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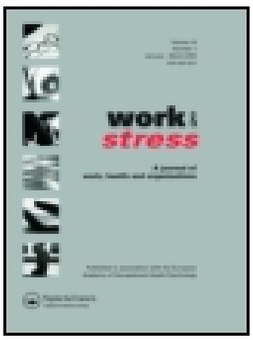

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IGLOO: An integrated framework for sustainable return to work in workers with common mental disorders

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ABSTRACT

Current research on return to work (RTW) for employees with common mental disorders suffers from two limitations. First, research mostly focuses on the influence of resources during the absence period ignoring the resources which may facilitate sustainable RTW, i.e. employees continuing to work and thrive at work post-return. Second, research tends to view the work and non-work domains separately and fails to consider the interaction of resources at the individual, group, leader and organisational levels, once back at work. In the present position paper, we present an integrated framework and a preliminary definition of sustainable RTW. Based on current occupational health psychology theory and existing research on RTW, we develop ten propositions for the resources in and outside work, which may promote sustainable RTW. In addition to the individual, group, leader, and organisational levels, we also argue for the importance of the overarching context, i.e. the societal context and the culture and legislation that may promote sustainable RTW. Our framework raises new questions that need to be addressed to enhance our understanding of how key stakeholders can support employees with common mental health disorders staying and thriving at work.

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Sustainable return to work; conservation of resources; integrated framework; resources; mental health; common mental disorders

The individual, social and economic costs of poor mental health in the workforce are significant (Bilsker, Wiseman, & Gilbert, 2006). Common mental disorders (CMDs) such as depression, anxiety disorders and adjustment disorders present a major problem in the OECD countries (OECD, 2015). It is estimated that 15% of the working population suffer from CMDs and 50% experience mental ill-health problems at least once in their life (Hewlett & Moran, 2014). Suffering from CMDs potentially has serious implications for employment prospects, productivity and wages (Hewlett & Moran, 2014). Typically, the unemployment rate among people with mental health problems is twice as high as those without; employment rates are 15–30% lower; and it is estimated that 45–50% of unemployment beneficiaries suffer from poor mental health (OECD, 2015).

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Even if employees with CMDs return to work, keeping them at work presents a major challenge. Koopmans et al. (2011) found that over a period of seven years, 19% of returned employees had a recurrence of sickness absence due to CMDs, and 90% of recurrences occurred within 3 years, and Norder et al. (2015) found that 29% of returned employees had recurrences over a ten-year period. Additionally, recurrent sickness absence spells due to CMDs often last longer than the first period (Koopmans et al., 2011) and frequent periods are related to increased risk of work disability (Koopmans et al., 2011). In both studies, long-term-sickness absence longer than three weeks was included. Recurrences were defined as at least one new episode of sickness absence due to CMDs after the complete return to work (RTW) for at least 28 days. Exploring the extent to which employees stayed in employment, Norder et al. (2017) found that 18% of returned employees had left employment five years post-RTW, 25% of these resigned, 30% were dismissed, 6% were granted disability pension and 31% retired early. Furthermore, Arends, van der Klink, van Rhenen, de Boer, and Bültmann (2014a) identified that conflicts with the supervisor, company size and chronic diseases were related to recurrent sickness absence. Together, these studies call for research on how we can create a working environment that prevents relapse, i.e. how sustainable RTW (SRTW) in employees with CMDs can be promoted.

In the present position paper, we extend and integrate current findings on RTW. First, we extend the existing literature by arguing for the need to look beyond the absence period and understand how we can enable SRTW. Previous research has focused on the period up to return (e.g. Andersen, Nielsen, & Brinkmann, 2012; Nigatu et al., 2016), and where sustainability has been considered it has mainly meant extending follow-up beyond RTW (Kausto et al., 2017; Koopmans et al., 2011) with limited consideration of the resources post-RTW that may prevent relapse. To the best of our knowledge, only one study has explored relapse prevention (Arends et al., 2014a) and this study focuses on the role of occupational physicians. Even intervention studies on work-focused cognitive–behavioural therapy have only explored the period up to return rather than the employees' ability to remain in work (Dewa, Loong, Bonato, & Joosen, 2015; Kröger et al., 2015; Lagerveld, Blonk, Brenninkmeijer, Wijngaards-de Meij, & Schaufeli, 2012). We argue that SRTW is an important part of occupational health psychology and that we need to understand how we can create the conditions for employees to stay and thrive at work after a period of sickness absence due to CMDs.

Second, a recent OECD report (OECD, 2014) concluded that health and employment are considered separate issues, and the OECD countries lack integrated efforts. Drawing on the conservation of resources (COR) theory (Hobfoll, 1989), we argue that integration is important in two ways: To ensure SRTW we need to (a) consider the integration of resources at five levels: the individual, the group, the leader, the organisational and the overarching contextual (IGLOO) level and (b) develop a holistic understanding of how resources in and outside work can be integrated to can promote SRTW for employees with CMDs. Although research focusing on RTW for employees with CMDs has increased in recent years (Andersen et al., 2012; Nigatu et al., 2016), focus has primarily been on the individual with limited attention paid to the context within which individuals with CMDs function (OECD, 2014). Where context is considered, features of context are considered in silos within the home or work sphere offering little understanding of how different features of the context contribute to, or act as barriers to, SRTW (Andersen et al., 2012; OECD, 2014). With the IGLOO framework, we propose a way to develop our

understanding of how the non-work context influences the ability of employees with CMDs to stay at work after the period of absence. The IGLOO framework has implications for how we develop interdisciplinary and cross-jurisdictional research strategies to ensure SRTW, as well as how we develop public and organisational policy and practice.

Defining sustainable RTW

To the best of our knowledge, there is no agreed definition of SRTW for employees with CMDs. Some studies have defined SRTW as the 30 days after the last day of the sickness benefit period (Kausto et al., 2017); however, such definitions may not adequately capture SRTW as they focus only on financial costs to society. Based on existing definitions of RTW as returning to working contracted hours and with equal earnings we suggest that these factors together with minimal recurrence of long-term-sickness absence spells characterise SRTW (recognising that employees may require time off to manage recurrent episodes of CMDs), functioning well at work and not dropping out of work prematurely either into work disability or early retirement (Hees et al., 2012). Long-term-sickness absence may depend on the national definitions, but it could be considered the period beyond which the organisation pays the employee a salary and social benefits take over which is common procedure in many developed countries.

As previous research has found that employees returning to work often have reduced work functioning, even after remission of CMDs (Arends et al., 2014a; de Vries, Koeter, Nieuwenhuijsen, Hees, & Schene, 2015; Norder et al., 2017; Ubalde-Lopez et al., 2017), it is critical to consider related outcomes such as work functioning as part of SRTW, not only the absence of relapse, and explore how resources may improve work functioning post-RTW. A recent literature review of the recurrences of sickness absence spells concluded that no studies have focused on how employees with CMDs can be fully reintegrated into the workplace (Dewa, Loong, & Bonato, 2014).

COR theory as a theoretical framework for SRTW

The present position paper draws on COR theory (Hobfoll, 1989) as its theoretical framework. COR theory suggests that individuals are motivated to protect and accumulate resources. Resources are defined as "anything perceived by the individual to help attain his or her goals" (Halbesleben, Neveu, Paustian-Underdahl, & Westman, 2014, p. 6). Resources enable employees to successfully complete their tasks and goals, as a way to enhance health and their work functioning (Bakker & Demerouti, 2007; Balducci, Schaufeli, & Fraccaroli, 2011) and may thus be instrumental in promoting SRTW. According to COR, both positive and negative spirals may occur. In a situation where individuals do not have sufficient resources to cope with the demands of the situation, resource depletion may be the result and in the case of employees with CMDs may result in relapse. Positive gain spirals, on the other hand, occur when individuals get the opportunity to engage in resource caravans: individuals invest resources to build additional resources and thus resources at multiple levels in and outside the workplace may create synergistic effects (Hobfoll, 1989).

In occupational health psychology, recent developments have focused on the need to identify resources at multiple levels and called for interventions to strengthen resources at four levels: the Individual, the Group, the Leader and the Organisational level, also

termed the IGLO model to develop practical interventions to ensure employee health and well-being (Day & Nielsen, 2017; Nielsen et al., 2017). The IGLO model suggests that the antecedents of employee health and well-being can be classified according to these four levels. We propose that this understanding of resources may be transferred to the RTW domain where resources can promote SRTW among employees with CMD. We build upon this model to develop our integrated framework outlining the resources at these four levels, which may promote SRTW.

There are, however, two limitations of the IGLO model when transferring this model to SRTW. First, it only considers the work context. Within the context of CMDs, not only the work context but also resources outside work spill into the work context and influence SRTW (OECD, 2015) and we, therefore, extend the model to include the non-work domain. Second, the IGLO model only considers the organisational level resources at the highest level. We propose that there is a need to look beyond the organisation to fully grasp SRTW. Previous research on RTW has identified resources outside the organisation at the national level, such as compensation systems, national legislation and social welfare policy, which may promote RTW (Loisel et al., 1994); however, the role of these resources in ensuring SRTW in employees with CMDs is not known. We therefore extend the IGLO model and add one more contextual level, the overarching context, which involves expansive environmental factors, e.g. national context, culture and welfare systems.

The integrated framework for SRTW takes a broad view on resources. We consider the individual's resources, the social resources (the resources inherent in social interactions, both vertically, interactions with leaders/line managers and horizontally, interactions with colleagues, and outside work friends and family), and the organisational resources relating to the way work is organised, designed and managed. We argue that these resources in and outside work can be cumulative and form resource caravans supporting SRTW or if they are not accessible may present a disadvantage whereby employees with CMDs return for a short period to work but then exit the labour market. For example, if there are no workplace policies to support SRTW and colleagues stigmatise employees returned to work these factors may increase the risk of future sickness absence and leaving the labour market altogether. The proposed IGLOO framework can be seen in Figure 1. In the following sections, we present the IGLOO framework and discuss each level separately. For each level, we put forward a proposition for how resources at work or outside work may contribute to SRTW in employees with CMDs.

Individual-level resources and SRTW

It has long been recognised that people experience a complex interplay of cognitive, affective and behavioural responses to both their illness and their situation (Ribeaux & Poppleton, 1978; Rosenberg & Hovland, 1960), and these responses are likely to influence employees' SRTW. The cognitive component concerns individuals' belief about their CMDs, their evaluation of the symptoms and the current situation (e.g. level of support) and their confidence (i.e. self-efficacy; Bandura, 1986) in their own abilities and skills in managing their CMDs. Although these evaluations and assessments are based on facts collected or acquired, their beliefs may not be accurate representations of the facts; they may be biased or incomplete.

Work	**Level**	Non-work context
1. Work-specific cognitive, affective and behavioural factors, e.g. work-related self-efficacy, job crafting	Individual	2. Individual cognitive, affective, and behavioural factors, e.g. life style behaviours
3. Colleague support, attitudes towards CMD and return, work group climate,	Group	4. Friends, family, frequency of contact, support etc.
5. Line managers' KSAs, attitudes, behaviour, support	Leader	6. Healthcare service providers' KSAs, attitudes, behaviour, support
7. Human Resource Management practices and policies, job design – espoused and actual. Occupational health services.	Organization	8. Community and voluntary organizations e.g. charities, local networks, telephone helplines and online chat fora
9. Country legislation, social welfare policy	Overarching/social context	10. Country legislation, social welfare policy

KSAs = knowledge, skills and abilities

Figure 1. IGLOO framework for integrated sustainable return to work. KSAs = knowledge, skills and abilities.

Individual resources at work

Cognitive, affective and behavioural responses to CMDs and to the work situation are likely to influence SRTW. Previous research has found that employee beliefs that employers will not implement work adjustments and feelings of being misunderstood influence the RTW process (Andersen et al., 2012) and if these beliefs and feelings do not change post-RTW, regardless of whether they are accurate or not, they are likely to increase the risk of relapse.

The affective component reflects the ability to experience and express feelings and emotions. Constructing certain cognitive and emotional representations of illness are known as "illness perceptions" and based on Leventhal's theory of self-regulation (Cameron & Leventhal, 2003). Employees with maladaptive illness perceptions are likely to perceive their CMDs as being less controllable or curable and having more consequences and therefore, they are more likely to have negative work experiences post-RTW (Løvvik, Øverland, Hysing, Broadbent, & Reme, 2014); and low self-efficacy in managing their CMDs at work (Holmgren & Ivanoff, 2004).

The behavioural component refers to the way individuals behave based on the integration of their cognitive and affective evaluations. Employees engage in behaviours at work aimed at creating a balance between the demands of the job and the individual's resources; such behaviours have been referred to as job crafting (Nielsen & Abildgaard,

2012; Tims & Bakker, 2010). The extent to which individuals succeed in crafting a job post-RTW and achieve a balance between the demands of the job and the resources available to the individual, considering their potentially reduced work functioning, is likely to minimise the risk of relapse. Personality factors may also play an important role. Hystad, Eid, and Brevik (2011) found that hardiness protected against the negative effects of high-demand-low control jobs on sickness absence.

Proposition 1: Employees with CMDs' work-related cognitive, affective and behavioural resources will influence their drive and ability to achieve SRTW.

Individual resources at play in the non-work domain

Employees with CMDs' general cognitive, affective and behavioural resources may also influence their ability to achieve SRTW outside the work domain. Psychological factors such as personality (perfectionism), feelings of hopelessness about the future, low self-esteem and low work-related self-efficacy are reported to be strong predictors of long-term-sickness absence and low RTW rates in employees with CMDs (Huijs, Koppes, Taris, & Blonk, 2012; Lagerveld, Blonk, Brenninkmeijer, & Schaufeli, 2010). These may also play a key role post-RTW. If the employee continues to keep up the appearance of a successful job, a busy social life together with an idealised family life while at the same time experiencing feelings of poor self-esteem, these feelings are likely to result in relapse. Indeed, in interviews, employees with CMDs reported work–home balance to be important for SRTW (Hees et al., 2012; Holmgren & Ivanoff, 2004; Noordik, van der Klink, Klingen, Nieuwenhuijsen, & van Dijk, 2010). With regards to behaviours, the positive effects of physical activity and nutrition on mental health have been well documented, (Joyce et al., 2016), and it is possible that building resources through physical activity and healthy eating may prevent relapse. Overall, however, very little is known about which individual resources that are work-related and non-work-related may contribute to SRTW.

Proposition 2: Employees with CMDs' generic cognitive, affective and behavioural resources will influence their drive and ability to achieve SRTW.

Group level resources and SRTW

Social interactions at work

Group level factors may influence SRTW. These factors include both general factors and the factors specific to the returned employee's situation. Social identity theory (Tajfel & Turner, 1979; Tajfel, 2010) suggests that it is not only individuals' own identity that determines their behaviour, but individuals also have a social identity, i.e. they are part of a social network and this identification also drives behaviour. In support of this assumption, Noordik et al. (2010) reported that employees with anxiety disorders found returning difficult due to high turnover in their work group and the individual did not feel part of the social network. Colleagues report being more willing to support and help the returned employee if they have a good relationship with them and there is a collective identity (Dunstan & MacEachen, 2013). Arends, van der Klink, Van Rhenen, de Boer, and Bültmann (2014b) found that organisation size mattered, suggesting that smaller organisations

may facilitate SRTW as colleagues may be more understanding of the returned employee's situation.

The group engagement model (Tyler & Blader, 2003) suggests that perceptions of fairness drive behaviours. In the SRTW context, we propose that colleagues' perceptions of CMDs and the fairness of returned employees' post-RTW conditions will drive their (continued) support of these employees. For example, returned employees may be allocated reduced responsibilities; however, if colleagues feel these reductions are unfair and that returned employees "just need to pull themselves together", they are less likely to support employees returning to work, accept the planned work reductions, and potentially take on extra work (Noordik et al., 2010). Colleagues are likely to be aware that returned employees have a CMD but may, in many cases, not know the nature of the CMD and therefore find it hard to understand the symptoms and work limitations of the returned employee (Dunstan & MacEachen, 2013). Colleagues who have an understanding of the nature and consequences of CMDs may more likely to perceive any work modifications as fair and reasonable (Dunstan & MacEachen, 2013).

Principles of vicarious learning (Bandura, 1986) suggest that role models at work are important to SRTW, e.g. colleagues who suffer/have suffered from CMDs and who have achieved SRTW may provide valuable information on how to manage symptoms and reduced work functioning in the work context.

Proposition 3: Employees with CMDs whose experiences of their work group are positive upon RTW are more likely to achieve SRTW.

Social resources in the non-work domain

There is limited research focusing on the importance of the social context outside work. Married employees are more likely to return to work (Norder et al., 2015). A few qualitative studies have found that understanding friends and family members is important for RTW (Holmgren & Ivanoff, 2004; Noordik et al., 2010). Similarly, in a Delphi study among occupational health professionals, users of RTW services and organisational representative, Reavley, Ross, Killackey, and Jorm (2012) found that family and friends should provide emotional and practical support to assist the employee's recovery and RTW. Transferring this to a SRTW setting, instrumental support from friends and family may be needed, e.g. friends and/or family helping out with household chores and childcare. Such non-work-related group resources may prevent employees with CMDs feeling overwhelmed having to perform a dual role of working and taking care of their home post-RTW. Previous research has found that a negative work–family spillover effect was related to higher levels of sickness absence (Väänänen et al., 2008).

As in the work domain, role models in non-work networks may also play an important role in ensuring SRTW, e.g. friends or family who have achieved SRTW and who share information and advice on how to manage CMDs outside the work context. To the best of our knowledge, there has been little empirical research on how the social networks outside work may act as resources to ensure SRTW, nor how these may interact with resources at other levels and in other domains to create resource caravans.

Proposition 4: Employees with CMDs who experience strong, positive social networks outside work are more likely to achieve SRTW.

Leader resources and SRTW

Resources at the leader level may play a significant role in SRTW. In the workplace, we define the leader as the first line manager. This level of leaders plays an important role in structuring the daily work of the returned employees and is often the person responsible for designing and implementing practical work adjustments. In the non-work domain, this role is less defined but we suggest that also outside the work context, do leaders exist that may shape the SRTW process. We propose that healthcare service providers may play a significant role as leaders outside the work context. In some systems, healthcare providers decide when the employee is ready for return and may play a significant role in shaping how the employee sees him- or herself as a returning employee.

Line manager resources at play

Line managers have a strong influence on employees' health and well-being outcomes (Kuoppala, Lamminpää, Liira, & Vainio, 2008; Skakon, Nielsen, Borg, & Guzman, 2010). Research adopting a behavioural perspective has attempted to elucidate the behaviours displayed by line managers to promote positive work environments (Yarker, Lewis, Donaldson-Feilder, & Flaxman, 2007), and those specifically relating to RTW (Munir, Yarker, Hicks, & Donaldson-Feilder, 2012).

In a RTW context, employees with CMDs are more likely to return when managers assume responsibility for the RTW process and adopt an individualised approach to managing the employees return (Aas, Ellingsen, Lindøe, & Möller, 2008; Munir et al., 2012), and where line managers and returned employees communicate effectively (Holmgren & Ivanoff, 2004; Munir et al., 2012). Although line managers often control employees' ability to access work adjustments, they often have limited knowledge on what adjustments can be made and how to implement them (Arends, Bültmann et al., 2014; Yarker, Munir, Donaldson-Feilder, & Hicks, 2010). Line managers also find it difficult to know how to approach conversations surrounding RTW or CMDs sensitively and effectively (Cohen, Allen, Rhydderch, & Aylward, 2012). This research echoes a concern that despite being a vital component to the RTW process, line managers are ill-equipped to manage the complexities of RTW for employees returning with CMDs (Business in the Community, 2016; Munir et al., 2012).

Based on focus groups with line managers and a survey of rehabilitation professionals and management representatives, Johnston et al. (2015) identified five key KSAs (knowledge, skills and abilities) line managers needed to ensure a SRTW. First, line managers need to communicate effectively with the employee in question. Second, they need to have the skills to sensitively manage privacy and disclosure to colleagues. Third, they need a set of enabling behaviours such as managing conflict, being able to deliver sensitive information and be seen as trustworthy. Fourth, line managers need to have knowledge of the RTW systems, processes and procedures and finally, fifth, they need to develop and monitor a RTW plan for the returned employee. Others have identified further factors: employees should not perceive pressure from line managers to attend work when they feel unwell (Ashby & Mahdon, 2010); employees should not feel a nuisance and that they add to the managers' workload (Munir et al., 2012); and line managers with personal experiences of CMDs may appreciate returned employees' needs to stay in work (Munir et al., 2012).

Proposition 5: Employees with CMDs who experience inclusive, considerate and individualised line management are more likely to achieve SRTW.

Links to healthcare service providers

We propose that healthcare service providers may play an equivalent role to that of the line manager in their role of managing and overseeing their medical or professional care outside the work domain, whereby continued access to healthcare service providers and the relationships with these employees may result in SRTW. By healthcare service providers, we refer to the wider general healthcare system that is not related to the work domain. These providers include psychiatrists, psychologists and general practitioners (GPs). Andersen, Nielsen, and Brinkmann (2014) suggested that RTW was facilitated when GPs and other contacts in the social work and healthcare system saw the individual with CMDs as a person rather than a patient/client. A continued good relationship with key social and healthcare service providers is likely to result in SRTW (Norder et al., 2015). Furthermore, continued access to appropriate professional intervention is imperative to SRTW. It is important to have an integrated approach to patient care. Although there is a growing focus on the benefits of integrated care within healthcare services both within research and practice (Andersen et al., 2012), there is need to extend this thinking to better understand how these co-ordinated providers available outside work are influenced or leveraged when the employee sustains work. In addition, once back at work, employees with CMDs may be less able to commit to, or prioritise training activities, thereby limiting the available resources to support their CMDs and increasing the likelihood of relapse of sickness absence and exit from work.

Proposition 6: Employees with CMDs who have a sustained positive relationship with their healthcare service providers are more likely to achieve SRTW.

Organisational level resources and SRTW

Organisations' provision of support

The Reavley et al. (2012) Delphi study also points to the importance of organisational resources. Job design characteristics, such as high demands and low control, have been found to be related to CMDs (Kouvonen, Mänty, Lallukka, Lahelma, & Rahkonen, 2016). Translated into a SRTW context, this means that employees with CMDs who have the opportunity to take breaks to clear their heads or who can decide how to organise their work to minimise strain may be able to manage their CMD symptoms better at work (Norder et al., 2015). Prang, Bohensky, Smith, and Collie (2016) found that employees returning to a job characterised by high work pressure were less likely to achieve SRTW.

Human resource management (HRM) practices are often classified according to the ability, motivation and opportunity (AMO) model, which classifies HRM practices according to three areas: ability-, motivation- and opportunity-enhancing practices (Appelbaum, Bailey, Berg, & Kalleberg, 2001; Jiang, Lepak, Hu, & Baer, 2012). These AMO-practices may act as resources that facilitate SRTW. Ability-enhancing practices include training. Returned employees with CMDs may receive training in how to structure their work and become better at recognising their symptoms and manage these in the

workplace setting. As such training may enhance individual resources, e.g. self-efficacy or job crafting. Motivation-enhancing practices include performance appraisals and career opportunities. Motivation-enhancing practices that facilitate SRTW include performance appraisals that consider CMD issues and adjusted work practices. Practices may also include adjusted career opportunities for returned employees, e.g. that career progression may take longer or could be lateral, i.e. rather than progressing to assuming a management position, returned employees develop their skills in their job to become an expert engineer. In particular, in relation to employees with CMDs, the provision of high quality occupational health services may be crucial. Occupational physicians with a good understanding of CMDs and how different types of jobs may be adjusted may be better suited to provide adequate guidance on work adjustments and accommodations. A good relationship with the occupational physician is also crucial to successful SRTW (Arends et al., 2014a).

Finally, opportunity-enhancing policies and practices offer opportunities for employees to exercise discretionary effort. For employees with CMDs, these may influence flexible working practices, flexi-time practices, part-time working and the opportunity to work from home. Such policies and practices may help returned employees with CMDs; allowing them to return to work at a reasonable pace that enables them to get re-accustomed to working. Qualitative research has described that returned employees found motivation-enhancing practices such as career guidance, opportunity-enhancing practices such as concrete individualised RTW plans, and ability-enhancing practices such as assertiveness training and support developing strategies to negotiate with managers helpful (Andersen et al., 2014). Although these HRM resources may be more prevalent in larger companies, research indicates that employees returning to work in larger companies are more likely to experience relapse (Arends et al., 2014b). There is therefore good reason to explore how these HRM practices facilitate SRTW and how smaller organisations may provide resources that compensate for these, i.e. a closer social network at the group level. Importantly, current employer guidelines do not consider reintegration into work post-RTW, only the RTW-process (Dewa, Trojanowski, Joosen, & Bonato, 2016).

Proposition 7: Employees with CMDs who have returned to an organisation where work is organised, designed and managed to support return are more likely to achieve SRTW.

Non-work organisational practices in the local environment

In the non-work context, there are a number of established informal voluntary and local community structures in place to support employees with CMDs functioning outside the formal contacts in the social and healthcare system. We propose that these voluntary and local community structures are equivalent to the organisational level support available within the workplace. The organisational-level equivalent to organisational practices, policies and procedures may be the structures in place to support the employee with CMDs outside work, that are not related to the formal social, healthcare and societal system. Community and voluntary organisations have long since been established to support employees with CMDs (e.g. Mind in the UK). Employees with CMDs who receive additional support outside of the healthcare and work context, i.e. through charities, are likely to achieve SRTW. For example, in a society where the returned employee has

access to information and guidance from a charity about how to talk to friends and colleagues about their CMDs, as well as a telephone helpline to access support outside standard general practice hours, employees are less likely to experience relapse.

Proposition 8: Employees with CMDs who live in well supported, expertly resourced and funded communities and who have access to voluntary resources are more likely to achieve SRTW.

Overarching level resources and SRTW

Work-related national legislation and policy to support SRTW

Organisational policies and practices operate within a wider national context. There are many variations in national legislation, insurance, social welfare policies and practices (e.g. sickness benefit compensation, surveillance). To fully understand the predictors of SRTW, resources must be considered within the overarching context, i.e. the societal context and the culture and legislation.

Although a few studies have identified commonalities and differences between countries with regard to the work-related risk factors for CMDs (e.g. Harvey et al., 2017) and one study compared sickness absence management in different countries (Gimeno et al., 2014), to our knowledge, there are no cross-cultural studies/national comparisons of the resources related to SRTW. Rather, where studies identify the resources related to SRTW they are conducted in one national context (e.g. Lagerveld, Bültmann, et al., 2010) and therefore it is difficult to separate the impact of RTW resources from the contribution of overarching policies and legislation. While systematic reviews or meta-analyses may inform our understanding of international comparisons, these do not allow for in-depth study of the overarching context. Employment services who receive their payment based on employees returning, but not staying at work, may have less of an interest in SRTW. Employees with CMDs living in countries with a generous welfare system to support those who do not return to work may be less concerned about relapse. Understanding the extent to which legislation, insurance and welfare policies influence SRTW behaviour is vital in planning and evaluating SRTW interventions.

Proposition 9: Employees with CMDs who live and work in countries within an overarching context where legislation and practices support organisations managing SRTW are likely to achieve SRTW.

Non-work national policies and attitudes to support SRTW

It is equally important to understand the factors related to the non-work context: for example, personal and financial freedom. Financial commitments and responsibilities such as a high mortgage or rent may initially motivate employees on sick leave to return to work (Ståhl & Stiwne, 2014); however, if they are not yet ready to return mentally, the consequence may relapse. The pressure to RTW may be greater in a country with little financial support, e.g. housing benefits. Likewise, societies where care for older or younger family members is offered, the double pressure from work and from the home environment may be minimised. Furthermore, the wider societal view on CMDs may

also play an important role. For example, where media will commonly openly discuss CMDs and do not stigmatise employees with CMDs, employees may more readily seek support for their CMDs. To the best of our knowledge, these issues remain under-researched in current SRTW research.

Proposition 10: Employees with CMDs who live in a society with good financial and care provision and where CMDs are widely accepted are more likely to achieve SRTW.

Discussion

In the present position paper, we have suggested an integrated framework for SRTW among employees with CMDs investigating the resources that may help facilitate SRTW in employees with CMDs. Using COR theory as the underpinning framework (Hobfoll, 1989), we have provided examples and drawn upon occupational health psychology theory to suggest which resources at the individual, the group, the leader and the organisational levels may facilitate SRTW. In recognition that also important resources exist outside work, we extend the IGLO model to include the overarching, i.e. the wider social and cultural context and the suggested non-work resources at each level that may also play a role in promoting SRTW. This integrated IGLOO framework calls for an inter-disciplinary approach to managing SRTW. We propose that researchers and practitioners in the fields of psychology, occupational health, vocational rehabilitation, public health, HRM, policy and media collaborate to explore how resources at different levels interact and develop and test multi-component interventions.

We have also proposed a preliminary definition of (components of) SRTW for employees with CMDs based on previous definitions. By no means, however, do we feel this definition is final. For SRTW to be achieved, there is a need for employees with CMDs to be able to engage in work and function well throughout their working life (Norder et al., 2017). It may be that a SRTW is not a return to existing roles and responsibilities. For example, some returned employees may not return to contracted hours, and/or return to a job with fewer responsibilities and subsequently lower pay, e.g. managers may benefit from returning to a non-managerial position; others may maintain their current role and avoid the pressures of career progression. Presently, we do not know enough about the factors important for SRTW to provide a final definition.

Our brief overview highlights several areas avenues for future research. Lewin (1943) argued that there is nothing as practical as a good theory and we have developed our framework partly building on existing occupational health psychology theory and partly on existing RTW research that may enrich our understanding of the factors influencing SRTW in employees with CMDs. The transference of these theories to the SRTW context has yet to be tested.

The current literature on RTW has primarily focused on RTW and explored the period prior to RTW; we extend the period to include the post-RTW period when the person has returned to work and argue that we need to understand the resources that may prevent relapse, facilitate good work functioning and ensure a good working life for employees with CMDs who, despite remission, are likely still to suffer impaired work functioning (Arends et al., 2014a; de Vries et al., 2015). Within each level and domain, there is still much to be researched, and the extent to which resources important for RTW are also important to the post-RTW period have yet to be understood.

We need to integrate resources at different levels and the work and non-work domain to fully understand the cumulative and interactive impact of these levels on SRTW and how these may form resource caravans. Specifying different levels of influence is important because different levels require different types of interventions to build resources (Day & Nielsen, 2017). There has been surprisingly little research trying to understand how employees' out-of-work behaviours crossover into the work domain and influence the individual's ability to stay at work and vice versa. For example, healthcare service providers may liaise more closely with supervisors to understand returned employees' work functioning. There is a need to look at interactions between the resources available to those experiencing CMDs. For example, Netterstrøm, Friebel, and Ladegaard (2012) found that among employees with stress, a group therapy intervention combined with workplace dialogue to make adjustments at work resulted in higher RTW compared to control groups. These results suggest that group therapy should not only focus on individual's symptoms and CMDs but also on how these influence the individual's work situation. Also, continued coordination between occupational physicians and supervisors has been found to be important, but this coordination is rarely afforded in practice (Arends, Bültmann et al., 2014). Understanding the interaction between levels of resources in- and outside the work domain may prove crucial to ensuring SRTW.

We need to understand how the overarching national and cultural context influences SRTW. The obvious national differences in whether organisations have a vested interest in helping employees stay at work, as is the case in the Netherlands, is likely to have a cascading effect on the organisational policies and practices of HRM and management. Also, in contexts where the media paint a negative image of individuals with CMDs as individuals feigning illness, may result in the employee with CMDs feeling uncomfortable at work if they perceive colleagues and line managers are tainted by this image. We also need to understand better how the extra-organisational context influences organisational strategies, for example, research has found that although small and medium enterprises (SMEs) lack formal HRM systems, informal HRM practices are often the result of external factors such as legislation and value chains (Harney & Dundon, 2006).

We need to follow returned employees with CMDs over time to understand their return journey, their work functioning (Ubalde-Lopez et al., 2017) and how their needs and experiences change over time in the years post-RTW. Longitudinal qualitative and quantitative research will allow us to explore the impact of work and non-work events and how these may prevent or provoke relapse. Despite a large body of evidence to the resources that help understand the predictors of RTW, there are significant gaps in our understanding of SRTW. We need to develop our understanding of how many employees with CMDs relapse and subsequently exit the workplace and eventually the labour market following a failed RTW, after how long, and for what reasons? We also need to understand how these can be helped back into work in other types of work and at other workplaces.

Our brief overview of the IGLOO framework can also be used to identify gaps in the current provision of care and support for employees with CMDs. For example, while there is growing evidence to suggest that support at the group level is important for SRTW, there is little guidance available for colleagues or for family and friends to help them support the employee with CMD. Our framework could be used to map existing service provision and encourage discussion between stakeholders to help ensure that benefits accrued from one resource are not lost due to the absence of another resource;

for example, the benefit of a significant investment in mental health care services may be compromised where colleagues or line managers are not supportive during and following the employees return; similarly, investment in line manager training and accommodating workplace adjustments may have limited effect if the individual receives limited support at home. This gap analysis could usefully be conducted at a national level or at the individual level.

We propose a more far-reaching approach is necessary to make the impact on SRTW to prevent the loss of employees from the work due to CMDs. As a consequence, we need to develop and test multi-component interventions that aim to build resources at multiple levels and across the work and non-work domains. Developing an understanding of the factors that work together to create SRTW for employees with CMDs will help organisations, healthcare service providers and policy-makers to better structure guidance and care during sickness absence, during the initial RTW phases and throughout their working lives. We propose that occupational health psychology and other disciplines need to consider how we can create the conditions for employees with CMDs to stay, functioning well and thrive at work such that the human and societal costs of sickness absence and dropout from the labour market can be minimised.

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