

BMJ Open Facilitators, barriers and ethical values related to the coordination of return-to-work among employees on sick leave due to common mental disorders: a protocol for a qualitative study (the CORE-project)

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ABSTRACT

Introduction Diagnoses related to common mental disorders such as anxiety, depression, adjustment disorders and stress-related disorders are one of the leading causes of long-term sick leave for both women and men in Organisation for Economic Co-operation and Development countries. To increase the rate of return-to-work workplace involvement in a coordinated return-to-work process has been included in recent best practice guidelines. This form of cooperation is a complex process, involving political structures and a wide range of stakeholders. The study's first aim is to describe facilitators and barriers to the coordination of return-to-work from the perspectives of: (A) employees on sick leave due to common mental disorders, (B) employers, (C) rehabilitation coordinators, (D) physicians and (E) other stakeholders. The second aim is to identify ethical issues that arise in the coordination of return-to-work and analyse how these can be resolved.

Methods and analysis The study has a qualitative design using interviews with employees on sick leave due to common mental disorders, employers, rehabilitation coordinators, physicians and other stakeholders. The study is conducted in the Swedish primary healthcare. Employees, employers and rehabilitation coordinators are recruited via primary healthcare centres. Rehabilitation coordinators receive information about the study and those who consent to participation are asked to recruit employees and employers. Interview guides have been developed from the consolidated framework for implementation research and ethical values and norms found in Swedish healthcare, social services and workplace legislation. Data will be analysed with qualitative content analysis reflecting manifest and latent content, and ethical issues will be analysed by means of reflective equilibrium methodology.

Ethics and dissemination The study was approved by the Regional Ethical Review Board in Stockholm, Sweden (Reg.no 2018/677-31/2 and 2018/2119-32). The findings will be disseminated through publication in scientific journals, social media, seminars and national and international conferences.

Strengths and limitations of this study

- A strategic sampling procedure is applied, which will provide a selection of participants with a wide range of experiences.
- Data will be analysed by multiple coders, which will strengthen the study's validity.
- The empirical results will be combined with a normative analysis.
- A possible limitation of the study is that the rehabilitation coordinators may include employees with a positive attitude to coordination. This will be over-ruled by informing the coordinators about the study's inclusion and exclusion criteria.

INTRODUCTION

Diagnoses related to common mental disorders (CMDs) such as anxiety, depression, adjustment disorders and stress-related disorders are one of the leading causes of long-term sick leave for both women and men in Organisation for Economic Co-operation and Development (OECD) countries, including Sweden.^{1,2} Sick leave due to CMDs decreased between 2005 and 2010 in Sweden but started to rise again in 2010. In 2016, CMDs caused about 45% of all sick leave among women and 32% of all sick leave among men in Sweden. CMDs continue to be the most common cause of sickness absenteeism in Sweden. Sick leave due to CMDs is longer and more likely to recur than sick leave for other diagnoses.² For the individual, CMDs cause suffering, increase the risk of social isolation and stigmatisation and can affect the private economy.³ Sick leave due to CMDs, furthermore, is a risk factor for receipt of a disability pension in the future.⁴ For society, depression has in recent years become the diagnosis with the highest

burden due to disability, reduced work ability and years lost to premature deaths.³ The OECD estimated in 2013 that the costs of CMD in terms of healthcare, social insurance and lost productivity were €620 billion per year in European Union (EU) countries.⁵

The first choice of clinical treatment for CMDs is primarily cognitive behavioural therapy and/or pharmacological treatment.⁶ These treatments have positive effects on symptom reduction and improved function. However, in our newly updated scoping review of occupational health service interventions designed to prevent or treat CMDs among employees, we found, in line with results from previous studies,^{7 8} that the severity of symptoms and return to work (RTW) are poorly correlated. This means that even though the symptoms were reduced, patients did not RTW.⁹ These results underline the need to address RTW early in the rehabilitation process by offering treatment for symptoms and methods to facilitate RTW simultaneously. It is evident that, to increase the rate of RTW, we need to design workplace interventions that include cooperation between the employee on sick leave, the employer, the healthcare services and other stakeholders such as the social insurance agency and the occupational health services.^{7 10} Workplace involvement in a coordinated RTW process has also been included in recent best practice guidelines.¹¹ However, this form of cooperation is a complex process, involving as it does both political structures and the wide range of stakeholders mentioned above.

Reducing sick leave is a political priority in Sweden and elsewhere. The Swedish government has agreed on the work-first principle, that is, the need for measures to increase labour market establishment among the unemployed and to increase RTW among employees after sick leave.

In an effort to operationalise the work-first principle, improve the RTW rate, prevent long-term sick leave and increase the involvement of the workplace, Swedish regions have started to appoint rehabilitation coordinators. Their role is to coordinate the rehabilitation process for persons on sick leave, regardless of cause, by, for example, involving the workplace in the RTW process. The coordinator function is based on the principles of care management¹² and should include at least: (1) individual support for the employee on sick leave, (2) cooperation between different professions at the primary healthcare centre (eg, general practitioner, psychologist and counsellor) and coordination of treatments and (3) cooperation with concerned parties outside the primary healthcare, for example, with the employer, the social insurance agency or the occupational health service.¹³ Rehabilitation coordinators are commonly registered nurses, physiotherapists, occupational therapists or social workers. Despite the widespread appointment of rehabilitation coordinators in Sweden, it remains unclear whether a coordinated RTW process actually speeds up RTW. Schandelmaier and colleagues¹⁴ suggested that a coordination of RTW results in small yet important benefits because it increases the likelihood of

persons on sick leave returning to work. However, Vogel and colleagues¹⁵ reported no reduction in number of days on sick leave (compared with care as usual) when employees on sick leave due to musculoskeletal pain or mental health problems received an intervention that included coordination aimed at RTW for at least 4 weeks. In a recent observational study, Skarpaas *et al*¹⁶ did not find any results to suggest that a coordinator reduces the number of days on sick leave. Their explanation is that the evaluated coordinator intervention did not include workplace involvement or a link to the workplace. In other words, the coordinators in the study primarily coordinated the healthcare services received by the individual.¹⁶

To the best of the authors' knowledge, there is a lack of previous research into barriers to and facilitators of a coordinated RTW process for persons on sick leave due to CMDs. Therefore, our presentation focuses on facilitators and barriers relevant for RTW in general.

Previous studies have identified factors that can facilitate RTW. These include: sufficient communication and cooperation between the different actors involved in the RTW process; the actors' motivation and degree of mutual goodwill and trust^{17 18}; and having a cooperation that is structured and planned.¹⁹ Another facilitator is the actors' awareness of the need to reduce the stigma related to mental illness.^{20 21}

A small number of qualitative studies have identified factors that facilitate the coordination of RTW for the employee. These include being treated fairly in meetings with the employer and/or healthcare representatives, giving the employee a sense of confidence in his or her contacts with the professionals. For example, employees who took part in meetings with their employer and a representative of the occupational health service or primary healthcare service in order to plan their RTW described how the quality of the encounter had a major influence on their perception of their own work ability and whether they were able to return to work.^{22 23} This is underlined by previous studies that have found that the employee's self-efficacy and sense of confidence in relation to RTW facilitates the employee's ability to communicate his or her workability, difficulties and resources during the coordinated RTW process.²⁴ However, CMDs and related symptoms tend to result in low self-efficacy and feelings of insecurity about one's ability to deal with issues such as work demands after returning to work. This must be taken into consideration when coordinating RTW for persons on sick leave due to CMDs.²³

Previous qualitative studies show that factors that impede coordination of RTW are the different interests and views of the various stakeholders—the primary healthcare system, the social insurance office and the rehabilitation services. The employee on sick leave might well lose out amidst all of these.^{22 25 26} Another problem arises when the actors fail to have a common definition of work ability—when there may be a mismatch between the employee's actual work ability and production demands, for example.²⁶

Ethical issues

Generally, unresolved ethical issues, can also impede the implementation of new interventions, even if these interventions are warranted. The coordination of RTW involves cooperation between the employee, the employer, healthcare professionals, the social insurance agency and the occupational health service. The cooperation between these actors in the RTW process has been described as challenging because each actor has a different perspective and different interests.²⁷ Value or ethical conflicts mainly relate to autonomy, privacy and fair use of resources.

To a certain extent the coordination of RTW requires compromises from all parties and therefore, almost by definition, implies restrictions on autonomy. These may well be justified. However, an unequal power balance between the parties can lead to unwarranted restrictions. Moreover, how to weigh different actors' autonomy against each other is far from clear.

A number of factors are important for how participants experience the coordination. These are the employee's health status and the risk of (self-)stigmatisation; the quality of communication between the employee and employer; and the interaction between the employee, employer and coworkers at the workplace.^{19 23 28} Such interaction requires information exchange about issues that might be sensitive, especially for the employee. It could also oblige the employer to share information about aspects of work or the work environment that might reflect badly on the employer. Hence, issues about privacy and how to weigh different privacy interests against each other are central.

Another potential ethical issue is how resources used for the coordination of RTW should be prioritised in relation to other primary healthcare resources. Primary care in Sweden faces great challenges with regard to prioritising between patients.²⁹ When a new intervention, such as coordination for RTW, is introduced, it will accordingly have to compete with other interventions. In Sweden, priority setting in healthcare is required to follow an ethics platform based on severity of condition, effect of intervention and cost-effectiveness.³⁰

Ethical perspective

The project adopts an applied ethics perspective, focusing on middle-level values and norms, implying values and norms guiding action and attitudes within a specific context, which in terms can be grounded in several more abstract ethical theories.³¹ In this case, there are several specific contexts involved: the healthcare system, the social services system and the workplace. To some extent, the ethical values and norms within the healthcare system is central, since the coordinating function is organised within this system. However, since there are differences in how ethical values and norms are understood within these different systems, it will be essential to also consider such differences or tensions. In Sweden, when it comes to the healthcare system and the social services system, we find established ethical frameworks, developed within Swedish authorities, that will be used.^{32 33} These focus on the value goals of the systems, the ethical side constraints, structural aspects influencing the realisation of values and norms, and long-term effects. For the workplace environment, no such developed framework is available, but the values and norms found in Swedish workplace legislation will form a starting point, for example, Work Environment Act³⁴ and Employment (codetermination at the workplace) Act.³⁵ In all contexts, we identify values and norms related to autonomy, privacy, resource use, responsibility and professional roles as important to explore.

Objective

Sweden is in the process of implementing a coordinator function with the aim of improving RTW among patients on sick leave (irrespective of the reason for sick leave).

Whether the coordinator function is implemented as intended is influenced by barriers and facilitators. Strategies can be developed that take identified barriers and facilitators into account. Successful implementation will result in the provision of effective treatment and care for employees on sick leave. In the present study, we identify barriers and facilitators on the meso-level and micro-levels described in figure 1.

One potential barrier is values conflicts. Finding ways to identify and resolve value conflicts is important for successful implementation and for the credibility of

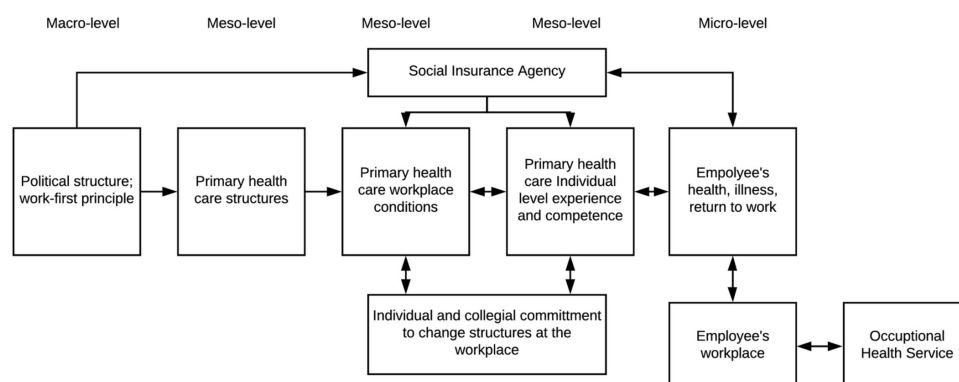


Figure 1 The CORE-project's conceptual framework based on the framework by Rugulies (2019).³⁷

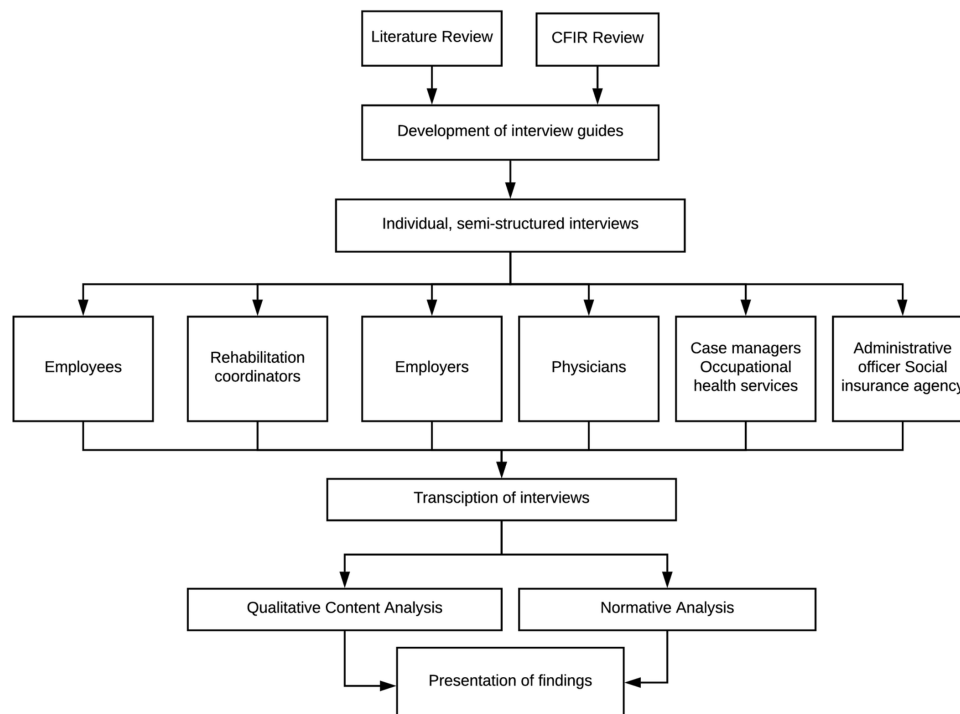


Figure 2 Flow chart describing the CORE-project's study design. CFIR, Consolidated Framework for Implementation Research.

the intervention. The most important conflicts tend to concern autonomy, privacy and fair resource use. However, we also explore potential conflicts related to issues of personal responsibility and professional roles.

Aim

The study has a twofold aim. The first is to describe facilitators and barriers to the coordination of RTW from the perspectives of: (a) employees on sick leave due to CMD, (B) employers, (C) rehabilitation coordinators, (D) physicians and (E) other stakeholders (eg, the social insurance agency officer and the occupational health service). The second aim is to identify ethical issues that arise in the coordination of RTW and analyse how these ethical issues can be resolved.

METHOD

This study has a qualitative design using interviews with rehabilitation coordinators, employees, employers, physicians, representatives of the social insurance agency and the occupational health services. These interviews reflect the different parties' unique perspective on the coordination of RTW (see [figure 2](#) for an overview of the study design). Qualitative methods for data collection and analysis are well suited to exploring a contemporary phenomenon in a real-life setting. This study protocol follows the recommendations of Tong *et al.*³⁶

Context

Based on the conceptual framework by Rugulies,³⁷ [figure 1](#) illustrates how macro-level structures (eg, work-first principle), impact meso-level phenomena (eg, the

Social Insurance Agency, primary healthcare and psychosocial working conditions), which in turn impact the micro level (eg, employee's health, RTW and workplace).

The framework starts with the political and social structures, in this case the work-first principle, which is integrated in the social welfare regime and legal system (eg, the Swedish social insurance system), and the structures of the primary healthcare system, such as conditions related to the funding of primary healthcare, staff competence, type of employment and resources. These will determine the psychosocial working conditions of primary healthcare employees (job demands, management support and work organisation). These working conditions will, in turn, have an impact on the ability of patients (ie, employees on sick leave) to receive adequate treatment and coordination. This, in turn, might influence their health and whether they succeed in returning to work. The primary healthcare providers will also initiate workplace involvement, for example, by arranging meetings between the employee on sick leave, his or her employer and the occupational health service. Hence, the coordination of RTW is a complex task and can be influenced by barriers and facilitators related to the different partners in the RTW process: the primary healthcare services, the social insurance agency, the employee, his or her employer and the occupational health service.

The Swedish Social Insurance Agency (SSIA) is in charge of the administration of sickness benefits for persons who are not able to work due to injury or sickness. The social insurance system is based on the government's work-first principle. Timelines have been added to the social insurance. For example, after day 90 of sick leave,

the patient should try adapted work tasks at their usual workplace. After day 180 and up to day 365 the person is entitled to sickness benefit if he or she cannot perform any work on the regular labour market. If a person has a permanently reduced work ability, they can be granted sickness compensation (disability pension). The SSIA is also in charge of the coordination of the rehabilitation process with other authorities that have other responsibilities. Medical rehabilitation is coordinated by the primary or secondary care services; vocational rehabilitation is the responsibility of the Swedish Public Employment Service; social rehabilitation is provided by municipalities.

Persons on sick leave due to CMDs receive most of their treatment from the primary healthcare service. Their medical rehabilitation is conducted by, for example, rehabilitation coordinators appointed by the primary healthcare service. Rehabilitation with a coordinated RTW process has been implemented in regions across Sweden. The study described in this protocol is being conducted in three regions. Swedish regions are responsible for providing primary and secondary healthcare services. The regions included in the present study were selected on the basis of their size, having assigned process leaders responsible for supporting clinicians in primary healthcare who work with a coordinated RTW process and the starting time of the implementation of rehabilitation coordinators.

The Västra Götaland region covers 200 primary healthcare centres, of which 180 have an on-site rehabilitation coordinator. The implementation of the rehabilitation coordinators started in 2006 and was fully implemented in 2008. Region Uppsala has 40 primary healthcare centres/30 rehabilitation coordinators. A small-scale implementation started in 2006 and were fully implemented in 2016. Region Stockholm has 210 primary healthcare centres/75 rehabilitation coordinators. A small-scale implementation started in 2012 and the full scale in 2015. Together, these regions cover 450 primary healthcare centres and 285 rehabilitation coordinators.

Selection and recruitment process

The study applies a strategic sampling procedure to obtain a range of opinions and experiences regarding the coordination of RTW. It uses the following inclusion criteria:

All participants should have participated in a three-party meeting, initiated by primary healthcare, with at least an employee, an employer and a rehabilitation coordinator present. The three-party meeting should have been conducted at the primary healthcare centre or the workplace or as a telephone conference. All participants should be able to speak and understand Swedish or English.

In addition, the following inclusion criteria are used to select employees: aged 25–65 years (the upper limit was chosen since the retirement age in Sweden is 67 years), ongoing sick leave or on sick leave for a maximum of 12 weeks in the previous 6 months due to CMD (ie, mild to

moderate depression, anxiety and adjustment disorder). CMDs are examined by a general practitioner or physician at the primary healthcare centre.

The study will include 45–55 participants grouped as follows: about 10 employees, 10 employers, 15–20 rehabilitation coordinators, about 5 general practitioners/physicians, 5 representatives from the SSIA and 5 from the occupational health services. The reasons for dropout will be recorded, if the study participant voluntarily tells about why he or she withdraw from the study. The recruitment of participants started on 1 May 2018 and will end on 31 December 2019.

Rehabilitation coordinators, physicians, employees and employers are recruited via the primary healthcare centres. Managers in primary healthcare centres are informed about the study's aim and the inclusion and exclusion criteria. Managers who consent to the study being conducted at their primary care centre inform the rehabilitation coordinator and physician, after which they are contacted by the first (EBB) or third author (TH) by telephone or at a face-to-face meeting. Rehabilitation coordinators who agree to participation are asked to recruit employees and employers. The coordinators receive oral and written information about the study's inclusion and exclusion criteria for the selection of employees and employers. They are instructed to inform all eligible employees and employers about the study, irrespective of the employee's or employer's attitudes towards the coordination. After this, the coordinators approach eligible employees and employers about participation. When the employees and employers have consented to participate, they are contacted by the project leader. We also plan to recruit by advertising in local media and snowball sampling.

Representatives from the SSIA and the occupational health services are recruited by region managers. The project leader (EBB) and TH informed managers about the study's aim and inclusion criteria. In turn, the managers tell eligible representatives about the study. If the latter agree to participate, they are contacted by the project leader.

Data collection

Three separate interview guides have been developed for: (1) employees, (2) employers and (3) rehabilitation coordinators, general practitioners/physicians and representatives of SSIA and occupational health services. A detailed description of the interview guides is given in the online additional file. The interviews are semistructured, that is, the interview guides include a predetermined set of open-ended questions in two parts. The first part comprises questions about barriers and facilitators in relation to the coordination of RTW. These questions were developed from the Consolidated Framework for Implementation Research (<https://cfirguide.org/>). The second part comprises questions about ethical values and norms, covering central ethical values and norms found in healthcare, social services and workplace legislation.³²

The interview guides start with the following definition of coordination:

Coordination is here defined as support to/received by the employee aimed at RTW and cooperation with his or her employer by means of a three-party meeting. The coordination should have been initiated by the primary healthcare.

The definition is in line with the Swedish Agency for Health Technology Assessment and Assessment of Social Services.¹³ A set of questions about background characteristics, including workplace sector, size of primary healthcare centre and the total number of sick listed at the primary healthcare centre have also been included. The interview guide for interviews with employees includes a question about length of sick leave. After that, the guides start with an open-ended question, 'Can you tell me about when you took part in coordination, aimed at return to work?'

The first interview was conducted on 1 June 2018. The interviews are conducted by telephone or face to face at a place suggested by the participant, for example, a public space, a clinic or workplace. Focus groups are used if relevant. In such cases, the same interview questions are used. The interviews are conducted by EBB and TH. EBB is the project leader of the CORE-project and a registered nurse, and TH is an occupational therapist. Both are female, appointed as researchers, have doctorates and are trained and experienced in qualitative interviewing. At the time for the interviews, EBB and TH presented themselves as researchers and clinical professions.

Data analysis

The interviews are digitally recorded and transcribed verbatim. The recordings and texts are then cross-checked for accuracy by the authors. For the study's first and second aim, a qualitative content analysis³⁸ reflecting the manifest and latent content is then applied in the following steps: (1) the transcripts are read through to get an overall insight into the content; (2) the content is explored through open coding; (3) meaning units are identified, condensed and labelled with codes; (4) the codes are compared; (5) codes with a similar content are classified into categories; (6) transcripts, codes and categories are reviewed to identify the links between them, and participants are invited via email or telephone to take part of the transcripts of their own interview and to comment on the analyses; and (7) dependent on the richness of data, themes will be developed.

In addition to the qualitative content analysis described above, the second aim of the study will be further examined with a normative analysis. By means of reflective equilibrium methodology,³⁹ according to which alternative suggestions for how to deal with ethical conflicts are tested against established ethical values and norms in Swedish healthcare, social services and the workplace. Strategies for how to deal with the identified ethical factors and problems will be developed, consistent with ethical values and norms.

The analyses will be performed by the research team and apply a multiple coding process. The initial analyses will be performed by one of the research team members, who will have the main responsibility for the analyses, in close collaboration with another research team member. In the latter phase of the analyses, all authors will discuss and reflect on the emerging results. The process will allow the analysis to be continuously discussed in the interprofessional research team in order to improve rigour.³⁶

Patient and public involvement

Patients and/or public have not been involved in the design and conception of the study.

DISCUSSION

The study has a qualitative design and investigates the barriers to and facilitators of the coordination of RTW. It identifies the ethical considerations of this type of coordination and strategies for dealing with barriers, facilitators and ethical issues from several perspectives, namely employees on sick leave due to CMD, employers, rehabilitation coordinators in primary healthcare and other stakeholders. Analyses are performed by means of qualitative content analysis and normative analysis in order to explore and describe the perspectives of the various types of stakeholders.

The intention of the study is to contribute to the advancement of scientific knowledge about coordinated RTW. More specifically we want to understand how this type of coordination might be further developed in a way which is in line with the views and preferences of the various stakeholders' perspectives as well as the ethical norms and values of the Swedish healthcare system, social services and workplace environment. Primary healthcare currently lacks a tradition of coordinating RTW for employees on sick leave with their employers, even though it is clear that the early involvement of the employer and/or workplace is important for increasing RTW and minimising the negative aspects of sickness absence. To increase the successful implementation of new ways of working (ie, coordinating RTW with the employer/workplace), it is important to gain a better understanding of what factors that might facilitate or impede these new ways of working. The results of the study will enable us to make recommendations about how the coordination of RTW can best be facilitated in primary healthcare settings. The study will in addition generate a better understanding of how the coordination of RTW can be guided by and based on ethical values and norms, how it can respect the employee's privacy and autonomy and how it can be reconciled with the fair use of scarce resources.

Considerations

In this qualitative study, participants are recruited by means of strategic sampling. Since it is the rehabilitation coordinators who recruit employees and employers, there is a risk of bias, that is, that the study only will include those

participants who have a positive attitude to coordination. To overcome this risk, the rehabilitation coordinators are told to select their eligible participants on the basis of inclusion and exclusion criteria and not according to the results of the coordination (eg, the employee returning to work). We are also advertising for participants that may, in turn, contribute to a strategic sample.

Confirmation bias, that is, a tendency to process and interpret data in line with one's own experiences and beliefs, is avoided by using multiple coders when analysing the data. In addition, we ask the study participants for their feedback about the analysis.

The report of the study's findings will include quotations from interviews with participants in order to show transparency and trustworthiness, as well as the links between the data and the authors' interpretations of the data.

ETHICS AND DISSEMINATION

All participants are told that their participation is voluntary, that they may withdraw at any time without giving any reason and that it will not be possible to identify them when the results are reported. Written informed consent must be obtained from all participants. The findings of the project will be published in about three manuscripts published in scientific journals and disseminated through social media, seminars with Sweden's labour market parties, companies and employers, primary healthcare and patient organisations as well as national and international conferences. Data will be deposited at the Karolinska Institutet, Sweden.

Contributors EBB is the project leader and has the main responsibility for the design and all other parts of the study, the writing of the protocol and acquiring of funding for the study. LS has contributed to the ethical perspective used in the study. TH has contributed to the design of the study. LK has made contributions to the design of the study and the implementation perspective used in the study. All authors have been involved in the drafting of the manuscript, have approved to the final version and have contributed with important intellectual content.

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Competing interests None declared.

Patient consent for publication Not required.

Ethics approval The study was approved by the Regional Ethical Review Board in Stockholm (Reg.no 2018/677-31/2 and 2018/2119-32).

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