
Book Section:
Nielsen, K. orcid.org/0000-0001-9685-9570, Yarker, J., Munir, F. et al. (1 more author) (2020) IGLOO: a framework for return to work among workers with mental health problems. In: Bültmann, U. and Siegrist, J., (eds.) Handbook of Disability, Work and Health. Handbook Series in Occupational Health Sciences, HDBSOHS 1 . Springer , pp. 615-632. ISBN 9783030243333

https://doi.org/10.1007/978-3-030-24334-0_38

IGLOO - a framework for return to work among workers with mental health problems

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Abstract

It is important for society and for organizations to support workers returning to work following mental health-related absence. Recent evidence points to an increase in mental health problems among the general population, with approximately 38.2% of the EU population suffering from a mental disorder each year (European Commission 2008, 2016). Of those who take a period of sick leave, 55% of workers make unsuccessful attempts to return to work (RTW) and 68% of those who do return have less responsibility and are paid less than before (Matrix Insight 2013). A number of challenges have been reported by workers following a period of long-term sickness absence, however current research has been somewhat limited by a focus on the initial return and a siloed approach where work and non-work contexts are considered separately.

In this book chapter, we apply the IGLOO (individual, group, leader, organizational and overarching contextual factors that may support sustainable RTW) model (Nielsen et al. 2018). In doing so, we focus on the sickness absence before return to work and consider the

factors that could support return to work following long-term sickness absence. We provide an overview of the resources that may facilitate return to work among workers who are on sick leave with mental health problems. Based on the IGLOO framework we identify and discuss resources, i.e. factors that facilitate return to work at five levels: The individual (e.g. beliefs about being able to manage a successful return to work, health behaviours), the group (work groups, friends and family), the leader (line managers and healthcare provides who take the lead in supporting workers return), the organisational (Human Resource policies and external organisations such a charities) and the overarching context (social security systems). We discuss these resources that pertain to the work context but also the non-work context and highlight the importance of understanding how resources apply at different levels. We argue that there is a need to understand how societal factors, such as legislation, culture and national policies, impact return to work outcomes. We propose a holistic approach, that focuses on integrating the resources in and outside work, is needed to facilitate successful and sustainable return to work for workers with mental health problems.

Keywords: Return to work, multi-level interventions, sickness absenteeism, mental health

1. Introduction

Recent evidence points to an increase in mental health problems among the general population (European Commission 2008, 2016). Mental disorders are highly prevalent in Europe and present a major burden on individuals, organizations, society and the economy of the European Union (EU). Approximately 38.2% of the EU population suffer from a mental disorder each year, most frequently anxiety disorders (14%), insomnia (7%), major depression (6.9%), somatoform disorders (6.3%), alcohol and drug dependence (4%)

(Wittchen et al. 2001). One quarter of the EU working population is expected to experience a mental health problem during their lifetime (EU-OSHA 2014).

Work, employment and mental health are closely intertwined for at least four reasons. First, it has been found that having a good quality job protects against poor mental health (Paul and Moser 2009). Second, workers with mental health problems are 6-7 times more likely to be unemployed suggesting that more could be done to promote good working lives for these workers (OECD 2014). Third, importantly not all jobs are good and there is significant evidence that poor working conditions are linked to poor mental health (Madsen et al. 2017; Stansfeld and Candy 2006), which in turn can be related to long-term sickness absence (Melkevik et al. 2018). Fourth, it has been found that 55% of workers with mental health problems make unsuccessful attempts to return to work (RTW) following an episode of long-term sick leave caused by poor mental health. Of those who do return, 68% have less responsibility and are paid less than before (Matrix Insight 2013). The costs of medical expenses, increased need of healthcare and social care costs due to mental ill-health exceed 4% of GDP in the OECD countries (OECD 2014). Together, these findings make it important for society and for organizations to manage mental health and support employees in the RTW process.

Although work is often mentioned as the main cause for sickness absence due to poor mental health (Løvvik et al. 2014), helping workers with mental health problems return to work is important because work can have a positive impact on mental health problems for at least six reasons (Ekbladh and Sandqvist 2015; Harnois et al. 2000). First, work means earning an income. Second, work provides a time structure to the day and a lack of structure has been found to be a major psychological burden. Third, work enables social interaction and prevents isolation. Fourth, work provides an identity as employment is an important element in defining oneself. Fifth, work presents an opportunity for collective effort and

purpose. It can give the worker a sense of making a meaningful contribution to a greater whole and this is achieved in collaboration with others. Finally, work offers the opportunity of regular activity and thus prevents individuals from overthinking, linking back to the old saying of idle hands are the devil's workshop. It is thus important to understand how we can create conditions that help workers with mental health problems return to work and to stay at work.

In the present book chapter, we apply the IGLOO (individual, group, leader, organizational and overarching contextual factors that may support sustainable RTW) model (Nielsen et al. 2018) to the RTW domain and review the literature on how this approach may support workers with mental health problems to return to work after long-term sickness absence. We thus focus on the sickness absence period *before* RTW. We know of no agreed definition of long-term sickness absence but suggest that the long-term sickness absence can be defined as the period beyond which the organization pays the worker a salary and social benefits take over which is the case in many developed countries. This period is different across national contexts due to the variations in national social security systems.

1.2 Developing a framework for RTW: IGLOO

As an analysis tool, we use the IGLOO framework to classify/order the resources that may support workers return to work. We draw on conservation of resources (COR) theory (Hobfoll 1989) as our underlying 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 et al. 2014, p.6), in this case RTW. 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 workers may not feel they have the necessary resources to return to work. 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), for example, when workers with mental health problems get support to build their resources this may make them confident that they can successfully return to work.

The IGLOO framework for RTW 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 organizational resources relating to the way work is organized, designed and managed.

In the field of work 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 Organizational level, also termed the IGLO model (Day and Nielsen 2017; Nielsen et al. 2017). More recently, the model has been extended with an additional level, the overarching context, i.e. the wider national legislation and culture (Nielsen et al. 2018), which may influence RTW. The IGLO(O) model suggests that the antecedents of worker health and wellbeing can be classified according to these five levels. We propose that this understanding of resources may be transferred to the RTW domain where resources can promote RTW among workers with mental health problems.

Insert table 1 around here.

2.2 Individual level resources

2.2.1 Cognitive, affective and behavioural resources related to work

At the individual level, RTW is influenced by a range of factors encompassing cognitive, emotional and behavioural responses related to work. The cognitive aspect relates to the individual's own belief about their mental health status, their assessment of their symptoms and their confidence (i.e. self-efficacy) in their own abilities and skills in managing their job demands upon RTW (de Vries et al. 2018). Combined with emotional responses to their illness (e.g. presence of, and level of emotional distress), these illness perceptions (Leventhal et al, 1997) influence an individual's own expectations of RTW and in turn, their actual behaviour in returning to, delaying, or not returning to work. Thus, RTW expectations have been found to be a strong predictor of actual RTW (Løvvik et al. 2014). Furthermore, beliefs about the causal attribution for the sick leave also impact RTW outcomes. Many individuals with mental health problems attribute the cause of their perceptions and beliefs about their problems to work. These include the work itself such as high job demands, to perceptions of attitudes and behaviours of supervisors and colleagues toward their illness (Løvvik et al. 2014; Corbière et al. 2016). Ability to attain work-related goals and worry about work-related factors is also associated with longer sickness absence (Norrmen et al. 2010). The causal attribution component of illness perceptions may influence various health behaviours and the sorts of strategies individuals use to control and cope with their illness (e.g. Olsen et al. 2010). For example, adopting avoidance coping strategies may prolong sick leave as the individual is reluctant to face the work issues, he or she believes caused their illness.

Proposition 1: Individuals' work-related cognitive, affective and behavioural resources influence individuals' readiness to RTW.

2.2.2 Individual resources at play in the non-work domain

Psychological factors such as low motivation to return, severity of depressive symptoms, perceptions of illness and personality traits (perfectionism) are reported to be strong predictors of long-term sick leave and low RTW rates (Lagerveld et al. 2010; Huijs et al. 2012; Nigatu et al. 2017). However, self-efficacy in RTW is a key factor in RTW itself and individuals who have higher RTW self-efficacy are more likely to RTW (Nigatu et al, 2017). Being willing to utilise healthy strategies to support both physical and mental wellbeing are therefore of great importance for RTW. These include exercising and eating healthily and regularly (Jansson et al, 2014); focusing on self-care and leisure (Cowls and Galloway 2009); building resilience towards work-related stress (Netterstrøm et al. 2013). These all contribute toward regaining a sense of a capable self (Nielsen et al. 2013) and a sense of control, which in turn contribute to RTW. However, encouraging an individual to engage with health restoring strategies is challenging if the individual perceives being on sick leave as beneficial to their mental health, continues to adopt reactive-passive coping strategies (Van Rhenen et al. 2008) and continues to perceive there is no work-related solution.

Proposition 2: Cognitive, affective and behavioural resources will influence an individuals' drive and ability to achieve RTW.

2.3 Group level resources

2.3.1 Social support at work during sick leave

A number of group level resources may influence RTW. Support from peers and colleagues may be crucial for successful RTW (de Vries et al. 2014), however, it must be carefully considered how, and which nature of support is needed. One underlying framework for understanding the role of social support for supporting workers with mental health problems return to work is the social identity theory (SIT, Tajfel and Turner 1979; Tajfel 2010). According to SIT (Tajfel and Turner 1979), individuals also have a social identity

beyond their individual identity. Having a social identity means that an individual feels s/he belongs to a wider social group, e.g. a group of colleagues at work. This belongingness partly determines the individual's behaviour. Transferring this to the RTW context, the extent to which workers feel part of a social network at their place of work will influence their RTW. Colleagues can do simple things to maintain the sense of belongingness to the work group, such as sending a card, chocolate or flowers, sending the occasional email and inviting them to social events. Although the worker on sick leave may not feel like attending events, they are reminded that the work group still sees them as part of the group.

Holmgren and Ivanoff (2004) found that workers who are on sick leave from a workplace with inherent conflicts found it difficult to return. Examples of such conflicts could revolve around being a female in a male-dominated workplace or being the only worker with a higher education. The nature of these conflicts meant that they were not easily solved. Workers on sick leave found themselves being questioned by their work-mates and felt the odd one out. Workers reported that colleagues who demonstrated an understanding of their problems were a major resource that helped them believe they could and would return (Dunstan and MacEachen 2013; Noordik et al. 2011).

Stigma is a prevalent problem and colleagues may have little understanding of the recovery process (Harnois et al. 2000). Workers on long-term sick leave may also fear they will not be welcomed back at work. If workers returned to a high-performance environment where pay for performance forms part of the reward structure, colleagues may be perceived to be less accepting of reduced work functioning (Saint-Arnaud et al. 2006; Noordik et al. 2011). In summary, current research has focused on the negative aspects of groups, but we propose that being part of a supportive group environment may be related to RTW.

Proposition 3: Workers with mental health problems who feel part of a supportive work group are more likely to return to work.

2.3.2 Social resources in the non-work domain

There is limited research focusing on the importance of the social context outside work. In their scoping review, de Vries et al. (2018) concluded that there was insufficient evidence to conclude whether factors such as family history of depression, the size of the social network and support from family and friends had a positive influence on RTW. Individual studies have found that married employees are more likely to return to work (Norder et al. 2015) and understanding friends and family members are also important (Holmgren and Ivanoff 2004; Noordik et al. 2010). Furthermore, there is indicative evidence that emotional and practical support from family and friends is important to RTW (Reavley et al. 2012), however, support from colleagues and family was not found to be related to shorter RTW (<3 months) (Ekberg et al. 2015). Although we found no research supporting this notion, being a member of religious or church groups may also provide an important social network outside work, which can help supporting the individual RTW.

Proposition 4: Employees with mental health problems are more likely to return to work if they have a supportive network outside work.

2.4 Leader level resources

2.4.1 *Line manager resources*

Line managers' behaviours have been associated with employee health and well-being (Arnold 2017; Harms et al. 2017; Inceoglu et al. 2018; Montano et al. 2017; Skakon et al. 2010). Previous research has found that line managers play an important role in supporting workers with mental health problems return to work (Aas et al. 2008; Munir et al. 2012). A good relationship and ongoing communication during sick leave is crucial, and studies indicate that line managers often do communicate with workers on sick leave (Negrini et al. 2018; Nieuwenhuijsen et al. 2004). Interestingly, these conversations were rarely about RTW

as most line managers were aware of the importance of not forcing the worker to return (Negrini et al. 2018; Nieuwenhuijsen et al. 2004). Only 22% of line managers supported return before symptoms of mental health had fully disappeared. Good communication between workers on sick leave and line managers resulted in full RTW when workers no longer reported depressive symptoms. Line managers were found to communicate better when return had an impact on the department's performance (Nieuwenhuijsen et al. 2004). This suggests that financial incentives may be important to motivate line managers supporting workers returning, however, there may also be at risk that it incentivizes line managers to coerce workers to return to work before they are ready.

Proposition 5: Employees with mental health problems who experience supportive line management are more likely to return to work.

2.4.2 Links to healthcare service providers

Outside the work context, healthcare service providers may be as important as line managers in supporting RTW. De Vries et al. (2014) found that healthcare providers who lacked expertise in mental health problems, provided inadequate treatment for mental health disorders and paid insufficient attention to the importance of returning to work delayed RTW. General practitioners or healthcare professionals may facilitate RTW when they acknowledge the worker on sick leave as an individual rather than as a patient/client (Andersen et al. 2014). Similarly, Sturesson et al. (2014) found that trust in the relationship, i.e. that workers on sick leave felt they had a say in decision making, that they were believed and felt listened to, were important for RTW, together with healthcare providers being seen as dedicated to support workers. Equally a relationship between the worker on sick leave and the healthcare provider that was characterized by professionalism, continuity and seeing the person as a whole has found to be important for RTW. In contrast, being in contact with specialized medical staff

was found to be negatively associated with full RTW (Nigatu et al. 2017), possibly because such healthcare professionals may not see return as a crucial outcome but focus more on treating the illness.

Healthcare service providers may also provide access to wider services. Access to therapy may also play an important role. A recent meta-analysis showed that cognitive behaviour therapy, stress reduction programmes and problem-solving therapy can reduce the number of sick-leave days in the intervention group compared to the control group (Nigatu et al. 2016) but do not lead to improved RTW rates over the control group.

Proposition 6: Healthcare providers with the necessary expertise in mental health issues and who provide adequate support may support workers with mental health issues return to work.

2.5 Organizational level resources

2.5.1 Organizational resources

Noordik et al. (2011) noted that there was a gap between solutions and intentions to return to work and their implementation at work for employees returning to work after mental ill-health sickness absence. It is important that organizational structures and processes are in place if intentions are to be translated into practice. Exploring the factors related to length of sickness absence, Ekberg et al. (2015) found that important resources supporting those returning after three months were fair procedures and a need for reduced demands at work. In the group of workers who returned between three to 12 months, reduced demands, also in terms of a reduced physical load, were important. Lacking resources in the form of an employer signalling wanting to get rid of the worker on sick leave or not providing guidance as to how to return was found to delay RTW (de Vries et al. 2014). In a study of women returning to work after long-term sickness absence due to poor mental health, Holmgren and

Ivanoff (2004) showed that women found it challenging to return to an organization where many changes had taken place and their job descriptions were no longer valid. De Vries et al. (2014) found that workers reported a poor fit with the organization after RTW. These findings suggest that an important resource at the organizational level is that Human Resources ensure job descriptions are reflective of the returning worker's tasks and are amended if needed.

The ability, motivation and opportunity (AMO) model proposed by Appelbaum et al. (2001), frequently used within Human Resource practices, offers a useful framework for ensuring that appropriate supports are in place for the returning worker. For example, considering whether there is there still a good fit between the role and the returner's abilities to do the job, their motivation for the task and the opportunities afforded to them to regain their skills and knowledge and develop new skills could help to mitigate problems experienced during the return that may lead to relapse. Occupational health professionals are well positioned to support this process.

Proposition 7: Employees with mental health problems who experience well organised work with clear and fair policies and practices are more likely to return to work.

2.5.2 Organizational resources in the non-work domain

Voluntary, third sector or community led support services operate outside the traditional formal mental health services (e.g. Mind in the UK and Denmark, beyondblue in Australia). These services may address gaps in formal service provision, which often outstrips demand, or complement existing services. To the authors' knowledge, there is no evidence to explore the impact of these complementary services, however, it is reasonable to suggest that those who are able to access these additional services, over and above therapeutic services, such as responsive telephone support, online e-health guidance

resources, drop in sessions or workshops are more likely to feel better supported during their absence and the initial RTW, thereby increasing the likelihood of a successful return.

Proposition 8: Employees with mental health problems who are able to access good quality advice from community and voluntary services to complement therapeutic treatments are more likely to return to work.

2.6 Overarching resources: Work and non-work related legislation and social welfare policy

Mental health problems are the leading cause of disease burden worldwide (Whiteford et al. 2015). Mental health problems affect not only individuals, their families and workplaces, but also communities and society. Therefore, means to promote the mental health and well-being of people of all ages are becoming increasingly important as well as effective national policies and practices to help people to return to work and to stay at work - both to extend working careers and to prevent labour market marginalisation, i.e., work disability, economic inactivity, unstable working career, downward occupational mobility, or status as 'working poor' (OECD 2012; European Commission 2010).

RTW policies and practices and measures to prevent work disability operate within a national legislative, health and social welfare policy context, e.g. sickness benefit compensation, health insurance, surveillance. Many different systems are involved in work disability prevention and the RTW process, such as the legislative, health and insurance system, i.e. the society's safety net with provincial and federal laws, regulations of jurisdiction and compensation (Loisel 2005). All these systems and their stakeholders must be considered, preferably in an integrated approach, when looking at RTW resources in the overarching, societal context, in which they are embedded. However, RTW policies and practices often do not acknowledge system influences.

When looking at work-related musculoskeletal disorders and work injuries, attempts have been made to compare different countries, i.e. Canada and Australia (Macpherson et al 2018), or eight different workers compensation systems within one country (Australia, Collie et al. 2016). As the majority of studies on RTW after mental health problems have been conducted in one jurisdictional context (Lagerveld et al. 2010), the impact of RTW resources from the contribution of overarching legislation, policies and practices cannot be separated out. A recent systematic review and meta-analyses on predictors of RTW after depression (Ervasti et al. 2017) has not only shown a significant heterogeneity between studies, but also concluded that there is a dearth of observational studies, and called particularly for more research focusing on the role of labour market factors. Another recent review by Nigatu and colleagues (2017) on prognostic factors for RTW in workers with common mental disorders, reported on two studies from Australia and the Netherlands addressing the contact with a medical specialist (Prang et al. 2016, Nieuwenhuijsen et al. 2004). De Vries and colleagues (2018) identified only one article focusing on system impacts of mental health coverage, fringe benefits, and disability management (Salkever et al. 2003) in a scoping review on determinants of sickness absence and RTW in workers with common mental disorders. Clearly, more research is needed on legislative, health and insurance system influences on RTW in workers with mental health problems – preferably by using a comparative approach to identify resources in the overarching context.

Uneven foci of work disability policy research across cause-based and comprehensive social security systems were identified in a recent scoping review by MacEachen and colleagues (2018). Articles on cause-based systems dwelled on system fairness and policies of proof of entitlement, while those on comprehensive systems focused more on system design complexities relating to worker inclusion and scope of medical certificates. Overall, a clear difference in the nature of problems examined in the different systems was observed.

For research to better inform policy making, the authors call for cross-pollination of research topics across the systems and more international comparison studies that are attuned to these policy differences (MacEachen et al. 2018).

Proposition 9: Employees with mental health problems who live and work in countries within an overarching context whose labour legislation and practices support RTW are more likely to RTW.

To date, research on the impact of welfare policies and cultural values for RTW after mental health problems is sparse. It can be speculated that countries with good systems for childcare or eldercare could alleviate additional external pressures. For example, in countries where childcare is readily available and reasonably priced, workers on sick leave may still be able to afford childcare and thus be able to get relief from childcare during the day. Similarly, in countries where the elder care burden is placed on society rather than the children of the elderly, having to deal with the care of the elderly in the family (such as cooking and cleaning in two homes, making hospital appointments, transporting the elderly and managing the elderly's finances), may alleviate the pressure. A culture accepting of people with mental health problems may mean organizations are more likely to employ workers with mental health problems as recruiters are less prejudiced. National public health campaigns on mental health are likely to reduce stigma and increase the understanding that workers with mental health problems do not just "need to get on with it" and are not scroungers on society.

Proposition 10: Employees with mental health problems who live and work in countries within an overarching context where welfare policies reduce potential external/additional strain on workers on sick leave and where the culture values are supportive of people with mental health problems are more likely to RTW.

3. Discussion

In this chapter we present a case for considering resources at multiple levels to support employees with mental health problems to return to work. Building on the work of Day and Nielsen (2017) and Nielsen et al. (2017), we identify resources at five levels: the Individual, the Group, the Leader, the Organizational level, and the Overarching context i.e. the wider national legislation and culture (Nielsen et al. 2018), which may influence RTW after mental health problems. In a recent review of RTW interventions, Dibben et al. (2018) found weak and contradictory evidence for either achieving employment outcomes or cost effectiveness. We propose that considering resources within and across the multiple levels may help us to develop more effective RTW interventions that accrue health, employability and financial gains for individuals, organisations and society.

For individual resources, the causal attributions of illness perceptions, RTW self-efficacy and RTW expectations are key psychological resources that influence the outcome of other individual resources and behaviours including the form of coping strategies utilized, ability to manage stress and motivating oneself to engage in healthy behaviours such as exercise which has an antidepressant effect (Such et al. 2016). Thus, causal attributions of illness, RTW self-efficacy and RTW self-expectations are of great importance in returning to work.

Although there is plenty of research suggesting that social support from colleagues is important, research has paid less attention to what this social support may look like while the worker is on sick leave. There are important issues concerning breaches of confidentiality and stigma that may prevent colleagues from keeping in touch with even close friends while they are on sick leave. More research needs to be conducted to understand the importance of keeping in touch, perhaps even visiting or taking the person on sick leave out for dinner or the movies. We know very little about whether this is done or whether it helps the RTW process. We need more research to understand how social networks outside work can

support workers' return. As concluded by de Vries et al. (2018) there is insufficient knowledge about which group level factors may support RTW. They suggest that previous history of mental health problems in the family may be important. This could work both ways. On the one hand, having previous history of mental health problems may mean that workers may be more prone to experience long-term issues. On the other hand, and on a more positive note, previous history may present opportunities for vicarious learning. The concept of vicarious learning (Bandura 1986) suggests that friends and family who have previous history of mental health and have recovered may act as role models and may share information and advice on how to manage the RTW process.

Despite growing acknowledgement that line managers play a vital role in supporting the returning worker, there is limited evidence to guide best practice. While maintaining communication during absence has been found to promote RTW (Aas et al. 2008), less is known about what should be done where the manager contributed to or was the cause of absence. Some research points to managers supporting returners more proactively when there are clear gains to performance (Nieuwenhuijsen et al. 2004), however, more research is needed to understand how managers can be incentivised to support the returning employee. Such incentives are particularly salient given that the majority of managers are reluctant to support a return unless the employee is fully recovered and symptom free (Negrini et al. 2018). Finding ways to encourage line managers to support employees back to work when they feel ready but are not yet at full capacity, presenting some symptoms, will be an important part of the RTW solution.

While there is an understanding that good job design and well managed work demands can help employees return to work following mental health sick leave (Ekberg et al. 2015), surprisingly little is known about the range of work adjustments that could be put in place to support returning employees. Despite the wide spread use of staged or phased RTW

programmes to support returning employees, there is little evidence to guide practice and help allied professionals and employers make informed, evidence-based decisions about how to structure the return or the length of time the phased return should be implemented. Importantly, despite increasing reliance on additional support from third sector services, the authors could not find any evidence for the benefits accrued from support provided by voluntary or charity sectors. This is not to suggest that these services have no important role to play, but rather to suggest that as yet we have little understanding of what supports are helpful, effective or provide a return on investment. Further research is needed, examining resources provided at work and outside work to understand what needs to be in place to support returning employees.

For the overarching societal context, work-related and non-work related national legislative, health and social welfare policy measures, e.g. sickness benefit compensation, health insurance, and culture may support RTW after mental health problems. We need to conduct more studies focusing on the impact of these overarching societal factors on RTW, separately, but also jointly with the resources available at other levels to better understand how these factors collectively shape the RTW trajectories of workers with mental health problems. Research has to address the complex interplay between the systems and stakeholders, i.e. the family, the workplace, the insurer, and the healthcare provider, who are interacting with the patient/worker in the RTW process.

Addressing this systemic and multidimensional RTW challenge requires adopting a transdisciplinary perspective. In addition, to better understand the impact of the societal context on RTW, more knowledge must be developed in cross-national or cross-jurisdictional, comparative approach.As is clear from our brief review much research has focused on the barriers to RTW and the lack of resources, less attention has been paid to the

positive factors, which may help workers return. There is a need to explore and identify which resources may have a positive impact and shorten sickness absence periods.

3.1 Interaction between resources

In the present framework, we outline the resources at five different levels, however, it is equally important to understand how resources at these levels interact. For example, the study by Nieuwenhuijsen et al. (2004) found that line managers often interacted with others, e.g. occupational health professionals, and were particularly motivated to do so when return influenced financial outcomes in their department. Furthermore, upper level resources may influence lower level resources. For example, national sickness benefit systems that put the onus on RTW and provide financial incentives for organisations to support workers return to work are more likely to result in organisations developing and implementing HR policies that proactively support workers returning. Likewise, organisational policies, programs and practices, such as training line managers in how to manage difficult conversations and policies for peer interaction with the person on sick leave are likely to influence the behaviours of line managers and colleagues. Also, whether GPs and healthcare providers provide access to additional services such as therapy depends on the social systems and the national strategies to provide funding for such services. Understanding the interaction between resources at different levels and in and outside the work domain becomes especially important in light of the studies by de Vries et al. (2014) that showed that occupational physicians and line managers did not agree on the factors that are important for RTW and Hees, Nieuwenhuijsen, Koeter, Bültmann and Schene (2012) that showed that employees found a "good work-home balance" important for a successful RTW (next to sustainability, job satisfaction and mental functioning) while occupational physicians and line managers regarded "sustainability" and "at-work functioning" to be of importance. These divergences in opinion may well influence how they each support workers returning and may at times

counteract each other. Finally, it is important that the different stakeholders at work and outside work on the different levels are aware of the expectations and resources of all involved stakeholders in the process towards RTW.

3.2 Conclusions

In the present book chapter, we employed the IGLOO framework to provide a broad overview of the resources, which may help workers with mental health problems return to work. Using the IGLOO model as our analytical framework helped us identify areas where we still lack knowledge on how to support RTW. In particular, there is a lack of understanding of how societal factors may support RTW. We need to develop our knowledge of how legislation, culture and national policies translate into RTW trajectories. At other levels, plentiful research has been conducted, e.g. there is a plenitude of research that shows the importance of peer support, however, despite the quantity of research there is still much to be learned about the nature of this research.

In summary, we argue that a more holistic approach is required that includes a strong focus on integrating the resources in and outside the work domain to facilitate a timely RTW for workers with mental health problems.

Acknowledgements: The author would like to thank Dr Susan Peters, Harvard Centre for Work, Health and Wellbeing at the University of Harvard for her useful comments on the book chapter.

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Table 1: Overview of resources that support workers' return to work

	Work domain	Outside work domain
Individual-level resources	Self-perceptions Attribution of mental health problems Goal orientation Coping strategies	Self-efficacy Self-esteem Motivation Resilience Self-care (exercise and healthy eating)
Group-level resources	Peer support Ongoing contact with colleagues Positive work climate Colleagues' understanding of mental health problems Collaborative work structure	Marital status Understanding family and friends Practical and emotional support from family and friends
Leader-level resources	Supervisor support Ongoing communication	Experienced healthcare providers Understanding the workers as a person, not a client/patient Trusting relationship with healthcare providers Continued and ongoing contact with the same healthcare provider Access to therapy
Organisational-level resources	Human Resource practices and policies Occupational health services	Access to voluntary and third sector support services
Overarching context resources	Sickness benefit compensation Health insurance Surveillance Work disability policies	Financial support, e.g. childcare provision Cultural values regarding mental health, e.g. prevalence and nature of debates in media