

# Gradual Return to Work in Germany: Protocol of a Qualitative Study to Examine Current Practices

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## Study protocol

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# Abstract

**Background:** Regarding demographic change, the rise in the working age and increase in long-term illnesses is a task for society to maintain the health of employees and return employees with long-term illnesses to work. In many countries like Germany, gradual return to work (GRTW) is used more and more frequently to achieve the full work capacity of employees, but little is known about its facilitators and obstacles.

**Methods:** This qualitative study will examine the current implementation of GRTW by means of 32 narrative interviews and 10 group discussions from different perspectives. Therefore, we will ask returning employees, their accompanying trusted person during GRTW in the company and organisations, and supra-organisational experts throughout Germany about their experiences with GRTW and attitudes toward the measure. The verbal data obtained will be analysed using the Documentary Method of Interpretation, focusing on the implicit and action-guiding knowledge of the study participants.

**Discussion:** This study will reveal facilitating and hindering factors of the recommendation, planning, utilisation, and implementation of GRTW in Germany. Future findings of the study can contribute to an improved use of GRTW, thus promoting a sustainable return to work. Based on this, recommendations for action can be developed for different actors.

**Trial registration:** German Clinical Trials Register (ID: DRKS00022892, October 1st, 2020).

## Background

### Development of long-term sickness absence

Long-term sickness absence and its consequences are a rising public health concern worldwide [1]. In the European Union, as well as in Germany, the process of return to work (RTW) after a prolonged illness is becoming increasingly important in medical-rehabilitative care [2, 3]. Being unable to work for at least six weeks in the last 12 months due to the same diagnosis is defined as long-term illness in Germany. It is irrelevant whether the duration of the incapacity for work is continuous or not. Therefore, this may also include chronic diseases, i.e., long lasting illnesses “[...] that cannot be cured entirely and resulting in a continuing or recurrently increased use of health care services” [4, p. 1].

Long-term cases of incapacity for work amount to only 4–5% of the total cases of sickness absence in Germany [5, 6]. However, they account for up to the half of all days of sickness absence [5–7]. As both life expectancy and retirement age rise, the duration of sickness absence and the number of chronic illnesses also increase [4, 5, 7]. While employees between 25 and 30 years old are sick listed an average of eight days per case, this number adds up to an average of 17 days in the group between 55 and 60 years old [8]. Five disease groups dominate long-term illnesses in Germany, regarding length and frequency, namely mental and behavioural disorders, musculoskeletal disorders, neoplasms, cardiovascular diseases, and injuries or poisoning [6, 7, 9, 10]. The longer the duration of sickness

absence lasts, the less likely it is that affected employees return to work. This increases the risk of unemployment or health-related disability pension [11].

In Germany, the retirement age due to reduced earning capacity in 2018 is 52 years, on average [8]. Without a health condition that threatens employment, affected employees would still have more than 13 years of work [12]. Given the increasing shortage of skilled workers, which is noticeable in many sectors in Germany [13], this development appears even more alarming. Additionally, the ongoing demographic change has led to prolonged employment biographies [3]. To secure the pension level, the estimated future retirement age is 70 years and older [14]. However, every second German reports suffering from at least one chronic disease from the age of 65 and older [4]. It is expected that the prevalence of chronic diseases, as well as long-term illnesses, will increase globally in the next few years [15].

## **Relevance of return to work**

The developments described above present great challenges for employees, companies, and the healthcare system to maintain health and workability. The current increase in population ageing [3, 16], sickness rates, and shortage of qualified staff in Germany has not only had a big impact on the individual, the society, and companies but also on the economy [15, 17, 18]. Thus, it is important to both maintain and restore the health, employability, and workability of the working population. According to the Federal Participation Act (2016), it is indispensable to (re)integrate people with a disability or those who feel threatened with a disability into working life in a sustainable manner.

Both the employees' participation at work and involvement in social life are central aspects of RTW after a long or severe illness. The ability to work can protect the (mental) health of employees [19, 20]. Pursuing a regular occupation also has positive effects on the employees' sense of purpose and coherence [20, 21]. For those people being sick listed or disabled, remaining in or re-entering work has a therapeutic meaning and helps to support full recovery and rehabilitation [19]. An early prepared, timely, and sustainable RTW is effective in preventing short- and long-term consequences, such as financial damage [22, 23] and adverse mental health effects (e.g., distress) [24]. Furthermore, it stabilises the health and workability of those affected [25].

## **Workplace adjustments during return to work**

RTW is a dynamic process [27] that should ideally target individual, work-related, structural, and environmental levels [28]. One measure that helps employees ease back into the workplace and enables a sustainable RTW [29, 30] is gradual return to work (GRTW).

Even though globally different concepts exist to handle RTW, many follow the same idea as GRTW for sick-listed employees in Germany, which is the return to full work after sickness absence by gradually regaining work capacity [29]. These concepts can, for example, include part-time or partial sick leave, light duties, work accommodations or work adaptations, graded activities, phased RTW, graded work exposure, or modified work. Not all of these measures are carried out at the workplace and must be distinguished from therapeutic measures (e.g., vocational or occupational therapy) involving the workplace.

# Outreach

Canadian employees who suffered a work-related injury were most likely provided with GRTW when meeting the following criteria: being not only severely injured but also on sickness absence for more than 30 days and female, aged between 35 and 54 years, employed at a larger company, and earning a higher wage [26]. These findings go along with previous studies showing that women had a higher proportion of GRTW than men [27–29]. A review by Kausto et al. [29] on partial sick leave in four Scandinavian countries showed that the acceptance of the programme was good. In three of four countries, the total number of utilisations is rising [29]. Most partial sick leave-users within all four Nordic countries were aged between 45 and 54 years and suffered either from mental or musculoskeletal disorders [29].

## Implementation

Using interviews with Canadian cancer survivors, health service providers, and employer representatives, Stergiou-Kita et al. [30] mapped out four recommended types of coordinated workplace accommodations during RTW that should be provided to employees who survived cancer, which are development of a GRTW plan, flexible scheduling, and modification of work duties and performance expectations. These adjustments are the main elements of GRTW in Germany (see FIGURE 1).

Returning employees are in contact with a range of systems and stakeholders during the (G)RTW process that each have different goals, needs, and expectations [31]. Andersen, Nielsen, and Brinkmann [32] examined the RTW-process of employees after a mental disorder with the use of a qualitative meta-synthesis. They found a lack of coordination between these different social and rehabilitation systems, which led to contradictory information and interests [32]. Employees returning after mental disorders are confronted with confusion and uncertainty at a time when they need stability and security [32]. Based on qualitative data, the authors concluded reducing working hours as the only measure of change was insufficient to ensure a sustainable RTW of employees with a mental disorder. Work-related duties and workload should also be gradually increased through appropriate workplace adjustments, such as: “adaptation of the job content, additional manpower, improvement of communication at the workplace, job shadowing, and discontinuation of night shifts [...]” [32, p. 100].

Regardless of the underlying disease, stable relationships to significant others and ongoing support, including the employer and social welfare or healthcare system, are repeatedly reported as highly relevant for a successful (G)RTW [33–35]. Bernacki et al. [36] investigated an early RTW programme over a 10-year period with employees who suffered a work-related injury or illness. The findings of the American study indicated that an active participation of medical care providers, employees, and supervisors increased the effectiveness of the programme [36].

## Effects

According to three reviews, workplace interventions after mental disorders, such as modified work programmes, including GRTW, reduce the duration of sickness absence [37–39] and compensation costs [38, 39]. The review by Franche et al. [38] showed “[...] that work disability duration is significantly reduced

by work accommodation offers and contact between healthcare provider[s] and workplace [s] [...]" (p. 607). De Vries et al. [40] investigated factors facilitating RTW after sick leave due to a mental disorder from the perspectives of patients, supervisors, and occupational physicians. The most crucial work-related factor stated by all groups was 'adaption of work', which is a key element of GRTW. Furthermore, a systematic review by Mikkelsen and Rosholm [41] indicated that GRTW is a successful RTW intervention for employees with mental disorders. Regarding its characteristics, the contact to the workplace had the biggest effect [41].

In addition to the reviews, other studies have examined GRTW and comparable measures after various diseases. According to a qualitative study, women returning to work after breast cancer identified work adjustments, e.g., reduction in tasks and working hours, as a helpful coping strategy [42]. These results are supported by a quantitative study, which showed that "[...] workplace accommodation as perceived by the employee is[sic] a key factor that increases the likelihood of return to work [...]" for women suffering from breast cancer [43, p. 351].

In a Canadian observational study on sick-listed employees with a musculoskeletal disorder, Durand and Loisel [44] showed positive effects of an additional therapeutic RTW programme after rehabilitation, which included GRTW to reach a sustainable return of employees. Two years after completion of the programme, 93% of the participants in the intervention were still at work, while the rate was not as high in the control group [44].

According to the Swedish version of GRTW, assigned part-time sick leave for employees with musculoskeletal disorders supported their recovery to full work capacity with a higher probability compared to those assigned full-time sick leave [45]. Their findings also support the German study conducted by Streibelt et al. [46], as Andrén and Svensson [45] pointed out that the positive effect of GRTW increase with an extended period of sickness absence before the beginning of the measurement. Another study by Andrén [47] examined the GRTW trajectories of employees with a mental disorder. The author showed that part-time sick leave was also more effective when employees had been assigned after 60 days of full-time sick leave.

Early part-time sick leave in Finland for employees with musculoskeletal disorders [48, 49] led to a reduction in sickness absence by 20% compared to the control group during the 12-month follow-up. The authors concluded that it "[...] might provide a faster and more sustainable return to regular duties than full-time sick leave among patients with musculoskeletal disorders." [48, p. 134]. Four years later, another Finnish study [50] confirmed the beneficial effects of partial sick leave on work participation in all age groups and diagnoses, especially mental disorders.

GRTW in the Netherlands has been shown to reduce the sickness absence duration by 18 weeks within the first two years after reporting sick [51]. A different study stated that graded work resumption, for example, plays an important role in the success of the Dutch RTW-process [52]. Thus, GRTW achieves a faster work resumption [52], especially when it starts early [51]. However, these findings were not applicable for employees with mental disorders [51], which aligns with a Danish study conducted by

Høgelund, Holm, and Eplöv [53] that examined part-time sick leave. The duration until returning to regular working hours was only significantly lower for employees with other disorders [53], which is conflicting evidence compared to the studies mentioned previously from Finland [50], Germany [46, 54], and the Netherlands [55]. The authors stated that an early partial RTW might facilitate full work resumption and thus is an essential factor for full RTW in employees with mental disorders [46, 50, 54, 55].

Participation in the Danish national GRTW programme significantly increased the probability of sick-listed employees going back to regular working hours [56]. The authors' study also indicated that it is important to complete the GRTW programme, as no significant effect was found when employees ended their programme without returning to regular working hours [56]. Another study from Denmark showed significantly different intervention effects of a national RTW programme in three municipalities [57]. The authors concluded that the success of returning to work is dependent on contextual factors [57].

## **Gradual return to work in Germany**

### **Legal aspects**

Volume nine of the German Social Code regulates legal benefits to strengthen the self-determination of people with disabilities and those threatened by a disability "[...] and promote[s] their full, effective and equal participation in society, to avoid or counteract disadvantages." (§ 1 German Social Code IX). Both the operational integration management (ger.: Betriebliches Eingliederungsmanagement) [58] and GRTW (ger.: Stufenweise Wiedereingliederung) are anchored in the same Social Code and thus aim to pursue the goals mentioned above. GRTW is an independent 'transitional instrument' [59] of tertiary prevention as a strategy to specifically facilitate RTW after long-term sickness absence [60]. The instrument aims to reintegrate employees, who were unable to work due to an injury or illness, back into working life. Key components are partially resuming the previous occupational activities at the original workplace and gradually adapting the work requirements (§ 44 German Social Code IX, § 73 German Social Code V, [61] (see FIGURE 1 for detailed information). Consequently, this means that relapse with renewed incapacity for work, a disability pension, and job loss due to illness must be averted in the long-term by resuming work [62].

Among other things, gradual reintegration is essential for operational integration management process (§ 167 Sect. 2 German Social Code IX), to which employers have been obliged by law since 2004 (see [60] for more details). However, it can also be initiated and carried out independently of the operational integration management's legal requirements and without being embedded in it. With the update of the German law in 2019 and 2020 (ger.: Arbeitsunfähigkeitsrichtlinie), the state has established a regular medical examination of the entitlement to GRTW after 6 weeks at the latest for each new sickness absence certificate. This has led to the creation of a procedure for the regular determination of GRTW (§ 74 German Social Code V).

Serving therapeutic purposes, GRTW, as an 'integrating core measure' [67], intends to positively influence the recovery and rehabilitation process. Therefore, an adjusted workload is recommended based on the

individual conditions of the employees' return and should be flexible, both in terms of time and content [64, 68]. A GRTW programme offers employees who are still unable to work, the opportunity to try out their work and stress capacity in the sense of 'training' at an early stage [67]. Based on this, they can not only learn to assess their resources in a professional setting with the help of medical and therapeutic guidance but also increase their stamina and identify challenges that need to be addressed [25, 64, 67].

Thus, returning employees can recover and stabilise their self-confidence in dealing with external and internal work demands, as well as reduce fears of a relapse or excessive demands [25, 64]. Blonk et al. [55] described that if workers are performing the tasks that they are "[...] able to do (with respect to duration, intensity or complexity, for instance), [these] individuals may acquire a sense of self-efficacy and control [...]" (p. 131).

The outlined aspects underpin the therapeutic orientation of GRTW. Nevertheless, in the course of a long-term illness, it functions as a measure for processing and coping with the disease [55] at the interface between the individual, medical-therapeutic, rehabilitative, and operational levels [63]. Starting with identifying the employees' needs through preparation, implementation, and aftercare, various stakeholders and experts are involved in the transitional process of GRTW. This includes treating physicians in clinics or private practices, who act on a supra-organisational level. They determine the employees' need for a GRTW and draw up, if necessary, in consultation with the treating therapist and social worker, an individual step-by-step or reintegration plan. During their return, employees who participate in a GRTW programme may have contact with many different stakeholders. Each of these transitions in contact and flows of information represent an interface [69], thus posing a challenge for (gradual) RTW.

## **Outreach**

GRTW is the measure most frequently offered by employers in Germany within the framework of operational integration management: 480 of 630 surveyed companies of different sizes in Germany stated that they offer a GRTW programme [70]. German literature suggests that the total number of GRTW programmes being recommended and carried out has steadily increased in recent years [61, 71]. Although the instrument anchored in social law has been in practice since the 1970s, current research on gradual reintegration in Germany shows gaps. An overview of the current implementation and dynamics over the last 45 years since the introduction of the measure is missing. Most of the studies are based on data from German Pension Insurance (GPI). However, GRTW under the responsibility of German statutory health insurances (GHI) is carried out much more frequently but remains largely unexplored.

A few published studies have shown that both the recommendation and utilisation rates of GRTW for treated rehabilitants vary considerably between rehabilitation clinics [71, 72]. The recommendation rates of outpatient clinics are far above those of inpatient rehabilitation facilities [71, 73]. When comparing the different sizes of clinics, the lowest recommendation rate was found in the group of large clinics [71]. In a comparison of different rehabilitation clinics and independent of the patient characteristics, the recommendation rates made by the doctors diverge considerably between 1.5–20% [71, 73], depending

on the study. Presumably, not only the doctors' assessment of appropriate GRTW criteria is subjective and therefore heterogeneous [63, 71] but clear indication criteria regarding the recommendation of GRTW is also lacking [72]. When looking at rehabilitants' characteristics, the factors of sickness absence times in the last 12 months before the start of the rehabilitation treatment, as well as the productivity assessed by the doctor, have the most significant influence on the recommendation [71]. The employer's attitude also plays an important role in the utilisation of GRTW, as the probability of the employee participating in a GRTW programme increases if the supervisor shows interest and support in the continued employment of the returning employee [73]. An analysis of GRTW rates on behalf of the GHI by Schneider et al. [74] showed that only one-quarter of the employees who received a recommendation for a GRTW programme participated in the measurement. In small companies, the participation rate is even lower.

Younger employees are more likely to receive and accept an offer for a GRTW programme, who, on average, have shorter periods of sickness absence and are already more probable to return to work [71, 73, 75]. GRTW participants in the study of Bürger and Streibelt [72] had lower rates in the intention of receiving a disability pension and, on average, showed a lower socio-medical risk than non-participants. This can be considered a positive selection of participants. Employees who leave their jobs for a long time (> 3 months) due to illness and who have a correspondingly high risk of an early retirement benefit the most from GRTW on behalf of GPI but do not receive the measure as frequently as they were supposed to, according to the authors' empirical criterion [72, 73]. However, there is an oversupply; in 20% of cases, the empirical criterion would not have required a decision in favour of GRTW [72].

GRTW after medical rehabilitation starts, on average, within six days after the end of treatment. Employees in outpatient clinics can start their programme faster compared to individuals in inpatient rehabilitation [73]. The start of GRTW also depends on the type of disease the employees suffered from. While employees with musculoskeletal disorders begin their GRTW programme the fastest after orthopaedic rehabilitation treatment, those in cardiac treatment start the latest [73].

Bethge [28] showed that about 16% of rehabilitants who attended an orthopaedic, cardiac, oncological, or psychosomatic rehabilitation participated in a GRTW programme. Employees with a GRTW were younger, more frequently female, and more severely restricted in working life [28]. A study conducted within a large German chemical company showed that 50% of all performed GRTW programmes were mainly due to diagnosed mental and behavioural disorders, as well as musculoskeletal disorders [61].

## Implementation

Regarding implementation, Bürger et al. [73] found several indicators for an insufficient adaptation of the measure within individual cases. Other forms besides the increase of working hours are rare. Only 2% of the GRTW cases used a daily increase in workload [73]. GRTW plans were hardly ever used to adjust the increase in time and duties individually [73]. In one-third of all examined GRTW cases, returned employees judged the duration of the programme to be too short and the increase in duties and stress too fast [73, 75]. More than half of the returning employees were dissatisfied with the support and care provided during GRTW, regardless of the disease. They wished for more assistance with health problems that may

arise, professional questions, and organisational issues [75]. In addition to the lack of handling individual demands regarding work time, the authors identified a later start after the rehabilitation treatment and only one level of increasing tasks and duties as risk factors for an unsuccessful RTW [75]. In contrast, interviews with returning employees showed that an orientation towards the individual needs of the employees and timely planning of GRTW seem particularly stabilising [67]. If these factors are considered, GRTW can minimise the employees' fears regarding their RTW [67].

## Effects

Reintegration rates after GRTW are not recorded consistently in Germany. They vary between 75 and 90%, depending on the illness, provider, or company [46, 61, 63, 75, 76]. It is not always clear how sustainable these trajectories are.

Streibelt et al. [46] pointed out that 88% of employees with chronic mental disorders that were supplied with GRTW sponsored by the GPI attained a full RTW, but only 73% of those attained this status without GRTW. With GRTW, the risk of becoming unemployed and receiving a disability pension fell by 60% [46]. Sickness absence within 15 months after completing GRTW decreased by six weeks. In addition, GRTW showed positive effects on the employees' subjective health ratings [46]. Gradual work resumption seems to be more beneficial for employees with an uncertain or negative subjective RTW prognosis.

Bethge [28] studied the effects of GRTW on the probability of a disability pension after various chronic diseases. The propensity score-matched analysis showed a decrease of almost 40% in entering disability benefits for employees who returned to work gradually [28]. Bürger and Streibelt [54] concluded from their research on GRTW provided by the GPI that after completion of psychosomatic rehabilitation, employees derive the greatest benefit from participating in a GRTW programme on the outcome 'RTW in good health', followed by GRTW after musculoskeletal rehabilitation. In oncology, as well as in cardiology, no additional benefit was identified [54].

The only study examining GRTW using data from the largest German sickness fund presents the advantages of participating in a GRTW programme on behalf of the GHI as follows: "for individuals with spells above 120 days, results suggest that return to work would have taken much longer, on average, without such a program." [74, p. 641]

As presented above, most studies on the outcomes of GRTW under the responsibility of GPI dominate the current research literature in Germany. Thus, it can only give insights on a small amount of GRTW programmes performed after the completion of rehabilitation treatment in Germany. The informative value is therefore limited since the results from GRTW carried out by the GHI cannot be transferred without restriction. Apart from this, the included studies from Germany used a quantitative approach throughout to investigate GRTW. Qualitative research focusing on expectations, decision making, planning, and implementation of GRTW is missing.

However, the studies to date provide the first indications of the deficits regarding the access, planning, and process quality of GRTW and their possible causes. The lack of studies leads to a gap in valuable

scientifically proven insights and findings that could in return guide actions to reduce deficits in access and process quality.

## Methods And Design

### Aim

Research has shown that the full potential of GRTW is currently not being exploited. Little is known about the reasons, barriers, and facilitators of GRTW, even though this knowledge is important for successful implementation and high quality, as well as to tap into the full potential of GRTW in Germany.

Our study aims to gain information and knowledge from different perspectives about the current process and practices of GRTW in Germany. Our research systematically focuses on the implementation of GRTW in Germany. We will examine current GRTW practices of the stakeholders involved, as well as the technical, operational, and experiential knowledge on which these practices are based. The case consultations of the individual interviews and the additional group discussions will offer the opportunity to explore multiple perspectives on the process (see FIGURE 2). The interviews will uncover the GRTW practices, expectations, and needs through both the employees' experiences and the company-associated trusted persons' perspectives. Additionally, existing barriers to the implementation and determinants for the success of GRTW as a policy instrument will be identified in the group discussions. On this basis, the results will be available for explanatory approaches, as well as action recommendations and practical tools (e.g., requirement criteria catalogues, recommendation routines, and guidelines for the creation of demand-oriented step-by-step plans).

### Research questions

We want to explore how affected employees, organisational and supra-organisational stakeholders, and experts experience and describe GRTW? In more detail, we will clarify the following three questions:

1. What experience and action-guiding knowledge do the affected employees and supra-organisational and organisational stakeholders and experts contribute to the planning and implementation of GRTW? How does this influence RTW in general?
2. What do affected employees and supra-organisational and organisational stakeholders and experts experience as beneficial or as hindering within the GRTW process, and why?
3. How do affected employees and supra-organisational and organisational stakeholders and experts describe and experience the decision-making within the GRTW process (e.g., GRTW design; step-by-step plan; underlying illness)?

### Study design

The study follows an explorative qualitative research approach. It aims to provide detailed insights into the GRTW practices in Germany from multiple perspectives. Qualitative research has proven its worth for

investigating action practices and implicit knowledge [77, 78]. The verbal data gathered through interviews and group discussions allow the reconstruction of the realities of the participants' experiences with GRTW [79].

The qualitative data will be collected in two study arms (displayed in FIGURE 2). In the first study arm, we will interview 12 returning employees individually, shortly before the start of their GRTW and three months later. Parallel to the three-month follow-up interviews, we will additionally interview eight organisational trusted stakeholders from the company who have accompanied the GRTW process of the questioned employees.

In the second arm of the study, we will interview returned employees, organisational stakeholders, and supra-organisational experts through 10 group discussions.

Thus, the present study will exploit the advantages of two different qualitative survey methods: narrative interviews and group discussions, both using guided questions as support.

The potential of the narrative interviews can be identified in the underlying narrative theory (ger.: Erzähltheorie) [80]. Given the researcher's greatest possible openness and a narrative-generating impulse, the respondents are free to structure their statements within the framework of the research topic 'GRTW'. The respondents consistently set the focus, as well as the beginning and end of the narrative [81]. We will not only ask for opinions and everyday theories of the respondents but also try to elicit narratives about personal experiences with GRTW, such as those experiences that are sound in the action practice [78]. Since the study aims to record the current GRTW practices from multiple perspectives, we perceive this method to be appropriate.

Group discussions, however, benefit from the emerging dynamics and self-running discourse, in which important collective experiences are addressed by the group [82].

By referring to different (especially contrary) views of the other participants, individual opinions and experiences on GRTW are expressed not only more spontaneously but also more clearly [83]. Thus, group discussions enable access both to a collective stratification of experience and to conjunctive contexts of origin for collective orientations in the field of RTW [84] in the sense of conjunctive experiential spaces (ger.: konjunktive Erfahrungsräume) [83].

Using the Documentary Method of Interpretation, both group discussions and interviews provide access to not only intentional practices, reflected views, and explicitly available expertise but also to preconscious action routines and implicit knowledge of actions and experiences within the field of RTW [78, 83, 85]. Methodologically, group discussions may complement the narrative interviews as part of a 'between (or) across methods triangulation' [85] to understand the phenomenon of GRTW in full depth [86]. We will look for possibly different but complementary information to get a bigger picture of the research subject. The combination of these two methods allows us to investigate GRTW comprehensively from multiple perspectives based on individual examples and collective orientations.

# Sample profile

The study population will consist of different target groups from the RTW context. All target groups must have experiences with GRTW to some extent that is referring to the research questions. We will aim to include as many individuals experienced with GRTW as possible in the present study population. In terms of field development and 'nosing around' [87] during the qualitative research process, the previously defined study population may change. In this context, it should be mentioned that during field development, first contacts with experts will be established, and information will be exchanged. In this way, we will gain new insights that can reflexively drive the future research process. Thus, it is possible that the participation of specific individuals or groups of persons will suddenly appear particularly relevant. Therefore, to a certain extent, the study population's definition will remain flexible.

All participants must be able to take part in a conversation and show adequate German language skills. At the current state of knowledge, the individuals and groups of persons will be included in the study population as follows:

## *Interviews*

- a. 12 returning employees who are planning to return to work using GRTW after a period of sickness absence and between 18 and 60 years old.
- b. Eight trusted persons from the same company of the interviewed employees who were proposed by the returning employee and who have accompanied GRTW of the employee referred to above.

# Group discussions

Four organisations or companies in Germany that differ in terms of company size, sector, and location will be included in the study. The study population will arise from the same company so that four pairs each will be assigned to an organisational group discussion.

- a. Four group discussions with three to five returned employees between 18 and 60 years old, who have returned to work via GRTW after a longer period of sickness absence at least once in the company they are currently employed at within the last three years of employment.
- b. Four group discussions with three to five organisational experts and stakeholders who have long or intensive professional experience in the field of GRTW or RTW.
- c. One group discussion with four to six supra-organisational experts and stakeholders from GPI, GHI, integration services, and other services that support RTW and who have professional experience in the field of GRTW and/or RTW in their current position.
- d. One group discussion with four to six supra-organisational experts and stakeholders from medical and/or therapeutic healthcare, social work, occupational medicine, rehabilitation, and acute clinics.

# Sample selection and recruitment process

The contrasting sampling procedure in this study is based on theoretical sampling [88]. Thus, recruiting will be an ongoing, accompanying process [87]. We will successively select the study participants based on the criteria mentioned above to ensure heterogeneity [87]. The procedure aims to represent the heterogeneity of the research field at least rudimentarily through conscious case selection [89]. The case selection will be based on continuous comparison of the cases, which highlights minimum and maximum contrasts following the criterion of proven theoretical relevance [88]. Sampling will be completed when the resulting theoretical concepts are saturated.

Regarding the recruitment, we have developed a study flyer that can be easily accessed and will be distributed by multipliers both for the interviews and group discussions.

## **Interviews**

At measurement point one, we will interview 12 returning employees to ensure that at least eight study participants can be interviewed twice.

With the help of gatekeepers, i.e., orthopaedic, psychosomatic, oncological, and cardiac rehabilitation and acute clinics, general practitioners' practices, and companies, potential study participants will be reached. The participating employees, in turn, will act as gatekeepers and will enable contact to the organisational stakeholder who accompanied their return. This contact will occur after the first interview and before the second survey time.

The cooperating clinics, medical practices, and companies will be located in different regions of Germany. The sample will be compiled as diversely as possible concerning the following criteria: age, gender, diagnosis, place of residence, and GRTW after rehabilitation versus without previous rehabilitation.

## **Group discussions**

For the recruitment purpose, we will use existing contacts from previous studies at the Federal Institute for Occupational Safety and Health. Furthermore, we will contact potential study participants directly at events by e-mail. Existing organisations, associations, and federations, as well as their distributors, will function as multipliers.

Doctors, therapists, and social workers of the cooperating clinics from the first study arm and other experts will participate in the group discussion with medical and therapeutic actors.

We will select the companies from various industries within different German regions. The aim is to achieve the greatest possible heterogeneity in terms of location, size of the company, and sector. Other participants in the group discussions will be recruited via an organisational contact person acting as a gatekeeper, such as disability managers or RTW coaches, who know the company structure and the returning employees they may approach.

## **Data collection**

We will develop the guiding questions for the interviews and group discussions based on the current literature and experience from previous qualitative studies at the Federal Institute for Occupational Safety and Health. The largest part of the guiding questions will be formulated to be as open as possible to trigger detailed narratives and descriptions. The second part will contain more explicit questions concerning personal opinions and assessments of both GRTW and RTW.

We will include questions referring to experiences with and attitudes towards GRTW, as well as its role in the process of RTW. The guides will be adjusted and tailored to address the different target groups of the study appropriately. A total of eight separate interview guides will be developed for the interviews (four) and group discussions (four). We will jointly prepare the guides and reflect on them in our team of researchers at the Federal Institute for Occupational Safety and Health. Using the feedback of two pilot interviews with returned employees, the questions will be revised in a participatory way. Please contact the first author for full provision of the interview and group discussion guides.

In addition to the narrative interviews and group discussions, the participating employees, organisational experts, and stakeholders will receive a short questionnaire in both the individual interviews and group discussions. These questionnaires will be designed to describe the sample in more detail and gather information about the target group, which will contribute to the final case or discourse description. The short questionnaires will contain questions regarding age, gender and GRTW, but also regarding the self-reported workability [90], the current health status [92] and RTW self-efficacy [93].

The first author will conduct the interviews and moderate the group discussions. At the beginning of data collection, an experienced researcher (second author) of the institute will both support the interviewer and give feedback. The participants will be informed about the aim of the study, the procedure, data privacy, and professional background of the research team and interviewer prior to the data collection in written and verbal form (see Ethics approval and consent to participate). Compared to the first interviews (t1) that will last 60 minutes and the second interview (t2) that will last 45 minutes, the group discussions will take 120 minutes. The first interview with the employees (t1), as well as the group discussions, will take place in person, e.g., at the rehabilitation clinic, at home, at the company, or at the Federal Institute of Occupational Safety and Health in Berlin. At the second measurement point (t2), the employees, as well as the associated trusted person, will be interviewed by telephone. Both the interviews and group discussions will be audio-recorded entirely for later transcription. An external provider will transcribe the data.

To keep the researchers' bias to a minimum, the researchers will maintain written records of their theories, assumptions, and impressions in a research diary. These notes will be recorded throughout data collection and will be reflected on.

## **Analysis**

Analysis and data collection will run in parallel by means of a circular research process and regarding theoretical sampling. We will analyse the verbal data obtained by using the Documentary Method of

Interpretation according to Ralf Bohnsack [83]. It is a method of reconstructive social research that can be used for both interviews and group discussions [83]. The interpretation takes place in the sequential reconstruction of narrative, interaction, and discourse processes [93].

According to Bohnsack, the method focuses on both levels of discourse, but goes beyond the literal or immanent meaning (by asking *what*) and asks for the documentary meaning, the pre-reflexive, implicit, or tacit knowledge (by asking *how*) [93]. The *how* aims to reveal in which framework the topic is dealt with, which is also called the framework of orientation [83]. Using the Documentary Method, the researcher “[...] is able to find an access to the structure of action and orientation, which exceeds the perspective of those under research.” [94, p. 101]. As stated by Bourdieu [95], the term structure of practice refers to the habitus or the *modus operandi* of everyday activities. The various evaluation steps (FIGURE 3) help with understanding (ger.: ‘Verstehen’), according to Mannheim [96], the action-guiding knowledge gained from previous experiences with GRTW that is evident in everyday practice and study participant’s activities. Subject to interpretation within the Documentary Method are the frameworks of orientation and patterns of meaning by comparing other cases or groups [94]. The task of the method is to explicate this implicit knowledge [94]. Regarding group discussions, Bohnsack [94] highlights: “[...] it is above all the (formal) organisation of discourse which has to be reconstructed. This means we have to characterise the way of how participants refer to each other formally in their utterances” (p. 111). This statement underlines the difference between interviews and group discussions clearly; in interviews, the participants set their own relevance and foci, while in group discussions, the reciprocal reference between the participants, the discourse, and the joint consensus are analysed equally.

The Documentary Method is also a comparative analysis procedure that, using contrastive case comparison, leads to cross-case findings, i.e., type and theory formation. We visualised the individual analysis steps in FIGURE 3.

The researchers will structure the material by means of sequences and themes of GRTW in a thematic course [97]. In this step, we will select passages that are relevant to the research questions and include them in the following interpretation. Thematic courses can be seen as the first part of the formulating interpretation [97]. In this more detailed evaluation, the material will be sequenced according to the main topics and subtopics [97]. The following step of interpretation, reflective interpretation, will be strictly separated to represent the differences between immanent and documentary meaning [78, 97]. First, the narrative text sequences will be analysed formally regarding their text types or genres and homologous patterns (e.g., proposition, elaboration, conclusion) [78, 93, 97, 98]. Second, the semantic level of interpretation will be targeted by comparing the framework of orientation in which the topics or problems are elaborated. Thereby, atheoretical, implicit knowledge will emerge.

Furthermore, the subsequent comparative analysis is of great importance for this reconstruction [83, 99]. The case with its particularities, as well as the overall shape of the case, will be relevant reference points for the case description of the interviews and discourse description of the group discussions [99]. It will contain a presentation and condensation of the interpretations and results [99]. We will incorporate all the

data collected into the descriptions by means of interviews or group discussions and short questionnaires. As an integral part of the Documentary Method, cross-case comparisons (person A versus person B), as well as case-internal comparisons (t1 versus t2 of person A), frame the whole process of analysis. During the progress of interpretation and comparison, the orientation patterns and frameworks of GRTW will become more and more explicit. Moreover, the process of analysis by means of the Documentary Method will conclude with the step of type formation [98, 100]. In this research project, we will strive for a sense-genetic type formation and look for topics or problems all cases or groups have in common [100]. Using the sense-genetic type formation, we will show similarities and differences of the orientation frameworks in which the study participants deal with topics and problems that focus on GRTW [100].

## Discussion

In summary, the gradual resumption of work after a long period of sickness absence is effective in getting employees back to work, keeping them at work, assuring their health, and reducing costs arising from prolonged sickness and loss of productivity. Next to other variables that affect the process of RTW, the current research and literature lead to the conclusion that a sustainable RTW is more likely when GRTW is facilitated.

Gradual RTW interventions at the workplace also vary widely from country to country and are therefore comparable to the German version of GRTW to a limited degree. However, it must be considered that there is conflicting evidence on GRTW for employees after mental disorders and that the studies often only examined the timing of (G)RTW instead of its sustainability. In terms of sustainability, it is also questionable whether early (G)RTW is superior to a time-sensitive return.

Regarding the legal requirements, GRTW is a flexible tool for returning to work. The measure creates opportunities to tailor the RTW process individually to the needs of those involved. However, the current evidence indicates that its flexibility and individual orientation is used to a very limited extent, leading to the presumption that its potentials are neglected.

The strengths of the study lie in the multiple perspectives included and the qualitative approach regarding triangulation to shed light on current practices and experiences with GRTW, as well as on the barriers and facilitators of GRTW, from different points of view. The individual interviews at two measurement points will accompany the process of reintegration and give insights into the perspectives of both the returning employee, comparing expectations and the actual implementation of GRTW, and the selected trusted person in the company. The group discussions will provide insights into the operational and systemic structures, as well as dynamics of GRTW and collective orientations, on a retrospective basis.

Due to the ongoing Covid-19 pandemic, we expect weaknesses in the recruitment of study participants and implementation of the surveys. It will not be possible to conduct all interviews and group discussions personally. Instead, video conferences and telephone interviews will be used. Therefore, we will reflect on differences in the type and manner of the surveys and, if necessary, in the analysis. In addition, the

effects of the pandemic could result in fewer GRTW programmes, making it more difficult to find enough study participants. Furthermore, it must also be considered that the GRTW programmes that take place during the Covid-19 pandemic may be carried out under very different circumstances than usual, such as home offices or limited contact with team members. Group discussions conducted retrospectively could possibly control for this effect.

The study will not only reveal barriers and potentials of the recommendation, planning, utilisation, and implementation of GRTW in Germany. It will also provide approaches to explain current problems and hindering determinants. By using the findings on the practices of approval, operational processes, and individual examples of implementation, this study will contribute to advancing the discussion on the optimisation of the quality and also the sustainability and long-term results of GRTW.

## **Abbreviations**

RTW

Return to work; GRTW: Gradual return to work; GPI: German Pension Insurance; GHI: German statutory health insurances

## **Declarations**

### **Ethics approval and consent to participate**

Participation in the study will always be voluntary. Before the beginning of data collection, we will inform potential study participants orally and in writing about the study's content, procedure, and data protection issues. The study participants will not suffer any disadvantages if they refuse to participate or withdraw from their participation. Their informed consent to participate in the study will be documented by signing the consent form. We will store the collected data separately from personal data and secure it for 10 years at the Federal Institute for Occupational Safety and Health in Berlin. During this period, the study data, such as audiotapes and short questionnaires, will remain sealed and only accessible to the project staff. After this period, we will delete all data.

The ethics committee at the University of Lübeck, Germany, approved the project in March 2020 (20-060). All procedures will be performed in accordance with the ethical standards in research laid down in the 1964 Declaration of Helsinki and the European General Data Protection Regulation, as revised in 2000.

The data protection officer at the Federal Institute for Occupational Safety and Health in Dortmund, Germany approved the study's data protection concept in May 2020. The study is registered at the German Clinical Trial Register.

### **Consent for publication**

Not applicable.

## Availability of data and materials

Interview and group discussion guides are available from the corresponding author upon request. Other data sharing is not applicable to this article as no datasets were generated or analysed yet.

## Competing interests

The authors declare that they have no competing interests.

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## Authors' contributions

IS, RS, and UW conceptualised the study and its design. IS, UW, and MB drafted the first version of this manuscript. IS was the major contributor in writing the manuscript. All authors reviewed the manuscript for intellectual content and approved the final version before submission.

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## Figures

Gradual return to work is a rehabilitative measure with the therapeutic objective of supporting employees who return to their previous workplace after an illness. It aims to slowly assess the employees' capacity to complete tasks and regain their original workability [63]. If employees are recovering in a GRTW programme, they remain on sickness absence.

GRTW is a voluntary measure for returning employees. It requires a prior assessment by a physician and the joint consent of the employee, physician, relevant social insurance institution, and employer. The measure is not legally binding for the employer unless the returning employee is severely disabled.

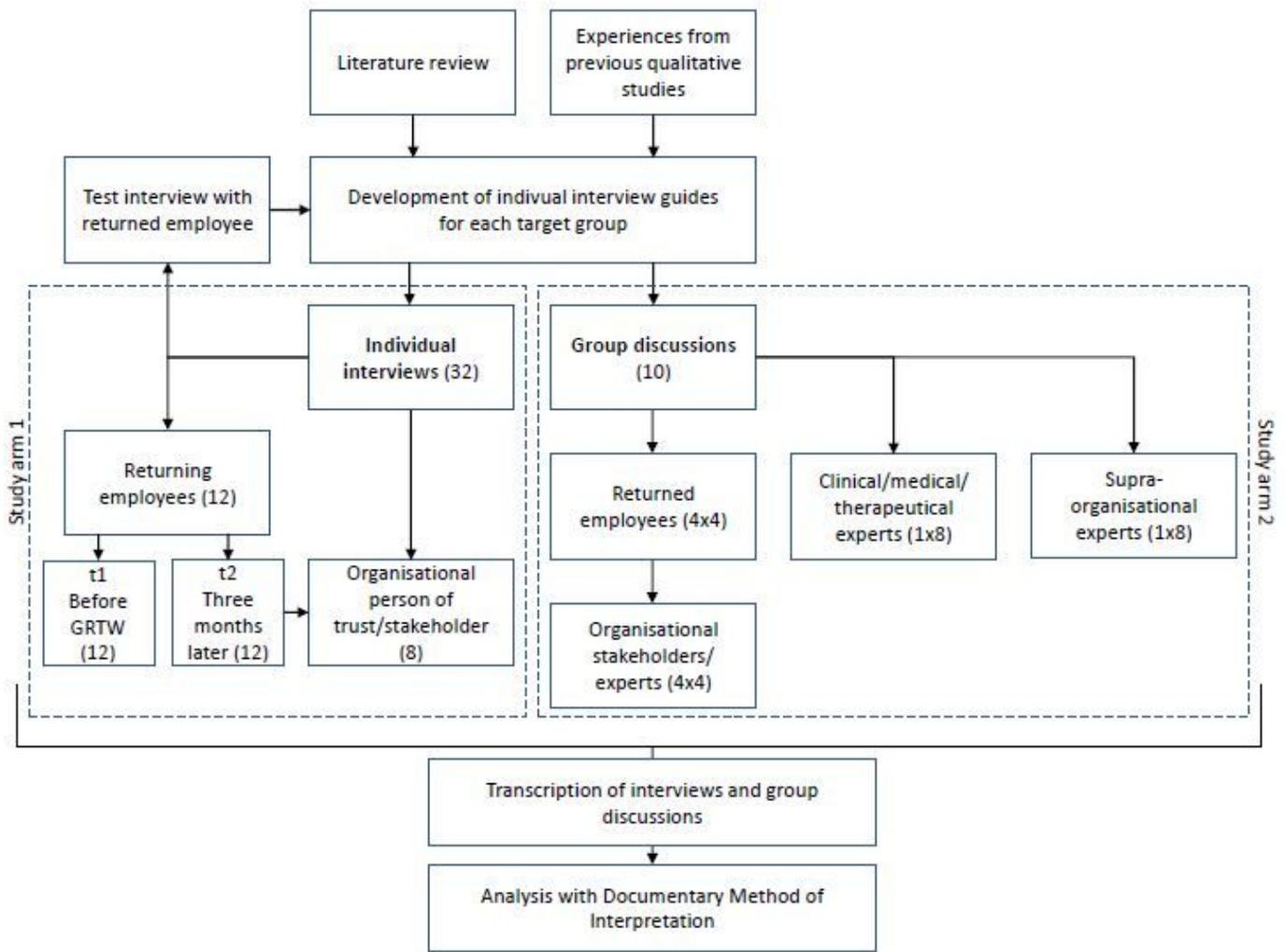
The employee must be unfit for work (medically certified sickness absence) if his or her ability to work can be fully restored. Both factors are determined medically by a physician. The increasing workload during the measure does not immediately lead to workability [64].

Any party involved can recommend or initiate a GRTW programme. It usually lasts between 6 weeks and 6 months. During this period, the responsible social insurance agency is obliged to provide sickness absence benefits for the returning employee [65], i.e., sickness benefits from the health insurance scheme or transitional allowance by the German pension insurance (provided that GRTW begins within 4 weeks after medical rehabilitation) or injury benefit from accident insurance (e.g., after an accident at work).

GRTW is based on a so-called step-by-step plan or reintegration plan drawn up by the referring physician, ideally with the participation of all parties involved. In this plan, the duration of GRTW and slow increases of tasks in terms of time and content are presented in the form of 'stages' [66].

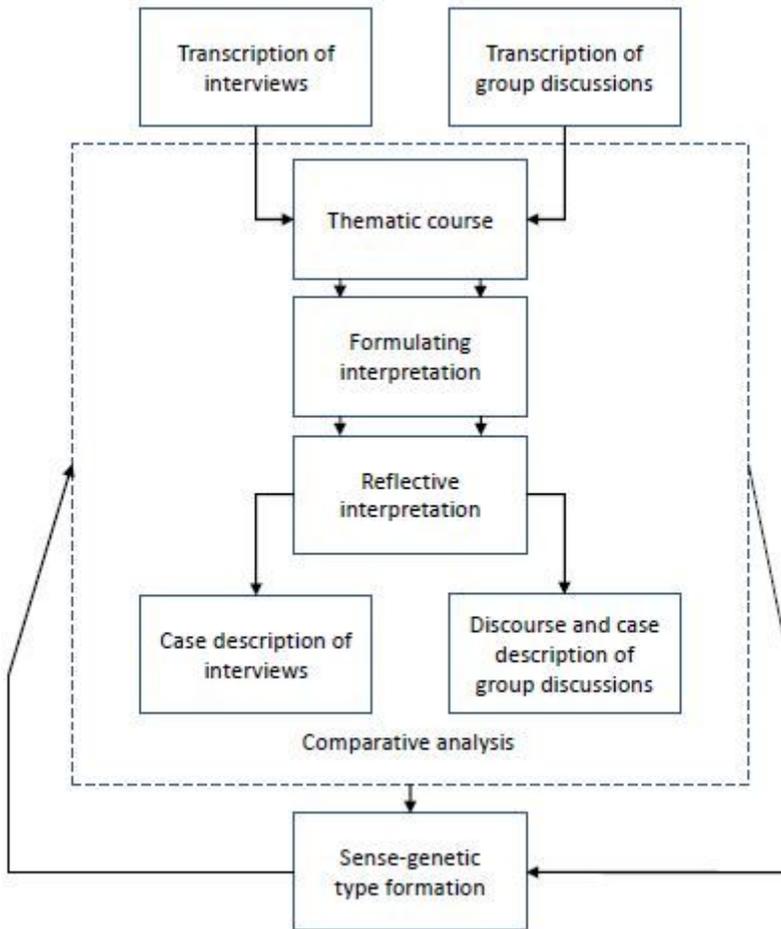
## Figure 1

Gradual return to work in Germany: rough overview of the process and responsibilities



**Figure 2**

Planned data collection and its embedding



**Figure 3**

Exemplified steps of analysis within the Documental Method of Interpretation

## Supplementary Files

This is a list of supplementary files associated with this preprint. Click to download.

- [ShortQuestionnaireEmployeesGroupDiscussion.docx](#)
- [ShortQuestionnaireEmployeesInterview1.docx](#)
- [ShortQuestionnaireEmployeesInterview2.docx](#)
- [ShortQuestionnaireOrgStakeholdersGroupDiscussion.docx](#)