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ORIGINAL ARTICLE

Developing a collaborative and sustainable return to work program for employees with common mental disorders: a participatory research with public and private organizations

Marc Corbière[a,b,c], Maud Mazaniello-Chézol[a,b,d], Tania Lecomte[b,e], Stéphane Guay[b,f] and Alexandra Panaccio[g]

[a]Research Chair Mental Health and Work, Institut universitaire en santé mentale de Montréal, Montreal, QC, Canada; [b]Research Centre, Institut universitaire en santé mentale de Montréal, Montreal, QC, Canada; [c]Department of Education and Pedagogy, Université du Québec à Montréal, Montreal, QC, Canada; [d]Department of Family Medicine, McGill University, Montreal, QC, Canada; [e]Department of Psychology, Université de Montréal, Montreal, QC, Canada; [f]School of Criminology, Université de Montréal, Montreal, QC, Canada; [g]John Molson School of Business, Concordia University, Montreal, QC, Canada

ABSTRACT

Purpose: To disentangle the key steps of the return to work (RTW) process and offer clearer recovery-focused and sustainable RTW for people on sick leave due to common mental disorders (CMDs).

Methods: This participatory research involves two large Canadian organizations. In each organization, we established an advisory committee composed of RTW stakeholders. We collected information in semi-structured interviews from RTW stakeholders ($n = 26$) with each member of the advisory committee in each organization, as well as with employees who had recently experienced CMDs. The interviews examined the RTW process for employees on sick leave due to CMDs as well as RTW stakeholders' perceptions of barriers and facilitators. A thematic approach was used to synthesize the data, following which, results were discussed with the two advisory committees to identify solutions considering key RTW steps.

Results: Ten common key steps within the three RTW phases emerged from the semi-structured interviews with RTW stakeholders and discussions with the two advisory committees: 1) At the beginning of sickness absence and involvement of disability management team (phase 1), we found 3 steps (e.g., taking charge of the file), 2) during the involvement in treatment rehabilitation with health professionals and preparation of the RTW (phase 2), 4 steps (e.g., RTW preparation), and finally 3) the RTW and follow-up (phase 3) consists of 3 steps (e.g., gradual RTW).

Conclusion: A participatory study involving RTW stakeholders helped identify 10 common key steps within three phases to support RTW sustainability of people with CMDs. Future research will need to address how RTW coordinators intervene in the RTW process of employees with CMDs within these steps.

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➤ IMPLICATIONS FOR REHABILITATION

- Rehabilitation professionals will benefit from a detailed description of the RTW process (10 steps spread out over 3 RTW phases), allowing them to standardize it while adopting a personalized approach for the employee on sick leave.
- Rehabilitation professionals are informed of stakeholders' role and actions required in the RTW process; as such the communication between RTW stakeholders should be improved.
- RTW coordinators will be able to tailor more precisely their intervention, considering the detailed RTW process and RTW stakeholders' role and actions, and thus will become the pivot occupational health specialists for the RTW process.

Introduction

In industrialized countries, common mental disorders (CMDs) account for 30 to 50% of all illness absences [1]. Although these numbers vary depending on the sector of activity, sickness absences for CMDs last on average six to eight months [2]. Gili et al. [3] specify that after a first episode of depression, the probability of a subsequent episode is about 50%; this figure rises to 70% after two episodes and 90% after a third episode. According to Nielsen et al. [4], recurrences in CMDs for returned employees vary from 20% to 30% regardless of the CMD and time evaluation. These percentages translate into direct and indirect costs that are expected to reach three to six trillion dollars over the next 30 years [5,6]. CMDs' prevalence in the workplace is so that they are considered a major public health problem [3,7]. It is not surprising, therefore, that policy makers, employers and other return to work (RTW) stakeholders are concerned about this issue, and eager to find strategies to better manage sickness absences, recovery and sustainable return to work for workers with CMDs.

Although CMDs rarely result in permanent work disability [8], the (RTW) process and work sustainability for employees on sick leave due to CMDs remain complex and fraught with internal and external obstacles [4,9,10]. As a process, RTW involves a series of

CONTACT Marc Corbière corbiere.marc@uqam.ca Université du Québec à Montréal, Département d'éducation et pédagogie –Counseling de carrièrePavillon Paul-Gérin-Lajoie, Local N-6720C.P. 8888, Succursale Centre-VilleMontréal (Québec), H3C 3P8, Canada

interactions and interventions enacted by multiple stakeholders, within multiple environments and systems [11,12]. In a recent scoping review, Corbière and colleagues [13] showed that eleven types of RTW stakeholders are implicated, and spread out across three systems – work (e.g., employer, manager, unions), health (e.g., family physician, rehabilitation professionals), and insurance (insurer, return to work coordinator) systems.

Studies have demonstrated that interventions integrating only clinical aspects show poor results in terms of duration of sickness absence or RTW [14–16]; RTW interventions combining workplace components with clinical interventions are recommended [16–21]. Interestingly, these RTW interventions have mainly focused on cognitive-behavior therapy (CBT) with the inclusion of a work component, generally named work-focused CBT [18]. These interventions are typically offered to the worker only, without including other RTW stakeholders. In their Cochrane review on RTW coordination programmes, Vogel et al. [22] identified only 2 studies (out of 14) related to people on sick leave due to CMDs, suggesting more studies are warranted on the integration of diverse RTW stakeholders.

To the best of our knowledge, the flow of the RTW process has not been described in detail, with at best only broad descriptions of the main components of the RTW process being offered. Indeed, studies often describe the RTW process in three phases: 1) beginning of sickness absence, with involvement of the disability management team; 2) involvement in treatment rehabilitation with health professionals and preparation of the RTW; and 3) gradual RTW and follow-up [10,13,23] including at times an additional phase on maintaining employment [24]. Unfortunately, these studies do not shed light on the needed key steps for the various RTW stakeholders during the entire RTW process, from the beginning of the sickness absence to sustainable RTW. The objective of this study was to develop a collaborative RTW program within a participatory research paradigm that includes the various RTW stakeholders. As such, we aimed to disentangle the key steps of the RTW process and offer a clearer recovery-focused and sustainable RTW for people on sick leave due to CMDs.

Methods

Design

This participatory research project is part of a larger two-phase study on the development and implementation of a sustainable return to work dedicated to employees on sick leave due to CMDs. The fundamental principle of participatory approaches is the active engagement of all stakeholders in decision-making about the research process. This process requires the ongoing sharing of knowledge, expertise and resources, as well as power sharing among participants [25]. In this study, it involves two large organizations in the province of Quebec (Canada). As suggested in this type of design [26], we established an advisory committee composed of representatives from each group of stakeholders identified in the RTW process [13]. Eight and ten RTW stakeholders from each sector (public and private) respectively participated in the advisory committee, stemming from the work, health and insurance systems (Table 1). Because of the nature of the group discussions and the risk of power dynamics compromising the process, we did not invite employees to be part of the advisory committee. However, employees were systematically consulted at each step in both organizations through individual semi-structured interviews (see below). In the public organization, occupational health and safety leaders of the three unions representing the four occupational groups were also part of the group discussions.

Table 1. Participant characteristics and data collection methods.

	Public organization	Private organization
Individual interviews ($N = 26$)	OSH/Insurer rep. ($N = 2$) Human resources ($N = 3$) Health care providers ($N = 2$) Managers ($N = 1$) Employees ($N = 2$) Union rep. ($N = 3$)	Insurer rep. ($N = 4$) Human Resources ($N = 4$) Managers ($N = 2$) Employees ($N = 3$)
6 Discussion groups ($N = 18$)	OHS/Insurer rep. ($N = 2$) Human resources ($N = 3$) Health care providers ($N = 2$) Union rep. ($N = 3$)	Insurer rep. ($N = 4$) Human Resources ($N = 4$)
6 Face validity meetings ($N = 18$)	OHS/Insurer rep. ($N = 2$) Human resources ($N = 3$) Health care providers ($N = 2$) Union rep. ($N = 3$)	Insurer rep. ($N = 4$) Human Resources ($N = 4$)
Documents	Internal statistics Management orientations and performance objectives Policy briefs Internal procedures and guidelines	

OSH: Occupational Safety and Health unit (only in the public org.).

Setting

The study took place in two Canadian organizations: 1) a Quebec public health organization with over 15,000 employees; 2) a private financial organization with over 15,000 employees across Canada. Differences between these two organizations lie in the presence or absence of some stakeholders involved in the RTW process. As such, union representatives were only present in the public organization (also part of the corresponding advisory committee). Also, the insurer is external to the private organization whereas it is internal to the public organization where employees receive a salary insurance from their public employer. At the time we began the study, both organizations had recently faced an increase of costs related to sick leaves due to CMDs. They were also in the process of implementing a shift in their management paradigm, towards *Agile*-influenced practices and governance [27,28]. This approach values the autonomy of employees in their tasks and encourages collaborative work between employees. As the current project took place concurrently within the two organizations (public and private), we will highlight the differences and similarities between them throughout the RTW process in the results section.

Data collection and analysis

Data were collected from individual semi-structured interviews ($n = 26$) to identify RTW barriers and facilitators, following which, results were discussed with the two advisory committees to identify solutions considering key RTW steps. Collection and analysis of the data concurrently occurred following three main steps:

1. Thanks to the advisory committees, we collected information related to each organization's management model, RTW policy, procedures and working documents, as well as absenteeism statistics. These data were useful to understand the organizational contexts.
2. Semi-structured audio-recorded individual interviews ($n = 26$) were conducted with each member of the advisory committee in each organization, as well as employees who had recently experienced CMDs (Table 1). These interviews aimed at understanding the full RTW process for employees on sick leave due to CMDs from different perspectives, as well as

stakeholders' perceptions of RTW barriers and facilitators. The interview guide was structured around two main questions: a) According to your perspective, what aspects or elements could be helpful to employees on sick leave due to a CMD in order to get back to work and stay at work?, and b) What can hinder their return-to-work and stay-at-work? Each interview was transcribed verbatim and analyzed using a framework approach with an a-priori codebook [29,30]. For each question, the codes (RTW barriers and facilitators) were developed according to the scientific literature, namely empirical findings and theories related to the RTW of employees with CMD (see introduction), considering the RTW process. Specifically, we identified when the barriers and facilitators could occur in order to assign them to one of the three specific RTW phases i.e., a) at the beginning of sickness absence, b) during the treatment rehabilitation and preparation of the RTW, and c) during the gradual RTW and follow-up. The two raters (M.C, M.M-C) independently coded and categorized the interviews' transcripts, cross-checking the codebook and the three RTW phases. A thematic approach was used to analyze the dataset [31]. Then, the two raters summarized RTW barriers and facilitators concretely located in the RTW process in a PowerPoint (Tables 1–3) to prepare the next step, and to discuss these steps in the discussions with the advisory committees;

3. Solutions were then explored and discussed with the advisory committee, informed by a scoping review that mapped the roles and actions of each stakeholder in the three RTW phases [13]. To do so, we organized, with the advisory committee members, 12 regular group discussions and face validity meetings (presentation of the slide deck from the previous step of data collection) to evaluate and target key RTW facilitators, barriers (informed by the semi-structured interviews' results) and to identify solutions in terms of key RTW steps, spread out over the three RTW phases. For each emerging solution, the research team proposed a summary which was discussed until all members of the advisory committees reached a common agreement. Finally, all RTW steps including RTW barriers, facilitators, and solutions were presented to the two advisory committees to make final adjustments as needed. Two members of the research team systematically took notes to document the discussions and validation steps. These final encounters allowed all the stakeholders to endorse the collaborative and sustainable return to work program for employees with CMDs presented in the results section.

Ethical considerations

This project has been approved by the Research Ethics Board of the CIUSSS-de-l'Est-de-l'Île-de-Montréal, in Québec. All participants signed an informed consent form prior to the interviews and group discussions.

Results

We present selective examples of barriers and facilitators to support the 10 steps spread out on the three phases of the RTW process. All results (barriers and facilitators) are presented and summarized in Tables 2–4, following data collection and analysis described above. From these barriers and facilitators, inherent to the RTW process, solutions emerged and were discussed with RTW stakeholders participating in the advisory committee. These solutions are summarized for each step in this section. Finally, Figure 1 shows the logic flow of a sustainable RTW collaborative program (10 steps spread out on three phases).

Phase 1: beginning of sickness absence and involvement of disability management team

Step 1: sickness absence announcement

Description. This step consists of announcing the sick leave to the organization. It is the very first step in the RTW process.

Table 2. Return to work Phase 1 barriers and facilitators.

Phase 1: Beginning of sickness absence and involvement of the disability management team			
Barriers		Facilitators	
Public	Private	Public	Private
Medical certificate: lack of specific information (e.g., diagnosis, treatment) Lack of knowledge among some OSH counsellors regarding mental health problems: → OSH more administrative than medical → Consultants who are not very careful with employees' needs and lack of communication Employee mistrust of OSH counsellors: → role conflict (employer/insurer) Lack of awareness about mental health.	Lack of follow up: if the manager does not track/document team members' absences, it goes unnoticed. Delayed payment of insurance affecting employee's health (not informed). CM harassing, over-justification of their actions/role, over-solicitation of services by CM, surveillance and suspicion: → Creates guilt in employees. → Experience of threats	Effective communication between the manager and OSH unit, and union. The union supports the employee in completing the forms.	Manager's trust in the employee.
No replacement of the absent person, except for nurses and assistant nurses. Impact of the absence on colleagues. Lack of manager awareness about mental health warning signs: Managers surprised when sick leave is announced. Lack of communication between OSH/Insurer and the manager to plan the return to work process.		Introduction of EAP or internal resources to the employee by the OSH/Insurer, manager or family physician. Good team spirit and work climate / Good relationship with colleagues and manager before the absence.	

CM: Case manager; CMD: common mental disorder; EAP: Employee Assistance Program; FP: Family Physician; OSH: Occupational Safety and Health unit (public); RC: Rehabilitation Counsellor; SW: social worker.

Table 3. Return to work Phase 2 barriers and facilitators.

Phase 2: Involvement in treatment rehabilitation with health professionals and preparation of the RTW			
Barriers		Facilitators	
Public	Private	Public	Private
Rehabilitation demanding for the employee (fatigue). FP does not discuss with employee the real causes of the problem (e.g., stress at work).	Inadequate managers' management (lack of time, knowledge of mental health and work accommodations, access to information).	Support for the development of coping strategies and tools (for the return to professional and personal activities). Shared/negotiated decision between family physician and employee. Inclusion of employees in the return to work decision to avoid second opinions and forced return.	Paying FPs to facilitate the rapid exchange of information and remove a burden from the employee's shoulders. Inform managers about triggers to better intervene in the work environment (e.g., to avoid relapses). Insurer allows an accommodation period to avoid suspending employee payments. Strategies to ensure health coverage. Maintaining communication during sick leave renewals (e.g., employee communicates to his/her manager to tell him/her that sick leave was extended).
Delay by FP in filling out the forms requested by OSH. Additional cost to obtain information quickly from the FP (documents provided by CM). Lack of specific knowledge of all stakeholders (family doctor, counsellor, medical advisor) about mental health and questioning of the diagnosis because it is considered too subjective. → from the FP regarding functional limitations for mental health cases, organizational context to set up accommodations, no time to explore with the employee the activities required in his work (20 min/month). → from the OSH regarding the employee's position (mismatch between accommodation and workstation needs). → from other stakeholders regarding opportunities for accommodations in the workplace. → Consequences of requesting an expertise Unshared decision making to prepare RTW: → RTW date perceived as imposed by Case manager (CM) → Letter for expertise received by the employee without having been notified by the OSH counsellor. Difficulty navigating the health and social services system (e.g., getting an appointment with a healthcare provider).			

CM: Case manager; CMD: common mental disorder; EAP: Employee Assistance Program; FP: Family Physician; OSH: Occupational Safety and Health unit (public); RC: Rehabilitation Counsellor; SW: social worker.

Barriers and facilitators. While good communication between managers and employees facilitate this step, a lack of documentation (e.g., supervisor's lack of means for following the employee on sick leave) can hinder the team's management in terms of workload redistribution or day-to-day operations:

> I've known [the importance to follow-up] in the field. So I ask for medical documents, medical certificate, or confirmations at the insurance level and all that to make sure that it's correct. It's for the well-being of the employees: because an employee who has a high rate of absenteeism, well, maybe there's something wrong, and we have to try to find out about it to try to help the employee too. Then you always - they're human beings - you always have those who use the system. Manager01 Private organization

In addition, mobilizing employees to deal with their sick leave absence emerged as an important facilitator. The union supporting employees in this step and engaging in discussion with the manager is another facilitator. For example, a union representative mentioned:

> It's really from day 1 when they have a work accident or a work disability, basically we explain to them the different forms to fill out, uh, the documents that need to be sent to the employer. Then … afterwards, we help them to complete, because it's a lot of questions … Union01 Public organization

Solutions. To take into consideration these key elements, employees should inform their manager (and not just human resources) of their sick leave the very first day, if possible, ideally with the support of union representatives. In turn, managers need to provide employees with information regarding potential organizational resources to support them in the recovery process.

Step 2: creating a file

Description. This step is the first contact between the occupational health and safety professional and the employee on sick leave.

Barriers and facilitators. An important barrier at this step was the lack of information (e.g., organizational resources, length of sick leave), resulting in employees and managers being left with many unanswered questions.

> If you just have a medical certificate that says "Stop working", unfortunately you can't justify your eligibility for a sick leave. You absolutely need this certificate. When we receive the certificate, if we have all the information we need, we justify the absence. Occupational Safety and Health unit (OSH)02 Public organization

Table 4. Return to work Phase 3 barriers and facilitators.

Phase 3: gradual RTW and follow-up			
Barriers		Facilitators	
Public	Private	Public	Private
Agreements according to seniority (collective agreement).	Stress for employee when underperformance before the absence. Gradual RTW too short, which does not take into account employee recovery (overload and accumulation of absence period). Transition from gradual to full RTW too abrupt (increase in tasks over a longer period of time). Tele-work as an accommodation: feeling of isolation. No follow up/assessment of what worked and what did not work during RTW (constructive feedback). Uneven skills and attitudes of managers in managing employee RTW (clumsiness, reluctance when previous relapse, lack of leadership, little experience, bias). Managers poorly equipped, particularly for underperformance and behavioural problems.	Develop an accommodation policy.	Use of vacation periods. Agreement with the manager on flexible work accommodations.
Managers focused on results and costs rather than human relations. Pressure from managers to perform and return to full time.		Use of resources (e.g., EAP) during the transition from gradual RTW. Use of health services during and after the gradual RTW.	
Managers' lack of time to prepare RTW. Lack of time for managers to get informed.		Development of concrete accommodations between manager and employee.	
Lack of recognition of the employee by the manager.		Assessment of functional cognitive limitations (e.g., by the occupational therapist) to implement work accommodations and suggest resources to the employee.	
Lack of follow-up once the employee has returned to work. No monitoring of the return to work by the OSH, the manager and the unions.		Intervention in the workplace when psycho-social risks are present (overload, conflicts).	
RTW in the environment same as before the sick leave: → Work overload (risk factors for relapse) → A lot of pressure (cuts, top-down management). → Employee loneliness, fear of stigma.			

CM: Case manager; CMD: common mental disorder; EAP: Employee Assistance Program; FP: Family Physician; OSH: Occupational Safety and Health unit (public); RC: Rehabilitation Counsellor; SW: social worker.

The role of the RTW coordinator, who responds to the insurer and the employer yet is there to support the employee is particularly ambiguous, which affects employees' trust in him/her.

> But often … it's our OSH 'insurance counselor role' that makes the worker suspicious. "She asks me for my medical notes, she sends me to an expert … She asks me personal questions … " OSH03 Public organization

Employees were also concerned about their compensation. Employer and insurer deplored a lack of specific information pertaining to the medical certificate.

> It was a bit last minute, I understand, but I also make my appointments every four weeks, so it fell right on the week when the doctor was not there, he was on vacation. It was the summer period. So, uh, that's it, so they docked my pay, but uh … For a few days only, until I provided them with the documents to be processed. That's a problem. Employee02 Private organization

Insurer and employer highlighted the usefulness of having and using organizational resources such as an employee assistance program (EAP).

> If it's not going well, that's okay, but give [them] time … I'll start the process, I'll first see the employee assistance program. Because it's certain that not everyone has medication right from the beginning, they'll only have medication to sleep, […] But they're going to be referred to the EAP … OSH03 Public organization

Solutions. All key stakeholders, especially family physicians, should be aware of the employee's sick leave to prepare for ongoing support throughout the process. The RTW coordinator should be made responsible for introducing the RTW program and provide relevant documentation to the stakeholders involved in the process (including family physicians), thus ensuring a flow of information to inform future actions. In doing so, they should also be gathering information from different stakeholders, such as employees' perceived sick leave causes/triggers. The RTW coordinator should establish virtual or in-person contact to initiate the RTW process and to clarify their role.

Step 3: checking and taking charge of the file

Description. This last step of Phase 1 consists of a review of collected medical and insurance-related information, to follow the contract procedures and organize Phase 2.

Barriers and facilitators. In both organizations, a lack of mental health knowledge, counselling expertise, medical and work environment information were perceived as delaying the review of the sick leave. In addition, family physicians do not always have the training to assess functional cognitive limitations (e.g., as the occupational therapist).

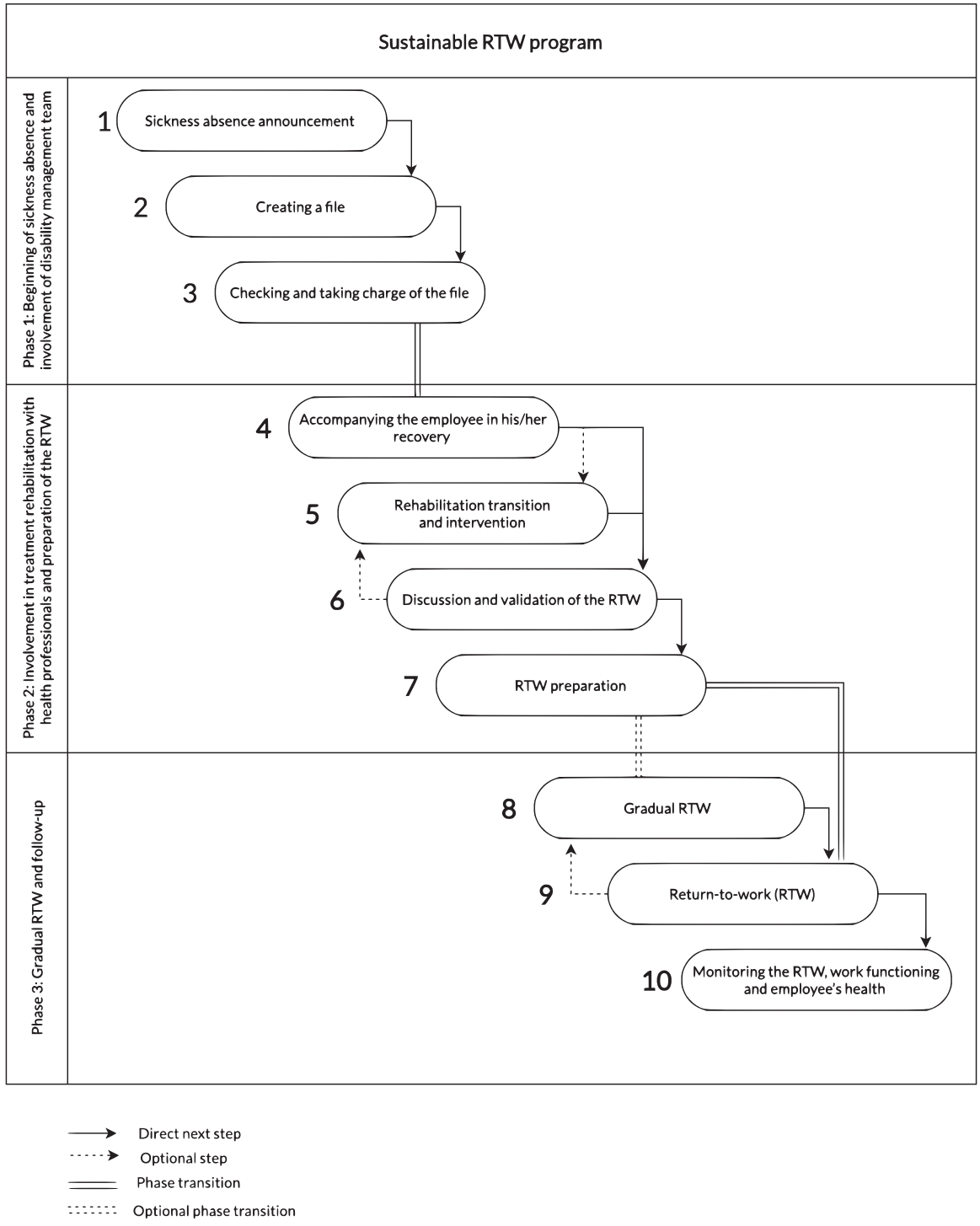

Figure 1. Sustainable return to work collaborative program and initial logic flow.

> Maybe I was a little disappointed that [my manager] didn't see it coming when I started to see the warning signs. [Silence] How sometimes you can feel … alone, you know really alone. So that's what really got to me. "You were so close, how could you not see it?" Employee03 Private organization

> The occupational therapist or the physiotherapist will really give a lot of insight, and I rely on them a lot, because obviously I don't do the functional evaluation in my office. So yes, that's it. But in terms of mental health, we're deficient on that. Family Physician (FP)01

In the public organization, the bureaucratic approach was mostly reported as detrimental to the employee's mental health (e.g., high rate of external additional medical expertise), whereas the insurer's knowledge of the work environment was considered helpful to prepare the following phase.

> To put [occupational] health and safety, which is commonly a very bureaucratic activity, let's say very administrative, we want to upgrade at the level of prevention and health promotion. Human Resources (HR)02 Public organization

When gathering the information needed, the insurer was perceived as over-soliciting the employee. Yet, in both organizations, the insurer may interrupt employees' compensation if information is not obtained.

> So we send the questionnaire, we obviously inform the insured that, uh, his file is suspended. And we wait for the medical information. So during that time, while we're waiting, the insured is not paid. So zero income during that time. Insurer03 Private organization

An effective communication between the manager, the OSH unit and union representative helps support the file, as well as a good relationship with colleagues and manager before the absence.

> What helped me is that I have a trusting relationship with my manager, which is not always the case. Employee03 Private organization

> There are 3 unions. The relationship is very good. Well … I had the chance to work here before, so some of the unions knew me and my approach as a worker. That makes it easier. OSH03 Public organization

Solutions. To set good conditions for the RTW process, the RTW coordinator should obtain accurate, sufficient information regarding the employee's situation and environment from a physician (e.g., employee's functional limitations), and the manager (e.g., work environment and potential accommodations). It would be advisable to have two RTW coordinators, one from the insurer and one from the employing organization (as was the case in the private org.). This would facilitate the sharing of information and bridge the two systems, the organization and the insurance company. These would avoid over-solicitation of employees and managers.

Phase 2: involvement in treatment rehabilitation with health professionals and preparation of the RTW

Step 4: accompanying the employee in his/her recovery

Description. This step consists of identifying risk and protective factors for the development of the intervention. This step also allows stakeholders to prepare the intervention per se, i.e., the rehabilitation transition, program and follow-ups.

Barriers and facilitators. A lack of knowledge from the physician about the employee's mental health and work environment makes the diagnosis questionable by the employer and insurer.

> For all patients, to know all the organizations they work in, all their [accommodation] options, and how to coach them in relation to that, honestly, it's their human resources department at best, because we can't do that, we don't have the knowledge of each organization. What is possible, what is not possible there … No, we don't know. FP01

This results in additional delays to complete the forms and ensuring the sick leave status of the employee.

> To fill out the form [provided by the OSH], well, he doesn't fill it out right away. He fills it out three weeks later, but I needed it now. I had to go back and they charged 50$for the form, it's expensive, plus 20 bucks for the doctor's bill, which you give right away to say that you're extended. Employee04 Public organization

Incentives (e.g., money) to receive prompted complementary information from family physicians helps reduce the delays.

> Yes, the doctor is open to your requests, in general. What he is less open to, in general, is the amount that we will pay to obtain this information, our usual rate is $60 for general practitioners. Sometimes they charge us double or triple that. We need the information. So we'll pay it, absolutely. Insurer03 Private organization

More precise information regarding risk factors helps avoid relapses.

> [Even if] there's no functional limitation, but you put that person back in that environment and they'll relapse. So to avoid a relapse, they would have to change supervisors, etc … Or sometimes the insured, the reason why we do the follow-up during, is to make sure that if the person experiences stress, or we review the resumption of his conditions, we try to intervene. We'll tell the manager, "Take care of your employee," or we'll tell the insured, "Make another appointment with your psychologist, with your therapist, and all that." Then we'll come back, sometimes we'll just have a discussion with the person to say, "It's normal that you're experiencing anxiety, remember what you learned during your disability, the tools for managing anxiety, and all that," so, um, but often it's the insured. We talk. Unfortunately, being in touch with the manager is difficult, so it's often the insured that will tell us what's going on. Insurer03 Private organization

> And that's where it becomes more difficult to work with these people, precisely because the stress is continuous, so it's a matter [for them] of learning to work with this stress, which may not be maintained, because sometimes with the meeting with the manager, us and the person, we can review certain expectations of the employee, and the context of the progressive return to work can also help the manager to understand certain things in relation to the capacity of his or her employee and all that. Insurer01 Private organization

As the family physician can be seen as having little expertise in functional limitations related to mental health, the employer often requests a formal external clinical assessment, which can create tensions between the employee, family physician and employer. Moreover, employees tend to mistrust the employer when a second opinion is required (e.g., a diagnostic interview) without prior notice.

> We really have some issues with the OSH unit. Uh … In relation to these second opinions. [The employee] brought back the medical certificate, two days later she was summoned for an expertise, even though the RTW was already planned, or I don't know what they made her say … And finally it ended up "Yes, indeed, she must return on the date of the medical certificate" [and not before]. Union Representative (UR)03 Public organization

Solutions. To collect information, a thorough assessment of the medical condition, anxiety and depression symptoms, triggers of sick leave, and perceived barriers for RTW is needed in order to articulate an adequate and responsive intervention. This information would better inform the different stakeholders on which actions should be taken next (e.g., whether the employee needs a rehabilitation program).

Step 5: rehabilitation transition and intervention (optional step)

Description. This step consists of a) the transition to a rehabilitation intervention/service (e.g., occupational therapy, psychiatric rehabilitation services) when identified as necessary for a sustainable recovery and RTW, and b) its implementation and follow-ups.

5a) Rehabilitation transition

Barriers and facilitators. Employees can find it difficult to navigate mental health care services, with few services offered by the employer to facilitate the employee's medical management (e.g., psychiatrist).

> Family physicians … Pfff … Now it's like FMGs [Family Medicine Groups] and all that. It's complicated, the Quebec health care system is complicated. Wow. If you already have a doctor, that's already a good sign! I would tell you that the health care system is not helping us. Not helping our insured, and then not helping us. In Toronto, there are no delays. You can see a family doctor. You want to make an appointment, well you have an appointment within two weeks. Insurer04 Private organization

EAP resources are often limited and do not allow for complete mental health care, even when more sessions are authorized by the employer. In the private organization, employees had not been consulted to design the rehabilitation plan. In addition, the insurer can be open to cover more rehabilitation services.

> Sometimes we will do what we call cost sharing. That is, we will refer the person, for example, who has seen a psychologist a few times, and we notice that the person may need occupational therapy for energy management, anxiety management, etc. We will authorize, for example, four occupational therapy sessions to work on these aspects, in order to help the person return to work. Yes, we will pay. So when we say shared, it's shared with the Health and Dental Department. Insurer03 Private organization

Solutions. To ensure adequate rehabilitation services for the employee, the RTW coordinator should contact the (internal or external) rehabilitation clinic to discuss the implementation of the rehabilitation program considering specific indicators, based on the information previously gathered. To reinforce the employee's adherence to the planned rehabilitation intervention, the RTW coordinator should liaise with the employee and consult his or her family physician. Family physician and employee should also meet to confirm the rehabilitation plan. The RTW coordinator would then follow the family physician's recommendation and extend employee compensations accordingly.

5b) Rehabilitation intervention/service

Barriers and facilitators. Rehabilitation interventions/services can enable employees to support the development of coping strategies and tools to prepare their RTW.

> Two weeks more or less, there is a meeting at the office. [OSH counselors] document the absence factors once again, and that's when the ROSES [Return-to-Work Obstacles and Self-Efficacy Scale] would be administrated. When I meet with my workers, I do the ROSES at the initial, or at the second meeting. For workers who tell me about a return to work at the first encounter, I can already administrate the ROSES, while other workers are not there at all. We're far from a return to work, we're really into rehabilitation first. OSH03 Public organization

It also allows all stakeholders to maintain communication during the sick leave.

> Yeah, [the employee] would call us or, it happened that she sent an email and said … I have my doctor's certificate, I'm not coming back. Then we told her, "Send your certificate to human resources through the internal mail, or put it in a confidential envelope, send it to [a colleague], and I'll forward it. If you trust that they won't open the envelope."It was a level of trust from the employee. Manager02 Private organization

However, interventions may be demanding for the employee (e.g., cause fatigue).

> I met [the OT] 3 times outside of my working hours. I found that tiring. That they ask me to see [her] who is there to help me return to work while I'm sick, I found that tiring. Employee04 Public organization

Solutions. The intervention should include regular sessions with rehabilitation professionals, as well as follow-ups. The first sessions should follow the physician-approved plan and lead to a global assessment using questionnaires capturing perceived barriers to RTW, and symptoms. Following up on this assessment, adjustments may be needed. In addition, regular check-ins with the employee and the RTW coordinator should be scheduled throughout the intervention to discuss possible adjustments, as it is of great importance to regularly tailor it to the employee's needs.

Step 6: discussion and validation of the RTW

Description. This step consists of planning the employee's gradual RTW, while considering work accommodations, and accounting for the employee's residual symptoms and functional and cognitive limitations.

Barriers and facilitators. The work environment is key for preparing employees' RTW. Yet, managers are not always aware of available work accommodations and how they could be implemented. The involvement of employees in the decision-making process regarding the selection of work accommodations facilitates their RTW planning.

> If we write to the doctor, either their doctor says, "Yes, I agree with the return plan" usually the attending physician will say yes, they will call their patient. "Your employer has asked me for your gradual return to work, I think they're right that you need to come back. I'm going to send [the form]" Most do that. Some don't. So when we get this, before sending this, normally you would have called your worker to say "I think you're ready for a gradual return, I'm going to write to your doctor" It's not a surprise. And when we get the Ok from the doctor, we call the worker back "Ok, we got the answer from your doctor: he agrees with our plan, so we're going" OSH02 Public organization

In the private organization, support services also help identifying work accommodations. When family physicians refuse the RTW plan, adjustments (discussed in collaboration) are recommended instead of seeking additional psychiatric expertise.

> I have rarely seen cases where the person is not advised that a gradual return to work is proposed. The times when we do it, it's been an abysmal failure. Because the person thinks we're playing behind their back and all that. So there's nobody who wins in all this. Insurer03 Private organization

Solutions. Managers should complete a questionnaire on the available work accommodations, accounting for the needs of the team, in order to support the employee's sustainable RTW. RTW coordinators should consider the workplace environment, as well as the employees' functional and cognitive limitations and residual symptoms (e.g., refine the list of work accommodations according to the organization) when identifying potential accommodations. The RTW coordinator should also involve rehabilitation professionals, managers, and family physicians to ensure the plan corresponds to the employee' needs and functional and cognitive limitations, and is feasible in the organization. Unions may also play a pivotal role in identifying work accommodations and discussing how the RTW can take place under the best conditions, while respecting the collective agreement. Once family physicians approve the RTW plan (with possible adjustments), the RTW coordinator should prepare the RTW in collaboration with the other stakeholders.

Step 7: RTW preparation

Description. This step consists of preparing the approved RTW plan, gradual RTW and work accommodations.

Barriers and facilitators. Managers often mentioned a lack of time to prepare and manage employees' RTW, as the notice from the insurer regarding the employee's RTW date was often sent at the last minute.

> I had problems with the insurer as such, when I want to follow up, if I want to take the initiative to call the insurer, or send an email, or ask questions or something, you have incredible delays, then you don't know who the dedicated agent is, sometimes it changes, you don't know … That goes into all your visibility, whether it's what's going on with the employee and his health. Manager01 Private organization

Managers often lack training on how to manage mental health in the workplace, and how to welcome employees who are returning to work after a sick leave due to a mental illness, and require work accommodations.

> I think it's more in the approach. I think that often the manager doesn't feel equipped, because he doesn't know for example the employee, or "What should I do? Should I call the employee first? Should I wait for the insurer?" HR01 Private organization

Informed discussions between the RTW coordinator and managers can help develop their ability to accommodate and manage employees' RTW. Proactive managers who identified and prepared the implementation of work accommodations early on were better at facilitating the employee's RTW.

> It's not the health department that's doing this, it's organizational development. The health department needs to sit down with organizational development so that we can share our field experience, our experiential experience to say, "Here are the gaps," and then they can tell us, "We're already offering this to managers. There needs to be a sharing of knowledge. To my knowledge, managers are not trained in helping relationships or psychological care. I don't think there's a toolbox that exists for them. OSH02 Public organization

While employees may be apprehensive about their RTW, some form of contact with colleagues or clients can alleviate these concerns.

> Then in preparation for that, two weeks before, I had gone to the office to have dinner with them. I knew all the apprehension of going back to work, contacting colleagues, the manager … It kind of took a layer off that too. Employee03 Private organization

Solutions. To overcome the lack of knowledge and facilitate shared decision-making process towards a sustainable RTW, the RTW coordinator should organize three meetings. First, the RTW coordinator should meet with the employee alone to discuss any apprehensions he/she may have as well as needed work accommodations. Second, he/she should meet with the manager alone, before the RTW date, to prepare the conditions under which the RTW will happen (e.g., replacements, colleagues who will support the employee). Third, the RTW coordinator should meet with both the employee and the manager to discuss the RTW plan. The managers would then be asked to announce the employee's RTW and work accommodations to the team, while respecting confidentiality. This would allow the team to prepare for the employee's RTW.

Phase 3: gradual RTW and follow-up

Step 8: gradual RTW (optional step)

Description. This optional step consists of the gradual return to work of the employee, for various reasons such as functional and cognitive limitations.

Barriers and facilitators. Managers often mentioned a lack of information in a timely fashion and a lack of training to implement work accommodations, particularly when welcoming an employee returning to work and managing the RTW process.

> In spite of everything … it remains that in daily life, as we have seen earlier in terms of the work to be done, well the availability that I have may not always be ideal. Either the return to work is announced, the person sees his doctor today - for example today - and returns tomorrow. That's not something we're used to. The return is tomorrow. And the way that we apprehend the return is in … Well, I get a notice, but it's in an e-mail box. It can be Friday at 3:00 for Monday. So I have to check my email box. If it's not seen … The person arrives on Monday. "Ah, you've arrived? - Yes." It's not always ideal conditions. Because when we talk about returning to work, there are sometimes accommodations. When we talk about assignment/accommodations, we're talking about other tasks, so we have to plan these other tasks. Manager03 Public organization

Insurers stop following employees as soon as they return to work, without paying attention to their risk of relapse.

> I know the other day I had a stack of letters from [the insurer], but as soon as I told them I had my return there … They sent me the payments bang, bang, bang. Thank you very much. They never called me back. They don't even know if I'm really at 5 days/week yet. Employee02 Private organization

Employees mentioned worries about their productivity, some feeling that they were expected to perform as before their sick leave. They also reported experiencing stress when former performance issues were noted.

> So we have to guide the manager. So what we do is we say to him, "You take up a conversation with him when he returns and say, "Listen, we've left it at that. Obviously you're on a gradual return, we'll pick this up at the end of your gradual return" "That'll be the intervention. We're going to be transparent with them, but at the same time, it creates stress for the employee. HR03 Private organization

Employees who were aware of available resources, and used these resources seemed to experience a smoother gradual RTW.

> Then I had tried everything there … I saw my EAP [Psychologist] six times, then I kept seeing her. I've been seeing her for over a year now, every week. Even more now [after the RTW]. Employee04 Public organization

Solutions. To facilitate a gradual RTW, a "buddy system" could be established, where a colleague supports and trains the employee to use tools or procedures implemented or changed after sick leave began (e.g., new software). Managers should follow up with team members regarding the evolution of the worker's accommodations. Regular follow up between the manager and the employee should be scheduled to ensure the pace and respect the RTW plan (with the help of a union representative, if possible). Based on these meetings, it might be room for adjustments. Discussions on performance issues should be limited until the end of the gradual RTW. Training managers on work accommodations and RTW management is strongly recommended. To ensure a RTW fitting employees' needs, functional and cognitive limitations, residual symptoms, and work environment, a reassessment and follow-up work accommodations is needed. A gradual RTW should be seen as a therapeutic tool rather than solely a way to get the employee to a desired level of performance within a specific timeframe. Therefore, the gradual RTW should be designed in consideration of time, volume and nature of work tasks. By the end of the period initially set for the gradual RTW, in agreement with the physician, the gradual RTW should either be extended, or the employee should move to a standard RTW (with the same conditions as before the sick leave).

Step 9: return-to-work (RTW)

Description. This step consists of the resumption of tasks according to the employment contract.

Barriers and facilitators. When experiencing a gradual RTW, the transition to regular RTW can be experienced as too abrupt by employees.

> Okay, well, as I was saying earlier, maybe the gradual return was too aggressive, I would say. I should have done it for example two weeks, two days/two weeks, three days/two weeks … You know, maybe one week more for each. Employee01 Private organization

Furthermore, the environment may be perceived by the employee and the manager as being the same as before the sick leave, namely in terms of work overload and pressure, for instance due to a top-down management approach.

> What does a doctor in his office do to recommend … Is withdrawal from work always the solution? When I see that the person six months later is in the same state. Well, I have doubts! I think that sometimes it's better not to continue a sick leave, because if work is the problem, the person comes back in the same environment. So it's more about the working environment. Manager03 Public organization

Employees can also experience loneliness at work following the implementation of certain accommodations such as telework, or fear being stigmatized by colleagues.

> If I have the possibility of telecommuting, I would probably have tried to have this opportunity. But I'm not adapted to work at home. I don't have an office there. I have a kitchen table, and I set it up as I can. Mmh, but that's it. Maybe I wouldn't have started at … It would have been possible, maybe that would have been the option I would have taken. Employee02 Private organization

> I was afraid of being stigmatized for sure … But I already was. Everyone saw me cry. Everyone saw me angry. "Poor little [name], poor little [name] … " or "We know that [she] is sick, she can't work … " or "Hey, you've been away for five months, you've had a good rest, right? "Yes … I rested, of course! I got a tan all summer, yeah! I think I put on my bathing suit once this summer, my Mom looked at me and said "My God, you're white! "Well yes, I didn't sunbathe, I was in bed! I was in bed, crying my life away, listening to TV. I didn't do anything! "People often think that we rested, that it was a vacation. Employee04 Public organization

In addition, some employees mentioned the lack of recognition for their efforts/work done during their RTW, and the need for follow up assessment on what worked and did not work.

> I was … You can't get sick from a job. It can't be. But it's because I love my work, and I've worked hard to get them out of trouble, many times. Then … there is no recognition. Employee04 Public organization

Some employees mentioned using paid vacations to take breaks during the RTW.

> What I did - I had accumulated a lot of vacation time, so I immediately planned a week of vacation. Then I worked for a month, I took a week of vacation. Then I worked a month, I took a week of vacation. Silence] Then I was on vacation for two weeks. Employee03 Private organization

Interventions in the workplace were also described as important when psychosocial risks were identified. In some cases, the continuing use of health services, such as occupational therapy, can help the RTW.

> Because also, the rehabilitation clinic can follow the person during the period of gradual return to work as well. So, it's not necessarily weekly interventions, but it can be once every two weeks, three weeks, just to make sure that it's going well too. To have maybe a safety net, I would say, a protection. Insurer01 Private organization

Solutions. An assessment should be done by the RTW coordinator to follow up on work accommodations and solutions to the identified barriers. RTW coordinators should schedule health/recovery follow-ups to ensure a balance with work productivity demands. As such, the RTW coordinator, manager and employee should assess work accommodations regularly. Later during the RTW, if appropriate, the manager and employee could have a discussion about productivity (and underperformance).

Step 10: monitoring the RTW, work functioning and employee's health

Description. This step consists of regular follow-ups of the RTW, monitoring employees' health and recovery as well as work functioning to prevent relapses, during the first 3 months after the RTW, at least. This serves the purpose of adjusting task distribution among colleagues if needed, and developing a culture of teamwork and collaboration to help prevent mental health issues at work.

Barriers and facilitators. Some employers mentioned a lack of awareness and training on how to manage RTW and to assess employees' work functioning and potential relapses.

> No follow-up! No look, I wash my hands and then … We leave the manager, I work, then when I finish my job, I tell you manager. I would say it's … And maybe it's the insurances, that's how it works, I can't say, but they are too much insurances, then there's nobody who looks at the big picture, who has a business, it has to go on … I can understand, then I understand absolutely that you can't give information, you don't know what can happen. But look, if there's some kind of portal that you can enter "Employee rendered … " Manager01 Private organization

Managers who mentioned being close and attentive to employees (e.g., looking for warning signs and having good interpersonal skills) appeared to better monitor their recovery, and work functioning. Managers lamented at times the lack of support from human resources, regarding their role in the employee's RTW process (e.g., implementation of feasible accommodations and follow-up).

> If we see that the person is coming back, we see what can be done at the person's level to facilitate his return … This could be occasional meetings with the health office, the officer in charge of the file who may have information to communicate … meet in the environment to announce the person's return, see what facilitating factors we can offer, limit irritants as much as possible. The work is there, we can't prevent it. The work is always there, but the way of doing things can be different, and the priorities can be different. It's a question of managing the priorities that the person will also do. Not everything is urgent, especially when the person has been replaced. See what needs to be done immediately, see what needs to be postponed to later, what can be done by other people. For example, when we talk about administrative agents, I meet with them to see how things work in their sector … what can be done, what is coming up, vacations, planning of the work that needs to be done if the other is not there. So, these are things that we have to do when we return, plan what needs to be done, what is urgent or not, the context, the colleagues, the link with the health offices, the follow-up also during the return. Avoiding a relapse … Manager03 Public organization

Different collective agreements in unions and units can make it difficult to implement certain types of accommodations, rendering the role of the union unclear.

> For us, it's really the charter of rights that applies, it's really the collective agreement, the activities that are provided for, the clauses that apply in the collective agreement or in salary insurance or in … occupational health and safety. UR02 Public organization

The notion of having 'fun at work' through one's professional identity and work environment (i.e., network, professional development, sense of belonging, space) was identified as a potential protective factor to avoid relapses and prevent the onset of concurrent mental health issues among the employee's team members.

> And I found that it was fun for me to come back to [these new open] spaces like that, because I didn't find my little world [that I] always [have had] next to me prior the sick-leave. Employee02 Private organization

Solutions. The RTW coordinator should assess recovery and work functioning/productivity regularly following the RTW (e.g., symptoms, availability and adequacy of resources). Employees should also have check-ups with their family physicians. Colleagues could be informally consulted to follow up on the accommodations and integration of the employee's RTW. The manager should continue to assess and adapt work accommodations as needed, and provide constructive feedback using interpersonal skills developed through training/coaching. Evaluating the satisfaction of stakeholders during the entire RTW process as well as the steps and associated outcomes should ensure continuous improvement of the program (e.g., plan-do-study-act cycles).

Discussion

Because of their high prevalence and recurrent sickness-linked work absences, common mental disorders (CMDs) are a major social and economic challenge [32]. Sustainable RTW for employees on sick leave due to CMDs involves personal and environmental factors, as well as several RTW stakeholders [9,13,33]. To our knowledge, key steps of the RTW process have until now been poorly described. Our aim was to develop a sustainable RTW program dedicated to employees on sick leave due to CMDs, using a participatory research paradigm, and thus involving RTW stakeholders stemming from two typical large organizations in Canada (private and public sectors). Results suggest 10 common key steps within the three RTW phases (Figure 1). A recent scoping review and current guidelines [5,13,34–36] support this clearly structured RTW process developed with several RTW stakeholders. The 10 key steps illustrated in Figure 1, while never described in such detail, are supported by several authors [10,13,23]. Although some authors consider follow-up/maintaining employment (Step #10) as a unique phase [24], we believe it belongs in Phase 3 as RTW sustainability should be planned at the onset of RTW. Some authors propose six steps [37]; our results rather support 10 distinct steps. Indeed, a first phase with three progressive steps captures the need for an evaluation of the health condition of the employee and of potential available resources and health services. This phase also contributes to fostering communication and concertation between RTW stakeholders, from the beginning of the sick leave (particularly the family physician (FP), employee on sick leave, insurer, manager, and the RTW coordinator). In our study, two additional steps at the beginning of Phase 2 were deemed crucial for RTW stakeholders, i.e., accompanying the employee in his recovery, and transitioning to a rehabilitation/intervention program, when needed. Indeed, to prevent eventual relapses, RTW stakeholders from both organizations (public and private) focused on the employee's recovery with an evaluation scheduled at the end of the rehabilitation intervention to determine the employee's level of readiness for RTW preparation (potential back loop, see Figure 1).

As illustrated in Phase 3 (see Figure 1), a gradual RTW is optional, though most often described in the literature as an essential step to facilitate the recovery process if implemented in a timely fashion [9,38]. Indeed, workers who return to work after CMDs may still struggle with health-related work limitations that hamper their ability to meet work demands, having an impact on work performance and productivity [32]. In order to better understand work and health outcomes (i.e., work functioning, clinical symptoms and relapses), scholars have attempted to describe the RTW trajectories of employees with CMDs [9,32,39]. Interestingly, Spronken et al. [39] found no differences on personal (e.g., age, gender, type of CMD) and work characteristics (e.g., sector) when comparing five trajectories (in terms of speed of RTW) with or without relapse. Arends et al. [9] found, in their longitudinal study, three higher order latent classes of recovery speed (slow, gradual and fast) for workers with CMDs, based on work functioning, speed of RTW, and symptoms (depressive and anxiety). They observed that 75% of their sample ($n = 158$) presented a slow or gradual recovery one year post RTW. Both studies recommended investigating psychological and relational work-related factors as well as outside-of-work context in order to better understand these trajectories (e.g., RTW barriers and self-efficacy, frequency and timing of communication between RTW stakeholders). This refers to the complex notion of *sustainable RTW*, and consequently, the need to investigate how resources and communication between RTW stakeholders may improve work functioning, and reduce clinical symptoms as well as potential relapses [4]. The results of our study, with their 10 steps within three phases, offer an interesting stepping stone from which to investigate more thoroughly RTW trajectories of workers with CMDs whilst using relevant and validated tools for individual psychosocial and organizational factors [40,41].

Dewa et al.'s review [5], based on guidelines from the Australian, Canadian, and UK governments or health agencies, recommends that RTW be coordinated and planned. To do so, the RTW plan or programme needs to be orchestrated by a designated coordinator who supports the communication and concertation of actions of the RTW stakeholders from different systems (i.e., insurance, organization and health systems) [13,42,43]. In a recent scoping review on the role of RTW stakeholders, Corbière et al. [13] observed that the RTW coordinator's role is critical in the RTW process, and more and more present (from 2010) in work disability, particularly to liaise with key RTW stakeholders such as FPs, managers, workers, and rehabilitation professionals [43,44]. To disentangle the liaison role of the RTW coordinator, Skarpaas et al. [45] distinguished two types of coordination: 1) horizontal Integration, where the RTW coordinator is responsible for coordinating their own program in a specific service (e.g., to coordinate with health professionals from a rehabilitation program); 2) vertical integration, where the RTW coordinator is responsible to coordinate programs across levels and institutions or systems. In that study, two out of three employees (of about 500 employees in total) who received RTW services were provided with a RTW coordinator by the program, i.e., horizontal integration. In our study, it is noteworthy that in the public organization, the RTW coordinator plays a pivotal role as occupational therapist, representative of the insurer and employee of the organisation, coordinating actions with the FP, manager, rehabilitation professionals and unions. This model is close to the definition of vertical integration. In the private organization, the model was also vertical, with coordination being ensured by an occupational therapist outside of the organization (working for the insurer) liaising with the employee, and a RTW coordinator within the organization (from the organization's human resources department), liaising with the manager. Both models of RTW coordination (public and private) need more investigation to identify their respective pros and cons, particularly on the notion of working alliance, trust and confidence between stakeholders, as highlighted in the FP - RTW coordinator dyads [44] or RTW coordinator - employee on sick leave dyads [46].

Our study has limitations. This study was conducted in only two organizations, reducing the applicability of the results to specific contexts; although each context was considered fairly typical of that type of organization. A participatory research methodology was recommended for this type of study since it takes into

account the stakeholders' perspectives and their evolution within their environment, thus promoting the appropriation and application of the study's results by the concerned stakeholders [25]. Another limitation is probably related to the fact that our conclusions might not apply to small organizations without human resource departments, for instance. Furthermore, although the 10 steps stemmed from consultations with key stakeholders, in both organizations, having a dedicated RTW coordinator was considered necessary to be able to go through these 10 key steps. We know that such training RTW coordinators on this process lasts at least a few days [43]. To be successful in this role, RTW coordinators need sufficient guidance and understanding of the necessary key actions and attitudes required. As recommended by MacEachen et al. [47], future research should examine the required competencies of RTW coordinators, and particularly the necessary attitudes, actions and knowledge in the implementation of a sustainable RTW program as proposed here.

To conclude, from a participatory study implemented in two large Canadian organizations, RTW stakeholders helped identify 10 common key steps comprised within three phases to support RTW sustainability of people with CMDs. Future research will need to address the notion of sustainability and particularly how it is measured and how RTW coordinators intervene in the RTW process of employees with CMDs, while aiming at reducing potential relapses, and balancing health and work functioning. It would be useful to map the integration of actions between RTW stakeholders, supported by a RTW coordinator to help ensure collective benefits in the recovery and sustainable RTW of employees on sick leave due to CMDs. We believe the proposed sustainable RTW program, integrating both public and private barriers and facilitators perceived by RTW stakeholders and supported by practical guidelines, could be very helpful in this regard.

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