

Occupational Rehabilitation

Studies and Research Projects

REPORT R-823



Supporting a Return to Work after an Absence for a Mental Health Problem

**Design, Implementation, and Evaluation
of an Integrated Practices Program**

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Bibliothèque et Archives nationales du Québec
2014
ISBN: 978-2-89631-730-1 (PDF)
ISSN: 0820-8395

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© Institut de recherche Robert-Sauvé
en santé et en sécurité du travail,
May 2014

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PEER REVIEW

In compliance with IRSST policy, the research results published in this document have been peer-reviewed.

ACKNOWLEDGEMENTS

The authors wish to acknowledge the IRSST's financial contribution, which made this research activity possible, as well as the contribution made by Québec's Ministère de la Santé et des Services sociaux and its CSSS¹ workplace partners, which helped fund this project.

We would also like to offer special thanks to all the workers who agreed to participate in this recovery and return-to-work support process, and to highlight the role played by all the members of the research steering committee who took part in the various stages of this project. In addition, we greatly appreciate the confidence placed in the project by the CSSS's senior management and its efficient, generous input, which made the project much easier to carry out. Lastly, our sincere gratitude goes to the personnel of the Occupational Health and Safety Department, who willingly submitted to the project demands, and to the workers' direct supervisors, who attended the meetings held with their absent employees and the process evaluation interviews.

¹ In Québec, Canada, a local authority called a *centre de santé et de services sociaux* or CSSS, referred to in English as a health and social services centre, is in fact a “multivocational institution operating a local community service centre, a residential and long-term care centre, and where applicable, a general and specialized hospital centre” (see *An Act Respecting Health Services and Social Services*, RSQ, c. S-4.2, s. 99.2 to 99.8).

SUMMARY

Mental health problems in the workplace are currently one of the main causes of work absence, a phenomenon that has seen a marked increase in the last two decades. Research work in the occupational rehabilitation and mental health field has highlighted the importance of a collaborative process involving the stakeholders in the return-to-work process. However, while a handful of studies have focused on the work reintegration of workers who held jobs but had been absent from them for mental health reasons, very few of these studies have specifically explored the design and implementation of return-to-work programs.

This report concerns the design, implementation, and evaluation of an integrated practices program for supporting a return to work following an absence for a mental health problem. The research project was carried out in response to a joint employee/employer request made by a health and social services establishment in Québec, Canada, for intervention regarding the problem of mental health-related work absences among its personnel and their return to work. To carry out the project, the research team utilized a multi-faceted employee/employer approach and worked with a research steering committee representing all the stakeholders. The steering committee's terms of reference were to assist in arriving at a consensus definition of the problem and of the means to be implemented to support both the return to work of workers who had been absent for mental health problems and their job retention. The committee was also responsible for developing a process based on consistent practices among the various workplace stakeholders and for reaching agreement on strategies conducive to the active involvement of all the organization's personnel in this issue. Its work led to the conceptualization of a program theory and the development of an operational model.

The method used to develop the program for supporting a return to work following an absence for mental health reasons had several components: a structured information-collection process that involved the analysis of absence data and of interviews with stakeholders engaged in the return-to-work process in order to determine their current practices; consultation of organizational documents on the return-to-work process; a review of the scientific literature on the topic; and an examination of current practices in workplaces concerned by this problem. This information laid the groundwork for conceptualizing the program theory in the form of a theoretical model, a logic model, and an operational model. With the steering committee's collaboration, the research team developed a process for assisting in and supporting the recovery and return to work of employees who were absent from work for mental health reasons. This process was aimed at identifying the clinical, personal, and organizational factors that had contributed to their stopping work. For most of the employees, the search for solutions to help them return to work and retain their jobs was a positive experience. The importance placed on welcoming back the returning employees and on supporting them in their work, implementing reassurance practices during their sick leave, and allowing them to make changes in their work would also appear to be a determining factor in a successful return to work.

This study further revealed that the success of such a program can be ensured only if the following essential conditions are in place: a climate of trust characterized by respect, effective communication, and collaboration among the various internal and external stakeholders involved in the return to work. Lastly, it should be noted that interventions carried out with absent workers

may also have an impact on other workers exposed to the same risk factors. Ultimately, the individual approach used in such a process could become an organizational process involving the other exposed workers. This research report details the various steps in the study and the main results and findings.

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1. PROBLEM

Workplaces have undergone major transformations over the past few decades, including market globalization, increased competitiveness and competition, corporate mergers, the downsizing of workforces, and increasingly individualized evaluation. These in turn have led to new work requirements, diversification of job types, work intensification, greater job insecurity, and more fragile work groups. All these changes under way in the world of work have inevitably had an impact on worker health and job retention. One of the most noteworthy phenomena in recent years has been the increase in the number of workers absent from work due to a mental health problem (see Appendix A for a definition of mental, or psychological, health problems). Mental health problems in the workplace currently constitute one of the main causes of worker absence, a phenomenon that has seen a marked increase over the last few years (Dewa, Goering, Lin & Paterson, 2002; Dewa, McDaid & Ettner, 2007; Gabriel & Liimatainen, 2000; Henderson, Glozier & Elliott, 2005; Houtman, 2007; Nystuen, Hagen & Herrin, 2001; Vézina & Bourbonnais, 2001). As a result, occupational health physicians, epidemiologists, ergonomists, sociologists, and psychiatrists are taking greater interest in the causative factors (Bourbonnais, Brisson, Vézina, Mâsse & Blanchette, 2005; Brun & Martel, 2003; Daniellou, 1999; Dejours, 1993, 1995; Stansfeld, Fuhner, Shipley & Marmot, 1999; Vézina, Cousineau, Mergler, Vinet & Laurendeau, 1992; Vézina et al., 2001; Vézina, Bourbonnais, Brisson & Trudel, 2004). Yet despite the concerns generated by these health problems and the magnitude of the phenomenon, studies on return-to-work practices following a mental health problem are virtually non-existent (see Appendix A for an overview of the studies on this topic). Few return-to-work programs have been formally structured and developed in discussion with the various partners involved (Briand et al., 2007). Companies are therefore starting to feel the need to adopt more comprehensive and integrated approaches to both work-absence management and employee health and productivity (Wyatt, 2005). The urgency felt in this regard signals the need to apply sound absence-management practices conducive to the return to work and job retention of workers who have been absent for mental health reasons.

The growing challenges faced by workplaces to ensure the job retention of an active, functional workforce requires the development and implementation of support practices that foster the recovery, return to work, and job retention of this category of workers. Studies carried out in the occupational rehabilitation and mental health field have cast light on the importance of a collaborative process among the stakeholders involved in the return-to-work process. However, while some studies have specifically explored the work reintegration of workers who have jobs but have been absent for a mental health problem, very few of them have focused on the design and implementation of return-to-work programs (Briand, Durand, St-Arnaud & Corbière, 2007).

1.1 Research objectives

The general objective of this research project was, in collaboration with a health and social services organization and its various partners, to develop a model for and implement an integrated practices program that fosters the return to work and job retention of workers following their absence for a mental health problem. The specific objectives were as follows:

- To form an overview of the current work-absence situation in the organization;
- To identify current practices and the paradigms underlying absence-management and return-to-work practices in the workplace;
- To identify the theoretical foundations and organizational practices pertaining to absence management and the return-to-work process;
- To develop, in partnership with the workplace, a theory and an operational model for a return-to-work support program;
- To implement the operational model of the program;
- To evaluate certain aspects of the program in the short term.

1.2 Research procedure

Workplaces today are seeing a sharp rise in the rate of absenteeism attributable to mental health problems, with the related disability insurance costs keeping pace. Faced with this reality, they have begun seeking ways to remedy the situation but do not feel equipped to take effective action to resolve the problem. This study therefore used a collaborative process to attain a shared understanding of the issue and greater insight into the factors possibly hindering a successful return to work. Section 2 discusses the main challenges involved in a collaborative process. Section 3 describes all the steps that led to the development of the program theory. The research team first profiled the initial work-absence situation in the organization (described in section 3.1). It then conducted individual interviews with the key stakeholders in the workplace who were involved in the return-to-work process, the goal being to shed light on their practices and the paradigms underlying work-absence management in the organization (section 3.2). It also investigated organizational work-absence management and return-to-work practices at various other organizations in the province of Québec to ascertain general trends in this area (section 3.3). This was followed by a state-of-the-art review of the literature on the various return-to-work support practices (section 3.4). This overview in turn led to the development of a program theory (section 3.5), including a theoretical model (section 3.5.1), a logic model (section 3.5.2), and an operational model (section 3.5.3), all adapted to the workplace and setting out the various steps required to implement a program for supporting a return to work following an absence for a mental health problem. The research team then implemented the relevant practices retained in the operational model of the program theory (section 6.6) in the organization. Lastly, the team evaluated the return-to-work support process in the short term (section 4) based on individual interviews and questionnaires completed by the workers and supervisors who took part and using statistical analyses of the data compiled on the participating workers. This relatively new, worker-centred approach revealed factors in the psychosocial work environment that may play a key role in the work-absence situation and conceivably allow us to leverage its various aspects for primary prevention purposes.

2. COLLABORATIVE PROCESS INVOLVING THE WORKPLACE

This study was conducted in response to a request made by an organization in the health and social services sector that was particularly concerned about the large number of mental health-related work absences it was experiencing and its lack of means for supporting its workers' return to work and job retention. The workplace targeted by the study was a CSSS (integrated health and social services organization) staffed by nearly 3,500 employees delivering front-line

health services, long-term care services, and social services. These services are designed to reduce or resolve health and social problems experienced by members of the public. The employees are mainly patient attendants (orderlies), nursing assistants, social workers, psychologists, kitchen workers, and support staff. The organization encompasses various local community service centres, residential and long-term care centres, family medicine units, and specialized outpatient consultation offices. A more detailed picture of the initial work-absence situation is provided in section 3.1 and Appendix B.

The organization's concerns, as well as its commitment to and interest in participating in the action research project, led the research team to engage in a collaborative initiative involving efforts to both develop and improve absence-management and return-to-work practices. To begin with, the research team formed a research steering committee comprised of researchers and representatives of the key workplace stakeholders concerned by work absences attributable to mental health problems and by return-to-work practices. A number of studies have cited the strategic role played by senior management, direct supervisors, unions, and those in charge of occupational health in implementing a return-to-work program (Baril et al., 2003; Franche et al., 2005; St-Arnaud, St-Jean & Damasse, 2004, 2006; Stock, 2005). The following individuals consequently sat on this committee: the organization's director general, the director of human resources, two stakeholders from the Occupational Health and Safety Department (manager and practitioners), three direct supervisors, and three union representatives. For some meetings, an invitation was also extended to one of the people responsible for the workplace-attendance action plan at the ministère de la Santé et des Services sociaux (MSSS) in order to promote knowledge transfer. The steering committee's terms of reference, which lasted three years, were to:

- develop an understanding and a shared vision of the work absenteeism problem and of the means to be implemented to effectively move toward its resolution;
- support and ensure consistency in the various processes and actions instituted within the establishment to address the issue of workplace attendance;
- agree on appropriate strategies for fostering the active involvement of all organizational personnel in this issue.

2.1 The challenges of collaborating with the workplace

To implement the participative process in the workplace together with the stakeholders, the first step in this study consisted of forming a working group of the key stakeholders involved in the return to work of individuals who had been absent from work. Senior management's support and commitment remain key factors in the development and implementation of an intervention that will impact on work organization and management practices. According to Baril et al. (2000), the values espoused by senior management have significant impact on intervention success. Subscribing to these principles, the organization's director general made a commitment to sit on the research steering committee. His presence served to support the project's credibility in the organization. The relationships between management and unions are also seen as having a major impact on return-to-work programs (Baril et al., 2003). Confrontational behaviours subside when unions and management pursue the common goal of their workers' health and well-being when they return to work. The presidents of the three unions representing more than 95% of the organization's workers therefore agreed to take part in the steering committee's activities. Their

participation is essential to the development of the return-to-work program as it means they are more inclined to support the proposed return-to-work measures (Baril et al., 2003; Stock et al., 1999).

The role of direct supervisors is also crucial. They are the first people directly involved when an employee returns to work and have the authority to make certain adjustments to the work, in particular to workload, schedule, and methods. They are also responsible for negotiating with senior management about changes to work organization (Franche et al., 2005). In this project, three supervisor representatives also volunteered to sit on the steering committee. Lastly, the Occupational Health and Safety Department's manager and practitioners were targeted as indispensable partners in the process. Together, the following elements constitute the prerequisites for a successful return-to-work program: the establishment of a climate of trust characterized by respect, effective communication, and collaboration among the various internal and external stakeholders involved in the return to work.

The role of the steering committee was to participate in the formulation of a consensual definition of the problem and of the means to be implemented to support the return to work and job retention of workers who had been absent for mental health reasons. The committee began meeting one year prior to project start-up at the time when the research protocol was being developed, and continued to meet throughout the entire four years of the project. The committee was also responsible for ensuring implementation of a process involving coherent practices among the various stakeholders in the workplace and for agreeing on strategies likely to involve the organization's entire workforce in the issue. However, despite the efforts made to ensure representation of the stakeholders involved in the process, the research team had to contend with high turnover among the steering committee's membership. Although the member distribution remained the same, several members had to be replaced due to retirements, position changes, and departures for health reasons. This situation had an impact on the team's ability to ensure that the process was clearly understood despite its efforts to remind committee members of the project's objectives, to describe the process and steps already carried out, and to prepare minutes of all the meetings. This points to the difficulty of transferring participation in decision making into development of the process. Yet participation in discussions that led to certain choices did enable them to identify with and support these decisions. These results would appear to support a theory advanced by Lescarbeau, Payette, and St-Arnaud (2003) in which they highlight the importance of the catalytic effect of the active involvement of workplace stakeholders on a process' success. The authors state that stakeholders' commitment from the project outset is vitally important to maintaining the stakeholders' involvement and committee members' desire to continue cooperating. The catalytic effect occurs when each group member participates in the development of a common process aimed at actively utilizing each party's particular skills in decision making. It gives the stakeholders a greater sense of responsibility and decision-making power as well as the feeling that they are personally and collectively involved in a process of change.

3. DEVELOPMENT OF THE PROGRAM THEORY

The method used to develop the program for supporting a return to work after an absence for mental health reasons was based on a scientific program-theory approach that takes both scientific and empirical data into account (Chen, 2005; Rossi, 2004; Weiss, 1997). A program theory describes “the set of assumptions that relate the program to the benefits it is supposed to realize and the strategy and tactics used to achieve the goals and objectives” (Rossi, 2004).

In accordance with several authors’ recommendations (Chen, 2005; Patton, 1997; Rossi, 2004; Weiss, 1997), the program theory was developed through a structured data-collection process involving analysis of work-absence data and of interviews of the stakeholders active in the return-to-work process in order to determine their current practices; consultation of the organization’s return-to-work-related documents; a review of the scientific literature on the topic; and an examination of current practices in the workplaces concerned by this problem. This information allowed us to conceptualize the program theory in the form of a theoretical model, a logic model, and an operational model. The following steps led to the creation of the program theory:

- Based on our consultation of a disability-management database, we formed an overview of the work-absence situation in the organization in the year prior to the development of the return-to-work support program.
- We identified current practices and the paradigms underlying absence-management and return-to-work practices in the organization under study in order to produce a schematic diagram of the customary practices in effect prior to program implementation.
- We identified the theoretical foundations for the return to work by conducting a state-of-the-art review of the scientific and normative literature on the subject.
- We documented the absence-management and return-to-work practices of various organizations based on interviews of the individuals in charge of managing return-to-work programs or protocols.
- In light of the results obtained in the preceding steps and in partnership with the steering committee, we developed a theoretical model, a logic model, and an operational model for a return-to-work support program.

Sections 3.1 to 3.5 detail the methodology and results of each step involved.

3.1 Overview of the initial work-absence situation in the organization

The purpose of this step was to describe the current situation in the organization with respect to work absences attributable to a mental health problem. Covering the period from April 2005 to March 2006, the data compiled came from a work-absence database containing information on the person (sex, age, and seniority), position, and diagnosis. Based on our analysis of these data and in light of the type of problem involved, and job status and type, we were able to describe changes in the prevalence and duration of work absences related to a mental health problem as diagnosed by the attending physician (see Appendix B for the result details).

3.1.1 An alarming work-absence situation

The picture obtained of the initial work-absence situation pertaining to a mental health problem revealed an alarming reality in the organization. Of the total of 3,527 workers, 720 (20%) had been absent from work between April 1, 2005 and March 31, 2006 for all categories of health problems, including 37% for a mental health problem. The prevalence rate of mental health problems was 8% for the organization as a whole. This finding spoke of a worrisome issue for the organization, particularly since these types of health problems are known to generate the longest work absences (Dewa et al., 2007). An analysis of the provincial work-absence database prepared by Québec's health network revealed that mental health problems account for 34% of the sick-leave diagnoses in health-sector employees, with 44% of disability insurance payouts going to workers affected by this problem.

These results concur with those of other studies conducted on the topic. Henderson et al. (2005) state that the "common" mental health problems such as depression and anxiety contribute more to the increase in workplace sick leave than do severe mental disorders. Generally speaking, adjustment disorders are the problems most often found in workers (Nieuwenhuijsen et al., 2003) and are usually transient disorders that manifest themselves in various emotional symptoms (anxious or depressive) or behavioural symptoms (irritability, carelessness) in reaction to a stressful event in an individual's personal or occupational life. Some studies assert that more than 50% of the people off work for a mental health problem have an adjustment disorder diagnosis (LISV, 2000, in Nieuwenhuijsen et al., 2003; van der Klink et al., 2003). However, Casey (2001) points out that it is difficult to assess the actual numbers since adjustment disorder diagnoses are not taken into account in most studies on mental disorder prevalence. As a general rule, the absences of people with an adjustment disorder are considered to be short term, ranging from four to six weeks, which is enough time for them to recover from stressful events (MSSS, 2009). However, when the stressful situation persists, the symptoms may worsen and lead to a more significant health problem, including major depression (Vézina et al., 1992).

Mood disorders, including major depression, are associated with longer periods of sick leave, (Brenninkmeijer et al., 2008; Kessler et al., 2006; Nieuwenhuijsen et al., 2006). Analysis of the data from a population survey conducted in France of a representative sample of workers revealed a mood disorder prevalence rate of 10% in men and 14% in women (Cohidon et al., 2009). This category of disorders also includes bipolar disorder, a disease usually occurring before age 35 and differentiated by the presence of abnormally euphoric periods and periods of major depression. Anxiety disorders, which include panic disorder, phobias, obsessive-compulsive disorder, and generalized anxiety disorder, generate the longest work absences, mainly because the individuals affected have greater difficulty seeking help. The study conducted by Cohidon et al. (2009) revealed an anxiety disorder prevalence rate of 17% in men and 25% in women. The prevalence rate for all anxiety disorder diagnoses would appear to be higher than that for major depression (Pélissolo et al., 2002; Waghorn & Chant, 2005), ranging from 20% to 25% (Cohidon, 2009; Kessler et al., 1994; Leon, Portera & Weissman, 1995). These diagnoses, which were infrequent among the subjects in our study, were also those with the longest average duration of absence. The average duration of all absences for a mental health problem, weighted for the number of people in each category, was 158 days, with 207 days for mood disorders, 126 days for adjustment disorders, and 299 days for anxiety disorders.

In addition to these mental health problems, some workers may manifest personality dysfunctions, which are not necessarily considered an illness even though they can generate relational or behavioural problems. Also, to a much smaller degree, some workers may have psychotic disorders, such as schizophrenia. These health problems are associated more with severe mental disorders for which work integration and job retention pose a major challenge (Corbière, Lesage, Villeneuve & Mercier, 2006; Corbière, 2008). Moreover, in this study, the majority of work absences for a mental health problem occurred in full-time and regular part-time workers. Yet it is in temporary full-time workers that we observe the longest work absences. It is also worth noting that nursing and patient attendant jobs were the job types associated with the largest number of episodes of work absence for a mental health problem, and that office work and nursing jobs were associated with the longest average duration of absence. In this regard, a study conducted in the health sector involving 1,454 nurses in the Québec City area also revealed that mental health problems ranked at the top of the list of most frequent diagnoses, with 25% of the episodes lasting an average of 70 days, followed by musculoskeletal problems (18%), for which the episodes lasted an average of 41 days (Bourbonnais et al., 2005).

3.2 Description of the workplace's practices and paradigms

The aim of this step was to shed light on the workplace's current practices and the paradigms underlying its absence-management and return-to-work practices in order to develop an operational model depicting the current practices. To achieve this objective, the research team:

- conducted 30 individual interviews of the workplace's key stakeholders (seven senior management staff members, ten direct supervisors, seven representatives of the Occupational Health and Safety Department, and six union and worker representatives) to clearly ascertain, by means of questions and case histories, the groups of stakeholders targeted, their roles and practices, and their relationships with the other stakeholders;
- consulted the documents currently used in absence management and the return-to-work process.

The methodology used for the interviews and the results obtained are presented in Appendix C.

3.2.1 The organization's challenges and stakeholders' values and commitment

Analysis of the practices and paradigms of the workplace's stakeholders revealed that the organization is at the centre of a complex system comprising groups of stakeholders with differing practices and cultures, a system in which the various stakeholders make decisions and sometimes take actions with diverging aims and objectives and that is characterized by many, sometimes contradictory, requirements. A study conducted by Contandriopoulos, Champagne, Denis, and Avargues (2000) showed that the capacity of such a system to attain its objectives depends on the degree of coherence among the various parties involved. We evaluated this coherence by analyzing the roles and responsibilities, action and decision-making mechanisms, resources, and principles and values of each group of stakeholders involved in the absence management and the return-to-work support process.

In terms of return-to-work support and assistance, senior management's roles and practices consist mainly of ensuring that the organization's approach to absence management and return-to-work support practices is passed on, in particular to middle managers, who in this case are the direct supervisors. Senior management personnel are also responsible for monitoring and reducing absence-related costs in their division and for supporting the direct supervisors in the performance of their mandate as well as properly equipping them to do so. Our analysis of the values and principles conveyed by senior management revealed the existence of dissimilar visions and perspectives in the various divisions. These differences were seen to generate not only contradictory practices among the stakeholders but also confusion among the direct supervisors and stakeholders in the Occupational Health and Safety Department, whose job is to operationalize senior management's expectations. A possible consequence of this would appear to be the implementation of practices having short-term impacts or, in the case of managers, direct supervisors, and Occupational Health and Safety Department stakeholders, practices that impact quickly on disability insurance costs. Moreover, the values and principles conveyed by the direct supervisors with regard to absence management and the return-to-work process reflect their difficulty in shifting from an "individualizing" and "psychologizing" representation of the problem to a multi-causal paradigm that takes account of the process complexity. This difficulty manifests itself as a vast array of principles guiding a number of diverse practices among this group of stakeholders. Yet studies have shown that supervisors who adopt support behaviours during the return to work have greater success with worker rehabilitation (Corbière & Lecomte, 2007). In addition, research done by Corbière et al. (2009) has shown that the self-esteem of individuals with a serious mental disorder who have secured a job tends to improve when they have a satisfying relationship with their direct supervisor.

For their part, the Occupational Health and Safety Department personnel are among the first to become involved in the process. They are responsible for managing the disability insurance file, following up on absences with workers, and initiating medical evaluation and treatment-plan monitoring measures. Their duties include providing support to workers during their absence, and in many instances, they are the first persons to contact the absent workers. In addition, Occupational Health and Safety Department staff have to support the direct supervisors, who sometimes consult them regarding absence management and during the return-to-work process. Caught between workers' needs and supervisors' demands, they are obliged to juggle contradictory demands. Senior management also encourages them to support the absent workers while exerting considerable pressure on them to reduce the rate of absenteeism. These contradictory requirements of their mission are reflected in their relationship with the supervisors, who, depending on their visions and principles, may make demands that are more focused on either support practices or increased control over the reasons for and duration of certain employees' absences. We further observed that psychiatric assessments are used to draw a line between support and control in this grey zone of their contradictory mission. One might well ask whether this dichotomy is truly based on the organization's support vision, given that absence management is associated more with achieving aims such as reducing absenteeism-related costs, in turn leaving little room for the creation of an environment that fosters respect, attentive listening, open-mindedness, and empathy in situations involving absences for mental health reasons.

Lastly, the union stakeholders' main role and responsibilities involve supporting workers in their recovery process, return to work, and job retention. Often the last to be informed of a worker's absence, they are the first who have to intervene in the event of a dispute, as they receive the worker's complaints and assist him² in the necessary steps. At the same time, they are responsible for adhering to the collective agreement and ensuring that all workers' rights are respected. Yet collective agreements, which often reserve the least physically demanding work for workers with the most seniority, can prove an impediment to accommodating workers who are returning to work (Baril et al., 2003). According to Baril-Gingras (2003), the values conveyed by stakeholders will be key factors in determining the changes sought by an organization. These values would also appear to guide the various stakeholders' conduct (Schwartz, 1992); when values are shared, the members of an organization identify with one another and tend to work more effectively toward common goals and to agree on the means for reaching them (Schwartz & Sagie, 2000). The different action logics underlying the practices of the key stakeholders met in the context of this study fit into three rationalities: (1) an economic rationality, dominated by an insurance logic and overriding concern with the high costs generated by sick leave; (2) an organizational rationality, focused on difficult working conditions and labour shortages; (3) a human and subjective rationality, focused primarily on health and well-being in the workplace.

Our analysis of the key stakeholders' discourse brought to light the need for management to take a clear position on its values and orientations regarding absence management and the return-to-work process. Interestingly, although the director general attested to his firm position in favour of a supportive approach to individuals and the organization, he nonetheless observed the persistence of diverging, often contradictory visions within his organization. This stage of the research project led the steering committee to undertake (1) to develop a reference framework defining the support vision proposed by the organization and (2) a discussion process with the various stakeholder groups for the purpose of describing and specifying their roles and responsibilities regarding the return-to-work support process. This finding also revealed the need to appoint a person who would coordinate the stakeholders' different roles to promote collaboration and coherence in practices.

3.3 Organizational practices regarding absence management and the return-to-work process

The purpose of this step was to document the absence-management and return-to-work practices in place in various organizations as gleaned from interviews with the persons in charge of managing return-to-work programs or protocols. The study revealed the various disability management practices in place in these different workplaces. To obtain a more generalizable intervention model, the organizations were selected on the basis of diversity, with the chosen organizations exemplifying various organizational practice models. The organizations had to have a return-to-work program developed specifically for their workers and administered internally rather than by an external firm. Organizations in the public, parapublic, and private sectors in the province of Québec were targeted. In addition, various industrial activity sectors

² The masculine form is used throughout this document solely in the interests of readability with no discrimination intended.

(primary, secondary, and tertiary) were selected to cover a broader spectrum of the different types of organizational practices. The nonprobability sampling method was employed, i.e. using certain specific population characteristics (Chauchat, 1985, cited by Poupart et al., 1997). A total of 17 interviews were conducted with the persons in charge of the return-to-work protocol or program (or their representatives) in 13 organizations in the public, parapublic, and private sectors. For details on the data collected during the interviews of these individuals and for a description of the return-to-work practices of the selected organizations, refer to Appendix D.

3.3.1 *A look at organizational practices*

Some of the organizations we investigated began taking an interest in the return-to-work process following an experience with a mental health problem and were daring enough to implement new practices. Our study highlighted the great variation in their practices. We also noted that the return-to-work protocols or programs were connected with different departments in the organizations and were offered by practitioners with varying backgrounds. We developed an operational model for each organization in order to summarize the organizational practices implemented in the context of its return-to-work program or protocol. Based on our analysis of the different models, a number of practices were found to be common to all the organizations. However, one of the major limitations of this study was the absence of validation with other stakeholders in the workplace; the study was essentially carried out with the persons in charge of the return-to-work program or protocol. One might well ask to what degree these practices were actually implemented and what results were obtained. A more in-depth analysis would help clarify these aspects.

This study also revealed three factors that appear to have fostered the development of organizational practices: the costs generated, legal obligations, and staff health. In fact, work absences for mental health reasons generate major costs, and the organizations visited were seeking to reduce these costs. The creation of legal obligations (such as the obligation to accommodate and the psychological harassment provision of Québec's *Act respecting labour standards*) was also mentioned as a factor that had induced the organizations to start their interventions. The fact that there are two types of concerns can lead to the adoption of different, sometimes contradictory practices. In addition, most of the prevention activities documented in the organizations were aimed at secondary and tertiary prevention of mental health problems. Few concerned primary prevention. Lastly, all the organizations visited had practitioners dedicated solely to carrying out activities specified in the return-to-work protocols. These individuals deliver various levels of intervention, ranging from simply controlling absences to coordinating more structured activities with the various stakeholders in the workplace.

3.4 Theoretical foundations for absence management and the return-to-work program

For the purpose of this research project, it proved necessary to perform an updated review of the literature on the various practices used to support workers who have been absent due to a psychological or physical health problem. A number of databases were therefore consulted: CINAHL, Medline, PsycInfo, Current Contents, American Business Index, Proquest, Science

Direct, Sociological Abstracts, and ASSIA. The review was conducted using the following key words: workplace, return to work, rehabilitation, job re-entry, sick leave, absenteeism, program evaluation, evidence-based practice, mental illness, mental health, depression, burnout, anxiety, adjustment disorders, psychological distress, disability management, human resource management, compensation costs, organizational behaviour, psychosocial work environment, organizational factors, and stakeholder relationships. To ensure comprehensive coverage, various unpublished documents, including research reports, articles submitted for publication, and abstracts of scientific presentations were also consulted. In addition, a Web search led to the description of other management and return-to-work programs for which no scientific studies had yet been conducted. This stage of the project involved establishing the theoretical foundations and best practices for managing work absences and the return to work.

Mental health studies on work reintegration recommend that individual factors be taken into account but also that careful consideration be given to the support offered in the workplace to help people reintegrate into their jobs. The dynamic model of the factors related to work withdrawal and reintegration in cases involving mental health at work is concerned (St-Arnaud et al., 2003), as well as the guide and tools proposed to support a return to work and job retention in cases involving musculoskeletal disorders (Stock et al., 2005), enabled us to apply the theoretical foundations to the implementation of an integrated approach to disability and return-to-work management in cases involving psychological health problems. Shown in Figure 3 (St-Arnaud et al., 2003), this dynamic model highlights the fact that psychological health and work capacity are defined by the interaction of individual characteristics, the psychosocial work environment, and life events outside work.

The model also helps situate the progression in the work reintegration process over time in relation to events that preceded the work absence and to the functional restoration process, the medico-administrative management of the absence, and lastly the working conditions that promote the recovery of health and work capacities. The return to work does not necessarily signal the recovery of health and work capacities. In fact, work capacities are not recovered at the end of a complete health recovery but rather during an ongoing process in which health is regained gradually in the context of the work activity itself. The possibility of returning to work gradually, the possibility of benefiting from the welcome-back efforts and support of co-workers and supervisors, and, above all, the adaptation of the psychosocial work environment are major determinants of a successful return to work. They characterize the conditions that facilitate the transition from a state of threatened vulnerability to one of reassured vulnerability. According to this model, it is important to intervene at the level of the work environment if we are to promote a successful return to work and job retention.

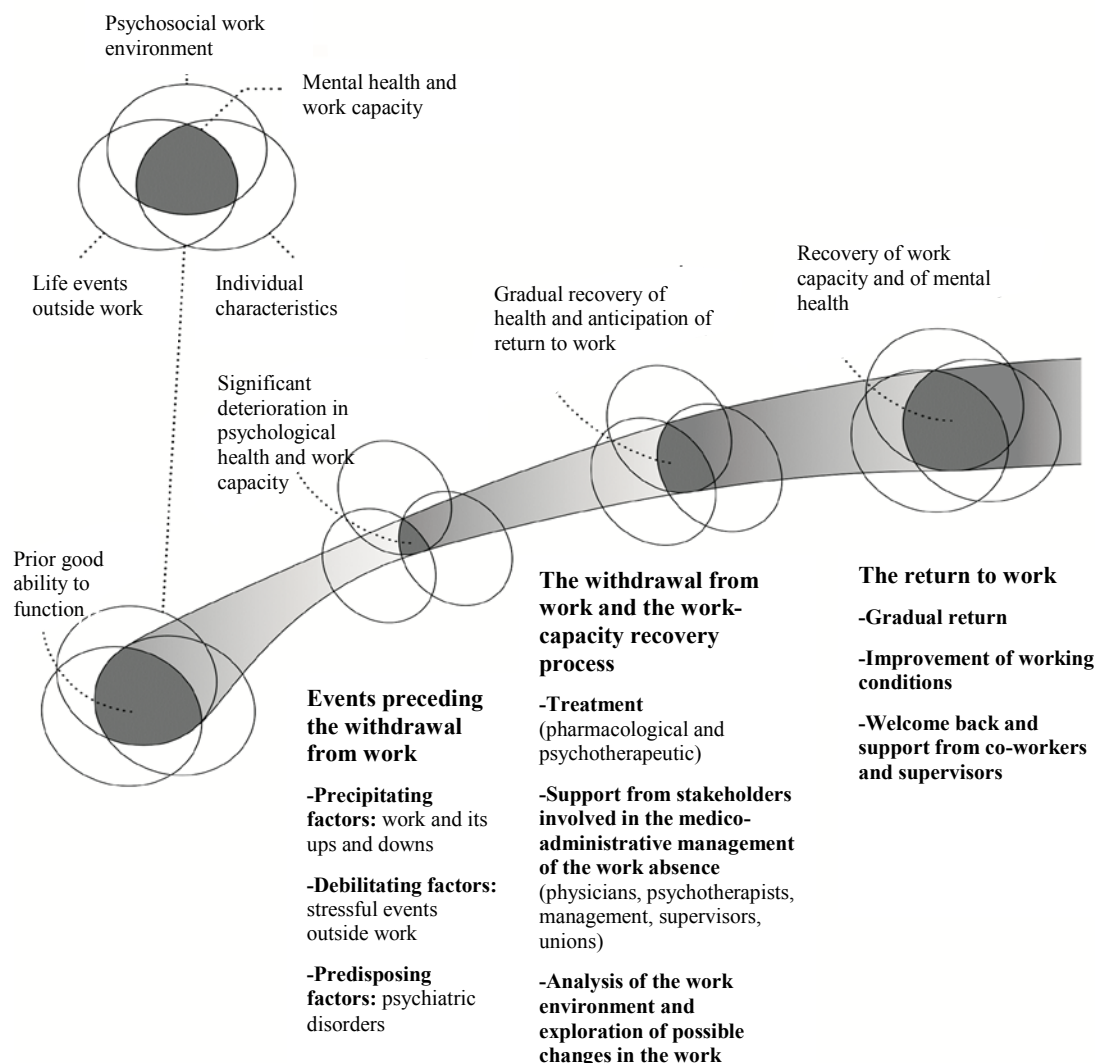


Figure 3 – Dynamic model of the factors related to the work withdrawal and reintegration process (Saint-Arnaud et al., 2003)

Returning to work after an absence due to a mental health problem remains a particularly difficult and risky process if the work-related risk factors are not taken into account. Lack of recognition at work, poor social support from supervisors and co-workers, and the absence of decision-making power regarding how to perform the work are among the key risk factors for mental health at work (Johnson & Hall, 1988; Karasek, 1979; Siegrist, 1996). Conversely, feeling supported in difficult situations, having influence over one's work, and feeling respected and appreciated are factors that help prevent mental health problems at work. These prevention factors can become key components of a successful recovery/return-to-work support process by turning risk factors into factors that support the process (see Figure 4, Appendix E).

According to several studies, at the level of the organization itself, senior management's commitment to health and safety helps reduce injuries (Habeck, Scully, van Tol & Hunt, 1998; Shannon, Mayer & Haines, 1997). Management's values and attitudes have a significant impact on the success of interventions. Chances of success are enhanced when there is a concern for worker health and safety and ongoing support for return-to-work programs, combined with case management interventions and prevention programs. Furthermore, by placing priority on a participative management style in the organization, senior management gives workers and direct supervisors a say in the planning and implementation of a return-to-work program (Stock et al., 1999). This management style brings together the prerequisites for a successful program: it establishes a climate of trust characterized by respect, effective communication, and collaboration among the internal and external stakeholders involved in the return-to-work process (Baril et al., 2003; Stock et al., 1999). Conversely, legal remedies diminish trust and hinder the return-to-work process and are actually considered obstacles to the return to work (Baril et al., 2003). A successful return to work requires commitment and consensus among all stakeholders in the workplace, including senior management, unions, and supervisors (Baril et al., 2000). Dialogue among all the stakeholders affected by the return-to-work process and their knowledge of each party's objectives and roles are also factors that should promote a return to work under better conditions, reduce the risk of relapses, and support job retention (Baril et al., 2003; Durand & Loisel, 2001; Franche et al., 2005; James, Cunningham & Dibben, 2002; McLellan, Pransky & Shaw, 2001; St-Arnaud et al., 2003, 2006). This dialogue among the various stakeholders remains key to establishing the various issues involved in the return to work and identifying common objectives that can serve as a basis for implementing an integrated approach to disability management. One way to construct a program in partnership with stakeholders is to adopt a program theory approach (Rossi, 2004).

Senior management's commitment is also apparent in the choices of outcome objectives that it submits to its managers. The retained parameters should not be limited solely to traditional performance indicators (absence rates, number of work days lost) but rather should include measures of the practices aimed at improving health conditions in the workplaces (Roy, Desmarais & Cadieux, 2005). To this end, the extent to which worker support measures are developed and implemented could serve as an indicator for evaluating intervention effectiveness. Better linkage between production and disability-prevention interventions can prevent role-conflict situations among direct supervisors while encouraging their involvement (Stock et al., 1999). In addition, to support sustainable changes in direct supervisors' attitudes toward workers who show signs of discomfort, disability management practices should be an integral part of supervisors' regular performance evaluations (McLellan et al., 2001). A number of studies attribute a significant role to supervisors by virtue of their position and attitudes toward their employees (Gates, 1993; Holmgren & Ivanoff, 2007; Linton, 1991; McLellan et al., 2001; Shaw, Robertson, Pransky & McLellan, 2006; Wood, 1987). Their receptiveness to the worker and their efforts to raise peer awareness of the disability's impact on the work process have major repercussions on the return to work (Gates, 1993). In the event of an absence due to a psychological health problem, the recovery of work capacities will be influenced by the attitudes and support behaviours adopted by co-workers and the supervisor inasmuch as they have a favourable view of the employee's work relationships (St-Arnaud, Saint-Jean & Damasse, 2004).

Training for direct supervisors on the factors contributing to work absences and factors facilitating work reintegration following a psychological health problem would help give them the necessary knowledge about prevention and rehabilitation to handle cases involving mental health at work and enable them to acquire know-how related to behavioural and communication skills. As Wood's study (1987) suggests, a workshop could be held on ways for supervisors to make initial contact with the absent worker, convey a positive message, and propose task modifications. A systematic approach could also be proposed to direct supervisors, including contact with the employee during the rehabilitation period, a preparatory meeting about the return to work, and a follow-up meeting to assess the outcomes (Linton, 1991). Contacts with absent employees should be characterized by an empathetic attitude and reassuring interventions in order to safeguard the recovery process. Studies on effective interventions for managing physical disability have used a disability-prevention approach focused on patient reassurance strategies (Loisel et al., 2001). Adopting such an approach requires shifting from a piecemeal perspective to a systemic view of work rehabilitation that takes both the person and his environment into account, and such a shift requires major changes both in the roles of the stakeholders involved and in processes (Durand et al., 2001). Medico-administrative measures could be taken to avoid jeopardizing this process. Preparing for the return to work involves first evaluating the various factors that initially precipitated the absence in order to determine the appropriate support measures during the return to work (St-Arnaud, 2004).

It has also been suggested that workplace strategies be implemented to improve communication between attending physicians and the workplace, such as creating a form to be completed by the attending physician and containing information on the worker's functional limitations or work restrictions that serve to guide the workplace in its selection of modified tasks, or making telephone contact with the attending physician to discuss the return to work (Baril et al., 2003; Stock et al., 1999). This procedure avoids placing the physician in a role conflict between his patient's recovery and the company's concerns about absenteeism (Stock et al., 1999). The development of a return-to-work plan provides an opportunity to determine strategies that will help restore work capacities and ensure a balance between rehabilitation objectives and performance objectives (use of a gradual return-to-work measure combined with possible modifications in working conditions, i.e. a gradual resumption of tasks over time) (St-Arnaud, 2004). Efforts should be made to assign the employee enriching tasks so as to reinforce his process of rebuilding a sense of purpose at work. Various factors should be considered in choosing the tasks: feasibility, organization of the work, compliance with a collective agreement, available resources, and the worker's and co-workers' viewpoints (Stock et al., 2005). Moreover, through this assessment process, the repercussions of an employee's return to work on his co-workers' workload can be ascertained, social relationships at work preserved, and conditions put in place to ensure a successful return to work and job retention. During the return phase, it is recommended that immediate follow-up be carried out to ensure that the work requirements correspond to the employee's capacities (Stock et al., 2005). The presence of factors that contribute significantly to the restoration of work capacities should also be verified: a gradually phased-in return, changes in the conditions that contributed to the work absence, and welcome-back efforts and support on the part of the supervisor and co-workers. Periodic follow-up should then be carried out to allow for necessary adjustments to the work to be made according to the employee's condition (Stock et al., 2005). It is important that this process be seen from the perspective of making optimal use of the employee's capacities without unduly hastening the

return to work (Stock et al., 2005). Again, the return to work does not take place at the end of a complete health recovery but rather through an ongoing process in which health is gradually restored in the context of the work activity and is gauged to work requirements (St-Arnaud, 2001). Lastly, practices are improved through a joint effort, in partnership with the stakeholders concerned, promoting reflection on current practices and evidence-based data (Patton, 1997; Weiss, 1997). The implementation of programs (and best practices) must also involve a systematic process of developing a program theory that reflects both scientific and empirical data (Chen, 2005; Rossi, 2004; Weiss, 1997).

3.5 Program theory

These initial stages of the research project were followed by two presentations: one to the research steering committee and the other to all of the organization's directors and executives. The first presentation concerned the results of the interviews with the organization's key stakeholders. At that time, the steering committee came up with its first major finding: no common vision of sick leave and the return-to-work process existed in the organization. The second presentation concerned the absence-management and return-to-work program adopted in various organizations and its theoretical foundations. Following that presentation, the steering committee had to give its assessment of the best practices proposed and build a program theory in collaboration with the research team. Five meetings were held at one-week intervals to jointly build the program theory. Each meeting began with a progress report based on analysis of the comments and suggestions submitted at the previous meetings. Once the program theory was approved by the steering committee, the research team proceeded to develop models for the theory in order to facilitate later evaluation. The program theory developed in the context of this project includes a theoretical model of the problem as well as logic and operational models of the program. The theoretical model documents the theoretical and empirical foundations of the problem situation on which the program is designed to act. The logic model presents the ultimate aim of the program designed to act on the problem situation, the intervention objectives that will be pursued to attain the ultimate objective, and the production objectives that will serve to carry out the intervention objectives. The purpose of the operational model is to translate the logic model into a concrete action plan. Each production objective is therefore associated with an action process representing what must actually be done to carry out the program. For detailed descriptions of the theoretical, logic, and operational models, see Figure 5.

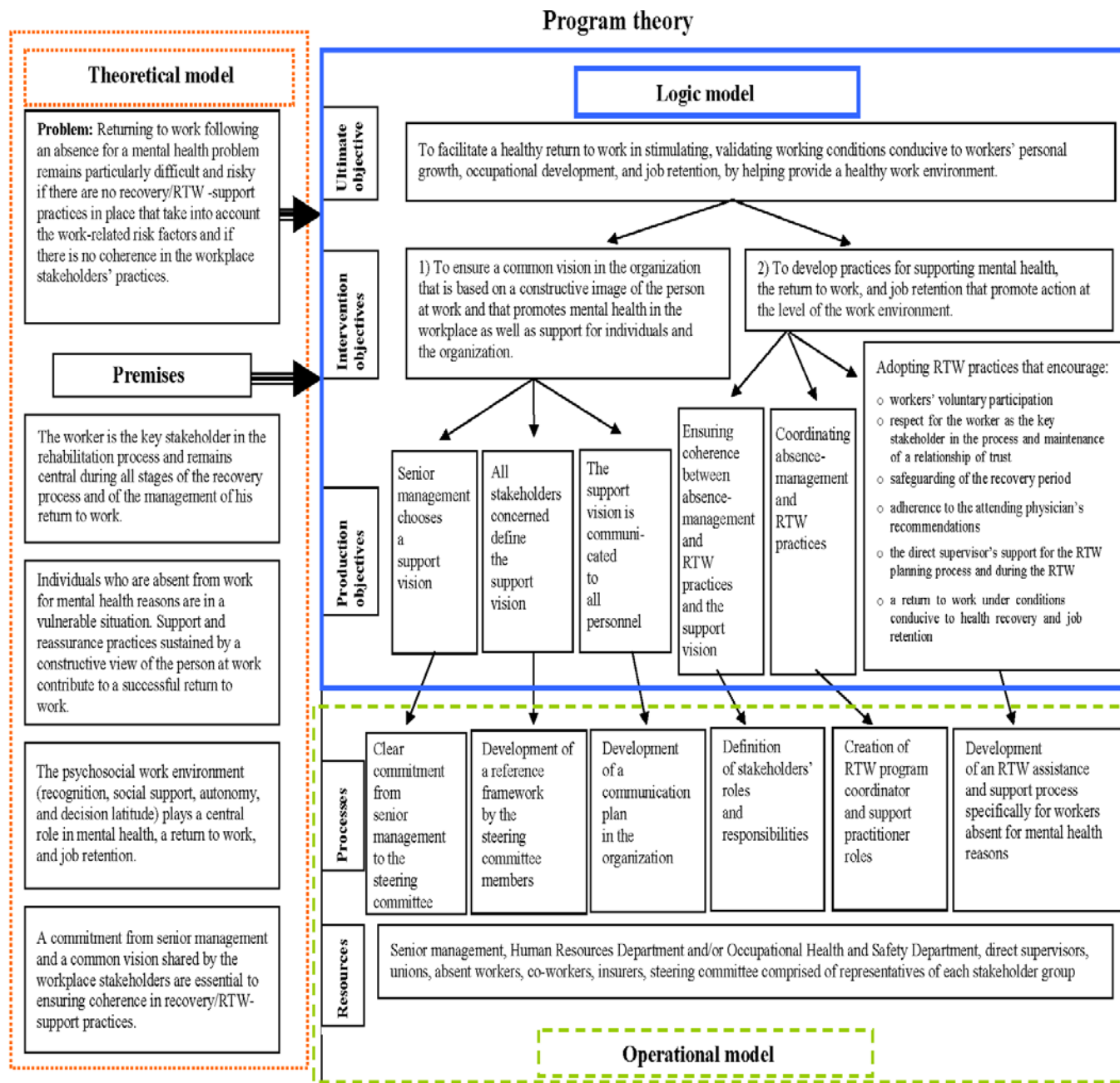


Figure 5 – Synthesis of the program theory

3.5.1 Theoretical model

3.5.1.1 Definition of the problem

Returning to work following an absence for a psychological health problem remains particularly difficult and risky if there are no recovery/return-to-work support practices in place that take into account work-related risk factors and if there is no coherence in the workplace stakeholders' practices.

3.5.1.2 Theoretical premises

Based on our analysis of the broad theoretical foundations for absence management and the return-to-work program, four main premises were identified to support the development of the program for workers absent for mental health reasons:

- The worker is the key stakeholder in the rehabilitation process and remains central during all stages of the recovery process and of the management of his return to work;
- Individuals who are absent from work for mental health reasons are in a vulnerable position. Support and reassurance practices sustained by a constructive view of the person at work contribute to a successful return to work;
- The psychosocial work environment (recognition, social support, autonomy, and decision-making power) plays a central role in mental health, a return to work, and job retention;
- A commitment from senior management and a common vision shared by the workplace stakeholders are essential to ensuring coherence in recovery/return-to-work support practices.

3.5.2 Logic model

The logic model of the program theory was therefore developed on the basis of the problem definition and the theoretical premises.

3.5.2.1 Ultimate objective of the program

The ultimate objective is to facilitate a healthy return to work in stimulating, validating working conditions conducive to workers' personal growth, professional development, and job retention by helping provide a healthy work environment.

3.5.2.2 Intervention objectives

- To ensure a common vision in the organization that is based on a constructive image of the person at work and that promotes mental health in the workplace as well as support for individuals and the organization;
- To implement practices for supporting mental health, the return to work, and job retention that promote action at the level of the work environment.

3.5.2.3 Production objectives

1. More specifically, to ensure a common vision in the organization that is based on a constructive image of the person at work and that promotes mental health in the workplace as well as support for individuals and the organization, it is essential that: senior management choose a vision of support for both individuals and the organization; that this support vision be defined by all stakeholders concerned; and that the support vision be communicated to all personnel.

1.1 Senior management chooses a support vision

To ensure that senior management adheres to the main premises underlying the program theory and that it opts to adopt a support vision in the organization, the steering committee must obtain **a clear commitment from senior management** to the effect that it will favour this support vision rather than an absence-control vision. This commitment must be expressed clearly and in writing, for example, in the minutes of a steering committee meeting. Senior management's commitment can also take concrete form such as offering formal recognition to direct supervisors who implement support practices for workers on their teams.

1.2 All stakeholders concerned define the support vision

The support vision can be defined by all stakeholders concerned by **developing a reference framework regarding mental health at work and support for individuals and the organization**. It is important that each group of stakeholders involved in absence management and the return-to-work process actively takes part in defining the reference framework in order to encourage the factoring in of diverging viewpoints and realities in the organization, so that everyone in the organization can identify with this new vision. The objectives of developing a reference framework are as follows: to adopt a clear policy on management's orientations regarding absence management and the return-to-work process, a policy that aims to show senior management's solid backing of an approach that supports recovery and the return to work; and to ensure that a common understanding of this approach is disseminated throughout the organization.

1.3 The support vision is communicated to all personnel

In concrete terms, this means **developing a communication plan in the organization** to convey the support vision and its various components to all personnel. To ensure a common vision in the organization that promotes mental health at work and support for individuals and the organization, it is necessary not only to have a clear commitment from senior management and to define this vision collectively, but also to inform all members of the organization of this vision.

2. To develop practices for supporting mental health, the return to work, and job retention that promote action at the level of the work environment, it is essential to ensure coherence between absence-management and return-to-work practices and the support vision; to coordinate these practices; and to adopt return-to-work practices that are based on the main foundations of mental health at work.

2.1 Ensuring coherence between absence-management and return-to-work practices and the support vision

Evidence-based data suggest that in addition to promoting workplace-based intervention programs, it is important to emphasize a collaborative process among the partners involved in the return-to-work process (Durand et al., 2001; Durand, Loisel, Charpentier, Labelle & Nha Hong, 2004; Franche et al., 2005; Loisel et al., 2001). Managers, unions, workers, human resources managers, medical resource persons, and insurers must all work together and act consistently during each stage of the return-to-work process (Stock et al., 1999). To ensure coherence among practices and with the previously defined support vision, it is essential to **define the roles and responsibilities of the various stakeholders** involved in absence management and the return-to-work process. According to Baril et al. (2003), it is preferable to separate absence-control functions from recovery/return-to-work support functions. Even if this distinction is made, the credibility of return-to-work support programs can be jeopardized. In fact, maintaining stakeholders with contradictory roles in a given organization can generate confusion as to the organization's real intentions. Like the vision of the reference framework, the stakeholders' roles and responsibilities must be defined by the stakeholders concerned as they are best placed to do so taking their reality into account. Once defined, the roles and responsibilities should be reviewed by all the other stakeholders to ensure coherence.

2.2 Coordinating absence-management and return-to-work practices

To maintain coherence in absence-management and return-to-work practices, it is important to ensure coordination. A growing number of studies recommend hiring a person to be responsible for coordinating the recovery/return-to-work support activities (return-to-work coordinator) (Olsheski, Rosenthal & Hamilton, 2002; Russo & Innes, 2002; Shaw, Hong, Pransky & Loisel, 2008; Young et al., 2005). This role can include both an organizational intervention function (program coordinator) and an individual intervention function (recovery/return-to-work support practitioner). In the operational model, it is a matter of creating these two roles to ensure the coordination of practices on both the organizational and individual levels. Two types of actions must be documented and carried out: (1) actions aimed at identifying and modifying organizational risk factors that affect not only the person who is absent from work, but also the other workers; (2) actions concerning more specifically the absent worker's situation and collaboration with his direct supervisor and the stakeholders in charge of his clinical or administrative follow-up, who can have different aims and contexts. A position of neutrality and independence, removed from medicolegal and administrative issues, is essential to performing this job. According to Shaw et al. (2008), the success of the intervention would appear to depend more on ergonomic skills, skills in assigning modified tasks, and communication and conflict-resolution skills than on medical skills.

2.3 Adopting return-to-work practices that are based on the main foundations of mental health at work

To adopt practices that support recovery and the return to work, it is useful to **implement a structured recovery/return-to-work assistance and support process for individuals who have been absent for a mental health problem**. The use of a “practices mapping” method is highly pertinent as it helps visualize the trajectory of a person involved in the process and the relationships among the various stakeholders concerned. This process is built on six main foundations underlying mental health at work: workers’ voluntary participation; respect for the worker as the key stakeholder in the process and maintenance of a relationship of trust; safeguarding of the recovery period; adherence to the attending physician’s recommendations; support offered by the direct supervisor during the return-to-work planning process and the return to work; and a return to work under conditions conducive to health recovery and job retention.

3.5.3 Operational model

The operational model provides a plan for using the logic model by specifying the actions needed to give concrete form to the production objectives. The operational model was designed in collaboration with the steering committee and in light of both the workplace’s current practices and the various practices implemented in other organizations. It comprises six intervention measures:

1. Obtain from senior management a clear commitment to the steering committee in favour of a support vision;
2. Develop a reference framework regarding mental health at work and support for individuals and the organization;
3. Create the position of return-to-work coordinator position (program coordinator and recovery/return-to-work support practitioner);
4. Define the roles and responsibilities of the different stakeholders;
5. Develop a communication plan in the organization designed to disseminate the information on the program;
6. Implement a recovery/return-to-work assistance and support process designed specifically for workers absent for mental health reasons.

Prior to implementation in the workplace, each of the six measures was developed jointly with the members of the research steering committee during the many meetings held to draft the action plan. Each intervention measure was submitted for approval by all the committee members and the organization’s senior management. Meetings with the organization’s steering committee also ensured senior management’s constant support and thorough understanding of the measures, thus promoting broader dissemination of information about the program in each division.

3.6 Implementation of the operational model

This section describes the implementation in the organization of the pertinent practices retained in the operational model of the program theory, with a sample of workers absent for mental health reasons.

3.6.1 Senior management's support vision and commitment

The theoretical foundations and our analysis of the current practices observed among the workplace stakeholders as well as the organization's absence-management and return-to-work support practices reinforced the development of a program theory and an operational model. The first step consisted of conceptualizing and operationalizing the importance of senior management's adoption of a clear position regarding support for recovery and return to work. Teamwork with the members of the steering committee was initiated to produce a reference framework that would specify an individual and organizational support vision and the roles and responsibilities of each stakeholder involved in the support process proposed by the organization. The challenge posed by the task of coordinating the various stakeholders' activities also led the committee to suggest hiring a return-to-work coordinator who would handle both communication and absent-worker support and follow-up. Lastly, a communication plan aimed at disseminating the reference framework content was developed to ensure dissemination of the organization's vision.

Senior management thus made a clear choice to adopt an individual and organizational support vision, a choice ratified by all stakeholder-group representatives on the steering committee. This management decision was reported in the minutes of one of the committee's meetings. It was agreed that this choice had to translate into the implementation of concrete actions explicitly underscoring senior management's commitment in this regard. The development of a reference framework, its dissemination to all personnel, and the allocation of a specific budget for hiring an additional resource person dedicated to the program were deemed concrete actions that would attest to the seriousness of senior management's commitment. In addition, the committee members discussed the importance of recognizing the support practices introduced by the direct supervisors. To this end, it was decided that the direct supervisors who were asked to participate in the assistance process would receive a letter of thanks signed by the organization's director general.

3.6.1.1 Reference framework

Developed in collaboration with each of the stakeholders on the steering committee, the reference framework was supposed to specify senior management's orientations regarding its vision of support for mental health at work and the organization's values regarding support for individuals. The framework also proved an ideal means for clarifying the roles and responsibilities of each group of stakeholders involved in the recovery and return-to-work support program. It was only after several meetings with the steering committee that the reference framework could be developed using a collaborative process that involved the representatives of the organization's various stakeholders. The individual and organizational support vision was defined as being:

- based on human values that regard a person at work as, above all, a stakeholder who is motivated by his work and whose absence is not desired;
- pivotal for defining practices aimed at helping individuals experiencing a mental health problem to regain their social and occupational capacities and a sense of well-being and of professional achievement;
- materialized through implementation of concrete actions targeting the psychosocial environment and ensuring the shift from individual support practices to organizational practices focused on prevention;
- the basis for practices carried out in an atmosphere of trust and reflecting an attitude built on respect for people as well as mutual help and collaboration among the workplace stakeholders.



Figure 6 – Coherence of stakeholder roles in the individual and organizational support vision

In addition, it was decided that the reference framework would be a useful tool for disseminating the organization's vision of support and of the stakeholders' roles and responsibilities. A communication plan was then drawn up in collaboration with the steering committee members. The reference framework was to be distributed to all the organization's employees to inform them of the support vision to which senior management had subscribed, the values advocated by this vision, and senior management's expectations regarding the roles and responsibilities to be adopted by the various stakeholders. The aim was to increase all personnel's awareness of the implications of adopting a support vision for the organization. In addition, several committee meetings were spent defining the roles of the organization's stakeholders (see Appendix F) that

sooner or later could be targeted by the recovery/return-to-work support process. The representatives of each group of stakeholders on the steering committee were responsible for determining their roles and responsibilities. All roles and responsibilities were then re-examined with all members of the committee to ensure their coherence with the support vision and coherence among the various stakeholder groups.

3.6.1.2 The shift from a biomedical to a psychosocial paradigm

One of the first points that emerged during the process of formally defining each stakeholder's role and responsibilities was the confusion between the role of the Occupational Health and Safety Department and that assigned specifically to the recovery/return-to-work support practitioner. In fact, the intervention process with the workers involved the voluntary participation of the absent workers. All workers absent for a mental health problem were systematically invited to take part in the process. It was decided that the individuals who preferred not to participate or who had not responded to the invitation would be subject to the organization's usual follow-up procedures. As noted earlier, the Occupational Health and Safety Department initiated two types of practices: the first focused on support and the second on control practices. In the latter case, the representatives of the Occupational Health and Safety Department continued their use of medical assessments leading to an anticipated date of return established by the attending physician. The maintenance of this practice as a process for controlling absence in terms of reasons and durations undermined the support vision, particularly in the eyes of the union stakeholders, who perceived these practices as running counter to the program objectives. Moreover, one of the major challenges faced by the support practitioner was that of earning the worker's trust while maintaining his own credibility with managers and the other parties involved (MacEachen et al., 2006). A position of neutrality and independence, removed from medicolegal and administrative issues, was key to carrying out this job. However, in reality, maintaining stakeholders in the organization who had contradictory roles created confusion as to the organization's real intentions. The fact that the Occupational Health and Safety Department maintained its dual role also undermined the impact of the position adopted by management in favour of providing individual and organizational support.

The Occupational Health and Safety Department's resistance to shifting from an absence-control paradigm and a vision centred on a clinical definition of the problem to a psychological-health-at-work paradigm that takes into account the relationship between the person and his environment is partly attributable to the training of the occupational health and safety manager and practitioners. In actuality, the training of the Occupational Health and Safety Department's personnel is based on clinical practices in nursing, medicine, and psychology. Yet according to Shaw et al. (2008), the success of return-to-work support interventions appears to depend more on skills in communication, conflict resolution, ergonomics, and modified task assignment than on medical training skills. These new practices require taking a different, more neutral position with direct supervisors and giving the absent workers back their voice so that their concerns can be taken into account. In addition, absences should not be controlled and recourse to psychiatric assessments in particular should be avoided (they are sometimes carried out at the direct supervisors' request in order to force the return to work of persons absent for reasons deemed to be unjustified, as, for example, following the threat of a disciplinary measure). The pressure

exerted by other managers on the Occupational Health and Safety Department manager can make it harder for him to maintain a neutral position.

3.6.2 Recovery/return-to-work assistance and support process in cases involving mental health at work

With the steering committee's collaboration, the research team developed a process for assisting and supporting the recovery and return to work of employees absent for mental health reasons. The process was represented schematically on the basis of the definition given to the support vision and the reference framework and of the workplace's current practices and structures regarding administrative follow-up of absences and return to work. These diagrams are shown in figures 7a, 7b, and 7c and were presented to the occupational health and safety team in the workplace to verify the feasibility of implementation. The process involved six steps:

1. Administrative procedures and invitation to participate in the assistance process;
2. First contact made with the participants;
3. Assisting each worker and identifying the factors hindering and facilitating his recovery and return to work;
4. Preparing for the return to work and drafting the return-to-work plan;
5. Return to work and implementation of the return-to-work plan;
6. Follow-up of the return to work and readjustments as needed.

The recovery/return-to-work support practitioner was the person responsible for carrying out the assistance process and helping participants from the start of their absence to the follow-up phase subsequent to their return to work.

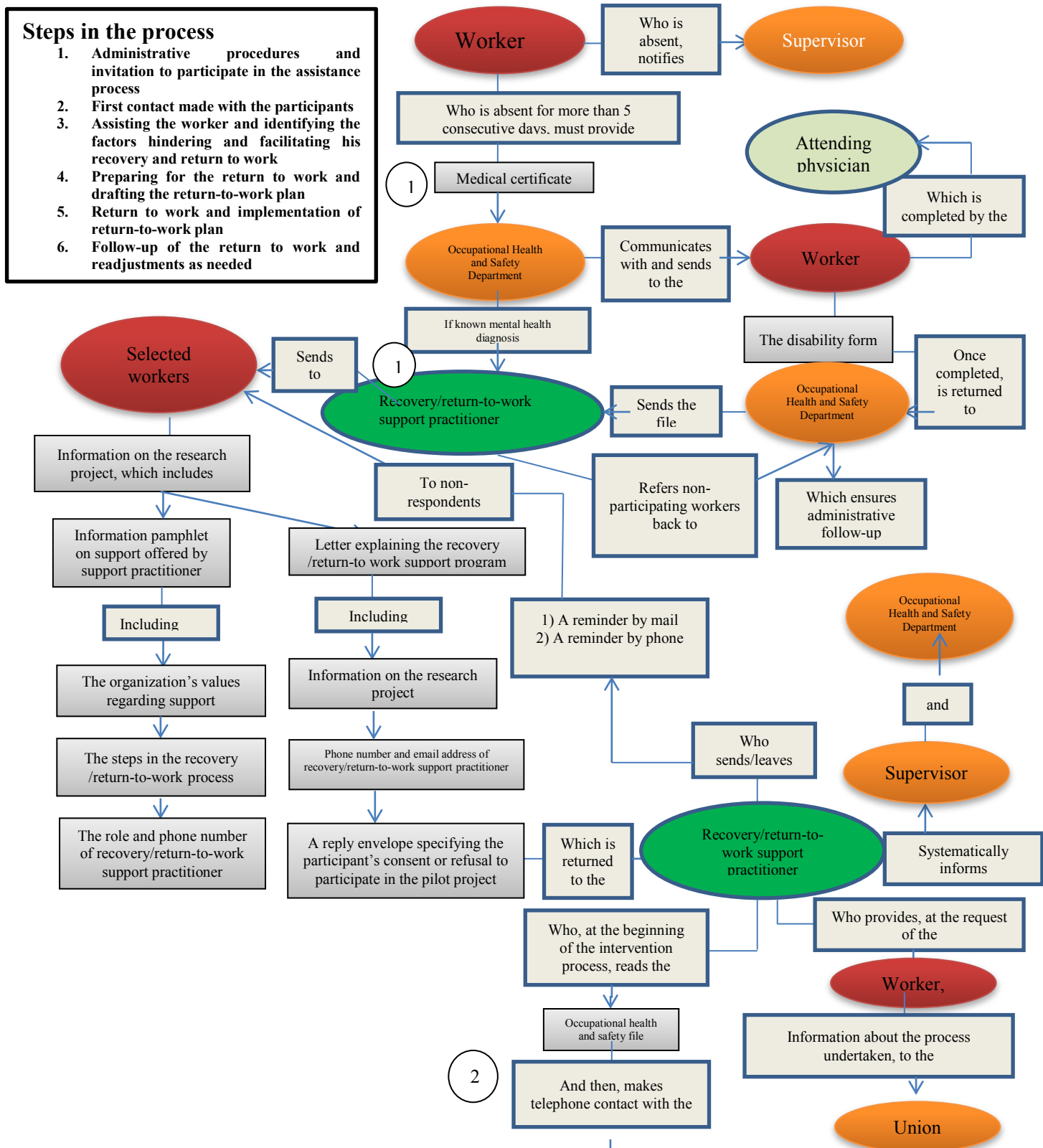


Figure 7a – Recovery/return-to-work assistance and support process, steps 1 and 2

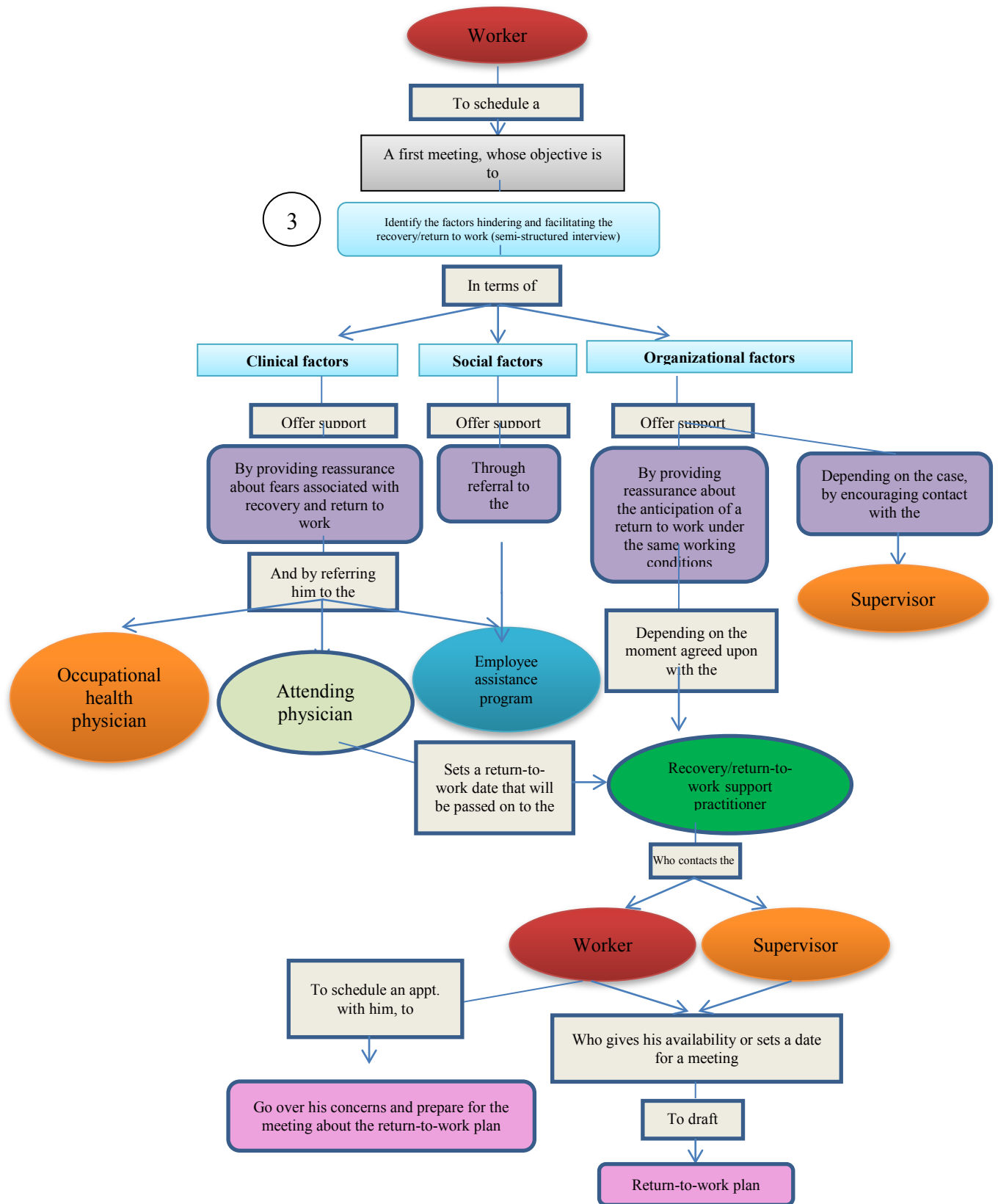


Figure 7 b – Recovery/return-to-work assistance and support process, step 3



Administrative procedures and invitation to participate in the assistance process

As part of this study, the organization's workers who were absent for a mental health problem certified by their attending physician were systematically invited to take part in the recovery assistance and support process prior to their return to work. An absence file was opened by the Occupational Health and Safety Department as soon as a person was absent for more than five consecutive days. The Occupational Health and Safety Department contacted the person in order to send him a disability form to be completed by his attending physician and returned to the department. This person's file was then transmitted to the recovery/return-to-work support practitioner. For each new absence related to a mental health problem, a file was sent by the Occupational Health and Safety Department to the support practitioner, who in turn sent each absent person a letter inviting him to participate in the process. If the support practitioner received no answer in ten days, a second invitation letter was sent out, stating that a telephone call would follow in the next ten days to gauge the person's interest in participating. The telephone call also provided an opportunity for clarifying the program objectives, answering potential questions, and reassuring the worker about the process. Participation in the process remained voluntary from start to finish. Anyone who agreed to participate was free to withdraw at any time. No negative consequences were associated with non-participation. All employees who declined to take part in the pilot project were followed in the usual manner by the Occupational Health and Safety Department.

3.6.2.1 First contact with the participants

Employees who agreed to take part in the program received a call from the support practitioner to determine the best time for scheduling a first meeting. This call provided an opportunity both to re-explain the program objectives and the terms and conditions of participation and to assure the person of the individualized pace and confidentiality of the process. In several instances, the support practitioner's neutral position had a reassuring effect. This first telephone contact also allowed some employees to express their concerns about their absence and return to work and it sometimes provided a sense of their state of health or energy level. Following this initial telephone contact with the worker, the support practitioner notified the direct supervisor that his employee was taking part in the process. The supervisor was also told what this participation would entail and the role that he would have to play at the preparatory meeting with the employee about his return to work. The support practitioner explained the steps in the process as well as his role and responsibilities. All the direct supervisors of the employees who agreed to participate in the pilot project were contacted and signed onto the process; some of them had more than one employee participating in the support program.

3.6.2.2 Assisting the worker and identifying the factors hindering and facilitating his recovery and return to work

As soon as the worker felt able to do so, usually a few weeks after the start of his sick leave and depending on what had been agreed to during the initial call, he was invited to a first interview with the support practitioner. The purpose of this meeting was, with the worker and based on his perception of things, to draw up a list of the factors hindering and facilitating his recovery and return to work. The meeting took place away from the employee's workplace, specifically at the

support practitioner's office, as previously agreed with the steering committee. This measure was designed to preserve the support practitioner's neutrality and ensure a degree of discretion for employees who did not necessarily wish to meet their co-workers or supervisor at this point in the process. All the participants underwent an initial individual interview with the support practitioner, which began with a brief review of the worker's employment history up to the last job held prior to the work absence. The worker was asked to talk about personal and organizational factors that contributed to the deterioration in his health, his stopping work, the steps he took to seek professional help, and his current state of health. The interview was conducted by means of open-ended questions in order to give the employee the opportunity to express his interpretation of the situation in his own words. When the worker felt able to talk about his work, the discussion focused in greater depth on specific aspects of it. He was then questioned about his tasks, his relationships with his supervisor and co-workers, and his worries about the idea of returning to work. This process gave the workers space to think about their work and the opportunity to describe an often ill-defined, sometimes poorly understood, experience in words, and gradually to identify the relative importance of their needs.

The interview also served to clarify the workers' resources and needs in terms of clinical support and social support outside work. By exploring aspects of their lives outside work, the support practitioner was able to ensure that they had the necessary support to assist them with their personal problems and inform them of specialized services they could turn to if needed. Support from family and friends and the fact of being able to resume activities outside work or to benefit from a change of scene were generally experienced as very helpful during the recovery period. Depending on the case, it was recommended either that the worker consult the employee assistance program (EAP) in his organization, which offers a guidance counselling service for workers with personal problems, or that he consult clinical support services more specialized in mental health and health at work with the support of his attending physician. The purpose of these recommendations was to make the treatment plan more effective by offering the worker and his physician access to specialized resources. In addition, the Four-Dimensional Symptom Questionnaire (4DSQ), which concerns distress and symptoms experienced in the previous week, was used to follow the workers clinically and help them pinpoint their assistance needs. The perception they had of their general state of health systematically concurred with their 4DSQ results.

The ultimate aim of the first meeting was to create a relationship of trust with the worker while also encouraging the re-establishment of a positive relationship with his work. This latter process is based on the fact that work is a very powerful component in the recovery process and in discovering one's own power to act on situations. However, in our project it was often too early at this stage to broach solutions that might enable the worker to envisage a return to work. The person often feels the need to detach from work and refocus on himself, his health, and his personal interests. Some direct supervisors were asked about the opportunity they had to communicate with their employees during their absence. The interview provided an occasion for checking the participant's willingness to be contacted by his direct supervisor during this period. The support practitioner was then able to act as the link between the supervisor and the employee. Between the time of the first interview and the time when the employee was preparing to return to work, and with his consent, the support practitioner performed regular follow-ups to maintain a supportive relationship built on trust. Not only did these calls allow the worker to

express his spontaneous view of any changes in his state of health and his specific needs, but they also allowed his thoughts and actions to be tracked (search for solutions to improve his health, to address his personal and work-related concerns; resumption of activities outside work). In addition, the employees had the opportunity to seek advice or administrative information about assistance resources and collective agreements. Some workers discussed their apprehensions about the meeting scheduled with their direct supervisor (to prepare the return-to-work plan).

3.6.2.3 Preparing for the return to work

When the worker was ready to return to work and the attending physician had set an official date for the return, the support practitioner offered to meet with the worker again to prepare for the eventual interview with his direct supervisor. At the previous meeting, the worker had had a chance to list and describe his concerns about his recovery and return to work. This second face-to-face meeting took place on a voluntary basis when the employee was at the point of returning to work. Actually, in some cases, the return-to-work preparatory meeting took place at the same time as the first meeting. The specific aim of the preparatory meeting was to pinpoint which of the worker's concerns were paramount for him and might be a topic of discussion with his direct supervisor with a view to identifying courses of action likely to facilitate his return to work and job retention. This meeting also had an impact on the worker's anticipation of the return-to-work conditions and reinforced his sense of self-efficacy by working on his power to act.

Once the worker's concerns had been clearly identified, the support practitioner drew up a preliminary draft of the return-to-work plan, including each of the points raised by the worker. Generally, it addressed three or four of the most important concerns. The draft return-to-work plan served as a working tool for the return-to-work planning meeting with the direct supervisor. The support practitioner then called the direct supervisor to organize the return-to-work planning meeting. During this call, the support practitioner was able to reassure the supervisor, if needed, of his role and to outline the meeting procedure. The aim of the return-to-work planning meeting between the worker, his direct supervisor, and the support practitioner was to establish a return-to-work plan that targeted, if needed, aspects of the work environment that could be altered to support the return to work and job retention.

3.6.2.4 Drafting the return-to-work plan: meeting between the worker, direct supervisor, and support practitioner

This meeting between the worker and his direct supervisor, led by the support practitioner, was designed to assist them in drafting a written return-to-work plan. First, each of the worker's concerns was raised by the support practitioner, explained by the worker, and discussed with the direct supervisor. The supervisor and worker were then asked to assume open-minded attitudes based on active listening and focused on looking for solutions. Possible courses of action were sometimes explored while taking into account the work organization constraints mentioned by the supervisor. The various levels at which action could be taken included: temporary adjustment measures to promote a gradual return; permanent adjustments to the work environment; conflict resolution or mediation activities; prospects of reassignment to another job or another unit; and accommodation measures. Lastly, the return-to-work plan also provided an opportunity for

identifying the welcoming-back activities planned to support the worker at the time of his return. Not only did the meeting give the worker a chance to express himself, to listen to his direct supervisor's point of view, and to discuss his concerns about his work with his supervisor, but it also allowed both of them to understand each other, to hear the constraints they each faced, and to grasp each other's realities and those of the organization. Moreover, the direct supervisors received very welcome support in their process of assisting in the return to work, as many of them often felt at a loss as to what to do or say. In short, this meeting facilitated the worker's return for all parties concerned, and they all received a copy of the return-to-work plan as soon as the worker returned to work.

3.6.2.5 Return to work and implementation of the return-to-work plan

The return-to-work plan stated the date of the planned return as well as the welcoming-back procedures agreed to by the worker and his supervisor. Generally speaking, the direct supervisor or someone mandated by him was present to greet the worker. As previously defined, the direct supervisor's responsibilities included implementing the return-to-work plan.

3.6.2.6 Follow-up of the return to work and readjustments

For his part, the support practitioner performed telephone follow-up one to three weeks after the return to work, speaking to the workers and their direct supervisors to learn how the return was going, whether the return-to-work plan was being adhered to, and whether adjustments were needed. The participants and direct supervisors were also encouraged to contact the support practitioner at any time after the return to work to discuss concerns or verify certain aspects of the return to work. In addition, the return-to-work procedures had to be adjusted to the real situations encountered by the worker upon his return. Readjustments were sometimes necessary to reflect the variably stable progression in his state of health and to keep pace with the many changes likely to occur within the work organization.

3.6.3 Reversal of risk factors through preventive practices: a winning strategy

The theoretical foundations identified and our analysis of the stakeholders' practices nonetheless highlighted the importance of repositioning the worker as the key player in his return-to-work process and of implementing an assistance process for the workers on leave who volunteered to participate. People who are off work for a mental health problem are in a vulnerable position in which their self-esteem and confidence in their ability to act are usually lowered. It was therefore decided to systematically implement reassurance practices throughout the process for the individuals who had agreed to participate. Fear of being perceived as weak because of their inability to handle the work pressure was one of the fears expressed by the workers on leave to explain why they had refused to see a physician or were absent from work. Conversely, some workers felt guilty about being absent, as if the erosion of their state of health signalled their weakness, despite real, particularly incapacitating symptoms (St-Arnaud et al., 2004, 2009). According to Haslam, Atkinson, Brown and Haslam (2005), mental health problems still elicit strong resistance in the workplace due to the related prejudices. This first finding makes the crucial importance of reassurance and support practices all the more understandable. The first

step in the assistance process was therefore to reassure the absent worker by offering him support throughout his recovery and return to work.

A few weeks after the start of his sick leave, the worker was invited to a first meeting with the support practitioner to determine with him, based on the worker's perception of the situation, the factors hindering and facilitating his recovery and return to work. However, it was up to the worker to decide when he felt ready for this first interview. Before contemplating work, he first has to recover (St-Arnaud et al., 2004). People's perceptions of their state of health remain an important factor to be considered in the rehabilitation process. Many studies have shown that such perceptions are generally accurate and valid (Moller, Kristensen & Hollnagel, 1996; Shalbolt, 1997). At this meeting, the clinical, social, and organizational factors were examined. The interview began with a brief review of the person's work history up to the last job held before the sick leave. Also, our analysis of the available resources and of the workers' needs in terms of clinical and social support revealed that several requests had been made for an extension of the psychological services offered through the employee assistance program. In a few instances, specialized psychiatric services were used to meet more specific clinical needs. This clinical assistance served to support the worker's attending physician by making complementary treatment available. Carried out with the consent of both the worker and his attending physician, the practice made it easier to support the individual in his efforts to manage his treatment plan. The assessment obtained using the Four-Dimensional Symptom Questionnaire (4DSQ) on distress and symptoms felt by the worker during the previous week served solely to confirm his perception of his state of health. The need to use such a tool may therefore be questioned if we focus instead on the activities designed to help the person regain confidence in his judgment and in his capacities to think and act.

Shedding light on the work-related obstacles and facilitators and providing a forum for dialogue where these factors can be discussed with the direct supervisor constitutes one of the key points in this process. This activity allowed the worker to talk about what worried him and gradually to see himself as a stakeholder in his recovery process by clarifying what he regarded as one of the factors undermining his state of health and what he still saw as an obstacle to his return to work (e.g. work overload, conflict with a co-worker). It also let him specify his needs in terms of support during his return to work. What was voiced at the first meeting with the support practitioner was distilled down to two or three major concerns that the worker wished to broach with his direct supervisor and for which he hoped to receive support. This activity can have a powerful impact in terms of the worker taking charge of his process of change and his power to influence his return to work and job retention. According to Le Bossé (2003), the power to act, or more specifically empowerment, consists of increasing a person's capacity to bring reality into line with his aspirations. This process is based on two important aspects: the availability and accessibility of resources in the workplace and the person's volition and capacity to take his life in hand. No changes occur if the necessary resources to achieve them do not exist or if the individual does not have the will to act. The two aspects are interdependent. This process is meant to be comprehensive: by taking into account the person in his work environment, it is concrete and contextualized. Again according to Le Bossé (2003), an empowerment-based process necessarily implies that the person involved is at the heart of the process of defining the desired change. With the support practitioner's help, the individual succeeds in taking conscious action within this change process. In addition to the importance of the welcoming-back process, the support offered at work, and the implementation of reassurance practices during the work

absence, it would appear that being able to make changes in his work is one of the key determinants of a worker's successful return (Brenninkmeijer et al., 2008; Caveen, Dewa & Goering, 2006; St-Arnaud et al., 2007). Anticipating a return under difficult conditions can be source of anxiety that hinders the recovery process (St-Arnaud et al., 2006), while conversely, being able to act on one's work environment is a key component of a successful return to work (St-Arnaud, 2007).

The meeting between the worker, his direct supervisor, and the support practitioner was aimed specifically at defining a return-to-work plan that would take into account aspects of the work environment conducive to the return and job retention. The supervisor was asked to adopt an open-minded attitude based on active listening and focused on searching for solutions. The courses of action explored took account of both the worker's needs and the work organization's constraints as expressed by the supervisor. Various levels of intervention were planned: temporary adjustment measures to promote a gradual return, permanent adjustments to the work environment, conflict resolution or mediation activities, prospects of reassignment to another job or unit, and accommodation measures. The return-to-work plan was also used to specify the welcome-back activities anticipated to support the worker at the time of his return. The prospect of gradually returning to work and of being welcomed back and supported by co-workers and supervisors, and above all, the adaptation of the psychosocial work environment are key determinants of a successful return to work that sets out the conditions for shifting from a state of threatened vulnerability to one of reassured vulnerability (St-Arnaud et al., 2003; St-Arnaud et al., 2007). The first days back at work are often characterized by a feeling of vulnerability and fear of relapse. Only gradually do people regain confidence in their capacity to work and feel that they are able to cope well with their work (St-Arnaud et al., 2004). The welcome and support they receive from their supervisor and co-workers remain critical during their return. In addition, follow-up must be carried out with both the worker and his direct supervisor. In our project, readjustments had to be made in some cases due not only to the variably stable progression in the person's state of health but also to changes in the work organization. The support practitioner enlisted the collaboration of the other stakeholders in the organization and management to ensure that the components of the return-to-work plan were complied with. One of the major challenges faced by the organization at this stage of the process was that of supporting the implementation of the return-to-work plans. As will be seen in the evaluation of the supervisors' practices, introducing changes and following up on interventions remain difficult challenges.

4. SHORT-TERM EVALUATION OF THE PROCESS

The aim of this part of the research project was to evaluate the workers' and supervisors' experience using individual interviews, questionnaires, and statistical analyses of the data compiled on the workers who participated in the program. The data sources used for this short-term evaluation of the process were: a profile of the program participants; statistical analyses obtained by comparing the results obtained by the workers who participated in the process with those of a control group; questionnaires that were distributed to program participants and designed to ascertain their experience; and interviews conducted with the direct supervisors (see Appendix G).

4.1 Practices targeting the essential issue

Our analysis of the program participants' profile revealed that the vast majority of the individuals met saw work as one of the main causes of their health problem and work absence. In fact, 45% regarded work as the main cause of their absence, 42% saw their absence as related to both their personal life and work, and 13% saw it essentially as related to their personal situation. These results concur with research conducted on this subject (Cohidon et al., 2009; St-Arnaud et al., 2007). In addition, more in-depth analysis of the average duration of absence by cause revealed that the average duration was shorter for individuals who were absent essentially due to work than for the other participants. Conversely, those absent for personal reasons appeared to take more time to return to work. These results may reflect the impact of an intervention designed to act on the anticipation of the return to work and strengthen the feeling of self-efficacy. In this regard, the study conducted by St-Arnaud et al. (2007) showed that fewer of those who identified work as the main cause of their work absence actually returned to work. However, the researchers observed that, among the returnees, those for whom a positive change had been made during their return to work exhibited the best profile in terms of resolving their health problem.

Comparative analysis with a control group comprised of non-program participants also clarified certain differences in absence duration between the two groups. Specifically, participants in the process seem to have taken more time to return to work in the short term. However, once they began the process of receiving support for their recovery and return to work, it appears it was easier for them to return to work. These results lend credence to the hypothesis that targeting factors in the psychosocial work environment has an impact on the anticipation of the return to work and facilitates the return. The study results also indicate that there was no difference with respect to diagnosis. However, these results essentially concern adjustment and depressive disorders; divergent results may be observed for other diagnoses. Moreover, the pattern noted for absence duration was essentially the same, with the control group returning faster but also having a smaller proportion of long-duration returnees. The overall percentages of absence duration (in months) for an adjustment disorder diagnosis indicate that, although the subjects in the program-participant group were slower to return to work, a larger number of them were back at work as of the fifth month of absence. Similarly, the overall percentages of absence duration (in months) for a diagnosis of depression indicate that, although the subjects in the program-participant group were slower to return to work, a larger number of them were back at work as of the sixth and a half month of absence. Lastly, gradual returns were of a significantly longer average duration in the program-participant group than in the control group. These results are likely attributable to the nature of the process which, during the follow-up of the work absence and return to work,

offered the worker constant support. Consequently, several program participants asked that their gradual return be extended, or discussions with the supervisor led to this type of proposal. It would be interesting to see, when the program participants return to work after a gradual return that is longer in duration than in the control group subjects, whether their mental health problem is more often resolved than in the control group, which could be evidenced in fewer relapses. However, it should be noted that these conclusions were based solely on a limited population sample.

4.2 Participants appreciative of the process but changes still tenuous

The in-house questionnaires sent to the workers who took part in the recovery/return-to-work assistance and support process provided an anonymous assessment of the various aspects of the process. The results must, however, be regarded with caution as the response rate was only 58%, meaning a non-response rate of 42%. That said, the results concur with the content of the participant follow-ups conducted by the support practitioner during their absence and after their return to work. The results of the questionnaires indicate that, generally speaking, the participants greatly appreciated being able to benefit from the assistance process, with the responses being particularly positive regarding the support practitioner's role in the recovery and return to work. These positive results suggest that the process enabled the workers to create a relationship of trust with the support practitioner, which fostered the reconstruction of a positive relationship with the organization. The open-ended questions also supported the hypothesis that the support practitioner's attentive listening role and neutrality were factors much appreciated by the participants, who confirmed that they felt respected and not judged. Moreover, the process helped the participants identify the factors that contributed to their work absence and find solutions to help them return to and retain their jobs, which in turn strengthened their ability to return to work. The more negative assessments of the process essentially related to the implementation of actual changes in their work or workplace as well as adherence to the conditions of the return-to-work plan and its follow-up by the direct supervisor. In fact, some direct supervisors were hesitant to become fully involved in the process. The contradictory messages they received about the place and importance of the process may have dampened their commitment to fully assuming their role in carrying out and following up on the return-to-work plans, a role that usually involved calling the work environment into question.

4.3 Supervisors interested but still uncertain about senior management's real orientations

The interviews with the direct supervisors who participated in the process revealed the many advantages they attributed to it. These included having the opportunity to meet with the worker in the presence of a neutral support practitioner; gaining a better grasp of the worker's viewpoint and situation; benefiting from the assistance of the support practitioner, who does the preparatory work with the employee and orchestrates the meeting procedure as well as the return to work; and preparing more effectively for the return to work prior to the scheduled return date. The interviews also revealed that the direct supervisors saw certain limitations in the process, in particular their not meeting individually with the support practitioner prior to the meeting with the worker. This was the result of a decision made by the research team and ratified by the steering committee. According to Le Bossé (2003), only subjects of the follow-up process will

have a tangible experience of the problems created by the situation in which they find themselves. This is why the research team decided to base itself on the viewpoint of workers actually experiencing a work-absence situation involving a mental health problem over and above any other viewpoint. This practice was intended not only to preserve the relationship of trust between the support practitioner and worker but also to safeguard the confidentiality of what was discussed at the individual interviews. The support practitioner ensures that the discussion goes smoothly and remains constructive, with mutual respect always a top priority. Basing himself on the concerns expressed by the worker, the direct supervisor is able to access the worker's vision of his situation and, from this vantage point, to initiate the discussion, which in turn promotes open-mindedness toward practices of recognition at work. The support practitioner's role is not to speak in place of the worker at the interview, as the worker is deemed the person best placed to talk about his own concerns; the practitioner's role is simply to offer support to the worker in the process. In addition, it is the worker who chooses what he feels ready to talk about and sets the limits as to what he says. For his part, the direct supervisor does not have to make an immediate decision about solutions to be incorporated into the return-to-work plan, as he always has the freedom to verify certain details before including them in the plan.

Without such a process, it can be difficult for workers to make their voices heard by their direct supervisors, sometimes because the latter are too busy or because employees see them as inaccessible or intimidating. A worker may also find it threatening to reveal his vulnerability to his direct supervisor, which is why it is considered essential to the process' success that the supervisor take an active-listening and supportive position. Adopting a supportive position means not basing oneself on exceptional cases but, instead, learning to put one's prejudices aside and risk taking as a starting premise that all people are motivated by their work and thus do not want to be absent. When direct supervisors find themselves in this paradigm, they act directly within the dynamics of recognition in the workplace: recognizing that the individual did not want to be absent, that what he is experiencing in the work context matters, and that he is to be trusted. Yet to successfully maintain this stance requires shifting from an absence-control paradigm to a personal-support paradigm. This shift is more difficult to make when contradictory values and practices are present. Recognizing the role of the psychosocial work environment and the central role played by employee-health management practices is also a core premise of the recovery/return-to-work assistance and support process. At the interviews, several supervisors confessed to carrying a significant work overload and lacking time to reflect on the impacts of work organization on mental health, mainly because, like firefighters with several fires to put out, they are constantly faced with having to resolve more urgent priorities.

For Six (2000), middle managers' work overload is attributable to their having to take a diverse range of players into account, each of whose requirements stem from objectives with contradictory criteria. From this vantage point, the direct supervisors are seen as workers themselves, also subject to requirements imposed by their managers, who manage a vast number of demands arising from different logics of their own and develop complex compromises in the course of their work. According to Brun et al. (2007), direct supervisors generally have a very heavy workload, which constitutes a risk factor not only for their health but also for the implementation of organizational changes aimed at workers' well-being and improved mental health. Direct supervisors' work overload prevents them from thinking through the work and reflecting on possible courses of action for improving their personnel's mental health. In

addition, the factors in the psychosocial work environment recognized as having impacts on mental health (e.g. recognition, social support, decision-making autonomy, and workload) directly concern management practices (Brun et al., 2002). One possible hypothesis is that it can be difficult for a direct supervisor, who himself implements management practices, to recognize the role that the work environment may have played in an absent worker's mental health. Direct supervisors may also feel caught between senior management's demands to reduce disability insurance costs, on the one hand, and the responsibility they bear for their workers' health and well-being (Franché et al., 2005), on the other hand. Making their voices heard by senior management and being reinforced in their return-to-work support practices represents a considerable challenge. Direct supervisors clearly have a strategic role to play in assisting in and supporting the return to work, notably by helping the worker to identify the aspects of the environment that could be modified to facilitate his return to work and ensure his job retention. Several studies promote the implementation of training programs designed to give supervisors a better grasp of the importance of their role and of the factors in the psychosocial work environment, in mental health problems at work (Nieuwenhuijsen, Verbeek, De Boer, Blonk & van Dijk, 2004). In fact, these training activities could help facilitate the shift from an absence-control paradigm to a personal-support paradigm (Shaw, 2005). However, focusing on training programs while overlooking the limitations associated with senior management's orientations risks increasing the pressure on the direct supervisor and perpetuating a vicious cycle rooted in a social relationship that is primarily defensive, where one party's silence falls on the other party's deaf ears. The role of the direct supervisor, deemed central in return-to-work support practices, can only be properly fulfilled with support from the rest of the organization, particularly from senior management.

5. SHIFTING FROM REHABILITATION TO PREVENTION: THE CHALLENGE AHEAD

Taken individually, each intervention involving the psychosocial work environment promotes the return to work and job retention of individuals absent for mental health reasons. However, these practices are limited to case-based management. The challenge here is to succeed in shifting from a case-by-case approach to a determination of the factors in the psychosocial work environment likely to affect other workers. A cross-sectional analysis of the various concerns raised by the workers and of the action targets in the psychosocial work environment proposed in the action plan facilitates the transition from an individual approach to one targeting all the workers in the organization. In this case, the task consists of characterizing the factors in the psychosocial work environment defined by the workers and direct supervisors during follow-up and identifying the factors likely to affect other workers. This descriptive work could be done using an analysis grid of the risk factors in the psychosocial work environment (Vézina, Chénard, Bourbonnais, Brisson, Brun, Gourdeau et al., 2009). In addition, a validation process with the workplace stakeholders (Human Resources Department, union leaders, occupational health and safety managers, etc.) should help better define the themes that correspond to the workplace's organizational concerns. The shift from supporting rehabilitation to supporting prevention (see Figure 12) is prerequisite to an effective intervention strategy that ensures workers' return to work and job retention.



Figure 12 – Vision of individual and organizational support that allows a shift from rehabilitation to prevention in cases involving mental health at work

6. CONCLUSION

The systematic development of a program for managing the absences and return to work specifically of workers with mental health problems is a major scientific contribution to the field of occupational mental health. Prior to this project, no integrated return-to-work program had been systematized in collaboration with a workplace organization and its various partners. The results of this research project have highlighted the importance of support practices in a recovery and return-to-work process following an absence for mental health reasons. These findings led to the implementation of an assistance and support process designed both for organizations and for individuals on sick leave and involving the following steps: (1) itemizing the factors hindering and facilitating recovery and return to work; (2) drafting a return-to-work plan with the direct supervisor; (3) welcoming back the employee and following up on the return-to-work conditions. The recovery/return-to-work assistance and support process revealed the need for a shift from a biomedical approach to work absences to a support approach. Paying particular attention to the risk factors in the psychosocial work environment, the assistance process is designed to promote the long-term job retention of people returning to work. It does so by opening the doorway to concrete practices aimed at the primary prevention of mental health problems in the workplace. This approach translates into the reversal of psychological-health risk factors (little recognition, little support, and little decision-making power) through the implementation, at the managerial level, of management practices to assist workers in the context of a return-to-work preparatory interview, to make them feel supported in difficult situations, to give them some influence over their work, and to enable them to feel respected and appreciated. The project also brought to light the importance of a collaborative process among the stakeholders involved in the return-to-work process and of the underlying issue involving the maintenance of contradictory visions. It is clear that senior management's commitment alone is not enough to re-orient the practices of all the stakeholders. Training and implementation follow-up activities are also essential to consolidating a common vision. It should further be noted that direct supervisors' voluntary participation in such a process depends on the support they receive from senior management and the implementation of concrete measures designed to recognize their employee support practices.

7. APPLICABILITY OF THE RESULTS

As constructed, the program may be applied in all workplaces interested in improving their return-to-work support practices. Potential users are primarily organizations with high rates of absenteeism, which include many employers in the private and public sectors. The results of this project provide a more integrated and collaborative vision of absence management and return-to-work practices by clearly delineating each stakeholder's roles and responsibilities and the practices to be favoured. The results are also supported by the scientific literature and the experiences of other organizations in various sectors, and by the experience of a specific workplace milieu with regard to the relevant practices in need of improvement, their feasibility, and the context conducive to their implementation.

8. POTENTIAL CONTRIBUTIONS

This innovative research project in the field of occupational mental health led to the modelling of a program theory that incorporates both empirical and scientific data. This theory will facilitate

the generalizability of the results to other workplaces wishing to improve their absence-management and return-to-work practices. The project resulted in the improved documentation, design, and implementation, in a specific workplace environment, of practices designed to support the recovery and return to work of workers absent for a mental health problem. It also shed light on the importance of the roles played by the various stakeholders involved in the return-to-work process, and helped define, in partnership with the organization, the roles and responsibilities of each stakeholder group in providing support for recovery and the return to work. The steering committee's efforts led to the structuring of a reference framework regarding mental health at work and individual and organizational support, a framework that promotes the implementation of a shared and integrated process. By developing a specific process for assisting the return to work of workers absent for a mental health problem, it became conceivable to shift from a biomedical approach focused on clinical interventions to a psychosocial approach focused on highlighting the work environment factors likely to foster a return to work and job retention. In addition, we observed that interventions carried out with employees on sick leave can also affect workers who, although not absent, are exposed to the same risk factors as those that caused their co-workers' absences. One of the potential contributions of this project may be the integration into the process of an analytical framework that will make it possible to shift from an individual-support approach to an organizational approach that also takes other workers into account. Ultimately, this analytical framework will allow for the transition from an individual rehabilitation approach to an organizational prevention approach involving other workers exposed to the same, potentially risky situation.

9. SCIENTIFIC ARTICLES PUBLISHED IN THE CONTEXT OF THIS PROJECT

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APPENDICES

APPENDIX A: DEFINITION OF MENTAL HEALTH PROBLEMS

According to an International Labour Office (ILO) report on mental health in the workplace that covers five industrialized countries (United States, Great Britain, Germany, Finland, and Poland), 20% of the adult population suffers from a mental health problem (Gabriel et al., 2000). The data from the European survey on working conditions, which was carried out in 2000, indicate that work-related stress is the second most frequent health problem across Europe after back pain (*Work-related stress*, European Foundation for the Improvement of Living and Working Conditions, 2005). In industrialized nations, including Canada and Québec, surveys have repeatedly shown that between one person in five and one person in four displays a high level of psychological distress (Institut de la statistique du Québec, 2000).

Mental health problems can have especially incapacitating effects and entail long periods of disability (Koopmans, Roelen & Groothoff, 2008) in addition to posing a high risk of relapse (Druss, Schlesinger & Allen, 2001; Gjesdal & Bratberg, 2003; Koopmans et al., 2008; Nieuwenhuijsen, Verbeek, de Boer, Blonk & Dijk, 2006). In Québec, a survey involving a representative population sample highlights the fact that mental health problems are the leading factors responsible for the increase in absenteeism at work (Vézina et al., 2001) and underscores that, besides being off work more often, the persons concerned are off work longer. Work disability following a depression reportedly lasts two and a half times longer than that caused by other diseases (Gabriel et al., 2000). The problems related to mental health at work are among the most costly for companies (Gabriel et al., 2000). According to Henderson et al. (2005) and Dewa et al. (2007), the rise in such absences is a major public health and economic problem. Incidentally, Health Canada concludes that mental health problems in the workplace cost Canadian companies nearly 14% of their annual income, which corresponds to approximately \$16 billion annually for all companies combined (Sroujian, 2003). For several disability insurance companies, mental health claims are the fastest-growing category of disability costs. At Standard Life, the incidence of long-term disabilities related to mental health problems increased 120% between 1991 and 2003 (Dubé & Parent, 2004). In 2004, as during the 13 preceding years, mental health problems, including depression and anxiety, constituted the main cause of disability cited in new claim applications, specifically 46% (Disability Insurance Board of Management, 2005). The same is true for the Commission de la santé et de la sécurité du travail (CSST) in Québec, which saw its total payouts for compensated occupational injuries related to stress, burnout, or other factors of a psychological nature go from \$5.8 million in 1995 to \$14.3 million in 2004 (CSST, 2006).

Although the notions related to mental health have changed over the years, there remains a great deal of confusion, as can be seen in the indiscriminate use of the terms “mental disorders,” “mental illnesses,” and “mental health problems.” It is often difficult to determine the differences and characteristics. The terms “mental health problems,” “mental illness,” and “mental disorders” have been defined by the World Health Organization (WHO) in an International Labour Office report on mental health in the workplace (Gabriel et al., 2000). The notion of “mental health problems” refers to less severe problems that are generally ranked below the level of illness and that may be alleviated by outside assistance without necessarily involving

treatment. For its part, the term “mental illness” is used to describe more serious problems that can be diagnosed and for which professional intervention and treatment are required. Lastly, “mental disorders” refers to a marked deterioration in mental functioning, usually characterized by changes in thinking, mood, or behaviour.

Similar distinctions were drawn in the Québec mental health policy (MSSS, 1989). The persons who exhibited a mental health problem were grouped according to the intensity of their problem. These distinctions aimed to determine the boundaries between health and illness. However, according to Sévigny (1994), this reality remains a complex and multi-faceted phenomenon. There is no real consensus regarding the definition of the problems. The erosion of the boundaries between health and illness as well as those that separate the individual from the social have contributed significantly to the expansion of the notion of mental health. Also, the difference between the notions of “mental health problems” and “mental disorders” relates to the need not only to draw a distinction based on the severity of the problems but also to account for circumstances that can have an influence on a person’s state of mental health. The notion of “mental disorders” refers to characterized illnesses that may be diagnosed and that involve a marked deterioration in cognitive, affective, and relational abilities. This definition of “mental health problems” appears to include both less and more serious but transient situations that can lead to a marked deterioration in state of health. However, it excludes persons who exhibit severe mental disorders, i.e. those that are designated as chronic mental illnesses. The main focus of this study is thus the return to work of a population of workers who had to interrupt their occupational activity due to problems related to their mental health; these persons exhibited a sufficiently high level of distress to necessitate consulting a physician and leaving work. The shift from being ill to stopping work indicates that the problem has reached a certain level of severity; however, generally speaking, these health problems are considered reversible and the employment relationship does point to the existence of social skills.

According to Nieuwenhuijsen, Verbeck, Siemrinc and Tummers-Nijssen (2003), the majority of workers who are off work due to a mental health problem suffer from transient mental disorders that can be grouped into three categories: adjustment disorders (which burnout is related to); mood disorders, including major depression; and anxiety disorders (Shiels, Gabbay & Ford, 2004; van der Klink & van Dijk, 2003). However, it remains difficult to accurately determine the incidence and prevalence of these three mental disorders in a working population. Care should be taken when interpreting and comparing the obtained measurements due to the variability of the methodologies used from study to study to obtain the incidence and prevalence rates (Antony & Swinson, 1996; Blazer, Kessler, McGonagle & Swartz, 1994; Lépine, 2002).

Work reintegration in cases involving mental health at work

The majority of studies surveyed in the mental health rehabilitation field focus on persons who present severe mental disorders, such as schizophrenia, and whose life trajectory is marked more by problems with joining or integrating into the labour force than with returning to work. In the occupational health field, rehabilitation studies focus mainly on workers who are victims of work-related accidents or occupational diseases. Even though they do not consider our study population, these mental health and occupational health studies allowed us to identify a number of findings about which interventions to favour in this field and, as such, they provide relevant

information. Some of these studies deal explicitly with the work reintegration of workers who have been employed but who are absent from work due to a mental health problem, although few have examined the design and evaluation of return-to-work programs (Briand et al., 2007). While some studies presented organizational approaches to primary and second prevention (mental illness information, screening for depression at work, improvement of employee assistance programs, company-based support measures, etc.), relatively few described reintegration measures (tertiary prevention) that take into consideration the worker, his work environment, and the various partners (Michie, Wren & Williams, 2004; Putnam & McKibbin, 2004). The documented tertiary prevention approaches, which are mainly oriented toward cognitive-behavioural problem-solving and stress management interventions, are considered to be interventions focused on the individual.

Limitations of interventions focused on the individual

The documented approaches to work reintegration generally aim to help the workers develop more effective individual adaptation strategies. They focus very little on the work environment or on cooperation among the various partners (Blonk, Brenninkmeijer, Lagervelt & Houtman, 2006; Nystuen & Hagen, 2003; van der Klink, et al., 2002, 2003).

According to Vézina et al. (1992) and Brun et al. (2003), interventions focused on the individual make it possible to act on workers' adaptation strategies but remain limited with respect to the factors related to the psychosocial work environment. Also, along the same lines, at the end of their study, van der Klink et al. (2003) recommend continuing the research in order to implement approaches that would make it possible to have an impact on the work environment, for example, the management style, building a community of belonging, and conflict resolution in the workplace.

Central role of work in mental health and job retention

Stressful events in one's personal life, such as the death of a loved one, assumption of responsibility for a sick relative or child, and marital or financial problems, are among the factors that can contribute to the undermining of one's state of health and lead to an adjustment disorder (St-Arnaud, St-Jean & Rhéaume, 2003). However, a large percentage of the workers who are absent from work because of mental health problems are so because of problems experienced as part of their work (Cohidon, Imbernon & Goldberg, 2009; St-Arnaud, Bourbonnais, St-Jean & Rhéaume, 2007). In a study of 1,850 workers off work due to a mental health problem certified by a medical diagnosis, a large majority of the workers cited problems experienced as part of their work to explain the deterioration of their state of health and their absence from work (St-Arnaud et al., 2007). In fact, only 9% of the subjects (10% among the women and 6% among the men) referred mainly to their personal life to explain their health problem and their absence from work; 32% attributed it directly to their work situation (27% of women and 43% of men), and nearly two-thirds of the respondents (63% of the women and 50% of the men) considered that it was due to both their personal life and their work. If we take into account the fact that 32% of the individuals felt that their absence was essentially due to their work and that nearly two-thirds mentioned both personal and work-related reasons, it gives a total of more than 90% of the subjects who mentioned problems experienced at work to explain the deterioration in their state

of health and their work absence. The various work demands mentioned by the subjects are: work overload (62%), non-recognition of efforts (48%), conflict with their supervisor (31%), conflict with co-workers (21%), negative evaluation of their work (19%), lack of autonomy at work (17%), and job insecurity (14%) (St-Arnaud et al., 2007).

These results are consistent with many studies indicating that, in recent years, work environments have undergone many radical changes that have had an impact on workers' mental health (Bourbonnais, Brisson, Vinet, Vézina & Lower, 2006a; Brisson, Larocque & Bourbonnais, 2001; Dejours, 1993, 1995; Karasek & Theorell, 1990; Niedhammer, Goldberg, Leclerc, Bugel & David, 1998; Rugulies, Bultmann, Aust & Burr, 2006; Siegrist & Marmot, 2004; Stansfeld et al., 1999; van der Doef & Maes, 1999). The increase in competitiveness and competition, together with corporate mergers and workforce downsizing, have created new demands in the workplace. These changes profoundly disrupt work organization methods and require some employers to move toward flexible management of production time and of their use of labour. Incidentally, the amount of work required of employees is increasing even as human and financial resources are decreasing. The intensification of work appears to be responsible for a significant percentage of absences related to a mental health problem (Vézina et al., 2004; Vézina, Bourbonnais, Marchand & Arcand, 2008). New management practices are also associated with this intensification of work, for example the elimination of downtime, individualized performance evaluation, and the recourse to subcontracting. These practices have impacts on the social relationships at work, putting workers into competition with each other, weakening work groups, and lowering the capacity for mutual support and getting along (Dejours, 2003). The pressures exerted by these transformations affect employees' work capacity, job retention, and mental health. According to Vinet, Bourbonnais and Brisson (2003), the sharp rise in absences due to a mental health problem and the proportional increase in group insurance premiums are indicative of the size and scale of this crisis.

From this viewpoint, returning to work after a mental health problem remains particularly difficult and uncertain if the work-related risk factors are not taken into account. In fact, returning to work is more difficult for persons who have been absent due to work-related factors (St-Arnaud et al., 2007). Conversely, an analysis of return-to-work conditions shows a significant correlation between the improvement of working conditions during the return to work and the resolution of mental health problems. A study by Brenninkmeijer, Houtman and Blonk (2008) on return-to-work predictive factors following a depression also points to the necessity of altering the tasks or making changes in work in order to favour recovery of health and the return to work. Intervention focused on the psychosocial work environment during the return to work is also a major determinant of health restoration and a successful return to work following a mental health problem.

Issues around interventions focused on the psychosocial work environment

In recent decades, research in the occupational rehabilitation field has evolved, moving from a biomedical approach often focused on the individual factors of the illness to an approach that takes work environment factors into account (Durand, Vachon, Loisel & Berthelette, 2003; Franche, Baril, Shaw, Nicholas & Loisel, 2005). According to Franche et al. (2005), changing the work environment, whether temporarily or permanently, remains a key component of the

interventions deemed effective in the workplace for ensuring a successful return to work. In fact, several studies support the importance of this measure and its action on the duration of the disability (Amick et al., 2000; Arnetz, Sjogren, Rydehn & Meisel, 2003; Hogg-Johnson & Cole, 2003; Loisel et al., 2001). In cases involving mental health at work, this dimension is all the more key in that the psychosocial work environment is responsible for a significant percentage of absences from work (Vézina et al., 2008). In addition, the work of Brenninkmeijer et al. (2008) and St-Arnaud et al. (2007) confirms the importance of acting on the psychosocial work environment in order to favour the return to work and job retention. Incidentally, a systematic review of preventative mental health interventions reveals the importance of intervening at various levels: with individuals but also with work teams and organizational and political structures (Corbière, Shen, Rouleau & Dewa, 2009).

The psychosocial work environment integrates the technical and human dimensions of work. The technical dimensions relate more specifically to the content and task. In other words, they condition the “what to do,” the “how to do it,” and even the “how much of it to do” at a given time. The human dimensions focus instead on the social relationships of work, i.e. the ways of interacting and communicating among people, be it vertically (supervisors and subordinates) or horizontally (co-workers) (St-Arnaud & Vézina, 1993). These dimensions directly affect work organization and management practices (Brun, 2009). In this respect, the company’s managers and, especially, the employee’s direct supervisor are directly implicated when the focus is on the factors related to the psychosocial work environment. According to Franche et al. (2005), these individuals hold a unique position in the organization, acting as the link between senior management and the worker. Among other things, they can alter the work, interpret the organization’s policies, and facilitate access to its resources. However, managers’ and direct supervisors’ ability to act on the factors associated with the psychosocial work environment will depend on the importance placed on the issue by the company and in particular by senior management. Basically, direct supervisors can often feel caught between senior management’s demands to increase productivity and their responsibilities with respect to the health and well-being of their employees (Franche et al., 2005).

The support and involvement of senior management remain key factors in planning and implementing an intervention that will affect work organization and management practices. According to Baril and Berthelette (2000), senior management’s values and the quantity of resources they allocate to supporting the intervention can affect the ability to act of the stakeholders concerned with transforming the work environment. Their values and attitudes have a significant impact on the interventions’ success. This takes the form of a concern for the workers’ health and sustained support of case management interventions in the workplace. In addition, by favouring a participative management style within the company, senior management allows the workers and direct supervisors to be stakeholders in the planning and implementation of a return-to-work program (Stock, Deguire, Baril & Durand, 1999). Relations between management and unions are also seen as having a major influence on return-to-work programs (Baril et al., 2003). Basically, confrontational behaviour decreases in situations where unions and management both hold the shared objective of ensuring workers’ well-being and health during the return to work. Indeed, return-to-work programs are more difficult to implement when the union plays a peripheral role, when the program is imposed by management, or when key parts of the collective agreements are not complied with. Conversely, unions are more likely to sign on

to the proposed return-to-work measures if they are well planned and well managed. A return-to-work program can succeed only if the following essential conditions are in place: a climate of trust marked by respect, effective communication, and collaboration among the various internal and external stakeholders concerned (Baril et al., 2003; Stock et al., 1999). Conversely, recourse to legal action reduces trust and interferes with the return-to-work process; it is considered an obstacle (Baril et al., 2003). From this viewpoint, the value placed on employees and the importance attached to the work climate influence the worker as a key stakeholder in his return to work (Baril et al., 2000). These elements encourage the worker to collaborate on early return-to-work measures if he sees that his concerns and suggestions are taken into account in the various participatory ergonomics projects (Stock et al., 1999).

In short, because they aim to diminish the effects of psychosocial demands by acting on the risks to mental health in the workplace at the source, interventions involving work organization constitute an effective solution (Kompier & Kristensen, 2001; Funk, Saraceno, Miguel, Harnois & Grigg, 2005). In recent years, among the various interventions evaluated, several showed positive effects on the improvement of the psychosocial work environment and on health (Anderzen & Arnetz, 2005; Bourbonnais et al., 2006; Dahl-Jorgensen & Sakswick, 2005; Eklof & Hagberg, 2006; Kauffeld, Jonas & Frey, 2004; Lavoie-Tremblay et al., 2004; Logan & Ganster, 2005; Michie, Wren & Williams, 2004; Mikkelsen & Gundersen, 2003; Ryan et al., 2005; Sluiter et al., 2005; Theorell, Emdad, Arnetz & Weingarien, 2001). A company that is interested in the health of its employees and in retaining them must therefore recognize the central role of work. It then follows that recognizing the factors associated with the psychosocial work environment that are likely to interfere with a return to work should be an integral part of the evaluation protocol for absent workers.

APPENDIX B: OVERVIEW OF THE INITIAL ABSENCE SITUATION

First, a frequency description provided a distribution of the absences for all diagnoses and for those associated with a mental health problem. The analyses were based on a sample of 3,527 workers. The SAS and S-Plus (Everitt, 2001; S-Plus, 1998) software packages were used to perform the statistical analyses.

For this part of the study, the duration of the episodes of absence due to a mental health problem was between April 1, 2005, and March 31, 2006. Consequently, the days before April 1, 2005 (for cases in which the episode began earlier) and the days after March 31, 2006 (for cases where the absence episode had not ended) are excluded from the duration. This duration makes it possible to calculate the average number of days and the mean number of days of the work absence episodes (within the period) for each type of mental health problem over a maximum period of 365 days.

Table 1 Description of the sample and of the prevalence of the absence episodes

Description	Number	Prevalence
Number of subjects in the organization (between April 1, 2005, and March 31, 2006)	3,527	100%
Number of employees having had at least one absence episode due to an illness (all causes combined)	720	20.4%
Number of employees having had at least one absence episode specifically due to a mental health problem	264	7.5%
Employees having had 1 episode	254	
Employees having had 2 episodes	9	
Employees having had 3 episodes	1	

In all, 720 of the 3,527 subjects studied had at least one absence episode due to an illness (all causes combined), which corresponds to a prevalence of 20% (see Table 1). In addition, 264 of these employees had at least one absence episode due to a mental health problem (prevalence of 8%). More specifically, 254 employees had a single episode, nine employees had two, and one employee had three episodes during the year under study for a total of 275 episodes related to a mental health problem between April 2005 and March 2006. Thus, the persons who were absent from work due to a mental health problem accounted for 37% of the organization's sick leave absences.

Absence episodes for a mental health problem, by diagnosis

The diagnosis of an adjustment disorder accounted for 55% of the 275 absence episodes related to a mental health problem (see Table 2), while 40% of the episodes were due to a mood disorder. For their part, anxiety diagnoses accounted for 3% of the episodes in this group of absences. Compared with all absence episodes, absences due to an adjustment disorder represented 21% of the episodes, while those due to a mood disorder represented 15%. Anxiety disorders and other mental health problems represented 1% and less than 1% respectively of the absence episodes of all 3,527 employees during this period.

Table 2 Distribution of absence episodes for a mental health problem, by diagnosis

Diagnosis	Distribution of episodes (275 episodes)	Distribution of episodes (among the 720 subjects having had an absence episode for any cause)
Adjustment disorder	55.3% (n = 152)	21.1% (n = 152)
Mood disorder	40.0% (n = 110)	15.3% (n = 110)
Anxiety disorder	2.5% (n = 7)	1.0% (n = 7)
Other mental health problems	2.2% (n = 6)	0.8% (n = 6)
All mental health diagnoses	100% (n = 275)	38.2% (n = 275)

We note (see Table 3) that anxiety disorders are the diagnoses with the longest average absence duration (299 days), followed by mood disorders, with an average of 207 days of absence. Similarly, the mean duration is 240 days for anxiety disorders and 173 days for mood disorders (duration calculated over a one-year period). All mental health diagnoses combined have an average absence duration of 158 days and a mean absence duration of 116 days.

Table 3 Average and mean absence duration, by diagnosis

Diagnosis	Average duration (in days)	Mean duration (in days)
Adjustment disorder	299	240
Mood disorder	207	173
Anxiety disorder	126	96
Other mental health problems	52	52
All mental health diagnoses	158	116

Absence episodes for a mental health problem, by employment status

Of the 275 absence episodes due to a mental health problem, 48% occurred in employees who had full-time employment status, 37% in permanent part-time employees, 13% in occasional part-time employees, and 2% in temporary full-time employees (see Table 4). Breaking down the absence episodes based on the distribution of employees by employment status, we note that the 766 permanent part-time employees, who constitute 22% of all the employees, accounted for 37% of the absence episodes related to a mental health problem and that the 1,407 full-time employees, who constitute 40% of all the employees, accounted for 48% of such episodes. Occasional part-time employees were absent from work at a rate that was much lower (13%) than their representation in the workforce (31%).

Table 4 Distribution of absence episodes for a mental health problem, by employment status

Employment status	Distribution of mental health-related absence episodes (out of 275 episodes)	Distribution of employee statuses (out of the total number of employees, n = 3,527)
Full time	48.4% (n = 133)	39.9% (n = 1,407 employees)
Permanent part-time	36.7% (n = 101)	21.7% (n = 766 employees)
Occasional part-time	12.7% (n = 35)	30.7% (n = 1,083 employees)
Temporary full-time	2.2% (n = 6)	3.0% (n = 105 employees)
Temporary part-time	None	4.7% (n = 166)

The average duration of the absence episodes experienced by the temporary full-time employees was 180 days (see Table 5), while it was 168 days for the full-time workers and 164 days for the permanent part-time employees. Table 5 also presents the mean absence duration, in days, for each employment status.

Table 5 Average and mean absence duration for a mental health problem, by employment status

Employment status	Average duration (in days)	Mean duration (in days)
Full-time	168	141
Permanent part-time	164	120
Occasional part-time	106	70
Temporary full-time	180	132

Absence episodes for a mental health problem, by job type

Table 6 presents the distribution of absence episodes according to the distribution of employees by job type. We note that the 1,056 nurses, who formed 30% of the workforce, accounted for 27% of the absence episodes related to a mental health problem and that the 632 patient attendants (orderlies), who formed 18% of the workforce, accounted for 25% of such episodes. The patient attendants had proportionally more absence episodes than the nurses. For their part, the family and social services support workers had absence episodes proportionate to their representation within the workforce (5%).

Table 6 Distribution of absence episodes for a mental health problem, by job type

Job type	Distribution of mental health-related absence episodes (out of 275 episodes)	Distribution of job types (out of the total number of employees, n = 3,527)
Family and social services support worker	5.1% (n = 14)	5.3% (n = 186)
Patient attendant	25.1% (n = 69)	17.9% (n = 632)
Client services professional	17% (n = 46)	Data not available
Technical support worker	3% (n = 8)	Data not available
Nurse	27.3% (n = 75)	29.9% (n = 1,056)
Office worker	13% (n = 35)	Data not available
Other	10% (n = 27)	Data not available

The average duration of the absence episodes for a mental health problem was 169 days for the nurses and for the office workers (see Table 7). The average duration was roughly the same for technical support workers (167 days), followed closely by the client services professionals (155 days). The job type with the longest mean duration of leave for a mental health problem was the client services professional (138 days) followed by technical assistance jobs (137 days).

Table 7 Average and mean duration of leave for a mental health problem, by job type

Job type	Average duration (in days)	Mean duration (in days)
Family and social services support worker	121	69
Patient attendant	147	111
Client services professional	155	138
Technical support worker	167	137
Nurse	169	123
Office worker	169	112
Other	146	98

APPENDIX C: INDIVIDUAL INTERVIEWS WITH THE ORGANIZATION'S KEY STAKEHOLDERS

The involvement of key stakeholders in the workplace was sought in order to maximize the range of viewpoints and obtain information about all the stakeholders involved in the return-to-work process. In all, 30 key stakeholders were identified by the research steering committee based on theoretical foundations (Baril et al., 2003; St-Arnaud et al., 2004) and on the common sense of the committee members as workplace stakeholders associated with the absence and return-to-work management process. According to Mayer, Ouellet, Saint-Jacques, Turcotte et al. (2000), in a classic qualitative research situation based on interviews, around 30 interviews are considered necessary to reach the data saturation point. Table 8 provides an overview of the various workplace stakeholders who were recruited for individual interviews.

Table 8 Key stakeholders and the number of divisions represented, by stakeholder group

<i>Stakeholder group</i>	<i>Key stakeholder</i>	<i>Divisions represented</i>
Senior management	7	5
Direct supervisors	10	4
Occupational Health and Safety Department	7	1
Unions and workers' representatives	6	4
Total	30	7 of 11 divisions

The 30 interviews carried out during the summer of 2007 brought together key stakeholders from four groups associated with the absence and return-to-work management process. Together, they represented seven out of 11 divisions. The semi-structured type interviews, which lasted 90 minutes on average, took place at the workplace or the research centre, as determined by the stakeholders. Invited to take part on a volunteer basis, the interviewees signed a consent form.

The interview guide was designed using the theoretical framework of this research project and the Hinings and Greenwood (1988) model. It aimed to identify the stakeholders' roles and practices as well as their relationships with the other stakeholders. Each interview was recorded for later verbatim transcription. The complete interview transcriptions were coded using Microsoft Word word-processing software. Also, after being anonymized, each interview was assigned a code.

Contandriopoulos and Souteyrand (1996) use the notion of an "organized action system" to better understand the reasoning and issues that shape a complex system. This field of action is delimited by: a context (or a specified period); physical, organizational, and symbolic structures; and a social space where the stakeholders interact. The ability of such a system to attain its objectives then depends on the degree of coherence of its various parts (Contandriopoulos, 2003). Each of the groups of stakeholders involved in the absence and return-to-work management process was therefore analyzed according to its roles and responsibilities, its action and decision-making mechanisms, the resources available to it, the underlying principles and values, and the objectives and result indicators (Hinings & Greenwood, 1988), which made it possible to evaluate the organization's action coherence. According to the Hinings and Greenwood model (see Ttable 9), internal coherence exists in the organization when the

structures and processes reinforce and reflect the interpretive schemes and when convergence develops among the various stakeholder groups.

Table 9 Summary of the analyzed themes*

	Structure and process			Interpretive schemes		Coherence
Stakeholder group	Roles and responsibilities	Action and decision-making mechanisms	Resources	Values and principles	Objectives and result indicators	Action logic
Senior management						
Unions and workers' representatives						
Occupational Health and Safety Department						
Direct supervisors						

*Based on the Hinings & Greenwood (1988) model

The interviews were analyzed using a systematic procedure for analyzing qualitative content (Laperrière, 1997). As the work environment is a complex system in which various stakeholders act according to different logics, the analysis was done by stakeholder group. The complete transcriptions were coded for manifest content and processed per the first steps proposed by L'Écuyer (1990), i.e. (1) determining the themes and (2) defining the classification units. The terminology of the Hinings and Greenwood model (1988) was used to identify the interviews' various themes: roles, practices, objectives, values/interpretive schemas, policy, and macro context. Sub-themes were also defined. To ensure coherence between the coding and the individual analysis of the various interviews, each coded interview was reread for validation purposes by one of the team's investigators and three team meetings were held. An initial team analysis of the interviews allowed the action logics of each of the stakeholders to be defined (main challenges and facilitating factors for absence and return-to-work management, coherences and incoherences among the roles, practices, and interpretive schemas). An individual summary of each interview then identified the main themes. The individual summaries were subsequently combined into an integrated summary for each stakeholder group. The workplace also provided the research team with all the documents used to manage absences and returns to work.

Analysis of the stakeholders' practices and the workplace paradigms

The interviews of 30 of the organization's key stakeholders revealed the range of absence and return-to-work management practices and the presence of two visions very strongly rooted in the four stakeholder groups that were analyzed (senior management, direct supervisors, Occupational Health and Safety Department, and union).

Senior management

Judging by the interviews of the key stakeholders in senior management, this group has adopted practices that reflect senior management's concerns about and involvement in mental health in the workplace and the return-to-work process. Senior management has implemented a workplace attendance action plan, set up a workplace attendance advisory committee, conducted a survey of its entire workforce on the organizational climate, and produced and distributed absence statistics. It has also expressed its interest in this research project and demonstrated the importance it attaches to it in order to take concrete action to improve the return-to-work practices. Nonetheless, the interview results also revealed differing visions of the problem within senior management; the interview texts contain statements that reflect a vision of supporting people and others that reveal a vision focused on controlling and managing absences. These two visions co-exist not only among the executives of the same organization but also within a given individual's discourse. On the one hand, a worker is considered to be a stakeholder motivated by his work, the absence from which is not desirable; people's health is seen as a concern that should be shared by all the organization's stakeholders; and difficult work conditions are viewed as being among the factors that can adversely affect their state of health. On the other hand, some feel that the worker is a paid employee who should be present at work and that he alone is responsible for taking charge of his health. This group sees mental health problems as usually related to personal situations and considers that numerous workers go on leave for reasons unrelated to an actual health problem, such as disciplinary measures or interpersonal conflicts. According to this latter view, to prevent abuses, a fair degree of absence control is required.

The interviews also cast light on the main questions raised by senior management regarding the implementation of an integrated return-to-work program. Having been subjected to mergers in recent years, the organization is considered by its executives to be a large corporation of nearly 4,000 employees that favours according to them, visions and directions for taking action that differ from division to division. According to some executives, the involvement of senior management—a crucial and necessary factor for dealing with the problem—is inadequate. All hierarchical levels need to feel concerned and to realize that everyone shares in the responsibility and that the effort needed is a long-term one. It is essential that the same message be transmitted throughout the organization and that it be understood and interpreted identically by all the stakeholders. Without a frame of reference for the roles, responsibilities, and absence and return-to-work management support measures, it is difficult to acquire a shared understanding of the issues and problem, to reconcile the differing visions in the organization, and to implement coherent practices.

The difficult conditions of the work environment are an additional concern. Senior management considers that the lack of personnel in the organization and the growing complexity of the case mix in some activity sectors increase the workload and contribute to employee burnout. According to senior management, departures for mental health reasons, combined with difficulty

in recruiting and retaining employees, contribute to the work teams' lack of stability, which does not favour the members of the organization taking ownership of the problem. Lastly, significant pressure from government authorities to quickly lower absence rates also represents a major problem for senior management in its management of absences and returns to work.

Direct supervisors

The interviews with key stakeholders from the group of direct supervisors revealed an on-the-ground reality that is marked by a range of practices and multiple demands. Lacking clear guidelines from senior management and the Occupational Health and Safety Department, each direct supervisor implements the practices he deems appropriate for the demands placed on him in accordance with his own values and priorities, as can be seen in the divergence of perceptions regarding their roles and responsibilities. The results show that some supervisors implement numerous practices to prepare for returns to work while others implement very few because they feel it is not their role to do so or because they feel overwhelmed by the problem. Basically, while some supervisors feel that the tasks of absence prevention and management fall to them, others consider it the role of the Occupational Health and Safety and Human Resources Department. Accordingly, some supervisors are centred on the person at work and his well-being, satisfaction, recognition, and mental health, while others are more focused on tasks and work performance. The results again show that the issue of communicating with the worker during his time off work is a frequent source of questions: Should he be called? What should be said to him? How will the call be perceived? What are we supposed to know? Communications with the Occupational Health and Safety Department, which is responsible for the medical-administrative management of absences, are not standardized in the organization. Some supervisors contact the department rarely or occasionally, while others do so regularly or systematically for each absence case. Lastly, we note that absence prevention practices are very rare and often limited to individual support actions.

The results of the interviews of the direct supervisors also revealed differing interpretations of the reasons for the absence when it is related to a mental health problem. Some consider that most of these absences stem from personal, family, or behavioural problems. Others feel that some are generated by conflictual relationships at work. Some think a number of employees are abusing the disability insurance system, i.e. that they are defrauders. Lastly, for some direct supervisors, work-related problems can have an impact on individuals' health.

The direct supervisors feel that senior management's contradictory demands constitute an obstacle to the management of absences and the return to work. They are expected to support their personnel while rigorously overseeing the persons off work, and to be present for their teams while sitting on numerous committees and attending meetings away from the workplace. The difficult work context (large teams, intensifying pace, increase in the number and increased complexity of cases) and the management of relationship conflicts, which consume much time and energy, add to the burden of the direct supervisors' task. The lack of human and financial resources and the sometimes restrictive rules governing the management of absences and return-to-work conditions limit the direct supervisors' manoeuvring room and hinder the adoption of support practices for workers on sick leave.

Occupational Health and Safety Department

The Occupational Health and Safety Department is made up of personnel officers responsible for the medical-administrative tracking of the cases of workers who receive disability insurance, of medical experts under contract with the organization, and of a department head. Workers on leave for mental health reasons who are tracked by the Occupational Health and Safety Department are required to submit a medical certificate and a disability insurance form filled out by their attending physician and detailing their diagnosis, plan of treatment, and the anticipated date of return to work.

The interviews with the key stakeholders from the Occupational Health and Safety Department showed that they feel responsible for contradictory missions. Essentially, they are given responsibility for the medical-administrative management of absences in a context marked by pressure to lower the absence rates. The rates set by the government authorities are deemed unreasonable and generate even more pressure. Thus the Occupational Health and Safety Department stakeholders must, on the one hand, meet the absence control demands designed to reduce the costs associated with disability insurance and, on the other hand, heed the message sent by senior management to give people the time they need to recover. Without putting pressure on workers during their leave, they have to make every effort to support them.

To accomplish these two contradictory missions, the members of the Occupational Health and Safety Department implement practices designed both to lower the disability insurance costs and to support the persons on sick leave. To achieve this double objective, they attempt to distinguish between mental health problems (the “real sick”) and other organizational factors that may explain the absence (the “fake sick”). As a result, persons on sick leave who have received a diagnosis implicating mental health undergo an evaluation by the Occupational Health and Safety Department, with cooperation from some direct supervisors, aimed at making a judgement call between two types of absence: absences related to mental illness and absences related to relationship conflicts, disciplinary measures, or problems related to the worker’s personal life. The Occupational Health and Safety Department stakeholders adopt their support and control practices based on this judgement call, which gives rise to different approaches for different cases. Thus, some workers will, from the outset, receive more support, be allowed more recovery time, and have access to additional sessions under the employee assistance program (EAP). Others will be pressured harder by telephone, have to submit to more questioning about their treatment and state of health, and be called more often into question.

Notices to appear for a second medical assessment are frequently issued, mainly to confirm the attending physician’s diagnosis, to ensure that the medication and treatment plan are adequate, and to review, as needed, the planned return-to-work date. It is usually the department’s healthcare officers who decide whether to call employees in for a second assessment, based on their own judgement or on information received from direct supervisors who question the legitimacy of the sick leave. Compliance with a notice to appear for a second medical assessment is mandatory and the report of the consulting physician may be contested only through medical arbitration, an occasionally used medico-legal procedure whose decision is binding and cannot be appealed. These practices involving referrals to consulting physicians enable the Occupational Health and Safety Department both to carry out its mission to lower the absence rate by quickly returning to work persons whose diagnosis and date of return are reviewed by a consulting

physician and to provide to the “real sick” with the services of physicians specialized in psychiatry who are not easily accessible through the public health care system.

Constantly having to fulfill contradictory missions is a significant challenge in managing absences and returns to work for the Occupational Health and Safety Department stakeholders, who must successfully reconcile the contradictory demands placed on them: providing support to the workers and giving them the time needed to recover versus lowering the absence rate and shortening the absence durations. Also, the high absence rates and increased complexity of the mental health problems among the personnel lead the stakeholders into a work overload situation that, according to them, makes adopting support practices harder. In the opinion of the interviewed persons from this department, applying the agreed-upon rules imposes a limit on more individualized intervention. As they see it, all these difficulties give workers a negative image of the Occupational Health and Safety Department due to absence follow-up practices that cause controversial reactions. This image constitutes an obstacle to the development of a program involving a more supportive role by the members of the Occupational Health and Safety Department.

Unions and workers’ representatives

This last group of stakeholders represents the various recognized union bodies in the organization and the representatives of workers who have already gone on leave with a mental health-related diagnosis. These stakeholders do not have a role in managing absences and returns to work but do have the responsibility of supporting the worker during his leave and return to work while also protecting the interests of all the other workers. Their practices therefore extend from individual support to collective representation. At the personal level, their work involves supporting the worker on leave, receiving his complaints, assisting him in his procedures, acting as an intermediary between him and the Occupational Health and Safety Department, and informing him of his rights, responsibilities, and obligations. At the collective level, they can negotiate with the Occupational Health and Safety and Labour Relations departments the adjustments necessary for the return to work of certain workers, while ensuring compliance with the collective agreement in order to protect the interests of all the workers. Addressing the individual needs of each worker while complying with the requirements of the collective agreement sometimes raises significant issues that have to be carefully weighed out. Also, these stakeholders are regularly called on to make policy-related representations to senior management in order to object to practices they deem abusive following worker complaints.

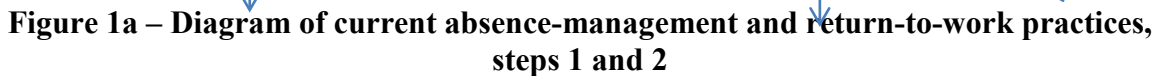
Documentation analysis

The documents used for managing workers’ absences and returns to work were collected from the key stakeholders during and after the interviews. All were read by one of the team’s research professionals, who then classified them by type. These tools provided a better understanding of the organization’s current practices and were complementary to the information gathered in the interviews. Among the sources consulted were reference documents from government authorities (disability duration guides, table of the various disability programs), organizational texts (strategic planning), documents intended for absence management (forms, medical assessment report, etc.), standard letters from the Health and Occupational Health and Safety Department (notice of return, notice to appear for a medical assessment, etc.), letters of complaint from

workers, documents used in arbitration procedures, letters of agreement, reports, and statistics on absence rates.

Current practices diagram

The information collected during the interviews and from the examined documents made it possible to diagram the detailed absence-management and return-to-work practices in the workplace in order to better describe and understand the current operational model. The four diagrams produced cover the prevention practices, the absence-management practices, the medical arbitration procedure, and the practices related to the return to work of persons on leave due to a mental health problem. Figures 1a and 1b diagram the current workplace practices.



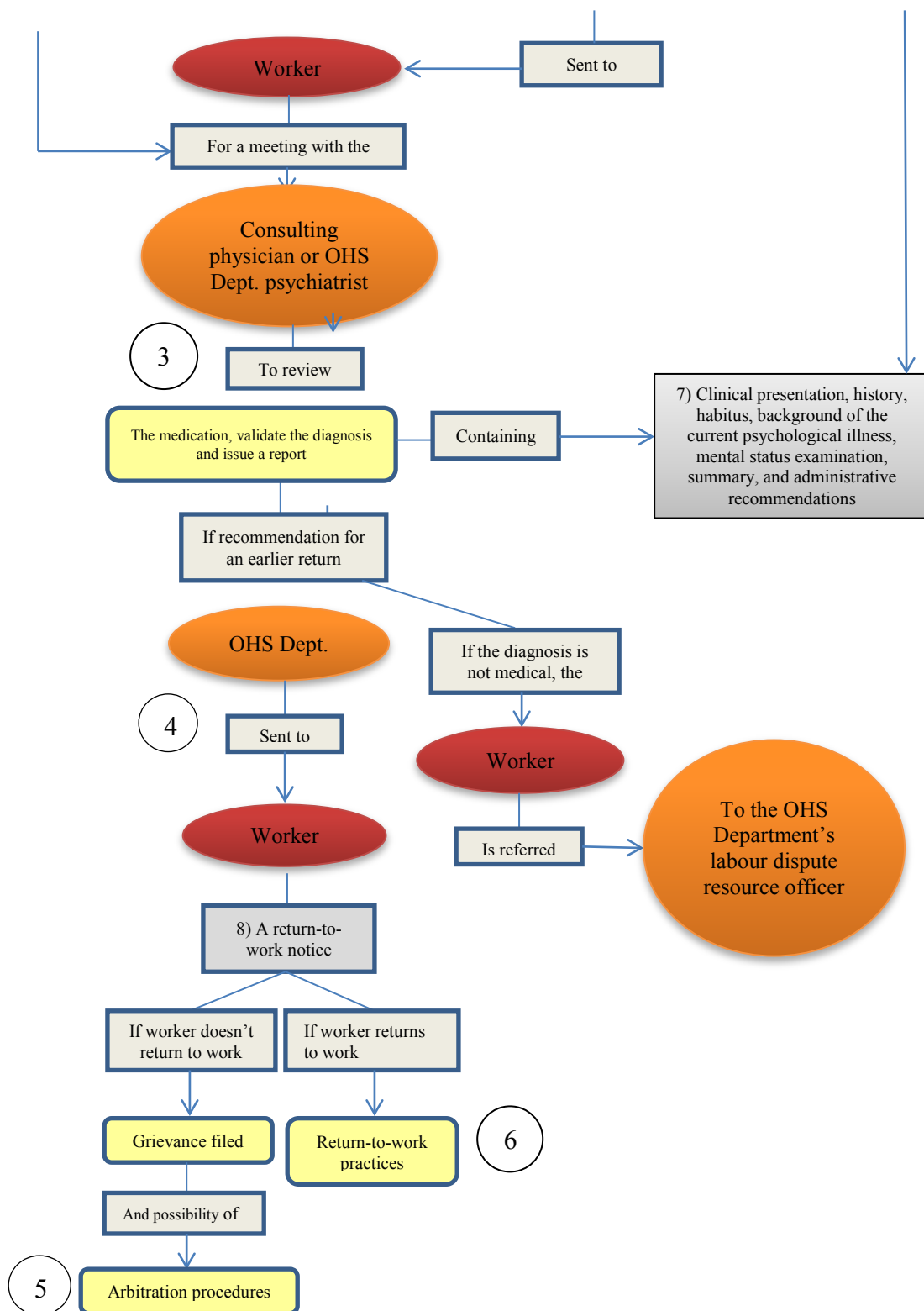


Figure 1b – Diagram of current absence-management and return-to-work practices, steps 3, 4, 5, and 6

APPENDIX D: INTERVIEWS WITH REPRESENTATIVES OF RETURN-TO-WORK PROGRAM COORDINATORS

The data were collected during an interview with a representative of the return-to-work protocol or program coordinator in each company. The content of the research project was explained to these individuals, who were initially contacted by telephone or email. They then received a consent form and the interview guide. The interviews were held in the offices of the visited companies, except for a single company for which the interview was done by telephone due to its remote location. The interviews were of the semi-structured type. The meetings allowed information on the return-to-work protocols to be obtained and the organizational practices and factors that influence them to be investigated. Other information was collected using documents available in the companies or by viewing their websites. Around 90 minutes long, the interview consisted of open-ended questions based on the review of knowledge on the subject. Thus, the interview guide made it possible to examine several important themes such as the organizational context, the activities and different steps of the return-to-work program, the various stakeholders' roles in the process, communication among these stakeholders, the direct supervisor's attitude during the absence, the type of mental health awareness activities performed with the supervisors, the organizational practices that hinder or assist in the employee's rehabilitation, return-to-work preparation, changes to the conditions that contributed to the worker's going on leave, and co-workers' involvement in the return-to-work process. At the end of each meeting, a free period was scheduled to allow the interviewee to provide additional information not discussed in the interview.

The interviews were carried out in three stages, which allowed the data processing and analysis process to begin while data collection continued. Since the interview guide evolved as interviews were conducted, four persons were contacted again by email or telephone to obtain missing data. This data collection was carried out over a one-year period, specifically from June 2007 to July 2008. Each interview was recorded and transcribed. Several steps were required to arrive at a general model of a return-to-work program in the workplace. An initial analysis of the data was based on examination of documents regarding the companies and their return-to-work protocol. There followed a floating reading of the material being studied (verbatim transcripts of the interviews, documents provided by the interviewees and their website). This second step involved carrying out a pre-analysis of the content and identifying the major ideas necessary for the analysis.

For the interview analysis, an initial model interview was selected due to its diverse descriptions of organizational practices and the richness of its content. Using the operational model created on the basis of this content, themes as well as a sequence of events were identified for each interview and an operational model was constructed for each of the companies visited. A thematic categorization prepared by means of a side-by-side comparison of the empirical and theoretical data made it possible to perform data coding. This mixed approach identified categories drawn from theory while another part was inferred through content analysis (Landry, 1993 cited by Mayer, Ouellet, Saint-Jacques, Turcotte et al., 2000). This theme-based coding led to the development of a general model. The study results are presented in the following paragraphs through a description of the characteristics of the interviewees and the visited

companies. A general model summarizing the organization return-to-work practices documented in the companies was then created.

Description of the companies and participants

The companies selected for this study are large unionized organizations that have more than 500 employees and whose return-to-work protocol integrates both psychological and physical health problems. The sample includes government, parapublic, and private corporations that work in various industry sectors: primary, secondary, and tertiary. In all, 17 representatives (persons of authority and stakeholders) from 13 companies were met: five from the public sector, three from the parapublic sector, and five from the private sector. Despite the small number of selected companies, empirical saturation was reached. The data collected during the interviews did not bring any new elements, which confirmed that it was not necessary to increase the number of meetings.

Factors influencing the implementation of the return-to-work program

The majority of the visited companies had set up their return-to-work program or protocol in order to reduce the number of absences related to mental health problems. Currently, the rate of disability-related absences due to mental health problems is high and represents a growing cost for the companies. Besides reducing the absences, the other issues associated with the costs are: employee retention, employee productivity, reintegrating employees into work, keeping them on the job, and preventing future relapses. Some of the representatives of the visited companies also mentioned their concern about the individuals' health. These companies are therefore attempting to review workplace-related risk factors in order to favour employees' return to work and job retention. Other factors such as the enforcement of laws, regulations, and social policies, or of policies implemented by the organization itself, are recognized as having contributed to the implementation of a return-to-work program. Elements related to the social context also favour the implementation of organizational work reintegration practices. For example, with respect to laws, it was mentioned that the duty to accommodate provided in the Canadian Charter of Rights and Freedoms, in particular regarding accommodation measures, is an element that has influenced the implementation of return-to-work protocols. Other laws, such as Québec's *Act respecting labour standards*, one of whose provisions concerns psychological harassment, were also acknowledged as having some influence.

Description of the return-to-work practices

Most of the visited companies systematically target all persons absent for mental health problems and offer them the possibility of taking part in the return-to-work program or protocol on a voluntary basis. Other companies tend instead to advertise the program and, before admitting employees into it, wait for them to express an interest. This practice ensures an ability to respond to requests, which are necessarily fewer in number.

Prevention and awareness activities

Prevention and awareness activities aimed at mental health problems have been implemented in most of the workplaces visited. The activities were grouped according to the classification of Leavell and Clark (1965) and cited by Blanchet, Laurendeau, Paul, and Saucier (1993), defining

three main prevention intervention categories on the basis of when they are applied in the pathological process. These are primary, secondary, and tertiary levels of prevention. Primary prevention covers all the measures designed to reduce the incidence of a disease in a population and to reduce the risk of new cases appearing. Secondary prevention is designed to decrease the prevalence of a disease in a population, i.e. to shorten its duration. Lastly, tertiary intervention comes into play when impairment and disability become a factor. It is designed to decrease the prevalence of chronic disabilities and relapses in a population, i.e. to reduce the functional limitations that result from the disease.

Although most of the visited companies focused on tertiary prevention activities, some went farther by offering primary and secondary prevention activities. For primary prevention, some companies use recognition activities, showing that they place value on and appreciate their employees in order to prevent mental health problems. Action is sometimes taken to reduce the workload, but only temporarily and often as part of a gradual return-to-work program following a mental health problem. For secondary prevention, some companies provide their employees with information on various subjects, including mental health, sound eating habits, physical activity, and stress management. There are also training and awareness activities on mental health problems. Some workplaces make various services and facilities available to employees, such as access to an inner courtyard, stress management activities, chair massages, improvisation leagues, the services of a nutritionist, a gym, and a peer helper network. Lastly, tertiary prevention takes the form of applying various practices associated with the return-to-work protocol and training managers in return-to-work management. The objective of these activities is to bring the employee back to work and avoid a relapse while encouraging his job retention, and to do so from the moment the employer receives the medical certificate confirming the employee's disability. The certificate allows the return-to-work coordinator/support practitioner to begin the intervention process by implementing case management and administrative follow-up.

Case management and administrative follow-up

The activities of the return-to-work protocol usually begin when the employee provides a medical certificate confirming his disability. In the visited companies, medical certificates are received in two ways: the person off work can send his medical certificate by surface mail or deliver it to his company's occupational health and safety department. The return-to-work coordinator/support practitioner then contacts the employee, either by meeting with him or speaking to him by telephone. This first exchange enables the coordinator/practitioner to explain to the employee the procedure adopted following his disability; it is also during this initial contact that the coordinator/ practitioner attempts to identify the causes of the absence. Some organizations try to learn whether the absence might be related to factors present in the workplace. Although the role of the coordinator/ practitioner is different in each of the visited companies, it appears that most of the time it is he who is responsible for coordinating the process and the other parties involved when a disability occurs.

Contact with the supervisor and co-workers

One of the objectives of the return-to-work protocol or program in most of the visited companies is to encourage contact between the absent employee and the workplace, in particular with his direct supervisor and co-workers. In general, the return-to-work coordinator/support practitioner will contact the employee's supervisor to ensure that he stays in touch with the absent employee.

When there is a conflict between the employee and the supervisor, other solutions are envisaged to encourage the employee to maintain contact with the workplace, often through co-workers. However, if the relationship with the supervisor is good, some of the interviewed coordinators/practitioners recommend to the supervisor that he invite the employee to social events organized by the workplace. The coordinators/practitioners can attempt to make the supervisors aware of mental health problems so that they can better understand the situation and intervene. However, according to the coordinators/practitioners interviewed, some direct supervisors appear to be reticent about maintaining contact despite the return-to-work program training and support that they receive. To some extent, they fear being perceived by the employee as harassers who have but one goal: to get the employee to return to work. Other supervisors reportedly find it easier to stay in touch with the employee. In their case, an organizational culture that values team work and workplace recognition appears more favourable to maintaining contact. According to the coordinators/practitioners interviewed, the quality of the contacts greatly depends on the direct supervisors' relationship skills and on the relation they had with the employee before his absence. Besides the contact with the supervisor and co-workers, the coordinator/practitioner's role is to track any changes in the employee's state of health by taking concrete steps to favour his recovery during his time off work.

Follow-up and interventions during the absence

The return-to-work coordinator/support practitioner acts as the case manager. He coordinates each party's interventions and does follow-up on the worker's absence with the insurer and employer. In some cases, he also provides a support and assistance service for the absent employee, though he may alternatively point the absent employee toward specialized services outside the company. In cooperation with the various stakeholders associated with the protocol, he plans the employee's return to work. However, some companies have very few activities during absences. The interventions are limited to medical-administrative management and action is taken only upon receipt of a new medical report.

Control practices and medical assessment

Some of the interviewed return-to-work coordinators/support practitioners may question the validity of the information on the medical certificate provided by the attending physician. Employees may then be subject to various verification practices. In most companies, medical assessment is used when a company or insurer representative has doubts about the employee's medical diagnosis, treatment, or medication. Medical assessment is a practice used to control absences or monitor the employee's recovery. Depending on the company's setup, different stakeholders can decide whether to have a medical assessment performed: the supervisor, the company's consulting physician, or the return-to-work coordinator. Medical assessment can also be requested by the insurer without the company having to consent, which can cause frustration for the return-to-work coordinator, who is trying to maintain a good relationship with the absent employee. Sometimes, the union is enlisted with the aim of reviewing the case in order to determine whether the absent employee should undergo medical assessment. In such cases, the factors influencing the decision are presented to the union in order to obtain its support. Some organizations consult with several persons before requesting an assessment. They maintain that this makes it easier to obtain all the relevant information, not all of which may be included in the medical report.

Managing relationship conflicts and psychological harassment

In most of the visited companies, a process for identifying conflicts and psychological harassment in the workplace is part of the return-to-work protocol or program. From the start of the absence, the return-to-work coordinator/support practitioner takes steps to obtain information on the context of the employee's departure. One of the interviewed coordinators/practitioners reported closely examining the medical certificate in order to spot any mention of an axis IV under the diagnostic criteria of the DSM-IV, the diagnostic tool used by physicians to categorize mental health problems. Axis IV indicates the presence of stress factors, especially when the employee's work is identified as a source of tension for him. When the physician mentions the presence of an axis IV and specifies that the stress factor is work-related, the coordinator/practitioner can look for the source of the problem by questioning the employee in order to uncover the presence of conflicts or harassment at the workplace. In other cases, when this process is not implemented, conflicts are managed only if the individual mentions them to the coordinator/practitioner. When there are conflicts or psychological harassment situations in the workplace, most organizations suggest, through their protocol, means for managing them. Some companies have various parties take part in the process. The employee can then be referred by the coordinator/practitioner to a labour relations consultant, who will attempt to resolve the conflicts with the parties involved and, if applicable, the union. In the case of more significant conflicts, some companies turn to external resources or a mediator to carry out the conflict management process. In addition, the employee receives external follow-up to help ensure his recovery. This follow-up is usually performed by individuals in helping professions, such as psychologists.

Reassignment and career management

Because of the duty to accommodate, companies must make an effort to reintegrate the employee into their organization. They must take into consideration the individual's functional limitations in order to offer him a position suited to his work capabilities. Generally speaking, if the employee has functional limitations, the return-to-work protocol systematically calls for his reassignment to another position. Sometimes the return-to-work coordinator/support practitioner has to contact the staffing department in order to find a suitable position. If the worker does not feel comfortable with his job or is no longer able to perform it, another position in the company can be suggested to him. To ensure that the employee makes a good choice, he is often offered the assistance of a guidance counsellor. Collective agreements sometimes limit attempts to accommodate or reassign an employee. The agreements have to be complied with and the coordinator/practitioner has to ensure that the employee is not given preference over another. Also, in some cases the employee cannot be relocated due to working conditions stipulated in the collective agreement. However, some companies have a joint labour-management process through which these conditions can be overridden by obtaining the union's agreement in order to accommodate the worker. Some companies offer career management and guidance counselling services to employees who cannot be reassigned to another position to help them choose a job in another work organization. These services are offered either internally or via external resources.

Preparing for the return to work

The first step in preparing for the return to work begins when the return-to-work coordinator/support practitioner receives a medical certificate stating that the employee is once again fit to work. As soon as the return date is set, the coordinator/practitioner contacts the employee's supervisor to inform him of it. In several companies, the return to work is planned in

accordance with the gradual return procedures prescribed by the physician, which form the foundation of the return-to-work plan. The return-to-work planning is always based on the physician's recommendations as well as the employee's functional limitations, which the physician will have defined. In some workplaces, a meeting may be scheduled between the supervisor, employee, and coordinator/practitioner. The goal of this meeting is to plan the return to work according to the procedures recommended by the attending physician. During this step, the supervisor evaluates the possibility of adjusting the schedule and workload to facilitate the employee's rehabilitation in accordance with the gradual return procedures. In most of the visited companies. Some companies sometimes go as far as making physical alterations or retaining the services of an ergonomist to facilitate the employee's return. In keeping with the duty to accommodate, permanent changes may also be made to the employee's tasks.

When the workplace factors that contributed to the cessation of work have not been determined during the employee's absence, some coordinators/practitioners highlight them during this step so that action may be taken. However, when there is no means for identifying the risk factors, the coordinators/practitioners attempt to identify the workplace factors that make the employee feel apprehensive during his return to work; once identified, they should be addressed in the return-to-work plan. If the work climate has not previously been ameliorated through conflict management, the coordinator/practitioner may attempt to do so at this stage. However, work organization does not appear to be considered because such changes—a reduction in workload, for example—are only temporary. In addition, the conditions that initially contributed to the departure are taken into account only when means for identifying the presence of these problems are put in place. In such cases, a few companies draft a return-to-work plan that takes into consideration all the previously mentioned items. The plan is then approved by the supervisor, employee, and coordinator/practitioner. The coordinator/practitioner also evaluates, with the supervisor, whether the employee requires training to bring him up to speed; the training can be included in the return-to-work plan. As these changes, even if temporary, can have an impact on the work of a number of employees, the team is informed of the procedures planned for their co-worker's return.

In some organizations, the coordinators/practitioners ensure that the supervisor prepares the employee's co-workers for the employee's return by soliciting their cooperation. The interviewed coordinators/practitioners mentioned that many taboos and prejudices persist in workers' minds around such cases, which can sometimes explain their lack of support. In addition, as they have to take on part of the employee's work, they may feel some resentment toward him. To avoid this situation, several workplaces offer workshops to make workers more aware of mental health problems and, sometimes, to explain the context of the employee's withdrawal from work. Interventions are often necessary when the absent employee is suffering from a personality disorder because often he will have been involved in conflicts with co-workers before withdrawing from work. During these workshops, an attempt is made to explain the person's earlier behaviour in order to reduce the apprehension surrounding his return. Although this meeting may be led by the supervisor, external resources specializing in mental health are often used instead. The goal is to convince the employees to cooperate and to explain what is expected of them during the person's return. In some workplaces, a written agreement committing the manager, employee, and work team is provided in order to ensure there are no feelings of unfairness.

Return to work and follow-up

The return to work is usually paced according to the employee's preference. In some organizations, after a long absence, the first day is set aside for reintegrating the employee into his workplace, letting him readapt to his work environment and re-establish contact with his co-workers, and doing follow-up on the relevant administrative documents. The follow-up may be handled by the manager or the person responsible for follow-up. If an outside professional was associated with the case, he will sometimes support the worker during the return to work. The person responsible for follow-up must be sure to communicate with the employee by email, telephone, or in person in order to check whether the reintegration is going smoothly. The frequency and duration of the follow-up depend on the duration of the gradual return to work. In the cases deemed the most precarious, another follow-up is performed with the employee after his gradual return.

Summary and general diagram of organizational return-to-work practices

For this part of the study, meetings were organized with 13 selected companies to learn about the return-to-work program or protocol they had implemented for absent employees dealing with a psychological or physical health problem. Working in the primary, secondary, and tertiary sectors, these public, parapublic, and private corporations were all large, unionized organizations with more than 500 employees. The diversity of the companies made it possible to obtain an overview of the various interventions discussed. An analysis of the collected results was then used to build a general diagram that summarizes the return-to-work practices (see Figure 2). This general diagram presents the main steps that are taken in most of the selected organizations. The four main steps are:

- Prevention and awareness;
- Administrative procedures at the time of the absence;
- Identifying the difficulties encountered;
- Preparing for the return to work.

(Please note that, in the following figures, return-to-work coordinator/support practitioner is abbreviated as RTWC/SP.)

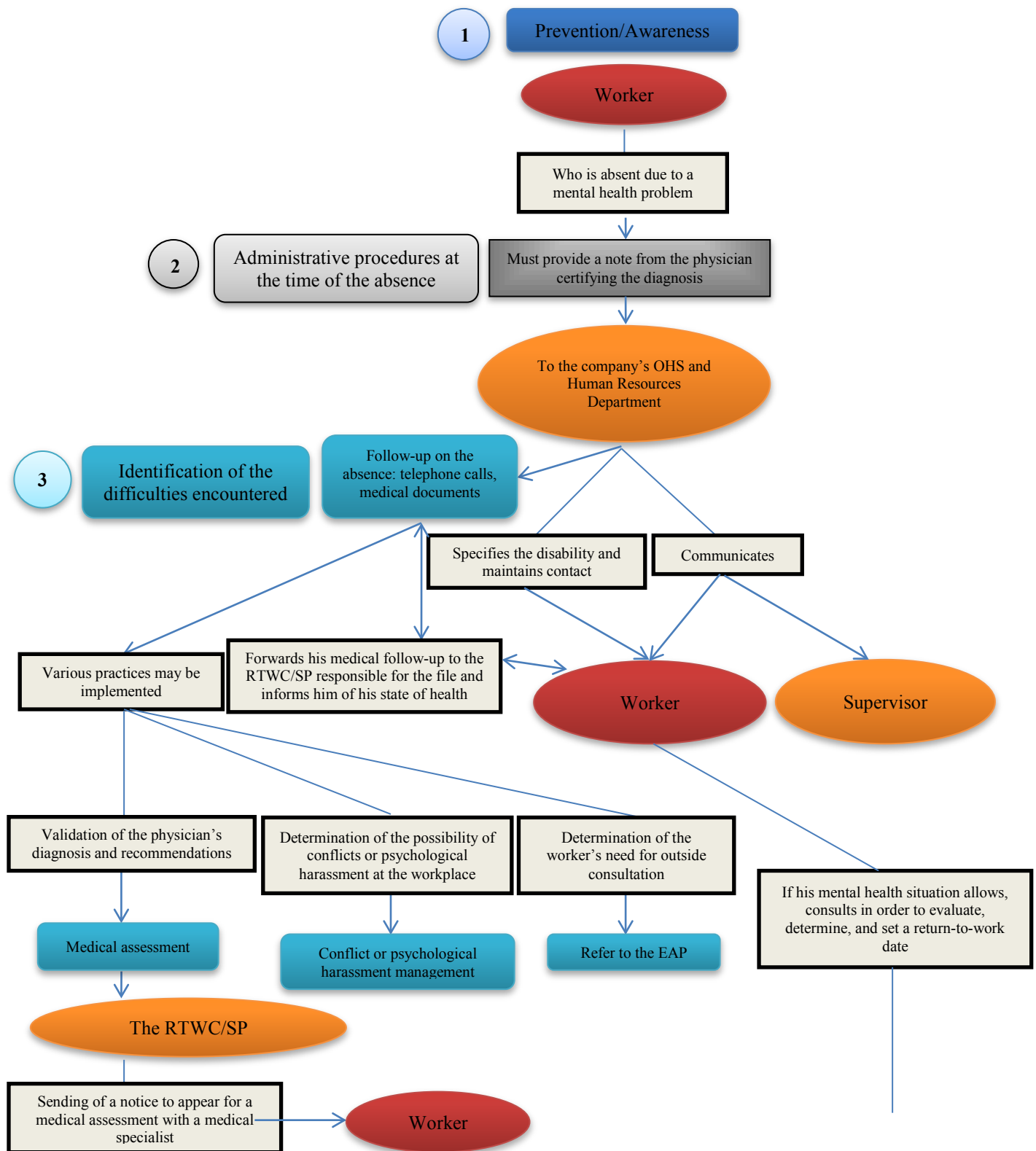


Figure 2a – Summary diagram of the organizational absence-management and return-to-work practices, steps 1, 2, and 3

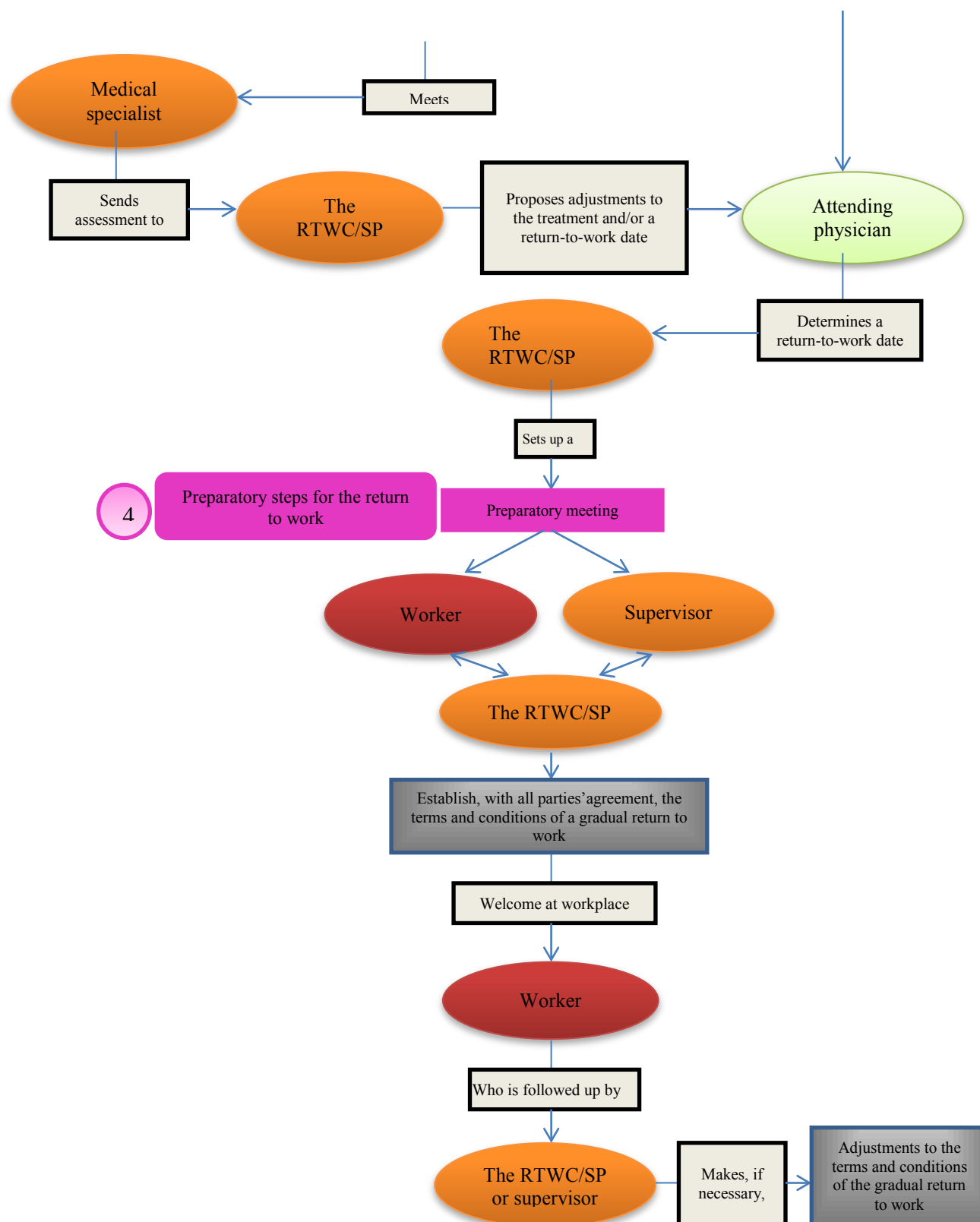


Figure 2b - Summary diagram of the organizational absence-management and return-to-work practices, step 4

Prevention and awareness

Prevention measures (talks, training sessions, brochures, etc.) for mental health problems have been implemented in most of the workplaces. Although this step is not part of the return-to-work conditions, the measures are intended to increase workers' and workplace stakeholders' awareness about mental health problems and the impact they can have on the individual and the work environment.

Administrative procedures at the time of the absence

The return-to-work program begins upon receipt of the medical certificate issued by the physician and sent by the worker to the occupational health and safety or human resources department informing them of his absence due to a diagnosis requiring a cessation of work. Upon receiving the medical certificate, the case manager begins playing his role as support practitioner and coordinator by making initial contact with the worker. This first conversation allows the manager to explain to the worker the procedure to follow during his absence. At the same time, the case manager attempts to learn more about the causes of the absence and to determine whether they include any aspects of work. The case manager also notifies the supervisor of the worker's absence and ensures that the supervisor will contact the worker in order to maintain the relationship throughout the worker's absence, thereby favouring an eventual return to work.

Identifying the difficulties encountered

The second part of the program consists in performing follow-up of the worker during his absence. The return-to-work coordinator/support practitioner makes frequent telephone calls while also ensuring that medical-administrative follow-up takes place. At this step, some practices may be planned to assist with the worker's recovery. If the worker is dealing with conflicts or psychological harassment, management techniques aimed at solving the problems are put in place by the coordinator/practitioner. A worker who needs to see a psychologist, social worker, resource person, or any other professional is directed toward the EAP (employee assistance program). If the coordinator/practitioner, the employer, or the company's consulting physician has doubts about the medical diagnosis, medication, or duration of the absence, the worker may be called to a meeting with a medical specialist. In such cases, the coordinator/practitioner notifies the worker in writing or by telephone and calls him in for a new assessment of the situation. The medical specialist's report is then sent to the coordinator/practitioner who, in turn, informs the worker's attending physician of the suggested adjustments to the treatment or to the return-to-work date. The worker usually consents to this practice, which is aimed mainly at ensuring his recovery.

Preparing for the return to work

The third part of the program takes shape when the attending physician feels that the worker is fit to return to work and determines a date for the return, which he conveys to the return-to-work coordinator/support practitioner. After receiving this notice, the coordinator/practitioner invites the worker and employer to attend a preparatory meeting during which the terms and conditions of the gradual return to work will be established based on the attending physician's recommendations and the worker's functional limitations. The worker then begins his return to work. The welcome given the worker should conform to the preferences expressed during the preparatory meeting. During the worker's gradual return, the coordinator/practitioner or employer provides follow-up and also changes or adjusts the initial return-to-work plan as needed.

DYNAMIC MODEL OF THE FACTORS

APPENDIX E: DIAGRAM OF THE SUPPORT FACTORS

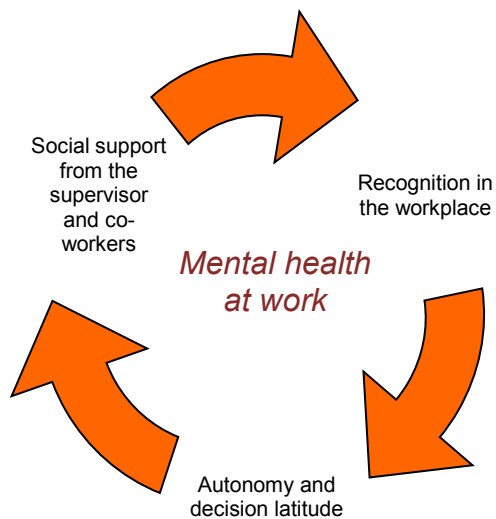


Figure 4 – Recovery and return-to-work support factors

APPENDIX F: STAKEHOLDERS' ROLES AND RESPONSIBILITIES

Senior management

- Promote to all personnel the reference framework based on an individual and organizational approach and apply it to their management practices;
- Maintain a clear position on management's values and orientations regarding the support of persons and the organization in the recovery, return-to-work, and job-retention processes;
- Support, promote, and implement a prevention action plan focused specifically on mental health at work, in cooperation with the stakeholders involved in supporting persons and the organization;
- Promote the role of the recovery/return-to-work support practitioner so that he is known and recognized by all the organization's members;
- Indicate senior management's expectations of managers with respect to the support practices to be adopted, implement evaluation mechanisms aimed at recognizing the efforts made by managers, and ensure they are updated;
- Free up the human and material resources necessary to support prevention and rehabilitation processes in cases involving mental health at work.

Union representatives

- Promote to their team the reference framework based on an individual and organizational approach and apply it to their practices;
- Work with the recovery/return-to-work support practitioner;
- In the area of absence prevention, bring to light the psychosocial risk factors present in the work environment and take part in the search for solutions;
- Promote the role of the recovery/return-to-work support practitioner so that he is known and recognized by all the organization's members;
- As necessary, take part in preparing a return-to-work plan together with the worker, his direct supervisor, and the support practitioner;
- Take part in developing the prevention action plan in cooperation with the partners concerned.

Occupational health and safety department

- Promote the reference framework based on an individual and organizational approach and apply it to the department's practices;
- Work with the recovery/return-to-work support practitioner;
- Prepare means for favouring the integration of support practices into medical-administrative management;
- Act as a recovery/return-to-work support resource for the direct supervisors, unions, and workers;
- Provide support to all the organization's partners in identifying the psychosocial risks present in the environment.

Direct supervisors

- Promote to their team the reference framework based on an individual and organizational approach and apply it to their management practices;
- Regarding absence prevention, bring to light the psychosocial risk factors present in the work environment and take part in the search for solutions;
- In the framework of the recovery/return-to-work support program:
 - Work with the recovery/return-to-work support practitioner;
 - Take part in preparing a return-to-work plan together with the worker, the support practitioner, and, as necessary, the union representative;
 - Plan the conditions in the return-to-work plan and follow up on them;
 - Prepare the co-workers and provide a positive reception for the worker during his return;
 - Plan follow-up meetings with the worker and make any adjustments to the conditions necessary to keeping the worker on the job.

Assistance and clinical support resources

- Offer specialized services to the worker to meet his individual needs of a clinical and social nature in order to support him in his recovery. For example, the services of an occupational therapist or a psychiatrist could be offered to support the person in his recovery process.

This role- and responsibility-defining activity brought to light the importance of adding two new roles to the organization structure, namely:

- The person responsible for the recovery/return-to-work support program (the return-to-work coordinator);
- The recovery/return-to-work support practitioner.

Supported by senior management, the research steering committee decided to hire a person who would be responsible for coordinating the recovery/return-to-work support practices as well as implementing the operational process in the organization. This person should be from outside the organization to ensure his impartiality with respect to the various paradigms and values in effect in the organization. The committee felt this impartiality was key to winning the workers' trust. Supported by the reference framework for mental health at work, this person was responsible for ensuring coherence between the recovery/return-to-work support practices of the various stakeholders. In the context of the research project, only one person was hired. Called the recovery/return-to-work support practitioner, this person nonetheless had to follow up on persons on leave in addition to coordinating activities in the organization. However, these two roles are presented and described separately as the program coordinator and the support practitioner in order to more clearly define their respective roles.

Program coordinator

- Promote the reference framework based on an individual and organizational approach and apply it to his practices;
- Be a resource person for the workers, direct supervisors, and the union in the area of recovery/return-to-work support;
- Coordinate the activities for promoting the recovery/return-to-work support program.

Recovery/return-to-work support practitioner

- In the context of the recovery/return-to-work support and assistance process, support the worker on sick leave throughout the process:
 - Meet with the worker during his absence in order to determine with him the factors hindering and facilitating his recovery and return to work (clinical, social, and organizational factors);
 - As necessary, inform the worker of the assistance and clinical support resources available to him;
 - Provide support to the worker during his recovery period by ensuring compliance with the times off prescribed by his attending physician;
 - Prepare for the meeting concerning the return-to-work plan and the return-to-work plan itself at a pace compatible with the worker and his abilities;
 - Define the return-to-work plan together with the worker, his direct supervisor, and, as required, his union representative;
 - Perform follow-up on the return-to-work plan and the job-retention conditions with the worker and his direct supervisor.
- Collaborate with the organization's other stakeholders in order to favour the worker's recovery, return to work, and job retention.

Communication plan and dissemination of program information

Various measures were put in place as part of the communication plan. First, the members of the steering committee were mandated to disseminate the content of the reference framework to the persons they represented so that each person could understand it and integrate it into his daily work. It was also agreed that the reference framework would be officially printed and distributed throughout the organization. Training and information sessions were held by the research team in cooperation with the steering committee members. In addition, training meetings bringing together the research team members and all managers were held to explain the theoretical foundations of a support vision. Eight information sessions, organized by the support practitioner to explain the program and each person's roles and responsibilities, were held in various locations in the organization and on a schedule planned to cover all the work shifts, so as to enable as many people as possible to take part. It was decided that the support practitioner would be accompanied by two employer representatives and two union representatives, all members of the steering committee. This measure increased the visibility of the joint employer-union side of the project. The sessions provided an opportunity to answer participants' questions and to provide reassurance regarding the organization's desire to implement such a program. The support practitioner was then invited to present the program to the management committees so that the managers could familiarize themselves with its content and promote the program within their teams. These information sessions also served as an opportunity for making initial contact with the direct supervisors and for them to invite the support practitioner to present the program during their team meetings.

A brochure explaining the recovery/return-to-work assistance and support process was developed and distributed through various means by the program coordinator in order to reach as many people as possible. More than 500 brochures were distributed in the organization.

APPENDIX G: PRESENTATION OF THE PARTICIPANTS AND STATISTICAL ANALYSES

Selecting the participants

The persons targeted in this process were the organization's workers who were absent due to mental health problems certified by their attending physician. Participant selection began on September 15, 2008, and ended on May 31, 2009. We decided to exclude workers suffering from an addiction or alcoholism problem due to the specific services available to them through the employee assistance program. Participants were selected by applying the following inclusion and exclusion criteria:

Inclusion criteria:

- 1) On sick leave due to a mental health problem certified as such on the medical certificate;
- 2) Between 18 and 60 years old;
- 3) Having worked 15 or more hours a week prior to going on leave.

Exclusion criteria:

- 1) Absent due to an addiction or alcoholism problem;
- 2) Absent due to a physical health problem;
- 3) Pregnant or having given birth in the preceding six months;
- 4) Intending to retire during the study period;
- 5) Student and temporary employee.

All the files of employees on leave due to a mental health issue from September 15, 2008 onward were retained. We began by inviting all the employees recommended in the first month only to find that some were unable to take part in the study for the reasons described below. It was therefore decided not to continue in a random manner. In all, 128 persons were directed to the program, though two had to be excluded due to their taking early retirement. Of the 126 people invited to take part in the process, 44 accepted. However, five had to be dropped from the sample for the following reasons: returned to work before the first interview, dropping out at the start of the process, and exclusion criteria learned about afterward (alcoholism). Thus, 39 persons ultimately took part in the support process (32 women and seven men). Incidentally, 42 persons refused to take part in the process while another 40 failed to reply to the invitations. Among these, it appears that some returned to work too soon to take advantage of the invitation, others quit, and still others went on leave without pay, thereby changing their sick leave status. Figure 8 presents a summary of the participant recruitment results.

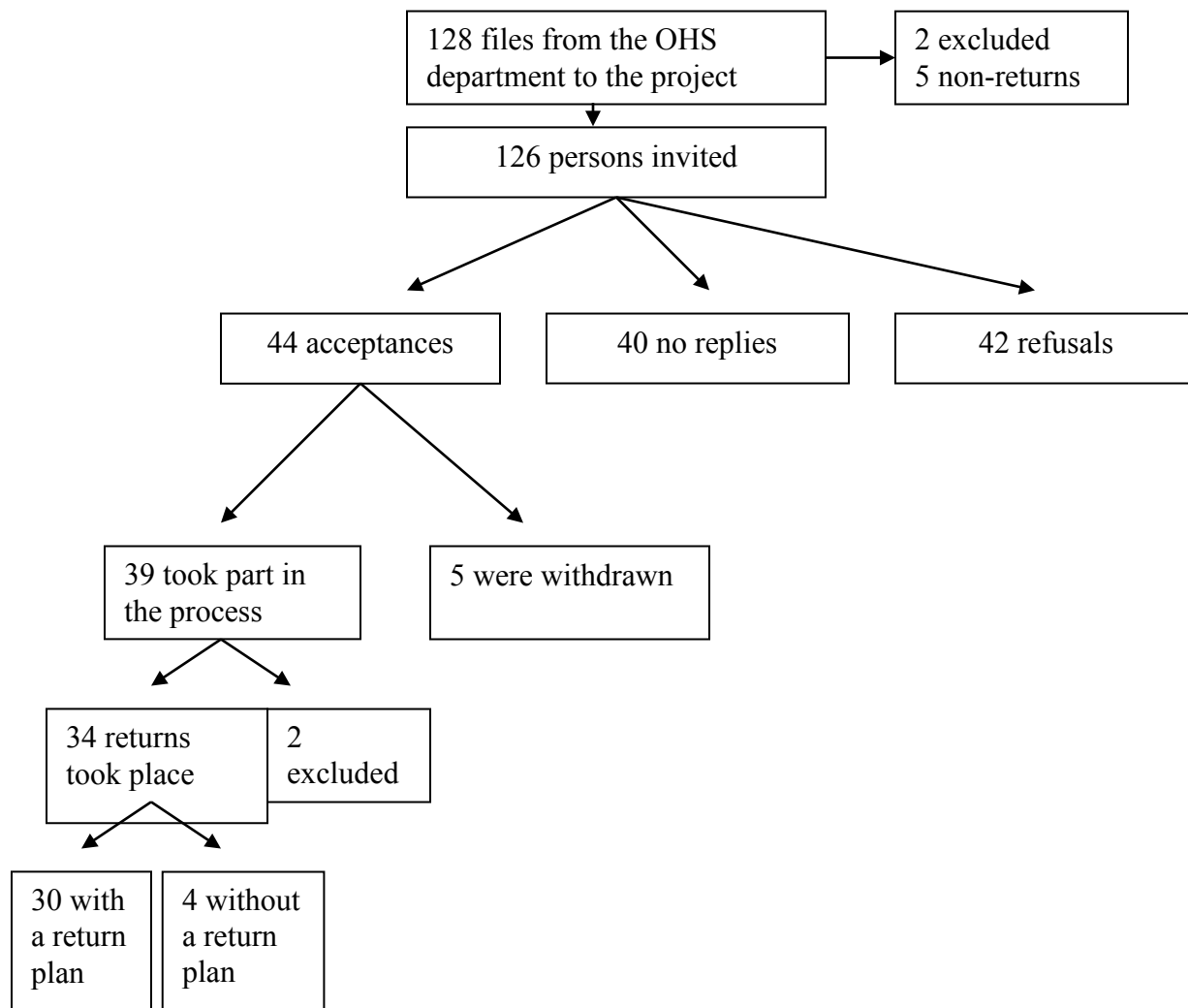


Figure 8 – Summary of the participant recruitment results

Profile of the participants

Of the 39 participants in the study, 32 were women and seven were men. The average age at the start of the disability was 48 years; more precisely, 31 participants were between 41 and 60 years old (table 10). The average seniority as a worker in the target organization was 13 years, and half the participants (18) had management or professional status, while 21 had the status of technician, assistant, or labourer. As for employment status, 23 participants had full-time status and 16 had part-time status. A large majority of the participants, namely 29, were off work due to adjustment disorders, while in nine cases the cause was major depression and in one case an anxiety disorder. The shortest absence was six weeks and the longest 52 weeks (the durations of absence were calculated on a maximum duration of 52 weeks), for an average duration of 22.44 weeks.

Table 10 – Characteristics of the participants

Characteristic	Number of participants (n = 39)
Gender	
- Male	7
- Female	32
Average age	48 years
Age bracket	
- 18 to 30 years	1
- 31 to 40 years	6
- 41 to 50 years	15
- 51 to 60 years	16
- 60 years and over	1
Average seniority	13 years
Position	
- Management or professional	18
- Technician, assistant, or labourer	21
Employment status	
- Full-time	23
- Part-time or occasional	16
Diagnosis	
- Depression	9
- Adjustment disorder	29
- Anxiety disorder	1
Duration of the absence	
- Average	22.44 weeks
- Minimum	6 weeks
- Maximum	More than 52 weeks

The causes that led to the program participants' work absence were tallied at meetings with the support practitioner (Table 11). It was found that the cause of the absence was entirely work-related for 45% of the participants, partially work-related for 42%, and not at all work-related for 13%. In other words, work was a factor in 87% of the participants' absences.

Table 11 – Cause of work absence of the subjects in the program participant group

Cause of work absence	Percentage of participants % (n)
- Entirely work-related	45% (18)
- Partially work-related	42% (16)
- Not at all work-related	13% (5)

More precisely, marriage or family problems, the illness of a loved one, grieving, loneliness, isolation, or financial problems were the non-work-related situations most often mentioned as

having contributed to the participants' stopping work. As Table 12 shows, the average absence duration varies according to the cause. Among the work-related factors that led to the work absence, the participants often mentioned problems communicating with co-workers or their supervisor, work overloads, and personnel shortages. The lack of recognition by their supervisor or the organization for work that they liked and considered important often created a feeling of unfairness and a loss of sense of purpose at work. In some cases, the participants also reported having experienced problems related to their tasks, role, occupational status, or work schedule, or, more rarely, with clients.

Table 12 – Average absence duration, by cause

Cause of work absence	Average absence duration
- Entirely work-related	17.6 weeks
- Partially work-related	25.9 weeks
- Not at all work-related	26 weeks

Comparative analyses between the program participants and a control group

Putting together the control group

First it was necessary to put together a control group so that the program participants could be compared with a group of non-participants. The non-participants in the program were handled using the organization's usual practices. These consisted mainly of medical-administrative follow-up by occupational health and safety officers and practitioners. The officers could call the employees on leave in order to check the dates of the employees' appointments with their attending physician. Some were seen by the company's consulting physician (psychiatrist) in order to assess their health status, treatment plan, and return-to-work date. The interventions focused on the biomedical aspects of the problem. The program participant group benefitted from a support process that went beyond biomedical monitoring, and in particular consisted of identifying the work-related factors that could hinder or facilitate returning to work and staying on the job, of a meeting with the direct supervisor to discuss the same, and lastly of developing and implementing an action plan focused on these aspects.

The control group was picked so as to have age, gender, and job-type characteristics in the same proportion as the group of program participants. In addition, all the subjects had been off work for more than five weeks, which made them comparable to the program participants, who had to have been absent for a certain time in order to have the time to reply to the invitation. Lastly, we excluded workers who had an anxiety disorder because only one subject in the program participant group had been on leave due to that diagnosis, which made comparison by diagnosis between the two groups impossible, thus maintaining only two diagnosis groups, namely persons diagnosed with an adjustment disorder and those diagnosed with depression. The control group so constituted consisted of 49 subjects, while the program participant group had 38 (after excluding the subject with an anxiety disorder).

Absence duration, by group

Analysis of the data indicates that the average absence duration for the program participant group is 22.2 weeks versus 24.3 weeks for the control group. There is no significant difference between these two averages (TestT = -0.645; dl = 85; p = 0.52; threshold of 0.05; CI: -8,738 – 4,455).

Table 13 presents the distribution of short-, medium-, and long-term absences, by group (program participant or control). We note that the proportion of workers absent for a short term (19.9 weeks or less) is higher in the control group than in the program participant group (59% vs. 45%). However, in the latter group, the proportion of medium-term absences is higher than in the control group (39% vs. 12%). Moreover, adding together the short- and medium-term durations of absence (39% and 45%) shows that most subjects in the program participant group returned to work in less than 31.9 weeks; more specifically, 84% of the subjects returned to work after a short- or medium-term absence, compared to a proportion of 71% in the control group (59% and 12%).

Generally speaking, Chi-square analysis indicates significant differences between the two groups based on the absence duration (Chi square = 8.940; dl = 2; p = 0.011; threshold of 0.05). Indeed, the Chi-square test shows that having taken part in the return-to-work program is associated with a greater number of participants returning to work. In fact, it appears that the participants were more likely to return to work after 20 to 31.9 weeks of leave.

Table 13 – Comparison of the categories of work absence duration between the program participant group and the control group

Category of work absence duration	Program participant group proportion (n = 38)	Control group proportion (n = 49)
- Short (less than 19.9 weeks)	45% (n = 17)	59% (n = 29)
- Medium (between 20 and 31.9 weeks)	39% (n = 15)	12% (n = 6)
- Long (more than 32 weeks)	16% (n = 6)	29% (n = 14)

Figure 9 makes it easier to distinguish between the two groups based on the cumulative percentage of the absence duration in months. This chart shows that the subjects in the program participant group returned to work less quickly but that, as of the fifth month, they were proportionally more numerous each month to have returned to work compared with the control group.

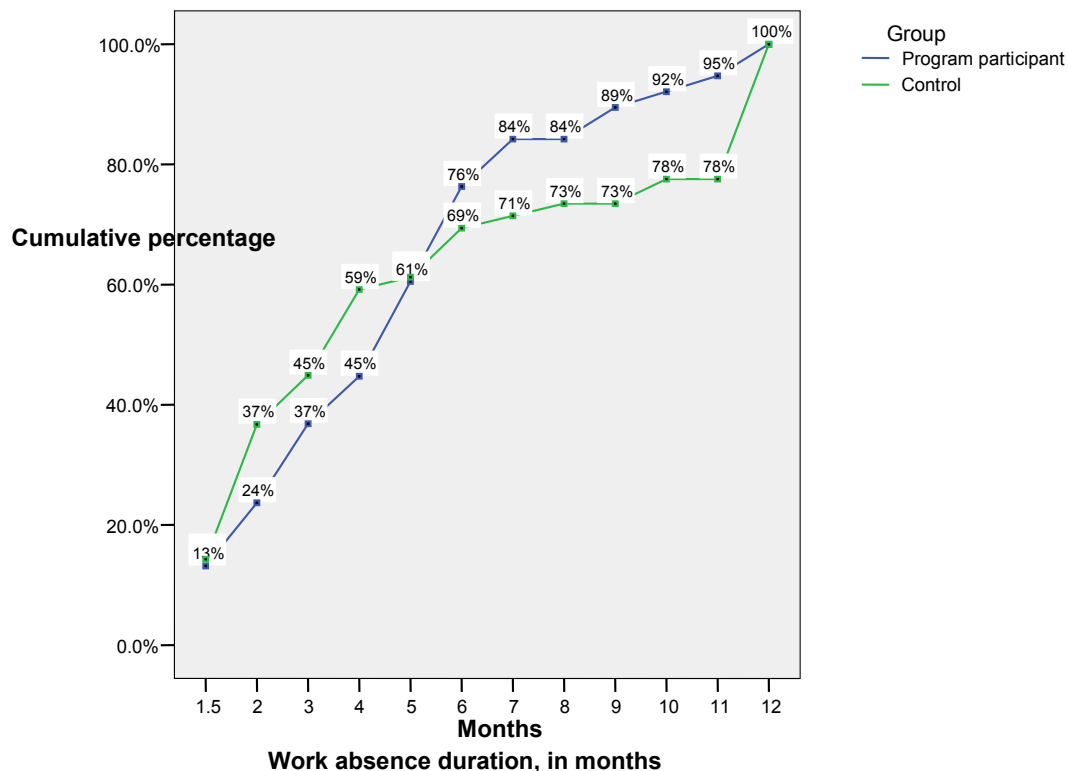


Figure 9 – Cumulative percentage of the absence durations, in months, of the program participant group and the control group

Absence duration, by diagnosis

A) Depression

Analysis of the data shows that the average absence duration for the subjects with a diagnosis of depression is about the same in both groups: 27.9 weeks for the participant group and 28.4 weeks for the control group. There is no significant difference between these two averages (TestT = -0.085; dl = 23; p = 0.933; threshold of 0.05; CI = -13.555 – 12.484).

However, more detailed analysis of the subjects' absence duration shows that the program participants have a lower proportion of short-term absences than the control group (11% vs. 50%) (table 14) but that the proportions are reversed when the duration is between 20 and 31.9 weeks. Specifically, 67% of the subjects in the program participant group return to work during that time period, compared with 13% for the control group. Adding together the short- and medium-term durations of absence (11% and 67%) shows that a larger proportion of program participants with a diagnosis of depression returned to work in a time period of less than 31.9 weeks (78% vs. 64%).

Generally speaking, a Chi-square analysis indicates significant differences between the two groups based on the absence duration (Chi square = 8.121; dl = 2; p = 0.017; threshold of 0.05). Indeed, the Chi-square test shows that having taken part in the return-to-work program is

associated with a greater number of participants returning to work. In fact, it appears that the participants were more likely to return to work after 20 to 31.9 weeks of leave.

Table 14 - Comparison of the categories of work absence duration between the program participant group and the control group in cases of diagnosis of depression

Category of work absence duration	Program participant group proportion (n = 9)	Control group proportion (n = 16)
- Short (less than 19.9 weeks)	11% (n = 1)	50% (n = 8)
- Medium (between 20 and 31.9 weeks)	67% (n = 6)	13% (n = 2)
- Long (more than 32 weeks)	22% (n = 2)	37% (n = 6)

Figure 10 makes it easier to distinguish between the two groups based on the cumulative percentage of the absence duration in months (for a diagnosis of depression). This graph shows that the subjects in the program participant group return to work less quickly but that, as of six and a half months of absence, they are proportionally more numerous each month to have returned to work than subjects in the control group.

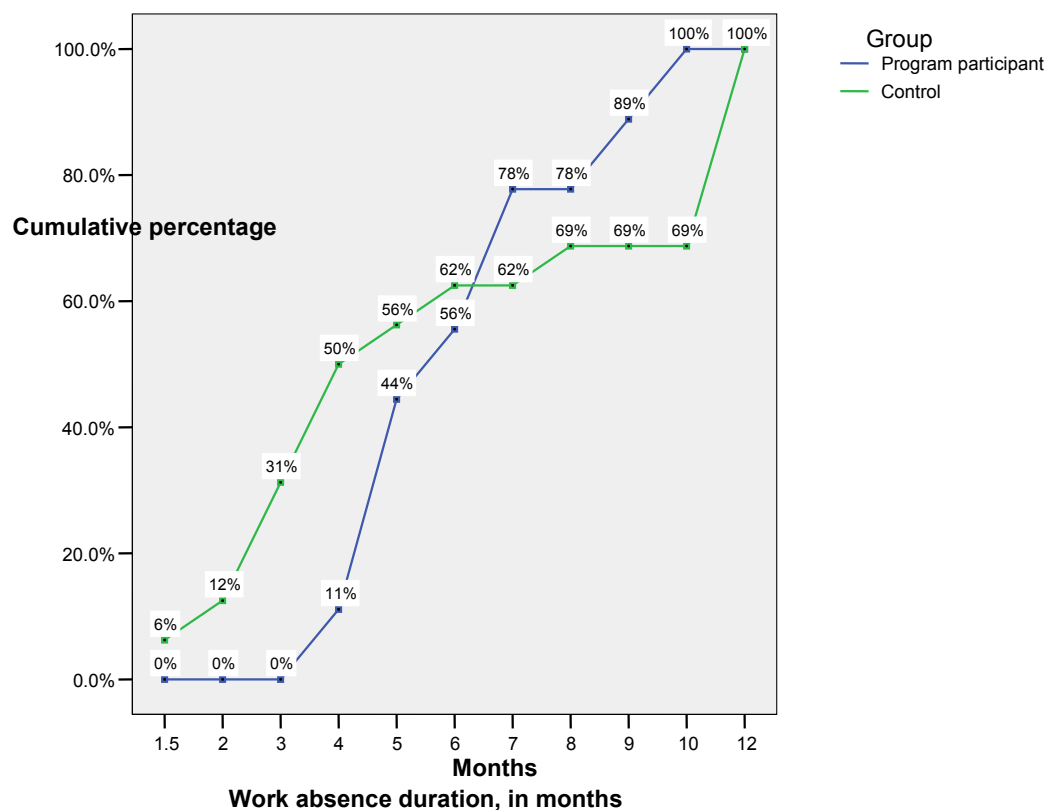


Figure 10 – Cumulative percentage of the absence durations, in months, of the program participant group and the control group in cases of diagnosis of depression

B) Adjustment disorder

Analysis of the data shows that the average absence duration for the subjects with a diagnosis of adjustment disorder is 20.4 weeks for the program participant group and 22.4 weeks for the control group. There is no significant difference between these two averages (TestT = -0.496; dl = 60; p = 0.621; threshold of 0.05; CI = -9.710 – 5.848).

However, more detailed analysis of the subjects' absence duration shows that the program participants have a lower proportion of short-term absences than the control group (55% vs. 64%) (Table 15) but that the proportions are reversed when the duration is between 20 and 31.9 weeks. Specifically, 31% of the subjects in the program participant group return to work during this time period, compared with 12% for the control group. Adding together the short- and medium-term durations of absence shows that a larger proportion of program participants returned to work in a time period of less than 31.9 weeks than did the control group subjects (86% vs. 76%).

Generally speaking, a Chi-square analysis indicates there is no significant difference between the two groups based on the absence duration (Chi square = 3.689; dl = 2; p = 0.158; threshold of 0.05).

Table 15 – Comparison of the categories of work absence duration between the program participant group and the control group in cases of diagnosis of adjustment disorder

Category of work absence duration	Program participant group proportion (n = 29)	Control group proportion (n = 33)
- Short (less than 19.9 weeks)	55% (n = 16)	64% (n = 21)
- Medium (between 20 and 31.9 weeks)	31% (n = 9)	12% (n = 4)
- Long (more than 32 weeks)	14% (n = 4)	24% (n = 8)

Figure 11 makes it easier to distinguish between the two groups based on the cumulative percentage of the absence duration in months (for a diagnosis of adjustment disorder). This graph shows that the subjects in the program participant group return to work less quickly but that, as of the fifth month of absence, they are proportionally more numerous to have returned to work each month than the subjects in the control group.

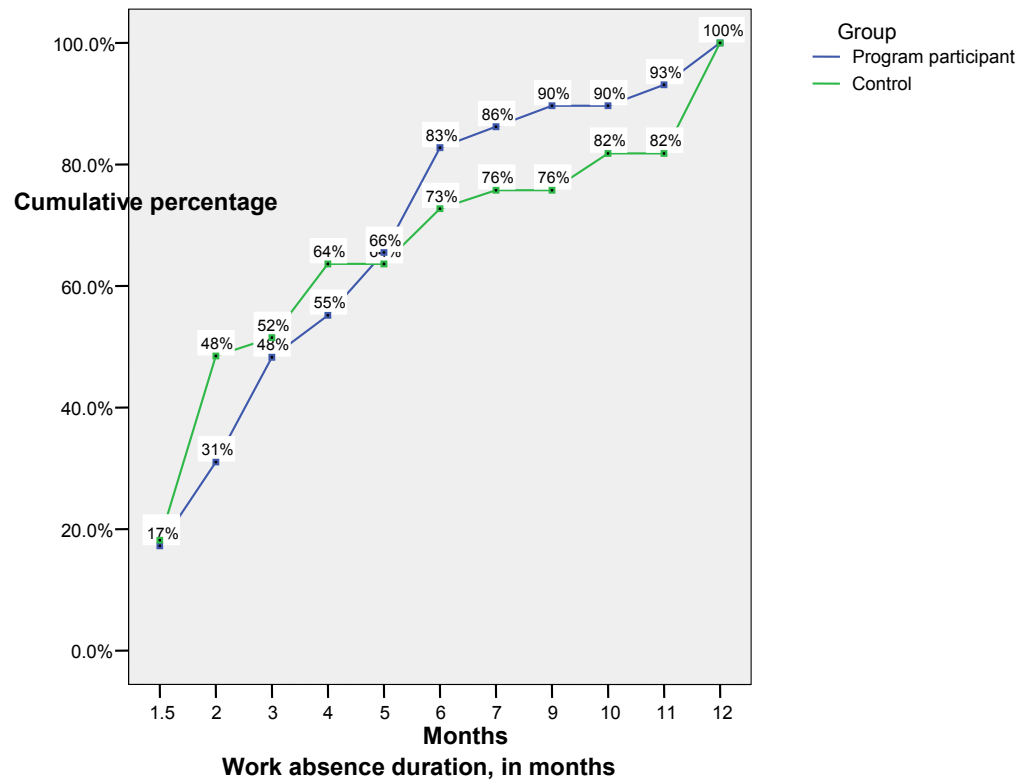


Figure 11 – Cumulative percentage of the absence durations, in months, of the program participant group and the control group in cases of diagnosis of adjustment disorder

Duration of the gradual return

Of the program's 38 participants, 28 (74%) made a gradual return to work. Of the 49 control group subjects, 22 (45%) made a gradual return.

The average duration of the gradual return for the program participant group was 8.4 weeks, compared with 5.6 weeks for the control group. These averages are significantly different (TestT = 2.066; dl = 48; p = 0.044; threshold of 0.05; CI = 0.075 – 5.506).

For the subjects who went on leave after receiving a diagnosis of depression and who had a gradual return (n = 15), the average duration of the gradual return was 12.51 weeks for the program participant group (n = 7) and 5.3 weeks for the control group (n = 8). These averages are significantly different (TestT = 2.196; dl = 13; p = 0.047; threshold of 0.05; CI = 0.119 – 14.401).

For the subjects who went on leave after receiving an adjustment disorder diagnosis and who had a gradual return (n = 35), the average duration of the gradual return was 7.01 weeks for the program participant group (n = 21) and 5.8 weeks for the control group (n = 14). These averages are not significantly different (TestT = 1.029; dl = 33; p = 0.311; threshold of 0.05; CI = -1.189 – 3.625).

Questionnaire for the workers taking part in the process

Between six and 12 weeks after returning to work, the workers who had taken part in the process received a questionnaire designed to evaluate their experience. In all, 39 questionnaires were mailed out with a return envelope addressed to the Université Laval research team. Twenty-three persons agreed to reply anonymously, giving a response rate of 58%. The questionnaire contained 38 questions, of which four were short-answer questions and 34 were multiple-choice questions. The questions dealt with five main themes: (1) the reasons for taking part in the process; (2) the benefits of taking part for the worker; (3) implementation and maintenance of the conditions specified in the return-to-work plan; (4) appreciation of the steps in the return-to-work assistance and support process; and (5) the aspects of the process to be improved (see Appendix H).

Reasons for taking part in the process

To the question “What made you decide to take part in the recovery/return-to-work assistance and support process?”, several participants mentioned their hope that the process would enable them to have a positive return-to-work experience and to make changes in their workplace. The human approach during the initial contact with the support practitioner gave them confidence. They also stated that they felt respected, listened to, and unrushed.

Benefits of taking part in the process for the worker

All of the respondents considered that the process allowed them to feel somewhat or very supported during the recovery period and, with respect to their health, confident and listened to by the recovery/return-to-work support practitioner

In addition, a large majority of the respondents felt that the process allowed them somewhat or very much to identify the factors that had played a role in the deterioration of their health (18/21)³, to find solutions for helping them return to work and stay on the job (21/23), and to make changes in their working life (18/22). In response to the questions about being supported and listened to and about having a trusting relationship with their direct supervisor, the replies were more mixed albeit generally positive.

Another section of the questionnaire was designed to qualitatively evaluate the benefits of the process for the worker by asking the respondents whether their participation in the process had supported various aspects of their recovery and return to work. All respondents either agreed or strongly agreed with the statement that the process had made it easier for their needs to be taken into account before they returned to work. In addition, a majority of respondents agreed or strongly agreed that the process favoured their ability to return to work (19/22) and resulted in a feeling of well-being at work (14/19) due to a supportive and respectful welcome from their co-workers (17/20) and direct supervisor (14/23), better communication with their co-workers (11/18) and direct supervisor (13/21), and a feeling of having been supported by their employer

³ The second number (denominator) is the number of persons who answered the question. Those who did not answer or who entered “not applicable” are not included in the total number. That is why even if 23 persons returned the questionnaire, the number of respondents for each question may be less than 23.

(16/23). Conversely, more respondents said they disagreed or strongly disagreed with the statement that the process favoured an earlier return to work (10/19), positive changes affecting their work (11/21), and positive changes affecting their work environment (11/19).

Implementation and maintenance of the conditions of the return-to-work plan

To the question “Were all the conditions specified in your return-to-work plan implemented and maintained?”, 13 persons replied that the plan had been fully implemented and maintained. Among the ten persons who replied negatively, several attributed the non-implementation and maintenance of the conditions of their return-to-work plan to a change of direct supervisor shortly after their return to work or to their supervisor’s lack of willingness to comply with the return-to-work plan.

Appreciation of the steps in the return-to-work assistance and support process

A vast majority of the respondents stated that they had somewhat or greatly appreciated each of the steps in the process. However, the return-to-work plan follow-up was appreciated by fewer respondents than the other steps (12/20).

Aspects of the process to be improved

At the end of the questionnaire, a space reserved for program participants allowed them to make suggestions for improving the process and to add any additional comments about issues that had not been addressed. Several respondents said that they were very happy to have taken part in the process and that, in their view, the program should be permanently implemented in their organization. Also, some suggested that there should be a more formal meeting with the support practitioner after the return to work, rather than just a telephone call, to follow up on the return to work.

Interviews with the direct supervisors taking part in the process

The direct supervisors taking part in the process were invited, on a voluntary basis, to share their assessment of the assistance and support process. Between six and 12 weeks after the return to work of their employee or employees, a member of the research team called the direct supervisors and invited them to a one-on-one meeting. The interview structure consisted of open-ended questions covering four main themes: (1) their participation in the process; (2) the carrying out of the return-to-work plan; (3) their perception of the recovery/return-to-work support program; and (4) the relationships with the psychosocial work environment and with absence prevention. The semi-structured interview lasted approximately 45 minutes. To encourage the freest and most natural possible expression by the direct supervisors, the interviews were not recorded. As recommended by Mayer et al. (2000), notes were taken during the interviews to reflect the participant’s discourse as fully and accurately as possible. A report was drafted immediately after each interview based on the notes, and the data were subsequently analyzed based on the reports. The analysis is presented in the following two sections: the advantages of the process as perceived by the direct supervisors, and the program’s limitations as indicated by the direct supervisors.

Of the 24 direct supervisors who took part in the process, 21 agreed to be interviewed, which corresponds to a response rate of 89%.

The advantages of the process as perceived by the direct supervisors

The direct supervisors described the assistance and support process as constructive, structured, clear, and precise. In their opinion, the process required very little time and energy compared with their other tasks. Actually, taking part in the process sometimes gave them the impression of saving time. As the support practitioner does the preparatory work with the worker, helps the worker more clearly identify his concerns regarding his return to work, plans the details of the meeting with the direct supervisor, and produces the return-to-work plan, the direct supervisors do not have to take on any of these activities, which, according to them, makes their job easier. Also, the support practitioner became a valuable resource person when difficulties occurred after the employee returned to work.

Several direct supervisors also stressed the advantage of spending time with the worker in a more “neutral” location away from the work unit. In the rush of daily activities, the supervisors say that it is not always easy to find the necessary time to meet with the worker before he returns to work: the telephone rings, there is a knock on the door, emergencies have to be dealt with, and so on. Setting a specific date for a meeting and holding it away from the worker’s and supervisor’s workplace provides a time away that sometimes enables the direct supervisor to get to know the worker better and understand his point of view. It also allows both sides to clarify certain perceptions after the worker’s departure on sick leave. The process therefore appears to provide a way of breaking the ice, of re-establishing contact with the worker before he returns to work. Some said they were pleased to be able to hear the worker express his concerns regarding his return to work but also to have a forum for being able to discuss their own limitations regarding the ways of addressing these concerns. The presence of the support practitioner and the climate of openness and willingness to listen favoured during the meeting were described as facilitators. On occasion, the process allowed the direct supervisor to cast light on or validate specific problems in the work environment: discussing with the worker the causes of his departure made it easier to understand a problematic work-related situation that could also affect other workers in his workplace. Lastly, the process also allowed the direct supervisors to better plan the first day back at work and the details of the welcome-back process, to prepare the team before the return, and to inform the worker of changes that had occurred during his absence. In general, the return-to-work plans were deemed easy to carry out.

The program’s limitations according to the direct supervisors

Several direct supervisors said they themselves would have liked to have had a private meeting with the support practitioner to give him their version of the circumstances of the worker’s absence and to tell him about the worker’s history or what they had attempted to do to avoid the absence or improve the situation. According to them, that would have given them the opportunity to know more about the content of the meeting with the worker (his concerns regarding his return to work) and, thus, to better prepare for finding solutions beforehand. They would have liked to have been better prepared to address the worker’s demands, sometimes fearing that it would be impossible, sometimes being surprised and not knowing how to respond.

Moreover, some direct supervisors experienced a degree of uneasiness at the meeting, feeling a little isolated because they had not taken part in the discussions between the worker and the support practitioner. Some direct supervisors even admitted that they were frightened by the idea of what the worker might have told the support practitioner, sometimes fearing that they were being held responsible for the worker's situation. However, most said that the meeting went very well and that their fears quickly evaporated.

The direct supervisors also raised another topic of concern about the process: reconciling the implementation of the return-to-work plans with changes that had occurred in the organization or compliance with instructions not to do certain actions agreed on in the return-to-work plan. Sometimes feeling as though they were breaking their word to their employee, some supervisors felt caught between a rock and a hard place, wanting to fulfill their duty to the returning employee but suffering from a lack of support from management around implementing the return-to-work plan. In fact, it is very important that senior management support the direct supervisors on the return-to-work plans, whose implementation maintains the workers' trust in the direct supervisors and the organization.

Lastly, the other topics of concern reported by the direct supervisors had to do with the following: how to support a worker returning from sick leave while maintaining good relations with the other team members; how to find the time, despite the work overload, to provide follow-up and implement the return conditions; and the lack of resources to take preventive action regarding mental health at work and to address some of the workers' concerns.

APPENDIX H: Questionnaire for the workers taking part in the process**Questionnaire for the Participating Workers**

Question:

Did your participation in the recovery/return-to-work assistance and support process enable you to:

	Not at all / Not much (n)	Somewhat / A lot (n)	Not applicable / No answer (n)
Feel supported during your recovery period?	0	21	2
Feel confident around the recovery/return-to-work support practitioner?	0	23	0
Feel listened to by the recovery/return-to-work support practitioner?	0	23	0
Identify the factors that played a role in the deterioration of your state of health and your capacity to work?	3	18	2
Find solutions for helping you return to work and stay on the job?	2	21	0
Make changes in your personal life?	6	14	3
Make changes in your working life?	4	18	1
Ask your direct supervisor to make changes in your work?	7	13	3
Feel supported regarding your health?	0	23	0
Feel listened to by your direct supervisor?	7	15	1
Feel confident around your direct supervisor?	8	14	1
Feel supported by your direct supervisor after returning to work?	9	13	1

Question:			
Your participation in the recovery/return-to-work assistance and support process favoured:	Strongly disagree / Disagree (N)	Agree / Strongly agree (N)	Not applicable / No answer (N)
Your ability to return to work	3	19	1
Your needs being taken into account before you returned to work	0	23	0
An earlier return to work	10	9	4
A supportive and respectful welcome from your co-workers when you returned to work	3	17	3
A supportive and respectful welcome from your direct supervisor when you returned to work	9	14	0
Positive changes affecting your work (tasks, schedule, workload, etc.)	11	10	2
Positive changes affecting your work environment (changes affecting the team)	11	8	4
Better communication with your direct supervisor	8	13	2
Better communication with your co-workers	7	11	5
The feeling of having been supported by your employer	7	16	0
A feeling of well-being at work	5	14	4

Question:			
How much did you appreciate the following aspects of the recovery/return-to-work support program?	Not at all appreciated / Not much appreciated (n)	Somewhat appreciated / Greatly appreciated (n)	Not applicable / No answer (n)
The way in which you were invited to take part in the program (letter, reminder letter, call)	1	22	0
The initial telephone contact with the recovery/return-to-work support practitioner	0	23	0
The running of the individual meetings with the recovery/return-to-work support practitioner	0	23	0
The telephone follow-up by the recovery/return-to-work support practitioner during your time off work	0	22	1
The availability of the recovery/return-to-work support practitioner	0	23	0
The running of the return-to-work planning meeting with your direct supervisor and the support practitioner	1	20	2
The content of the return-to-work plan	1	20	2
The welcome you received from your direct supervisor when you returned to work	3	15	5
The follow-up of the return-to-work plan by your direct supervisor after you returned to work	8	12	3
The follow-up by the recovery/return-to-work support practitioner after you returned to work	0	22	1