Occupational Rehabilitation

Studies and Research Projects

REPORT **R-847**

Factors Influencing the Return to Work after Depression

The Viewpoint and Role of Unions

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Legal Deposit
Bibliothèque et Archives nationales du Québec
2014
ISBN: 978-2-89631-764-6 (PDF)
ISSN: 0820-8395

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A PDF version of this publication is available on the IRSST Web site.

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-805) 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 all those individuals who participated in the focus groups held in the context of this study, specifically, all the union stakeholders. We would also like to thank all members of the follow-up committee for their insightful suggestions and help in recruitment, as well as the Institut de recherche Robert-Sauvé en santé et en sécurité du travail (IRSST) for its financial support, without which this study would not have been possible. Lastly, our thanks go to research professionals Anissa Adouane and Marjolaine Beaudry for their contribution to this project.

SUMMARY

In 2005, the World Health Organization (WHO) stated that in less than a decade, depression would be one of the leading causes of disability along with cardiovascular diseases (World Health Organization, 2005). In fact, we have seen an increase in disability benefits for mental disorders, particularly depression. These disorders now account for 40% of all salary insurance claims (MSSS, 2005). The return to work of employees who have been on sick leave for depression can be complex because it involves a number of stakeholders. To our knowledge, few studies have examined either the viewpoint of unions on factors that facilitate or hinder the return to work of individuals suffering from depression, or their role in the return to work of such employees.

The aim of this study was therefore to gain a better understanding of the role of unions in the return to work of individuals who have suffered from depression, as well as the factors that, from union stakeholders' viewpoint, facilitate or hinder this return. The main questions were: In your role as a union representative, what have you done within the return-to-work process of employees who have suffered from depression? What do you think helps people return to work after suffering from depression? What hinders or complicates their return?

A qualitative study was conducted in which 23 people (12 men and 11 women) connected with three union organizations participated in one of three focus groups. The focus group was selected as an interview technique not only to provide access to a range of union stakeholders' viewpoints, but also to encourage group reflection. The study sample consisted of equal numbers of union representatives and peer workers; the latter, by definition, play a more direct role with employees. The target population was union stakeholders who had several years of experience in a union environment and had been in contact with employees who had suffered from depression. The discussions were transcribed verbatim and the content was analyzed.

First, the results show an ambiguity in the definition of the union stakeholders' role with employees who have suffered from depression. Their involvement appears to vary considerably from case to case, specifically based on the type of union stakeholder on the union team (union representatives, peer workers), the relationship between the employee and the union and its active members, and employer-union cooperation within the organization. Results related to factors perceived by the union stakeholders as facilitating or hindering the return to work of individuals who have experienced depression are then provided. The factors that emerged are presented by stakeholder group, i.e. employer and organization, co-workers, the employee who has suffered from depression, the union, and physicians and medical services. Four recurring inter-stakeholder factors (convergence analysis) emerged: an organizational culture that values mental health and the human aspect of work, support and follow-up throughout the sick leave and return to work, lack of resources, and stakeholders' prejudices and discomfort regarding depression.

The findings of this research fill an empirical void in the literature on the return to work of individuals who have experienced depression. The results of the focus groups held with union

representatives portray the viewpoint of these key stakeholders on factors that facilitate or hinder the return to work, while highlighting the poorly defined but central role of unions with employees who have suffered depression. This study also takes account of the role of these stakeholders as intermediaries or special conciliators between the parties involved in the return-to-work process and of the importance of clarifying their role and practices to facilitate an employee's return to work after a mental disorder, particularly depression.

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Mental disorders currently represent a major cause of work absence (Cohidon, Imbernon & Gorldberg, 2009; Corbière & Durand, 2011; Dewa, Goering, Lin & Paterson, 2002; Dewa, McDaid & Ettner, 2007; Henderson, Glozier & Elliott, 2005; Vézina & Bourbonnais, 2001). Sometimes repeated and often long-term, these absences can lead to job termination[1] (Koopsmans, Roelen & Groothoff, 2008). Mental disorders include major depression[2], which has an incidence rate of between 2% and 7% among the working population (Dewa, McDaid, & Sultan-Taïeb, 2011). The consequences of this illness directly affect Canadian employers, since between 30% and 60% of the related social costs are associated with the drop in productivity (Greenberg et al., 2003; Stephens & Joubert, 2001; Lim, Jacobs, Ohinmaa, Schopflocher & Dewa, 2008). Moreover, in 2005, the World Health Organization (WHO) stated that in less than a decade, depression would rank as one of the leading causes of disability along with cardiovascular diseases (World Health Organization, 2005). These health problems account for 40% of all salary insurance claims (MSSS, 2005). It is therefore becoming increasingly urgent that we document mental disorders in general and depression in particular, as they generate substantial human and social costs due to the absenteeism often associated with them.

Return-to-work interventions or practices[3] for employees with a mental disorder are virtually non-existent within work organizations (Nieuwenhuijsen, Bruinvels, & Frings-Dresen, 2010; Nieuwenhuijsen et al., 2008). Yet current knowledge about the return to work[4] of individuals suffering from a mental disorder suggests that these interventions or practices are important in the return-to-work process (Corbière, Negrini, & Dewa, 2013). Many parallels can also be drawn between the return-to-work process of employees with a mental disorder, particularly depression, and that of employees with a musculoskeletal disorder (MSD) (Briand, Durand, St-Arnaud, & Corbière, 2007; Durand, Corbière, Coutu, Reinharz, & Albert, 2014), even if each group of people has its own specific characteristics such as length of work absence and symptoms. The work carried out in the MSD field can therefore provide a source of inspiration for research on the return to work of individuals with a mental disorder, particularly depression (Goldner et al., 2004).

[1]In the specialized literature, authors differentiate between individuals with a mental disorder who have maintained their employment relationship with a specific organization and those who have been out of the regular labour market for a prolonged period (employment relationship with a work organization has been terminated). In the first instance, we are generally talking about individuals with a common mental disorder who will eventually return to work in the same organization where they worked prior to their absence. In the second instance, we are talking about individuals with a severe mental disorder who are in the process of reintegrating into the regular labour market (Corbière & Durand, 2011). This distinction refers above all to the work situation (return to work or reintegration into the labour market), not to the mental disorder as such. Moreover, a person suffering from major depression may at a given moment be involved in a return-to-work process (employment relationship maintained), but if the absence becomes significantly long-term (with termination of the employment relationship), that person will then be involved in a process of reintegrating into the regular labour market. This report focuses essentially on individuals who have experienced major depression and are in the process of returning to work in the organization for which they worked prior to their absence.

[2]Major depression is characterized by a depressive mood and/or loss of interest or pleasure, combined with other symptoms of an emotional, physical and cognitive nature that persist over a period of at least two consecutive weeks (American Psychiatric Association, 2000). In this report, the term “depression” is used to refer to the diagnosis of major depression.

[3]Return-to-work interventions or practices within a work organization refer to actions taken by the various stakeholders in an organization to facilitate the return to work of a person who has experienced major depression or another mental disorder (e.g. adjustment disorder). If successful, they represent a factor conducive to the return to work.

[4]In the specialized literature, the expression “return to work” refers to a broader process than the specific day on which a return to work takes place. It can refer to both preparation for the return and job retention following the return.

The data on employees with MSDs reveal that return-to-work interventions or practices within an organization have a positive impact on the duration and cost of work disability (Franche, Baril, Shaw, Nicholas, & Loisel, 2005; MacEachen, Clarke, Franche, Irvin, & Workplace-based Return to Work Literature Review Group, 2006). In addition, many studies on these disorders now recognize that the majority of factors that hinder the return are minimally associated with the original deficiency/illness, and more with psychosocial and environmental factors (Franche, Cullen, et al., 2005; Loisel et al., 2001; Marois, 2007; Waddell, Burton, & Main, 2003). These findings served to support the design of the work disability paradigm of Loisel et al. (2005), which was developed for MSDs but can provide inspiration regarding other physical and mental disorders (Corbière & Durand, 2011; Loisel & Anema, 2013). The work disability paradigm consists of taking into account not only the employee's characteristics (physical, cognitive, affective, and social), but also his[5] environment, comprised of three main social systems (Loisel et al., 2005; Loisel et al., 2001). First is the health care system, which seeks to treat the illness and its symptoms and to offer health care via a variety of clinicians (e.g. physicians, occupational therapists, physiotherapists, and nurses). Second, there is the system within the organization, which refers to the physical, social, and organizational factors present in the workplace, including the stakeholders involved in the return-to-work process and the measures that have been developed to promote it (e.g. employee assistance programs). Last of all is the legislative and insurance system, which includes the many financial support schemes that are available and that vary according to the legal and social contexts (administrative regulations and provincial/federal laws) (Corbière & Durand, 2011).

This radical change in our understanding of the causes of work absenteeism has led to a shift from a biomedical conceptual model, where the focus is on understanding and treating the illness, to a biopsychosocial model (Engel, 1977; Main & Watson, 1999; Pincus et al., 2002; Waddell, 1987), which places importance on taking into account the complexity of the human being in the various spheres of activity in his work environment. A better understanding of the factors influencing the return to work of individuals with a mental disorder, particularly depression, could therefore be gained by studying the systems within which depression develops.

This study forms part of a broader research project concerning the system within the organization and whose objective is to describe the factors that facilitate and hinder the return to work from the viewpoint of four groups of stakeholders: employers, direct supervisors, unions, and individuals who have experienced depression. In particular, it focuses on unions. The following few paragraphs, however, provide a brief look at the context of each of the aforementioned stakeholders. This is followed by a more exhaustive discussion of union stakeholders, who are the focus of this report.

[5] The masculine form is used in this text with no gender discrimination intended and solely in the interests of readability.

1.1 Roles of the various stakeholders in the return to work of individuals with a mental disorder

The literature tells us that each of the stakeholders in the organization's system has a role and responsibilities in the return-to-work process (Corbière & Durand, 2011). A summary of so-called "best" practices for managing absences related to MSDs or mental disorders (Durand et al., 2014) revealed that the employer bears responsibility for creating a supportive atmosphere for the employees in its organization by informing managers of its expectations and formally monitoring their efforts in this regard (Lemieux, Corbière, & Durand, 2011; St-Arnaud et al., 2011). The employer endeavours to provide managers with appropriate training and raise their awareness of issues concerning health at work, and to provide employees with conditions that foster their productivity and job satisfaction (NICE, 2009a, 2009b).

Again according to the literature on "best" practices, managers—because they work directly with absent employees—are responsible for adopting an empathetic attitude toward the latter, proposing work accommodation measures[6] adapted to their condition, reducing their performance expectations (Lemieux et al., 2011; Shaw, Robertson, Pransky, & McLellan, 2003), and enlisting the cooperation of co-workers at the time of the return (St-Arnaud et al., 2011). Moreover, in two recent Canadian studies (return to work and reintegration into the labour force), it was observed that the introduction of work accommodation measures to meet the needs of individuals with mental disorders was associated, first, with a significant reduction in their risk of still suffering from this mental disorder one year later (Bolo, Sareen, Patten, Schmitz, Currie, & Wang, 2013) and, second, with a significant increase in the length of their job retention (Corbière, Villotti, Lecomte, Bond, Lesage, & Goldner, 2014). It is worth noting that the most helpful work accommodations for this population involved the supports offered by direct supervisors and co-workers (Bolo et al., 2013; Corbière et al., 2014).

The role of an employee who has experienced a mental disorder, in terms of his participation in return-to-work planning, is not necessarily well defined in the specialized literature. This is probably due to his vulnerable position, a position characterized by both a self-esteem and a feeling of competence that are undermined by the illness, not to mention the fear of being stigmatized (de Vries, Koeter, Nabitz, Hees, & Schene, 2012). Such employees can, however, tell their work team, with the support of a health professional in charge of the return-to-work process (e.g. a return-to-work coordinator) which work tasks they are able to carry out and which not. These work tasks can later be reassessed, as needed, by the various stakeholders within the organization to ensure a gradual progression toward a full workload. Good communication between the direct supervisor, co-workers, health professional in charge of the return-to-work process, and the employee who experienced the depression is therefore essential (St-Arnaud & Pelletier, 2013). Unions may be situated at the crossover point between these various stakeholders and the employee who had the depression.

A number of authors (Baril, Clarke, Friesen, Stock, & Cole, 2003; MacEachen et al., 2006;

[6] The term "work accommodation measure" is used throughout this document to refer to measures taken by the employer (or other stakeholders in the organization) for the purpose of facilitating the return to work of persons who have experienced depression. These measures may be the consequence of the employer's legal obligation to accommodate, or consist of minor adjustments or natural supports that have nothing to do with the legal aspect of the term. Work accommodation measures should therefore be understood in the generic sense in the context of this report.

Pomaki et al., 2010) have reported that the relationship between an organization's management staff and the labour union is perceived as having a significant impact on the implementation of return-to-work measures. When these two groups of stakeholders share the same objectives regarding employees' health and interests during their return to work, there is greater harmony within the organization and a significant drop in conflicts. The union therefore plays an important role in the return-to-work process, yet few studies focus on this crucial stakeholder (Pomaki et al., 2010) compared to other stakeholders such as the employer (Glozier, 1998), managers (Nieuwenhuijsen et al. 2004), co-workers (Dunstan & MacEachen, 2013), or the employees living with major depression (de Vries et al., 2012). This study is based on the hypothesis that the union—as the employees' representative and because it is positioned at the crossover point between several return-to-work stakeholders in terms of its actions—plays a key role and has an informative, albeit little-known, viewpoint on the return-to-work process of individuals who have experienced depression.

The union's role in the return-to-work process of employees on sick leave primarily involves offering them support. This support may consist of providing information on the services available, the terms and conditions of the return to work, and the employee's rights and responsibilities, while respecting confidentiality throughout. The union may also serve as the intermediary between the employee and the organization's health department, negotiating possible work accommodation measures with the latter, accompanying the employee in the event of a dispute, and participating in the development of the return-to-work plan (Pomaki et al., 2010; St-Arnaud et al., 2011). In addition, the union has the role of protecting and representing the employee, which it fulfils by challenging practices that it considers unfair, handling complaints, and making political representations to senior management. It also takes part in developing and negotiating collective agreements and clauses intended to support the return to work by, for example, guaranteeing the right to a gradual return. Lastly, the union may play a role of prevention agent by highlighting risk factors, helping develop a prevention strategy, and promoting the role of the various parties involved (Baril et al., 2003; St-Arnaud et al., 2011). All these roles correspond to activities that a union may carry out on behalf of employees who are in the process of returning to work. However, the degree of involvement of each party can vary from one organization to another and from one union stakeholder to another (Baril et al., 2003).

Even when desired, this involvement on the part of the union and the stakeholders that make it up can also create impediments that vary from one organization to another. Those most frequently cited in the literature concern MSDs and the possibilities of conflict between the process of implementing work accommodation measures for the employee involved in a return-to-work process and the union's mandate, which consists of protecting the rights of all employees. For example, temporary work assignments and changes in jobs due to functional limitations can infringe certain clauses of the collective agreement that give priority to employees with the most seniority to obtain jobs involving less physically demanding work (Baril & Berthelette, 2000). The union therefore finds itself caught between the rights of some workers and the rights of others. Tension in labour relations represents another factor that can hinder joint efforts to develop an effective return-to-work plan (Franche, Baril, et al., 2005).

In summary, the union's involvement as a support agent, protector, representative, and prevention agent varies from one organization to the other and can be characterized by a number

of organizational tensions. What is abundantly clear from the literature is that establishing an atmosphere of trust, respect, and cooperation among the various stakeholders in the workplace is essential to the successful return to work of an employee on sick leave (Baril et al., 2003; MacEachen et al., 2006; Pomaki et al., 2010; Stock, Deguire, Baril, & Durand, 1999). To develop such an atmosphere, it is important to have a clear definition of the roles of each party involved (St-Arnaud et al., 2011). Pomaki et al. (2010) state that there is a lack of evidence-based data on the union's role in the return-to-work process, despite its importance in this process. There is also a lack of data, in work organizations, on return-to-work interventions aimed at employees with a mental disorder, particularly those who currently have or who have had depression. Most of the available knowledge concerns MSDs. This study seeks in part to fill these gaps while innovating with its specific focus on depression, the mental disorder with the highest prevalence in Québec and elsewhere.

2. AIM

The main aim of this research project was to better define the role of unions, and to describe, from their viewpoint, the factors influencing the return to work of individuals who have experienced depression.

3. METHOD

3.1 Design

A descriptive study was conducted in which 23 people who were connected with three union organizations[7] participated in one of three focus groups. A qualitative methodology was used to explore, examine in greater depth, and refine our understanding of union stakeholders' viewpoints on the factors influencing the return to work of individuals who have experienced depression.

3.2 Data collection

The focus group was chosen as the interview technique not only to gain access to the range of viewpoints among union stakeholders, but also to encourage reflection and interactions within the group that would enrich the exchanges. This technique also allows participants to explore and clarify their own opinions by means of the interactions generated (Kitzinger, 1995). The number of groups (three) was chosen for reasons of feasibility and of obtaining the viewpoint of at least three different and large union organizations. Group size was chosen in accordance with the size considered ideal for fostering exchanges, namely, from four to eight participants (Kitzinger, 1995).

The focus groups were held during the months of January and February 2012. An experienced facilitator oversaw the smooth running of the groups and was assisted by one research agent who took notes and a second who observed the focus group and had the option of intervening if necessary to clarify any points under discussion. The facilitation guidelines were set out in a Guide for Focus Groups (Appendix A) developed by the research team in light of the study objectives and the length of the discussions. The main points covered in the guide are as follows:

- the role of union stakeholders in the return-to-work process of employees who have experienced depression;

- the factors facilitating and hindering the return to work of a person who has experienced depression.

At the beginning of each focus group, participants were asked to reflect alone on the factors facilitating and hindering the return to work of individuals who have experienced depression, and to note down any ideas that came to mind. They were then asked to discuss their personal thoughts in the group. This procedure casts light on all the perceptions of the individuals in the group and eliminates the likelihood of anyone not being able to express his viewpoint (Kitzinger, 1994, 1995). However, the participants' personal notes were not collected. At the end of the session, the participants were asked to complete a short sociodemographic questionnaire.

[7]The term "union organization" is used here to refer to umbrella organizations grouping together several unions in a community of interest at the regional, provincial, or national level.

The three focus groups lasted a maximum of two hours each and were recorded to facilitate data analysis. The exercise was carried out in such a way as to encourage participants to express themselves freely and thus to identify the factors perceived by the union stakeholders as influencing the return to work of individuals who have suffered depression. We also broached another topic with these groups, that of union stakeholders' role in the return-to-work process, in order to gain a better grasp of all the activities they carry out in their union and with the employees they represent.

3.3 Participants

Two inclusion criteria for building the study sample were applied: participants had to have union experience involving individuals with a mental disorder, in particular, depression; and they had to have a certain number of years of experience (a minimum of two) in the union setting. Also, the composition of each group was designed to reflect a diverse spectrum of individual profiles according to their role in the union, the hierarchical level of the union position held, the organization's activity sector, and the workplace setting (urban, semi-urban, or rural).

After obtaining the approval of the human research ethics committee of the Centre hospitalier universitaire de Sherbrooke (CHUS, or Sherbrooke university hospital centre), recruitment began using the snowball sampling method. An invitation to participate in a focus group was first sent to several union stakeholders who were referred by members of the project's follow-up committee. The individuals who expressed an interest were then invited to refer members of their own network who met the inclusion criteria. This method led to the formation of three groups, each comprising seven or eight participants from the same union organization.

The sample retained reflected the desired profile diversity, as shown in Table 1. It included 12 men and 11 women mainly between the ages of 41 and 60 (70%) and usually working in large public organizations operating in a variety of activity sectors. The age of the participants, most of whom were midway through their careers, revealed the scope of their union experience, which averaged 15 years.

Table 1: Sociodemographic Data (n=23)

Sex	
Male	12
Female	11
Age	
21–40	5
41–60	16
61 or over	2
Activity sector	
Public	18
Education and daycare	*8*
Municipal and governmental	*4*
Health and social services	*5*
Other	*1*
Private	5
Service organizations	*4*
Other	*1*
Organization size	
5 to 99 employees	2
100 to 499 employees	3
500 employees or more	18

The study sample comprised equal numbers of union representatives and peer workers[8] distributed unevenly among the three groups. Union representatives are employees elected by their co-workers to represent them at the union level. They may or may not be released from some of their work tasks by their employer to perform their union duties, which consist primarily of managing issues related to the collective agreement and labour relations. Peer workers are employees who are members of a peer worker network, usually orchestrated by a union organization. During the 1980s and 1990s, union organizations developed this type of activity to encourage self-help initiatives and to grapple with problems of alcoholism, drug addiction, and mental health in the workplace. Peer workers receive training from their union organization to help them develop listening and referral skills. They act on a voluntary and ad hoc basis to support co-workers in need. Some of them are released from their regular tasks, in whole or in part, to perform these functions. Peer workers are not found in all organizations. It should also be noted that these are general definitions only, as the union structure varies from one union to the other. Moreover, four participants belonging to the same union organization did not fit either of these two definitions. They were classified in the "Other" category (see Table 2). They are workers who left their jobs within the organization to hold remunerated non-elected positions within the union in order to ensure a permanent presence. They are in charge of issues related to labour relations and occupational health and safety, in collaboration with the union representatives.

Thirteen of the 23 participants in the sample were released for their union duties or worked full-

[8]The term "peer worker" is used here to designate individuals working directly with employees. It was also chosen for the sake of consistency, as the term used for this stakeholder varies from one organization to the other (peer support person, social steward, etc.).

time for their union (56%), and the majority (78%) had already participated in a continuing education course or activities directly related to mental health. Examples include symposia arranged by the union organization, the Commission de la santé et de la sécurité du travail (CSST), or community groups; training sessions on the prevention of harassment or suicide; and peer worker training sessions, to name but a few. Table 2 provides an overview of the study participants' involvement in the union.

Table 2: Overview of Study Participants (n=23)

Role in the union	
Union representatives	9
Peer workers	10
Other	4
Number of years involved in the union	
1 to 5	4
6 to 10	6
11 to 15	4
16 to 20	3
21 or more	6
Number of hours per week involved in the union	
1 to 10	6
11 to 20	3
21 to 30	1
31 or more	13
Continuing education courses in mental health	
Yes	18
No	5

3.4 Analyses

The discussions were recorded, and anonymized verbatim transcripts were then produced for purposes of content analysis that would allow the data to be organized in a structured manner. First, three evaluators who had attended the focus groups developed a coding system based on a reading of the transcript of the first focus group discussion. Their presence at the discussions meant that they had all the necessary data in mind when it came to defining the codes. The evaluators' work was then compared and discussed until consensus was reached (Miles, 2003; Van der Maren, 1995). The codes that emerged were used to classify the content of all the transcripts in light of themes (the union's role) and factors (facilitating or hindering the return to work) (Bardin, 1993; L'Écuyer, 1987). Lastly, the themes were grouped according to the roles played by the union stakeholders in the return-to-work process. The factors regarded as facilitating or hindering the return to work, which had been divided up by the union stakeholders, were then retained. Lastly, for the sake of brevity, convergence analysis was carried out to identify any recurring factors, i.e. those that emerged outside the initial division according to types of stakeholders (that is, recurring inter-stakeholder factors). Two evaluators performed this analysis independently, then discussed and pooled their findings.

4. RESULTS

The results are presented in three parts: first, a description is provided of the spectrum of roles (13 in number) that union stakeholders are asked to fill with employees who have experienced depression. The factors regarded as facilitating or hindering the return to work are then presented by stakeholder group: employer and organization, co-workers, employee who has experienced depression, unions, physicians, and medical service providers. Only those factors raised in two or three focus groups are presented in the section on the study results, for a total of 46 factors. The Results section ends with a brief convergence analysis of the data, which serves to highlight the recurring inter-stakeholder factors. The latter factors are re-examined in the Discussion section.

Excerpts from the verbatim transcripts are used in the Results section by way of illustration to give the reader a clearer idea of a theme or factor retained, and to better reflect what the union stakeholders said by citing their own words. However, while the excerpts from the transcripts were compiled word for word, they have been presented in a way that facilitates reading. Also, some terms have been modified to protect the confidentiality of the participants or their union organization.

4.1 Role of unions

The collected data shed light on the role of unions with employees who have experienced depression. This role may begin at the onset of the first symptoms and continue during the employee's absence and return to work. Table 3 summarizes the main themes that emerged in defining the role of union stakeholders during each period in the trajectory of an employee who has experienced depression.

Union involvement is rarely systematic or even formal and therefore varies considerably, depending on the organizational contexts and the stakeholders themselves. It varies in particular according to the type of union stakeholder (union representative, peer worker) that makes up the union team, the type of relationship the employee has with the union and its active members, the availability of the union stakeholders, and the collaboration between the employer and the union operating in the organization. A union may thus be involved in one case, but not at all in another. This reality may be represented by a continuum of involvement of the union and its stakeholders ranging from total absence to major involvement. The following results present the union stakeholders' perception of the various roles they may fill regarding an employee who has experienced depression rather than a typical profile.

Table 3: Spectrum of Roles that Union Stakeholders May Fill Regarding the Employee Who Has Experienced Depression

Prior to the absence	During the absence	During the return to work
Detecting first symptoms	Maintaining contact	Participating in a preparatory meeting
Getting involved in medical steps	Providing emotional support	Negotiating and following up on work accommodation measures
Offering resources	Providing support during administrative steps	Taking action with regard to co-workers
	Offering resources	Reducing organization-related causes of the absence
	Communicating with the physician	Providing support

4.1.1 Prior to the absence

According to the participants, the union's involvement sometimes starts before the employee even goes on sick leave. The union stakeholder may detect the problem and intervene at the first signs of depression, before the employee has even consulted about his clinical symptoms. He takes the employee in charge sometimes without informing the employer for reasons of confidentiality, or sometimes at the request of the employer, a close friend or family member, or even a co-worker.

> *I'm going to talk about a case in which the wife of one of my co-workers called me and said, "I don't understand my husband anymore." He'd talked about committing suicide. I told her, "Bring him with you and come to see me." And then, one thing led to another, and the next day, he had an appointment with a doctor at the polyclinic. The doctors signed a paper giving him sick leave of indeterminate length, and then I got him an appointment with a psychologist on Saturday morning. (Peer worker, Group 2, Participant 12)*

Union stakeholders may also become involved in the medical steps surrounding the departure on sick leave. They may, for example, accompany the employee to see a health professional, tell the employee what points he needs to verify on the doctor's forms, or even speak directly with the physician.

Lastly, union stakeholders may provide referrals to psychological assistance services before or during the absence. Some have taken sentinel training on suicide prevention and thus feel better equipped to detect certain signs of distress experienced by employees whom they see every day.

For sure, the little training session that people had [in the peer helper network] was about offering support but also referrals. We work with the person to try to see if there is a resource that could help him, and if we think he might have suicidal thoughts, we have questions to ask him since we took the sentinel training in our organization. (Peer worker, Group 1, Participant 6)

4.1.2 During the absence

When union stakeholders become involved in the process prior to the work absence, they generally remain involved during the absence as well. However, the union stakeholders affirm that when the employee does not seek them out on his own initiative, the union is frequently unaware of the employee's departure on sick leave unless either someone notifies them, the organization's administrative structures involve them in absence management, or the employee is close to the union. When union stakeholders are aware of the employee's sick leave, they often maintain contact with him, offering emotional and administrative support. They may also collaborate with the various other stakeholders involved in the case as needed, always working in the employee's interest. However, this involvement usually remains informal and unsystematic. It depends on the union stakeholders' personal involvement in their role and their relationship with the employee.

During the work absence, contact is most often maintained at the employee's initiative with the encouragement of the union stakeholder. The employee calls to obtain administrative assistance or information, or because he has established a link with a member of the union team who has urged him to keep in touch. The union stakeholder may also take the initiative to make contact. When he does not know the employee well, he may use proactive strategies to maintain contact.

Since we manage the insurance, we can always use that excuse to call people in order to maintain the link during the absence: "How are things going? Are your papers in order so far? And your treatment?" And then there are people whom we'll call more naturally because they pass by the union office more often, so we have a little closer contact. (Union representative, Group 1, Participant 5)

In addition to maintaining a link with the workplace, this contact keeps the union informed of the employee's date of return and allows it to offer him support during his absence. This support is sometimes emotional and sometimes administrative. The employee often has questions about his salary or insurance, or worries about the return to work. The union stakeholder can listen to the person, provide the necessary information, and act as a representative or conciliator with the other stakeholders concerned.

Someone who's on disability wants to know what's going to happen to him. The simple fact of saying, "if it's too complicated [for you] with your doctor, give me permission and I'll contact him," helps demystify a lot of things because it takes the pressure off. It's the same thing regarding [contact with] the employer. We say, "Look, don't worry about it. I'll speak with your employer." (Union representative, Group 3, Participant 22)

Again, the support offered varies from one case to the other and from one union stakeholder to the other, since they do not all have the same ability to lend a listening ear and emotional support. That is one of the specific tasks of the peer worker.

As the preceding excerpt shows, union stakeholders may also communicate directly with the physician during the worker's absence. They may do so, for example, when the employee does not know what questions to ask or what information to give the physician.

4.1.3 During the return to work

According to the participants in the focus groups, when union stakeholders are involved in the return to work, it can be at different levels: participating in the preparatory meeting, negotiating and following up on work accommodation measures, taking action with regard to co-workers when necessary, reducing the organizational causes of the absence, and offering support.

During the preparatory meeting, which may be held immediately prior to the return to work, at the union's initiative or not, the union stakeholders' role is to support the employee. They help the employee plan what he wants to say to the employer's representative; they may also participate in negotiating work accommodation measures with the direct supervisor and the organization's health department, or simply reassure the employee by being present.

> *Before the preparatory meeting, we do preparation work to check with the person what his needs are. Then we go to the workplace, we contact the employer [to set up a meeting]. (Other, Group 3, Participant 22)*

> *The [preparatory] meeting is held with the [organization's] medical department and a peer worker from the [same] sector, because we know that the peer worker has been present before the person was in distress; he's there during and he's there afterwards. So for us it's important that he be at the meeting. (Peer worker, Group 2, Participant 14)*

Following this meeting, union stakeholders may also follow up on the work accommodation measures to make sure they are respected and still suitable for the employee, and to prevent the employee from being afraid to ask for the changes he needs.

> *We make sure the treatment plan is good, and often during the first few weeks of the gradual return to work, we ask the person to drop by the medical department at the end of his work day to talk a bit about how things have gone […]. Because if the supervisor gives him too much work and he is unable to say so, he might be able to tell us and then we call the supervisor up and say, "Look, you might be giving too much work… (Peer worker, Group 2, Participant 14)*

In addition, union stakeholders may take action with regard to co-workers, either at the employee's request or because co-workers' prejudices, judgments, or frustrations risk undermining the smooth progression of the return to work. They may, for example, organize or participate in a meeting that brings together the employer, the employee, and his co-workers, or

they may speak directly with the co-workers to make them aware of the employee's situation while preserving the confidentiality of the person's health issues (e.g. diagnosis).

> *We also try to raise the awareness of co-workers who work closely with the person without telling them exactly what's going on. We tell them to go a little easier than usual on the person because he's fragile. (Peer worker, Group 2, Participant 10)*

Union stakeholders may also take steps to reduce the organizational factors that may have contributed to the depression. For example, sometimes they inquire about the work climate, even going so far as to conduct an investigation when necessary. They try to identify what could have led to the depression and apply pressure to have these causes eliminated in order to prevent a risk of relapse.

> *In our union, there's a peer worker network, but there's also a harassment prevention committee. People come to see us about all kinds of things, such as a conflict over the fact that a task is poorly organized. We go to see [what's going on] in the workplace, and when we think the situation might be more serious, we investigate; we meet with people and ask them what we consider relevant questions. We try to base ourselves on facts. (Peer worker, Group 1, Participant 6)*

During the return to work, union stakeholders continue offering the employee their support, usually at his request, but this theme was only touched upon very superficially in the focus groups.

Lastly, a theme emerged that was related to the general role of unions, beyond their role in specific work-absence and return-to-work cases: that of raising employer awareness. Unions constantly try to make the employer aware of the advantages of taking preventive action, of modifying certain working conditions in order to reduce the number and length of absences, of offering resources to employees, of allowing a self-help atmosphere to be created in the workplace, and so forth.

> *What we can do, as a union organization, is bring the employer around to creating an open-minded atmosphere so that we can [help each other in the workplace]. (Peer worker, Group 1, Participant 1)*

4.2 Factors facilitating and hindering the return to work

The results obtained show that union stakeholders are front-row observers of the return to work within an organization by virtue of their roles of intermediary and conciliator between the various parties involved (employer, co-workers, physicians and medical service providers, and employees). This position affords them a unique viewpoint on the factors facilitating and hindering the return to work of individuals who have experienced depression. The next section presents an analysis of these factors, by stakeholder group.

4.2.1 Employer and organization

The factors associated with the employer and the organization are discussed in two sub-sections: first, factors pertaining to the workplace; and second, those pertaining to organizational and procedural aspects related to the absence and return to work of employees who have experienced depression (tables 4 and 5).

The workplace

First, an organizational culture of open-mindedness is seen as an important facilitating factor. The term *open-mindedness* here has three main dimensions. The first is the open-mindedness of the various organizational authorities about the idea of acting to promote employees' mental health and their return to work. This may be reflected, for example, in an employer's openness to training its personnel on problems related to mental health.

> *I think there are workplaces that might be more open-minded. Here [in our company], the boss even sent some senior executives to do the peer worker training course offered by the union organization. (Peer worker, Group 1, Participant 6)*

The second concerns flexibility, or an organization's capacity to adapt its practices to the needs of an employee who is in the process of returning to work. This may translate, for example, into reducing the work schedule of an employee who has experienced depression in order to prevent a relapse.

> *In some sectors, [the employer] will accept that you come back half a day or two half-days a week, then after that, three half-days, but in other sectors, [the employer] will say, "No, no, I don't accept half-days." Very often it's left to the employer's discretion. (Union representative, Group 1, Participant 2)*

Lastly, a culture of open-mindedness also means displaying a form of empathy, which refers to the fact of taking the human aspect of the illness into account. For example, this may take the form of implementing a supportive rather than confrontational dynamic. In fact, lack of empathy emerged as a factor hindering the return to work. The union stakeholders are referring here to organizations that are only interested in short-term productivity, which may be incompatible with the needs of an employee in the process of returning to work.

There are managers who don't seem to really take the illness into account. It's all very, very bureaucratic; it's "Ok, on such and such a date, you start." It's the human element that's not taken into account, that seems to be left out. (Peer worker, Group 3, Participant 18)

However, a culture of open-mindedness and empathy at the employer's also interacts with other aspects to determine the approach taken by the organization's representatives to employees who have experienced depression. In fact, one point that emerged from the focus groups was that good work performance was likely to elicit greater open-mindedness from the employer.

I would say that someone who has the [reputation] of being a good employee, that already helps a lot. If it's a good [employee], there's automatically more open-mindedness. But if it's been years that [the organization] has been wondering why it puts up with the person, that it's been wondering how to get rid of him and he's sick [all the time], then the situation isn't so good. (Union representative, Group 3, Participant 19)

In addition to organizational culture, work climate was mentioned by the members of the focus groups as an organizational factor hindering the return to work. According to the union stakeholders, a toxic work climate can take different forms: harassment, excessive competitiveness generated by performance management policies, or a demotivating atmosphere due to a department on the decline. This type of work climate acts on two levels: it creates an environment conducive to burnout and depression, and it fosters relapses. In fact, it emerged that when the work climate originally contributed to the depression, neglecting to change the problematic issues before the employee's return to work is seen as a major obstacle to the worker's successful reintegration.

What the [competition-based performance management] program does is [create] a lot of people who are in distress but who don't want to go on sick leave. Because they know they're going to have problems with their co-workers. So this leads to cases of "burn in." You work, but you're not really there. (Peer worker, Group 2, Participant 14)

According to the union stakeholders, prejudices about mental disorders also hinder the return to work. These prejudices are associated with a perception of weakness or incompetence, or the belief that someone who has suffered depression will inevitably relapse. Such prejudices are held by all stakeholders and are difficult to counteract.

It's dramatic when ignorance about depression leads to prejudices. And when they're not expressed openly, it's even worse. When they're expressed blatantly, we can always try to set things straight, but when they're insidious, when people think them but don't say anything, we can't rectify them. (Peer worker, Group 1, Participant 1)

Moreover, the existence of awareness in the workplace was considered a factor facilitating the return to work. It emerged that ideally, awareness raising efforts should be ongoing in an organization, with employer/employee involvement. According to the participants, these efforts should target both employer and co-workers, with different objectives for each group. There should be several awareness-raising objectives for the employer: helping it understand the link

between employees' mental health and the workplace (e.g. work climate), encouraging the employer's representatives to adopt an open-minded attitude toward employees who are returning to work, and convincing them that it is more beneficial to act early and to recognize behaviours symptomatic of the illness to promote early detection. The objectives of raising awareness among co-workers would be early detection through education about symptomatic behaviours, then reducing prejudices and stigmatization regarding individuals with a mental disorder such as depression.

To attain these objectives, three methods of raising awareness were envisaged by the participants. First, training and lectures should be offered to manager and employees. This method is already in use and works well for themes such as harassment in the workplace. Second, it was proposed that discussions on occupational health and safety should be held during team meetings. Some participants said this would be beneficial but difficult to implement because direct supervisors would be too concerned about team performance targets to allow time for prevention issues. Lastly, it was emphasized that awareness raising efforts made directly by co-workers can be particularly effective.

> *What I often see in my workplace is, for example, someone who at a team meeting will say, "I've heard rumours about a worker who was taking too many sick days, and I find that disrespectful. I'd like to see us stop doing that as a team." (Peer worker, Group 1, Participant 7)*

Apart from these few suggestions, participants were more or less unanimous about the need to raise employer and co-worker awareness, but also asked questions about the proper methods to use.

Lastly, cooperation between and joint efforts by the union and the employer were cited as a facilitating organizational factor. When these two stakeholders work together for the employee's well-being, all parties emerge as winners.

> *The company accepts that union representatives be peer workers, that they get involved with these people. They release us, with our time paid by the company, to take care of people. These people talk about their problems more readily, go on sick leave faster, and come back faster. (Peer worker, Group 2, Participant 13)*

Joint efforts can take different forms, and when initiated, affect various aspects of the return to work, including respecting the return-to-work conditions stipulated by the physician, and introducing and following up on work accommodation measures.

> *[The employer] calls us and says, "Listen, we've got someone who's been on sick leave and she's coming back to work. Do you think you could give her a call? Maybe we can sit down together." Now that's really a perfect match; we all sit down with the person, we stick to the doctor's return-to-work plan; we try to look at the tasks that need to be reduced, teaching him new techniques or skills to bring him up-to-date if necessary; pairing [the person] with a co-worker; the employees are also prepared, we meet with the group. (Union representative, Group 2, Participant 11)*

While this type of cooperation is regarded as a powerful facilitating factor in the employee's return to work, it is always seen as somewhat rare, as indicated in this continuation of the preceding excerpt:

But that's an ideal situation that doesn't happen very often. There are other places where, as everyone says, the employer wants nothing to do with it. (Union representative, Group 2, Participant 11)

Table 4 summarizes the various workplace-related factors regarded as facilitating or hindering the return to work.

Table 4: Factors Related to the Workplace

Facilitating factors
– Organizational culture: Open-mindedness, flexibility, and empathy
– Workplace awareness of the "mental health in the workplace" issue
– Joint efforts by employer and union
Hindering factors
– Lack of empathy
– Poor work climate
– Prejudices

Organizational and procedural aspects related to absences and the return to work

The holding of a preparatory meeting a few days or even hours before the return-to-work date was identified in the focus groups as facilitating the return. This practice involves different stakeholders in the workplace, such as the health department or human resources department, the union, and the employee and his direct supervisor. Its purpose is to allow the employee to express his fears, find solutions, and discuss possible work accommodation measures to be put in place, among other things. However, the meeting must preserve confidentiality regarding the worker concerned.

> *We hold the meeting before [the person] returns to work, to find out a bit about his worries. The meeting is held with the [organization's] medical department and a peer worker […]. Then the supervisor joins us because we keep the medical part confidential. He [the supervisor] can tell us whether it's possible to accommodate [the worker] or not. When we finish our meeting, there's a consensus between the medical department, employee, supervisor, and the EAP [Employee Assistance Program]. (Peer worker, Group 2, Participant 14)*

While the members of the focus groups regard these meetings as very effective, they do not see them taking place systematically. Generally speaking, such meetings are held when the employee requests one. The gradual return is also regarded as facilitating the return because it allows tasks to be resumed incrementally.

> *For someone who's been absent for quite a while, in my opinion, it's hard to return full-time. We know that, for starters, it's very demanding physically. So [a facilitating factor] would to establish a plan for a gradual return-to-work with the doctor. (Union representative, Group 2, Participant 11)*

It was mentioned that the longer the absence has been, the longer the gradual return should be. Sometimes the terms and conditions are pre-defined in the collective agreement, although management may have the final say in light of the organization's needs or the availability of a replacement. Here is an example of conditions that were pre-defined in a collective agreement:

> *I come back two days [a week] and the person replacing me does three days; I come back three days and the other person does two days; I come back four days and the other person does one day. Then I come back five days and the other person is gone. (Other, Group 3, Participant 16)*

Sometimes a gradual return to work is granted but is not compliant with the conditions prescribed by the physician. Lastly, depending on the job, the gradual return can pose additional challenges in terms of work organization, given that the job has to be shared by two different people who are not present at the same time to coordinate everything.

The reception the worker receives upon returning to work was also cited as a determining factor. A warm reception makes the worker feel welcome, that people are waiting for him. One employee's experience was recounted as follows by a union stakeholder:

> *When I came back, my [boss] was on the second floor on the balcony. When she saw me, she said, "Hi, X. I'm happy to see you. We'll catch each other later." Just like that! She recognized me, saw me, and greeted me. That made my day. (Other, Group 3, Participant 23)*

A sensitive reception can be very simple and subtle, yet have a very positive impact. One participant in the focus group recounted his own experience:

> *I was off work for depression, and when I came back, they had cleaned off my desk. I knew that a pile of work was waiting for me, but it wasn't on my desk. Maybe it's silly to*

say. But then gradually, they would ask me, "Do you feel like doing this today?" They made two or three little piles for me, and off I'd go with my little pile. That was less depressing. (Peer worker, Group 2, Participant 13)

Due to confidentiality clauses, if the employer does not take charge of the employee's reception, it can happen that a worker returns to his job on a particular day and no one even knows about it.

There are people who come back to work with no one there to greet them. They simply return to the office on Monday morning at 8:30 a.m. Sometimes co-workers are indifferent, sometimes they're angry, and sometimes the boss isn't even there… (Union representative, Group 2, Participant 11)

Feeling that your co-workers don't even know you're coming back is really irritating. You really want people to know that you're back. (Other, Group 2, Participant 13)

According to the focus group participants, a warm reception requires proper preparation. In fact, lack of preparation for the return emerged, as did lack of any reception at all, as a factor hindering the return to work. The employer should, among other things, prepare and inform the work team of the terms and conditions of the return to work, and ensure that the factors having contributed to the illness have been modified to prevent relapses. Here again, this practice can be both a hindering and facilitating factor because it has a mirror effect.

In fact, members of the three focus groups mentioned the importance of evaluating and treating the organizational causes (if any) of the employee's depression. If this is not done, chances of relapse are higher.

If the person returns to the same work environment, well, nothing will have been resolved. The person may have been treated, but if the work environment hasn't been treated, he'll be returning to the same environment that made him sick. (Peer worker, Group 1, Participant 6)

In their view, it is therefore imperative that the causes of the depression be evaluated before the worker's return and that the necessary actions be taken to eliminate the toxic aspects of the work environment or job. When this is done, it facilitates the return; when not done, it hinders the return.

In addition to investigating and modifying the organizational causes of the depression, performance expectations should be revised. The participants recognize the employer's right to require a certain performance level, but point out that it is wrong to pretend, as some collective agreements do, that a returning worker is capable of performing his job fully as of the very first day. Performance expectations that do not reflect this reality hinder a smooth return to work by creating anxiety and worries for the employee, whereas adjusted expectations facilitate the return.

The person may have to catch up on certain information that he missed during his absence. Also, the employer's expectations should not be too high, because we know that

if the person is returning on a gradual basis, he won't be able to do as much as he used to do before his depression. (Union representative, Group 2, Participant 11)

Non-adherence to the work accommodation measures recommended by the physician is also seen as hindering the return to work. The process of implementing these measures can be disruptive for the workplace, be it the employer, co-workers, or even the person who has experienced depression. In other words, these measures require everyone to adapt to the returning employee.

Sometimes the doctors set temporary limitations. They're not always very well received by the employer and they're not always applied either. As soon as there's a functional limitation, right away the employee isn't welcome, [the employer] isn't happy, it's a problem for him, he has to entirely rethink how he organizes his personnel. It's complicated. (Union representative, Group 2, Participant 11)

Yet this adaptation to the needs of the employee who comes back and is still fragile was specifically identified by some union stakeholders as being beneficial for the return to work. The fact of following up on these measures and on the person after his return is seen as a facilitating factor. Follow-up provides the opportunity to check that everything is going well, identify any problems, and take any necessary corrective action. It can focus on the application of the work accommodation measures or the worker's subjective experience. Sometimes it is done formally according to a follow-up plan, and sometimes informally. Lack of follow-up is regarded as promoting relapses.

Assisting him [the person] when he returns, but also afterward, in the following months, to make sure things are going well, to make sure the workplace is open-minded enough so that, if anything needs to be changed in the months after the return, it will make the necessary changes. (Peer worker, Group 1, Participant7)

Actually, it is recommended that follow-up begin during the absence. In other words, maintenance of contact between the organization and the employee on sick leave is seen as facilitating the return to work. This contact may be with a representative of the employer, or a co-worker, a peer worker, or some other person deemed appropriate by the organization.

Regular contact. Regular doesn't mean often, but rather contact from time to time during the absence to maintain a relationship with the workplace, to keep this relationship alive, particularly if the person is gone for a long time. (Peer worker, Group 1, Participant 6)

Maintaining contact is important, but so too is the nature of this contact, as emphasized in the following excerpt.

I've often had comments from people who've said, "When I called the personnel office to take them my sick leave certificate, they told me to take care of myself and all that stuff." This becomes a determining factor in the perception formed by the person, who says to himself, "I'm still welcome back, there's still a place for me there." (Union representative, Group 1, Participant 2)

Lastly, the possibility of adjusting the work schedule emerged as a factor facilitating the return, while contestation of the diagnosis by the organization's health department emerged as a factor hindering the return. However, the discussion of these points was too superficial to elaborate on them here.

Table 5 summarizes the various organizational and procedural aspects regarded as either facilitating or hindering the return to work.

Table 5: Factors Related to Organizational and Procedural Aspects

Facilitating factors
– Preparatory meeting – Gradual return – Reception – Taking action to address the causes of the absence – Lowering performance expectations – Doing follow-up – Maintaining contact – Adjusting the work schedule
Hindering factors
– Absence of reception efforts and of preparation for the return – Maintenance of the causes of the absence – High performance expectations during the return – Non-adherence to the work accommodation measures – Lack of follow-up – Contestation of the diagnosis

4.2.2 Co-workers

The co-workers of an employee who has experienced depression are seen by union stakeholders as sources of factors that potentially both hinder and facilitate a successful return to work (Table 6). Co-worker support and solidarity emerged as facilitating the return. The mere fact of finding oneself again with co-worker after a more or less lengthy absence can be helpful, and all the more so when co-workers are willing to lend support. Support can take the form, for example, of occasionally offering spontaneous assistance with tasks when the employee needs it. However, it was also pointed out that while this support can play a determining role, workplaces are largely unaware of this fact, which places the burden of supporting the returning employee on the employer. Nor do all co-workers have the same ability to offer such support. It was also mentioned that co-workers who are likely to be supportive are more easily found in certain types of professions, such as those that involve helping relationships.

Support may also be offered before the employee's absence by the early detection of symptoms, which leads a co-worker to inform the union of the situation and thus allows the latter to take prompt action. This type of co-worker intervention received mixed reactions from the union stakeholders, some of whom saw it as a gesture of solidarity while others regarded it as whistle-blowing. However, after discussion among the participants, everyone agreed on the solidarity aspect of this type of action. Lastly, co-worker support and solidarity tend to increase following a dramatic event.

> *That's when people open up. At our company, we had someone who committed suicide, and that's when people opened up. "You know, I also went through a depression." (Peer worker, Group 2, Participant 9)*

On the other hand, co-workers can be awkward in the way they greet an employee who has experienced depression, which risks hindering the return. Some are uncomfortable about depression and do not know how to interact with the person. This discomfort is exacerbated by the taboo surrounding confidentiality, or contrarily when the employee says too much and overjustifies himself. Judging by what was said by the focus group participants, it is hard to find the right balance.

> *If the person doesn't talk about it, there's discomfort. Then there's the person who overjustifies his illness, who keeps on justifying himself, giving endless reasons. (Union representative, Group 1, Participant 3)*

Another obstacle to the return to work that plays out in the relationship with co-workers is the curiosity shown by some of them. Their questions can disturb the worker. One peer worker gave examples of questions asked by co-workers:

> *"Where'd you go? What happened to you?" (Peer worker, Group 2, Participant 9)*

This curiosity is regarded as voyeurism by some union stakeholders, as can be seen in the following exchange:

- *It's a problem for us not knowing what the other person has.*
- *That's voyeurism.*
- *Yes, we're voyeurs, and we're curious to know, but essentially, it's none of our business. (Union representatives, Group 1, Participants 2 and 3)*

Prejudices about mental illnesses in general and depression in particular can also make the return more difficult. Confronted with his co-workers' preconceived ideas, the employee may become the object of mockery.

> *Co-workers make fun of him: "So you had a good vacation, did you! What were you up to, how long were you away?" (Peer worker, Group 1, Participant 8)*

Prejudices and discomfort regarding depression are exacerbated by the fact that co-workers often have to take on the employee's work tasks before his departure, during his absence, or upon his

return to work. This is especially true when the worker suffering from depression has not been replaced during his absence to prevent a potential backlog of tasks. In this case, co-workers often have to handle a work overload that they tend to blame on the absent worker rather than on poor management of the absence, as suggested by some of the union stakeholders. One union representative paraphrased an employee's co-worker as saying:

> *"Look, she's been at home resting for 13 months. 'Now listen here. We've done your job while you were away.' That's how they speak to some people. (Union representative, Group 2, Participant 11)*

Moreover, negative repercussions on co-workers' workloads can arise from implementation of work accommodation measures. One union representative paraphrased a co-worker in the following words:

> *Does it have an impact on "my" workload? Is it going to increase my workload? Hey, I'm ready to listen to him until tomorrow morning, as long as it doesn't increase my workload. If he comes back and I have to do [one of his tasks] because he's not able to… (Union representative, Group 3, Participant 17)*

A worker back at work after depression may also have displayed some unpleasant or inappropriate behaviours (e.g. fits of anger) around his co-workers before going on sick leave. In these cases, co-workers are often less indulgent with the worker when he returns.

> *That person was having a depressive episode and she would do things that just weren't right. She'd call people at 2 o'clock in the morning; she'd go knocking on their doors. When it was time for her to come back to work, the employer was really open about it, but her co-workers were really closed because they were afraid the same things would happen again. (Other, Group 3, Participant 16)*

The union stakeholders mentioned that one way to reduce the hindering factors caused by co-workers' frustrations, prejudices, or discomfort would be to prepare the team for the employee's return. It is important to make co-workers aware of the person's situation and to clearly explain the terms and conditions of the return and the work accommodation measures that have been put in place. Yet this does not always happen. Sometimes the employee rejoins a team that has not even been informed of the date of his return. When the necessary preparation is not done by the employer or direct supervisor, sometimes it is done by a union stakeholder.

> *This means raising awareness among the employees who work closely with the person without telling them what's going on, but telling them to go a little easier than usual on the person because he's fragile. (Peer worker, Group 2, Participant 10)*

However, sometimes, the repercussions in the workplace are too big and the worker who has suffered the depression earns a bad reputation.

> *Often when people have a mental health problem, it's accompanied by problems in the workplace as well. Sometimes it creates work overloads for co-workers; people complain*

about it, and over the years, this gives the person a bad reputation. And then even if the person changes departments, the new team is already waiting to pounce on him. (Union representative, Group 1, Participant 3)

Table 6: Factors Related to Co-Workers

Facilitating factors
- Support and solidarity
- Preparation of co-workers
Hindering factors
- Discomfort regarding depression
- Voyeurism
- Prejudices
- Work overload for co-workers
- Tarnished reputation

4.2.3 Employee who has experienced depression

No facilitating factors were identified for an employee who has experienced depression, only hindering factors (Table 7). The first factor pertained to disclosure of the diagnosis and of information about the absence. Disclosure is a thorny issue for the worker since, as mentioned earlier, too much or too little disclosure can easily create discomfort within the team. Too much disclosure on the part of the worker may hinder the return by creating discomfort among his co-workers, who are not always ready to hear such personal information. The fact of revealing private information publicly can also hinder the employee's return by conveying a misleading image that only increases his co-workers' and direct supervisor's prejudices.

I had one case where I was pretty sure the worker had left because of major depression. Then he dared to write on Facebook that he was going to Vegas, and later that he was going to Disney World with his kids… You just don't do that. Because then, if you tell your co-workers, "I went through a really bad depression," they're going to say, "Yeah, but on such and such a date, you went to Disney World with your kids. (Peer worker, Group 2, Participant 9)

According to the union stakeholders, the emotions experienced by employees returning to work after depression can also pose an obstacle. Denial, shame, and fear emerged as potentially hindering the return to work. Denial refers to the employee's resistance, either conscious or unconscious, to acknowledging that he has a mental disorder. It poses an obstacle because it prevents prompt action from being taken to manage the problem.

We have a lot of people who clearly have depressive symptoms but refuse to acknowledge it, or who know it but tell others they don't have them. (Union representative, Group 1, Participant 5)

There was one person who went to see her doctor because she was feeling tired. She talked to him and he said to her, "Ms. X, you're suffering from major depression. She started crying as if all the stops had been pulled at once because she'd never thought of that, but the fact that the doctor gave it a name turned on all the taps. (Peer worker, Group 1, Participant 1)

Shame is another element that enters into the relationship with co-workers. It is actually mentioned by one union representative in the next excerpt.

I think there's a prejudice against weakness. You know, the idea that "they weren't mentally strong enough to get through something in their life"; these people are afraid they'll be seen as weak. (Union representative, Group 1, Participant 5)

Fear is also present and accompanies the sense of shame. Here we are referring to the fear of no longer being able to perform one's work, of being judged, and of the well-foundedness of the absence being questioned. This can make relations with co-workers difficult, as the following excerpt illustrates:

Personally, I had known some co-workers for years, but when they'd pass by me in the hallway, they would hug the wall. They were really uncomfortable. You could say that a distance had been created between us, as if they were afraid of again being unable to work with or meet people or to function in the workplace. (Peer worker, Group 3, Participant 18)

It was pointed out that the conditions under which the employee left also influence how he feels when he comes back. If the depression caused unusual behaviours or performance problems, the employee may feel more uncomfortable and anxious about reintegrating into his workplace.

We know that the person had symptoms before leaving. He might have made mistakes. You know, there's a discomfort there before the departure, and then the person stays stuck there, holding onto that anxiety, throughout his sick leave, and he lives with that feeling. (Union representative, Group 3, Participant 22)

Lastly, the question of performance expectations placed on the employee was touched upon, without going into depth. It emerged that, just as the employer can have overly high expectations during the person's return to work, so too can the employee have expectations of himself that do not take his fragility into account. This self-imposed pressure can also hinder the return to work.

Table 7: Factors Related to the Employee Who Has Experienced Depression

Hindering factors
- Disclosure
- Denial
- Shame
- Fear
- Poor conditions at time of departure
- Performance expectations

4.2.4 Unions

Showing a capacity for self-reflection, the union stakeholders also identified facilitating and hindering factors concerning their own group (Table 8). First, the peer workers stressed that the presence of a peer worker network is useful in the return to work of employees who have experienced depression. These peer workers are in a better position to spot employees who are not doing well, to encourage them to consult someone, and to gradually build a relationship of trust with employees in need. This relationship of trust can be ongoing throughout the employee's recovery and return to work, and when he is actually maintaining his employment. Unlike the union representatives, who only rarely have time to offer such support, the peer workers say they are more available since that is their main mandate.

> *It's easier for a network of peer workers, when there is one, because they don't have all the other responsibilities to handle as well. Peer workers don't negotiate with the employer or with the department head; that's done at another level, but often their task is to offer the person support. (Peer worker, Group 1, Participant 1)*

They added that employees feel comfortable with the peer worker network since they know these workers are obliged to respect confidentiality. In addition, as these positions are voluntary and performed by volunteers, and as listening and support is their main mandate, they are generally held by people interested in supporting their co-workers. However, even when there is such a network, the peer workers are not able to follow all cases. The confidentiality of employees' medical files results in union stakeholders often being kept out of the loop about disability cases, with the result that they are not informed of employees' absences or returns. Moreover, unions lack resources for managing all the employees who need it. With mental health problems on the rise, they require more staff to be able to meet the needs for assistance and support of all the employees coping with depression.

> *If we had to help everyone who was on sick leave in our workplaces, currently, because of depression, we simply wouldn't be able to do it. There'd have to be at least 40 of us just for that. (Other, Group 3, Participant 23)*

Also, union representatives generally lack the knowledge and skills needed to help these employees in difficulty. Unlike peer workers, union representatives are not trained in active listening or in giving referrals. And neither union representatives nor peer workers receive training as mental health professionals. Indeed, one participant raised the question as to whether it was in fact the union's role to provide support to these employees.

> *She started to cry, cry, cry on the phone, and I said to myself, "Oh my God. I'm not a psychotherapist, I'm not anybody […] And unfortunately, sometimes we don't succeed; we don't succeed no matter what we try to do; we don't have all the means we need to help people. (Union representative, Group 4, Participant 4)*

In fact, in some workplaces, interventions involving individuals with a mental disorder now account for the majority of the work done by union stakeholders, including union representatives.

> *I'd be inclined to say that 70% of union interventions concern mental health problems [rather] than matters involving the collective agreement and grievances. (Peer worker, Group 2, Participant 13)*

The return to work is further hindered, according to some union stakeholders, by certain clauses in collective agreements. First, there is often a double standard regarding the rights of workers who are on sick leave for disability, depending on their status. One union representative talked about employees who have temporary status, sometimes after as many as 20 years of service:

> *As soon as [temporary employees] are absent and it's been more than 12 months that they've been on sick leave, even if they're still sick, they lose their jobs. We're still trying to obtain parity in this regard, but we're always stonewalled. (Union representative, Group 2, Participant 11)*

Collective agreements too can pose an obstacle because of the rigidity of the framework they define:

> *Disability is still seen as total, when in fact sometimes it can be partial, but we have no access to that [status] because it wasn't provided for in our employment contracts. (Union representative, Group 1, Participant 2)*

Two other hindering factors were raised, although the participants in the focus groups did not have the opportunity to discuss them in depth. First, the union stakeholders cited their powerlessness to act and to influence the employer, a powerlessness that sometimes prevents them from intervening as they would like to regarding the problems they are witnessing. Also, often the union stakeholders do no follow-up in the weeks following the return to work, or the follow-up is neither systematic nor formal. Lastly, the assistance and coaching offered by certain union stakeholders were identified as factors facilitating the return to work of employees who have experienced depression. The example of one union stakeholder's intervention with the attending physician was mentioned, an intervention in which the union may refer the physician, for example, to the employee's workplace.

Table 8: Factors Related to Unions

Facilitating factors
- Presence of a peer worker network - Confidentiality respected - Assistance and coaching
Hindering factors
- Confidentiality disregarded - Lack of resources (staff, training) - Restrictions built into the collective agreement - Powerlessness to act - Lack of follow-up

4.2.5 Physicians and medical services[9]

Appropriate medical follow-up was mentioned as a factor facilitating the return to work. An employee who has received treatment and benefitted from rest during his sick leave will have greater chances of maintaining his employment upon his return. However, according to some union stakeholders, employees sometimes go on sick leave for depression but do not receive any medical or psychological treatment. The lack of specialized mental health consultations (as opposed to general medicine consultations) also emerged as a factor hindering the return to work.

> *Often people are diagnosed as suffering from depression, but then there is no treatment, no medical follow-up; they simply go on sick leave for a month or two. Then they come back to work under the same working conditions and leave again two weeks later. We have employees who've been working on and off for ten years because they've never really been treated. (Union representative, Group 1, Participant 5)*

In fact, psychiatric services, like general medicine services, were mentioned as being difficult to access for the purpose of obtaining a diagnosis and having insurance forms filled out, and for obtaining adequate treatment during the sick leave. Once the employee is back at work, follow-up with the organization's health department may also be helpful.

> *Often during the first few weeks of the gradual return to work, we ask the person to drop by the organization's health department at the end of his workday to talk a little about how it was, about how things went. (Peer worker, Group 2, Participant 14)*

Collaboration between physician and employer was also identified as a factor facilitating the return.

> *A doctor who's willing to collaborate means one who works in accordance with the*

[9] The term "medical services" is used here to refer to public health services and services offered by the health departments in organizations.

employer's practices. He's ready to follow the person a little more closely. This is difficult now because there are fewer family physicians. (Other, Group 3, Participant 23)

Employer collaboration may be manifested, for example, by its acceptance of the gradual return to work prescribed by the physician. Lastly, some union stakeholders questioned the accuracy of depression diagnoses issued by general practitioners. These possible misdiagnoses would appear to lead to improper responses to the problem.

Table 9 summarizes the various factors related to physicians and medical services that are regarded as facilitating or hindering the return to work.

Table 9: Factors Related to Physicians and Medical Services

Facilitating factors
- Medical follow-up
- Physician/employer collaboration
Hindering factors
- Consultations with medical practitioners not specialized in mental health
- Lack of availability of medical services
- Inaccurate diagnosis

4.3 Analysis of recurring inter-stakeholder factors

Four recurring factors emerged from the inter-stakeholder convergence analysis. The first is an organizational culture that places importance on mental health and the human aspect of work. This recurring factor includes facilitating factors that reveal how such a culture may be manifested, but also, hindering factors, which mirror symptoms of the absence of such a culture. The concept of organizational culture is used in this report to refer to a propensity to place importance on mental health and the human aspect. From the unions' viewpoint, it means that various stakeholders within the organization place emphasis on these two elements. The importance placed on mental health is manifested, for example, in efforts to raise staff awareness of the various problems related to mental health in the workplace, or in the presence of a peer worker network in the organization. The notion of importance placed on the human aspect of work is reflected in attitudes and actions that take the human aspects of the return to work into account, notably in labour relations. It can be seen, for example, in the attention paid to preparing co-workers for the employee's return to work, or in the temporary adjustment of performance expectations.

A second recurring factor that emerged from the inter-stakeholder convergence analysis was support and follow-up during the absence and return to work. This refers to a supportive presence or assistance and to follow-up that the employee may be offered by the employer, union, co-workers, or physician. More specifically, support and follow-up may take the form of maintaining contact with the worker during his absence, holding a preparatory meeting at the time of his return, or modifying the organizational causes of the depression, if any. According to the union stakeholders, when support and follow-up are present, they constitute factors facilitating the return to work of employees who have experienced depression.

A third recurring factor is the lack of resources, which, according to the union stakeholders, affect the union, co-workers, and health services. The union stakeholders mentioned a lack of both staff and training to support all the workers suffering from depression, particularly in a context where mental disorders are on the rise in the workplace. The work overload borne by co-workers is also a source of tension during the return to work, as, for example, when work accommodation measures such as a gradual return to work are implemented. Moreover, health services are not sufficiently available, with employees having difficulty, for example, accessing a psychiatrist within a reasonable timeframe. The union stakeholders regard this lack of resources as a factor hindering the return to work of individuals who have experienced depression.

The last recurring factor that emerged involved discomfort and prejudices regarding depression. These may be present both in the person himself and in co-workers, the union, the employer, and the organization. Such discomfort and prejudices hinder the return to work by creating an additional source of stress for the worker, and simultaneously by affecting the support offered to him. These elements may also put the worker in a position where he feels obliged to disclose confidential information such as his diagnosis.

5. DISCUSSION

The aim of this study was to better define the role of unions, and to describe, from their viewpoint, the factors influencing the return to work of individuals who have experienced depression. Three focus groups composed of union representatives and peer workers were held to discuss three main questions: In your role as a union stakeholder, what have you done within the return-to-work process of employees who have experienced depression? In your view, what helps these individuals return to work? What hinders their return to work or makes it more difficult? Analysis of the discussions led to identification of facilitating and hindering factors that the participants associated with groups of stakeholders involved in the return-to-work process (e.g. co-workers). The results of this study shed light not only on the involvement of union stakeholders in the return-to-work process of employees who have experienced depression, but also on their often poorly defined or unsystematic role in this process.

What emerges from this study is that union stakeholders' involvement varies considerably, depending on their status within the union team, the worker's relationship with the union and its active members, the collaboration existing between the employer and the union within the organization, and the union resources available. Little consistency exists in the involvement of unions and their representatives with employees who have experienced depression. Nonetheless, by virtue of their front-row positions in the organization, the focus group participants were able to share their viewpoints on the factors facilitating and hindering the return to work of employees coping with depression, taking into account the various stakeholders in the organization. Their work is also carried out in interaction with various stakeholders, many of whom, according to the participants, have an impact on the return to work of employees who have experienced depression, including, in particular, the employer and the organization, co-workers, the worker who himself experienced the depression, the physician, and medical service providers. Analysis of the recurring inter-stakeholder factors brought to light two facilitating and two hindering factors over and above the initial division established by type of stakeholder. These are, respectively, an organizational culture that places importance on mental health and the human aspect of work, support and follow-up throughout the process, the lack of resources faced by various stakeholders, and discomfort and prejudices regarding depression. The following paragraphs identify and discuss certain aspects of the role of unions and then the recurring inter-stakeholder factors.

5.1 Role of unions with employees who have experienced depression

The results of this study revealed certain aspects of the interconnection, in a Québec context, of the various levels of union involvement in the return-to-work process of employees who have experienced depression, although this involvement may remain ambiguous depending on the organizational context and the union stakeholder's status. In this sense, the analysis of the discussions brought to light the fact that union involvement may begin at the time of the initial symptoms manifested by the worker with the depression and last until it is certain he will retain his employment, or there may be no involvement at all. These variations do not depend on specific or systematic rules, but instead reveal a haziness regarding the role of union stakeholders

in the return-to-work process. These stakeholders sometimes feel the need to respond to employees' distress and become personally involved to support them, using the resources available to them. This support (self-help role) speaks to their union values, but is not guided by any clear rule or policy. Pomaki et al. (2010) stress that since policies on the return to work of individuals with mental disorders are being developed, the role of unions in this process also needs to be defined, particularly as they are recognized as key stakeholders in this type of problem. Moreover, assuming that the best return-to-work practices to date are considered to be systematic, structured, planned, and well-coordinated by the various stakeholders (Durand et al., 2014; Pomaki et al., 2010), the vagueness surrounding the role and involvement of unions poses a problem. Their responsibilities in the process must therefore be discussed and clarified.

Their poorly defined involvement appears to be attributable, first, to the fact that unions, depending on the organizations in which they work, may or may not be informed of employee departures on sick leave and returns to work. This situation makes their involvement with all the employees concerned more complicated. In fact, the results show that, for the people met within this study, unions are usually informed of a worker's return via informal channels. For example, when the case involves an employee who is known to the union or because the union keeps itself informed, union stakeholders are generally aware of his absence. Also, many employees contact the union themselves during their absence or when they return to work in order to obtain information or support. The union may also be informed of the situation because a peer worker has detected the employee's distress, or because a co-worker or close relative of the employee has called the union to seek assistance on his behalf. In summary, the inconsistent information available to the union about the absences and returns to work of their members appears to be a key factor in the vagueness surrounding the union's role in the return to work.

While union involvement can vary depending on access to information among other things, according to our study participants it is also influenced by the composition of the union team (union representative or peer worker), their availability, and the relationship between the worker experiencing depression and the union. The question of the union stakeholder's availability raises that of the resources available to unions to deal with a growing number of employees having experienced depression. In fact, according to the participants, current staff numbers are insufficient to ensure systematic involvement with all employees who have suffered depression or who are presenting with depressive symptoms, the early signs of the illness. In addition, not all union stakeholders are trained in the basic skills required for intervening with a worker who has experienced depression or for referring the person to a mental health professional if necessary. Thus, if return-to-work policies define a specific and systematic role for union stakeholders, they should also re-examine the number of staff and their training to ensure that they are equipped to fulfill their new responsibilities.

Defining a specific role for unions in the return-to-work process also raises the question of the structure of unions in Québec. The results suggest considerable variation in structures from one union and one organization to the other (presence or not of a peer worker network, proximity between the peer worker network and the union executive, presence or not of full-time occupational health and safety counsellors, activity sector, etc.). Given this variation, the task of defining a specific and consistent role for unions in the return-to-work process remains difficult.

Based on the findings of this report, future research could seek to define, by means of a participatory process directly involving union stakeholders (union representatives, peer workers),

the role they should be given in return-to-work policies and practices for individuals with mental disorders such as depression. In addition, it is essential that this process be carried out in collaboration with the other stakeholders involved in the return to work, given that shared objectives lie at the heart of a successful return to work (Durand et al., 2014).

5.2 Factors facilitating and hindering the return to work

Union stakeholders involved in the return-to-work process are also optimally positioned observers. The results of this study highlighted the factors, which, from their viewpoint, facilitate or hinder the return to work of employees who have experienced depression. These factors were then grouped according to stakeholder groups in the organization. Of all the factors, four were identified as recurring across the groups (recurring inter-stakeholder factors). Three of these will be discussed here: organizational culture, support and follow-up, and prejudices and discomfort regarding depression in the workplace. The fourth recurring factor, the lack of resources, will not be discussed in this section as it was covered in the previous section.

Organizational culture

The union stakeholders appear to regard both an organizational culture that is open-minded about and supportive of employees and an employer demonstrating empathy and interest regarding mental health issues, as factors facilitating the return to work of employees who have experienced depression. Employers and managers working in this type of environment are more aware of mental health problems and the human aspects of work, which in turn enhances collaboration among all the stakeholders and more flexible procedures during the return to work of the individuals concerned. Indeed, some consensus was reached around the idea that an organization whose main representatives demonstrate open-mindedness, flexibility, and empathy was a guarantee of productive collaboration and a successful return to work.

The importance of the organizational culture is reiterated in the literature on the best return-to-work practices for MSDs and mental disorders, as documented by many authors (Durand et al., 2014; Pomaki et al., 2010; St-Arnaud et al., 2011). In fact, they state that effective management of sick leaves related to MSDs or mental disorders requires, first, the implementation of a health and employment maintenance policy that is clear, detailed, and effectively communicated, and that reflects an organizational concern for employee health. According to Pomaki et al. (2010), such a policy would cultivate an organizational culture oriented toward employee well-being, thus fostering the prevention and early detection of mental disorders. This in turn would reduce the severity and duration of the illness, as well as the costs associated with the worker's health condition. The policy would also convey the organization's values to its various stakeholders (Durand et al., 2014), including direct supervisors, co-workers, and union stakeholders.

According to the union stakeholders met in the focus groups, such a culture that places importance on mental health and the human aspect of the return to work is somewhat rare. This impression is substantiated by the literature, which reports sick leave management practices more often geared to reducing sick leave duration than to employee support and health (Durand et al., 2014). St-Arnaud et al. (2006) add that employers tend to focus their attention and interventions more on the worker with a mental disorder than on the environment in which he works because it involves lower costs (in the short term) for the organization in terms of

psychosocial factor analyses and work task interruptions. However, the literature and the results of this study indicate that in order to be effective, such ad hoc interventions with employees must take place in a work environment where importance is placed on employee health and well-being and where the organizational resources they need to do their jobs are offered (Corbière et al., 2013).

While the mission of unions is to defend employees and assure them decent working conditions, the growing pressures being placed on employees due to new management practices (St-Arnaud, Saint-Jean, & Rhéaume, 2003) were only rarely mentioned in the focus groups. Yet several studies have shown that certain factors associated with the psychosocial work environment are predictive of employees' mental health (Corbière et al., 2013; Niedhammer, Goldberg, Leclerc, Bugel, & David, 1998; Stansfeld, Fuhrer, Shipley, & Marmot, 1999), which suggests that the increased prevalence of work disability due to mental disorders could be related to recent transformations in the world of work (Corbière & Durand, 2011). This raises questions about the role of union stakeholders and unions with respect to the social problem of increased work disability due to mental disorders such as depression. Why then did the union stakeholders in the focus groups not highlight these transformations taking place in their organizations? Was it simply by omission, due to the flagrant reality of these transformations? Was it the way in which the focus groups were run that prevented this perspective from being raised? Was it because they feel unable to act on their work environment, or because they believe it is more important to focus on the concept of support and solidarity at work to offset these work transformations?

In summary, an organizational intervention or practice aimed at the return to work of individuals who have experienced depression requires ad hoc and personalized interventions, which can be carried out in an appropriate work environment, one that is characterized by working conditions reflecting a concern for employees' mental health and recognition of the human aspect of work.

Support and follow-up

Support and follow-up during both sick leave and the return to work refer to moral support and concrete actions that are taken by the employer, union, co-workers, or physician, and that are designed to maintain contact with the employee, support him during his sick leave and return, and implement the necessary adjustments to ensure that he retains his job.

Regarding follow-up during the return to work, the union stakeholders met in the focus groups noted that when such follow-up is lacking, the employee may be reticent to talk about the problems he encounters and adjustments he needs. However, it is impossible to identify which person should be responsible for this follow-up on the basis of the results of this study. The union stakeholders sometimes do follow-up in a natural and informal manner, and on rare occasions because it has been jointly planned with the employer. Yet, according to Durand et al. (2014), follow-up during the return to work is a key component of sick leave management, and all stakeholders should be involved, each at a different level and sometimes at different key times. That said, the direct supervisor is considered one of the key people responsible for following up on work accommodation measures. It is up to him to give the worker feedback and ensure that the necessary adjustments are made to promote his job retention. A number of authors support these results by stating that the direct supervisor is the key person to ensure the worker's smooth return to his job, even though the supervisor has numerous responsibilities that do not always allow him to systematically follow up on the work accommodations (Lemieux et al., 2011; Shaw et al., 2003). This acknowledged importance of the direct supervisor's role contrasts with the results of this study, in which the direct supervisor is perceived as being virtually absent from the process. In fact, the union stakeholders met made only rare mention of his role in the success or failure of the return to work of an employee who has experienced depression. Instead, they made numerous references to the employer, meaning either senior management or the various representatives of the organization (human resources, managers, etc.), which may partly explain the little mention made of the direct supervisor per se.

Apart from follow-up of the work accommodation measures, the reception afforded the returning employee, elimination of psychosocial risks in the work environment, adaptation of performance expectations, presence of a peer worker network, and support from co-workers are all manifestations of support and follow-up that were mentioned by the focus group participants. Some of these elements overlap the concept of natural supports advanced by Trach and Mayhall (1997). For these authors, natural supports are the human and technical resources available to all individuals in the workplace and that foster their integration, satisfaction, and pursuit of their goals and interests. The peer worker network and support offered by co-workers are natural supports. These supports have been shown to promote job retention by individuals with a mental disorder following their re-entry into the regular labour force, or to reduce the risk that employees who are returning to work suffer a relapse a year later (Bolo et al., 2013; Corbière, Vilotti, Lecomte et al., 2014). These natural supports thus represent an essential organizational resource not only for facilitating the reintegration into work of the person concerned, but also for preventing possible relapses. These findings are supported by studies demonstrating that weak social support at work on the part of co-workers and the direct supervisor is associated with the future onset of mental disorders (Coutu et al., 2011; Niedhammer et al., 1998; Stansfeld et al., 1999). The presence of the aforementioned elements of support and follow-up reveals that a degree of importance is placed on the human and relational aspects of work, and would appear to

be an expression of the organizational culture mentioned earlier.

Prejudices and discomfort regarding depression

According to the union stakeholders met, the prejudices held by organizational stakeholders as a whole and the discomfort present in co-workers and the depressed person himself regarding depression create stress in the employee who is returning to work and diminish the support he receives. Lack of knowledge about mental disorders, particularly depression, and issues related to disclosure of confidential information were cited as factors associated with these prejudices and discomfort. In fact, according to the participants, discomfort could be exacerbated by the taboo surrounding the reason for the sick leave. This lack of information can fuel rumours and prejudices, with each person interpreting the facts in his own way based on what he knows. By contrast, open and personal interactions with a person suffering from a mental disorder and who is regarded as an equal are recognized as the most effective ways to counteract the stigmatization of this group of individuals (Corrigan & Penn, 1999; Islam & Hewstone, 1993; Kolodziej & Johnson, 1996). However, the solution proposed by the union stakeholders is not as simple as that of breaking confidentiality. Just as divulging the mental disorder in the workplace may reduce discomfort and prejudices, so too can it increase them. According to the participants in this study, it is difficult to find the appropriate balance. This result is supported by the literature, where the issue of divulging a mental disorder in the workplace is regarded as a thorny one since it can just as readily facilitate implementation of work accommodation measures as contribute to worker stigmatization (Corbière et al., 2014). The literature recommends that each situation be assessed on a case-by-case basis and that the worker be the one who decides whether or not to divulge certain information, with the role of the other parties being to ensure that he is fully aware of the possible repercussions of his decision (Bilsker, Gilbert, & Samra, 2007; Corbière, Samson, Villotti, & Pelletier, 2012; Durand et al., 2014).

6. SCOPE AND LIMITATIONS OF THE RESULTS

The results obtained in this study fill a void in the scientific literature about factors facilitating and hindering the return to work of individuals who have experienced depression, as seen from the union viewpoint. In fact, although union stakeholders are regarded by many authors as key parties in the return-to-work process, their viewpoints and actions in regard to this issue remain little documented to date (e.g. Pomaki et al., 2010). Clarification of their role would enable employers, managers, employees, and union stakeholders themselves to compare their practices to those in other organizations and to draw inspiration from the ones considered most effective. In addition, defining the spectrum of roles filled by union stakeholders would help to delineate a clearer place for them in future policies and practices regarding employees' return to work after a mental disorder such as depression, and would allow adjustments to be made in work organization (e.g. informing the union of the date of the return) and to the resources available to them to meet their responsibilities properly.

The results of this study were obtained using the focus group method, which provided the in-depth viewpoint of numerous individuals representing a variety of union functions, levels of experience, and activity sectors. The focus group format also allowed the participants to support or clarify ideas expressed by others and to compare their various practices. The snowball sampling (or recruitment) method, as well as the division into groups according to union organization, produced homogenous groups of individuals from the same occupational or union network. This provided access to more natural interactions in which peers were able to support ideas expressed by other participants in the focus group by referring to concrete examples or shared anecdotes (Kitzinger, 1994). However, this proximity may also have increased social desirability bias by hindering the expression of dissenting opinions, which would explain the few divergences that emerged in the results. A larger number of groups would have been beneficial as it would have provided more information on differing organizational contexts, but the three groups formed nonetheless offered an overview of their viewpoints on this theme. Lastly, the inclusion criteria specifying that the union stakeholders had to have prior involvement with employees who had experienced depression provided data on practices in union circles regarding this problem. This created more homogenous groups of participants who were aware of the issue of depression in the workplace and thus better equipped to take actions to prevent it. This inclusion criterion can therefore be seen as both a strength and limitation of this study.

Data analysis was carried out by three individuals working independently to ensure good inter-rater reliability. The use of citations from several different participants ensured good transparency in the results presentation. Lastly, while the division of facilitating and hindering factors by stakeholder group provided an overview of the perceived contribution of each factor to the success or pitfalls of the return to work, such a process can also result in a fragmentation of certain factors (the same factor may be associated with several stakeholder groups). The authors of this report sought to overcome this limitation by proposing a summary of factors recurring in different stakeholder groups.

7. CONCLUSION

The aim of this study was to identify the factors facilitating or hindering the return to work of individuals who have experienced depression, from the viewpoint of unions, while specifying beforehand their role with respect to the issue of the return to work of this group of individuals. The results obtained suggest that union stakeholders are front-row observers of the return to work within an organization by virtue of their role of intermediary or conciliator between the various parties involved. The factors hindering or facilitating the return to work that emerged from the focus groups were divided up according to the different stakeholders in the workplace: the employer and the organization, co-workers, the worker who experienced the depression, the union, physicians, and medical service providers. Four inter-stakeholder factors emerged, highlighting two facilitating and two hindering factors: an organizational culture that places importance on mental health and the human aspect of work; support and follow-up provided during the sick leave and the return to work; the lack of resources; and the prejudices and discomfort present in organizational stakeholders regarding depression. The results also made it possible to document the scope and limitations of union stakeholders' involvement in the return to work of individuals who have experienced depression, raising the question both of their responsibilities in this process and of the resources available to them to meet these responsibilities adequately.

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APPENDIX A: GUIDE FOR FOCUS GROUPS

Review the main points on the consent form with the group to ensure that they have thoroughly understood the nature and purpose of the study. Make sure they have no questions before starting.

- All the information you provide in the focus group will remain confidential and be used solely for purposes of this study. No information revealing your identity or that of your organization will be disclosed or published without your written consent.
- This focus group will be recorded in order to produce a verbatim transcript of your discussions. The audio recordings will be kept in a filing cabinet under lock and key, and your name will not appear on it. Similarly, the transcripts of the discussions will be anonymized.

Introduction: The aim of this study is to gain a better understanding of your union experience with employees who have experienced depression in order to more clearly identify the factors influencing their return to work and job retention. There are no right or wrong answers. We are interested in **your opinions and experience** regarding this issue. To ensure discussions that are as concrete as possible, we ask you to recall the trajectory of employees who have experienced depression and with whom you have been involved. It is important that everyone have the opportunity to express his viewpoint. We therefore ask that only one person speak at a time. Some people may not be inclined to speak at all, but I will invite them to participate.

Questions

1. In your role as a union stakeholder, what have you done as part of the return-to-work process of employees who have experienced depression (i.e. before/during the sick leave; during the return to work; during the time back on the job)?

2.
   a. In your opinion, what factors facilitate the return to work of a person who has experienced depression?
   b. In your opinion, what factors hinder the return to work of a person who has experienced depression?

3. Taking into account the various parties involved (i.e. direct supervisors, co-workers, employers, human resources, health professionals, the employee's family), what, in your opinion, are the attitudes and behaviours that facilitate or hinder the return to work of individuals who have experienced depression?