Bilaga till rapport

Effekter av arbetsmarknadsinsatser för personer långvarigt sjukskrivna på grund av depression, ångest eller stressreaktion/
Effects of return-to-work interventions for persons on long-term sick-leave due to mood-, anxiety- or adjustment disorders
rapport 352, (2022)

Bilaga 4 Tabell över kvalitativa studier / Appendix 4 Characteristics of qualitative studies

First author Year Country Study quality	Aim and method Teoretisk ref ram	Population: CMD Return to work program	Results (themes) Conclusion/s
Andersen **2014** **Denmark [1]** **Small or insignificant limitations**	**Aim** The aims of this study were to investigate how sick-listed persons with CMD experienced participating in an RTW intervention and how workability assessments and RTW activities influenced their RTW-process, and to examine the working mechanisms of the intervention. **Method**	**Participants** Participants : N=17 Women : N=13 Age: 23-61 years. Eight persons were on sick leave due to depression, nine due to stress. **RTW program** The RTW program consisted of an early, multidisciplinary, and coordinated effort within the existing legal framework and	Almost all participants reported symptoms such as concentration problems, memory problems, feelings of inadequacy, self-reproach, low self-esteem, low energy, negative thinking. They experienced considerable and unpredictable fluctuations of symptoms, which made it difficult for them to estimate the state of their mental condition, and, consequently, when and how to return to work. They all found it difficult that their health problem was invisible and diffuse, and they lacked certain knowledge about when they had recovered. Without this knowledge it was difficult for them to navigate and make decisions about RTW.

	Three semi-structured interviews were conducted with each participant over a period of 6-7 months, in total 51 interviews. NVivo was used for organizing data. Interpretative Phenomenological Analysis (IPA) was used.	under the management of the municipal sickness benefit offices. The multidisciplinary unit held weekly meetings where they coordinated and discussed cases and decided on a tailored RTW plan suggesting relevant RTW activities for the person on sick leave. According to Danish law, members of the multi-disciplinary team are not allowed to offer traditional treatment such as psychotherapy. Instead, the offered RTW activities typically consisted of psycho-educative group sessions, a few individual sessions with the psychologist, physical exercise, and meetings with the workplace. (see figure) Participation in the intervention was not voluntary.	**Persons with CMD's Experiences of Workability Assessments** The participants reported different experiences with the assessment consultations with the RTW team. The participants who had positive experiences with the assessment felt that it helped create structure and direction in their somewhat chaotic and uncertain situation. Furthermore, they felt it enhanced their knowledge of their health situation and of how and when to return to work. But participation in the assessment consultations could also create frustration and uncertainty in some of the participants. The negative experiences should be understood in the light of the characteristics of CMD and were mainly related to: (1) uncertainty about the aim of the consultations, (2) trouble verbalizing one's problems and condition, and (3) fear of intensification of symptoms. *- Participants' Uncertainty About the Aim of the Assessment Consultations* Several participants failed to see the purpose of the RTW coordinator referring them to consultations with the RTW team or clinical unit. The difficulty of deciphering and understanding the aim of the assessment consultations may be explained by the fact that a number of the core symptoms reported by the participants such as

			reduction of executive functions seem to reduce the ability to decode the purpose and tasks of the different RTW professionals. The confusion about the aim may, furthermore, be increased by the fact that the participants experienced that the RTW professionals had not always been sufficiently explicit about the aims of the consultations. A third factor that seemed to create uncertainty about the aim of the assessment consultations was that some of the participants were already in contact with other health practitioners (typically psychologists and physicians). These practitioners were often of the utmost importance to the sick-listed persons, their conception of their condition and of the compatibility between the job and their recovery. *- The Difficulty of Verbalizing One's Mental Condition* A number of participants found it difficult to describe their situation and their mental condition during the assessment consultations with the RTW professionals. It frustrated some of the participants that they were unable to produce ''objective'' proof of their health problem or reduced workability, and they found it difficult to state precisely what exactly they could or could not do during the one hour set aside for the consultation. Besides, some participants questioned the ability of the RTW professionals to judge competently on the basis of one single

			consultation how ready they were for work, which RTW activities they needed, and if they were entitled to sickness benefit. Some participants were convinced that relatively intimate knowledge of a person and his or her inner dynamics and outer world is needed to be able to give an opinion of the seriousness of the mental health problem, workability and need for RTW activities. Some participants experienced that RTW professionals expected a comparatively concrete description and explanation of their situation and its cause plus an estimate of when they were ready for RTW. The fluctuation of symptoms and the often complex causes of the CMD made it difficult for the participants to provide the precise and concrete answers that they felt the RTW professionals expected. *- Fear of Intensification of Symptoms* For some of the participants a number of negative occurrences and experiences preceded the development of the CMD and sickness absence, and, as mentioned above, some were ashamed of being sick-listed with a mental health problem. The assessment consultations could be emotionally demanding as verbalization of the past and the CMD for a few participants seemed to actualize negative feelings and experiences.

			Altogether, according to the participants, the assessment consultations with the RTW professionals seem suited to perform workability and health assessment. But for them the nature of mental health problems, and the experience of being sick listed because of these, call for special attention to how the assessment consultations are introduced and conducted. **Persons with CMD's Experiences of RTW Activities** *- Few Individual Sessions with RTW Psychologist* The participants were generally satisfied with the consultation with the psychologist, and they found the work-related focus of the consultation useful. Participants with comparatively minor health problems mentioned benefiting most from the consultations. A few participants found it unsettling and confusing that no traditional treatment was offered. If the consultations had identified and clarified central problems (e.g., additional diagnosis or problematic personality traits) the participants felt abandoned without help or tools to cope with the problems disclosed to them during the consultations. *- Psycho-Educational Group Sessions* The participants who were offered psycho-educational group sessions found the offer relevant and helpful. In particular they appreciated that they had gained

			knowledge of the interconnection of body and mind, and also that they had developed a new framework for understanding their symptoms and had been inspired to apply new coping strategies when returning to their former job or to a new one. The participants felt put at ease about their physical and mental symptoms, which some feared were chronic or downright life-threatening. The participants also emphasized the advantage of being with other sick-listed persons in the same situation. Being with others in the same situation seemed to normalize the condition of the participants, restored their self confidence and reduced the feeling of being alone. Several participants stressed that it was decisive for the positive outcome of the group session that the other participants had identical or similar health problems. *- Inadequate RTW Activities* Not all participants had taken part in RTW activities after the assessment consultations. Sometimes the absence of activities agreed with the participants' own sense of not needing or having the energy to participate in an RTW activity. Sometimes, however, activities were absent but were seen as needed, and one or more of the RTW activities contained in the RTW program might have met these needs. Based on the interviews conducted with the participants we assume that there may be an

			association between a lack of offers of either individual consultation, psycho-educational group sessions or contact with the workplace and an increase in the risk of recurrent sickness absence or aggravation of mental health problems for a few participants. A few participants, on the other hand, felt that the interval before return to the labour market was too long. For other participants it was stress-inducing to have to participate in the minimum 10-h-per-week mandatory RTW activities. They felt that neither their health nor their energy level allowed them to fulfill this requirement. All in all, there seemed to be a wide variation in the participants' need for intervention, timing of intervention and extent of intervention. **Working Mechanisms of the RTW Program** *- Individual Approach* Several participants described how 'being seen' and 'being met'—or the opposite—was decisive for whether the RTW program was experienced as useful and relevant or not. If the participants felt that RTW professionals focused on them as unique persons with specific problems there was a clear tendency for possible resistance to and skepticism of assessment and RTW activities to be minimized. This approach to the sick-listed person can be described as taking an 'individual approach'. The participants characterized the RTW

			professionals that applied this approach as attentive, interested, open-minded, reflective, empathic and sympathetic. Feeling 'met' by an individual approach was perceived to be essential for participants to open up and describe their difficult and emotionally exhausting situation during assessment consultations. Without confidence and openness, the RTW professionals would not get the necessary information during the assessment consultations, information which was considered important to form a 'true' picture of the sick-listed persons' CMD and challenges and resources for RTW. Not all participants had been in contact with RTW professionals who favored an individual approach. Regardless of whether the participants felt they had been met with an individual approach or not, it is a significant finding that every single one expressed a strong need for the RTW professionals to focus on them as concrete and unique individuals and to show genuine interest in them, their situation, their needs and their RTW-process. - *RTW Professionals as Legitimate Experts* for the RTW professionals to be able to effectively intervene through RTW activities and influence the participants' perception of their health problem, their symptoms and the compatibility of the job with these, they had to achieve a position as legitimate experts in the RTW-process of the sick-listed person. This position, however, was not always achieved at the first consultation. One person

			sick-listed with stress illustrated how she didn't see the RTW professionals as legitimate experts at the assessment consultations. - *Multidisciplinary* Several participants mentioned that the multidisciplinary coordination made them feel confident that the RTW professionals together included as many aspects of their case as possible. A few participants even noticed that the RTW coordinator replaced a rather patronizing, impersonal approach to them with a more individual approach after discussing their case with the other RTW professionals at the weekly multidisciplinary conference. .. A central difference between his experience of the first and the second consultation is that the relation is no longer based on pressure and coercion. These have been replaced by a fruitful—if not equal—dialogue about a well-defined goal—RTW. **Conclusion (extracts)** We have shown that the assessment consultations have the potential to result in both motivation and frustration, and three overall challenges in relation to the assessment have been identified. Our results indicate that psycho-educational group sessions have the potential to transform illness representations and increase readiness

			to RTW whereas individual sessions with a psychologist are mostly helpful for sick-listed persons with less severe social, health- and work-related problems. We have illuminated how the individual approach seems necessary for the realization of the positive potential in the RTW program. However, the fact that the RTW professionals are both the helpers and the authorities in the sick-listed persons' RTW-process is an inherent paradox in the RTW program, which can impede the establishment of a high-quality relationship between the sick-listed persons and the RTW professionals. We have suggested that researchers and practitioners in the field of RTW interventions take inspiration from research on therapeutic alliance and therapist factors when designing and evaluating RTW interventions. More research is needed on which types of alliance, therapist factors, and client factors are associated with a successful outcome of an RTW intervention and RTW practitioners should be trained in relevant interpersonal competencies and be provided with optimal conditions to put these into practice.
First author **Year** **Country** **Study quality**	**Aim and method** **Teoretisk ref ram**	**Population: CMD** **Return to work program**	**Results** **(themes)** **Conclusion/s**
Johanson **2019** **Sweden [2]**	**Aim** The purpose was to illustrate the IES model and process	**Participants** N=5	**Cross-case findings: enabling engagement in return to work**

Moderate	in five cases, based on the perspectives of participants, employment specialists, and on documents and memos. The key questions were: How did the individual IES processes develop in terms of direction and content? and What were the main characteristics of the IES model that influenced the return- to-work processes? **Method** Multiple data sources were used to collect sufficient and in-depth information about the cases, comprising semi- structured interviews and intervention documents and memos and interviews with employment specialists. Inductive content analysis. Within and cross-case analyses and an analytical generalization were performed.	Women: N=3 Age: 25-52 years. Diagnosis: Depression or bipolar disorder All are on long term sick leave, i.e., unemployed for one year previous to entering IES. **The Individual Enabling and Support (IES) model** The model is an adapted, supported employment program developed to meet motivational, cognitive and time-use needs of people with affective disorders.	An overarching theme was formulated as Enabling engagement in return to work. **Self-confidence and motivation** The participants underlined the importance of having an employment specialist who supported them throughout the intervention, especially after setbacks. The employment specialist was also perceived as a person who encouraged them and the relationship was experienced as equal. Furthermore, by emphasizing the participants' previous work achievements, they were encouraged to start seeking jobs. This communication approach based on motivational interviewing and a discussion about changes was described as inspiring and planting a seed of possibility. Encouragement also included focusing on personal resources by highlighting abilities and interests, which seemed to further strengthen the participants' self- confidence. Moreover, some participants particularly described the usefulness of sorting out their inner motivation and work ambivalence in relation to the pros and cons of a working life. **Faith in own abilities** The participants described how their mistrust in their own abilities in relation to skills, coping strategies, specific work tasks or interpersonal communication hindered them from engaging in return to work and searching for jobs. In spite of a lack

			of trust, the employment specialists facilitated the process by connecting resources and abilities to concrete working goals. During the enabling phase, there was a continuous effort to break behavioural or occupational patterns of inactivity, which entailed a combination of discussions and applying activities in real-life settings. **Enhancing thinking and behavioural strategies** None of the participants in this case study had previously developed and used their own thinking and behavioural strategies in relation to work. Four of them expressed that they had gained awareness about how to use coping strategies for a flexible interaction with other people during the intervention. This resulted in that the participants became able to modify their behaviour when needed. Having the opportunity to practise a specific behaviour was expressed as important, such as communicating one's own point of view at meetings or job interviews. **Balancing occupations in relation to family** Two participants experienced that the possibility of engaging in the return-to-work process was clearly related to family relationships and other daily occupations. A socially vulnerable situation can impact negatively on the possibility of focusing on job seeking. In such circumstances, the support needs to consider time use and daily routines and structure, in order to search for a

			job further on. This individualized support was valued by the participants and helped to sustain the trustful relationship between them and the employment specialist. When being unemployed for several years, occupations and routines in the family may form a pattern in which the parent at home takes greater responsibility for organizing the family's everyday life and performing household chores. When this parent becomes employed, a change will occur that affects the whole family. Support for the participants in involving their family members in this process of change is thus something that needs to be attended to. **Conclusion** This study illustrates the IES model through different return-to-work processes among people with affective disorders. The most influential characteristic for the processes was described as the close and continuous support with a respectful and equal relationship between the participant and the employment specialist, which enabled the participants to overcome their low self-confidence and increase their self-efficacy related to return to work. Moreover, the MI, CBT and TiW strategies gave the participants an opportunity to develop a broader range of behaviours and coping strategies in relation to job seeking, gaining employment and working, after long-term sick leave. We suggest that a combination of these strategies when

			integrated with SE can support the individual engagement in return to work. To provide person-centered support and build interventions on participants' resources, interests and preferences and provide them with opportunities to experience positive reinforcement seems to be beneficial for people with affective disorders who participate in vocational programs and want to return to work.
First author **Year** **Country** **Study quality**	**Aim and method** **Teoretisk ref ram**	**Population: CMD** **Return to work program**	**Results** **(themes)** **Conclusion/s**
Strömbäck 2020 **Sweden [3]** **Moderate**	**Aim** The aim of this study was to explore experiences of persons with SED (stress induced exhaustion mental health disorder) who participated in a dialogue-based workplace intervention with a convergence dialogue meeting performed by a rehabilitation coordinator. NB: The dialogue-based WP intervention was conducted alongside a multimodal rehabilitation intervention with weekly, three-hour cognitive behavioral therapy group sessions during 22 weeks.	**Participants** N=15 Women N=13 Age: 33-56 years All had a confirmed diagnosis of SED, current employment, and were on at least 50% sick leave. They had participated on a 24-week multimodal rehabilitation program. **Dialogue-based workplace intervention with a convergence dialogue meeting** A structured three-step interview model with follow ups and was performed and organized by a Stress Rehabilitation Clinic.	The core category, restoring confidence on common ground, described participant progress from the emotional entrance when they started to prepare for RTW, through experience of the empowering change when they became safe in the RTW process due to the intervention's supportive guidance. **The first phase, emotional entrance**, is comprised of three properties: vulnerability, anxiety/distress, and expectations. This phase represents the participants' emotional experiences reflecting on their workplace as they start to prepare for RTW. We interpret this phase as visualizing the emotional exposure that people with SED experience related to the cause of their illness and the meaning of the work environment when planning for RTW.

	The convergence dialogue meeting built upon a health promotion approach focusing work environment, including physical, organizational and social factors when discussing work tasks in relation to work ability. **Method** Seven semi-structured group interviews, each with 2-3 persons lasting1-1,5 hours. A modified grounded theory was used for analysis.	The intervention aimed to facilitate dialogue between the participant and supervisor responsible for rehabilitation at the workplace, and other involved stakeholders in the RTW process. The first step was an individual interview of the participant by a rehabilitation coordinator. In the second step, the supervisor was interviewed at the Stress Rehabilitation Clinic, by phone, or by video link. The structured interviews included questions about expectations and concerns for rehabilitation, perceived main causes for the participant´s sick leave, possible ways to adjust the work situation, suggestions on how to facilitate RTW, and motivation and confidence for RTW. In addition, the supervisor answered questions about systematic work environment issues, access to occupational healthcare and if specific actions were planned. In the third step, the rehabilitation coordinator performed a convergence dialogue meeting with the participant and supervisor. The participant could invite a representative from the workplace or trade union.	- *Vulnerability* captures participant experiences of personal failure, loss of control, and causing problems for colleagues and family. Participants were "ashamed of being exhausted" and blamed themselves for "being weak and not able to manage as much as others". - *Anxiety/distress* represented participant concerns about their relation to the workplace and the supervisor. An additional distress was if they distrusted the supervisors' capability to understand, see, handle, and acknowledge problems related to the work environment. The participant below reflected on situations of "not being heard" and times when complaints about the work environment were not taken seriously. - *Expectations* encompassed participant intentions to RTW. Participants were grateful for getting help, support and guidance in this process. **The second phase, supportive guidance** captured three properties: competence, coordination, and balancing power. This phase represented participant experiences of the role of the rehabilitation coordinator in the intervention and the convergence dialogue meeting. This phase explains the supportive qualities of personal guidance and structured support. Moreover, the rehabilitation coordinator's neutrality was central to participant experiences of the convergence dialogue meeting.

		The convergence dialogue meeting lasted for about 1.5 hours. The supervisor had the responsibility for initiating continuous follow-ups.	- *Competence* represents participant experiences of practical and emotional support from the rehabilitation coordinator in contacts with the supervisor and Social Insurance officials. Presence of the rehabilitation coordinator was described as having someone "on my side", "backing me up" or "not being alone". - *Coordination* was central to participant experiences of supportive guidance. The rehabilitation coordinator made participants feel safe arranging and carrying out meetings and keeping structure and pace by "holding the reins". The rehabilitation coordinator also "made things happen" by being a deliverer, catalyst, or energizer. - *Balancing power* represents experiences of the rehabilitation coordinator as a mediator who balanced relationships and questions of responsibility. Participants perceived the rehabilitation coordinator as supportive of the supervisor, which made it possible to improve poor relationships. **The third phase, empowering change**, encompassed participant experiences of the intervention, such as carrying out agreements made in the written plan, follow-ups, and starting to have expectations for the future. This phase consisted of three properties: heading toward confidence, transferring knowledge, and improved collaboration. This phase explains personal progress toward RTW, as well as experiences of progress among supervisors and workplace colleagues.

			- *Heading toward confidence* represents experiences of being trusted and encouraged "to take steps forward" and how support from the intervention helped them to successfully RTW. Participants described that following a written plan supported them in the practice of strategies they learned in multimodal rehabilitation. Examples include to "slow down", "take breaks", "breathe", and "set limits". Practicing such strategies was helpful in formulation of a realistic plan, such as finding balance in energy use during the day, prioritizing the amount of workload, and developing new routines. The written plan and follow-ups supported participants in efforts to "keep on track", and recall adjustments that were made, and by whom. Writing down agreements and solutions clarified questions of responsibility and opened up the opportunity to "talk about" problems in the workplace. - *Transferring knowledge* represents experiences of changed approaches and behaviors among supervisors and colleagues. Participants thought the intervention educated supervisors about SED and related impairments, such as difficulty concentrating, memory problems or fatigue. In addition, participants experienced that supervisor increased their knowledge about work rehabilitation issues, for example making plans and agreements, or making relevant adjustments in the work environment. Increased knowledge raised supervisor awareness, and that contributed to an

			improved work environment and changed attitudes toward persons on sick leave. *-Improved collaborations* with the supervisor, workplace, and Social Insurance Office. Experiences of clarified roles and allocated responsibility for each person involved increased participant safety in RTW. Improved collaboration empowered participants to discuss weaknesses and implement relevant adjustments at the workplace. Participants felt that the Social Insurance officials trusted the intervention, and this also made them feel secure. Overall, participants experienced that the intervention had a "ripple effect" by positively influencing stakeholders involved in the process. Having good relationships with involved stakeholders facilitated RTW. Nevertheless, participant expectations for the future also involved worries, for example about their ability to handle future challenges. **Conclusion** (extracts) The dialogue-based workplace intervention with convergence dialogue meetings provided valuable support enhancing RTW for persons with SED. The intervention's health promoting pedagogy empowered participants to progress and feel safe in the RTW process. Continuous guidance from a rehabilitation coordinator, with a structured framework with a convergence dialogue meeting, joint planning and follow-ups enhanced communication and collaboration

			between the employee, supervisor and other involved stakeholders. Participants said that communication and collaboration balanced relationships, conveyed knowledge, and changed attitudes about SED among supervisors and workplace colleagues. Entry of a rehabilitation coordinator who performs a dialogue-based workplace intervention has a beneficial contribution that enhances RTW for persons with SED, and bridges the gaps between healthcare, the workplace, and other organizational systems. The intervention also contributes to a positive re-orientation towards a successful RTW instead of viewing SED as an endpoint for employment or a career in the workforce. In a prolonged process, a dialogue-based workplace intervention with convergence dialogue meetings and a rehabilitation coordinator may secure a sustainable RTW for persons with SED.
First author **Year** **Country** **Study quality**	**Aim and method** **Teoretisk ref ram**	**Population: CMD** **Return to work program**	**Results** **(themes)** **Conclusion/s**
Wisenthal **2019** **Canada [4]** **Small or insignificant limitations**	**Aim** to gain insight into underlying factors contributing to CWH's effectiveness in RTW preparation following depression.	**Participants** N=21 Disability leaves at baseline ranged from <12 months to ≥24 months. 12 were working at the three months follow-up.	**CWH structure** A common theme in much of their feedback related to the CWH work schedule which comprised a gradual increase in work hours. The majority of participants linked the work hardening structure to adopting a routine which ultimately helped them prepare for the

	Method Questionnaire (open-ended questions) and semi-structured. NVivo was used for organizing data. Content analysis was used.	Women: N=13 Age: 21-57 years BDI II Depression severity <u>At start</u>: - minimal N=5 - severe N=9 <u>After CWH</u>: - minimal N=10 - severe N=2. **Cognitive work hardening program, CWH** CWH program offered by the principal author in a community based occupational therapy practice in Ottawa, Ontario. The intervention was provided in a simulated (office) work environment equipped with workstations, computers, software applications, and other resources typically used by a knowledge worker. The core elements of the CWH intervention included: • An intake assessment • Customized work simulations • Pacing techniques to educate clients • Targeted behavioral skill development.	routine associated with work. Experiencing such a daily rhythm contributed to participants' beliefs in their ability to master morning routine and belief in their RTW potential **Work simulations** Reference was made to the customized nature of the simulations such as the manner in which specific job demands were captured and the relevance of the simulations to participants' pre disability work. The progressive nature of the work simulations, which included graded task complexity and variable task completion deadlines, enabled participants to gradually rebuild their cognitive abilities and work skills. **The simulated office environment** was reported as being conducive to their RTW preparation. Participants commented on how the physical environment in the CWH setting was a 'realistic' work environment similar to their actual workplaces thus contributing to their positive experiences at CWH and enhancing their belief that they could indeed return to their workplaces. **Safe and supportive environment** Nine participants identified the safe and supportive atmosphere of the CWH environment. Specific references were made to having a safe place to 'try and fail'.

		The intervention spanned over four weeks, in total 31 hours with some flexibility based on client need.	**Feedback from occupational therapist** Four participants reflected on the importance of feedback from the treating occupational therapist during the CWH-intervention. This was discussed mostly in relation to work tasks which provided markers of performance through the therapist's feedback regarding one's functioning and feedback for work well done. Participants reflected on how this feedback provided insight into their progress and contributed to their motivation. **Pacing education** Learning pacing strategies was noted by four participants as an important intervention element providing concrete strategies and practice for fatigue management. **Coping strategy education** This intervention element includes videos, OT coaching, and role plays which contribute to the development of coping strategies designed to help participants better manage work demands and potential stressors once back at work. Fourteen participants made reference to one or more of the three underlying elements. Being exposed to and practicing interpersonal skills were noted as being relevant to dealing with potential issues once back at work. The most frequently reported **treatment gains** are presented in the rank ordering of participants' responses.

			- Routine Nineteen of the 21 study participants reported that they acquired a routine as a result of CWH which helped their RTW preparation. This was discussed in terms of the consistency and the sense of purpose that participants obtained. **- Confidence** Eighteen participants commented about the impact that the CWH intervention had on their self-confidence. Participants linked their participation in CWH with a progressive increase in believing in themselves and their abilities. This was associated with increased self-confidence and the ability to move forward and to engage in other areas of functioning which some participants linked to overall well-being and purposefulness. **- Stamina** Fifteen participants reported that their stamina improved as a result of their CWH experience. This was often linked to the progressive nature of the intervention with respect to hours as well as task complexity. Participants qualified their work stamina in terms of overall improved tolerance to work hours, longer periods of sustained task concentration, and increased energy to engage in activity outside of work sessions. **- Cognitive abilities** The positive impact that CWH had on cognitive abilities was discussed by eight participants. This included rebuilding dormant

			abilities such as concentration, attention to detail, reading, and comprehension. Participants indicated that many of these skills had atrophied during their depression and while home on disability leave. They were aware of the need to re-establish their cognitive functioning before returning to work. **- Communication and other coping skills** Seven participants recounted how CWH assisted them with improving their communication skills and developing more effective coping strategies. This included learning to be more assertive and establish better boundaries which was seen by many participants as important in managing some of the work stressors that contributed to their disability leave. Improved organizational and time management skills were described in terms of helping them better deal with work demands. **- Technical skills** The importance of refreshing technical skills and/or learning new ones as an important part of easing the transition back to the workplace was noted by four participants. Establishing technical currency was particularly relevant for participants who had been on disability leave for an extended period. **- Pacing** Mastery of pacing techniques was noted by four participants and linked to working

			through fatigue once back at work. Participants discussed pacing in terms of learning to balance work and breaks in order to conserve energy and increase work efficiency. **- Self-efficacy** Three participants discussed their increased belief in their abilities as a result of the CWH-intervention. **- Additional participant feedback – areas for improvement** Several comments related to the importance of returning to work soon after completion of the CWH intervention so that gains attained transferred more seamlessly to the workplace. A time delay was viewed as breaking the continuity of their progress and hindering a smooth transition back to work. Some participants highlighted the importance of better linkages between the intervention and the workplace so that the employer is more prepared to receive and accommodate the returning employee. **CONCLUSIONS:** Study findings enhance understanding of CWH with relevance to clinical practice. Key intervention elements deemed important for RTW are discussed and may provide guidance for other work-re-entry programs.

First author Year Country Study quality	Aim and method Teoretisk ref ram	Population: CMD Return to work program	Results (themes) Conclusion/s
Wästberg **2013** **Sweden [5]** **Moderate**	**Aim** The aim of this study was to investigate some of the participants' perceptions and experiences of taking part in the ReDO program. **Method** Two semi-structured interviews. Manifest and latent content analysis.	**Participants** N=7 Women: 7 Age: 35 - 57 years (median 40). Six women had Sweden as their native country, and one was born in another European country. Diagnosis: all women suffered from stress-related disorders, most often diagnosed as depression or adjustment disorder. One woman was on part-time (50%) and the other six on full-time sick leave when entering the ReDO. **ReDO-program** The aim of was to raise the participants' awareness of their daily occupations in terms of what they do, how they do it, and how they	**Perceptions of the ReDO programme** Statements reflecting perceptions and experiences related to the different parts of the programme and its suitability for the informants' needs were mostly positive, but they also contained suggestions about things that could have been different *Programme – participant match.* All informants thought that the programme had been good and suitable for them. The ReDO programme was seen as a step forward in the return-to-work course. *Content and structure.* The content and structure were seen as good; the informants thought the topics touched upon in the programme were relevant and they could recognize themselves in the themes discussed. They found it relevant to work with all activities in a 24-hour day, not only paid work. Some informants had expected the programme to contain more practical exercises, such as relaxation techniques, breathing exercises, and meditation, and some wished for extended time for the theoretical part of the programme. Some

		perceive it. While in the program, the participants received support in identifying and becoming aware of hassles and interruptions in their daily occupations, as well as of their demands on themselves and demands from others. They also received support in finding strategies for changing and coping with their daily occupations, at work as well as at home, and to shape a balance between engagement in occupations and rest. The program, which was group-based with individual support, started with a 10-week theoretical part. The group sessions, held twice a week, consisted of information, goal-formulation, practical exercises, and discussions, where the participants shared their problems and experiences as well as practical solutions. In between the meetings the participants received assignments, such as identifying a hassle at home and trying to remove or reduce their negative perceptions of it. An evening seminar with information for family members, friends, and	of them, however, wished the family members and managerial staff from the workplace would have been even more involved. **The intrinsic process** "The intrinsic process" contained the informants' perceptions of how they worked with analysing and changing their own situation and the support received for this. *Self-analysis.* The informants thought that the way the programme was devised contributed to their self-analysis and forced them to work actively with their own situation. They thought it was good not to get any fixed solutions, but instead to have to think about what they wanted and needed. During the meetings the informants did practical tasks and exercises, discussed, and reflected on their daily activities. The informants specifically highlighted the activity circle, where they wrote down how much time they spent on their daily activities (work, taking care of oneself, domestic duties and taking care of other persons, recreation and rest, time for having fun, and sleep) during the 24 hours. *Support in the intrinsic process*. The informants felt they got support from the group leaders as well as from their fellow group members in the self-analysis and

		managers was included. After the theoretical part, a six-week period of work training followed, generally at the participants' ordinary workplaces, during which the working hours and other demands were individually adjusted.	the process of change. Being part of a group was seen as beneficial; the informants received confirmation and felt they were not alone, and they could share experiences. **Person-related changes** When the informants were asked about their perceptions of the ReDO program, they also spoke of perceived changes in themselves as persons, such as better health, a new self-image and awareness of their own situation. They also struggled to perform their activities in alternative ways. *Perceived better health*. Better health as a result of the ReDO programme was mentioned by most informants. They said they had learnt to manage their feelings of stress, had become calmer and happier, got more energy, and felt physically better. Some informants also said they had finished other therapies because their problems had been solved by the ReDO programme. *New self-image*. The women also described that their self-image had changed and become more positive. At the end of the ReDO programme they believed in their own capacity and could put themselves in focus, although it was not always easy. *Awareness of own situation*. The informants thought they had become aware of their own situation and had realized that they

			could not perform and control everything themselves. Being aware of what they spent time on during the 24 hours and gaining insight into how they performed activities helped them know how they could change their situation. *Performing activities in new ways*. All informants spoke of performing activities in alternative ways. They had learnt to accept having less control over things, and at the same time, they had set limits for themselves and for others at home and at work. **Perceptions of returning to work** Reflections and feelings regarding return to work were evoked by and intertwined with perceptions of the work practice. Some of the informants had not worked for a long time and expressed mixed feelings about returning to work. Having the work demands adjusted and getting support during the work practice and when returning to work were emphasized as important. *Demands–capacities match*. Although the informants wanted to work, they expressed feelings of uncertainty regarding whether they would accomplish the work practice and about returning to work again. They felt the former work demands were more than they could manage, but the work practice was seen as an opportunity for finding out if

			they could manage to perform their former work at all. *Support in returning to work*. The importance of receiving support in returning to work was highlighted by the informants. On the other hand, they also expressed dissatisfaction with lack of support. Some informants thought that the support they received had helped them decide about changing workplace or beginning to study, with which they were satisfied. **Conclusion** The informants were satisfied with the ReDO program and what they saw as a result: that they had become aware of their daily activities and had changed ways of performing them. The result highlighted "Critical parts of the rehabilitation process", which concerned the importance of the programme itself, the intrinsic process and the informants' changes, as well as their perceptions of returning to work. These different parts of the rehabilitation process might be of importance also for programs other than the ReDO and could be considered in general when planning and evaluating work rehabilitation programmes.

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