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The capacity note - a communication facilitator in the sick leave process of patients with common mental disorders. A qualitative study of user perceptions

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ABSTRACT

Objective: To describe the development of a communication facilitator, the Capacity Note, for the sick leave process of patients with common mental disorders (CMD) in primary care, and to explore users' perception of it.

Design: Qualitive study.

Setting: Primary health care in Region Västra Götaland, Sweden.

Participants and methods: The Capacity Note was developed inductively based on data from six qualitative studies of work capacity and CMD and was introduced at primary health care centers during 2018–2019. Individual semi-structured interviews were performed with 13 informants (eight patients, two general practitioners and three managers) who had used the Capacity Note at least once. Interviews were audio-recorded and transcribed verbatim and inductive manifest qualitative content analysis was used to analyze the data.

Results: The Capacity Note comprised questions about work situation, work capacity limitations and possible work adjustments. Based on the interviews, four categories relating to its role as a facilitator for communication about work and health were identified: *Content and format, Understanding, legitimacy and action, Openness and timing,* and *Time and efficiency*. The participants considered the Capacity Note relevant and easy to use, and as having the potential to improve communication about and understanding of the patient's situation. The increased understanding was perceived as contributing to a sense of legitimacy and agency. Achieving these benefits required, according to the participants, openness, an investment of time and using the Capacity Note at the right time in the sick leave process.

Conclusion: The Capacity Note was found to be relevant and had, under the right conditions, the potential to improve communication and facilitate the sick leave process.

STRENGTHS AND LIMITATIONS OF THIS STUDY

- This study describes a novel approach to stakeholder communication in the sick leave process of patients with common mental disorders (CMD).
- The communication facilitator was developed based on stakeholders' own reports of work capacity and CMD.
- A broader representation of GP characteristics (for example in working experiences) might have led to a greater variation in the findings.
- Transferability of findings may be limited to settings with similar sickness insurance schemes, sick leave processes and primary health care organization.

INTRODUCTION

A closer collaboration between stakeholders has been described as important for a good sick leave and return-to-work process but also as difficult to achieve.[1-5] This study qualitatively examined how patients, general practitioners (GPs) and managers perceived and used a communication facilitator, the Capacity Note, for the sick leave process of patients with common mental disorders (CMD).

There is today no golden standard for how to best achieve sustainable work participation for patients sick-listed with CMD.[6 7] In Sweden, these patients are generally treated in primary care where GPs are responsible for sickness certification when needed. To assess work capacity and need for sick leave and rehabilitation is a difficult task in general, and even more so in cases of CMD.[3 8 9] In these conditions, symptoms and associated work capacity and

rehabilitation needs are highly individual and often unpredictable.[10-12] This makes guidelines and standard assessments less useful and calls for an increased recognition of the individual and subjective parts of the assessment.[9 12-14] In addition, the work place must be considered which is yet another piece of information that is individual and difficult to assess.[8] GPs rarely communicate with employers—lack of time and disclosure concerns being commonly mentioned reasons—but have to rely on the patient's descriptions of what can be done at the work place.[3 15] The assessment is further complicated by the fact that the patients with CMD themselves find it difficult to grasp and describe their reduced work capacity.[10]

At the patient's work place, the manager is responsible for facilitating the employee's return to work, for example by providing work adjustment.[16] But managers too struggle with the vagueness of mental health problems and find it hard to identify, describe and deal with them.[15 17 18] In Sweden, due to confidentiality laws, employees do not have to disclose any diagnosis to the manager, only the effects of the diagnosis on functioning (e.g. difficulties concentrating) and how that affects their capacity to work (e.g. they cannot learn new tasks).[19] Such information should be stated in the sickness certificate but is often limited, especially statements about work capacity.[20] Moreover, with their medical focus, sickness certificates can be hard to interpret for managers. Consequently, with restricted knowledge of the patient's specific problems, individualized adjustments can be hard to accomplish.

Increased communication in the sick leave process has been approached in different ways, for example information exchange between health professionals,[21] structured conversations between employer and employee,[22] and a guide for patients' discussions with various stakeholders.[23] Our focus was to promote communication about health and work among the three key stakeholders: patient, GP and manager. For this purpose, we developed a communication facilitator – the Capacity Note. The aim of this study was to describe the

development of the Capacity Note and to qualitatively examine how the stakeholders perceived its content, format and use.

METHODS

Development of the Capacity Note

The Capacity Note was developed based on data from six qualitative studies examining work capacity and CMD: three studies with individuals having personal experiences of CMD and work,[10 11 24] two studies with physicians and other health care professionals,[14 25] and one literature review.[3] Data relevant to the purpose of the Capacity Note was identified inductively in the results sections of each of the six articles and condensed into items. The items were compared across the six sources and grouped into content areas. Then, considering the short consultation times in primary health care, a selection of the items was chosen as the most relevant. Based on the selected items, questions about work situation, work capacity and corresponding work adjustments were formulated. The draft was discussed at a seminar with researchers from different fields such as medicine, occupational therapy, physiotherapy and public health, and thereafter finalised. Characteristics of the six studies that provided data to the Capacity Note and examples of their contributions are presented in Table 1.

Table 1. Characteristics of the six studies that provided data to the Capacity Note, and examples of their contributions.

Author and year of publication	Aim	Study design and method for analysis	Informants	Number of identified items	Example of identified data	Item	Corresponding question in the Capacity Note
Bertilsson et al (2013)	Explore experiences of work capacity in persons working while depressed and anxious to identify the essence of the phenomenon 'capacity to work'	Phenomenological, Focus groups	Persons working at least part-time with diagnosed or self-reported depression, anxiety or exhaustion (n=17)	34	"Interpersonal encounters were described by the participants as the most demanding type of work task." (p.1707)	Interaction with other people	Right now my capacity to work is affected because it is stressful to interact with other people (e.g. pupils, colleagues, customers) (Tick box if agree)
Bertilsson et al (2015)	To explore health care professionals' experience-based understanding of work capacity in individuals with depression and anxiety disorders	Focus groups, Inductive content analysis	Health care professionals from occupational, psychiatric, and primary health care with experience of treating patients with common mental disorders (n=21)	26	"Capacity to work was described in patient-narratives as being affected by changed and more sensitive perceptions of sensory input such as vision and hearing." (p. 129)	Sensitive to sensory input	Right now my capacity to work is affected because I am easily disturbed by sound and visual impressions, I need to work separately (Tick box if agree)
Bertilsson et al (2018)	To explore physicians' tacit knowledge of their assessment of work capacity in patients with depression and anxiety disorders	Video vignettes and open-ended interviews, Inductive content analysis	Physicians specialized in general practice, occupational health or psychiatry with experience of treating patients with common mental disorders (n=24)	45	"An important dimension was to assess whether the decreased work capacity could lead to failures or accidents at work..." (p.8)	Risks	Do any of these claims pose a risk to you or others in your work situation? (e.g. driving a commercial vehicle, operating a dangerous machine) (If yes, state in what way)
Danielsson et al (2017)	To explore experiences of work instability in workers with common mental disorders	Grounded theory, Individual interviews	Employed persons with current diagnosed or self-reported common mental disorder (n=27)	29	"The participants described feeling estranged, tense, exhausted and weakened." (p.6)	Physical weakness	Right now my capacity to work is affected by weakness/ loss of strength in the body (Tick box if agree)
Danielsson et al (2017)	To explore workers' strategies to keep working while affected by common mental disorders	Grounded theory, Individual interviews	Employed persons with current diagnosed or self-reported common mental disorder (n=27)	14	"The participants tried to compensate for negative changes [...] It could mean taking on more simple tasks to compensate for a lack of concentration and creativity." (p.6)	Loss of creativity	Right now my capacity to work is affected because it is difficult to be creative (Tick box if agree)
Nordling et al (2020)	Synthesize existing research on what and how physicians do when they assess work capacity	Systematic literature review, Thematic synthesis of qualitative data	Qualitative studies describing physicians' practices when assessing work capacity as part of sickness certification (n=12)	8	"Questions about work tasks and demands could include aspects such as heavy lifting, opportunity to take a break or adjust work pace." (p.8)	Possibility to take breaks	Is it possible to take regular breaks? (Yes/No/Yes partly)

Study design

A qualitative study design with individual interviews was chosen as appropriate to examine the users' perceptions of the Capacity Note. Participation was based on informed consent and participants were informed that they could withdraw at any time. No incentives for participation were offered.

Setting and participants

The Capacity Note was used at eight public and private primary health care centers (PCCs) in the southwest part of Sweden in 2018 and 2019 as part of a pilot study focusing on patients' agency and sick leave during follow-up (data not presented in this study).

Participants for this study were recruited from the pilot study based on the following inclusion criteria: *Patients* must have used the Capacity Note with their physician no more than nine months previously and agreed to be contacted about the interview study; *GPs* must have used the Capacity Note with at least one patient no more than nine months previously; *managers* must have used the Capacity Note with at least one employee no more than nine months previously and the employee must have agreed to their participation.

The 15 patients that filled the inclusion criteria were contacted in a random order via telephone. If interest was shown, written information and a consent form were sent by mail. Eight patients agreed to participate. Lack of time or energy were the most common reasons for not participating. Ten GPs met the inclusion criteria. For one we could not retrieve the correct contact information and therefore nine GPs were invited to participate in the study via their work email. Two GPs agreed to participate, two declined due to lack of time and five did

not reply to the invitation or the two reminders. Of the 15 eligible patients, four agreed to let their manager participate. These four managers were contacted by telephone (n=3) or work email (n=1) and they all agreed to participate. One of them fell ill at the time of the interview and could not reschedule, leaving a final sample of three managers. The characteristics of participants are presented in Table 2.

Table 2. Characteristics of participants.

	Patients n=8	GPs n=2	Managers n=3	Total n=13
Gender				
Female	7	0	3	10
Male	1	2	0	3
Age				
Mean (range)	27-58 (44)	44 (44)	38-68 (54)	27-68 (45)
Type of occupation				
Skilled	3			
Unskilled	5			
Years of experience as GP/manager		7-10	2-40 (2)	
Range (median)				
Geographic setting (workplace)				
Urban	1	1	1	3
Rural	7	1	2	10
Number of employees				
Range (mean)			10-74 (36)	
Months since used Capacity Note	1-9 (4)	1-7 (4)	4-7 (5)	1-9 (4)

Range (mean)	

Data collection and analysis

Thirteen individual interviews were conducted by the first author (PN) during June–December 2019. Interviews took place in a conference room at a hotel or research center, or at the participant's work place if preferred, and lasted 18-58 min (mean 31 min). The interview guide was semi-structured and contained questions regarding the content, use and usefulness of the Capacity Note. All interviews were audio-recorded and transcribed verbatim. Data was analyzed using manifest qualitative content analysis.[26] This method was found suitable as most participants had experienced the Capacity Note only briefly and we sought to explore how they perceived it during this brief use, i.e. their first impression rather than more far reaching (lived) experiences. When all the interviews had been transcribed, PN and AJ independently read the first three transcripts, first to get an overview, then line-by-line to identify meaning units. The findings were compared to ensure that they related to the research questions and that nothing relevant had been missed. At this stage, preliminary codes could be formulated but the main focus was on identifying meaning units. Then, the same procedure was applied for the remaining transcripts, three or four at a time. When all transcripts had been discussed, the authors jointly coded all meaning units. Then, similar codes were grouped into categories and related categories were grouped into higher order categories. An example of the coding process is found in Figure 1. Codes and categories were rearranged several times to until no new subcategories or categories were identified. The preliminary results were presented at a seminar with external researchers which prompted a further revision of the categories into the final results.

Patient and public involvement

There was no involvement of patients/public in the design or conduct of this study.

RESULTS

The Capacity Note comprised three parts with questions about work situation, work capacity limitations and possible work adjustments respectively. The full Capacity Note is presented in Appendix 1. A schematic presentation of how the participants used it is presented in Figure 2. We found four categories relating to the role of the Capacity Note as a facilitator for communication about work and health: Content and format, Understanding, legitimacy and action, Openness and timing, and Time and efficiency (Figure 3). Each is presented below, with corresponding subcategories. The categories and subcategories represent the participants' joint perceptions of the Capacity Note as generated from the data. Within each category different perspectives and nuances were found and these are also presented.

Content and format

Providing structure and content to the conversation

The participants agreed that the Capacity Note was clear, well-structured and easy to use. The content was considered relevant and "comprehensive but not too much to handle". As such, the Capacity Note provided a good starting point and framework for a discussion about health and work, and also had the potential to extend and deepen the dialog. The structure made it easy to see what one had missed but also posed a risk—that other potentially important issues were overlooked. The ability to provide content and structure to the conversation was

considered of greatest benefit to GPs and managers with little previous experience of sick-listed patients/employees with CMD. For more experienced professionals it was perceived as not providing any knew knowledge.

Some suggestions for further content were made: additional physical symptoms (e.g. heart palpitations, shortness of breath), how the health situation affects private life, how private life affects the capacity to work, a more detailed description of the work environment (including psychosocial factors), specific situations that trigger or worsen the symptoms and other available resources (e.g. support from occupational health services).

The presented suggestions for work adjustments were considered relevant but, depending on the type of job, not always possible to implement.

> I believe it resulted in a deeper conversation. […] Because in some way you had something to relate to, not just my notes but this was slightly more… here you had a few more examples… some structure. (Interview 11)

Finding the right format

Participants expressed disparate views on the best format for the Capacity Note. The paper format was questioned by the physicians; an electronic form was suggested as a smoother and more dynamic alternative, preferably connected to the sickness certificate and one where all three stakeholders could add and update information continuously. Contrary to this, patients appreciated seeing things in "black and white". Using the Capacity Note over the telephone was not perceived as suitable as it made the conversation more static.

> I think it was great, what's annoying… was annoying was, uh… the paper format. (Interview 7)

Putting words to the patient's situation

A central finding was the Capacity Note's ability to help describe the patient's situation. Many patients said that the specific wordings in the Capacity Note were helpful for putting words to what they experienced, which was felt as a relief. Similarly, the physicians said that the Capacity Note facilitated the difficult task of describing the patient's cognitive functional limitations in the sickness certificate.

> …it became clearer, partly for me and that I could put it into words [to the doctor] … which I couldn't before but when I got them [the words] here… it was, well, that's exactly how it is. (Interview 1)

Understanding, legitimacy and action

Contributing to one's own and others' understanding

Another central finding was that the Capacity Note could contribute to an increased understanding of the situation. First of all, when reflecting upon the questions in the Capacity Note, the patient's own understanding of his/her situation could improve; one patient described it as an "aha-experience". This was considered to be the main benefit of the Capacity Note and had the potential to improve the sick leave process, e.g. by making it easier for the GP to explain things to the patient and/or by triggering action (see below). Secondly, it could add to the GP's understanding of the patient's situation, depending on how much had been discussed at previous consultations. Thirdly, discussing possible work adjustments could help the patient see what the manager was already doing to improve the work situation.

None of the participating managers had discussed part 2 of the Capacity Note with their employee, i.e. the part which describes the work capacity limitations. The managers agreed

that it could have increased their understanding of the patient as a person but were uncertain whether it would have affected the discussion about and execution of work adjustments.

> …possibly I would say that the advantage of the form for… from the employee's point of view, I noticed, may be that he, she gets a, eh… what should we call it… a little eye-opener about his, her situation at work. (Interview 11)

Understanding promotes action

We found that when the patients understood their situation better, it helped them to choose strategies and make decisions about their situation. For example, they became more motivated to accept the interventions offered by the health care or adopt new strategies at work. The impact on physicians' and employers' actions was less evident but one participant felt it had facilitated team work at the PCC.

> …I think it motivated the patients to, eh… take their… interventions that we recommend, like therapy, like taking their medications […] … and some of the patients also noticed that they did not take breaks normally and now they have begun… (Interview 7)

Legitimacy before oneself and others

Legitimacy was touched upon in several interviews. Firstly, for the patients themselves, the Capacity Note gave legitimacy to their situation by describing it so well, which made them understand that their problems were normal and real. Secondly, getting the physician to really listen was perceived by patients as a major benefit of the Capacity Note. Also, several participants noted that it could be supportive for the patient in the conversation with the manager, which was described as an even more vulnerable situation.

> I felt that… I'm not imagining. When I saw it on paper or like when I had ticked it […] you felt that it… it was really like this. […] And then I also think in front of others too, it was good to have this as a support […] that I knew that this is how it is and then I could sort of, uh… take it in a different way when others might think that, well… you are on sick leave. (Interview 5)

> If he [the boss] had sat with this note, he might have understood what I have been trying to tell him for six months. […] that what I have been saying all these months is actually true. […] Because when you do it with a doctor, there's another authority in the whole thing, unfortunately. (Interview 6)

Openness and timing

The role of openness and honesty between stakeholders

The issues of openness and honesty were also discussed, and the perspectives were contradictory. It was said that how much you want to disclose will differ from person to person and that the patient's agenda and how he/she perceives the purpose of the Capacity Note will affect his/her answers. In contrast, it was also said that the Capacity Note could help the patients to be honest about their symptoms, work disabilities and needs when they saw that they were legitimate. The patients stressed that the Capacity Note helped them to more fully explain their situation to the GP, which was perceived as positive. In contrast, the willingness to disclose the same information to the manager was described as depending on the manager's attitude. None of the patients had actually discussed it with their manager. To some, this was a relief, as they did not want to reveal their "shortcomings". Others said that they would have wanted the manager to see it, as they believed it would have increased the manager's (and the whole workplace's) understanding of what it was like to work with CMD.

One manager suggested that a form for communication between only doctor and manager would lead to more honest communication about the patient/employee, as it can be difficult to be fully honest in front of the patient. In contrast, other participants suggested that a joint meeting with all three stakeholders would lead to a better common understanding of the situation as everyone hears what is said. It was suggested that the Capacity Note could serve as a basis for such a meeting.

> I might not have wanted to show it to him, the boss I had then, because it… it was too hard. […] It was just… that boss was not receptive to it. (Interview 3)

Uncertainty about the right timing

The participants expressed uncertainty about when would be the best time to use the Capacity Note. Generally, an early use was advocated—to map the situation and/or to stimulate return to work. But not too early some said, as it might take focus off the medical aspects and the patient might not have enough energy or motivation yet to discuss return to work. For those that had partially returned to work when they used the Capacity Note it was perceived as less useful since they had already gained an understanding of their situation and work adjustments had already been discussed.

> There is much to go into at a first doctor's visit and sick leave, which may well be high on the patient's agenda but it… it must have a lower medical priority, we must first find out if the patient is about to die or… or has something that requires medicine… (Interview 8)

Time and efficiency

Time is essential for good communication and understanding

The issue of time was often discussed in the interviews, especially the lack of it. From the patients' perspective, the physicians' lack of time could cause feelings of stress and lead to thinking less before answering, and stood in the way of a good conversation and use of the Capacity Note. Managers' lack of time (or interest) resulted in a limited discussion of the Capacity Note (the employee did not have a say, the manager just ticked the boxes) or in it not being used at all. Participants who had given or been given the time to discuss the Capacity Note more in-depth more often perceived that they had gained a better understanding of the situation and were the most positive about the Capacity Note.

I: How do you think it affected your conversation [with the doctor] to complete it?

IF: Well… I was probably a little affected by the fact that there were so many 'yes'. […] Eh… at the same time we didn't have much time, I felt, to talk about it…

[…]

I: If you had had more time, would you have wanted to discuss it more?

IF: Mm, yes, I would have. (Interview 12)

Striving to be efficient

The GPs expressed contradictory perceptions about the "cost-benefit" of the Capacity Note. When used over the phone, after the consultation, it was perceived as lengthy (approx. 7-8 min) and not very useful. When used within the consultation it was described as taking even longer (approx. 15-20 min) but worth the effort (due to the increased understanding it provided, as discussed above). The GPs' lack of time was recognized by both patients and GPs and several suggestions and attempts to resolve it were described. For example, it was suggested that patients fill in the form alone or with other health care personnel before the doctor's visit. One patient filled it in by herself during the consultation, explicitly to save the

GP's time. At the same time, participants recognized the benefits of discussing the Capacity Note together.

> Yes, I probably would have wanted to do it myself first, without her [the GP] sitting in the same room. … Because I was stressed, it's part of the disease sort of… (Interview 4)

> … if the patient had completed it at the beginning, before we met, I'm not sure but then… I think that maybe the sick leave assessment itself could have become a little sharper in less time, a bit… fewer questions and so on. On the other hand, it might not have been an equally open conversation, unconditional, but perhaps the conversation risks being mostly about the sick leave issue, perhaps. […] …you think about being able to work or not, rather than in what way I am sick and what suffering I'm actually experiencing and what we should do. (Interview 8)

DISCUSSION

In this study we presented the development of the Capacity Note and qualitatively examined how users (patients, GPs and managers) perceived and used it. Overall, the participants were pleased with the content and structure of the Capacity Note. An important perceived benefit of the Capacity Note was the ability to increase the users' understanding of the patient's situation, especially the patient's own understanding. This is an important finding because patients with CMD have expressed uncertainty about their condition and what can be expected regarding work participation,[10] as well as concerns about the legitimacy of being on sick leave due to CMD.[13] The precise descriptions in the Capacity Note of how the patient's work capacity was affected represented one way to bring clarity. Putting words to this has been described as difficult by patients,[13] physicians,[27] and employers.[17] To think about the

questions and finding the right words contributed to the patient's understanding and feelings of legitimacy and agency.[28] Moreover, the Capacity Note could help the GP describe the patient's cognitive functional limitations more clearly. This is equally important as the sickness certificate is the basis for the patient's entitlement to sickness benefits. The benefits of describing the specifics of the situation is also interesting in relation to the modern practice of focusing on abilities instead of disabilities in vocational rehabilitation.[29] One could assume that focusing on what the patient *can* do will increase the patient's motivation and agency. But by focusing only on abilities, the question of how to work with disabilities cannot be answered properly.[30 31] In line with this, we found that putting words to what the patient *cannot* do was the catalyst for further actions.

Having enough time was found to be important for good use of the Capacity Note, which is in line with previous research on work capacity assessments,[3] and collaboration.[32] GPs lack of time was described as being "the bottleneck" and suggestions for a more "effective" use were given. One was electronic information transfer, which physicians also have suggested in other studies.[33] As a working tool for professionals it might be the smoothest option, but confidentiality regulations can be a hindrance to implementation.[34] Despite the perceived lack of time, several suggestions for additional items in the Capacity Note were made. Also, joint meetings with all stakeholders were proposed as better for achieving a common understanding, but these are indeed time consuming and hard to achieve.[32] On the whole, this suggest a tension between what you want to achieve and what is possible. The suggestions for streamlining should perhaps not be seen as ways to achieve an optimal tool but as ways to make the most of what you have got. There was a common understanding among the participants that understanding takes time and participants acknowledged that streamlining comes with a risk of losing the core of the Capacity Note—the discussion. It also raises the question of who is the primary owner and beneficiary of the Capacity Note. The stakeholders

all had different needs. The professionals primarily wanted to receive information that would facilitate their job of managing the patient/employee's sick leave, something which can be achieved in many ways. The patients, on the other hand, seemed primarily to want understanding which requires more purposeful interaction.[13]

Openness and honesty were identified as necessary for good communication and understanding. The Capacity Note was perceived both as a potential help and hindrance for this, depending on how the patient perceived its purpose. The GP's traditional role as the patient's advocate was reflected in the patient's stories about how the Capacity Note helped them explain their situation to their GP. At the same time, there is a power balance,[35] where the patient is at a disadvantage in relation to both the physician (to get the sickness certificate) and the employer (to get adjustments, to keep position, etc.) which could affect the patient's answers. In relation to this, communication directly between GP and manager was suggested. However, confidentiality regulations prohibit the physician from sharing any information without the patient's consent.[19] Also, information transfer without involving the patient might not efficiently affect work resumption.[21] From the patients' point of view, being open and honest with the employer was more difficult and depended greatly on the employers' attitude. This is in line with previous research identifying support and mutual trust as important for the sick leave and return-to-work process.[35-37] In addition, stigma regarding mental health can make employees reluctant to share health information with their employer.[11 38] Managers might be skeptical,[15] or lack sufficient knowledge,[39] of the causes and effects of CMD, which affects how they address it and support the employee.

The Capacity Note was perceived as most beneficial to inexperienced professionals, a finding also reported by Hoefsmit et al.[40] regarding their "conversation roadmap" for employers and employees. While the professionals in this study did not perceive that their understanding of

the patient's situation increased, several patients felt that the GP understood them better after using the Capacity Note. The same was not said about the managers, most likely because the employee's health and work capacity (part 2 of the Capacity Note) were not discussed in those conversations, only work adjustments. The conversation between employee and manager about the employee's work capacity limitations was an important part of the Capacity Note and an aspect that has not, to our knowledge, been examined before. However, due to the lack of descriptions of such a conversation and its potential benefits and drawbacks, it was not possible to analyze further. This could be approached in future studies. For managers, the perceived usefulness of the Capacity Note was also limited by the fact that the suggested work adjustments were not always possible to execute.[41]

Participants were unsure about when would be the best time to use the Capacity Note. In general, an early use was considered desirable, which is in line with the intended use as well as national sick leave recommendations for patients with CMD. But readiness for returning back to work was also mentioned as important. This tension between recovery and return to work has been observed in several other studies and supports our finding that the timing of the intervention is important and must be considered for each patient individually.[28 36]

Methodological considerations

All interviews took place at a "neutral" place, and participants seemed to be at ease. PN performed all interviews, ensuring similar interviews for all participants. She was a medical doctor with work experience in Swedish primary care, and had been involved in the development of the Capacity Note and as a research assistant in the pilot study. This ensured a good understanding of the content and context of this study. PN also analysed the data. To reduce the risk of preconceptions influencing interpretation of data, the analysis was

performed together with the second author (AJ) who had not taken any prior part in the project.

Recall bias may have occurred since the interviews took place up to nine months after using the Capacity Note. Selection bias, that those most positive to the Capacity Note participated, cannot be ruled out, but wanting to help research concerning mental health issues (regardless of opinion of the Capacity Note) was a commonly stated reason for participating. We also noted occasional bias regarding giving socially desirable answers, for example following up a negative comment with a positive one. Some, but not all, participants were aware of the interviewer's central role in the project. A broader representation of GP characteristics (for example in working experiences) would have been desirable but recruitment of GPs proved difficult, presumably due to time constraints.[42]

Conclusion

The participants considered the Capacity Note relevant and easy to use and as having the potential to improve communication about and understanding of the patient's situation. The increased understanding could contribute to a sense of legitimacy and agency in the patients. Achieving these positive effects required openness, an investment of time, and using the Capacity Note at the right time in the sick leave process.

DECLARATIONS

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Authors' contributions

PN was involved study design, data collection, data analysis and drafted the manuscript. AJ was involved in data analysis and critical revision of the manuscript. GH initiated the study and was involved in study design and critical revision of the manuscript. All authors read and approved the final version of the manuscript.

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Competing interests

The authors declare that they have no competing interests.

Consent for publication

Not required.

Ethics approval

The study was approved by the Regional Ethical Review Board in Gothenburg, Sweden (reference number 1115-17).

Availability of data

Data supporting the findings of this study are available from the corresponding author upon reasonable request.

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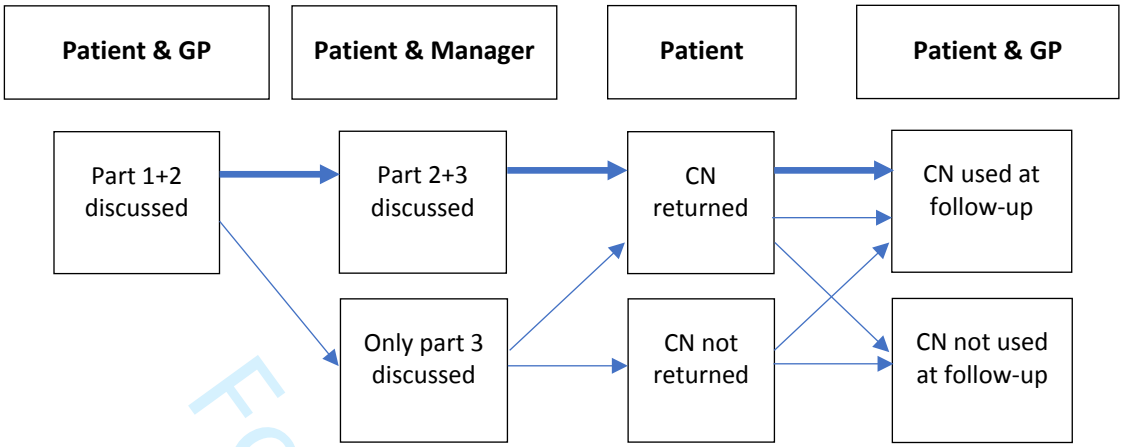
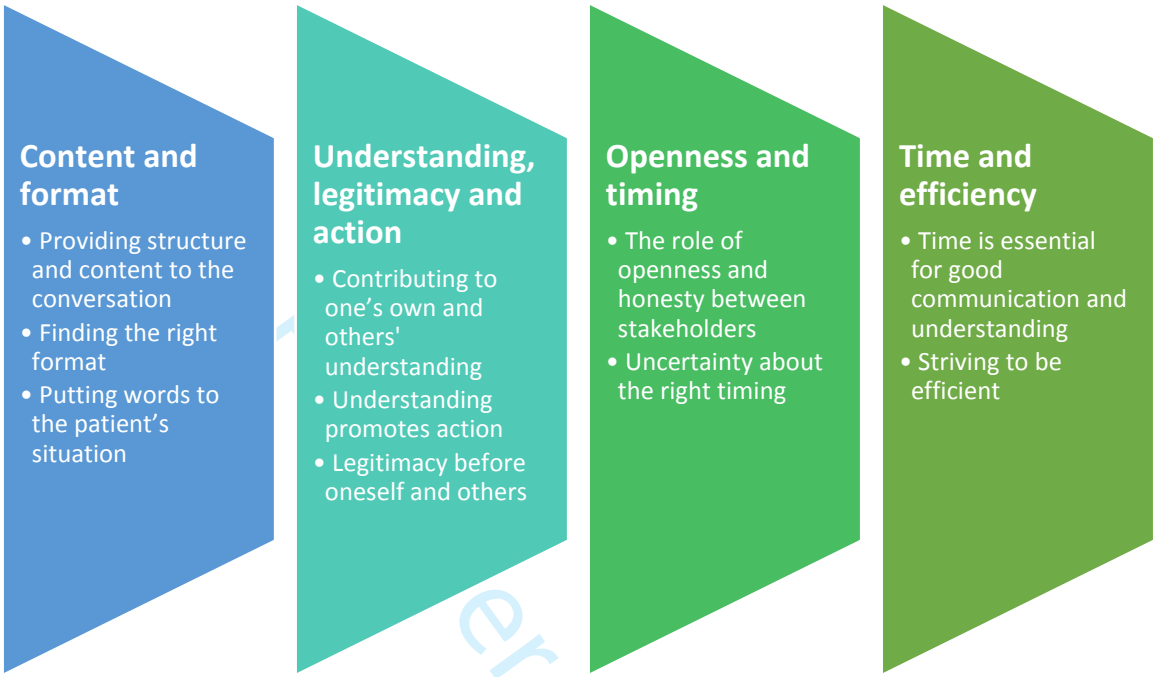
Meaning unit	Code	Subcategory
There were very clear questions that made me… well, yes it was a bit of an aha experience.	Eye opener	Contributing to one's own and others' understanding
Because he asked such questions then a… a conversation arose about this and then I thought he, yes… he understands.	The doctor understands	
It probably helped me a lot that I kind of understood and accepted […] That way, eh… I was very receptive to all the help I could get.	Accept help	Understanding promotes action
Because part three… the one with… we should have done with the boss, it made me think that I can no continue as I have done but you have to do something because otherwise I will end up there again.	Make decisions	
Yes, when you see it in black and white, and read it in black and white, all these things… then you realize that you are not unique and that you are not alone […] you really have something.	Understand that it is normal	Legitimacy before oneself and others
…but if I tell a doctor that I am in pain and we together write down exactly what it is, then of course it weighs more than if I tell my boss that I am in pain.	Legitimacy towards the employer	





The Capacity Note

The capacity note describes how your current health affects your ability to work, and gives you the opportunity to discuss it with your employer to find a suitable way forward. It is intended to be used as follows:

1) Fill in parts 1 and 2 together with your doctor.
2) Bring the capacity note to your manager or supervisor. Together, you discuss what adjustments can be made in the workplace based on the health you have right now, and fill in this in part 3.
3) Send back the capacity note in the enclosed envelope. The capacity note is entered into your journal so you and your doctor can discuss your work situation at the next visit. Only part 1 will be used for research.

The project

The capacity note is part of the research project *Capacity Note – early and systematic communication between doctor, patient and employer*, a collaborative project between New Ways at the University of Gothenburg and Region Västra Götaland. Read more at https://www.gu.se/en/research/new-ways-mental-health-at-work.

Part 1 – Information about you and your work

Date:

Name: **Swedish social security number:**

Enter your profession/occupation (be as specific as possible):

Do you work full or part-time?

☐ Full-time (40 hrs/week) ☐ Part-time: ____%

Can overtime work occur?

☐ No ☐ Yes: _____hours per week

What are your working hours?

☐ Day time ☐ Irregular hours ☐ Shift work

What is your employment form?

☐ Permanent ☐ Temporary post ☐ Project position

☐ Self-employed

Other information about your work situation

☐ Management position ☐ Flexible work (able to adapt time and place)

☐ Other:

Part 2 – Information about how your health affects your capacity to work

Cross all the statements that apply to you and your situation right now.

Concentration and memory

Right now my capacity to work is affected because it is difficult to:

☐ concentrate, thoughts are 'slow'

☐ take in information

☐ learn new tasks at work

☐ remember (e.g. meeting times, how to do tasks at work)

☐ prioritize tasks at work

☐ get tasks started

☐ complete tasks

☐ perform complex tasks (i.e. tasks that are not standardised or routine)

☐ do several things at the same time ("keep several balls in the air")

☐ lead work, both my own and others' (i.e. have an overview, make decisions, delegate etc.)

☐ keep the ability to concentrate up for more than short moments

☐ keep a high tempo for more than short moments

☐ work under time pressure

☐ other:

Feelings

Right now my capacity to work is affected because it is difficult to:

☐ control emotions

☐ take criticism

☐ handle change

☐ feel engagement

☐ be creative

☐ other:

Body

Right now my capacity to work is affected by:

☐ weakness/loss of strength in the body

☐ tenderness or tension in the body

☐ I am easily disturbed by sound and visual impressions, I need to work separately

☐ other:

Social

Right now my capacity to work is affected because it is:

☐ stressful to interact with other people (e.g. colleagues, customers, students)

☐ stressful to participate in contexts where many people are gathered (e.g. meetings, coffee breaks)

☐ difficult to do my job when others are looking or listening

☐ other:

NOTE! Do any of these claims pose a risk to you or others in your work situation? (e.g. if you are driving a commercial vehicle or operating a dangerous machine)

If yes, state in what way:

Other possible difficulties:

Part 3 - How can your work be adapted?

Is it possible to:

Change tasks at work (e.g. ”routine tasks” instead of complex tasks, administrative tasks instead of customer contact)

☐ no ☐ yes

☐ yes, partially or temporarily (state how):

Change contacts with patients, students, customers etc. (e.g. fewer, shorter time)

☐ no ☐ yes

☐ yes, partially or temporarily (state how):

Change contacts with colleagues

☐ no ☐ yes

☐ yes, partially or temporarily (state how):

Reduce the number of internal meetings (e.g. workplace meeting, planning meeting)

☐ no ☐ yes

☐ yes, partially or temporarily (state how):

Take regular breaks

☐ no ☐ yes

☐ yes, partially or temporarily (state how):

Work with less intensity (e.g. fewer tasks, slower tempo)

☐ no ☐ yes

☐ yes, partially or temporarily (state how):

Work without overtime

☐ no ☐ yes

☐ yes, partially or temporarily (state how):

Reduce physical load (e.g. heavy lifts, twisted postures)

☐ no ☐ yes

☐ yes, partially or temporarily (state how):

Reduce time in front of computer screen

☐ no ☐ yes

☐ yes, partially or temporarily (state how):

Change sound or light environment

☐ no ☐ yes

☐ yes, partially or temporarily (state how):

Change workplace (e.g. room, place in room, from out to in or vice versa)

☐ no ☐ yes

☐ yes, partially or temporarily (state how):

Arrange for a temporary relocation

☐ no ☐ yes

Partial sick leave

Is it possible, in view of your duties and the adaptations that can be made, for you to work part-time (in combination with partial sick leave)?

If yes, specify degree of work:

☐ 10 - 25% ☐ 26 - 49% ☐ 50 - 75% ☐ 76 - 90%

Any other possibilities for adaptations:

COREQ (COnsolidated criteria for REporting Qualitative research) Checklist

A checklist of items that should be included in reports of qualitative research. You must report the page number in your manuscript where you consider each of the items listed in this checklist. If you have not included this information, either revise your manuscript accordingly before submitting or note N/A.

Topic	Item No.	Guide Questions/Description	Reported on Page No.
Domain 1: Research team and reflexivity			
Personal characteristics			
Interviewer/facilitator	1	Which author/s conducted the interview or focus group?	20
Credentials	2	What were the researcher's credentials? E.g. PhD, MD	20
Occupation	3	What was their occupation at the time of the study?	20
Gender	4	Was the researcher male or female?	20
Experience and training	5	What experience or training did the researcher have?	20
Relationship with participants			
Relationship established	6	Was a relationship established prior to study commencement?	20
Participant knowledge of the interviewer	7	What did the participants know about the researcher? e.g. personal goals, reasons for doing the research	20
Interviewer characteristics	8	What characteristics were reported about the inter viewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	20
Domain 2: Study design			
Theoretical framework			
Methodological orientation and Theory	9	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	9
Participant selection			
Sampling	10	How were participants selected? e.g. purposive, convenience, consecutive, snowball	7
Method of approach	11	How were participants approached? e.g. face-to-face, telephone, mail, email	7
Sample size	12	How many participants were in the study?	8
Non-participation	13	How many people refused to participate or dropped out? Reasons?	8
Setting			
Setting of data collection	14	Where was the data collected? e.g. home, clinic, workplace	8
Presence of non-participants	15	Was anyone else present besides the participants and researchers?	8
Description of sample	16	What are the important characteristics of the sample? e.g. demographic data, date	8
Data collection			
Interview guide	17	Were questions, prompts, guides provided by the authors? Was it pilot tested?	8-9
Repeat interviews	18	Were repeat inter views carried out? If yes, how many?	n/a
Audio/visual recording	19	Did the research use audio or visual recording to collect the data?	9
Field notes	20	Were field notes made during and/or after the inter view or focus group?	n/a
Duration	21	What was the duration of the inter views or focus group?	8
Data saturation	22	Was data saturation discussed?	n/a
Transcripts returned	23	Were transcripts returned to participants for comment and/or	-

Topic	Item No.	Guide Questions/Description	Reported on Page No.
		correction?	
Domain 3: analysis and findings			
Data analysis			
Number of data coders	24	How many data coders coded the data?	9
Description of the coding tree	25	Did authors provide a description of the coding tree?	9
Derivation of themes	26	Were themes identified in advance or derived from the data?	9
Software	27	What software, if applicable, was used to manage the data?	n/a
Participant checking	28	Did participants provide feedback on the findings?	-
Reporting			
Quotations presented	29	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? e.g. participant number	9-16
Data and findings consistent	30	Was there consistency between the data presented and the findings?	9-16
Clarity of major themes	31	Were major themes clearly presented in the findings?	9-16
Clarity of minor themes	32	Is there a description of diverse cases or discussion of minor themes?	9-16

Developed from: Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*. 2007. Volume 19, Number 6: pp. 349 – 357

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The capacity note - a communication facilitator in the sick leave process of patients with common mental disorders. A qualitative study of user perceptions

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The capacity note - a communication facilitator in the sick leave process of patients with common mental disorders. A qualitative study of user perceptions

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ABSTRACT

Objectives: To describe the development of a communication facilitator, the Capacity Note, for the sick leave process of patients with common mental disorders (CMD) in primary care, and to explore users' perceptions of it.

Design: Qualitive study.

Setting: Primary health care in Region Västra Götaland, Sweden.

Participants and methods: The Capacity Note was developed inductively based on data from six qualitative studies of work capacity and CMD and was introduced at primary health care centers during 2018–2019. Individual semi-structured interviews were performed with 13 informants (eight patients, two general practitioners and three managers) who had used the Capacity Note at least once. Interviews were audio-recorded and transcribed verbatim and inductive manifest qualitative content analysis was used to analyze the data.

Results: The Capacity Note comprised questions about work situation, work capacity limitations and possible work adjustments. Based on the interviews, four categories relating to its role as a facilitator for communication about work and health were identified: *Content and format, Understanding, legitimacy and action, Openness and timing,* and *Time and efficiency*. The participants considered the Capacity Note relevant and easy to use, and as having the potential to improve communication about and understanding of the patient's situation. The increased understanding was perceived as contributing to a sense of legitimacy and agency. Achieving these benefits required, according to the participants, openness, an investment of time and using the Capacity Note at the right time in the sick leave process.

Conclusion: The Capacity Note was found to be relevant and as having, under the right conditions, the potential to improve communication and facilitate the sick leave process.

STRENGTHS AND LIMITATIONS OF THIS STUDY

- This study describes a novel approach to stakeholder communication about work capacity in the sick leave process of patients with common mental disorders (CMD).
- It is considered a strength that the communication facilitator was developed based on stakeholders' own reports of work capacity and CMD.
- The results regarding user perceptions represent a limited experience of the communication facilitator. A higher number of participants, in particular general practitioners and managers, may have provided richer data and greater variation in the findings.

INTRODUCTION

A closer collaboration between stakeholders has been described as important for a good sick leave and return-to-work process but also as difficult to achieve.[1-5] This study qualitatively examined how patients, general practitioners (GPs) and managers perceived and used a communication facilitator, the Capacity Note, for the sick leave process of patients with common mental disorders (CMD).

There is today no golden standard for how to best achieve sustainable work participation for patients sick-listed with CMD.[6 7] In Sweden, these patients are generally treated in primary care where GPs are responsible for sickness certification when needed. To assess work capacity and need for sick leave and rehabilitation is a difficult task in general, and even more so in cases of CMD.[3 8 9] In these conditions, symptoms and associated work capacity and rehabilitation needs are highly individual and often unpredictable.[10-12] This makes guidelines and standard assessments less useful and calls for an increased recognition of the individual

and subjective parts of the assessment.[9 12-14] In addition, the work place must be considered which is yet another piece of information that is individual and difficult to assess.[8] GPs rarely communicate with employers—lack of time and disclosure concerns being commonly mentioned reasons—but have to rely on the patient's descriptions of what can be done at the work place.[3 15] The assessment is further complicated by the fact that the patients with CMD themselves find it difficult to grasp and describe their reduced work capacity.[10]

At the patient's work place, the manager is responsible for facilitating the employee's return to work, for example by providing work adjustment.[16] But managers too struggle with the vagueness of mental health problems and find it hard to identify, describe and deal with them.[15 17 18] In Sweden, due to confidentiality laws, employees do not have to disclose any diagnosis to the manager, only the effects of the diagnosis on functioning (e.g. difficulties concentrating) and how that affects their capacity to work (e.g. they cannot learn new tasks).[19] Such information should be stated in the sickness certificate but is often limited, especially statements about work capacity.[20] Moreover, with their medical focus, sickness certificates can be hard to interpret for managers. Consequently, with restricted knowledge of the patient's specific problems, individualized adjustments can be hard to accomplish.

Increased communication in the sick leave process has been approached in different ways, for example information exchange between health professionals,[21] structured conversations between employer and employee,[22] and a guide for patients' discussions with various stakeholders.[23] Our focus was to promote communication about health and work among the three key stakeholders: patient, GP, and manager. For this purpose, we developed a communication facilitator – the Capacity Note. The idea was to have the patient as the main informant and the Capacity Note as a transmitter of written information between physician and manager. The intent was to increase the manager's understanding of reduced capacity to

work from the medical perspective, and the physician's understanding of possible measures to adjust the work environment from the workplace perspective. The aims of this study were to describe the development of the Capacity Note and to qualitatively examine how the stakeholders perceived its content, format and use.

METHODS

Development of the Capacity Note

The Capacity Note was developed based on data from six qualitative studies examining work capacity and CMD: three studies with individuals having personal experiences of CMD and work,[10 11 24] two studies with physicians and other health care professionals,[14 25] and one literature review.[3] Data relevant to the purpose of the Capacity Note was identified inductively in the results sections of each of the six articles and condensed into items. The items were compared across the six sources and grouped into content areas. Then, considering the short consultation times in primary health care, a selection of representative items from each content area were chosen. Based on the selected items, questions about work situation, work capacity and corresponding work adjustments were formulated. The draft was discussed at a seminar with researchers from different fields such as medicine, occupational therapy, physiotherapy and public health. This prompted some minor revisions, after which it was completed. Characteristics of the six studies that provided data to the Capacity Note and examples of their contributions are presented in Table 1.

Table 1. Characteristics of the six studies that provided data to the development of the Capacity Note, and examples of their contributions.

Author and year of publication	Aim	Study design and method for analysis	Informants	Number of identified items	Example of identified data	Item	Corresponding question in the Capacity Note
Bertilsson et al (2013)	Explore experiences of work capacity in persons working while depressed and anxious to identify the essence of the phenomenon 'capacity to work'	Phenomenological, Focus groups	Persons working at least part-time with diagnosed or self-reported depression, anxiety or exhaustion (n=17)	34	"Interpersonal encounters were described by the participants as the most demanding type of work task." (p.1707)	Interaction with other people	Right now my capacity to work is affected because it is stressful to interact with other people (e.g. pupils, colleagues, customers) (Tick box if agree)
Bertilsson et al (2015)	To explore health care professionals' experience-based understanding of work capacity in individuals with depression and anxiety disorders	Focus groups, Inductive content analysis	Health care professionals from occupational, psychiatric, and primary health care with experience of treating patients with common mental disorders (n=21)	26	"Capacity to work was described in patient-narratives as being affected by changed and more sensitive perceptions of sensory input such as vision and hearing." (p. 129)	Sensitive to sensory input	Right now my capacity to work is affected because I am easily disturbed by sound and visual impressions, I need to work separately (Tick box if agree)
Bertilsson et al (2018)	To explore physicians' tacit knowledge of their assessment of work capacity in patients with depression and anxiety disorders	Video vignettes and open-ended interviews, Inductive content analysis	Physicians specialized in general practice, occupational health or psychiatry with experience of treating patients with common mental disorders (n=24)	45	"An important dimension was to assess whether the decreased work capacity could lead to failures or accidents at work..." (p.8)	Risks	Do any of these claims pose a risk to you or others in your work situation? (e.g. driving a commercial vehicle, operating a dangerous machine) (If yes, state in what way)
Danielsson et al (2017)	To explore experiences of work instability in workers with common mental disorders	Grounded theory, Individual interviews	Employed persons with current diagnosed or self-reported common mental disorder (n=27)	29	"The participants described feeling estranged, tense, exhausted and weakened." (p.6)	Physical weakness	Right now my capacity to work is affected by weakness/ loss of strength in the body (Tick box if agree)
Danielsson et al (2017)	To explore workers' strategies to keep working while affected by common mental disorders	Grounded theory, Individual interviews	Employed persons with current diagnosed or self-reported common mental disorder (n=27)	14	"The participants tried to compensate for negative changes [...] It could mean taking on more simple tasks to compensate for a lack of concentration and creativity." (p.6)	Loss of creativity	Right now my capacity to work is affected because it is difficult to be creative (Tick box if agree)
Nordling et al (2020)	Synthesize existing research on what and how physicians do when they assess work capacity	Systematic literature review, Thematic synthesis of qualitative data	Qualitative studies describing physicians' practices when assessing work capacity as part of sickness certification (n=12)	8	"Questions about work tasks and demands could include aspects such as heavy lifting, opportunity to take a break or adjust work pace." (p.8)	Possibility to take breaks	Is it possible to take regular breaks? (Yes/No/Yes partly)

Study design

A qualitative study design with individual interviews was chosen as appropriate to examine the users' perceptions of the Capacity Note. Participation was based on informed consent and participants were informed that they could withdraw at any time. No incentives for participation were offered.

Setting and participants

The Capacity Note was used at eight public and private primary health care centers (PCCs) in the southwest part of Sweden in 2018 and 2019 as part of a pilot study focusing on patients' agency and sick leave during follow-up (data not presented in this study). In the pilot study, the Capacity Note was used by 28 patients, 14 GPs and, as far as we know, 12 managers.

Participants in this study were a convenience sample recruited from the pilot study based on the following inclusion criteria: *patients* must have used the Capacity Note with their physician no more than nine months previously and agreed to be contacted about the interview study; *GPs* must have used the Capacity Note with at least one patient no more than nine months previously; *managers* must have used the Capacity Note with at least one employee no more than nine months previously and the employee must have agreed to their participation.

The 15 patients that filled the inclusion criteria were contacted in a random order via telephone. If interest was shown, written information and a consent form were sent by mail. Eight patients agreed to participate. Lack of time or energy were the most common reasons for not participating. Ten GPs met the inclusion criteria. For one of them, we could not

retrieve the correct contact information. The remaining nine GPs were invited to participate in the study via their work email. Two GPs agreed to participate, two declined due to lack of time and five did not reply to the invitation or the two reminders. Of the 15 eligible patients, four had agreed to let their manager participate. These four managers were contacted by telephone (n=3) or work email (n=1) and they all agreed to participate. One of them fell ill at the time of the interview and could not reschedule, leaving a final sample of three managers. The characteristics of participants are presented in Table 2.

Table 2. Characteristics of participants.

	Patients n=8	GPs n=2	Managers n=3	Total n=13
Gender				
Female	7	0	3	10
Male	1	2	0	3
Age				
Range (mean)	27-58 (44)	44 (44)	38-68 (54)	27-68 (45)
Type of occupation				
Skilled	3			
Unskilled	5			
Years of experience as GP/manager		7-10	2-40 (2)	
Range (median)				
Geographic setting (workplace)				
Urban	1	1	1	3
Rural	7	1	2	10
Number of employees				
Range (mean)			10-74 (36)	

Months since used Capacity Note Range (mean)	1-9 (4)	1-7 (4)	4-7 (5)	1-9 (4)
Number of times having used the Capacity Note Range	1	1-4	1	1-4

Data collection and analysis

Thirteen individual interviews were conducted by the first author (PN) during June–December 2019. Interviews took place in a conference room at a hotel or research center, or at the participant's work place if preferred, and lasted 18-58 min (mean 31 min). The interview guide was semi-structured and contained questions regarding the content, use and usefulness of the Capacity Note. All interviews were audio-recorded and transcribed verbatim. Data was analyzed using manifest qualitative content analysis.[26] This method was found suitable as most participants had experienced the Capacity Note only once and we sought to explore how they perceived it during this use, i.e. their first impression rather than more far reaching (lived) experiences. When all the interviews had been transcribed, PN and AJ independently read the first three transcripts, first to get an overview, then line-by-line to identify meaning units. The findings were compared to ensure that they related to the research questions and that nothing relevant had been missed. At this stage, preliminary codes could be formulated but the main focus was on identifying meaning units. Then, the same procedure was applied for the remaining transcripts, three or four at a time. When all transcripts had been discussed, the authors jointly coded all meaning units. Then, similar codes were grouped into categories and related categories were grouped into higher order categories. An example of the coding process is found in Figure 1. Codes and categories were rearranged several times to until no

new subcategories or categories were identified. The preliminary results were presented at a seminar with external researchers which prompted a further revision of the categories into the final results.

Patient and public involvement

There was no involvement of patients/public in the design or conduct of this study.

RESULTS

The Capacity Note comprised three parts with questions about work situation, work capacity limitations and possible work adjustments, respectively. It is presented in full in Appendix 1. The Capacity Note was meant to be used once for each patient during his/her sick leave process, but at two separate occasions: first a discussion between patient and GP, and then a discussion between patient/employee and employer. A schematic presentation of the intended use, and the actual use (as described in the interviews), is presented in Figure 2.

We identified four categories relating to the role of the Capacity Note as a facilitator for communication about work and health: Content and format, Understanding, legitimacy and action, Openness and timing, and Time and efficiency (Figure 3). Each is presented below, with corresponding subcategories. The categories and subcategories represent the participants' joint perceptions of the Capacity Note as generated from the data. Within each category different perspectives and nuances were found and these are also presented.

Content and format

Providing structure and content to the conversation

The participants agreed that the Capacity Note was clear, well-structured and easy to use. The content was considered relevant and, according to one participant, "comprehensive but not too much to handle". As such, the Capacity Note was thought to provide a good starting point and framework for a discussion about health and work. The informants also stated that it had the potential to extend and deepen the dialog by giving examples that had to be considered; these might not have been discussed otherwise but would now be elaborated and could take the discussion further. The structure was experienced as making it easy to see what one had missed, but also as a potential risk—that other potentially important issues were overlooked. The professionals (GPs and managers) suggested that the Capacity Note was of greatest benefit to GPs and managers with little previous experience of sick-listed patients/employees with CMD, while for more experienced professionals it was perceived as not providing any knew knowledge.

Some suggestions for further content were made: additional physical symptoms (e.g. heart palpitations, shortness of breath), how the health situation affects private life, how private life affects the capacity to work, a more detailed description of the work environment (including psychosocial factors), specific situations that trigger or worsen the symptoms and other available resources (e.g. support from occupational health services).

The presented suggestions for work adjustments were considered relevant but, depending on the type of job, not always possible to implement.

> I believe it resulted in a deeper conversation. […] Because in some way you had something to relate to, not just my notes but this was slightly more… here you had a few more examples… some structure. (Interview 11)

Finding the right format

Participants expressed disparate views on the best format for the Capacity Note. The paper format was questioned by the two participating physicians; an electronic form was suggested as a smoother and more dynamic alternative, preferably connected to the sickness certificate and one where all three stakeholders could add and update information continuously. Patients appreciated seeing things "black on white". Informants also mentioned that using the Capacity Note over the telephone was less suitable as it made the conversation more static.

> I think it was great, what's annoying… was annoying was, uh… the paper format. (Interview 7)

Putting words to the patient's situation

Patients said that the specific wordings in the Capacity Note were helpful for putting words to what they experienced, and that this was a relief. Similarly, the physicians said that the Capacity Note could facilitate the difficult task of describing the patient's cognitive functional limitations in the sickness certificate.

> …it became clearer, partly for me and that I could put it into words [to the doctor] … which I couldn't before but when I got them [the words] here… it was, well, that's exactly how it is. (Interview 1)

Understanding, legitimacy and action

Contributing to one's own and others' understanding

According to informants, the patient's own understanding of his/her situation could improve when reflecting upon the questions in the Capacity Note. One patient described it as an "aha-experience". This, according to one GP, made it easier for the GP to explain things to the patient. It was also said that using the Capacity Note could add to the GP's understanding of

the patient's situation, and that this was depending on how much had been discussed at previous consultations. One manager stated that discussing the suggested work adjustments could help the patient see what the manager was already doing to improve the work situation.

None of the participating managers had discussed part 2 of the Capacity Note with their employee, i.e. the part which describes the work capacity limitations. The managers agreed that it could have increased their understanding of the patient as a person but were uncertain whether it would have affected the discussion about and execution of work adjustments.

> …possibly I would say that the advantage of the form for… from the employee's point of view, I noticed, may be that he, she gets a, eh… what should we call it… a little eye-opener about his, her situation at work. (Interview 11)

Understanding promotes action

Some informants stated that when the patients understood their situation better, it helped them to choose strategies and make decisions, such as accepting the interventions offered by the health care or adopt new strategies at work. The impact on physicians' and employers' actions was less evident but one participant felt it had facilitated team work at the PCC.

> …I think it motivated the patients to, eh… take their… interventions that we recommend, like therapy, like taking their medications […] … and some of the patients also noticed that they did not take breaks normally and now they have begun… (Interview 7)

Legitimacy before oneself and others

Legitimacy was touched upon in several interviews. According to the patients, the Capacity Note gave legitimacy to their situation by describing it so well, which made them understand

that their problems were normal and real. Also, getting the physician to really listen was perceived by patients as a benefit of using the Capacity Note. Informants noted that the Capacity Note could be a support for the patient in the conversation with the manager, which was described as an even more vulnerable situation. One informant however, questioned whether it would be enough support.

> I felt that… I'm not imagining. When I saw it on paper or like when I had ticked it […] you felt that it… it was really like this. […] And then I also think in front of others too, it was good to have this as a support […] that I knew that this is how it is and then I could sort of, uh… take it in a different way when others might think that, well… you are on sick leave. (Interview 5)

> If he [the boss] had sat with this note, he might have understood what I have been trying to tell him for six months. […] that what I have been saying all these months is actually true. […] Because when you do it with a doctor, there's another authority in the whole thing, unfortunately. (Interview 6)

Openness and timing

The role of openness and honesty between stakeholders

The issues of openness and honesty were also discussed, and the perspectives were contradictory. It was said that how much you want to disclose will differ from person to person and that the patient's agenda and how he/she perceives the purpose of the Capacity Note will affect his/her answers. On the other hand, it was also said that the Capacity Note could help the patients to be honest about their symptoms, work disabilities and needs when they saw that they were legitimate. The patients stressed that the Capacity Note helped them to more fully explain their situation to the GP, which was perceived as positive. In contrast,

the willingness to disclose the same information to the manager was described as depending on the manager's attitude. None of the patients had actually discussed it with their manager. To some, this was a relief, as they did not want to reveal their "shortcomings". Others said that they would have wanted the manager to see it, as they believed it would have increased the manager's (and the whole workplace's) understanding of what it was like to work with CMD.

One manager suggested that a form for communication between only physician and manager would lead to more honest communication about the patient/employee, as it can be difficult to be fully honest in front of the patient. Other participants suggested that a joint meeting with all three stakeholders would lead to a better common understanding of the situation as everyone hears what is said. It was suggested that the Capacity Note could serve as a basis for such a meeting.

> I might not have wanted to show it to him, the boss I had then, because it… it was too hard. […] It was just… that boss was not receptive to it. (Interview 3)

Uncertainty about the right timing

The participants expressed uncertainty about when would be the best time to use the Capacity Note. Generally, an early use was advocated—to map the situation and/or to stimulate return to work. But not too early, some said, as it might take focus off the medical aspects and the patient might not have enough energy or motivation yet to discuss return to work. For those that had partially returned to work when they used the Capacity Note it was perceived as less useful since they had already gained an understanding of their situation and work adjustments had already been discussed.

> There is much to go into at a first doctor's visit and sick leave, which may well be high on the patient's agenda but it… it must have a lower medical priority, we must first find out if the patient is about to die or… or has something that requires medicine… (Interview 8)

Time and efficiency

Time is essential for good communication and understanding

The issue of time was often discussed in the interviews, especially the lack of it. Patients expressed that the physicians' lack of time could cause feelings of stress and lead to thinking less before answering, and that the managers' lack of time (or interest) resulted in a limited discussion of the Capacity Note (the employee did not have a say, the manager just ticked the boxes) or in it not being used at all.

> I: How do you think it affected your conversation [with the doctor] to complete it?
> IF: Well… I was probably a little affected by the fact that there were so many 'yes'. […] Eh… at the same time we didn't have much time, I felt, to talk about it…
> […]
> I: If you had had more time, would you have wanted to discuss it more?
> IF: Mm, yes, I would have. (Interview 12)

Striving to be efficient

One GP had used the Capacity Note over the phone, after the consultation, and perceived it as lengthy (approx. 7-8 min) and not very useful. The other GP had used it several times within the consultation and described it as taking even longer (approx. 15-20 min) but worth the effort, due to the increased understanding it provided, as discussed above. The GPs' lack of

time was recognized by both patients and GPs and several suggestions and attempts to resolve it were described. For example, it was suggested that patients fill in the form alone or with other health care personnel before the doctor's visit. One patient filled it in by herself during the consultation, explicitly to save the GP's time. At the same time, participants recognized the benefits of discussing the Capacity Note together.

> Yes, I probably would have wanted to do it myself first, without her [the GP] sitting in the same room. … Because I was stressed, it's part of the disease sort of… (Interview 4)

> … if the patient had completed it at the beginning, before we met, I'm not sure but then… I think that maybe the sick leave assessment itself could have become a little sharper in less time, a bit… fewer questions and so on. On the other hand, it might not have been an equally open conversation, unconditional, but perhaps the conversation risks being mostly about the sick leave issue, perhaps. […] …you think about being able to work or not, rather than in what way I am sick and what suffering I'm actually experiencing and what we should do. (Interview 8)

DISCUSSION

In this study we presented the development of the Capacity Note and qualitatively examined how users (patients, GPs and managers) perceived and used it. Overall, the participants were pleased with the content and structure of the Capacity Note. An important perceived benefit of the Capacity Note was the ability to increase the users' understanding of the patient's situation, especially the patient's own understanding. This is an important finding because patients with CMD have expressed uncertainty about their condition and what can be expected regarding work participation,[10] as well as concerns about the legitimacy of being on

sick leave due to CMD.[13] The precise descriptions in the Capacity Note of how the patient's work capacity was affected represented one way to bring clarity. Putting words to this has been described as difficult by patients,[13] physicians,[27] and employers.[17] To think about the questions and finding the right words contributed to the patient's understanding and feelings of legitimacy and agency.[28] Moreover, the Capacity Note could help the GP describe the patient's cognitive functional limitations more clearly. This is equally important as the sickness certificate is the basis for the patient's entitlement to sickness benefits. The benefits of describing the specifics of the situation is also interesting in relation to the modern practice of focusing on abilities instead of disabilities in vocational rehabilitation.[29] One could assume that focusing on what the patient *can* do will increase the patient's motivation and agency. But by focusing only on abilities, the question of how to work with disabilities cannot be answered properly.[30 31] In line with this, we found that putting words to what the patient *cannot* do was the catalyst for further actions.

Having enough time was found to be important for good use of the Capacity Note, which is in line with previous research on work capacity assessments,[3] and collaboration.[32] Informants who experienced that they had given or been given the time to discuss the Capacity Note more in-depth more often stated that they had gained a better understanding of the situation and were the most positive about the Capacity Note.

GPs lack of time was described as being "the bottleneck" and suggestions for a more "effective" use were given. One was electronic information transfer, which physicians also have suggested in other studies.[33] As a working tool for professionals it might be the smoothest option, but confidentiality regulations can be a hindrance to implementation.[34] Despite the perceived lack of time, several suggestions for additional items in the Capacity Note were made. Also, joint meetings with all stakeholders were proposed as better for

achieving a common understanding, but these are indeed time consuming and hard to achieve.[32] On the whole, this suggest a tension between what you want to achieve and what is possible. The suggestions for streamlining should perhaps not be seen as ways to achieve an optimal tool but as ways to make the most of what you have got. There was a common understanding among the participants that understanding takes time and participants acknowledged that streamlining comes with a risk of losing the core of the Capacity Note—the discussion. It also raises the question of who is the primary owner and beneficiary of the Capacity Note. The stakeholders all had different needs. The professionals primarily wanted to receive information that would facilitate their job of managing the patient/employee's sick leave, something which can be achieved in many ways. The patients, on the other hand, seemed primarily to want understanding which requires more purposeful interaction.[13]

Openness and honesty were identified as necessary for good communication and understanding. The Capacity Note was perceived both as a potential help and hindrance for this, depending on how the patient perceived its purpose. The GP's traditional role as the patient's advocate was reflected in the patient's stories about how the Capacity Note helped them explain their situation to their GP. At the same time, there is a power balance,[35] where the patient is at a disadvantage in relation to both the physician (to get the sickness certificate) and the employer (to get adjustments, to keep position, etc.) which could affect the patient's answers. In relation to this, communication directly between GP and manager was suggested. However, confidentiality regulations prohibit the physician from sharing any information without the patient's consent.[19] Also, information transfer without involving the patient might not efficiently affect work resumption.[21] From the patients' point of view, being open and honest with the employer was more difficult and depended greatly on the employers' attitude. This is in line with previous research identifying support and mutual trust as important for the sick leave and return-to-work process.[35-37] In addition, stigma regarding mental health can

make employees reluctant to share health information with their employer.[11 38] Managers might be skeptical,[15] or lack sufficient knowledge,[39] of the causes and effects of CMD, which affects how they address it and support the employee.

The Capacity Note was perceived by the GPs and managers as most beneficial to inexperienced professionals, a finding also reported by Hoefsmit et al.[40] regarding their "conversation roadmap" for employers and employees. While the professionals in this study did not perceive that their understanding of the patient's situation increased, several patients felt that their GP understood them better after using the Capacity Note. The same was not said about the managers, most likely because the employee's health and work capacity (part 2 of the Capacity Note) were not discussed in those conversations, only work adjustments. The conversation between employee and manager about the employee's work capacity limitations was an important part of the Capacity Note and an aspect that has not, to our knowledge, been examined before. However, due to the lack of descriptions of such a conversation and its potential benefits and drawbacks, it was not possible to analyze further. This could be approached in future studies. For managers, the perceived usefulness of the Capacity Note was also limited by the fact that the suggested work adjustments were not always possible to execute.[41]

Participants were unsure about when would be the best time to use the Capacity Note. In general, an early use was considered desirable, which is in line with the intended use as well as national sick leave recommendations for patients with CMD. But readiness for returning back to work was also mentioned as important. This tension between recovery and return to work has been observed in several other studies and supports our finding that the timing of the intervention is important and must be considered for each patient individually.[28 36]

Methodological considerations

All interviews took place at a "neutral" place, and participants seemed to be at ease. PN performed all interviews, ensuring similar interviews for all participants. She was a medical doctor with work experience in Swedish primary care, and had been involved in the development of the Capacity Note and as a research assistant in the pilot study. This ensured a good understanding of the content and context of this study. PN also analysed the data. To reduce the risk of preconceptions influencing interpretation of data, the analysis was performed together with the second author (AJ) who had not taken any prior part in the project.

The main limitation of the study is the low number of participating GPs and managers. Recruitment of GPs proved difficult, presumably due to time constraints.[42] Managers were positive to participation but since only four patients had consented to us contacting their manager, only four managers could be contacted. A broader representation of GP and manager characteristics (for example in working experiences) might have led to greater variation in the findings. Also, a higher total number of participants may have added additional aspects to the results, as most participants had used the Capacity Note only once. The Capacity Note was meant to be used once for each patient during his/her sick leave process and therefore, patients and managers in the pilot study would naturally use it only once. GPs, on the other hand, could use it several times (with different patients).

We cannot rule out that those most positive to the Capacity Note participated while those less positive refrained participation. However, wanting to help research concerning mental health issues (regardless of opinion of the Capacity Note) was a commonly stated reason for participating. Recall bias may have occurred since the interviews took place up to nine months after using the Capacity Note. We also noted occasional bias regarding giving socially

desirable answers, for example following up a negative comment with a positive one. Some, but not all, participants were aware of the interviewer's central role in the project.

Conclusion

The participants considered the Capacity Note relevant and easy to use and as having the potential to improve communication about and understanding of the patient's situation. The increased understanding could contribute to a sense of legitimacy and agency in the patients. Achieving these positive effects required openness, an investment of time, and using the Capacity Note at the right time in the sick leave process.

DECLARATIONS

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Authors' contributions

PN was involved study design, data collection, data analysis and drafted the manuscript. AJ was involved in data analysis and critical revision of the manuscript. GH initiated the study and was involved in study design and critical revision of the manuscript. All authors read and approved the final version of the manuscript.

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Competing interests

The authors declare that they have no competing interests.

Consent for publication

Not required.

Ethics approval

The study was approved by the Regional Ethical Review Board in Gothenburg, Sweden (reference number 1115-17).

Availability of data

Data supporting the findings of this study are available from the corresponding author upon reasonable request.

FIGURE CAPTIONS

Figure 1. Example of the coding process.

Figure 2. A schematic presentation of the intended use (thick arrows) of the Capacity Note (CN) and the alternative ways it was used (thin arrows) by participants as described in the interviews.

Figure 3. Categories and subcategories.

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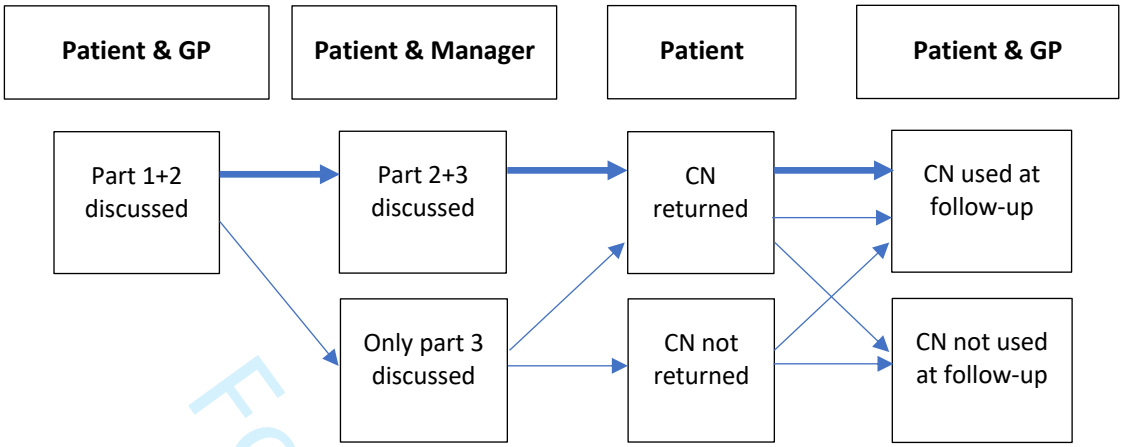
Meaning unit	Code	Subcategory
There were very clear questions that made me... well, yes it was a bit of an aha experience.	Eye opener	Contributing to one's own and others' understanding
Because he asked such questions then a... a conversation arose about this and then I thought he, yes... he understands.	The doctor understands	
It probably helped me a lot that I kind of understood and accepted [...] That way, eh... I was very receptive to all the help I could get.	Accept help	Understanding promotes action
Because part three... the one with... we should have done with the boss, it made me think that I can no continue as I have done but you have to do something because otherwise, I will end up there again.	Make decisions	
Yes, when you see it in black and white, and read it in black and white, all these things... then you realize that you are not unique and that you are not alone [...] you really have something.	Understand that it is normal	Legitimacy before oneself and others
...but if I tell a doctor that I am in pain and we together write down exactly what it is, then of course it weighs more than if I tell my boss that I am in pain.	Legitimacy towards the employer	



Content and format	Understanding, legitimacy and action	Openness and timing	Time and efficiency
Providing structure and content to the conversation	Contributing to one's own and others' understanding	The role of openness and honesty between stakeholders	Time is essential for good communication and understanding
Finding the right format	Understanding promotes action	Uncertainty about the right timing	Striving to be efficient
Putting words to the patient's situation	Legitimacy before oneself and others		

The Capacity Note

The capacity note describes how your current health affects your ability to work, and gives you the opportunity to discuss it with your employer to find a suitable way forward. It is intended to be used as follows:

1) Fill in parts 1 and 2 together with your doctor.
2) Bring the capacity note to your manager or supervisor. Together, you discuss what adjustments can be made in the workplace based on the health you have right now, and fill in this in part 3.
3) Send back the capacity note in the enclosed envelope. The capacity note is entered into your journal so you and your doctor can discuss your work situation at the next visit. Only part 1 will be used for research.

The project

The capacity note is part of the research project *Capacity Note – early and systematic communication between doctor, patient and employer*, a collaborative project between New Ways at the University of Gothenburg and Region Västra Götaland. Read more at https://www.gu.se/en/research/new-ways-mental-health-at-work.

Part 1 – Information about you and your work

Date:

Name: **Swedish social security number:**

Enter your profession/occupation (be as specific as possible):

Do you work full or part-time?

☐ Full-time (40 hrs/week) ☐ Part-time: ____%

Can overtime work occur?

☐ No ☐ Yes: _____hours per week

What are your working hours?

☐ Day time ☐ Irregular hours ☐ Shift work

What is your employment form?

☐ Permanent ☐ Temporary post ☐ Project position

☐ Self-employed

Other information about your work situation

☐ Management position ☐ Flexible work (able to adapt time and place)

☐ Other:

Part 2 – Information about how your health affects your capacity to work

Cross all the statements that apply to you and your situation right now.

Concentration and memory

Right now my capacity to work is affected because it is difficult to:

☐ concentrate, thoughts are 'slow'

☐ take in information

☐ learn new tasks at work

☐ remember (e.g. meeting times, how to do tasks at work)

☐ prioritize tasks at work

☐ get tasks started

☐ complete tasks

☐ perform complex tasks (i.e. tasks that are not standardised or routine)

☐ do several things at the same time ("keep several balls in the air")

☐ lead work, both my own and others' (i.e. have an overview, make decisions, delegate etc.)

☐ keep the ability to concentrate up for more than short moments

☐ keep a high tempo for more than short moments

☐ work under time pressure

☐ other:

Feelings

Right now my capacity to work is affected because it is difficult to:

☐ control emotions

☐ take criticism

☐ handle change

☐ feel engagement

☐ be creative

☐ other:

Body

Right now my capacity to work is affected by:

☐ weakness/loss of strength in the body

☐ tenderness or tension in the body

☐ I am easily disturbed by sound and visual impressions, I need to work separately

☐ other:

Social

Right now my capacity to work is affected because it is:

☐ stressful to interact with other people (e.g. colleagues, customers, students)

☐ stressful to participate in contexts where many people are gathered (e.g. meetings, coffee breaks)

☐ difficult to do my job when others are looking or listening

☐ other:

NOTE! Do any of these claims pose a risk to you or others in your work situation? (e.g. if you are driving a commercial vehicle or operating a dangerous machine)

If yes, state in what way:

Other possible difficulties:

Part 3 - How can your work be adapted?

Is it possible to:

Change tasks at work (e.g. ”routine tasks” instead of complex tasks, administrative tasks instead of customer contact)

☐ no ☐ yes

☐ yes, partially or temporarily (state how):

Change contacts with patients, students, customers etc. (e.g. fewer, shorter time)

☐ no ☐ yes

☐ yes, partially or temporarily (state how):

Change contacts with colleagues

☐ no ☐ yes

☐ yes, partially or temporarily (state how):

Reduce the number of internal meetings (e.g. workplace meeting, planning meeting)

☐ no ☐ yes

☐ yes, partially or temporarily (state how):

Take regular breaks

☐ no ☐ yes

☐ yes, partially or temporarily (state how):

Work with less intensity (e.g. fewer tasks, slower tempo)

☐ no ☐ yes

☐ yes, partially or temporarily (state how):

Work without overtime

☐ no ☐ yes

☐ yes, partially or temporarily (state how):

Reduce physical load (e.g. heavy lifts, twisted postures)

☐ no ☐ yes

☐ yes, partially or temporarily (state how):

Reduce time in front of computer screen

☐ no ☐ yes

☐ yes, partially or temporarily (state how):

Change sound or light environment

☐ no ☐ yes

☐ yes, partially or temporarily (state how):

Change workplace (e.g. room, place in room, from out to in or vice versa)

☐ no ☐ yes

☐ yes, partially or temporarily (state how):

Arrange for a temporary relocation

☐ no ☐ yes

Partial sick leave

Is it possible, in view of your duties and the adaptations that can be made, for you to work part-time (in combination with partial sick leave)?

If yes, specify degree of work:

☐ 10 - 25% ☐ 26 - 49% ☐ 50 - 75% ☐ 76 - 90%

Any other possibilities for adaptations:

COREQ (COnsolidated criteria for REporting Qualitative research) Checklist

A checklist of items that should be included in reports of qualitative research. You must report the page number in your manuscript where you consider each of the items listed in this checklist. If you have not included this information, either revise your manuscript accordingly before submitting or note N/A.

Topic	Item No.	Guide Questions/Description	Reported on Page No.
Domain 1: Research team and reflexivity			
Personal characteristics			
Interviewer/facilitator	1	Which author/s conducted the interview or focus group?	20
Credentials	2	What were the researcher's credentials? E.g. PhD, MD	20
Occupation	3	What was their occupation at the time of the study?	20
Gender	4	Was the researcher male or female?	20
Experience and training	5	What experience or training did the researcher have?	20
Relationship with participants			
Relationship established	6	Was a relationship established prior to study commencement?	20
Participant knowledge of the interviewer	7	What did the participants know about the researcher? e.g. personal goals, reasons for doing the research	20
Interviewer characteristics	8	What characteristics were reported about the inter viewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	20
Domain 2: Study design			
Theoretical framework			
Methodological orientation and Theory	9	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	9
Participant selection			
Sampling	10	How were participants selected? e.g. purposive, convenience, consecutive, snowball	7
Method of approach	11	How were participants approached? e.g. face-to-face, telephone, mail, email	7
Sample size	12	How many participants were in the study?	8
Non-participation	13	How many people refused to participate or dropped out? Reasons?	8
Setting			
Setting of data collection	14	Where was the data collected? e.g. home, clinic, workplace	8
Presence of non-participants	15	Was anyone else present besides the participants and researchers?	8
Description of sample	16	What are the important characteristics of the sample? e.g. demographic data, date	8
Data collection			
Interview guide	17	Were questions, prompts, guides provided by the authors? Was it pilot tested?	8-9
Repeat interviews	18	Were repeat inter views carried out? If yes, how many?	n/a
Audio/visual recording	19	Did the research use audio or visual recording to collect the data?	9
Field notes	20	Were field notes made during and/or after the inter view or focus group?	n/a
Duration	21	What was the duration of the inter views or focus group?	8
Data saturation	22	Was data saturation discussed?	n/a
Transcripts returned	23	Were transcripts returned to participants for comment and/or	-

Topic	Item No.	Guide Questions/Description	Reported on Page No.
		correction?	
Domain 3: analysis and findings			
Data analysis			
Number of data coders	24	How many data coders coded the data?	9
Description of the coding tree	25	Did authors provide a description of the coding tree?	9
Derivation of themes	26	Were themes identified in advance or derived from the data?	9
Software	27	What software, if applicable, was used to manage the data?	n/a
Participant checking	28	Did participants provide feedback on the findings?	-
Reporting			
Quotations presented	29	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? e.g. participant number	9-16
Data and findings consistent	30	Was there consistency between the data presented and the findings?	9-16
Clarity of major themes	31	Were major themes clearly presented in the findings?	9-16
Clarity of minor themes	32	Is there a description of diverse cases or discussion of minor themes?	9-16

Developed from: Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*. 2007. Volume 19, Number 6: pp. 349 – 357

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The capacity note - a communication facilitator in the sick leave process of patients with common mental disorders. A qualitative study of user perceptions

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The capacity note - a communication facilitator in the sick leave process of patients with common mental disorders. A qualitative study of user perceptions

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ABSTRACT

Objectives: To describe the development of a communication facilitator, the Capacity Note, for the sick leave process of patients with common mental disorders (CMD) in primary care, and to explore users' perceptions of it.

Design: Qualitive study.

Setting: Primary health care in Region Västra Götaland, Sweden.

Participants and methods: The Capacity Note was developed inductively based on data from six qualitative studies of work capacity and CMD and was introduced at primary health care centers during 2018–2019. Individual semi-structured interviews were performed with 13 informants (eight patients, two general practitioners and three managers) who had used the Capacity Note at least once. Interviews were audio-recorded and transcribed verbatim and inductive manifest qualitative content analysis was used to analyze the data.

Results: The Capacity Note comprised questions about work situation, work capacity limitations and possible work adjustments. Based on the interviews, four categories relating to its role as a facilitator for communication about work and health were identified: *Content and format, Understanding, legitimacy and action, Openness and timing,* and *Time and efficiency*. The participants considered the Capacity Note relevant and easy to use, and as having the potential to improve communication about and understanding of the patient's situation. The increased understanding was perceived as contributing to a sense of legitimacy and agency. Achieving these benefits required, according to the participants, openness, an investment of time and using the Capacity Note at the right time in the sick leave process.

Conclusion: The Capacity Note was found to be relevant and as having, under the right conditions, the potential to improve communication and facilitate the sick leave process.

STRENGTHS AND LIMITATIONS OF THIS STUDY

- This study describes a novel approach to stakeholder communication about work capacity in the sick leave process of patients with common mental disorders (CMD).
- It is considered a strength that the communication facilitator was developed based on stakeholders' own reports of work capacity and CMD.
- The results regarding user perceptions represent a limited experience of the communication facilitator. A higher number of participants, in particular general practitioners and managers, may have provided richer data and greater variation in the findings.

INTRODUCTION

A closer collaboration between stakeholders has been described as important for a good sick leave and return-to-work process but also as difficult to achieve.[1-5] This study qualitatively examined how patients, general practitioners (GPs) and managers perceived and used a communication facilitator, the Capacity Note, for the sick leave process of patients with common mental disorders (CMD).

There is today no golden standard for how to best achieve sustainable work participation for patients sick-listed with CMD.[6 7] In Sweden, these patients are generally treated in primary care where GPs are responsible for sickness certification when needed. To assess work capacity and need for sick leave and rehabilitation is a difficult task in general, and even more so in cases of CMD.[3 8 9] In these conditions, symptoms and associated work capacity and rehabilitation needs are highly individual and often unpredictable.[10-12] This makes guidelines and standard assessments less useful and calls for an increased recognition of the individual

and subjective parts of the assessment.[9 12-14] In addition, the work place must be considered which is yet another piece of information that is individual and difficult to assess.[8] GPs rarely communicate with employers—lack of time and disclosure concerns being commonly mentioned reasons—but have to rely on the patient's descriptions of what can be done at the work place.[3 15] The assessment is further complicated by the fact that the patients with CMD themselves find it difficult to grasp and describe their reduced work capacity.[10]

At the patient's work place, the manager is responsible for facilitating the employee's return to work, for example by providing work adjustment.[16] But managers too struggle with the vagueness of mental health problems and find it hard to identify, describe and deal with them.[15 17 18] In Sweden, due to confidentiality laws, employees do not have to disclose any diagnosis to the manager, only the effects of the diagnosis on functioning (e.g. difficulties concentrating) and how that affects their capacity to work (e.g. they cannot learn new tasks).[19] Such information should be stated in the sickness certificate but is often limited, especially statements about work capacity.[20] Moreover, with their medical focus, sickness certificates can be hard to interpret for managers. Consequently, with restricted knowledge of the patient's specific problems, individualized adjustments can be hard to accomplish.

Increased communication in the sick leave process has been approached in different ways, for example information exchange between health professionals,[21] structured conversations between employer and employee,[22] and a guide for patients' discussions with various stakeholders.[23] Our focus was to promote communication about health and work among the three key stakeholders: patient, GP, and manager. For this purpose, we developed a communication facilitator – the Capacity Note. The idea was to have the patient as the main informant and the Capacity Note as a transmitter of written information between physician and manager. The intent was to increase the manager's understanding of reduced capacity to

work from the medical perspective, and the physician's understanding of possible measures to adjust the work environment from the workplace perspective. The aims of this study were to describe the development of the Capacity Note and to qualitatively examine how the stakeholders perceived its content, format and use.

METHODS

Development of the Capacity Note

The Capacity Note was developed based on data from six qualitative studies examining work capacity and CMD: three studies with individuals having personal experiences of CMD and work,[10 11 24] two studies with physicians and other health care professionals,[14 25] and one literature review.[3] Data relevant to the purpose of the Capacity Note was identified inductively in the results sections of each of the six articles and condensed into items. The items were compared across the six sources and grouped into content areas. Then, considering the short consultation times in primary health care, a selection of representative items from each content area were chosen. Based on the selected items, questions about work situation, work capacity and corresponding work adjustments were formulated. The draft was discussed at a seminar with researchers from different fields such as medicine, occupational therapy, physiotherapy and public health. This prompted some minor revisions, after which it was completed. Characteristics of the six studies that provided data to the Capacity Note and examples of their contributions are presented in Table 1.

Table 1. Characteristics of the six studies that provided data to the development of the Capacity Note, and examples of their contributions.

Author and year of publication	Aim	Study design and method for analysis	Informants	Number of identified items	Example of identified data	Item	Corresponding question in the Capacity Note
Bertilsson et al (2013)	Explore experiences of work capacity in persons working while depressed and anxious to identify the essence of the phenomenon 'capacity to work'	Phenomenological, Focus groups	Persons working at least part-time with diagnosed or self-reported depression, anxiety or exhaustion (n=17)	34	"Interpersonal encounters were described by the participants as the most demanding type of work task." (p.1707)	Interaction with other people	Right now my capacity to work is affected because it is stressful to interact with other people (e.g. pupils, colleagues, customers) (Tick box if agree)
Bertilsson et al (2015)	To explore health care professionals' experience-based understanding of work capacity in individuals with depression and anxiety disorders	Focus groups, Inductive content analysis	Health care professionals from occupational, psychiatric, and primary health care with experience of treating patients with common mental disorders (n=21)	26	"Capacity to work was described in patient-narratives as being affected by changed and more sensitive perceptions of sensory input such as vision and hearing." (p. 129)	Sensitive to sensory input	Right now my capacity to work is affected because I am easily disturbed by sound and visual impressions, I need to work separately (Tick box if agree)
Bertilsson et al (2018)	To explore physicians' tacit knowledge of their assessment of work capacity in patients with depression and anxiety disorders	Video vignettes and open-ended interviews, Inductive content analysis	Physicians specialized in general practice, occupational health or psychiatry with experience of treating patients with common mental disorders (n=24)	45	"An important dimension was to assess whether the decreased work capacity could lead to failures or accidents at work..." (p.8)	Risks	Do any of these claims pose a risk to you or others in your work situation? (e.g. driving a commercial vehicle, operating a dangerous machine) (If yes, state in what way)
Danielsson et al (2017)	To explore experiences of work instability in workers with common mental disorders	Grounded theory, Individual interviews	Employed persons with current diagnosed or self-reported common mental disorder (n=27)	29	"The participants described feeling estranged, tense, exhausted and weakened." (p.6)	Physical weakness	Right now my capacity to work is affected by weakness/ loss of strength in the body (Tick box if agree)
Danielsson et al (2017)	To explore workers' strategies to keep working while affected by common mental disorders	Grounded theory, Individual interviews	Employed persons with current diagnosed or self-reported common mental disorder (n=27)	14	"The participants tried to compensate for negative changes [...] It could mean taking on more simple tasks to compensate for a lack of concentration and creativity." (p.6)	Loss of creativity	Right now my capacity to work is affected because it is difficult to be creative (Tick box if agree)
Nordling et al (2020)	Synthesize existing research on what and how physicians do when they assess work capacity	Systematic literature review, Thematic synthesis of qualitative data	Qualitative studies describing physicians' practices when assessing work capacity as part of sickness certification (n=12)	8	"Questions about work tasks and demands could include aspects such as heavy lifting, opportunity to take a break or adjust work pace." (p.8)	Possibility to take breaks	Is it possible to take regular breaks? (Yes/No/Yes partly)

Study design

A qualitative study design with individual interviews was chosen as appropriate to examine the users' perceptions of the Capacity Note. Participation was based on informed consent and participants were informed that they could withdraw at any time. No incentives for participation were offered.

Setting and participants

The Capacity Note was used at eight public and private primary health care centers (PCCs) in the southwest part of Sweden in 2018 and 2019 as part of a pilot study focusing on patients' agency and sick leave during follow-up (data not presented in this study). In the pilot study, the Capacity Note was used by 28 patients, 14 GPs and, as far as we know, 12 managers.

Participants in this study were a convenience sample recruited from the pilot study based on the following inclusion criteria: *patients* must have used the Capacity Note with their physician no more than nine months previously and agreed to be contacted about the interview study; *GPs* must have used the Capacity Note with at least one patient no more than nine months previously; *managers* must have used the Capacity Note with at least one employee no more than nine months previously and the employee must have agreed to their participation.

The 15 patients that filled the inclusion criteria were contacted in a random order via telephone. If interest was shown, written information and a consent form were sent by mail. Eight patients agreed to participate. Lack of time or energy were the most common reasons for not participating. Ten GPs met the inclusion criteria. For one of them, we could not

retrieve the correct contact information. The remaining nine GPs were invited to participate in the study via their work email. Two GPs agreed to participate, two declined due to lack of time and five did not reply to the invitation or the two reminders. Of the 15 eligible patients, four had agreed to let their manager participate. These four managers were contacted by telephone (n=3) or work email (n=1) and they all agreed to participate. One of them fell ill at the time of the interview and could not reschedule, leaving a final sample of three managers. The characteristics of participants are presented in Table 2.

Table 2. Characteristics of participants.

	Patients n=8	GPs n=2	Managers n=3	Total n=13
Gender				
Female	7	0	3	10
Male	1	2	0	3
Age				
Range (mean)	27-58 (44)	44 (44)	38-68 (54)	27-68 (45)
Type of occupation				
Skilled	3			
Unskilled	5			
Years of experience as GP/manager		7-10	2-40 (2)	
Range (median)				
Geographic setting (workplace)				
Urban	1	1	1	3
Rural	7	1	2	10
Number of employees				
Range (mean)			10-74 (36)	

Months since used Capacity Note Range (mean)	1-9 (4)	1-7 (4)	4-7 (5)	1-9 (4)
Number of times having used the Capacity Note Range	1	1-4	1	1-4

Data collection and analysis

Thirteen individual interviews were conducted by the first author (PN) during June–December 2019. Interviews took place in a conference room at a hotel or research center, or at the participant's work place if preferred, and lasted 18-58 min (mean 31 min). The interview guide was semi-structured and contained questions regarding the content, use and usefulness of the Capacity Note. All interviews were audio-recorded and transcribed verbatim. Data was analyzed using manifest qualitative content analysis.[26] This method was found suitable as most participants had experienced the Capacity Note only once and we sought to explore how they perceived it during this use, i.e. their first impression rather than more far reaching (lived) experiences. When all the interviews had been transcribed, PN and AJ independently read the first three transcripts, first to get an overview, then line-by-line to identify meaning units. The findings were compared to ensure that they related to the research questions and that nothing relevant had been missed. At this stage, preliminary codes could be formulated but the main focus was on identifying meaning units. Then, the same procedure was applied for the remaining transcripts, three or four at a time. When all transcripts had been discussed, the authors jointly coded all meaning units. Then, similar codes were grouped into categories and related categories were grouped into higher order categories. An example of the coding process is found in Figure 1. Codes and categories were rearranged several times to until no

new subcategories or categories were identified. The preliminary results were presented at a seminar with external researchers which prompted a further revision of the categories into the final results.

Patient and public involvement

There was no involvement of patients/public in the design or conduct of this study.

RESULTS

The Capacity Note comprised three parts with questions about work situation, work capacity limitations and possible work adjustments, respectively. It is presented in full in Appendix 1. The Capacity Note was meant to be used once for each patient during his/her sick leave process, but at two separate occasions: first a discussion between patient and GP, and then a discussion between patient/employee and employer. A schematic presentation of the intended use, and the actual use (as described in the interviews), is presented in Figure 2.

We identified four categories relating to the role of the Capacity Note as a facilitator for communication about work and health: Content and format, Understanding, legitimacy and action, Openness and timing, and Time and efficiency (Figure 3). Each is presented below, with corresponding subcategories. The categories and subcategories represent the participants' joint perceptions of the Capacity Note as generated from the data. Within each category different perspectives and nuances were found and these are also presented.

Content and format

Providing structure and content to the conversation

The participants agreed that the Capacity Note was clear, well-structured and easy to use. The content was considered relevant and, according to one participant, "comprehensive but not too much to handle". As such, the Capacity Note was thought to provide a good starting point and framework for a discussion about health and work. The informants also stated that it had the potential to extend and deepen the dialog by giving examples that had to be considered; these might not have been discussed otherwise but would now be elaborated and could take the discussion further. The structure was experienced as making it easy to see what one had missed, but also as a potential risk—that other potentially important issues were overlooked. The professionals (GPs and managers) suggested that the Capacity Note was of greatest benefit to GPs and managers with little previous experience of sick-listed patients/employees with CMD, while for more experienced professionals it was perceived as not providing any knew knowledge.

Some suggestions for further content were made: additional physical symptoms (e.g. heart palpitations, shortness of breath), how the health situation affects private life, how private life affects the capacity to work, a more detailed description of the work environment (including psychosocial factors), specific situations that trigger or worsen the symptoms and other available resources (e.g. support from occupational health services).

The presented suggestions for work adjustments were considered relevant but, depending on the type of job, not always possible to implement.

> I believe it resulted in a deeper conversation. […] Because in some way you had something to relate to, not just my notes but this was slightly more… here you had a few more examples… some structure. (Interview 11)

Finding the right format

Participants expressed disparate views on the best format for the Capacity Note. The paper format was questioned by the two participating physicians; an electronic form was suggested as a smoother and more dynamic alternative, preferably connected to the sickness certificate and one where all three stakeholders could add and update information continuously. Patients appreciated seeing things "black on white". Informants also mentioned that using the Capacity Note over the telephone was less suitable as it made the conversation more static.

> I think it was great, what's annoying… was annoying was, uh… the paper format. (Interview 7)

Putting words to the patient's situation

Patients said that the specific wordings in the Capacity Note were helpful for putting words to what they experienced, and that this was a relief. Similarly, the physicians said that the Capacity Note could facilitate the difficult task of describing the patient's cognitive functional limitations in the sickness certificate.

> …it became clearer, partly for me and that I could put it into words [to the doctor] … which I couldn't before but when I got them [the words] here… it was, well, that's exactly how it is. (Interview 1)

Understanding, legitimacy and action

Contributing to one's own and others' understanding

According to informants, the patient's own understanding of his/her situation could improve when reflecting upon the questions in the Capacity Note. One patient described it as an "aha-experience". This, according to one GP, made it easier for the GP to explain things to the patient. It was also said that using the Capacity Note could add to the GP's understanding of

the patient's situation, and that this was depending on how much had been discussed at previous consultations. One manager stated that discussing the suggested work adjustments could help the patient see what the manager was already doing to improve the work situation.

None of the participating managers had discussed part 2 of the Capacity Note with their employee, i.e. the part which describes the work capacity limitations. The managers agreed that it could have increased their understanding of the patient as a person but were uncertain whether it would have affected the discussion about and execution of work adjustments.

> …possibly I would say that the advantage of the form for… from the employee's point of view, I noticed, may be that he, she gets a, eh… what should we call it… a little eye-opener about his, her situation at work. (Interview 11)

Understanding promotes action

Some informants stated that when the patients understood their situation better, it helped them to choose strategies and make decisions, such as accepting the interventions offered by the health care or adopt new strategies at work. The impact on physicians' and employers' actions was less evident but one participant felt it had facilitated team work at the PCC.

> …I think it motivated the patients to, eh… take their… interventions that we recommend, like therapy, like taking their medications […] … and some of the patients also noticed that they did not take breaks normally and now they have begun… (Interview 7)

Legitimacy before oneself and others

Legitimacy was touched upon in several interviews. According to the patients, the Capacity Note gave legitimacy to their situation by describing it so well, which made them understand

that their problems were normal and real. Also, getting the physician to really listen was perceived by patients as a benefit of using the Capacity Note. Informants noted that the Capacity Note could be a support for the patient in the conversation with the manager, which was described as an even more vulnerable situation. One informant however, questioned whether it would be enough support.

> I felt that… I'm not imagining. When I saw it on paper or like when I had ticked it […] you felt that it… it was really like this. […] And then I also think in front of others too, it was good to have this as a support […] that I knew that this is how it is and then I could sort of, uh… take it in a different way when others might think that, well… you are on sick leave. (Interview 5)

> If he [the boss] had sat with this note, he might have understood what I have been trying to tell him for six months. […] that what I have been saying all these months is actually true. […] Because when you do it with a doctor, there's another authority in the whole thing, unfortunately. (Interview 6)

Openness and timing

The role of openness and honesty between stakeholders

The issues of openness and honesty were also discussed, and the perspectives were contradictory. It was said that how much you want to disclose will differ from person to person and that the patient's agenda and how he/she perceives the purpose of the Capacity Note will affect his/her answers. On the other hand, it was also said that the Capacity Note could help the patients to be honest about their symptoms, work disabilities and needs when they saw that they were legitimate. The patients stressed that the Capacity Note helped them to more fully explain their situation to the GP, which was perceived as positive. In contrast,

the willingness to disclose the same information to the manager was described as depending on the manager's attitude. None of the patients had actually discussed it with their manager. To some, this was a relief, as they did not want to reveal their "shortcomings". Others said that they would have wanted the manager to see it, as they believed it would have increased the manager's (and the whole workplace's) understanding of what it was like to work with CMD.

One manager suggested that a form for communication between only physician and manager would lead to more honest communication about the patient/employee, as it can be difficult to be fully honest in front of the patient. Other participants suggested that a joint meeting with all three stakeholders would lead to a better common understanding of the situation as everyone hears what is said. It was suggested that the Capacity Note could serve as a basis for such a meeting.

> I might not have wanted to show it to him, the boss I had then, because it… it was too hard. […] It was just… that boss was not receptive to it. (Interview 3)

Uncertainty about the right timing

The participants expressed uncertainty about when would be the best time to use the Capacity Note. Generally, an early use was advocated—to map the situation and/or to stimulate return to work. But not too early, some said, as it might take focus off the medical aspects and the patient might not have enough energy or motivation yet to discuss return to work. For those that had partially returned to work when they used the Capacity Note it was perceived as less useful since they had already gained an understanding of their situation and work adjustments had already been discussed.

> There is much to go into at a first doctor's visit and sick leave, which may well be high on the patient's agenda but it… it must have a lower medical priority, we must first find out if the patient is about to die or… or has something that requires medicine… (Interview 8)

Time and efficiency

Time is essential for good communication and understanding

The issue of time was often discussed in the interviews, especially the lack of it. Patients expressed that the physicians' lack of time could cause feelings of stress and lead to thinking less before answering, and that the managers' lack of time (or interest) resulted in a limited discussion of the Capacity Note (the employee did not have a say, the manager just ticked the boxes) or in it not being used at all.

> I: How do you think it affected your conversation [with the doctor] to complete it?
> IF: Well… I was probably a little affected by the fact that there were so many 'yes'. […] Eh… at the same time we didn't have much time, I felt, to talk about it…
> […]
> I: If you had had more time, would you have wanted to discuss it more?
> IF: Mm, yes, I would have. (Interview 12)

Striving to be efficient

One GP had used the Capacity Note over the phone, after the consultation, and perceived it as lengthy (approx. 7-8 min) and not very useful. The other GP had used it several times within the consultation and described it as taking even longer (approx. 15-20 min) but worth the effort, due to the increased understanding it provided, as discussed above. The GPs' lack of

time was recognized by both patients and GPs and several suggestions and attempts to resolve it were described. For example, it was suggested that patients fill in the form alone or with other health care personnel before the doctor's visit. One patient filled it in by herself during the consultation, explicitly to save the GP's time. At the same time, participants recognized the benefits of discussing the Capacity Note together.

> Yes, I probably would have wanted to do it myself first, without her [the GP] sitting in the same room. … Because I was stressed, it's part of the disease sort of… (Interview 4)

> … if the patient had completed it at the beginning, before we met, I'm not sure but then… I think that maybe the sick leave assessment itself could have become a little sharper in less time, a bit… fewer questions and so on. On the other hand, it might not have been an equally open conversation, unconditional, but perhaps the conversation risks being mostly about the sick leave issue, perhaps. […] …you think about being able to work or not, rather than in what way I am sick and what suffering I'm actually experiencing and what we should do. (Interview 8)

DISCUSSION

In this study we presented the development of the Capacity Note and qualitatively examined how users (patients, GPs and managers) perceived and used it. Overall, the participants were pleased with the content and structure of the Capacity Note. An important perceived benefit of the Capacity Note was the ability to increase the users' understanding of the patient's situation, especially the patient's own understanding. This is an important finding because patients with CMD have expressed uncertainty about their condition and what can be expected regarding work participation,[10] as well as concerns about the legitimacy of being on

sick leave due to CMD.[13] The precise descriptions in the Capacity Note of how the patient's work capacity was affected represented one way to bring clarity. Putting words to this has been described as difficult by patients,[13] physicians,[27] and employers.[17] To think about the questions and finding the right words contributed to the patient's understanding and feelings of legitimacy and agency.[28] Moreover, the Capacity Note could help the GP describe the patient's cognitive functional limitations more clearly. This is equally important as the sickness certificate is the basis for the patient's entitlement to sickness benefits. The benefits of describing the specifics of the situation is also interesting in relation to the modern practice of focusing on abilities instead of disabilities in vocational rehabilitation.[29] One could assume that focusing on what the patient *can* do will increase the patient's motivation and agency. But by focusing only on abilities, the question of how to work with disabilities cannot be answered properly.[30 31] In line with this, we found that putting words to what the patient *cannot* do was the catalyst for further actions.

Having enough time was found to be important for good use of the Capacity Note, which is in line with previous research on work capacity assessments,[3] and collaboration.[32] Informants who experienced that they had given or been given the time to discuss the Capacity Note more in-depth more often stated that they had gained a better understanding of the situation and were the most positive about the Capacity Note.

GPs lack of time was described as being "the bottleneck" and suggestions for a more "effective" use were given. One was electronic information transfer, which physicians also have suggested in other studies.[33] As a working tool for professionals it might be the smoothest option, but confidentiality regulations can be a hindrance to implementation.[34] Despite the perceived lack of time, several suggestions for additional items in the Capacity Note were made. Also, joint meetings with all stakeholders were proposed as better for

achieving a common understanding, but these are indeed time consuming and hard to achieve.[32] On the whole, this suggest a tension between what you want to achieve and what is possible. The suggestions for streamlining should perhaps not be seen as ways to achieve an optimal tool but as ways to make the most of what you have got. There was a common understanding among the participants that understanding takes time and participants acknowledged that streamlining comes with a risk of losing the core of the Capacity Note—the discussion. It also raises the question of who is the primary owner and beneficiary of the Capacity Note. The stakeholders all had different needs. The professionals primarily wanted to receive information that would facilitate their job of managing the patient/employee's sick leave, something which can be achieved in many ways. The patients, on the other hand, seemed primarily to want understanding which requires more purposeful interaction.[13]

Openness and honesty were identified as necessary for good communication and understanding. The Capacity Note was perceived both as a potential help and hindrance for this, depending on how the patient perceived its purpose. The GP's traditional role as the patient's advocate was reflected in the patient's stories about how the Capacity Note helped them explain their situation to their GP. At the same time, there is a power balance,[35] where the patient is at a disadvantage in relation to both the physician (to get the sickness certificate) and the employer (to get adjustments, to keep position, etc.) which could affect the patient's answers. In relation to this, communication directly between GP and manager was suggested. However, confidentiality regulations prohibit the physician from sharing any information without the patient's consent.[19] Also, information transfer without involving the patient might not efficiently affect work resumption.[21] From the patients' point of view, being open and honest with the employer was more difficult and depended greatly on the employers' attitude. This is in line with previous research identifying support and mutual trust as important for the sick leave and return-to-work process.[35-37] In addition, stigma regarding mental health can

make employees reluctant to share health information with their employer.[11 38] Managers might be skeptical,[15] or lack sufficient knowledge,[39] of the causes and effects of CMD, which affects how they address it and support the employee.

The Capacity Note was perceived by the GPs and managers as most beneficial to inexperienced professionals, a finding also reported by Hoefsmit et al.[40] regarding their "conversation roadmap" for employers and employees. While the professionals in this study did not perceive that their understanding of the patient's situation increased, several patients felt that their GP understood them better after using the Capacity Note. The same was not said about the managers, most likely because the employee's health and work capacity (part 2 of the Capacity Note) were not discussed in those conversations, only work adjustments. The conversation between employee and manager about the employee's work capacity limitations was an important part of the Capacity Note and an aspect that has not, to our knowledge, been examined before. However, due to the lack of descriptions of such a conversation and its potential benefits and drawbacks, it was not possible to analyze further. This could be approached in future studies. For managers, the perceived usefulness of the Capacity Note was also limited by the fact that the suggested work adjustments were not always possible to execute.[41]

Participants were unsure about when would be the best time to use the Capacity Note. In general, an early use was considered desirable, which is in line with the intended use as well as national sick leave recommendations for patients with CMD. But readiness for returning back to work was also mentioned as important. This tension between recovery and return to work has been observed in several other studies and supports our finding that the timing of the intervention is important and must be considered for each patient individually.[28 36]

To sum up, this study focused on participants' perceptions of the Capacity Note and the results showed that there may be important benefits from using it but there are also barriers to its use and the proposed benefits. The results from the pilot study, in which the Capacity Note was used and from which the participants in the current study were recruited, will provide further information about the feasibility of the intervention.

Methodological considerations

All interviews took place at a "neutral" place, and participants seemed to be at ease. PN performed all interviews, ensuring similar interviews for all participants. She was a medical doctor with work experience in Swedish primary care, and had been involved in the development of the Capacity Note and as a research assistant in the pilot study. This ensured a good understanding of the content and context of this study. PN also analysed the data. To reduce the risk of preconceptions influencing interpretation of data, the analysis was performed together with the second author (AJ) who had not taken any prior part in the project.

The main limitation of the study is the low number of participating GPs and managers. Recruitment of GPs proved difficult, presumably due to time constraints.[42] Managers were positive to participation but since only four patients had consented to us contacting their manager, only four managers could be contacted. A broader representation of GP and manager characteristics (for example in working experiences) might have led to greater variation in the findings. Also, a higher total number of participants may have added additional aspects to the results, as most participants had used the Capacity Note only once. The Capacity Note was meant to be used once for each patient during his/her sick leave process and therefore, patients and managers in the pilot study would naturally use it only once. GPs, on the other hand, could use it several times (with different patients).

We cannot rule out that those most positive to the Capacity Note participated while those less positive refrained participation. However, wanting to help research concerning mental health issues (regardless of opinion of the Capacity Note) was a commonly stated reason for participating. Recall bias may have occurred since the interviews took place up to nine months after using the Capacity Note. We also noted occasional bias regarding giving socially desirable answers, for example following up a negative comment with a positive one. Some, but not all, participants were aware of the interviewer's central role in the project.

Conclusion

The participants considered the Capacity Note relevant and easy to use and as having the potential to improve communication about and understanding of the patient's situation. The increased understanding could contribute to a sense of legitimacy and agency in the patients. Achieving these positive effects required openness, an investment of time, and using the Capacity Note at the right time in the sick leave process.

DECLARATIONS

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Authors' contributions

PN was involved study design, data collection, data analysis and drafted the manuscript. AJ was involved in data analysis and critical revision of the manuscript. GH initiated the study and was involved in study design and critical revision of the manuscript. All authors read and approved the final version of the manuscript.

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Competing interests

The authors declare that they have no competing interests.

Consent for publication

Not required.

Ethics approval

The study was approved by the Regional Ethical Review Board in Gothenburg, Sweden (reference number 1115-17).

Availability of data

Data supporting the findings of this study are available from the corresponding author upon reasonable request.

FIGURE CAPTIONS

Figure 1. Example of the coding process.

Figure 2. A schematic presentation of the intended use (thick arrows) of the Capacity Note (CN) and the alternative ways it was used (thin arrows) by participants as described in the interviews.

Figure 3. Categories and subcategories.

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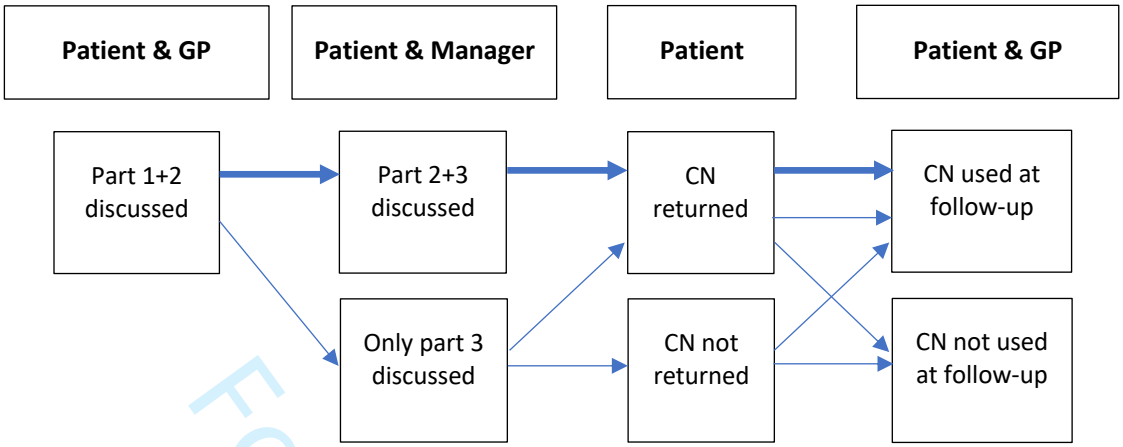
Meaning unit	Code	Subcategory
There were very clear questions that made me... well, yes it was a bit of an aha experience.	Eye opener	Contributing to one's own and others' understanding
Because he asked such questions then a... a conversation arose about this and then I thought he, yes... he understands.	The doctor understands	
It probably helped me a lot that I kind of understood and accepted [...] That way, eh... I was very receptive to all the help I could get.	Accept help	Understanding promotes action
Because part three... the one with... we should have done with the boss, it made me think that I can no continue as I have done but you have to do something because otherwise, I will end up there again.	Make decisions	
Yes, when you see it in black and white, and read it in black and white, all these things... then you realize that you are not unique and that you are not alone [...] you really have something.	Understand that it is normal	Legitimacy before oneself and others
...but if I tell a doctor that I am in pain and we together write down exactly what it is, then of course it weighs more than if I tell my boss that I am in pain.	Legitimacy towards the employer	



Content and format	Understanding, legitimacy and action	Openness and timing	Time and efficiency
Providing structure and content to the conversation	Contributing to one's own and others' understanding	The role of openness and honesty between stakeholders	Time is essential for good communication and understanding
Finding the right format	Understanding promotes action	Uncertainty about the right timing	Striving to be efficient
Putting words to the patient's situation	Legitimacy before oneself and others		

The Capacity Note

The capacity note describes how your current health affects your ability to work, and gives you the opportunity to discuss it with your employer to find a suitable way forward. It is intended to be used as follows:

1) Fill in parts 1 and 2 together with your doctor.
2) Bring the capacity note to your manager or supervisor. Together, you discuss what adjustments can be made in the workplace based on the health you have right now, and fill in this in part 3.
3) Send back the capacity note in the enclosed envelope. The capacity note is entered into your journal so you and your doctor can discuss your work situation at the next visit. Only part 1 will be used for research.

The project

The capacity note is part of the research project *Capacity Note – early and systematic communication between doctor, patient and employer*, a collaborative project between New Ways at the University of Gothenburg and Region Västra Götaland. Read more at https://www.gu.se/en/research/new-ways-mental-health-at-work.

Part 1 – Information about you and your work

Date:

Name: **Swedish social security number:**

Enter your profession/occupation (be as specific as possible):

Do you work full or part-time?

☐ Full-time (40 hrs/week) ☐ Part-time: ____%

Can overtime work occur?

☐ No ☐ Yes: _____hours per week

What are your working hours?

☐ Day time ☐ Irregular hours ☐ Shift work

What is your employment form?

☐ Permanent ☐ Temporary post ☐ Project position

☐ Self-employed

Other information about your work situation

☐ Management position ☐ Flexible work (able to adapt time and place)

☐ Other:

Part 2 – Information about how your health affects your capacity to work

Cross all the statements that apply to you and your situation right now.

Concentration and memory

Right now my capacity to work is affected because it is difficult to:

☐ concentrate, thoughts are 'slow'

☐ take in information

☐ learn new tasks at work

☐ remember (e.g. meeting times, how to do tasks at work)

☐ prioritize tasks at work

☐ get tasks started

☐ complete tasks

☐ perform complex tasks (i.e. tasks that are not standardised or routine)

☐ do several things at the same time ("keep several balls in the air")

☐ lead work, both my own and others' (i.e. have an overview, make decisions, delegate etc.)

☐ keep the ability to concentrate up for more than short moments

☐ keep a high tempo for more than short moments

☐ work under time pressure

☐ other:

Feelings

Right now my capacity to work is affected because it is difficult to:

☐ control emotions

☐ take criticism

☐ handle change

☐ feel engagement

☐ be creative

☐ other:

Body

Right now my capacity to work is affected by:

☐ weakness/loss of strength in the body

☐ tenderness or tension in the body

☐ I am easily disturbed by sound and visual impressions, I need to work separately

☐ other:

Social

Right now my capacity to work is affected because it is:

☐ stressful to interact with other people (e.g. colleagues, customers, students)

☐ stressful to participate in contexts where many people are gathered (e.g. meetings, coffee breaks)

☐ difficult to do my job when others are looking or listening

☐ other:

NOTE! Do any of these claims pose a risk to you or others in your work situation? (e.g. if you are driving a commercial vehicle or operating a dangerous machine)

If yes, state in what way:

Other possible difficulties:

Part 3 - How can your work be adapted?

Is it possible to:

Change tasks at work (e.g. ”routine tasks” instead of complex tasks, administrative tasks instead of customer contact)

☐ no ☐ yes

☐ yes, partially or temporarily (state how):

Change contacts with patients, students, customers etc. (e.g. fewer, shorter time)

☐ no ☐ yes

☐ yes, partially or temporarily (state how):

Change contacts with colleagues

☐ no ☐ yes

☐ yes, partially or temporarily (state how):

Reduce the number of internal meetings (e.g. workplace meeting, planning meeting)

☐ no ☐ yes

☐ yes, partially or temporarily (state how):

Take regular breaks

☐ no ☐ yes

☐ yes, partially or temporarily (state how):

Work with less intensity (e.g. fewer tasks, slower tempo)

☐ no ☐ yes

☐ yes, partially or temporarily (state how):

Work without overtime

☐ no ☐ yes

☐ yes, partially or temporarily (state how):

Reduce physical load (e.g. heavy lifts, twisted postures)

☐ no ☐ yes

☐ yes, partially or temporarily (state how):

Reduce time in front of computer screen

☐ no ☐ yes

☐ yes, partially or temporarily (state how):

Change sound or light environment

☐ no ☐ yes

☐ yes, partially or temporarily (state how):

Change workplace (e.g. room, place in room, from out to in or vice versa)

☐ no ☐ yes

☐ yes, partially or temporarily (state how):

Arrange for a temporary relocation

☐ no ☐ yes

Partial sick leave

Is it possible, in view of your duties and the adaptations that can be made, for you to work part-time (in combination with partial sick leave)?

If yes, specify degree of work:

☐ 10 - 25% ☐ 26 - 49% ☐ 50 - 75% ☐ 76 - 90%

Any other possibilities for adaptations:

COREQ (COnsolidated criteria for REporting Qualitative research) Checklist

A checklist of items that should be included in reports of qualitative research. You must report the page number in your manuscript where you consider each of the items listed in this checklist. If you have not included this information, either revise your manuscript accordingly before submitting or note N/A.

Topic	Item No.	Guide Questions/Description	Reported on Page No.
Domain 1: Research team and reflexivity			
Personal characteristics			
Interviewer/facilitator	1	Which author/s conducted the interview or focus group?	20
Credentials	2	What were the researcher's credentials? E.g. PhD, MD	20
Occupation	3	What was their occupation at the time of the study?	20
Gender	4	Was the researcher male or female?	20
Experience and training	5	What experience or training did the researcher have?	20
Relationship with participants			
Relationship established	6	Was a relationship established prior to study commencement?	20
Participant knowledge of the interviewer	7	What did the participants know about the researcher? e.g. personal goals, reasons for doing the research	20
Interviewer characteristics	8	What characteristics were reported about the inter viewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	20
Domain 2: Study design			
Theoretical framework			
Methodological orientation and Theory	9	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	9
Participant selection			
Sampling	10	How were participants selected? e.g. purposive, convenience, consecutive, snowball	7
Method of approach	11	How were participants approached? e.g. face-to-face, telephone, mail, email	7
Sample size	12	How many participants were in the study?	8
Non-participation	13	How many people refused to participate or dropped out? Reasons?	8
Setting			
Setting of data collection	14	Where was the data collected? e.g. home, clinic, workplace	8
Presence of non-participants	15	Was anyone else present besides the participants and researchers?	8
Description of sample	16	What are the important characteristics of the sample? e.g. demographic data, date	8
Data collection			
Interview guide	17	Were questions, prompts, guides provided by the authors? Was it pilot tested?	8-9
Repeat interviews	18	Were repeat inter views carried out? If yes, how many?	n/a
Audio/visual recording	19	Did the research use audio or visual recording to collect the data?	9
Field notes	20	Were field notes made during and/or after the inter view or focus group?	n/a
Duration	21	What was the duration of the inter views or focus group?	8
Data saturation	22	Was data saturation discussed?	n/a
Transcripts returned	23	Were transcripts returned to participants for comment and/or	-

Topic	Item No.	Guide Questions/Description	Reported on Page No.
		correction?	
Domain 3: analysis and findings			
Data analysis			
Number of data coders	24	How many data coders coded the data?	9
Description of the coding tree	25	Did authors provide a description of the coding tree?	9
Derivation of themes	26	Were themes identified in advance or derived from the data?	9
Software	27	What software, if applicable, was used to manage the data?	n/a
Participant checking	28	Did participants provide feedback on the findings?	-
Reporting			
Quotations presented	29	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? e.g. participant number	9-16
Data and findings consistent	30	Was there consistency between the data presented and the findings?	9-16
Clarity of major themes	31	Were major themes clearly presented in the findings?	9-16
Clarity of minor themes	32	Is there a description of diverse cases or discussion of minor themes?	9-16

Developed from: Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*. 2007. Volume 19, Number 6: pp. 349 – 357

Once you have completed this checklist, please save a copy and upload it as part of your submission. DO NOT include this checklist as part of the main manuscript document. It must be uploaded as a separate file.