

Return-to-Work Coordination Practices of Large Organizations in Québec

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Bibliothèque et Archives nationales du Québec
2017

ISBN : 978-2-89631-942-8

ISSN : 0820-8395

IRSST – Communications and Knowledge

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www.irsst.qc.ca

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en santé et en sécurité du travail

August 2017

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This study was funded by the IRSST. The conclusions and recommendations are solely those of the authors. This publication is a translation of the French original; only the original version (R-934) is authoritative.



PEER REVIEW

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

ACKNOWLEDGEMENTS

We wish to extend our warmest thanks to the key informants who participated in the exploratory interviews conducted prior to our development of the survey questionnaire. Their input enabled us to construct a questionnaire adapted to the realities of large employers in Québec. Our gratitude also goes to our online survey participants, whose enthusiastic response to our call was a clear sign of their interest in sharing their work experiences.

We are also grateful to the Institut de recherche Robert-Sauvé en santé et en sécurité du travail (IRSST) for its financial support, which made this project possible.

SUMMARY

Every year, a large number of workers find themselves having to go on sick leave due to physical or mental health problems. Some of these workers will have difficulty reintegrating into work and will end up taking long-term leave. These difficulties are referred to as “work disabilities.” Given the magnitude of the human and financial costs generated by these health problems, a number of strategies have been proposed to facilitate the return to work (RTW). Several studies have shown that the presence of a return-to-work coordinator (RTWCo) helps reduce long-term disabilities and the related costs. A RTWCo is a professional who facilitates the RTW of an employee with a work disability by working hand in hand with the various stakeholders who may be involved in the process (direct supervisor or manager, union representative, health professionals, insurer, etc.) While several scientific articles recommend coordination of the RTW process, current Québec practices in this regard remain largely unknown.

The main objective of this study was to describe the practices of the individuals responsible for RTW coordination in large private and public organizations in Québec. The first specific objective was to describe the individuals involved in the process and the organizations for which they work. The second specific objective was to describe the tasks and activities carried out by these individuals, identify the stakeholders with whom they have to collaborate, and determine the personal attributes and aptitudes required to perform the coordination task. Lastly, the third specific objective was to explore the facilitators and barriers associated with performing these tasks and activities, as well as those associated with the return to work.

Using various Web sites, a list was drawn up of potentially eligible private and public organizations, specifically, those with at least 500 employees in Québec. Of the 652 organizations identified, 471 were found to qualify following telephone contact. Of this number, 327 individuals filling the role of RTWCo agreed to provide their email addresses in order to receive an invitation to complete an online survey (programmed in SurveyMonkey). All told, 195 individuals answered all the questions in the survey, which included several questions related to each of the specific objectives. Bivariate and multivariate analyses were performed using version 18 of PASW statistical software.

Regarding specific objective 1, the standard RTWCo profile was identified: female, between 35 and 54 years of age, holder of a university degree, and active in the RTW coordination field for nearly 13 years. One surprising finding was the fact that the word “disability” came up very infrequently in the job titles of the RTWCos, not to mention the fact that the expression “return to work” was totally absent. Approximately half of the surveyed organizations used the services of external firms for disability case management. In addition, musculoskeletal and mental health disorders virtually tied as the main reason for sick leave, and the reported absence rate was rarely higher than 10%.

Regarding specific objective 2, the results obtained revealed that the individuals filling the RTWCo role in large organizations in Québec were required to carry out many varied tasks and activities. Several significant associations were found between the frequency with which these tasks and activities were performed and the characteristics of the RTWCos or of their organizations. Regression analyses showed, however, that the fact of having nursing or occupational health and safety (OHS) training is one characteristic of people performing RTWCo tasks that should not be overlooked when examining the factors influencing the frequency of their practices. The results obtained also showed that the RTWCos have to work with workers on sick leave and their direct supervisor or manager on a regular basis, but less frequently with the human resources counsellor, health professionals, and the absent workers' co-workers. The results further indicated that the RTWCos regard it as important that they have a broad range of personal attributes and aptitudes (e.g., tactfulness, creativity in problem solving, strong organizational skills) in order to perform their jobs.

Regarding specific objective 3, the results showed that, by and large, the RTWCos deemed their work environment and working conditions to be highly favourable. They also reported having much greater difficulty managing cases involving MHDs than those involving musculoskeletal disorders. Several factors facilitating and hindering the RTW were considered important by the RTWCos, and many of these were associated with the attitudes and behaviours of the direct supervisors or managers, and with the contacts between them and the worker.

This study describes, for the first time in Québec, the practices of RTWCos in large organizations. These practices appear to be relatively homogenous and, for the most part, to form part of a spectrum of more varied tasks. The results of this study highlight once again that managing MHDs appears to be much harder than managing MSDs, that the role of the direct supervisor or manager is essential to a smooth process, and that major efforts are needed to ensure concerted action in these workplaces. Additionally, the RTWCo profile that should be recommended has yet to be evaluated in terms of its impact on sick leave duration, number of relapses, and associated costs. To date, the many challenges and needs identified by the RTWCos in this survey point to the need for additional training, for example, on MHDs, reintegration into the workplace, and ways to ensure concerted action. It is important to remember that this study reflects practices found in organizations in good overall health, and that the RTWCo role should be explored in the context of small and medium-sized businesses.

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1. INTRODUCTION

1.1 The Occupational Health and Safety Problem

Every year, a large number of workers find themselves having to go on sick leave for several months or even years due to physical or mental health problems. Some of these workers will have difficulty reintegrating into their regular jobs or the labour force. These difficulties are referred to as “work disabilities.”¹ Workers in organizations may experience difficulty staying at work (partial work disability) or may have to go on long-term sick leave due to health problems (total work disability). The health problems leading to work absenteeism are generally associated with work-related accidents, occupational diseases, or other health issues such as occupational burnout or depression. The Enquête québécoise sur des conditions de travail, d’emploi et de santé et de sécurité du travail [Québec survey on working and employment conditions and occupational health and safety] (EQCOTESST, 2011) showed that nearly 238,000 workers reported having been absent from work during the pre-survey year owing to a musculoskeletal disorder (MSD) that they regarded as primarily work-related. It also showed that nearly 50% of the workers absent from work for depressive symptoms had been absent for 11 or more working days (i.e. over two weeks) and that approximately one-quarter of them had been absent for more than 60 working days, or roughly more than three months.¹ It is a recognized fact that absenteeism has considerable human consequences as well as incurring major costs. Moreover, the Organization for Economic Cooperation and Development (OECD) points out that “spending on disability benefits has become a significant burden to public finances in most OECD countries and hinders economic growth as it reduces effective labour supply.”² In addition, despite the slight decline observed in the incidence of work absenteeism in recent years, the associated costs continue to rise.

As already mentioned, the costs are not only financial, but human as well. Work constitutes adults’ primary activity and a source of financial autonomy, social status, fulfilment, and time and space management.³ As early as the 1980s, in a study on the outcome of the rehabilitation process of the Commission des normes, de l’équité, de la santé et de la sécurité du travail (CNESST)², Baril et al.⁴ showed that these prolonged MSD-related work disabilities resulted in significant human costs. For example, workers may experience worries and insecurities caused by lack of clarity about their health condition and misconceptions about the administrative and legal rules, demotivation about occupational reintegration, social isolation, a drop in quality of life, and a feeling of loss of dignity and autonomy. Other studies documenting these aspects have been carried out since then.⁵⁻⁸ In addition, it has been shown that being unemployed is associated with a higher mortality rate, poorer general health, greater use of medications, and more frequent medical consultations and hospitalizations, whereas promoting a RTW helps lower the risks of long-term disability and the associated physical and mental effects, reduce poverty, and improve quality of life and well-being.⁹⁻¹¹

¹ “Disability” is the common term used to refer to a partial or total inability to work.

² On January 1, 2016, the CSST became the Commission des normes, de l’équité, de la santé et de la sécurité du travail (CNESST).

Given the magnitude of the human and financial costs generated by work disability, a number of strategies have been developed to facilitate workers' RTW. As indicated in the next few paragraphs, several studies have suggested that the presence of a return-to-work coordinator (RTWCo) helps reduce long-term disabilities and the associated costs by ensuring collaboration among employers, workers, insurers, and healthcare providers. While several scientific articles recommend that this role be filled, the actual practices of RTWCos in Québec organizations remain largely unknown.

The next section provides an overview of current knowledge on work disability management and of studies on RTW coordination practices.

1.2 Current Scientific Knowledge

1.2.1 *Work disability paradigm*

In the early 1980s, work disability management models focussed on reducing or eliminating the impairment, in other words, the injury that triggered the disability. Yet it has been shown that this type of intervention is largely ineffective in helping people return to work. Several subsequent studies established that the factors preventing workers from returning to work were associated less with the illness itself and more with the resulting disabilities.¹² These converging results led to the emergence of a new paradigm to describe the construction and maintenance of work disability. This paradigm proposes taking into account not only the workers' characteristics but also those of their environment, which comprises the three main social systems involved: the healthcare system (responsible for treating the illness), the workplace system, and the compensation system (which varies according to the legal and social context)^{12,13} (see figure 1). This paradigm is now widely accepted by both the scientific community and professionals in the field. No longer do interventions concentrate solely on reducing the impairment, but rather on preventing or reducing the disability. Numerous studies now recognize that most of the factors hindering the RTW have little to do with the original impairment, and that they are associated above all with psychosocial and environmental factors.^{12,14-19} For example, a person's level of satisfaction with his or her work, the availability of light tasks, the corporate culture, and the person's fears about the RTW are all factors contributing to prolonged sick leave.^{16,20} This major transformation in our understanding of the causes of work absenteeism has led to a shift from a so-called "medical" conceptual model, which focusses on understanding and treating the illness, to a biopsychosocial model, which places importance on taking into account the complexity of the human being and environment involved.²¹⁻²⁴ This in turn requires practitioners and researchers to move beyond the medical diagnosis and attempt to understand what it is, in the interaction between the personal and environmental characteristics, that maintains a worker's disability, or contrarily, renders the person fit to resume his or her occupational activities.⁴

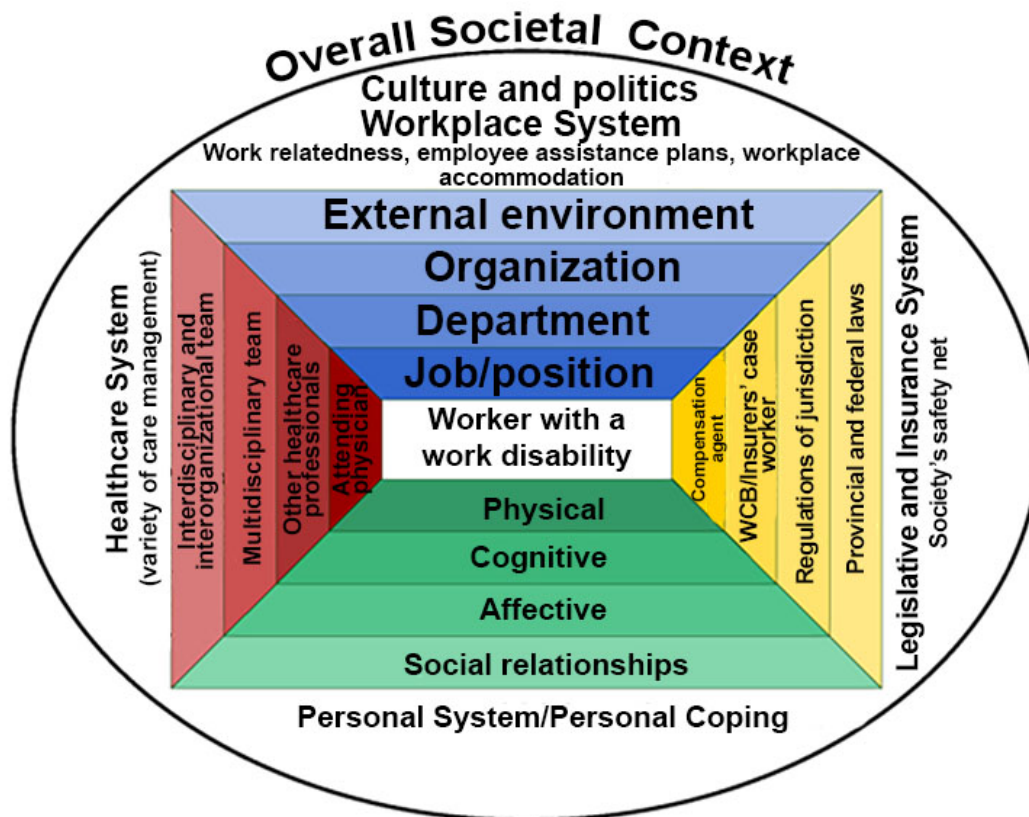


Figure 1: Work disability paradigm¹²

1.2.2 *Management of workers with a work disability and involvement of workplace stakeholders*

Various intervention approaches have been implemented and evaluated in field of managing workers on sick leave. Several high-calibre studies on RTW programs have examined clinical rehabilitation interventions (healthcare system). For workers on long-term sick leave, interdisciplinary RTW interventions have proven effective in reducing pain intensity as well as the duration of the sick leave and disability.²⁵⁻³⁴ Scientific knowledge also indicates that practitioners should give priority to quick intervention directly in the workers' real workplace.^{25,30} Workers' rapid re-integration into their jobs appears to promote their ability to stay at work or to reassume their regular role in both their social and physical environments.^{35,36}

Apart from the healthcare system, an ever-larger role is being given to the workplace system in matters of early RTW interventions. In the last two decades, we have witnessed growing interest on the part of organizations in becoming involved in health promotion and disability management programs.³⁷ Moderate to strong evidence shows that such programs are effective and that the cost-effectiveness ratio is advantageous.³⁷⁻⁴⁰ The evidence also suggests that as soon as a work disability becomes apparent at work, workplaces should implement interventions to reassure the worker, provide adequate support, coordinate care to facilitate access to the

appropriate evaluations/treatments, and offer accommodations in the workplace.^{14,28,41-46} Thus, sound management of a disability as soon as it first appears, maintenance of a relationship with the employer, collaboration and communication among the various partners concerned, and the presence of a favourable environment are all assets for a successful RTW approach.^{14,41,43,47-53} More recently, the specific roles played by direct supervisors or managers and by co-workers during the RTW process have been identified.^{41,43,51,53}

1.2.3 Emergence of a new role: the return-to-work coordinator (RTWCo)

A new role – that of RTWCo – has emerged in response to the need to encourage sound disability management and the application of optimal practices in organizations. A RTWCo is a professional whose role is to promote the RTW of a worker with a work-related disability by joining forces with all stakeholders involved in the process, such as the direct supervisor or manager, health professionals, the insurer, and the union representative.⁴¹

A systematic literature review conducted in 2005 on RTW interventions revealed moderate evidence that RTW coordination is associated with shorter disability duration and a significant reduction in the costs of absenteeism.¹⁴ The study authors asserted that it represented a promising avenue, but that further studies including long-term follow-up were required to study the impact of variations in RTW coordination practices, for example, to compare the effectiveness of workplace-based interventions versus those offered by a third party.¹⁴ This systematic review included ten quality studies, only four of which included an intervention involving a RTWCo.⁵⁴⁻⁵⁹ A meta-analysis published in 2012, involving randomized controlled trials that included RTW coordination activities and workers off work for at least four weeks, obtained similar results.⁶⁰ A pooling of the results of the selected trials^{26,29,61-66} showed moderate quality evidence regarding RTW in the short term. All told, further studies are needed to assess whether programs including RTW coordination activities yield positive outcomes that persist over time and whether the cost-effectiveness ratio is advantageous in the long term. Other studies not included in this systematic review or this meta-analysis have evaluated RTW coordination programs in organizations and obtained positive results. For example, Ahrens and Mullholland (2001)⁶⁷ showed, based on a seven-year follow-up, that the presence of a RTWCo in a construction company resulted in a 40% reduction in compensation and long-term disability costs. Also, Burton and Conti (2000)⁶⁸ observed a reduction in disability duration after implementing a disability management program with a RTW coordination component in a large corporation in Chicago. Thus, in light of current knowledge, the introduction of a RTWCo appears to offer a promising solution for promoting the RTW and reducing the direct and indirect costs of work disability.

More recently, a group of Canadian and American researchers joined forces in an effort to identify the tasks, activities, personal attributes, and competencies required of RTWCos. Their first study consisted of a literature review encompassing 22 studies and sought to describe the activities of RTWCos with workers off work for physical health problems.⁶⁹ This review identified 29 tasks and activities related to the RTWCo role, including, for example, “Meet on-site with worker, supervisor, stakeholders,” “Inventory/prioritize perceived problems or barriers,” “Collective brainstorming of possible solutions,” “Facilitate agreement on acceptable accommodations,” “Assign responsibilities to implement job modifications,” and “Respond to

individual concerns of worker.” The authors grouped each of these tasks and activities under what they defined as the six basic competencies required of a RTWCo: (1) ergonomic and workplace assessment, (2) clinical interviewing, (3) social problem solving, (4) workplace mediation, (5) knowledge of business and legal aspects, and (6) knowledge of medical conditions. To complement this review, a second study, which was based on interviews of the researchers involved in the studies retained in the earlier review, was carried out to obtain a broader spectrum of essential competencies. Ten groups of competencies were identified: (1) the personal attributes required (being positive, flexible, etc.), (2) relevant knowledge base (ergonomic interventions, knowledge of legislation pertaining to compensation and workers’ rights, etc.), (3) RTW focus (not letting oneself be distracted by medical problems and staying focussed on the RTW objective, defending workers’ interests), (4) organizational and administrative skills (having a good sense of organization, being able to manage one’s time well, etc.), (5) assessment skills (assessing the job requirements/demands, empathizing with all parties involved regarding the impact that the injured worker has on them, etc.), (6) communication skills (establishing effective communication with all parties involved, facilitating communication between the injured worker and his or her supervisor, etc.), (7) interpersonal relationship skills (being able to put oneself in the worker’s or supervisor’s position, developing and maintaining good relations with all parties, etc.), (8) conflict resolution skills (having strong negotiating skills, being able to remain neutral and to avoid making judgments), (9) problem-solving skills (demonstrating an open mind, focussed on solutions not problems, etc.), and (10) RTW facilitation skills (being able to establish one’s credibility in the workplace and to mobilize all parties involved in the RTW process, etc.). According to the researchers interviewed, the RTWCo played a very important, if not vital, role in the success of their RTW programs. The interview results also suggest that the RTWCo should have specific aptitudes in order to operate in a context where the relational dynamics are complex, as, for example, between the workplace, insurer, and physician.⁷⁰

The researchers continued their efforts by conducting a study on the competencies required of RTWCos in three countries (Canada, the United States, and Australia). The methodology involved eight focus groups held with 75 experienced coordinators. This study yielded a list of several competencies required in eight distinct categories: professional credibility, communication, conflict management, evaluation, problem-solving, administration, individual personal attributes, and information gathering.⁷¹ An online survey was then administered to 148 coordinators to assess the importance they placed on these competencies. The competencies they regarded as most important were “Respecting and maintaining confidentiality,” “Having ethical practices,” “Having listening skills,” “Ability to communicate well verbally... and in writing...,” “Being consistent between what you say and what you do,” and “Being committed to goal of early RTW.” The competencies deemed least important included “Ability to provide resources and support for the family,” “Ability to find out about co-worker responses to the employee being out of [sic] work and returning,” “Having medical evaluation skills,” and “Being aware of how socio-cultural differences impact RTW.” Overall, the authors found a consensus among the respondents regarding the importance of the various competencies. Another study, conducted in Australia, of 25 coordinators responsible for returning injured nurses to work, James et al. (2011)⁷² brought certain statements to light during the focus groups, specifically, that personal attributes such as an ability to earn people’s trust, to be a “driving force for mobilization,” and to manage conflicts competently were deemed as important, if not more

important, than having a knowledge of the worker compensation system or of the consequences of work absences for the organization, or than having ergonomic or medical expertise. Additionally, having good communication skills and the ability to maintain confidentiality, show empathy, and create an atmosphere of trust were deemed necessary in the RTW process. A very similar study published in 2014 and involving Australian RTWCo who were engaged in developing and implementing policies and procedures in organizations operating in different sectors, yielded results that concur with those mentioned above.⁷³

Other authors have also investigated the challenges of assuming the role of RTWCo in an organization. Apart from potentially diverging opinions and conflicts of interest between stakeholders involved in the RTW process,⁷⁴ RTWCos have to face other challenges in their job, such as having to play multiple roles, handling an excessive workload for the time allotted, coping with the emotional impacts associated with the difficult situations experienced by some workers, and dealing with the absence of light tasks in the organization and insufficient support and collaboration on the part of the workplace.⁷⁵ Moreover, a number of RTW facilitators or barriers can simplify or complicate the task faced by RTWCos. Southgate et al. (2011)⁷⁶ questioned RTWCos directly to pinpoint the factors facilitating injured nurses' RTW. They found that when employers treat nurses as valuable resources, offer a wide range of light tasks, propose a RTW plan that takes life circumstances into account (e.g. financial and family responsibilities), and promote the creation of a support-based relationship between the RTWCo and the nurse right from the beginning of the work absence, these factors facilitate the RTW. Based on interviews of 11 supervisors with experience in RTW involving employees with common mental disorders, Lemieux et al. (2011)⁷⁷ identified three groups of facilitators and barriers associated respectively with the worker, the work context, and the RTW process. Among other things, the study mentioned worker isolation, degree of dissatisfaction at work, prejudice toward mental health disorders (MHDs), and lack of information about the worker's condition or diagnosis. However, a large number of facilitators and barriers concern the contacts and follow-ups between absent workers and their supervisors, who are recognized as a pivotal players in an employee's RTW process.⁷⁸ In this regard, the lack of concerted action (defined as the pooling of the various stakeholders' resources and expertise with a view to achieving the shared objective of a sustainable RTW⁷⁹) is seen by supervisors as a major barrier.⁷⁷ Yet a number of authors recognize that the ideal person for ensuring the planning and smooth execution of concerted action is clearly the RTWCo.^{41,43,79}

In summary, the presence of a RTWCo appears to be conducive to reducing long-term disabilities by ensuring collaboration among employers, insurers, and healthcare providers, to name but a few of the stakeholders.^{14,69} While the literature reveals diverging views of the notion of competency – sometimes used to refer to tasks, activities, or knowledge, and at others, to skills, personal attributes, or aptitudes – the role of RTWCo still requires acting on several fronts, displaying various attributes, and collaborating with different stakeholders. This role also requires meeting numerous challenges regarding both practices and returns to work. Yet, as stated earlier, the actual practices of RTWCos in Québec organizations remain largely unknown to date.

2. OBJECTIVES

The general objective of this study was to describe the practices of individuals responsible for return-to-work coordination in large organizations in Québec.

The specific objectives of the study were to:

1. Describe the individuals involved in return-to-work coordination and the organizations for which they work;
2. Describe the tasks and activities carried out by these individuals, identify the stakeholders with whom they have to collaborate, and determine the personal attributes and aptitudes required to perform the coordination task;
3. Explore the facilitators and barriers associated with performing these tasks and activities, and those associated with the return to work.

3. METHOD

The method retained for this study was that of conducting an online survey⁸⁰ of RTWCos working in large organizations.

3.1 Definition and Selection of the Study Population

The study population consisted of all the individuals responsible for RTW coordination in large private and public organizations in Québec. Large organizations are those having 500 or more employees.⁸¹ This decision was partly based on the fact that the health and safety measures implemented in large organizations are deemed to differ from those in small and medium-sized enterprises (SMEs), where it is less likely to see a person assigned to coordinating returns to work, and partly to obtain greater homogeneity in health and safety measures. While SMEs represent the majority of Québec enterprises, large organizations create the most jobs.⁸²

3.1.1 Sampling frame

The sampling frame was defined using information taken from various Web sites: (1) the newspaper *Les Affaires*' ranking of the 500 largest corporations in Québec, (2) the directory of the Centre de recherche industrielle du Québec (CRIQ) containing information on Québec industrial and commercial businesses, (3) the Registre des entreprises du Québec, (4) Industry Canada's Canadian Company Capabilities Web site, and (5) the Information sur le marché du travail (IMT) Web site of Québec's Ministère de l'Emploi et de la Solidarité sociale. A total of 652 potentially eligible private and public organizations were identified after eliminating duplication. These organizations and their contact information were recorded in an Excel file.

The participant inclusion criteria were as follows: (1) responsible for coordinating the RTW of the organization's employees, (2) involved in coordinating the RTW of at least one person during the previous year, regardless of the reason for the work absence, and (3) working for a private or public organization with 500 or more employees in Québec.

To verify the eligibility of the participants and organizations, a research assistant contacted their Human Resources department by telephone. However, for organizations in the healthcare network and those encompassing one or more plants, among other things, it was usually necessary to speak with a person in the health office or department or with the person in charge of occupational health and safety.

3.1.2 Sampling strategy

The anticipated response rate for the type of population under study ranges from 30% to 50%.^{83,84} No sampling strategy was put forward, given that the sampling frame contained only 652 organizations prior to the direct verification of eligibility with a spokesperson for each organization. This meant that a maximum number of potential participants was contacted over a six-month period. The sample obtained was a convenience sample, as all eligible and interested persons were permitted to complete the online survey.

3.2 Steps in Constructing the Questionnaire

The first version of the survey questionnaire was developed by the team researchers. The sources used were a literature review, the researchers' experience in organizations with respect to the management of work absences and returns to work, and three exploratory interviews of key informants (interview guide provided in Appendix A). The informants worked for two large private-sector organizations and one public-sector organization. Based on the literature review, we were able to identify many tasks and activities that RTWCos have to perform in the context of their work, as well as the various personal attributes and aptitudes required to do so. Some factors hindering or facilitating their practices and the RTW were also identified during this step. The exploratory interviews then served to enhance this information and put it in the Québec context.

A first version of the questionnaire, programmed in the online software SurveyMonkey,⁸⁵ was administered to the same informants who had participated in the exploratory interviews. First, they had to complete the questionnaire like a real respondent and determine the time required to do so. Second, they had to evaluate the following aspects: the quality of the presentation, clarity of the instructions, presence of software-related problems, and acceptability of the questions. They were also given the opportunity to suggest additional response categories and to give their opinion on the usefulness of the open-ended questions.^{80,86}

A second version of the questionnaire was then produced in light of the minor comments received. This was the version used to collect information from our study population.

3.3 Variables Studied

Regarding Objective 1, the variables measured concerned the participants' sociodemographic profiles (gender, age group, level of education, etc.) and occupational profiles (job title, tenure in the currently held job, number of workers under the respondent's responsibility for purposes of absence management, etc.). The participants had to answer the questions mainly using nominal and ordinal scales that offered a variable number of choices. In some cases, the online survey was programmed to require manual entry of the answer (job title, job tenure, etc.). The same approach was used for the questions on the characteristics of the organizations surveyed (activity sector, number of work sites in Québec, approximate percentage of workers absent, etc.).

Regarding Objective 2, the definition used for the concept of competency corresponded to that given by Tardif, namely "complex practical knowledge built on the effective mobilization and combination of a variety of internal and external resources within a set of situations" [free translation].⁸⁷ We thus deemed a competency to be characterized by (1) several tasks or activities, (2) collaboration among the parties involved (the literature suggests that various actors may join in RTW coordination efforts), and (3) a handful of essential personal attributes or aptitudes. By choosing such a definition and characterization, the main purpose was to offset the differences and gaps observed in the various articles regarding the actual definition of "competency" and to provide an analysis grid that would allow for clearer identification of the components. The aim was also to give the online survey a more systematic structure for

respondents and a framework for presenting the results of this objective. Four main competencies were established for RTWCos: “Adapting one’s practices to the needs and capacities of an absent worker involved in the process of returning to work”; “Actively engaging the workplace stakeholders concerned and appropriate external resources in the employee’s return-to-work process”; “Developing practices in line with the laws, regulations, agreements, and procedures pertaining to work absences and the return to work”; “Re-examining/questioning one’s practices and viewpoints regarding work absences and occupational health, and encouraging the various workplace stakeholders to do the same.” In concrete terms, we retained 49 tasks and activities that may be performed by RTWCos as part of their work, and then categorized them under one or another of these four main competencies. Nine other tasks and activities related to involvement in absence management programs, but that did not fall under any of the four competencies, were also included. Various potential collaborators were then considered: the worker, direct supervisor or manager, union representative, human resources counsellor, health professionals, insurer’s representatives, employee’s co-workers, and other work absence managers within the organization. Lastly, 24 personal attributes or aptitudes, also grouped under one or another of the four main competencies, were retained.

Regarding Objective 3, various facilitators of and barriers to coordination practices were examined, and the participants had to answer the questions using nominal or ordinal scales offering a variable number of choices. With regard to the 53 RTW facilitators or barriers investigated, the means of responding to each question was standardized and is described below.

An ordinal scale was used to document task or activity frequency (“4” = often, “3” = occasionally, “2” = rarely, and “1” = never). The frequency of collaboration between RTWCos and various stakeholders (the worker, direct supervisor or manager, union representative, etc.) was also measured using an ordinal scale (“4” = often, “3” = occasionally, “2” = rarely, and “1” = never). The personal attributes and aptitudes required of a RTWCo were assessed using the same type of scale (“4” = very important, “3” = fairly important, “2” = not very important, and “1” = not at all important). Regarding the facilitators of and barriers to practices (collaboration, support and recognition from direct supervisors, managers, directors, and the workers’ union, etc.), the participants had to provide answers using nominal and ordinal scales offering a variable number of choices. Lastly, with respect to the perception of the RTW facilitators or barriers, the answer choices proposed were the same as those for the required personal attributes and aptitudes.

It took from 30 to 45 minutes to complete the survey. The questionnaire used in the survey appears in Appendix B.

3.4 Data Collection

The entire recruitment process was conducted by carrying out the various phases successively, with approximately 60 organizations. For each phase, once the participants’ eligibility had been verified over the phone against the inclusion criteria and the objectives and nature of the project had been explained, they were asked to forward an email address where they could receive an official invitation to participate in the survey. The invitation contained pertinent information relating to the project, i.e. objectives pursued, privacy statement, our contact information where

we could be reached regarding any questions, and a URL link for accessing the online survey. It should be noted that during the telephone conversation, no mention was made of the \$25 that would be remitted to each participant as a thank you gesture. This information was only provided in the official email inviting them to take part in the survey.

Two weeks after the initial mailing of the email invitation, a first reminder was sent to all those who had not responded. Approximately three weeks later, a second reminder was sent to those who still had not completed the online survey. At least five attempts were made to contact each organization. After four or more tries, if we were unable to reach anyone or if we repeatedly reached a voice mailbox, a descriptive message was left asking the person to return the call.⁸⁰

3.5 Bias Control

Measures were proposed to minimize potential bias that could undermine the study's internal and external validity. The two main types of bias identified were coverage bias and non-response bias.

Coverage biases are present when not all members of the study population had equal and non-zero chances of participating in the survey.⁸⁰ As indicated earlier, to minimize these biases we consulted various Web sites to compile the most comprehensive possible list of potentially eligible organizations. We also included organizations with just under 500 employees in cases where their workforce had exceeded this number since they last updated their Web sites. Despite these precautions, it is highly likely that some eligible organizations were not included when they should have been. However, it is impossible to determine the exact number. Conversely, the search filters that we were able to apply were more or less precise, depending on the Web site consulted, and this probably increased the number of non-eligible organizations.

Non-response biases are present when a large number of subjects do not respond to the survey or when non-respondents' characteristics differ from those of respondents.⁸⁰ To maximize the response rate, two reminders were issued after the invitation had been sent. In addition, the project presentation document (sent upon request) and the online survey included the logo of the Centre de santé et de services sociaux (CSSS) Champlain–Charles-Le Moyne and that of the Université de Sherbrooke, as this would increase the study's credibility. Lastly, the small monetary incentive and our commitment to informing interested participants of the survey highlights may also have fostered the target individuals' collaboration.

3.6 Data Analysis

First and foremost, Cronbach's coefficient alphas were calculated to assess internal consistency between the items (tasks and activities) related to each of the four competencies proposed in the questionnaire. For objectives 1 and 2, aimed at describing the participants' and organizations' characteristics, as well as the tasks and activities performed by the participants, descriptive statistical analyses (frequencies, means, and standard deviations) were performed first.

For the four main competencies under study, a performance frequency rating (dependent variable) was calculated for each participant by totalling the responses obtained for each task and

activity. Given the large number of independent variables, a first step was carried out to reduce the number to be included in the regression models. Depending on the nature of the variables under study, correlation and *t* tests were performed on the participants' and organizations' characteristics. When statistically significant associations were found, the variables were included in the linear regression analyses. The stepwise approach was used. These analyses allowed us to establish which variables best explained the variation in performance frequency ratings. The adjusted R^2 value was retained to account for the proportion of the variance explained by these variables.

Frequencies only are presented for the participants' collaborators. Means and standard deviations of the importance ratings are presented for the required personal attributes and aptitudes. Means and standard deviations of the importance ratings are also presented for the RTW facilitators and barriers. Moreover, for the latter, differentiated analyses based on various characteristics of the participants and organizations were performed using the *t* test.

For all the bivariate and multivariate analyses, the gaps, associations, or differences were deemed statistically significant when the margin of error was less than 5%. All the statistical analyses presented in this report were performed using version 18 of PASW software.⁸⁸

Since the database in the PASW was created automatically using SurveyMonkey, no data entry, which might have introduced errors, was necessary. However, a codebook was designed for recording the way in which certain variables were computed, recoded, or created.

3.7 Ethical Considerations

This project was approved by the Research Ethics Committee of the CSSS Champlain-Charles-Le Moyne. The Committee did not consider it necessary for the participants to sign a consent form for the online survey. To induce them to exercise informed consent, details on the study were included in the invitation email that provided the URL link to the online survey. However, the key informants who participated in the exploratory interviews all signed an informed consent form attesting that they agreed to being audio-recorded.

The information concerning the participants' and organizations' names and contact information was entered into a password-protected Microsoft Excel 2007 database. This information was destroyed after the SurveyMonkey data was imported into PASW.

4. RESULTS

In the end, 471 of the 652 organizations initially considered were found to meet the study's inclusion criteria. The most frequent reason for ineligibility was having "fewer than 500 employees in Québec." Other reasons were also noted, particularly "disability management and return-to-work coordination carried out independently by each of the organization's franchisees" and "organization closed or merged with another organization." At 91 organizations, it was impossible to speak with anyone in charge of RTW coordination to request participation in the online survey. We also met with 53 refusals, usually due to a lack of time. A total of 327 email invitations were therefore mailed out, and 195 surveys were completed in their entirety between April and October 2014. Relative to the number of eligible organizations, the response rate was 41.4% (195/471). Relative to the number of invitations mailed out, the response rate was 59.6% (195/327).

The main results are presented in the following pages for each of the three study objectives.

4.1 Objective 1: Describe the individuals involved in return-to-work coordination and the organizations for which they work

4.1.1 *Participants' sociodemographic and occupational profiles*

Table 1 shows the data for the sociodemographic and occupational profiles of the respondents to the online survey. The typical sociodemographic profile was as follows: female (76.7%), between 35 and 54 years of age (64.3%), holder of a university diploma (82.6%), and trained in various areas, but most often in human resources (35.9%). The typical occupational profile was as follows: active in the field of disability management for nearly 13 years (mean of 12.81 years) and in the currently held job for just over seven years (mean of 7.25 years), in charge of managing both disability cases and CSST cases (84.6%), and responsible for between 500 and 1,000 employees (32.8%) or between 1,001 and 5,000 employees (36.4%). In addition, the participants sometimes had varying job titles, the most frequent being "director of human resources" (11.8%), "person responsible for remuneration" (11.8%), "occupational health and safety counsellor" (10.8%), and "human resources coordinator" (9.7%). However, the word "disability" occurred infrequently in their job titles, and was seen in only 8.2% of the responses.

Table 1: Sociodemographic and occupational profiles of participants (N=195)

Variables	N (%)
Gender	
Male	45 (23.3)
Female	148 (76.7)
Age group	
18 to 34 years	38 (19.7)
35 to 54 years	124 (64.3)
55 years or over	31 (20.0)
Area of training (several answers possible)	
Human resources	70 (35.9)
Administration	53 (27.2)
Industrial relations	50 (25.6)
Nursing or OHS*	52 (26.7)
Other	43 (22.1)
Highest level of education completed	
High school or less	8 (4.1)
College/CEGEP	26 (13.4)
University	141 (82.6)
Job title	
Director of human resources	23 (11.8)
Person responsible for remuneration	23 (11.8)
Occupational health and safety counsellor	21 (10.8)
Human resources coordinator	19 (9.7)
Human resources counsellor	17 (8.7)
Personnel and work attendance management officer	17 (8.7)
Head, occupational health and safety	14 (7.2)
Nurse	10 (5.1)
Occupational health and safety coordinator	10 (5.1)
Other	41 (21.1)
Mean number of years of work in the field of absence management (S.D.)	12.1 (8.59)
Mean number of years in the currently held job (S.D.)	7.25 (6.78)
Absence management responsibilities	
Handles disability cases only	30 (15.4)
Manages both disability cases and CNESST cases	165 (84.6)
Number of workers under the participants' responsibility with respect to absence management	
Over 5,000	13 (6.7)
Between 1,001 and 5,000	71 (36.4)
Between 500 and 1,000	64 (32.8)
Between 100 and 499	31 (24.2)

*OHS: occupational health and safety

4.1.2 Characteristics of the organizations surveyed

Table 2 presents the detailed characteristics of the organizations surveyed. The organizations, most of which were private (57.9%), operate in different activity sectors. Overall, the best represented organizations were those in the following sectors: healthcare and social assistance (22.1%), manufacturing (16.4%), educational services (8.2%), retail trade (8.2%), and professional, scientific, and technical services (8.7%). Disregarding their location, nearly nine organizations out of ten (87.2%) were divided over two or more sites. Of the nine organizations, nearly all had at least two sites in Québec (92.9%) and several had at least one site in another Canadian province (43.5%), and sometimes outside Canada (31.2%). The participants reported that absence management practices were mostly the same (63.5%) or very similar (20.5%) from one site to another in Québec. Slightly more variations in practices were observed from one

Canadian province to another: 27.0% of the participants reported that they were the same, 28.4% that they were very similar, and approximately one-third (32.4%) that they were somewhat similar. For the most part, the organizations surveyed had between 500 and 1,000 (53.8%) or between 1,000 and 5,000 (36.9%) employees in Québec. The majority of the participants reported that all or most of the employees were unionized (65.6%) and that the unionized workers were affiliated with two or more unions (83.8%).

As a general rule, disability management and RTW coordination were carried out by the organization's human resources department (78.5%). Approximately eight of the ten participants reported always or often being informed of an absent worker's diagnosis (82.6%). The remainder (17.4%) reported occasionally, rarely, or never being informed. Roughly half of the participating organizations used the services of an external firm for disability case management, either for all or some of the cases involved (48.2%). Slightly more than six participants out of ten (61.5%) reported their organizations as using regular jobs that were deemed less demanding either often or occasionally for employees on temporary assignments or gradually returning to work. Approximately half this number, or 29.2%, reported their organizations going so far as to create new jobs involving light tasks, often or occasionally, for such employees. MSDs and MHDs were reported by the participants as being virtually equal in terms of the most frequent reason for absence (46.1% and 47.7%, respectively) and the absence rate was rarely 10% or more (7.9%). The complete and detailed profiles of the participants and the organizations are found in Appendix C.

Table 2: Characteristics of organizations surveyed (N=195)

Variables	N (%)
Nature of the organization	
Public	82 (42.1)
Private	113 (57.9)
Self-reported activity sector	
Public Administration	13 (6.7)
Retail Trade	16 (8.2)
Manufacturing	32 (16.4)
Educational Services	16 (8.2)
Professional, Scientific, and Technical Services	17 (8.7)
Healthcare and Social Assistance	43 (22.1)
Transportation and Warehousing	11 (5.6)
Other	47 (24.1)
Number of sites operated by the organization, regardless of location	
Only one site	25 (12.8)
Two or more sites	170 (87.2)
Number of sites in Québec (sub-sample, n = 170)	
Organizations with two or more sites	158 (92.9)
Organizations not operating two or more sites	12 (7.1)
Number of sites in another Canadian province (sub-sample, n = 170)	
Organizations with at least one site	74 (43.5)
Organizations with no other site	96 (56.5)
Number of sites outside Canada (sub-sample, n = 170)	
Organizations with at least one site	53 (31.2)
Organizations with no other site	117 (68.8)
Number of workers in Québec	
More than 10,000	7 (3.6)
Between 5,000 and 10,000	11 (5.6)
Between 1,000 and 5,000	72 (36.9)

Variables	N (%)
Between 500 and 1,000	105 (53.8)
Department or unit involved in disability management	
Human Resources	153 (78.5)
Occupational Health and Safety	15 (7.7)
Health Services	18 (9.2)
Administration and Remuneration	6 (3.1)
Other	3 (1.5)
Mean number of people responsible for disability management and return-to-work coordination, for Québec as a whole (S.D.)*	3.52 (4.16)
Presence of health services or a health office	
Yes, present	82 (42.1)
No, absent	113 (57.9)
Organizations using an outside firm for disability management	
Yes, for all disability cases	22 (11.3)
Yes, but for only some disability cases	72 (36.9)
No	101 (51.8)
Presence of a program to assist workers who are experiencing problems (e.g. EAP)	
Yes, present	182 (93.3)
No, absent	13 (6.7)
Proportion of unionized employees	
All	24 (12.3)
Most	104 (53.3)
A minority	20 (10.3)
None	47 (24.1)
Distribution of unionized employees (sub-sample, n = 148)	
One union	24 (16.2)
Two or more unions	124 (83.8)
Approximate percentage of people absent from work	
Less than 1%	37 (20.7)
Between 1 and 3%	43 (24.0)
Between 4 and 6%	51 (28.6)
Between 7 and 9%	34 (19.0)
10% or more	14 (7.9)
Most frequent reason for absence	
Musculoskeletal disorders	89 (46.1)
Mental health disorders	92 (47.7)
Heart diseases	1 (0.5)
Chronic diseases (diabetes, migraines, asthma, etc.)	8 (4.1)
Cancers	3 (1.6)

* Standard deviation

Statistically significant differences were noted between public and private organizations. The chi-square tests showed that proportionally more public organizations had a health office or health services (65.9% versus 24.8%, $p=0.000$), had all or a majority of unionized employees (96.3% versus 43.4%, $p=0.000$), had a work absence rate higher than 6% (38.4% versus 18.9%, $p=0.000$), and reported having a program to assist workers experiencing difficulty (100.0% versus 88.5%, $p=0.001$) and that MHDs were the most frequent reason for absence (61.0% versus 37.8%, $p=0.000$). In addition, the participants from the public organizations were found to be more likely than those from the private organizations to be informed, always or often, of the absent workers' diagnoses (93.9% versus 74.3%, $p=0.000$). Proportionally more private than public organizations were found to use an external firm for disability case management, whether for all or some of these cases (55.8% versus 37.8%, $p=0.013$).

Moreover, it was impossible to compare the respondents' and non-respondents' characteristics. The RTWCos were not in fact obliged to identify themselves when answering the online survey, precisely to preserve their anonymity. This made it impossible to establish a correspondence between the invitations sent and the surveys completed or not. Thus, apart from our knowing whether they met the study's inclusion criteria or not, we had no more specific information about the non-respondents' characteristics.

4.2 Objective 2: Describe the tasks and activities carried out by these individuals, identify the stakeholders with whom they have to collaborate, and determine the personal attributes and aptitudes required to perform the coordination task

Prior to examining the main results obtained for Objective 2, we assessed the quality of the groupings of the statements (tasks and activities) under the four competencies retained for the survey and found it to be "satisfactory."⁸⁹ The Cronbach's alphas ranged from 0.756 to 0.922, clearly showing internal consistency.

The main results are presented in the following pages. Complete and detailed results concerning the tasks and activities performed by the participants, the stakeholders with whom they collaborate, and the personal attributes and aptitudes required, are found in Appendix D.

A task or activity was considered particularly frequent when the mean of the responses fell between 3.01 and 4.00. We therefore opted for a decision based on the descriptors. For frequency, everything above 3.00 (3 signified "occasionally" and 4 "often") was therefore performed more often than occasionally. A similar logic was applied for the personal attributes and aptitudes.

4.2.1 Competency 1: Adapting one's practices to the needs and capacities of an absent worker involved in the process of returning to work

4.2.1.1 Tasks and activities

Of the 20 tasks and activities grouped under this competency, nine were found to be frequently performed by the participants. Of these nine, "contacting the absent worker" and "using the medical diagnosis and functional limitations to plan the return to work" were particularly frequent. The tasks and activities that involve taking into account cultural differences and their impact on absence management and advising the workers to help them appreciate and focus on their strengths were, however, performed much less frequently. Table 3 shows the mean performance frequency for each task and activity.

Table 3: Mean performance frequency, by task and activity – Competency 1

Tasks and activities	Mean (S.D.)*
Most frequent	
Contacting the absent worker	3.66 (0.65)
Using the medical diagnosis and functional limitations to plan the return to work	3.48 (0.80)
Following the employee’s progress in order to attain the objective of a return to regular work	3.28 (0.83)
Assessing the workplace factors that may hinder the return to work	3.28 (0.80)
Identifying tasks suited to the worker’s capacities	3.28 (0.81)
Ensuring a clear understanding of the medical terminology	3.27 (0.93)
Clarifying mutual expectations and the nature of your relationship with the worker	3.25 (0.76)
Assessing the capacities of the worker who has returned to work after an absence	3.15 (0.97)
Identifying the worker’s emotional reactions regarding his or her absence	3.10 (0.79)
Least frequent	
Taking into account cultural differences and their impact on absence management	2.09 (0.91)
Advising the worker to help him or her appreciate and focus on personal strengths	2.42 (0.94)
Helping the worker to understand and cope with his or her stress	2.55 (0.96)
Assessing the support available to the worker (family, friends, and community)	2.62 (0.97)
Re-examining the employee’s workload with him or her	2.65 (0.91)
Recognizing psychological problems (depression, suicidal ideation) that require prompt consultation or referral to a specialist	2.86 (0.90)
Meeting with the absent worker to demonstrate interest in his or her situation	2.90 (0.96)
Analyzing the need for work accommodations	2.91 (0.86)
Analyzing the postures required at the employee’s work station	2.95 (0.91)
Assisting the worker if his or her health condition deteriorates following the return to work	2.96 (0.86)
Identifying the factors that can hinder the worker’s motivation regarding his or her rehabilitation	2.99 (0.90)

* Standard deviation

Given that 20 tasks and activities were grouped under Competency 1, the performance frequency rating varied between 20 and 80 for each of the participants surveyed. Overall, the mean rating was 59.7 and the median rating was 62.0. A regression analysis showed that three variables explained 19.5% of the total adjusted variance in this rating ($F(3, 175) = 15.353, p = 0.000$): having nursing or OHS training (versus training in other fields) ($t = -4.095, p = 0.000, \beta = -0.282$), having more years of experience in the job held ($t = 3.722, p = 0.000, \beta = 0.251$), and working for a public organization (versus private) ($t = -3.146, p = 0.002, \beta = -0.217$). Other variables, despite showing significant correlations at the outset, were included in the regression model, but did not prove significant in explaining the variance: work absence rate, presence of a health office or services, and proportion of unionized employees.

4.2.1.2 Collaborators

Approximately three-quarters of the participants reported collaborating often with the absent worker’s direct supervisor or manager and with the worker directly. By contrast, proportionally fewer participants reported collaborating often with the human resources counsellor, insurer’s representative, health professionals, and union representative, among others. Table 4 shows the frequency of collaboration between the participants and the various stakeholders.

Table 4: Frequency of collaboration between participants and various stakeholders – Competency 1

Stakeholders	N (%)			
	Often	Occasionally	Rarely	Never
Direct supervisor or manager	147 (75.4)	45 (23.1)	2 (1.0)	1 (0.5)
Worker	146 (74.9)	34 (17.4)	14 (7.2)	1 (0.5)
Human resources counsellor	88 (45.1)	72 (36.9)	15 (7.7)	20 (10.3)
Insurer's representative	72 (36.9)	55 (28.2)	36 (18.5)	32 (16.4)
Health professionals	44 (22.6)	97 (49.7)	32 (16.4)	22 (11.3)
Another work absence manager within the organization	31 (15.9)	57 (29.2)	33 (16.9)	74 (37.9)
Union representative	24 (12.3)	68 (34.9)	51 (26.2)	52 (26.7)
Employee's co-workers	1 (0.5)	29 (14.9)	88 (45.1)	77 (39.5)

4.2.1.3 Personal attributes and aptitudes needed

The survey participants indicated that the seven personal attributes and aptitudes presented to them in connection with Competency 1 were all important in the performance of their duties. The mean response rating was higher than 3.01 for each of the seven. The three personal attributes and aptitudes considered most important were being a good listener, ability to win the worker's trust, and being tactful. Table 5 shows the mean importance placed on each quality or aptitude.

Table 5: Mean importance placed on personal attributes and aptitudes – Competency 1

Personal attributes and aptitudes	Mean (S.D.)*
Being a good listener	3.88 (0.33)
Ability to win the worker's trust	3.87 (0.34)
Being tactful	3.82 (0.42)
Being positive	3.78 (0.44)
Being empathetic	3.69 (0.50)
Being flexible	3.57 (0.56)
Ability to believe in each person's worth	3.52 (0.57)

* Standard deviation

4.2.2 Competency 2: Actively engaging the workplace stakeholders concerned and appropriate external resources in the employee's return-to-work process

4.2.2.1 Tasks and activities

Of the 15 tasks and activities grouped under this competency, determining whether work accommodations are possible, coordinating workplace resources to implement RTW plans, and collaborating with the insurer's representative to ensure that services are coordinated, appropriate, and delivered in a timely manner constituted the tasks and activities most frequently

performed by the participants. By contrast, communicating with the absent worker’s family, assessing the impact of the worker’s absence on the organization’s other workers, and selecting health professionals in light of the worker’s needs were the least frequently performed tasks and activities. Table 6 shows the mean performance frequency for each of these tasks and activities.

Table 6: Mean performance frequency, by task and activity– Competency 2

Tasks and activities	Mean (S.D.)*
<i>Most frequent</i>	
Determining whether work accommodations are possible	3.08 (0.79)
Coordinating workplace resources to implement the return-to-work plans	3.04 (0.92)
Collaborating with the insurer’s representative to ensure that services are coordinated, appropriate, and delivered in a timely manner	3.02 (1.06)
<i>Least frequent</i>	
Communicating with the absent worker’s family	1.54 (0.66)
Assessing the impact of the worker’s absence on the organization’s other workers	2.33 (0.94)
Selecting health professionals based on the worker’s needs (physiotherapists, occupational therapists, psychologists, etc.)	2.47 (1.00)
Communicating with the attending physician or other specialists to facilitate planning of the return to work	2.59 (1.03)
Communicating with the health professionals involved, during an employee’s return to work	2.59 (0.92)
Participating in the creation of a lighter job	2.60 (0.97)
Drafting return-to-work plans	2.79 (1.08)
Indicating the nature of a worker’s problem when the worker is referred to the insurer’s representative	2.81 (1.07)
Reporting on a worker’s progress to the parties concerned	2.81 (0.96)
Participating in a brainstorming session to identify tasks suitable for the worker	2.82 (0.89)
Assessing the work-related risks	2.96 (0.95)
Consulting the insurer’s representative about a worker’s functional capacities, prognosis, and treatment plans	2.98 (1.08)

* Standard deviation

Fifteen tasks and activities were included under Competency 2, with the performance frequency rating ranging from 15 to 60. The mean rating for all respondents was 40.4, and the median rating 42.0. Regression analysis showed two variables as explaining 6.3% of the total adjusted variance in this rating ($F(2, 176) = 6.961, p=0.001$): having nursing or OHS training (versus other fields) ($t=-2.434, p=0.000, \beta=-0.182$) and an increased rate of employees absent from work ($t=2.169, p=0.031, \beta=0.162$). Three other variables were initially included in the regression model, but ultimately did not prove significant in explaining the variance: the number of years of experience in the absence management field, the presence of a health office or services, and the fact that the organization did not use an external firm for disability case management.

4.2.2.2 Collaborators

As was the case for Competency 1, the participants reported collaborating regularly with the absent worker’s direct supervisor or manager and with the worker, but much less frequently with the other stakeholders. Table 7 shows the frequency of collaboration between the participants and various stakeholders.

Table 7: Frequency of collaboration between participants and various stakeholders – Competency 2

Stakeholders	N (%)			
	Often	Occasionally	Rarely	Never
Direct supervisor or manager	163 (83.6)	21 (10.8)	11 (5.6)	0 (0)
Worker	154 (79.0)	27 (13.8)	11 (5.6)	3 (1.5)
Human resources counsellor	82 (42.1)	65 (33.3)	26 (13.3)	22 (11.3)
Insurer's representative	72 (36.9)	54 (27.7)	34 (17.4)	35 (17.9)
Health professionals	41 (21.0)	83 (42.6)	44 (22.6)	27 (13.8)
Another work absence manager within the organization	28 (14.4)	45 (23.1)	43 (22.1)	79 (40.5)
Union representative	27 (13.8)	63 (32.3)	45 (23.1)	60 (30.8)
Employee's co-workers	7 (3.6)	24 (12.3)	76 (39.0)	88 (45.1)

4.2.2.3 Personal attributes and aptitudes needed

The participants indicated that the nine personal attributes and aptitudes associated with Competency 2 were all important in their work. Four of these stood out slightly more than the others: knowing how to respect confidentiality, ability to win the trust of the various stakeholders, ability to establish one's credibility in the workplace, and being able to establish effective communication. Table 8 shows the mean importance placed on each quality or aptitude.

Table 8: Mean importance placed on personal attributes and aptitudes – Competency 2

Personal attributes and aptitudes	Mean (S.D.)*
Knowing how to respect confidentiality	3.94 (0.24)
Ability to win the trust of the various stakeholders	3.85 (0.38)
Ability to establish one's credibility in the workplace	3.84 (0.37)
Being able to establish effective communication	3.84 (0.37)
Being able to set priorities	3.67 (0.49)
Being creative in problem solving	3.54 (0.63)
Being skilled in negotiating, mediating, or resolving conflicts	3.49 (0.65)
Being a leader	3.39 (0.72)
Ability to defend the worker	3.08 (0.63)

* Standard deviation

4.2.3 Competency 3: Developing practices in line with the laws, regulations, agreements, and procedures pertaining to work absences and the return to work

4.2.3.1 Tasks and activities

Competency 3 encompasses eight tasks and activities, and differs considerably from the first two competencies. First, it does not require direct collaboration from other stakeholders, and second, the mean frequency was higher than 3.01 for each included task and activity, reflecting their importance in the participants’ practices. Nonetheless, some were performed more frequently than others, namely, applying the laws, policies, and regulations governing work absences and the RTW; performing various administrative tasks and completing forms; and keeping up-to-date on the laws, policies, and regulations governing work absences and the RTW. Table 9 shows the mean performance frequency for each of these tasks and activities.

Table 9: Mean performance frequency, by task and activity– Competency 3

Tasks and activities	Mean (S.D.)*
Applying the laws, policies, and regulations governing work absences and the return to work	3.83 (0.48)
Keeping up-to-date on the laws, policies, and regulations governing work absences and the return to work	3.46 (0.64)
Performing various administrative tasks and completing forms (for example, claim forms)	3.46 (0.78)
Informing workers about return-to-work programs	3.44 (0.75)
Directing workers to the appropriate bodies (SAAQ, CNESST, IVAC, etc.)	3.32 (0.77)
Informing workers of their rights under the law	3.26 (0.85)
Writing notes and reports on returns to work	3.11 (0.93)
Taking the worker’s job tenure, and more generally, collective agreements, into account	3.07 (1.16)

* Standard deviation

For the eight tasks and activities included under Competency 3, the performance frequency rating varied between 8 and 32. The mean and median ratings for all the participants were both 27.0. Regression analysis showed that three variables explained 11.6% of the total adjusted variance in this rating ($F(3, 175) = 8.788, p=0.000$): the fact that all or most of the employees were unionized (versus a minority or none) ($t=-3.335, p=0.001, \beta=-0.237$), the fact that the organization did not use an external firm for disability case management (versus using such a firm) ($t=2.560, p=0.011, \beta=0.182$), and an increased number of years of experience in the field of absence management ($t=2.149, p=0.033, \beta=0.152$). Four other variables were initially included in the regression model, but were not retained to explain the variance: the number of years of experience in the currently held job, the presence of a health office or services, the work absence rate, and having nursing or OHS training.

4.2.3.2 Personal attributes and aptitudes needed

Four personal attributes and aptitudes related to Competency 3 were presented to the participants. In their view, it was slightly more important to comply with standards and have good analytical skills than to be organized and methodical. Table 10 shows the mean importance placed on these aspects.

Table 10: Mean importance placed on personal attributes and aptitudes – Competency 3

Personal attributes and aptitudes	Mean (S.D.)*
Complying with standards	3.84 (0.37)
Having good analytical skills	3.82 (0.40)
Being organized	3.77 (0.42)
Being methodical	3.68 (0.49)

* Standard deviation

4.2.4 Competency 4: Re-examining/questioning one's practices and viewpoints regarding work absences and occupational health, and encouraging the various workplace stakeholders to do the same

4.2.4.1 Tasks and activities

This competency encompasses six tasks and activities, four of which were performed frequently by the participants. Of these, keeping up-to-date in the fields of occupational health and safety and rehabilitation and taking preventive action regarding occupational health and safety were the most frequently performed. The two least frequently performed tasks were assessing the organization's performance in occupational health and safety activities or initiatives, and raising workplace awareness of prejudices and stereotypes regarding people with work disabilities. Table 11 shows the mean performance frequency for these tasks and activities.

Table 11: Mean performance frequency, by task and activity – Competency 4

Tasks and activities	Mean (S.D.)*
<i>Most frequent</i>	
Keeping up-to-date in the fields of occupational health and safety and rehabilitation (reading, continuing education, participating in symposia, etc.)	3.30 (0.68)
Taking preventive action regarding occupational health and safety	3.26 (0.92)
Analyzing the organization's work absence and occupational health and safety management practices for the purpose of optimization	3.13 (0.83)
Promoting occupational health and safety activities and initiatives in the workplace	3.07 (0.93)
<i>Least frequent</i>	
Assessing the organization's performance in occupational health and safety activities and initiatives	2.64 (0.98)
Raising workplace awareness of prejudices and stereotypes regarding people with work disabilities	2.90 (0.78)

* Standard deviation

For the six tasks and activities included under Competency 4, the performance frequency rating varied between 6 and 24. Regression analysis showed that two variables explained 8.5% of the total adjusted variance in this rating ($F(2, 176) = 9.294, p=0.000$): having nursing or OHS training (versus other fields) ($t=-2.566, p=0.011, \beta=-0.189$) and an increased rate of employees absent from work ($t=2.755, p=0.006, \beta=0.203$). Four other variables initially included in the regression model did not prove to be significant in explaining the variance: the number of years of experience in the field of absence management, the presence of a health office or health services, the fact of working for a public organization, and the proportion of unionized employees.

4.2.4.2 Collaborators

Regarding the tasks of analyzing the organization’s work absence and occupational health and safety management practices for purposes of optimization and assessing the organization’s performance in occupational health and safety activities and initiatives, direct supervisors or managers and human resources counsellors were reported as having to work most frequently with the participants. By contrast, workers and union representatives had to work with the participants much less often. Table 12 presents the results relating to the participants’ collaboration with the various stakeholders.

Table 12: Collaboration between participants and various stakeholders – Competency 4

Tasks/activities	Stakeholders involved, the word “Yes” – N (%)			
	Workers	Direct supervisors or managers	Union representatives	Human resources counsellors
Analyzing the organization’s work absence and occupational health and safety management practices for purposes of optimization	36 (18.5)	136 (69.7)	50 (25.6)	130 (66.7)
Assessing the organization’s performance in occupational health and safety activities and initiatives	38 (19.5)	124 (63.6)	47 (24.1)	108 (55.4)

4.2.4.3 Target populations

For the tasks and activities consisting of raising workplace awareness of prejudices and stereotypes regarding people with work disabilities, taking preventive action regarding occupational health and safety, and promoting occupational health and safety activities and initiatives, it is more a question of target populations than of collaborators. For these three tasks and activities, the primary target population was direct supervisors and managers. The second most important target population was workers. Lastly, to a lesser but still significant degree, human resources counsellors and union representatives were also target populations. Table 13 shows the results concerning the participants’ target populations.

Table 13: Informants or participants’ target populations – Competency 4

Tasks/activities	Target population, “Yes” – N (%)			
	Workers	Direct supervisors or managers	Union representatives	Human resources counsellors
Raising workplace awareness of prejudices and stereotypes regarding people with work disabilities	92 (47.2)	178 (91.3)	37 (19.0)	75 (38.5)
Taking preventive action regarding occupational health and safety	165 (84.6)	166 (85.1)	93 (47.7)	78 (40.0)
Promoting occupational health and safety activities and initiatives in the workplace	160 (82.1)	163 (83.6)	94 (48.2)	85 (43.6)

4.2.4.4 Personal attributes and aptitudes needed

Of the four personal attributes and aptitudes included in the survey, the participants indicated that being a good communicator and being open-minded were the two most important, even more so than being persuasive and being curious. Table 14 shows the importance placed on each.

Table 14: Mean importance placed on personal attributes and aptitudes – Competency 4

Personal attributes and aptitudes	Mean (S.D.)*
Being a good communicator	3.77 (0.43)
Being open-minded	3.74 (0.47)
Being persuasive	3.57 (0.57)
Being curious	3.38 (0.64)

* Standard deviation

4.2.5 Involvement in absence management programs

Virtually all the participants (91.8%) reported being involved in the absence management programs, be it in developing, coordinating, evaluating, or promoting them. The most frequently performed tasks and activities were coordinating such programs and developing related policies, procedures, and guidelines. By contrast, the least frequently performed tasks and activities were conducting research and publishing the results of studies related to these programs, developing related business plans and strategies, and ensuring training related to the programs. Table 15 presents the mean performance frequency of the tasks and activities associated with these programs.

Table 15: Mean performance frequency, by task and activity – Absence management programs

Tasks and activities	Mean (S.D.)*
<i>Most frequent</i>	
Coordinating these programs	3.49 (0.77)
Developing policies, procedures, and guidelines for these programs	3.12 (0.90)
<i>Least frequent</i>	
Conducting research and publishing the results of studies related to these programs	1.74 (0.89)
Developing business plans and strategies for these programs	2.36 (0.99)
Ensuring training related to these programs	2.60 (1.00)
Promoting a change in attitude and behaviour in workplace representatives to support the objectives of these programs	2.83 (0.87)
Performing cost-benefit analyses of these programs	2.84 (0.96)
Promoting these programs to the unions, management, and other workplace stakeholders	2.88 (0.97)
Using information management systems in these programs to track types of absence, costs, and outcomes obtained	2.99 (1.03)

* Standard deviation

4.3 Objective 3: Explore the facilitators and barriers associated with performing these tasks and activities, and those associated with the return to work

4.3.1 Facilitators of and barriers to practices

The facilitators and barriers were divided into three categories related to (1) the structure or organization of work absence and RTW management, (2) the participant's work or the work of the participant and his or her team, and (3) the type of health disorder. The complete and detailed data are provided in Appendix E.

4.3.1.1 Related to the structure or organization of work-absence and return-to-work management

Nearly eight of the ten organizations surveyed (79.4%) had a policy, procedures, or a document setting forth guidelines for managing absences and returns to work. The participants reported that their decisions and actions were largely (71.2%), if not completely (19.9%), based on these documents. The vast majority also considered that the absence and RTW management procedures were clearly or well defined (77.8%), and that, generally speaking, these procedures underwent occasional revisions or additions.

Relatively frequent meetings were held among various stakeholders in the organization to follow up on workers' cases. Most of the participants (68.1%) reported weekly, monthly, or bimonthly meetings. However, in approximately one-third of the organizations (31.9%), such meetings were held only a few times a year, if not less. Moreover, overall, the frequency of joint committee meetings, where work-absence and return-to-work management is discussed, was very low: 64.2% of the participants indicated that these committees met rarely or never. Lastly, a little more than six participants out of ten (60.3%) indicated that their organization had a well-established computer system or software program for managing work absences and returns to work.

Differentiated analyses based on the organizations' characteristics were performed. Only statistically significant differences were observed in the frequency of worker follow-up meetings held among various stakeholders within the organization. Chi-square tests showed that these meetings were more likely to be held at least once or twice a month in the organizations that had a health office or services (78.0% versus 60.2%, $p=0.008$) and in those where all or most of the employees were unionized (77.3% versus 49.3%, $p=0.000$).

4.3.1.2 Related to the participant's work or the work of the participant and his or her team

Overall, the work environment and working conditions were highly favourable for the participants or the teams they headed or were part of. More than nine participants out of ten (91.8%) considered their initiatives or new ideas about work absence and RTW management to be very well or relatively well received by their superiors. To similar degrees, the participants felt that (1) their work benefitted from some or a lot of support from their superiors, managers,

directors, and the workers' union (90.2%), (2) that the collaboration received from these stakeholders was quite or very good (95.4%), and (3) that communication among the various stakeholders involved in an employee's RTW process was quite good or very good (96.3%). To a slightly smaller but still significant degree (76.3%), the participants considered that their work received some or a lot of recognition.

Moreover, the participants reported benefitting from good credibility among the workers in their organization. In fact, 90.7% of them reported that a good number or nearly all of the workers were aware of their role. Generally speaking (60.7%), the participants felt that the workers saw them as being neutral and as representing the employer's interests as much as their own. However, some 36.1% of the participants considered that the workers saw them above all as representing the employer's interests and less their own. On another note, approximately one-third of the participants (33.6%) reported having an overly heavy workload, while the remainder found their workload totally manageable.

Given the polarization of the participants' responses, differentiated analyses were performed, but only with regard to the recognition given to their work, the perception held of them by employees who were in the process of returning to work, and the size of the participants' workload. The independent variables used for these analyses were the same as those used for the previous point.

Proportionally more of the participants working in a public organization than those in a private organization saw their work as receiving great or some recognition (87.5% versus 71.6%, $p=0.009$). Also, proportionally more of the participants working in an organization where all or most of the employees were unionized than those working in an organization where a minority or no employees were unionized also considered that their work received great or some recognition (83.3% versus 68.3%, $p=0.018$).

Several significant differences were observed regarding the perception held of the participants by employees in the process of returning to work. The chi-square tests showed that proportionally more of the participants working in public organizations than those working in private organizations thought that these employees saw them as representing more the employer's interests than their own³ (55.1% versus 24.5%, $p=0.000$). Moreover, proportionally more participants working in an organization with a health office or services than those working in an organization without, also thought this (48.1% versus 29.0%, $p=0.007$). The same applied to participants working in an organization with more than 5,000 employees in Québec compared to those in organizations with between 500 and 1,000 employees or between 1,001 and 5,000 employees (61.1% versus 26.7% and 46.4% respectively, $p=0.003$). A similar tendency was noted regarding the number of employees under the participants' responsibility. The finding was identical when we compared the participants reporting an absence rate of 4% or more to those reporting an absence rate of 3% or less (46.9% versus 21.1%, $p=0.007$) and when we compared the participants working in an organization where all or most of the employees were unionized to those where a minority or no employees were unionized (46.3% versus 20.0%, $p=0.000$). By contrast, proportionally more of the participants working in an organization that used an external

³ The other answer choice that was considered in the analyses was "They have the impression that I am neutral, in other words, that I represent as much the employer's interests as their own." [free translation]

firm for disability case management than those working in an organization that did not, thought that employees in the process of returning to work saw them as being neutral (70.0% versus 56.1%, $p=0.049$).

Regarding workload, proportionally more of the participants working in an organization with over 5,000 employees in Québec, versus those in organizations with between 500 and 1,000 employees or between 1,001 and 5,000 employees, considered their workload to be too heavy (50.0% versus 25.7% and 40.8% respectively $p=0.034$). In addition, proportionally more of the participants working in an organization that used an external firm for disability case management than those working for an organization that did not use such a firm considered themselves to have a reasonable workload (74.2% versus 59.4%, $p=0.029$).

4.3.1.3 Related to the type of health disorder

Mental health disorders (MHDs,) and musculoskeletal disorders (MSDs) definitely posed different challenges to the participants. While two-thirds of them (66.5%) considered it much more or a little more difficult to manage cases involving MHDs than MSDs, only 6.2% considered the opposite, i.e. that it was much more or a little more difficult to manage cases involving MSDs than those involving MHDs.

Several reasons were given to justify the greater difficulty associated with managing MHDs, and each was cited many times. The reason most often mentioned was stigmatization, prejudices, or discomfort on the part of co-workers or the employer ($n=33$). A very close second was case complexity, the multifactorial nature of MHDs, or the fact that each case was different ($n=32$). The subjective aspect and less tangible nature of MHDs compared to MSDs ($n=29$), as well as unclear or vaguer diagnoses ($n=27$), also figured among the most frequently cited reasons.

Three reasons were cited 20 times each, but were still not negligible: difficulty assigning light tasks, difficulty modifying the work station, or more difficult reintegration into tasks ($n=18$), longer absences, frequent relapses or a higher risk of chronicity ($n=16$), and the employee's living in denial, i.e. of not acknowledging his or her problem or of being unwilling to talk about it ($n=14$).

4.3.2 RTW facilitators and barriers

The section of the online survey concerning the importance placed on various facilitators of or barriers to the RTW of absent workers was optional. We made this section optional because this aspect was not initially included in the project's specific objectives, and we wanted to avoid a situation where the participants would not complete the entire survey due to undue length. The survey was already quite long, even without this series of items. Of the 195 participants who completed the survey, 124 of them nonetheless agreed to answer this section as well, representing a participation rate of 63.6%. Table 16 shows the participants' perception of the importance of various RTW facilitators, grouped under four main categories. Table 17 shows the participants' perception of several RTW barriers; these too are divided into main categories. These divisions were not shown in the survey, but are used here to facilitate understanding. As was the case with the tasks and activities, a facilitator was perceived as particularly important when the mean of the responses fell between 3.01 and 4.00. Anything over 3.00 (3 signified

“quite important” and 4 “very important”) was considered more important than “quite important.” Again, this decision was based on the descriptors.

4.3.2.1 Facilitators

The RTW facilitators were grouped into four main categories. These categories concern the worker’s attitudes and behaviours, worker/direct supervisor contacts, RTW procedures, and support and consideration.

For the first category, “Worker’s attitudes and behaviours,” the fact that a worker is motivated to return to work or to stay there after returning was regarded as the most important RTW facilitator. In the participants’ opinion, it was also the most important facilitator of all those presented. Moreover, the fact that a worker is aware of his or her limitations and expresses them and the fact that he or she shows perseverance also ranked at the top of the list of facilitators. The fact that a worker accepts having less control over his or her life was perceived as being less important than the other facilitators.

For the second category, “Worker/direct supervisor contacts,” the participants considered the four facilitators listed to be particularly important. Thus, mutual trust between the direct supervisor or manager and the employee, regular communication between the direct supervisor or manager and the worker to assess the progress made, a meeting between the worker and his or her direct supervisor or manager on the first day of the RTW, and understanding on the part of the direct supervisor or manager appeared to be factors that should also be taken into account in efforts to promote an absent employee’s RTW.

The third category, “Return-to-work procedures,” includes a total of ten facilitators. Of the ten, seven were considered important by the participants: providing the worker with information about his or her RTW, holding follow-up meetings with the employee during the first few days or weeks of his or her RTW to ensure that it is going well, and being clear about the tasks to be performed and workplace expectations. By contrast, having the possibility of holding a different job with the same direct supervisor or manager and a work environment free of excessive stimulus were regarded as the least important facilitators of the five, for which the mean of the responses was below 3.01.

Lastly, for the fourth category, “Support and consideration,” the participants saw the fact that the worker feels he or she is taken seriously and that there is a pleasant work atmosphere as the two most important facilitators. By contrast, transparency with co-workers about the employee’s situation was seen as less important than the other factors.

Table 16: Perception of importance of various return-to-work facilitators, by main category (N=124)

Facilitators	Mean (S.D.)*
Worker’s attitudes and behaviours	
<i>Most important</i>	
The worker is motivated to return to work or to stay there after returning	3.85 (0.40)
The worker is aware of his or her limitations and expresses them	3.56 (0.53)
The worker shows perseverance	3.50 (0.53)
The worker has self-confidence	3.46 (0.56)
The worker is able to identify his or her problems	3.40 (0.60)
The worker allows him-/herself to make errors	3.23 (0.69)
The worker sets realistic goals in terms of productivity	3.23 (0.65)
<i>Least important</i>	
The worker accepts having less control over his or her life	2.97 (0.78)
Worker/direct supervisor contacts	
Mutual trust between the direct supervisor or manager and the employee	3.78 (0.47)
Regular communication between the direct supervisor or manager and the worker to assess the progress made	3.77 (0.46)
A meeting between the worker and his or her direct supervisor or manager on the first day of the return to work	3.77 (0.46)
Understanding on the part of the direct supervisor or manager	3.74 (0.48)
Return-to-work procedures	
Providing the worker with information about the return to work (steps, tasks, supervision, etc.)	3.76 (0.45)
Follow-up meetings with the employee during the first few days or weeks following the return to work to ensure that it is going well	3.71 (0.46)
Clarity about the tasks to be performed and workplace expectations	3.70 (0.51)
Adjusting the workload	3.47 (0.58)
Reducing stress by temporarily eliminating stressful tasks	3.33 (0.59)
Being able to return to work promptly	3.32 (0.69)
Returning to work that involves simple, familiar tasks	3.26 (0.64)
<i>Least important</i>	
Having the possibility of holding a different job with the same direct supervisor or manager	2.55 (0.74)
A work environment free of excessive stimuli (noise, disruptions, etc.)	2.61 (0.67)
The employee sets his or her own work pace and organizes his or her own tasks	2.77 (0.73)
Presence of a replacement worker during the return to work, if needed	2.78 (0.75)
Adjustment of working hours	2.94 (0.70)
Support and consideration	
The worker feels that he or she is taken seriously	3.66 (0.52)
A pleasant work atmosphere	3.63 (0.52)
Understanding and support on the part of co-workers	3.43 (0.56)
Good support from his or her close family or friends, etc.	3.42 (0.60)
The worker receives compliments or words of appreciation from co-workers and his or her direct supervisor or manager	3.26 (0.61)
<i>Least important</i>	
Transparency with co-workers about the employee’s situation	2.97 (0.75)

* Standard deviation

4.3.2.2 Barriers

The RTW barriers were divided into five categories, with essentially the same names as those used for the facilitators, apart from the following: “Direct supervisor’s attitudes and behaviours” replaced the “Worker/direct supervisor contacts” category, and an “Other” category was added to cover the few items not directly related to any of the proposed categories. First, it should be noted that the mean response rating fell between 3.01 and 4.00 for all the barriers taken into account in the survey, with one exception: the organization’s financial constraints. We will look

only at the barriers that stood out most in each category, although all factors should be considered possible RTW barriers and should not be overlooked.

Regarding the “Worker’s attitudes and behaviours” category, the participants considered the worker’s attitude during his or her RTW to be the most important barrier. A history of multiple work absences for a mental and/or physical health disorder ranked second. For the “Direct supervisor’s attitudes and behaviours” category, the direct supervisor or manager’s attitude during the RTW and high performance expectations were seen as the two most important barriers.

Regarding the “Return-to-work procedures” category, the participants regarded a premature RTW as a particularly important barrier. Next, they cited the lack of concerted actions among the various stakeholders involved in the RTW process. Regarding the “Support and consideration” category, the participants saw a tense atmosphere or a conflictual relationship prior to the worker’s absence and social isolation at work as the two most important barriers.

Lastly, among the barriers in the “Other” category, the participants saw both the attending physician’s lack of knowledge of the workplace realities and the fact of doubting the worker’s diagnosis as barriers that should not be overlooked.

The differentiated analyses performed for the participants’ and organizations’ various characteristics did not reveal any particular tendencies. The complete and detailed data on the facilitators of and barriers to coordination practices and the RTW are provided in Appendix E.

Table 17: Perception of importance of various return-to-work barriers, by main category (N=124)

Barriers	Mean (S.D.)*
Worker’s attitudes and behaviours	
Worker’s attitude during his or her return to work	3.74 (0.49)
History of multiple work absences due to a mental and/or physical health disorder	3.58 (0.61)
Level of dissatisfaction with work	3.56 (0.53)
Presence of other stress factors in the worker’s personal life	3.53 (0.50)
Worker’s attitude during his or her absence	3.29 (0.72)
Direct supervisor’s attitudes and behaviours	
Direct supervisor’s or manager’s attitude during the return to work	3.75 (0.50)
High performance expectations on the part of the direct supervisor or manager	3.52 (0.67)
Lack of involvement of the direct supervisor or manager in the return-to-work plan	3.49 (0.68)
Direct supervisor’s or manager’s attitude during the worker’s absence	3.27 (0.71)
Direct supervisor’s or manager’s lack of knowledge about mental health disorders	3.17 (0.67)
Direct supervisor’s or manager’s lack of knowledge about physical health disorders	3.05 (0.65)
Return-to-work procedures	
Premature return to work	3.50 (0.55)
Lack of concerted actions among the various stakeholders involved in the return to work	3.44 (0.64)
Lack or total absence of contact between the direct supervisor or manager and the worker, prior to the return to work	3.31 (0.78)
Support and consideration	
A tense atmosphere or conflictual relationship prior to the worker’s absence	3.76 (0.43)
Social isolation at work	3.61 (0.52)
Prejudices about mental health disorders	3.40 (0.65)
Other	
Attending physician’s lack of knowledge about the workplace realities	3.34 (0.70)
The fact of doubting the worker’s diagnosis	3.27 (0.75)
Lack of information about the worker’s diagnosis or condition	3.11 (0.77)
<i>Least important</i>	
Organization’s financial constraints	2.65 (0.84)

* Standard deviation

* Translator’s note: The following two barriers were omitted from the French in error:

Under “Support and consideration,” “A work team that is little or poorly prepared for a worker’s return: 3.22 (0.69),” and under “Other,” “Changes in the organization during the worker’s absence 3.06 (0.64).”

Figure 2 shows the key elements emerging from the preceding results. A key element is considered neutral, i.e. it may become an RTW facilitator if it is present or positive, or conversely, a barrier if it is absent or negative. Only those elements perceived as either facilitators or barriers are reported here.

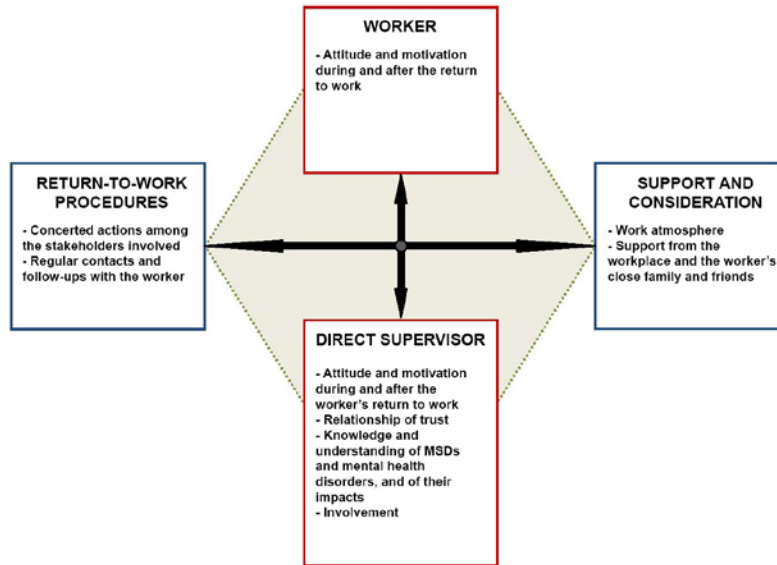


Figure 2: Key elements in return to work as perceived by participants

5. DISCUSSION

The primary aim of this study was to describe the RTW coordination practices of individuals working in large organizations in Québec. The typical profile of these individuals is female, between 35 and 54 years of age, holder of a university diploma, trained in a variety of fields but most often in human resources, active in the disability management field for nearly 13 years, in the current job for a little more than seven years, and responsible for managing both disability cases and CNESST cases.

The first finding was that these individuals can have a wide variety of job titles, such as director of human resources, person responsible for remuneration, OHS counsellor, and human resources counsellor. In fact, the word “disability” rarely appears in their job titles, and the words “coordination” and “return to work” are totally absent. These results suggest that the role of managing disability and coordinating returns to work constitutes, for some of the people interviewed, only one “task” among a range of tasks associated with their duties. In other words, it is not a specialization, but rather a portion of their work.

Tasks and activities

The results obtained revealed that approximately half of the tasks and activities included in the online survey were performed frequently (mean rating of 3.01 or more), with these tasks and activities falling into one or another of the four main competency categories identified by the research team. It should be recalled that we generated a list of 49 tasks and activities grouped under four competencies, whereas Shaw et al.⁶⁹ defined 29 tasks classified under six competencies, and Pransky et al.⁷¹ defined eight competencies. We found that the individuals we interviewed in Québec who saw themselves as filling the role of the RTWCo in whole or in part, carried out additional activities to those described by Shaw et al.⁶⁹ in his review of 22 studies. However, as stated earlier, our list of tasks and activities is much more exhaustive than theirs due to the additional of complementary literature^{72,73}, the exploratory interviews conducted with key informants, and the contributions of the group of researchers concerned. In fact, the complementarity of the disciplines represented (ergonomics, psychology, and occupational therapy) made it possible to clarify the statements. The results showing low performance frequencies, such as “communicating with the absent worker’s family,” “assessing the impact of the worker’s absence on the organization’s other workers,” and “taking into account cultural differences and their impact on absence management,” concur with the results obtained by Pransky et al.⁷¹

In summary, regarding tasks and activities, the individuals interviewed and working in large Québec organizations appear to have practices similar to those described in existing studies. However, it is difficult to establish a perfect correspondence because the statements are sometimes formulated differently and even the definition of a competency varies from one study to another. In fact, Shaw et al.⁶⁹ formulated their competencies as either factual knowledge (knowledge of the enterprise, legal aspects, and medical conditions) or skills (ergonomic and workplace assessment, social problem solving, and workplace mediation). Similarly, Pransky et al.⁷¹ refer to attitudes and behaviours (personal attributes and professional credibility) and skills (conflict management, evaluation, problem solving, and information gathering). The definition of

competency we retained is “complex practical knowledge built on the effective mobilization and combination of a variety of internal and external resources within a set of situations” [free translation].⁸⁷ Moreover, our process was particularly revealing in that it demonstrated, through the computation of Cronbach’s alphas, that the tasks and activities grouped under the four main competencies appeared to be related. Therefore, despite the lack of opportunities for comparing competencies, the quality of our process was supported.

A number of significant associations were observed between the performance frequency of the tasks and activities associated with the competencies and the participants’ or organizations’ characteristics. Patterns were noted. The number of years of experience in managing absences and the organization’s absence rate correlated positively with the performance frequency rating for the tasks and activities associated with each competency. In addition, the participants with nursing or OHS training and those working for an organization with a health office or services posted higher mean performance frequency ratings than those working for organizations without. Other characteristics, such as increased number of years of experience in the current job, the fact of working for a public organization versus a private one, the fact of working for an organization where all or most of the employees were unionized versus an organization where a minority or no employees were unionized, as well as the fact that the organization did not use an external firm for disability case management versus an organization that did, were all associated with two or three of the four main competencies under study. Also, it appears that the size of the organization and the number of people in charge of disability management for Québec were not associated with any of the competencies. A totally consistent profile thus emerged: the performance frequency of the tasks and activities was higher when the participant was more experienced in absence management, when there were more absences, and when the disability cases were managed and returns to work were coordinated by individuals with health training. These links had never been documented in the available literature, but in our view, were highly logical.

Moreover, regression analyses of the performance frequency ratings for the tasks and activities associated with the competencies revealed that the percentage of variation explained was satisfactory only for Competency 1 (20.8%). The variables retained were the number of years of experience in the current job, the fact of working for a public organization, and the fact of having nursing or OHS training. It should be noted, however, that in the end this last variable was included in the regression model for three of the four main competencies. The fact of having nursing or OHS training would appear to be a key characteristic for more frequent deployment of the tasks and activities studied. Regrettably, the number of participants who reported having such training did not allow us to perform more specific analyses. However, it appears that this profile is more consistent with the disability paradigm presented.¹² In fact, a person with health training, working in an organization, and endeavouring to keep employees at work and healthy, begins with knowledge of the workplace, healthcare, and personal coping systems right from the outset. This complementarity suggests that they have a greater understanding of the factors potentially contributing to work disability and their interaction. This in turn corresponds more closely to the profile of RTWCos who have nursing or OHS training, as the latter have more in-depth expertise regarding workplace and personal coping systems. The Burton and Conti study also recommends that the RTWCo have health training.⁶⁸ In Québec, this recommendation is only plausible if RTW coordination is the person’s primary function. However, as our results show, this does not

appear to be a widespread practice in Québec, and thus raises two questions: do people who assume this role as part of their duties have adequate training and sufficient knowledge of health?

Depending on the context, the question that remains is the effects of practices on aspects such as duration of work absences, number of relapses, and related costs. First, it may be pertinent to compare these aspects in an organization that manages disability cases and coordinates returns to work internally with those in another organization that partially or largely entrusts these tasks to an outside firm. Second, these aspects could be compared in an organization where the RTWCo has a health office or services with another organization which does not. Third – and despite the fact that our study showed the respondents as benefitting from strong facilitators to support them in their practices (e.g. recognition, communication, collaboration, and support) – it may be pertinent to study and compare these same aspects according to whether the RTWCo benefits from good support in his or her practices or can only count on modest support. Another question remains concerning the impact of performing the role of RTWCo on a part-time or full-time basis. Does this factor influence practices? To optimize RTWCos' practices, a cost-effectiveness study comparing different contexts and different RTWCo profiles might be very useful for both employers and employees. From this same perspective, a study documenting the compatibility between the practice profiles of RTWCos and organizations' values and cultures might also be informative. In fact, a study by Durand et al.⁴¹ on optimal absence management and RTW coordination practices clearly established that in order for such practices to be implemented in organizations and accepted by the various parties involved (employer, employees, union), they must fall within broader policies designed to keep employees healthy. The practices of RTWCos regarding work disability should therefore form part of broader efforts to promote workers' overall health. This aspect was explored only cursorily in this study in the presentation of the results obtained for Competency 4.

Collaborators

The literature on optimal disability management and RTW coordination practices^{41,53} clearly states the nature and importance of collaboration among the various stakeholders. In our survey, this theme was covered mainly through competencies 1 and 2, which may require collaboration among various stakeholders, whether they are physically present in the workplace or elsewhere. Our results showed that the participants had to work with the absent worker and his or her direct supervisor or manager on a regular basis, but less frequently with the human resources counsellor, insurer, and health professionals. Collaboration with the union representative and the absent employee's co-workers was even less frequent, and could even be described as marginal. Our results thus concur perfectly with those of studies showing the crucial nature of the direct supervisor's or manager's participation in the processes surrounding the RTW.^{41,77,78}

Furthermore, roughly only two-thirds of the organizations surveyed held team follow-up meetings to discuss the progression in worker absence cases. Nor were there joint committees to discuss absence management in approximately two-thirds of the organizations. Thus, while a number of authors regard joint action as a highly effective facilitator for rallying the various stakeholders (co-workers, supervisor, insurer, union, health professionals) around a common RTW objective,^{41,43,90} our results suggest that the RTWCos interviewed focussed mainly on the

worker/supervisor dyad. Among other things, collaboration with the employee's co-workers was completely overlooked. Yet studies show that when the problem leading to the work absence is a mental health disorder, this collaboration becomes extremely important in facilitating the RTW.^{41,43,90} Also, in many organizations, a worker's absence and his or her gradual RTW significantly increases the workload borne by co-workers. This situation sometimes generates a work overload that can have negative impacts if it persists. In fact, it can alter work relations or cause the employee's co-workers to suffer burnout and in turn develop a health problem themselves.^{41,43,90} A sizeable gap therefore appears to exist between actual and optimal collaboration practices, which are known to be a prerequisite for a successful and sustainable RTW. Future research could evaluate the effect of implementing a more integrated model of collaboration among the various stakeholders.

Personal attributes and aptitudes needed

Twenty-four personal attributes and aptitudes, associated with one or another of the four main competencies, were taken into account in this study. These included notably "Being a good listener," "Knowing how to respect confidentiality," "Complying with standards," and "Being a good communicator." In the participants' opinion, it is important to have all these personal attributes and aptitudes, without exception, to perform their duties. This is hardly surprising, given that a large number of them were extracted from or derived from papers in which they were all deemed important.^{71,74} However, the fact of deeming a personal attribute or aptitude to be important is different from actually demonstrating this belief in one's professional practices.^{91,92} Several studies have documented the perceptions that stakeholders can have of one another. It would be interesting to explore this issue further and examine the personal attributes and aptitudes manifested by RTWCos during RTW processes in order to document whether they actually translate into actions.⁹³

Facilitators of and barriers to task performance and the return to work

As a whole, the participants considered their work environment and working conditions to be highly favourable. However, they reported experiencing much greater difficulty managing cases involving MHDs than those involving MSDs, for a number of previously identified reasons: stigmatization and prejudices, greater case complexity, and unclear or vaguer diagnoses.⁹⁴⁻⁹⁶ These difficulties have already been cited by other authors and are largely attributable to stakeholders' lack of knowledge about MHDs, which in turn generates fears about the risk of aggravating the illness and about the possibility of a crisis at work or of the worker's suicide.^{43,90,97,98} The impact of a mental health training program for RTWCos clearly constitutes a research avenue that warrants exploration.

A number of RTW facilitators and barriers are considered important, including many associated with the direct supervisor's attitudes and behaviours, and with the contacts between the latter and the worker. Others are related to the worker's attitudes and behaviours, RTW procedures, and the support and consideration given to the worker. These last factors have been mentioned previously in other studies.^{5,41,51,99} Differentiated analyses based on the participants' and organizations' different characteristics did not reveal any particular tendencies. The individuals interviewed in large Québec organizations therefore appear to have a common perception of the

facilitators and barriers. As mentioned in the section on collaboration, the direct supervisor's or manager's participation in the steps and process related to an employee's RTW plays a key role in concerted action.^{41,43,90} A number of questions come to mind in this regard. Do the organizations' structures promote the active participation of direct supervisors or managers in returns to work? If so, how? For example, what impact does the integration of a person who can perform only 50% of his or her regular tasks have on the direct supervisor or manager? Is the strategy of engaging a worker on partial disability in the capacity of a "surplus employee" (person assigned for an indefinite period to a job not considered permanent) applied systematically? Is the value of the time allotted to assist a worker who is gradually returning to work recognized in the evaluation of the supervisor's performance? Does the organization focus mainly on production without taking actual resources into account? What are the real incentives offered to the direct supervisor or manager to be active in employees' RTW processes? The actual structure of the jobs in which direct supervisors or managers perform their duties may thus have a direct influence on their involvement with workers returning to work. Further research would be worthwhile in order to identify the management models that foster active stakeholder participation in the RTW processes, and to do so in various activity sectors.

Profile of the organizations

The primary purpose of this study was to describe the practices of individuals involved in RTW coordination in large organizations in Québec. However, coming back to the organizations themselves, we found the following. Despite the fact that a convenience sample was used, the distribution of the organizations by type (private or public), number of employees in Québec, rate of unionization, and number of work sites in the province suggests that the sample was fairly representative of all large organizations in the province. Also, the distribution of the organizations across the 20 activity sectors shows the broad spectrum represented. It is important to note that even within a given sector, the characteristics and realities of the organizations can vary substantially. For example, in the manufacturing sector, we may equally well find an organization specializing in the manufacture of car parts as one specializing in the manufacture of food products.

This study could be continued with a more in-depth exploration of certain activity sectors that have high absenteeism rates in order to assess the RTWCo profiles that should be given priority and their practices. Recommendations could also be made in light of the particular constraints of different activity sectors, such as construction, health care, or social assistance.

5.1 Strengths and Limitations of the Study

Several aspects point to the robustness of the results of our study: the large sample size (N=195), the satisfactory response rate, and the quality of the questionnaire design process. As mentioned earlier, the questionnaire was developed on the basis of a literature survey, the researchers' experience in organizations with regard to work-absence and return-to-work management practices, and three exploratory interviews with key informants. The questionnaire was then pre-tested. This process ensured the reliability and representativeness of the data obtained. The importation of the SurveyMonkey data into PASW also reduced the biases associated with third-party data handling.

Participation in the study was voluntary, which may have raised the reported performance frequency of tasks and activities as well as the importance placed on the personal attributes and aptitudes. In fact, very high frequencies were identified in the distribution of responses, specifically regarding task and activity performance, the importance placed on the personal attributes and aptitudes, and the importance placed on the RTW facilitators and barriers. However, we find this result somewhat surprising because several variables related to these aspects emerged as important and crucial in earlier studies and in our face-to-face interviews. That said, our results were undoubtedly influenced somewhat by the choice of rating scales. For the tasks and activities, it might have been better to add the descriptor “Always” to the answer choices. We also chose to convert performance frequencies for the tasks and activities into numerical ratings and to perform regression analyses using these ratings. This may have resulted in some loss of information and accuracy, not to mention a lower specificity of each task and activity. In fact, several associations and significant correlations – some of greater interest than others – were identified for the tasks and activities considered separately, but these have not been presented in this report. The purpose was to remain focussed on the essential so as not to overburden the reader with information. It should also be remembered that the groups of tasks and activities all showed high internal consistency ratings (Cronbach’s alphas between 0.756 and 0.922), confirming the legitimacy of performing analyses using the ratings.

A degree of uncertainty also remains about the choice of individuals interviewed: despite a rigorous selection process, were they the best persons in the organization to answer the survey? That said, there were very few occasions during the telephone contacts when the choice of informant proved difficult. Lastly, it was not possible to compare the respondents’ characteristics with those of the non-respondents since they were not obliged to divulge their identity when answering the online survey. We therefore have no specific information about the characteristics of the non-respondents, which remains a limitation of this study.

5.2 Other Possible Avenues for Research

Several pertinent avenues for future research related to the current results have already been mentioned and are grouped together below:

- What are the impacts of the different contexts in which RTWCos practice on the effectiveness and cost-effectiveness of RTW coordination?
- Is the health knowledge of RTWCos who fulfill this role on a part-time basis sufficient for them to adopt optimal practices?
- Do the practices of RTWCos in organizations fit in consistently with the organization’s values?
- What are the effects of implementing integrated models of collaboration among various stakeholders on RTWCos’ practices and the duration of worker absences?

- Do RTWCos actually display the personal attributes and aptitudes they deem necessary to perform their duties (empathy, good listening skills, etc.)?
- Which management models promote active participation of direct supervisors or managers in employees' return to work?
- In what ways could we promote greater and optimal participation of co-workers in RTW efforts, knowing that they can be important players and that a RTW can also have repercussions on them (e.g. a work overload)?
- In organizations with high absenteeism rates, which RTWCo profiles and practices should be favoured?
- Lastly, what is the viewpoint of RTWCos as to the skills required, depending on whether the worker is back at work following a musculoskeletal disorder or a mental health disorder? As these two conditions differ in their causes and treatments, they may not require the same type of skills.

We began our investigation of the RTWCo role in large organizations. However, the vast majority of workers in Québec work in small or medium-sized enterprises (SMEs). The problem is significantly different in these enterprises, given their limited resources and expertise, and the fact that SMEs are often associated with prevention mutuals. It would be timely to try to identify what goes on there and what the practices of their RTWCos are. It is likely that the results would differ from those presented here on several levels. To improve worker health and that of organizations, numerous studies are therefore needed in the years ahead.

6. CONTRIBUTIONS AND CONCLUSION

This study describes, for the first time in Québec, the practices of individuals involved in RTW coordination in large organizations. Their practices appear relatively homogenous and are generally carried out as part of a more varied set of tasks. This study again underscores the fact that managing cases involving mental health disorders appears to be more difficult than those involving musculoskeletal disorders, that the direct supervisor's or manager's role is essential to promoting a smooth process, and that major efforts are needed to integrate concerted action into these workplaces. Depending on the difficulties faced, RTWCos or direct managers could be supported through training. More in-depth reflection on the structures and level of commitment of the stakeholders involved is also needed. It is important to remember that this study reflects practices within organizations in good overall health, and that the role of individuals involved in RTW coordination should be explored in the context of small and medium-sized organizations.

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APPENDIX A

Guide for Exploratory Interviews

1. First, what is your role in the organization and what tasks are you typically required to perform?
 - Determine the hierarchical structure;
 - Find out whether any other people have the same functions;
 - Find out the composition of the work team;
 - Find out the % of time required to manage work absence cases.

2. To your knowledge, what is the magnitude of work absences associated with musculoskeletal disorders (MSDs) or mental health disorders (MHDs) in your organization?

3. Does your organization make use of temporary assignments for cases involving MSDs or MHDs? If so, what is your role in this process?
 - Establish the temporary assignment/work absence ratio;
 - Determine the level of ease/difficulty associated with the temporary assignment process + establish the causes.

4. Can you describe to me what happens from the moment you become aware that a worker is absent due to an MSD or MHD?
 - Establish the amount of time it generally takes to be informed of an absence;
 - Find out whether a formal structure exists (systematic screening, case by case, procedure based on impairment, etc.) + and who is in charge of what.

5. When managing a work absence case, with whom do you have to work? How is each stakeholder involved in an employee's return to work?
 - If need be, mention the manager, supervisor, co-workers, physician, union, etc.;
 - Establish who holds the decision-making power in the management of absence cases;
 - Find out if the occupational health and safety committee, external resources (health professionals, medical services, etc.), or others are involved;
 - Determine how services are chosen and coordinated.

6. What are the factors that hinder your practices? In other words, what factors can complicate your management of a work disability case?
 - Ask for examples.
7. In contrast, what factors can facilitate your practices? In other words, what factors can make it easier for you to manage a work disability case?
 - Ask for examples.
8. How are you generally seen by the various stakeholders involved in an employee's return to work and by the absent employee him-/herself?
 - Determine the level of communication among the stakeholders, and of recognition and support offered;
 - Raise the question of neutrality.
9. In your opinion, what competencies and personal attributes are required by a person like yourself who is in charge of the return to work of individuals with a work disability?
10. In your view, what skills and knowledge should a person in charge of returns to work have?
 - Find out about the tasks and activities performed;
 - Find out about participation in professional development or continuing education activities;
 - Find out whether the person is interested in/keeps up-to-date with the recent professional/scientific literature.
11. What aspects need to be improved with regard to the return-to-work process in your organization?
 - Determine whether there are any occupational health activities or policies, as well as any risk and disability prevention initiatives;
 - Establish whether these activities, policies, and initiatives are promoted;
 - Establish whether there is any performance evaluation done regarding these activities, policies, and initiatives.
12. Are there any other points you would like to add?

APPENDIX B

The original survey is available in the French version of the report (<http://www.irsst.qc.ca/publications-et-outils/publication/i/100900/n/pratiquesdes-grandes-organisations-au-quebec-en-regard-de-la-coordinationdu-retour-au-travail>).

Appendix D provides an English courtesy translation of the survey questions and shows the frequencies of the participant responses.

Hello,

You have been invited to participate in a study because you are involved in managing work absences in your organization.

STUDY OBJECTIVES AND PARTICIPATION

The general objective of this study, which was funded by the Institut de recherche Robert-Sauvé en santé et en sécurité du travail (IRSSST), is to form a picture of absence management practices in large organizations in Québec. More specifically, it seeks to better understand the profile of the individuals working in this field, their tasks, the knowledge and competencies required, and the factors facilitating or hindering their practices.

You will be approached only once in this study, specifically, to answer this online survey. After you have completed the entire survey and entered the identifier number we gave you, you will receive an amount \$25 by mail to thank you for participating.

Please note that there are no right or wrong answers. You simply have to answer the survey to the best of your knowledge. Therefore, you will not need to consult your co-workers or your organization's reports or records regarding absence management.

Ideally, this survey should be completed in one sitting. If you have to stop, for example, half-way through, make sure you leave your Web browser window open so that you can pick up at the same place later on without having to start back at the beginning. Your answers will only be saved when you have completed the entire survey.

CONFIDENTIALITY

We ensure that the information collected during your participation in the study remains confidential. The information you provide will be used for scientific purposes and treated in the strictest confidence. Neither your identity nor that of your organization will be disclosed.

Only anonymized results will be presented. These results will be disseminated in the form of reports, scientific articles, or presentations at symposia.

Your participation in this study is voluntary and you may therefore refuse to participate. However, by participating, you will help us to better understand the realities you experience and to develop guides to practices that could be used for managing absences.

CONTACT PERSONS

Should you have any questions concerning the study, you may contact Michael Bernier, the study coordinator, at 450-463-1835, ext. 61786.

You may also contact Marie-José Durand, the principal investigator, at 450-463-1835, ext. 51466.

For more information about your rights as a participant in a research project, you may contact the secretary of the Comité d'éthique de la recherche of Hôpital Charles-Le Moyne at 450-466-5000, ext. 2564.

In addition, if you have any complaints as a research participant and wish to speak with an impartial third party, you may contact the Service Quality and Complaints Commissioner of Hôpital Charles-Le Moyne at 450-466-5434.

Thank you for your invaluable cooperation.

1. First and foremost, we would like to know if you are required to manage disability cases only or both disability and CSST cases (occupational diseases and accidents).

- Manage disability cases only
- Manage both disability and CSST cases

Please note that throughout this questionnaire, we will use the expression “absence management” to refer to the management of both CSST cases and disability cases. The latter includes the coordination of returns to work.

First, we would like to know more about your training background, your professional path, and your organization.

2. For how many years have you worked in the field of absence management?

Enter the number (round off, if applicable)

3. For how many years have you held your current job?

Enter the number (round off, if applicable)

4. What is your current job title?

5. In what field(s) were you trained?

You may check off (√) more than one box.

- Human resources
- Administration
- Industrial relations
- Nursing or nursing sciences
- Other (please specify)

6. What is the highest level of education you completed?

- High school or less
- College/CEGEP – Pre-university sector
- College/CEGEP – Technical sector
- University undergraduate level – Bachelor’s degree
- University graduate level – Master’s degree
- University doctoral level – PhD
- Other (please specify)

7. Is your organization public or private?

- Public
- Private

To which department or unit in your organization are you attached?

- Human Resources
- Occupational Health and Safety
- Health Services
- Other (please specify)

8. Sometimes organizations such as yours have more than one site (office, plant, branch, etc.), whether in Québec, another Canadian province, or outside Canada. Which of the following statements describe(s) the situation in your organization?

You may check off (✓) more than one box.

- My organization has only one site in Québec.
- My organization has two or more sites in Québec.
- My organization has at least one site located in another Canadian province.
- My organization has at least one site located outside Canada.

9. Which of the following statements best describes absence management practices in your organization in Québec, comparing one site to the other?

- The practices are the same.
- The practices are very similar.
- The practices are somewhat similar.
- The practices are somewhat different.
- The practices are very different.
- The practices are not at all the same.

10. How similar or different are the absence management practices and procedures from one province to the other?

- The practices and procedures are the same.
- The practices and procedures are very similar.
- The practices and procedures are somewhat similar.
- The practices and procedures are somewhat different.

- The practices and procedures are very different.
- The practices and procedures are not at all the same.

11. Is your organization governed by Canadian laws regarding disability management?

- Yes
- No

12. Are there health services or is there a health office present in your organization?

- Yes
- No

13. Which of the following professionals are present in your health services or health office?

You may check off (√) more than one box.

- Doctor(s)
- Physiotherapist(s)
- Occupational therapist(s)
- Nurse(s)
- Other (please specify)

14. Does your organization use an external firm for disability management?

- Yes, for all disability cases
- Yes, for some disability cases
- No

15. Does your organization offer a program to assist workers experiencing problems (e.g. EAP)?

- Yes
- No

16. To the best of your knowledge, how many workers does your organization have in Québec?

- More than 10,000
- Between 5,000 and 10,000
- Between 1,000 and 5,000
- Between 500 and 1,000
- Between 400 and 500
- Fewer than 44

17. Including yourself, how many people are responsible for managing disability cases and returns to work in your organization, for Québec as a whole? If it is only yourself, enter “1.”

Enter the number (approximate, if necessary).

18. How many workers are you responsible for in terms of absence management?

- More than 5,000
- Between 1,000 and 5,000
- Between 500 and 1,000
- Between 400 and 499
- Between 300 and 399
- Between 200 and 299
- Between 100 and 199
- Between 50 and 99
- Fewer than 50

19. Are the workers under your responsibility unionized?

- Yes, all of them
- Yes, most of them
- Yes, a few of them
- No

20. Do these unionized workers belong to the same union or to two or more unions?

- Same union
- Two or more unions

21. Which person(s) in your organization other than yourself is/are directly involved in absence management?

You may check off (√) more than one box.

- Administrative technician
- Human resources counsellor(s) or manager(s)
- Representative(s) of the Occupational Health and Safety Committee
- Union representative(s)
- Other (please specify)

22. Which person(s) is/are usually responsible for reporting worker absences to the organization?

You may check off (√) more than one box.

- Worker him-/herself
- Co-workers
- Union representative
- Direct supervisor or manager
- Administrative technician
- External services agent or service provider
- Organization's health services
- Other (please specify)

23. Are you informed of the absent worker's diagnosis?

- Yes, always
- Yes, often
- Yes, occasionally
- Yes, but rarely
- No, never

24. What is the approximate percentage of absent workers in your organization?

Enter the %.

25. Please rank the following reasons for work absence in order of number of cases, where "1" is the largest number and "5" the smallest number for your organization.

- Musculoskeletal disorders
- Mental health disorders
- Cardiac diseases
- Chronic diseases (diabetes, migraines, asthma, sleep disorders, multiple sclerosis, etc.)
- Cancer

The following questions concern the tasks and activities you may be asked to perform as part of your work, as well as the aptitudes and personal attributes that may be required. We have grouped the tasks and activities as well as the aptitudes and personal attributes under four main competencies for easier understanding. These competencies are:

COMPETENCY 1: “ADAPTING ONE’S PRACTICES TO THE NEEDS AND CAPACITIES OF AN ABSENT WORKER INVOLVED IN THE PROCESS OF RETURNING TO WORK”

COMPETENCY 2: “ACTIVELY ENGAGING THE WORKPLACE STAKEHOLDERS CONCERNED AND APPROPRIATE EXTERNAL RESOURCES IN AN EMPLOYEE’S RETURN-TO-WORK PROCESS”

COMPETENCY 3: “DEVELOPING PRACTICES IN LINE WITH THE LAWS, REGULATIONS, AGREEMENTS, AND PROCEDURES PERTAINING TO WORK ABSENCES AND THE RETURN TO WORK”

COMPETENCY 4: “RE-EXAMINING/QUESTIONING ONE’S PRACTICES AND VIEWPOINTS REGARDING WORK ABSENCES AND OCCUPATIONAL HEALTH, AND ENCOURAGING THE VARIOUS WORKPLACE STAKEHOLDERS TO DO THE SAME”

COMPETENCY 1: “ADAPTING ONE’S PRACTICES TO THE NEEDS AND CAPACITIES OF AN ABSENT WORKER INVOLVED IN THE PROCESS OF RETURNING TO WORK”

26. How frequently do you have to perform each of the following tasks or activities in relation to Competency 1?

COMPETENCY 1: “ADAPTING ONE’S PRACTICES TO THE NEEDS AND CAPACITIES OF AN ABSENT WORKER INVOLVED IN THE PROCESS OF RETURNING TO WORK”

	Often	Occasionally	Rarely	Never
Clarifying mutual expectations and the nature of your relationship with the worker				
Identifying the worker’s emotional reactions regarding his or her absence				
Recognizing psychological problems (depression, suicidal ideation) that require prompt consultation or referral to a specialist				
Assessing the support available to the worker (family, friends, and community)				
Identifying the factors that can hinder the worker’s motivation regarding his or her rehabilitation				
Taking into account cultural differences and their impact on absence management				
Contacting the absent worker				
Meeting with the absent worker to demonstrate interest in his or her situation				
Assessing the workplace factors that may hinder the return to work				
Analyzing the postures required at the employee’s work station				

	Often	Occasionally	Rarely	Never
Analyzing the need for work accommodations				
Identifying tasks suited to the worker's capacities				
Re-examining the employee's workload with him or her				
Using the medical diagnosis and functional limitations to plan the return to work				
Ensuring a clear understanding of the medical terminology				
Assessing the capacities of the worker who has returned to work after an absence				
Following the employee's progress in order to attain the objective of a return to regular work				
Helping the worker to understand and cope with his or her stress				
Advising the worker to help him or her appreciate and focus on personal strengths				
Assisting the worker if his or her health condition deteriorates following the return to work				

27. How frequently do you usually have to work with each of the following stakeholders in relation to Competency 1?

COMPETENCY 1: “ADAPTING ONE’S PRACTICES TO THE NEEDS AND CAPACITIES OF AN ABSENT WORKER INVOLVED IN THE PROCESS OF RETURNING TO WORK”

	Often	Occasionally	Rarely	Never
Worker				
Direct supervisor or manager				
Union representative				
Human resources counsellor				
Health professionals				
Insurer’s representative				
Employee’s co-workers manager				
Another work absence manager within the organization				

28. How important is it that you demonstrate each of the following personal attributes and aptitudes in relation to Competency 1?

COMPETENCY 1: “ADAPTING ONE’S PRACTICES TO THE NEEDS AND CAPACITIES OF AN ABSENT WORKER INVOLVED IN THE PROCESS OF RETURNING TO WORK”

	Very important	Quite important	Not very important	Not at all important
Being positive				
Ability to believe in each person’s worth				
Being flexible				
Being empathetic				
Being tactful				
Being a good listener				
Ability to win the worker’s trust				

COMPETENCY 2: “ACTIVELY ENGAGING THE WORKPLACE STAKEHOLDERS CONCERNED AND APPROPRIATE EXTERNAL RESOURCES IN AN EMPLOYEE’S RETURN-TO-WORK PROCESS”

29. How frequently do you have to perform each of the following tasks or activities in relation to Competency 2?

COMPETENCY 2: “ACTIVELY ENGAGING THE WORKPLACE STAKEHOLDERS CONCERNED AND APPROPRIATE EXTERNAL RESOURCES IN AN EMPLOYEE’S RETURN-TO-WORK PROCESS”

	Often	Occasionally	Rarely	Never
Selecting health professionals based on the worker’s needs				
Communicating with the health professionals involved, during an employee’s return-to-work				
Indicating the nature of a worker’s problem when the worker is referred to the insurer’s representative				
Collaborating with the insurer’s representative to ensure that services are coordinated, appropriate, and delivered in a timely manner				
Consulting the insurer’s representative about a worker’s functional capacities, prognosis, and treatment plans				
Participating in a brainstorming session to identify tasks suitable for the worker				
Determining whether work accommodations are possible				
Participating in the creation of a lighter job				
Assessing the impact of a worker’s absence on the organization’s other workers				
Communicating with the absent worker’s family				
Drafting return-to-work plans				

	Often	Occasionally	Rarely	Never
Coordinating workplace resources to implement the return-to-work plans				
Communicating with the attending physician or other specialists to facilitate planning of the return to work				
Reporting on a worker's progress to the parties concerned				
Assessing the work-related risks				

30. How frequently do you usually have to work with the following stakeholders in relation to Competency 2?

COMPETENCY 2: “ACTIVELY ENGAGING THE WORKPLACE STAKEHOLDERS CONCERNED AND APPROPRIATE EXTERNAL RESOURCES IN AN EMPLOYEE’S RETURN-TO-WORK PROCESS”

	Often	Occasionally	Rarely	Never
Worker				
Direct supervisor or manager				
Union representative				
Human resources counsellor				
Health professionals				
Insurer’s representative				
Employee’s co-workers manager				
Another work absence manager within the organization				

31. How frequently do joint committees meet to discuss absence management?

- Often
- Occasionally
- Rarely
- Never

32. How important is it that you demonstrate each of the following personal attributes and aptitudes in relation to Competency 2?**COMPETENCY 2: “ACTIVELY ENGAGING THE WORKPLACE STAKEHOLDERS CONCERNED AND APPROPRIATE EXTERNAL RESOURCES IN AN EMPLOYEE’S RETURN-TO-WORK PROCESS”**

	Very important	Quite important	Not very important	Not at all important
Being skilful in negotiating, mediating, or resolving conflicts				
Being creative in problem solving				
Ability to defend the worker				
Being able to establish effective communication				
Being a leader				
Ability to establish one’s credibility in the workplace				
Ability to win the trust of the various stakeholders				
Knowing how to respect confidentiality				
Being able to set priorities				

COMPETENCY 3: “DEVELOPING PRACTICES IN LINE WITH THE LAWS, REGULATIONS, AGREEMENTS, AND PROCEDURES PERTAINING TO WORK ABSENCES AND THE RETURN TO WORK”

33. How frequently do you have to perform each of the following tasks or activities in relation to Competency 3?

COMPETENCY 3: “DEVELOPING PRACTICES IN LINE WITH THE LAWS, REGULATIONS, AGREEMENTS, AND PROCEDURES PERTAINING TO WORK ABSENCES AND THE RETURN TO WORK”

	Often	Occasionally	Rarely	Never
Keeping up-to-date on the laws, policies, and regulations governing work absences and the return to work				
Applying the laws, policies, and regulations governing work absences and the return to work				
Informing workers of their rights under the law				
Informing workers about return-to-work programs				
Taking the worker’s job tenure, and more generally, collective agreements, into account				
Writing notes and reports on returns to work				
Performing various administrative tasks and completing forms (for example, claim forms)				
Directing workers to the appropriate bodies (SAAQ, CSST, IVAC, etc.)*				

*N.B. This last item was omitted in error from the French.

34. How important is it that you demonstrate each of the following personal attributes and aptitudes in relation to Competency 3?

COMPETENCY 3: “DEVELOPING PRACTICES IN LINE WITH THE LAWS, REGULATIONS, AGREEMENTS, AND PROCEDURES PERTAINING TO WORK ABSENCES AND THE RETURN TO WORK”

	Very important	Quite important	Not very important	Not at all important
Being methodical				
Having good analytical skills				
Complying with standards				
Being organized				

COMPETENCY 4: “RE-EXAMINING/QUESTIONING ONE’S PRACTICES AND VIEWPOINTS REGARDING WORK ABSENCES AND OCCUPATIONAL HEALTH, AND ENCOURAGING THE VARIOUS WORKPLACE STAKEHOLDERS TO DO THE SAME”

35. How frequently do you have to perform each of the following tasks or activities in relation to Competency 4?

COMPETENCY 4: “RE-EXAMINING/QUESTIONING ONE’S PRACTICES AND VIEWPOINTS REGARDING WORK ABSENCES AND OCCUPATIONAL HEALTH, AND ENCOURAGING THE VARIOUS WORKPLACE STAKEHOLDERS TO DO THE SAME”

	Often	Occasionally	Rarely	Never
Raising workplace awareness of prejudices and stereotypes regarding people with work disabilities				
Taking preventive action regarding occupational health and safety				
Promoting occupational health and safety activities and initiatives in the workplace				
Assessing the organization’s performance in occupational health and safety activities and initiatives				
Analyzing the organization’s work absence and occupational health and safety management practices for the purpose of optimization				
Keeping up-to-date in the fields of occupational health and safety and rehabilitation (reading, continuing education, participating in symposia, etc.)				

36. Who are your usual key informants or target populations for the tasks and activities listed below, in relation to Competency 4? Check off (✓) as many boxes as applicable.

COMPETENCY 4: “RE-EXAMINING/QUESTIONING ONE’S PRACTICES AND VIEWPOINTS REGARDING WORK ABSENCES AND OCCUPATIONAL HEALTH, AND ENCOURAGING THE VARIOUS WORKPLACE STAKEHOLDERS TO DO THE SAME”

	Workers	Direct supervisors or managers	Union representatives	Human resources counsellors	Other (please specify in the space provided below)
Raising workplace awareness of prejudices and stereotypes regarding people with work disabilities					
Taking preventive action regarding occupational health and safety					
Promoting occupational health and safety activities and initiatives in the workplace					

Other (please specify)

--

37. With whom do you usually have to work, in relation to Competency 4, for the two tasks or activities listed below? Check off (√) as many boxes as applicable.

COMPETENCY 4: “RE-EXAMINING/QUESTIONING ONE’S PRACTICES AND VIEWPOINTS REGARDING WORK ABSENCES AND OCCUPATIONAL HEALTH, AND ENCOURAGING THE VARIOUS WORKPLACE STAKEHOLDERS TO DO THE SAME”

	Workers	Direct supervisors or managers	Union representatives	Human resources counsellors	Other (please specify in the space below)	No other
Analyzing the organization’s work absence and occupational health and safety management practices for the purpose of optimization						
Assessing the organization’s performance in occupational health and safety activities and initiatives						

Other (please specify)

--

38. In the context of your work, how important is it that you demonstrate the following personal attributes and aptitudes in relation to Competency 4?

	Very important	Quite important	Not very important	Not at all important
Being a good communicator				
Being open-minded				
Being curious				
Being persuasive				

39. In your organization, are regular jobs that are considered to be less demanding used for employees on temporary assignments or involved in a gradual return to work?

- Yes, often
- Yes, occasionally
- Yes, but rarely
- No, never

40. Generally speaking, how easy or hard is it to assign a regular job that is considered less demanding?

- Very easy
- Somewhat easy
- Somewhat hard
- Very hard

41. Do you have to take job tenure into account in assigning regular jobs that are considered less demanding for employees on temporary work assignments or involved in a gradual return to work?

- Yes
- No

42. In your organization, are new, lighter jobs created for employees on temporary assignments or involved in a gradual return to work?

- Yes, often
- Yes, occasionally
- Yes, but rarely
- No, never

43. Generally speaking, how easy or hard is it to create a new, lighter job?

- Very easy
- Somewhat easy
- Somewhat hard
- Very hard

44. Do you have to take job tenure into account when assigning new, lighter jobs for employees on temporary assignments or involved in a gradual return to work?

- Yes
- No

45. Regarding absence management programs, are you involved in at least one of the following phases: development, coordination, evaluation, or promotion?

- Yes
- No

46. You may be required to perform various tasks or activities in the context of these programs. Please indicate how frequently you have to perform each task or activity listed below.

	Often	Occasionally	Rarely	Never
Coordinating these programs				
Performing cost-benefit analyses of these programs				
Developing policies, procedures, and guidelines for these programs				
Developing business plans and strategies for these programs				
Promoting these programs to the unions, management, and other workplace stakeholders				
Ensuring training related to these programs				
Promoting a change in attitude and behaviour in workplace representatives to support the objectives of these programs				
Using information management systems in these programs to track types of absence, costs, and outcomes obtained				
Conducting research and publishing the results of studies related to these programs				

The next questions concern factors that can facilitate your work, or conversely, make it more complicated.

47. Does your organization have procedures, a policy, or a document setting forth guidelines for managing absences?

- Yes
- No
- No, but there are plans to develop one or one is currently being developed

48. To what degree do these procedures, policies, or documents orient your decisions and actions when you are managing absences and returns to work?

- My decisions and actions are completely based on them
- My decisions and actions are largely based on them
- My decisions and actions are partially based on them
- My decisions and actions are essentially not based on them
- I do not know their content

49. Which people have been designated to develop these procedures, this policy, or this document?

- Myself alone
- Myself with people in my organization who have identical or similar functions
- Myself with people in my organization who have different functions
- Other people in my organization
- External resources
- Other (please specify)

50. Who are these other people in your organization or these external resources?

51. Which of the following statements best reflects the absence management procedures in your organization?

- The procedures are clearly defined
- The procedures are well-defined and occasionally subject to revisions or additions
- The procedures are well-defined and rarely subject to revisions or additions
- The procedures are more or less well-defined and nothing is done to improve the situation
- The procedures are more or less well-defined, but work is underway to define them more clearly
- The procedures are poorly defined

52. Generally speaking, how are your initiatives and new ideas regarding the management of absences received by your superiors?

- They are very well-received
- They are somewhat well-received
- They are somewhat poorly received
- They are very poorly received
- I do not really propose any initiatives or new ideas
- I don't know

53. Generally speaking, who makes the decisions regarding the management of absences?

- Myself alone
- Together with another person appointed for this purpose
- Together with another person, but not always the same person
- Myself and several other people
- I am not really involved in these decisions
- Other (please specify)

54. Who is this person or who are these people?

55. Which of the following statements best reflects the degree of recognition you or you and your team are given in the workplace?

- My/our work receives great recognition
- My/our work receives some recognition
- My/our work does not really receive much recognition
- My/our work receives no recognition at all
- I don't know

56. Which of the following statements best reflects the overall degree of support you or your team are given team by your superiors, managers, directors, and the workers' union?

- My/our work receives great support
- My/our work receives some support
- My/our work does not receive much support
- My/our work receives no support at all

57. Which of the following statements best reflects the overall degree of collaboration you or your team are offered by your superiors, managers, directors, and the workers' union?

- They offer very good collaboration
- They offer somewhat good collaboration
- They offer somewhat bad collaboration
- They offer very bad collaboration

58. Generally speaking, how would you describe the quality of communication among the various stakeholders involved in an employee's return-to-work process?

- Communication is very good
- Communication is somewhat good
- Communication is somewhat bad
- Communication is very bad

59. In your opinion, how aware of your role or your team's role are the workers under your responsibility?

- Virtually all the workers are aware of my/our role
- Many workers are aware of my/our role
- Few workers are aware of my/our role
- Virtually none of the workers are aware of my/our role

60. In your opinion, what perception do the employees in the process of returning to work or those under your responsibility have of you or your team?

- They have the impression that I represent more the employer's interests than their own
- They see me as being neutral, that is, they have the impression that I represent as much the employer's interests as their own
- They have the impression that I represent more their interests than those of the employer

61. How frequently are meetings held among various stakeholders in your organization to do follow-up of workers' cases?

- Every week
- Once or twice a month
- A few times a year
- Approximately once a year
- Less often
- Never

62. Do you have a well-established computer system or software program at your disposal that allows you to soundly manage your work absence cases?

- Yes
- No
- No, but there are plans to introduce such a system shortly or to purchase software for this purpose

63. Regarding your workload, which of the following statements best reflects your situation?

- It is too heavy
- It is not suitable
- It is not very heavy

64. Which of the following situations best reflects your opinion of the task of managing musculoskeletal and mental health disorders?

- It is much harder to manage cases involving mental health disorders than those involving musculoskeletal disorders
- It is a little harder to manage cases involving mental health disorders than those involving musculoskeletal disorders
- Managing both these types of disorders poses an equal challenge
- It is a little harder to manage cases involving musculoskeletal disorders than those involving mental health disorders
- It is much harder to manage cases involving musculoskeletal disorders than those involving mental health disorders

65. For what reason(s)?

- Reason 1

- Reason 2

- Reason 3

The next questions concern factors that can facilitate an employee's return to work or ability to stay at work, or conversely, that can hinder these processes.

66. Various factors can facilitate an employee's return to work or ability to stay at work following a long-term absence. Please indicate how important you regard each of the following factors to be.

	Very important	Quite important	Not very important	Not at all important
The worker feels that he or she is taken seriously				
The worker is aware of his or her limitations and expresses them				
Reducing stress by temporarily eliminating stressful tasks				
Adjusting the workload				
Clarity about the tasks to be performed and workplace expectations				
A pleasant work atmosphere				
Returning to work that involves simple, familiar tasks				
The employee sets his or her own work pace and organizes his or her own tasks				
A work environment free of excessive stimuli (noise, disruptions, etc.)				
Adjusting the working hours				
Regular communication between the direct supervisor or manager and the worker to assess the progress made				
Understanding on the part of the direct supervisor or manager				
Mutual trust between the direct supervisor or manager and the employee				
Understanding on the part of co-workers				

The worker receives compliments or words of appreciation from co-workers and his or her direct supervisor or manager				
Transparency with co-workers about the employee's situation				
The worker sets realistic goals in terms of productivity				
The worker is able to identify his or her problems				
The worker has self-confidence				
The worker shows perseverance				
The worker allows him-/herself to make errors				
The worker accepts having less control over his or her life				
The worker is motivated to return to work or to stay there after returning				
Good support from his or her close family or friends, etc.				
Being able to return to work promptly				
Having the possibility of holding a different job with the same direct supervisor or manager				
Presence of a replacement worker during the return to work, if needed				
A meeting between the worker and his or her direct supervisor or manager on the first day of the return to work				
Follow-up meetings with the employee during the first few days or weeks following the return to work to ensure that it is going well				

Providing the worker with information about the return to work (steps, tasks, supervision, etc.)				
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67. Conversely, various factors can hinder a worker’s return to work or ability to stay at work after a long-term absence. Please indicate how important you regard each of the following hindering factors to be.

	Very important	Quite important	Not very important	Not at all important
Social isolation at work				
Presence of other stress factors in the worker’s personal life				
Level of dissatisfaction at work				
Organization’s financial constraints				
History of multiple work absences due to a mental and/or physical health disorder				
Premature return to work				
Prejudices about mental health disorders				
A tense atmosphere or conflictual relationship prior to the worker’s absence				
Changes in the organization during the worker’s absence				
Direct supervisor’s or manager’s lack of knowledge about mental health disorders				
Direct supervisor’s or manager’s lack of knowledge about physical health disorders				
The fact of doubting the worker’s diagnosis				
Lack of information about the worker’s diagnosis or condition				
Lack or total absence of contact between the direct supervisor or manager and the worker, prior to the return to work				

Lack of involvement of the direct supervisor or manager in the return-to-work plan				
A work team that is little or poorly prepared for a worker's return				
High performance expectations on the part of the direct supervisor or manager				
Direct supervisor's or manager's attitude during the worker's absence				
Direct supervisor's or manager's attitude during the return to work				
Worker's attitude during his or her absence				
Worker's attitude during his or her return to work				
Lack of concerted actions among the various stakeholders involved in the return to work				
Attending physician's lack of knowledge about the workplace realities				

In closing, here are a few questions about you, as well as a space where you can add any other comments, if you wish.

68. What is your gender?

- Male
- Female

69. Into which of the following age groups do you fall?

- 18 to 24 years
- 25 to 34 years
- 35 to 44 years
- 45 to 54 years
- 55 to 64 years
- 65 years or over

70. If you have any other comments you would like to add, please enter them in the spaces below.

71. Please enter the identifier number you were sent in the email inviting you to complete this survey. We can then send you an amount of \$25 as a thank you for participating.

Thank you for your invaluable cooperation!

APPENDIX C

SOCIODEMOGRAPHIC AND OCCUPATIONAL PROFILES OF PARTICIPANTS (N=195)

Variables	N (%)
Gender	
Male	45 (23.3)
Female	148 (76.7)
Age group	
18 to 24 years	4 (2.1)
25 to 34 years	34 (17.6)
35 to 44 years	64 (33.2)
45 to 54 years	60 (31.1)
55 to 64 years	30 (15.5)
65 years or over	1 (0.5)
Area of training (several answers possible)	
Human resources	70 (35.9)
Administration	53 (27.2)
Industrial relations	50 (25.6)
Nursing or OHS	52 (26.7)
Other	43 (22.1)
Highest level of education completed	
High school or less	8 (4.1)
College/CÉGEP – Pre-university sector	4 (2.1)
College/CÉGEP – Technical sector	22 (11.3)
University undergraduate level – Bachelor’s degree	110 (56.4)
University graduate level – Master’s degree	31 (15.9)
University doctoral level – PhD	0 (0)
University level – Certificate or short program (Occupational Health and Safety, Human Resources, etc.)	20 (10.3)
Job title	
Personnel and work attendance management officer	17 (8.7)
Disability management counsellor	5 (2.6)
Disability management and occupational health and safety counsellor	3 (1.5)
Human resources counsellor	17 (8.7)
Occupational health and safety counsellor	21 (10.8)
Labour relations counsellor	4 (2.1)
Human resources coordinator	19 (9.7)
Occupational health and safety coordinator	10 (5.1)
Head, human resources	8 (4.1)
Head, occupational health and safety	14 (7.2)
Director of human resources	23 (11.8)
Director of occupational health and safety	4 (2.1)
Disability manager	7 (3.6)
Manager of medical department	2 (1.0)
Person responsible for remuneration	23 (11.8)
Employee benefits technician	3 (1.5)
Human resources technician	4 (2.1)
Nurse	10 (5.1)
Nurse, disability management	1 (0.5)
Mean number of years of work in the field of absence management (S.D.)	12.81 (8.59)
Mean number of years in the currently held job (S.D.)	7.25 (6.78)
Absence management responsibilities	
Handles disability cases only	30 (15.4)
Manages both disability cases and CNESST cases	165 (84.6)

Variables	N (%)
Number of workers under the participants' responsibility with respect to absence management	
Over 5,000	13 (6.7)
Between 1,001 and 5,000	71 (36.4)
Between 500 and 1,000	64 (32.8)
Between 400 and 499	20 (10.3)
Between 300 and 399	11 (5.6)
Between 200 and 299	5 (2.6)
Between 100 and 199	4 (2.1)
Between 50 and 99	4 (2.1)
Under 50	3 (1.5)

CHARACTERISTICS OF THE ORGANIZATIONS SURVEYED (N=195)

Variables	N (%)
Nature of the organization	
Public	82 (42.1)
Private	113 (57.9)
Self-reported activity sector	
Public Administration	13 (6.7)
Agriculture, Forestry, Fishing and Hunting	4 (2.1)
Arts, Entertainment and Recreation	7 (3.6)
Retail Trade	16 (8.2)
Wholesale Trade	7 (3.6)
Construction	9 (4.6)
Mining, Quarrying and Oil and Gas Extraction	3 (1.5)
Manufacturing	32 (16.4)
Finance and Insurance	7 (3.6)
Management of Companies and Enterprises	0 (0)
Accommodation and Food Services	2 (1.0)
Information and Cultural Industries	4 (2.1)
Administrative and Support, Waste Management and Remediation Services	3 (1.5)
Educational Services	16 (8.2)
Real Estate and Rental and Leasing	0 (0)
Professional, Scientific, and Technical Services	17 (8.7)
Public Services	1 (0.5)
Healthcare and Social Assistance	43 (22.1)
Transportation and Warehousing	11 (5.6)
Number of sites operated by the organization, regardless of location	
Only one site	25 (12.8)
Two or more sites	170 (87.2)
Number of sites in Québec (sub-sample, n = 170)	
Organizations with two or more sites	158 (92.9)
Organizations not operating two or more sites	12 (7.1)
Number of sites in another Canadian province (sub-sample, n = 170)	
Organizations with at least one site	74 (43.5)
Organizations with no other site	96 (56.5)
Number of sites outside Canada (sub-sample, n = 170)	
Organizations with at least one site	53 (31.2)
Organizations with no other site	117 (68.8)
Number of workers in Québec	
More than 10,000	7 (3.6)
Between 5,000 and 10,000	11 (5.6)
Between 1,000 and 5,000	72 (36.9)
Between 500 and 1,000	105 (53.8)
Department or unit involved in disability management	
Human Resources	153 (78.5)

Variables	N (%)
Occupational Health and Safety	15 (7.7)
Health Services	18 (9.2)
Administration and Remuneration	6 (3.1)
Other	3 (1.5)
Mean number of people responsible for disability management and RTW coordination, for Québec as a whole (S.D.)	3.52 (4.16)
Presence of health services or a health office	
Yes, present	82 (42.1)
No, absent	113 (57.9)
Organizations using an outside firm for disability management	
Yes, for all disability cases	22 (11.3)
Yes, but for only some disability cases	72 (36.9)
No	101 (51.8)
Presence of a program to assist workers who are experiencing problems (e.g. EAP)	
Yes, present	182 (93.3)
No, absent	13 (6.7)
Proportion of unionized employees	
All	24 (12.3)
Most	104 (53.3)
A minority	20 (10.3)
None	47 (24.1)
Distribution of unionized employees (sub-sample, n = 148)	
One union	24 (16.2)
Two or more unions	124 (83.8)
Approximate percentage of people absent from work	
Less than 1%	37 (20.7)
Between 1 and 3%	43 (24.0)
Between 4 and 6%	51 (28.6)
Between 7 and 9%	34 (19.0)
10% or more	14 (7.9)
Most frequent reason for absence	
Musculoskeletal disorders	89 (46.1)
Mental health disorders	92 (47.7)
Heart diseases	1 (0.5)
Chronic diseases (diabetes, migraines, asthma, etc.)	8 (4.1)
Cancers	3 (1.6)

APPENDIX D

**COMPETENCY 1: “ADAPTING ONE’S PRACTICES TO THE NEEDS AND CAPACITIES OF AN ABSENT WORKER INVOLVED IN THE PROCESS OF RETURNING TO WORK”
(N=195)**

Tasks/activities	N (%)				Mean (S.D.)
	Often	Occasionally	Rarely	Never	
Contacting the absent worker	146 (74.9)	34 (17.4)	13 (6.7)	2 (1.0)	3.66 (0.65)
Using the medical diagnosis and functional limitations to plan the return to work	123 (63.1)	49 (25.1)	16 (8.2)	7 (3.6)	3.48 (0.80)
Ensuring a clear understanding of the medical terminology	104 (53.3)	52 (26.7)	26 (13.3)	13 (6.7)	3.27 (0.93)
Following the employee’s progress in order to attain the objective of a return to regular work	95 (48.7)	67 (34.4)	26 (13.3)	7 (3.6)	3.28 (0.83)
Assessing the workplace factors that may hinder the return to work	91 (46.7)	74 (37.9)	24 (12.3)	6 (3.1)	3.28 (0.80)
Identifying tasks suited to the worker’s capacities	91 (46.7)	74 (37.9)	23 (11.8)	7 (3.6)	3.28 (0.81)
Assessing the capacities of the worker who has returned to work after an absence	89 (45.6)	64 (32.8)	24 (12.3)	18 (9.2)	3.15 (0.97)
Clarifying mutual expectations and the nature of your relationship with the worker	83 (42.6)	81 (41.5)	28 (14.4)	3 (1.5)	3.25 (0.76)
Identifying the factors that can hinder the worker’s motivation regarding his or her rehabilitation	67 (34.4)	71 (36.4)	46 (23.6)	11 (5.6)	2.99 (0.90)
Identifying the worker’s emotional reactions regarding his or her absence	65 (33.3)	91 (46.7)	33 (16.9)	6 (3.1)	3.10 (0.79)
Assisting the worker if his or her health condition deteriorates following the return to work	59 (30.3)	80 (41.0)	46 (23.6)	10 (5.1)	2.96 (0.86)
Meeting with the absent worker to demonstrate interest in his or her situation	59 (30.3)	77 (39.5)	39 (20.0)	20 (10.3)	2.90 (0.96)
Analyzing the postures required at the employee’s work station	58 (29.7)	86 (44.1)	34 (17.4)	17 (8.7)	2.95 (0.91)
Recognizing psychological problems (depression, suicidal ideation) that require prompt consultation or referral to a specialist	53 (27.2)	76 (39.0)	52 (26.7)	14 (7.2)	2.86 (0.90)
Analyzing the need for work accommodations	49 (25.1)	93 (47.7)	39 (20.0)	14 (7.2)	2.91 (0.86)
Assessing the support available to the worker (family, friends, and community)	45 (23.1)	54 (27.7)	73 (37.4)	23 (11.8)	2.62 (0.97)
Re-examining the employee’s workload with him or her	37 (19.0)	74 (37.9)	63 (32.3)	21 (10.8)	2.65 (0.91)
Helping the worker to understand and cope with his or her stress	36 (18.5)	65 (33.3)	64 (32.8)	30 (15.4)	2.55 (0.96)
Advising the worker to help him or her appreciate and focus on personal strengths	25 (12.8)	69 (35.4)	64 (32.8)	37 (19.0)	2.42 (0.94)
Taking into account cultural differences and their impact on absence management	15 (7.7)	45 (23.1)	77 (39.5)	58 (29.7)	2.09 (0.91)

COMPETENCY 1 – WORK TEAM (N=195)

Stakeholders	N (%)				Mean (S.D.)
	Often	Occasionally	Rarely	Never	
Direct supervisor or manager	147 (75.4)	45 (23.1)	2 (1.0)	1 (0.5)	3.73 (0.50)
Worker	146 (74.9)	34 (17.4)	14 (7.2)	1 (0.5)	3.67 (0.63)
Human resources counsellor	88 (45.1)	72 (36.9)	15 (7.7)	20 (10.3)	3.17 (0.96)
Insurer's representative	72 (36.9)	55 (28.2)	36 (18.5)	32 (16.4)	2.86 (1.09)
Union representative	24 (12.3)	68 (34.9)	51 (26.2)	52 (26.7)	2.33 (1.00)
Health professionals	44 (22.6)	97 (49.7)	32 (16.4)	22 (11.3)	2.84 (0.91)
Another work absence manager within the organization	31 (15.9)	57 (29.2)	33 (16.9)	74 (37.9)	2.23 (1.12)
Employee's co-workers	1 (0.5)	29 (14.9)	88 (45.1)	77 (39.5)	1.76 (0.72)

COMPETENCY 1 – PERSONAL ATTRIBUTES AND APTITUDES (N=195)

Personal attributes/aptitudes	N (%)				Mean (S.D.)
	Very important	Quite important	Not very important	Not at all important	
Being a good listener	171 (87.7)	24 (12.3)	0 (0)	0 (0)	3.88 (0.33)
Ability to win the worker's trust	170 (87.2)	25 (12.8)	0 (0)	0 (0)	3.87 (0.34)
Being tactful	161 (82.6)	32 (16.4)	2 (1.0)	0 (0)	3.82 (0.42)
Being positive	154 (79.0)	39 (20.0)	2 (1.0)	0 (0)	3.78 (0.44)
Being empathetic	138 (70.8)	54 (27.7)	3 (1.5)	0 (0)	3.69 (0.50)
Being flexible	116 (59.5)	75 (38.5)	3 (1.5)	1 (0.5)	3.57 (0.56)
Ability to believe in each person's worth	109 (55.9)	79 (40.5)	7 (3.6)	0 (0)	3.52 (0.57)

COMPETENCY 2: “ACTIVELY ENGAGING THE WORKPLACE STAKEHOLDERS CONCERNED AND APPROPRIATE EXTERNAL RESOURCES IN THE EMPLOYEE’S RETURN-TO-WORK PROCESS”

Tasks/activities	N (%)				Mean (S.D.)
	Often	Occasionally	Rarely	Never	
Collaborating with the insurer’s representative to ensure that services are coordinated, appropriate, and delivered in a timely manner	83 (42.6)	60 (30.8)	25 (12.8)	27 (13.8)	3.02 (1.06)
Consulting the insurer’s representative about a worker’s functional capacities, prognosis, and treatment plans	82 (42.1)	56 (28.7)	29 (14.9)	28 (14.4)	2.98 (1.08)
Coordinating workplace resources to implement the RTW plans	72 (36.9)	72 (36.9)	37 (19.0)	14 (7.2)	3.04 (0.92)
Drafting RTW plans	66 (33.8)	53 (27.2)	45 (23.1)	31 (15.9)	2.79 (1.08)
Assessing the work-related risks	65 (33.3)	77 (39.5)	34 (17.4)	19 (9.7)	2.96 (0.95)
Indicating the nature of a worker’s problem when the worker is referred to the insurer’s representative	62 (31.8)	67 (34.4)	32 (16.4)	34 (17.4)	2.81 (1.07)
Determining whether work accommodations are possible	60 (30.8)	100 (51.3)	26 (13.3)	9 (4.6)	3.08 (0.79)
Reporting on a worker's progress to the parties concerned	53 (27.2)	73 (37.4)	48 (24.6)	21 (10.8)	2.81 (0.96)
Participating in a brainstorming session to identify tasks suitable for the worker	46 (23.6)	84 (43.1)	49 (25.1)	16 (8.2)	2.82 (0.89)
Communicating with the attending physician or other specialists to facilitate planning of the RTW	46 (23.6)	58 (29.7)	57 (29.2)	34 (17.4)	2.59 (1.03)
Participating in the creation of a lighter job	38 (19.5)	70 (35.9)	58 (29.7)	29 (14.9)	2.60 (0.97)
Communicating with the health professionals involved, during an employee’s RTW	31 (15.9)	82 (42.1)	54 (27.7)	28 (14.4)	2.59 (0.92)
Selecting health professionals based on the worker’s needs (physiotherapists, occupational therapists, psychologists, etc.)	30 (15.4)	74 (37.9)	48 (24.6)	43 (22.1)	2.47 (1.00)
Assessing the impact of the worker’s absence on the organization’s other workers	22 (11.3)	63 (32.3)	68 (34.9)	42 (21.5)	2.33 (0.94)
Communicating with the absent worker’s family	1 (0.5)	15 (7.7)	73 (37.4)	106 (54.4)	1.54 (0.66)

COMPETENCY 2 – WORK TEAM (N=195)

Stakeholders	N (%)				Mean (S.D.)
	Often	Occasionally	Rarely	Never	
Direct supervisor or manager	163 (83.6)	21 (10.8)	11 (5.6)	0 (0)	3.78 (0.54)
Worker	154 (79.0)	27 (13.8)	11 (5.6)	3 (1.5)	3.70 (0.65)
Human resources counsellor	82 (42.1)	65 (33.3)	26 (13.3)	22 (11.3)	3.06 (1.00)
Insurer's representative	72 (36.9)	54 (27.7)	34 (17.4)	35 (17.9)	2.84 (1.11)
Health professionals	41 (21.0)	83 (42.6)	44 (22.6)	27 (13.8)	2.71 (0.95)
Another work absence manager within the organization	28 (14.4)	45 (23.1)	43 (22.1)	79 (40.5)	2.11 (1.10)
Union representative	27 (13.8)	63 (32.3)	45 (23.1)	60 (30.8)	2.29 (1.05)
Employee's co-workers	7 (3.6)	24 (12.3)	76 (39.0)	88 (45.1)	1.74 (0.810)

COMPETENCY 2 – PERSONAL ATTRIBUTES AND APTITUDES (N=195)

Personal attributes/aptitudes	N (%)				Mean (S.D.)
	Very important	Quite important	Not very important	Not at all important	
Knowing how to respect confidentiality	183 (93.8)	12 (6.2)	0 (0)	0 (0)	3.94 (0.24)
Ability to win the trust of the various stakeholders	166 (85.1)	28 (14.4)	1 (0.5)	0 (0)	3.85 (0.38)
Ability to establish one's credibility in the workplace	163 (83.6)	32 (16.4)	0 (0)	0 (0)	3.84 (0.37)
Being able to establish effective communication	163 (83.6)	32 (16.4)	0 (0)	0 (0)	3.84 (0.37)
Being able to set priorities	132 (67.7)	61 (31.3)	2 (1.0)	0 (0)	3.67 (0.49)
Being creative in problem solving	118 (60.5)	67 (34.4)	8 (4.1)	2 (1.0)	3.54 (0.63)
Being skilful in negotiating, mediating, or resolving conflicts	109 (55.9)	74 (37.9)	10 (5.1)	2 (1.0)	3.49 (0.65)
Being a leader	101 (51.8)	71 (36.4)	21 (10.8)	2 (1.0)	3.39 (0.72)
Ability to defend the worker	47 (24.1)	116 (59.5)	32 (16.4)	0 (0)	3.08 (0.63)

COMPETENCY 3: “DEVELOPING PRACTICES IN LINE WITH THE LAWS, REGULATIONS, AGREEMENTS, AND PROCEDURES PERTAINING TO WORK ABSENCES AND THE RETURN TO WORK”

Tasks/activities	N (%)				Mean (S.D.)
	Often	Occasionally	Rarely	Never	
Applying the laws, policies, and regulations governing work absences and the return to work	169 (86.7)	21 (10.8)	3 (1.5)	2 (1.0)	3.83 (0.48)
Performing various administrative tasks and completing forms (for example, claim forms)	121 (62.1)	47 (24.1)	23 (11.8)	4 (2.1)	3.46 (0.78)
Informing workers about return-to-work programs	113 (57.9)	59 (30.3)	19 (9.7)	4 (2.1)	3.44 (0.75)
Taking the worker’s job tenure, and more generally, collective agreements, into account	106 (54.4)	29 (14.9)	28 (14.4)	32 (16.4)	3.07 (1.16)
Keeping up-to-date on the laws, policies, and regulations governing work absences and the return to work	104 (53.3)	79 (40.5)	10 (5.1)	2 (1.0)	3.46 (0.64)
Informing workers of their rights under the law	96 (49.2)	60 (30.8)	33 (16.9)	6 (3.1)	3.26 (0.85)
Directing workers to the appropriate bodies (SAAQ, CNESST, IVAC, etc.)	95 (48.7)	72 (36.9)	24 (12.3)	4 (2.1)	3.32 (0.77)
Writing notes and reports on returns to work	80 (41.0)	71 (36.4)	29 (14.9)	15 (7.7)	3.11 (0.93)

COMPETENCY 3 – PERSONAL ATTRIBUTES AND APTITUDES (N=195)

Personal attributes/aptitudes	N (%)				Mean (S.D.)
	Very important	Quite important	Not very important	Not at all important	
Complying with standards	164 (84.1)	31 (15.9)	0 (0)	0 (0)	3.84 (0.37)
Having good analytical skills	160 (82.1)	34 (17.4)	1 (0.5)	0 (0)	3.82 (0.40)
Being organized	151 (77.4)	44 (22.6)	0 (0)	0 (0)	3.77 (0.42)
Being methodical	134 (68.7)	59 (30.3)	2 (1.0)	0 (0)	3.68 (0.49)

COMPETENCY 4: “RE-EXAMINING/QUESTIONING ONE’S PRACTICES AND VIEWPOINTS REGARDING WORK ABSENCES AND OCCUPATIONAL HEALTH, AND ENCOURAGING THE VARIOUS WORKPLACE STAKEHOLDERS TO DO THE SAME”

Tasks/activities	N (%)				Mean (S.D.)
	Often	Occasionally	Rarely	Never	
Taking preventive action regarding occupational health and safety	101 (51.8)	55 (28.2)	27 (13.8)	12 (6.2)	3.26 (0.92)
Keeping up-to-date in the fields of occupational health and safety and rehabilitation (reading, continuing education, participating in symposia, etc.)	81 (41.5)	94 (48.2)	18 (9.2)	2 (1.0)	3.30 (0.68)
Promoting occupational health and safety activities and initiatives in the workplace	77 (39.5)	69 (35.4)	35 (17.9)	14 (7.2)	3.07 (0.93)
Analyzing the organization’s work absence and occupational health and safety management practices for the purpose of optimization	70 (35.9)	92 (47.2)	22 (11.3)	11 (5.6)	3.13 (0.83)
Raising workplace awareness of prejudices and stereotypes regarding people with work disabilities	40 (20.5)	106 (54.4)	39 (20.0)	10 (5.1)	2.90 (0.78)
Assessing the organization’s performance in occupational health and safety activities and initiatives	38 (19.5)	81 (41.5)	44 (22.6)	32 (16.4)	2.64 (0.98)

COMPETENCY 4 – WORK TEAM (N=195)

Tasks/activities	Stakeholders involved, “Yes” answers – N (%)					
	Workers	Direct supervisors or managers	Union representatives	Human resources counsellors	Other	No other
Analyzing the organization’s work absence and occupational health and safety management practices for purposes of optimization	36 (18.5)	136 (69.7)	50 (25.6)	130 (66.7)	47 (24.1)	11 (5.6)
Assessing the organization’s performance in occupational health and safety activities and initiatives	38 (19.5)	124 (63.6)	47 (24.1)	108 (55.4)	37 (19.0)	23 (11.8)

COMPETENCY 4 – TARGET POPULATIONS (N=195)

Tasks/activities	Target populations concerned, “Yes” answers – N (%)				
	Workers	Direct supervisors or managers	Union representatives	Human resources counsellors	Other
Raising workplace awareness of prejudices and stereotypes regarding people with work disabilities	92 (47.2)	178 (91.3)	37 (19.0)	75 (38.5)	11 (5.6)
Taking preventive action regarding occupational health and safety	165 (84.6)	166 (85.1)	93 (47.7)	78 (40.0)	12 (6.2)
Promoting occupational health and safety activities and initiatives in the workplace	160 (82.1)	163 (83.6)	94 (48.2)	85 (43.6)	15 (7.7)

COMPETENCY 4 – PERSONAL ATTRIBUTES AND APTITUDES (N=195)

Personal attributes/aptitudes	N (%)				Mean (S.D.)
	Very important	Quite important	Not very important	Not at all important	
Being a good communicator	152 (77.9)	42 (21.5)	1 (0.5)	0 (0)	3.77 (0.43)
Being open-minded	147 (75.4)	45 (23.1)	1 (0.5)	0 (0)	3.74 (0.47)
Being persuasive	118 (60.5)	71 (36.4)	5 (2.6)	1 (0.5)	3.57 (0.57)
Being curious	90 (46.2)	90 (46.2)	14 (7.2)	1 (0.5)	3.38 (0.64)

INVOLVEMENT IN ABSENCE MANAGEMENT PROGRAMS (N=179)

Tasks/activities	N (%)				Mean (S.D.)
	Often	Occasionally	Rarely	Never	
Coordinating these programs	111 (62.0)	52 (29.1)	9 (5.0)	7 (3.9)	3.49 (0.77)
Using information management systems in these programs to track types of absence, costs, and outcomes obtained	74 (41.3)	50 (27.9)	35 (19.6)	20 (11.2)	2.99 (1.03)
Developing policies, procedures, and guidelines for these programs	69 (38.5)	76 (42.5)	20 (11.2)	14 (7.8)	3.12 (0.90)
Promoting these programs to the unions, management, and other workplace stakeholders	50 (27.9)	80 (44.7)	26 (14.5)	23 (12.8)	2.88 (0.97)
Performing cost-benefit analyses of these programs	49 (27.4)	74 (41.3)	35 (19.6)	21 (11.7)	2.84 (0.96)
Promoting a change in attitude and behaviour in workplace representatives to support the objectives of these programs	41 (22.9)	79 (44.1)	46 (25.7)	13 (7.3)	2.83 (0.87)
Ensuring training related to these programs	38 (21.2)	60 (33.5)	52 (29.1)	29 (16.2)	2.60 (1.00)
Developing business plans and strategies for these programs	25 (14.0)	57 (31.8)	55 (30.7)	42 (23.5)	2.36 (0.99)
Conducting research and publishing the results of studies related to these programs	9 (5.0)	27 (15.1)	52 (29.1)	91 (50.8)	1.74 (0.89)

APPENDIX E

FACILITATORS OF OR BARRIERS TO PRACTICES (N=194)

Facilitators or barriers	N (%)
Presence of procedures, a policy, or a document setting forth guidelines for managing absences and returns to work	
Yes, present	154 (79.4)
No	25 (12.9)
No, but there are plans to develop one or one is currently being developed	15 (7.7)
Degree to which the procedures, policy, or document orient decisions and actions during management of absences and returns to work (N=156)	
Decisions and actions are completely based on them	31 (19.9)
Decisions and actions are largely based on them	111 (71.2)
Decisions and actions are partially based on them	12 (7.7)
Decisions and actions are essentially not based on them	1 (0.6)
The respondent does not know their content	1 (0.6)
Definition and revision of procedures for managing absences and returns to work in the organizations	
The procedures are clearly defined	22 (11.3)
The procedures are well-defined and occasionally subject to revisions or additions	104 (53.6)
The procedures are well-defined and rarely subject to revisions or additions	25 (12.9)
The procedures are more or less well-defined and nothing is done to improve the situation	11 (5.7)
The procedures are more or less well-defined, but work is underway to define them more clearly	28 (14.4)
The procedures are poorly defined	4 (2.1)
Way in which initiatives and new ideas regarding the management of absences and returns to work are received by the respondents' superiors	
They are very well-received	71 (36.6)
They are somewhat well-received	107 (55.2)
They are somewhat poorly received	3 (1.5)
They are very poorly received	1 (0.5)
The respondent does not really propose any initiatives or new ideas	8 (4.1)
The respondent does not know	4 (2.1)
Degree of recognition given to the respondent or to the respondent and his or her team in the workplace	
Their work does not receive great recognition	42 (21.6)
Their work receives some recognition	106 (54.6)
Their work does not really receive much recognition	37 (19.1)
Their work does not receive any recognition at all	4 (2.1)
The respondent does not know	5 (2.6)
Degree of overall support given to the respondent or to the respondent and his or her team from their superiors, managers, directors, and the workers' union	
Their work receives great support	65 (33.5)
Their work receives some support	110 (56.7)
Their work does not receive much support	17 (8.8)
Their work does not receive any support at all	2 (1.0)
Degree of overall collaboration offered to the respondent or to the respondent and his or her team by their superiors, managers, directors, and the workers' union	
They are offered very good collaboration	62 (32.0)
They are offered somewhat good collaboration	123 (63.4)
They are offered somewhat bad collaboration	9 (4.6)
They are offered very bad collaboration	0 (0)

Facilitators or barriers	N (%)
Quality of communication among the various stakeholders involved in an employee's return-to-work process	
Communication is very good	61 (31.4)
Communication is somewhat good	126 (64.9)
Communication is somewhat bad	7 (3.6)
Communication is very bad	0 (0)
Awareness of the respondent or his or her team among the workers under their "responsibility"	
Virtually all the workers are aware of their role	66 (34.0)
Many workers are aware of their role	110 (56.7)
Few workers are aware of their role	18 (9.3)
Virtually none of the workers are aware of their role	0 (0)
Perception held of the respondent or of the respondent and his or her team by employees in the process of returning to work	
They have the impression that the employer's interests are represented more than their own	70 (36.1)
They see the respondent or the respondent and his or her team as being neutral, that is, they have the impression that the respondent or the respondent and his or her team represent as much the employer's interests as their own	118 (60.8)
They have the impression that the respondent or the respondent and his or her team represent more their interests than those of the employer	6 (3.1)
Usual frequency of meetings among various stakeholders in the organization for the purpose of following up on workers' cases	
Every week	55 (28.4)
Once or twice a month	77 (39.7)
A few times a year	41 (21.1)
Approximately once a year	7 (3.6)
Less often	4 (2.1)
Never	10 (5.2)
Presence of a well-established computer system or software program allowing for sound management of cases involving work absences and returns to work	
Yes	117 (60.3)
No	60 (30.9)
No, but there are plans to introduce such a system shortly or to purchase software for this purpose	17 (8.8)
Size of the workload	
It is too heavy	65 (33.5)
It is suitable	129 (66.5)
It is not very heavy	0 (0)
Opinion of the management of musculoskeletal or mental health disorders	
It is much more difficult to manage cases involving mental health disorders than those involving musculoskeletal disorders	65 (33.5)
It is a little more difficult to manage cases involving mental health disorders than those involving musculoskeletal disorders	64 (33.0)
Managing both these types of disorders poses an equal challenge	53 (27.3)
It is a little more difficult to manage cases involving musculoskeletal disorders than those involving mental health disorders	8 (4.1)
It is much more difficult to manage cases involving musculoskeletal disorders than those involving mental health disorders	4 (2.1)
Frequency of joint committee meetings to discuss absence management	
Often	21 (10.8)
Occasionally	49 (25.1)
Rarely	43 (22.1)
Never	82 (42.1)

PERCEPTION OF IMPORTANCE OF VARIOUS RETURN-TO-WORK FACILITATORS
(N=124)

Facilitators	N (%)				Mean (S.D.)
	Very important	Quite important	Not very important	Not at all important	
The worker is motivated to return to work or to stay there after returning	107 (86.3)	15 (12.1)	2 (1.6)	0 (0)	3.85 (0.40)
Mutual trust between the direct supervisor or manager and the employee	100 (80.6)	21 (16.9)	3 (2.4)	0 (0)	3.78 (0.47)
Regular communication between the direct supervisor or manager and the worker to assess the progress made	98 (79.0)	24 (19.4)	2 (1.6)	0 (0)	3.77 (0.46)
A meeting between the worker and his or her direct supervisor or manager on the first day of the return to work	98 (79.0)	24 (19.4)	2 (1.6)	0 (0)	3.77 (0.46)
Providing the worker with information about the return to work (steps, tasks, supervision, etc.)	95 (76.6)	28 (22.6)	1 (0.8)	0 (0)	3.76 (0.45)
Understanding on the part of the direct supervisor or manager	94 (75.8)	28 (22.6)	2 (1.6)	0 (0)	3.74 (0.48)
Clarity about the tasks to be performed and workplace expectations	90 (72.6)	31 (25.0)	3 (2.4)	0 (0)	3.70 (0.51)
Follow-up meetings with the employee during the first few days or weeks following the return to work to ensure that it is going well	88 (71.0)	36 (29.0)	0 (0)	0 (0)	3.71 (0.46)
The worker feels that he or she is taken seriously	85 (68.5)	36 (29.0)	3 (2.4)	0 (0)	3.66 (0.52)
A pleasant work atmosphere	80 (64.5)	42 (33.9)	2 (1.6)	0 (0)	3.63 (0.52)
The worker is aware of his or her limitations and expresses them	72 (58.1)	50 (40.3)	2 (1.6)	0 (0)	3.56 (0.53)
The worker shows perseverance	64 (51.6)	58 (46.8)	2 (1.6)	0 (0)	3.50 (0.53)
Adjusting the workload	62 (50.0)	59 (47.6)	2 (1.6)	1 (0.8)	3.47 (0.58)
The worker has self-confidence	61 (49.2)	59 (47.6)	4 (3.2)	0 (0)	3.46 (0.56)
Good support from his or her close family or friends, etc.	58 (46.8)	61 (49.2)	4 (3.2)	1 (0.8)	3.42 (0.60)
Understanding on the part of co-workers	57 (46.0)	63 (50.8)	4 (3.2)	0 (0)	3.43 (0.56)
The worker is able to identify his or her problems	57 (46.0)	60 (48.4)	7 (5.6)	0 (0)	3.40 (0.60)
Being able to return to work promptly	55 (44.4)	55 (44.4)	13 (10.5)	1 (0.8)	3.32 (0.69)
Reducing stress by temporarily eliminating stressful tasks	48 (38.7)	70 (56.5)	5 (4.0)	1 (0.8)	3.33 (0.59)
The worker allows him-/herself to make errors	47 (37.9)	59 (47.6)	18 (14.5)	0 (0)	3.23 (0.69)
Returning to work that involves simple, familiar tasks	44 (35.5)	69 (55.6)	10 (8.1)	1 (0.8)	3.26 (0.64)
The worker receives compliments or words of appreciation from co-workers and his or her direct supervisor or manager	42 (33.9)	73 (58.9)	8 (6.5)	1 (0.8)	3.26 (0.61)
The worker sets realistic goals in terms of productivity	42 (33.9)	69 (55.6)	12 (9.7)	1 (0.8)	3.23 (0.65)
The worker accepts having less control over his or her life	31 (25.0)	62 (50.0)	27 (21.8)	4 (3.2)	2.97 (0.78)
Transparency with co-workers about the employee's situation	29 (23.4)	66 (53.2)	25 (20.2)	4 (3.2)	2.97 (0.75)
Adjustment of working hours	24 (19.4)	72 (58.1)	25 (20.2)	3 (2.4)	2.94 (0.70)
Presence of a replacement worker during the return to work, if needed	20 (16.1)	61 (49.2)	39 (31.5)	4 (3.2)	2.78 (0.75)
The employee sets his or her own work pace and organizes his or her own tasks	18 (14.5)	64 (51.6)	38 (30.6)	4 (3.2)	2.77 (0.73)
Having the possibility of holding a different job with the same direct supervisor or manager	13 (10.5)	47 (37.9)	59 (47.6)	5 (4.0)	2.55 (0.74)
A work environment free of excessive stimuli (noise, disruptions, etc.)	10 (8.1)	59 (47.6)	52 (41.9)	3 (2.4)	2.61 (0.67)

PERCEPTION OF IMPORTANCE OF VARIOUS RETURN-TO-WORK BARRIERS (N=124)

Barriers	N (%)				Mean (S.D.)
	Very important	Quite important	Not very important	Not at all important	
Worker's attitude during his or her return to work	(95) 76.6	26 (21.0)	3 (2.4)	0 (0)	3.74 (0.49)
A tense atmosphere or conflictual relationship prior to the worker's absence	94 (75.8)	30 (24.2)	0 (0)	0 (0)	3.76 (0.43)
Direct supervisor's or manager's attitude during the return to work	92 (74.2)	29 (23.4)	3 (2.4)	0 (0)	3.75 (0.50)
History of multiple work absences due to a mental and/or physical health disorder	80 (64.5)	36 (29.0)	8 (6.5)	0 (0)	3.58 (0.61)
Social isolation at work	78 (62.9)	44 (35.5)	2 (1.6)	0 (0)	3.61 (0.52)
High performance expectations on the part of the direct supervisor or manager	76 (61.3)	38 (30.6)	9 (7.3)	1 (0.8)	3.52 (0.67)
Lack of involvement of the direct supervisor or manager in the return-to-work plan	73 (58.9)	40 (32.3)	10 (8.1)	1 (0.8)	3.49 (0.68)
Level of dissatisfaction with work	72 (58.1)	50 (40.3)	2 (1.6)	0 (0)	3.56 (0.53)
Presence of other stress factors in the worker's personal life	66 (53.2)	58 (46.8)	0 (0)	0 (0)	3.53 (0.50)
Premature return to work	65 (52.4)	56 (45.2)	3 (2.4)	0 (0)	3.50 (0.55)
Lack of concerted actions among the various stakeholders involved in the return to work	63 (50.8)	53 (42.7)	7 (5.6)	1 (0.8)	3.44 (0.64)
Prejudices about mental health disorders	60 (48.4)	55 (44.4)	8 (6.5)	1 (0.8)	3.40 (0.65)
Lack or total absence of contact between the direct supervisor or manager and the worker, prior to the return to work	60 (48.4)	44 (35.5)	18 (14.5)	2 (1.6)	3.31 (0.78)
Attending physician's lack of knowledge about the workplace realities	56 (45.2)	56 (45.2)	10 (8.1)	2 (1.6)	3.34 (0.70)
Worker's attitude during his or her absence	54 (43.5)	53 (42.7)	16 (12.9)	1 (0.8)	3.29 (0.72)
The fact of doubting the worker's diagnosis	53 (42.7)	53 (42.7)	16 (12.9)	2 (1.6)	3.27 (0.75)
Direct supervisor's or manager's attitude during the worker's absence	52 (41.9)	53 (42.7)	19 (15.3)	0 (0)	3.27 (0.71)
A work team that is little or poorly prepared for a worker's return	44 (35.5)	65 (52.4)	13 (10.5)	2 (1.6)	3.22 (0.69)
Lack of information about the worker's diagnosis or condition	41 (33.1)	59 (47.6)	21 (16.9)	3 (2.4)	3.11 (0.77)
Direct supervisor's or manager's lack of knowledge about mental health disorders	40 (32.3)	65 (52.4)	19 (15.3)	0 (0)	3.17 (0.67)
Changes in the organization during the worker's absence	29 (23.4)	73 (58.9)	22 (17.7)	0 (0)	3.06 (0.64)
Direct supervisor's or manager's lack of knowledge about physical health disorders	28 (22.6)	75 (60.5)	20 (16.1)	1 (0.8)	3.05 (0.65)
Organization's financial constraints	19 (15.3)	53 (42.7)	42 (33.9)	10 (8.1)	2.65 (0.84)