions addressed and activated a process of change for both the individual and the workplace simultaneously (32). Especially interventions such as career guidance, strategies to negotiate and communicate with employers, assertiveness training (37), and the development of a concrete individualized RTW plan (32) were experienced as useful.

Thus, it seems that different systems had different forms of impact on employees in terms of employees' views on their readiness for RTW, the timing of the RTW, and the consequences of their CMD.

The right time to return. According to some studies, employees considered it difficult to estimate *when* they were ready to return to work. They did not know how many or how severe their symptoms were supposed to be when they returned and some were anxious about returning too soon due to fear of a relapse (38, 39). One study found that employees were recommended to develop stability of symptoms at home before returning to work (32) while another study noted that employees were encouraged to return while still experiencing symptoms (36). None of the studies reviewed identified indicators for employees' readiness for RTW.

Employees did not always appear to be in a position to decide on their own when to return to work. Sometimes it was the authorities (caseworkers at the social insurance office or doctors) who assessed the employees' work capacity and decided either to extend the sick leave or refuse to prolong it (33, 38). Some studies found that it could be highly anxiety-inducing and stress-provoking if the person on sick leave was incapable of controlling the timing of the RTW (33, 38).

Gap between intentions and implementation. Several studies dealt with the issue of whether the persons returning to work managed to implement and maintain the planned and developed strategies for RTW at their workplace. RTW strategies could be oriented toward the individual such as reducing perfectionism and learning new ways of thinking about demanding situations and dealing with emotions or they could be workplace oriented such as introducing structural changes and work accommodations (32, 34, 36, 38).

The reviewed studies showed that in quite a few cases a problematic gap between the intentions and implementation of the strategies existed and that this gap could result in stagnation of the RTW process, relapse, and recurring sick leave (36, 38, 39). Both work-related and individual factors were found to be related to insufficient implementation. One study found that the focus of the workplace on productivity and performance-oriented goals could result in a cancellation of the agreement on gradual RTW and work modifications as there was limited time to implement the necessary changes (38). Performance-oriented goals could also prevent colleagues and supervisors from providing support as it was difficult for them to slow down their work pace to help the returned employee (38). Individual factors such as responsibility and perfectionism seemed also to contribute to the gap as these attributes could make it difficult for the employee to accept the legitimacy of using RTW interventions such as work accommodations and gradual RTW (34, 36).

Another reason for the problematic gap was offered by one study that concluded that interventions focusing solely on the person on sick leave could result in an insurmountable discrepancy between the new values and strategies of the person returning and the values and conditions of the workplace. This would make it impossible for the person to reintegrate into the culture and conditions of the workplace as only the individual and not the workplace had changed (39).

Discussion

Before we move on to the third-order synthesis, we will shortly sum up the findings from the second-order analysis and discuss some apparent contradictions between the key concepts.

We have shown that employees experienced obstacles and opportunities in relation to handling individual demands, social support, and accommodations at the

workplace, and the systems. They found it difficult to judge when the opportunities for returning outnumbered the obstacles, which made it difficult for them to decide the appropriate time to return. After RTW, they found it difficult to implement the planned solutions due to individual factors such as perfectionism, a high sense of responsibility, and low self-efficacy and work-related factors such as lack of social support and organizational structures complicating the implementation of work accommodations and gradual RTW.

Employees tend to rush to resume their tasks too quickly and find it difficult to protect themselves from exceeding their work capacity. At the same time, however, employees prefer to return to work gradually and they are anxious about the impact of work on their health. This could at a first glance be construed as a contradiction in findings. It may, however, be interpreted as an expression of an inner conflict and a feeling of ambivalence: employees struggle to maintain a (self-) image as competent, attractive, and resourceful individuals while struggling to regain mental health. This meta-synthesis reveals that it is difficult for employees to balance these two desires. The seeming contradiction could, however, also be a result of a fear of being fired or losing sickness benefits forcing the employees to return to work too early and at too high a pace even though they prefer a gradual RTW.

Synthesis – third-order interpretations

On the basis of the key concepts, we developed two third-order interpretations. The first one describes how pre-illness conditions influence the RTW process and the second highlights insufficient coordination between the systems. Finally, we suggest how an optimal RTW intervention could be designed.

Pre-illness conditions influence the RTW process. An important focus of this meta-ethnography is what characterizes the RTW process for employees with CMD. We conclude that we need to understand the RTW process as a continuous and coherent process where the employees' experiences of the past and their expectations of the future influence how they think, feel, and behave in the present in relation to RTW. Research has suggested that long-term sick leave due to musculoskeletal disorders consists of different temporal phases (13, 41, 42), but phase-oriented models deal only with the period *after* the onset of the sick leave (13, 42). This synthesis shows that it is insufficient only to look at this period to understand the outcomes of long-term sick leave. We also need to focus on the conditions under which employees left work because the cause of the CMD and sick leave seem to affect the degree of social support from supervisors and colleagues and the way employees anticipate their chances of returning. In addition, the employees' anticipation of their ability to change themselves and cope with the work-related conditions in the future also seems to affect the employees' decision about returning.

Lack of coordination between the systems. The meta-synthesis points to an unfortunate lack of coordination between the different systems with which the employee is in contact during the RTW process. Each system has a different focus on the employee's situation and seem to have different – and sometimes conflicting – interest on behalf of the employee. The mental healthcare system tends to address only factors related to the health conditions and thereby forgets to handle obstacles in the workplace, whereas the social insurance office tends to have an interest in encouraging an early RTW forgetting how the medical condition may interfere with RTW. The occupational rehabilitation system mostly focuses on factors related to the workplace and therefore risks neglecting the involvement of the other systems. The lack of coordination can cause a feeling of confusion and uncertainty about *how* and *when* to return to work as the employee may be met with different advice, recommendations, and demands in a situation where the employee actually needs predictability, certainty, and a feeling of control over the mental health problem and the RTW process.

As mentioned, employees are not always in a position to decide themselves when to return to work. Sometimes authorities (caseworkers at the social insurance office or doctors) decide either to extend the sick leave or refuse to prolong it. An important question remains unanswered in the studies included in this meta-synthesis: Who is best qualified to decide when and how to return? Should employees decide the timing even though they find it difficult to estimate when they are ready to return to work and even though their fear of relapsing could prolong their sick leave unfavorably? Or are authorities the best judges of the capability and readiness of the employee to return? The findings of this meta-synthesis indicate that neither the employee nor one single authority is capable of making this decision. Decisions in relation to the RTW process should be made jointly between the employees, supervisors, doctors, and social insurance offices as this could reduce the doubt and uncertainty in relation to when and how to return.

How can we improve RTW for employees with CMD?

A synthesis of our five key concepts developed across the eight studies induced us to suggest that RTW interventions should be based on the biopsychosocial model (43). Our meta-synthesis identified obstacles in all three components of the model: (i) exhaustion, reduced concentration, and forgetfulness can be seen as an obstacle

at the biological level; (ii) perfectionism, a high sense of responsibility and low self-efficacy can be seen as obstacles at the psychological level; and (iii) low social support and lack of coordination between the systems can be seen as obstacles at the social level.

In light of the above, we therefore argue that an optimal RTW intervention identifies and addresses obstacles and opportunities within all three components of the biopsychosocial model and considers their interrelation. For example, the presence of medical symptoms would not necessarily be a decisive obstacle for RTW if the work capability of the employee were assessed and a detailed individualized RTW plan for how the work tasks should be modified were developed.

To reduce the gap between intention and implementation, the RTW intervention should not only focus on the coping strategies of the employee but also on the workplace and facilitate social integration of the returned employee. This could be done by training a colleague to become a mentor for the returning employee or by teaching supervisors and colleagues about CMD and how to support the employee in the RTW process. As the RTW process is a continuous and coherent process involving the past, present, and future, it is important to illuminate how supervisors and colleagues perceive the cause of the CMD and sick leave because this can influence the support offered to the returning employee.

Coordination between systems is a precondition for a successful RTW. In Denmark, a large-scale RTW program based on the biopsychosocial model and aiming to enhance the coordination between the systems is being tested (44). The goal is to educate caseworkers to act as designated RTW coordinators responsible for the coordination between the different systems and the workplace. The RTW coordinator works in close collaboration with a designated multidisciplinary RTW unit consisting of a psychologist, physical therapist, medical doctor, and a psychiatrist. The RTW unit assesses the work capability of the employee and meets with the RTW coordinator to discuss work modifications necessary for return – all in close collaboration with the person on sick leave. Approximately 12 600 working-age adults on sick leave due to mental or physical health problems will participate in the RTW program from April 2010 until March 2012. The Danish National Research Centre for the Working Environment is conducting a process and effect evaluation of the program. The results of the study will be available in 2013.

Qualitative evidence: strengths and limitations

We found the meta-ethnography method suitable for the investigation of our research questions, and it helped us identify the complexities and multiple factors of the RTW process. The development of the five key concepts provided a relevant and significant starting point for our synthesis. We believe that our systematic integration of qualitative research has contributed to the literature by illuminating underlying factors important for RTW for employees with CMD and offering insights into how RTW might succeed or fail. No single study described all the obstacles to and facilitators of RTW that we identified in this meta-synthesis. In addition, by integrating the different timeframes of the individual studies, we were able to describe the RTW process as a continuous and coherent process involving the past, present and future.

Conducting this meta-ethnography presented us with a number of challenges and limitations that need to be considered. Despite having a comprehensive search strategy, only eight studies met our inclusion criteria. This is a limited number compared to the meta-ethnography on severe psychiatric conditions by Fossey & Harvey (12), who identified and included 20 studies and MacEachen et al (20), who identified and included 13 studies. This result highlights the need for more qualitative studies on RTW of employees with CMD from the perspective of the person with CMD in order to obtain a greater understanding of how employees perceive the RTW process and which factors facilitate return.

Another possible limitation is that the studies included in our meta-ethnography differed from each other in a number of ways. First, the studies were conducted in four different countries (The Netherlands, Canada, Sweden, and the UK) and therefore employees in the studies had somewhat different contextual conditions for their RTW process. Second, some of the studies recruited only women (34, 39) whereas others recruited both men and women (33, 36–38, 40). Third, differences were identified between the studies and within the individual study regarding the severity of the CMD and the length of the employees' absence from work. Finally, the studies used different qualitative research methods. A criticism often leveled against meta-syntheses is the risk of overlooking the explanatory context when studies from different contexts are included (23, 45). Unfortunately, only two of the eight studies reported on the sociocultural context relevant for RTW (36, 39) and none of the studies did sub-sample analysis or reported whether any differences existed in the employees' perceptions of RTW depending on the length of their sick leave or medical condition. We considered it to be too demanding and time consuming to uncover and describe the complex sociocultural context of the countries from which the studies originated at the specific time the data of each study were collected. It is therefore not possible for us to take these differences into consideration even though they might be relevant for our findings. Although, none of the related meta-ethnographies have addressed or solved this challenge,

our meta-ethnography has shown that the identified opportunities and obstacles in relation to RTW are quite consistent irrespective of contextual factors.

Another challenge for this meta-ethnography was that only three of the studies were of high quality. Nevertheless, we concluded that the studies of medium quality also contributed with relevant and significant information to this meta-ethnography.

Future research

In this meta-ethnography, we draw attention to the need for more high-quality qualitative research on RTW for employees with CMD that takes contextual factors into consideration (eg, how the system is set up, legislation and policies, doctors' attitude to RTW) and investigates whether the RTW process and facilitators of and obstacles to RTW differ in relevant subgroups such as (i) employed versus unemployed persons with CMD and (ii) employees on short- versus long-term sick leave. We also recommend conducting a review including studies of relevant stakeholders' views on the RTW process, for example through the lens of supervisors, case managers, or personnel in the mental healthcare system.

As we argue that the RTW process needs to be seen as a continuous and coherent process, a trajectory research approach is requested. We therefore call for qualitative studies that investigate the employees' thoughts about the past, present, and future and that follow employees over an extended period by conducting multiple interviews to investigate if, how, and why their behaviors, thoughts, and feelings in relation to RTW change over time. We would also encourage research that examines causes of and solutions to the identified gap between intentions and implementation as there is a high risk of recurrent sick leave for employees with CMD (46). It is therefore important to conduct qualitative studies that identify what employees, supervisors, colleagues, practitioners, and other stakeholders can do to minimize the gap.

A further call for future research that we will only mention in passing here concerns a promising framework for investigating the process of sick leave and RTW. Through empirical research on back troubles, Gannik (47, 48) has developed a social theory on situational disease inspired by Alonzo's situational perspective on illness behavior (49, 50). Gannik's theory on situational disease has the advantage of looking at health problems as social and relational phenomena developed and shaped through the interaction between people in different situations. According to Gannik's theory, a disease is reversible and changeable depending on changes in the person–situation relation. Gannik's perspective on disease, therefore, aligns with the findings of this meta-ethnography that social relations and contextual conditions at the workplace determine employees' experience of their readiness to return to work and opportunities for returning. We therefore encourage future research to use Gannik's situational perspective on disease to enhance our understanding of the RTW process.

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