Special Section on Action Research

The Paradoxes of Managing Employees' Absences for Mental Health Reasons and Practices to Support Their Return to Work

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Abstract

The capacity to implement effective strategies in an organization largely depends on the capacity to mobilize on-site stakeholders around a common project. This study aims to identify the practices and paradigms of workplace stakeholders involved in managing and following up on the return to work of employees who have been absent for mental health reasons.

Keywords: mental health, employees, workplace, absenteeism

Over recent decades, workplaces have undergone a great deal of upheaval, which has affected the health of workers (Vézina et al., 1992; Vinet, 2004; Bourbonnais et al., 2005). Production modes have been altered by the rapid growth of the service sector, the development of new information and communication technologies, the globalization of markets, and increased competition, as well as mergers and downsizing. These great changes have, in particular, led to new work requirements, a diversification of forms of employment, work intensification, and increasing job insecurity, which have had disastrous effects on the socio-occupational integration of individuals and their capacity to work and remain in their jobs (Vézina et al., 2004; Bourbonnais et al., 2005).

In fact, work-related mental health problems are currently one of the leading causes of absence from work, and this phenomenon has grown markedly over the last two decades (Gabriel & Liimatainen, 2000; Vézina & Bourbonnais, 2001; Dewa, Goering, Lin & Paterson, 2002; Henderson, Glozier & Elliott, 2005; Dewa, McDaid & Ettner, 2007; Houtman, 2007). This rise in absences represents a major social problem for both public health and the economy (Henderson et al., 2005; Dewa, 2007). According to Vézina (2008) and Vinet (2004), this phenomenon appears to be a direct result of new forms of work organization and their effects on the psychosocial environment at work. These mental health problems can have particularly incapacitating effects resulting in long periods of disability (Koopmans, Roelen & Groothoff, 2008), and involve a high risk of relapse (Conti & Burton, 1994; Druss, Schlesinger & Allen, 2001; Gjesdal et al., 2003; Nieuwenhuijsen, Verbeek, de Boer, Blonk & Djik, 2006; Koopmans et al., 2008). Thus, organizations are beginning to feel the need to adopt more comprehensive and integrated approaches to the management of employees' absences and health (Watson Wyatt, 2005; Dewa, McDaid & Ettner, 2007). Some studies have specifically examined the work reintegration of employees who held a job but were absent due to a mental health problem; however, few of these studies have focused on the design of return-to-work programs (Briand, Durand, St-Arnaud & Corbière, 2007). The urgency felt in this regard signals the need to develop best practices in absence management in the workplace which will foster the return to work and job retention of employees who have been absent for mental health reasons (Brenninkmeijer, Houtman & Blonk, 2008; Briand, Durand & St-Arnaud, 2007; St-Arnaud, Bourbonnais, Saint-Jean & Rhéaume, 2007).

In recent years, research in the field of occupational rehabilitation has evolved from a biomedical approach, often centered on the individual factors of illness, toward an approach that takes into account the factors related to the work environment (Durand, Vachon, Loisel & Berthelette, 2003; Franche, 2005). According to Franche et al. (2005a), making temporary or permanent changes in the work environment remains a crucial component of workplace interventions considered to be effective in terms of ensuring a successful return to work. In fact, several studies stress the importance of this measure and its effectiveness with regard to the duration of work disability (Hogg-Johnson & Cole, 2003; Amick et al., 2000; Arnetz, Sjogren, Rydehn & Meisel, 2003; Loisel et al., 2001). For mental health at work, this dimension is all the more crucial since the psychosocial environment at work is responsible for a large percentage of work absences (Vézina, Bourbonnais, Marchand & Arcand, 2008). In addition, the studies of Brenninkmeijer, Houtman & Blonk (2008), and St-Arnaud, Bourbonnais, St-Jean & Rhéaume (2007) confirm the importance of acting on the psychosocial environment at work in order to foster employees' return to work and job retention. Moreover, a review of best practices used to support the return-to-work process has shown the importance of taking action at the individual level and also at the organizational level (Briand et al., 2007). Furthermore, evidence-based data suggest that, in addition to promoting intervention programs in the workplace, emphasis should also be put on a collaborative process that includes the various partners involved in the return-to-work process (Durand & Loisel, 2001; Loisel et al., 2001; Durand, Vachon, Loisel & Berthelette, 2003; Franche et al., 2005a, 2005b). Thus, managers, unions, workers, human resources managers, medical resource persons and insurers must work together and take consistent actions at each step of the return-to-work process (Stock et al., 1999).

Support and commitment from senior management are still key factors in the development and implementation of interventions targeting work organization and management practices. According to Baril & Berthelette (2000), the values of senior managers and the quantity of resources they allocate to supporting such interventions can influence the capacity for action of stakeholders involved in changing the work environment. In fact, their values and attitudes have a significant impact on the success of interventions. A positive attitude will be translated into a concern for

workers' health and sustained support for interventions in the workplace. Moreover, by favoring a participative management style in the organization, senior managers allow workers and direct supervisors to be stakeholders in the planning and implementation of a return-to-work program (Stock, Deguire, Baril & Durand, 1999; Health and Safety Executive, 2004). Relations between management and unions are also perceived as having a major impact on return-to-work programs (Baril et al., 2003; Williams, Westmorland, Shannon & Amick, 2007). Instances of confrontational behaviour decrease when unions and management share the common goal of ensuring workers' health and well-being upon their return to work. Return-to-work programs are more difficult to implement when the union plays only a marginal role in the program and especially when the program is decided on and imposed by management. Conversely, unions are more likely to approve the return-to-work measures put forward if the latter are well planned and properly managed. The following factors constitute the conditions that are essential to the success of a return-to-work program: establishing a climate of trust marked by respect, effective communication, and collaboration between the various internal or external stakeholders involved in the return-to-work process (Baril et al., 2003; Stock et al., 1999).

In Quebec, a number of researchers have been involved in participative research aimed at improving the prevalence of mental health problems at work. Some of these studies were conducted with workers in short- and long-term care (Bourbonnais et al., 2005, 2006a and 2006b), white-collar workers in public administration (Brisson et al., 2006) and correctional service officers (Vézina et al., 2006; Bourbonnais et al., 2007). These studies, based on the research of Kompier et al. (1998) and Goldenhar et al. (2001), identified the conditions for a successful participative intervention process in mental health at work, including, namely: commitment and support from senior management, effective communication, a climate of openness and transparency, and the use of a joint and participative approach. Nevertheless, it should be noted that organizations are at the centre of a complex system wherein changes in practices and mentality are long and painful processes. According to Gaulejac (2005), the corporate world is increasingly contradictory, with workers and managers being forced to develop their capacity to cope in an environment that is marked by paradoxes. Moreover, the capacity of organizations to implement effective strategies in a given field appears to depend on their capacity to mobilize the various groups of stakeholders around common projects and to foster the emergence of a culture based on trust and reciprocity (Contandriopoulos & Souteyrand, 1996). However, in an organization, each group of stakeholders is faced with specific challenges which may or may not be mutually consistent (Contandriopoulos & al., 1996; Hinings & Greenwood, 1988). Based on this perspective, this study aimed to define the practices and paradigms of workplace stakeholders involved in the management and follow up of the return to work of employees who have been absent for mental health reasons.

Method

The proposed research method was based on individual interviews conducted with stakeholders involved in managing employees' absences for mental health reasons and supporting their return to work in the same organization. Several studies have revealed the strategic role played by senior managers, direct supervisors, occupational health officers, and the union as stakeholders involved in developing a return-to-work program (Stock et al., 2006; Baril et al., 2003; Franche et al., 2005; St-Arnaud, St-Jean & Damasse, 2004, 2006). To maximize the variety of approaches and obtain data from a full range of stakeholders involved in the organization's return-to-work process, key informants associated with each group of workplace stakeholders were invited to participate in the study. In total, 31 key stakeholders from four groups of stakeholders were identified by a work committee made up of researchers and representatives of the main stakeholders in the workplace

affected by work absences for mental health reasons and involved in return-to-work practices. According to Mayer, Ouellet, Saint-Jacques, Turcotte et al. (2000), in standard qualitative research based on interviews, it is estimated that approximately 30 interviews are needed to achieve data saturation. Table 1 shows the various stakeholders and groups of stakeholders in the workplace who were recruited to participate in an individual interview.

Table 1. Distribution of Key Stakeholders and Number of Departments Represented, by Group of Stakeholders

Groups of Stakeholders	***Key Stakeholders***	***Departments Represented***
Senior managers	7	5
Direct supervisors	10	4
Occupational health officers	7	1
Unions and worker representatives	6	4
Total	30	7 out of 11 Departments

Thirty (30) interviews were conducted during the summer of 2007 with key stakeholders involved in managing absences for mental health reasons and supporting the return-to-work process, representing seven out of 11 departments in the same organization. The interviews were semi-structured and lasted approximately 90 minutes. They were held in the workplace or at the research centre, depending on the stakeholder's preference. The interviewees were invited to participate on a voluntary basis and signed a consent form.

The interview schedule was constructed in a flexible way in order, on the one hand, to allow for the participants' experience to emerge and, on the other hand, to bring out the structures, processes and interpretive schemes of each group of stakeholders. More specifically, the interview questions dealt with the roles, responsibilities, practices, goals and result indicators as well as the principles and values of each group of stakeholders with regard to managing absences and the return-to-work process. Moreover, the participants were invited to use examples to illustrate their accounts. Each interview was tape-recorded and then transcribed word for word. The verbatim transcripts of interviews were codified using Microsoft Word. Moreover, each interview was made anonymous and assigned a code.

In order to better understand the types of rationality and the issues involved in this "organized system of action," intra- and inter-group analyses of stakeholders were conducted. First, each group of stakeholders in the organization was examined in relation to their roles and responsibilities, the mechanisms for action and decision making, the resources available to them, the principles and values underlying their actions, and the goals and result indicators used by them. According to Hinings & Greenwood's model (1988), coherent action exists when the structures and processes reinforce and reflect the interpretive schemes. This intra-group analysis of stakeholders thus brought out the contradictions existing within each group of stakeholders. Second, the groups of stakeholders were compared among themselves in order to identify the levels of convergence. According to Contandriopoulos (2003), a system's capacity to achieve its goals depends on the degree of coherence and convergence among its various parts.

The analyses conducted brought out the contradictions existing within each group of stakeholders and between the groups of stakeholders. These contradictions result from the analysis and are not

the reflection of conscious contradictions or those pointed out by the stakeholders. This method aims to objectify the types of rationality for action in a complex organization and thus allow for an objective examination of the issues that shape action and decision making.

The interviews were analyzed according to a systematic procedure for qualitative content analysis (Laperrière, 1997). The analysis was performed by group of stakeholders since the workplace represented a complex system involving action by various stakeholders based on different types of rationality. The verbatim transcripts were codified on the basis of manifest content and processed according to the first two steps put forward by L'Écuyer (1990), that is, (1) the identification of themes, and (2) the definition of classification units. The terminology in Hinings & Greenwood's model (1988) was used to bring out the different themes in the interviews. The themes explored were: roles, practices, goals, values/interpretive schemes, policy and macro context. Subthemes were also identified within these main themes. To ensure consistency between those responsible for codification and those responsible for the analysis of individual interviews, each codified interview was reread for validation purposes by a researcher in the team. A summary of each individual interview was written up and these summaries were divided into groups according to the main themes. The individual summaries were then combined into one integrative summary for each group of stakeholders. Three team meetings were held. The workplace also provided the research team with all pertinent documents related to the management of absences and the return-to-work process.

Results

Groups of Stakeholders with Contradictory Practices

The interviews conducted with 31 key stakeholders in the organization revealed a diversity of practices in managing absences and the return-to-work process, as well as the presence of two opposing and deeply rooted approaches in the four groups of stakeholders examined (senior managers, direct supervisors, occupational health officers and the union).

Senior Managers

The interviews conducted with the key stakeholders in senior management showed that this group of stakeholders adopted practices which reflected the concerns and commitment of senior management with regard to mental health at work and the return-to-work process. In fact, senior managers adopted an action plan related to managing work attendance, set up an advisory committee on work attendance, surveyed their entire staff regarding the climate in the organization, and produced and disseminated statistics on absences. Moreover, senior managers got involved in this research project studying an integrated approach to the return-to-work process, which clearly demonstrated their concerns in this respect and the importance they attached to taking concrete action to improve return-to-work practices.

Nevertheless, the interview results also revealed that there were differing perspectives on the issue within senior management. Thus, an analysis of the database of interviews with this group of stakeholders brought out both elements which reflected an approach based on supporting individuals, and elements which revealed an approach based on controlling and regulating absences, and these two approaches coexisted not only among the leaders in the same organization, but also in the discourse of a single person. Thus, on the one hand, it was considered that the worker "*was first of all a stakeholder motivated by his/her work who therefore did not wish to be absent from work*," that the health of individuals was a concern that must be shared by all

stakeholders in the organization and that difficult working conditions were among the factors which weakened workers' health. On the other hand, it was maintained that the worker was a salaried employee who had to be present at work, and that he/she was solely responsible for looking after his/her health. "*Many workers are absent for reasons that are not related to a real health problem (as a result of disciplinary measures or interpersonal conflicts, and so on).*" "*In these circumstances, the absences should be properly controlled so as to avoid abuses.*" The interviews also highlighted the main challenges faced by senior management in implementing an integrated return-to-work program. Having been subject in recent years to mergers, the organization in question was considered by its leaders to be very large and complex which, in their view, fostered different perspectives and approaches for action in the various departments involved. According to the senior managers interviewed, the commitment of senior management was an essential and necessary factor for dealing with the issue, but not sufficient on it own. They expressed the view that all levels in the hierarchy needed to feel concerned and realize that they each held their own share of responsibility and that this issue involved a long-term process.

"*It's everybody's responsibility; all levels of the hierarchy should be involved in dealing with this issue. Human Resources will play a support role, but the front-line managers [direct supervisors] are the first to take action; it's important to recognize that the problem exists within our own team and it's also important to ensure that our managers feel equipped and able to deal with the problem.*"

The senior managers felt that it was crucial that the same message be conveyed throughout the organization and be understood and interpreted in the same way by all stakeholders. In their view, without a reference framework on the roles, responsibilities and measures related to supporting the management of absences for mental health reasons and the return-to-work process, it was not possible to achieve a common understanding of the issue, reconcile the different approaches existing in the organization and develop consistent practices.

"*I think it takes investment in terms of resources but it also takes promoting awareness among managers so that they understand their role.*"

Another challenge faced by senior managers in implementing a return-to-work support program involved the difficult working conditions currently prevailing in the work environment. In fact, the organization was short of staff and the clientele in some sectors was becoming more complex, which consequently increased the staff's workload and eventually led to burnout among them. "*The shortage of staff explains a large part of this situation because the difficulty recruiting workers inevitably means that a great deal is demanded of those who are already here.*" According to the senior managers, the fact that workers were absent for mental health reasons, combined with the difficulty recruiting and retaining staff, contributed to a lack of stability in the work teams, which thus made it impossible for members of the organization to act effectively on the issue.

Moreover, intense pressure from government authorities to rapidly reduce the rates of absences represented another major challenge for senior managers with regard to managing absences and the return-to-work process.

Direct Supervisors

The interviews conducted with key stakeholders in the group of direct supervisors revealed a reality in the organization marked by diverse practices and numerous demands. Senior management

expected the direct supervisors to support their staff while rigorously supervising cases of absence, and to make their presence felt within their teams while also sitting on numerous committees and attending meetings outside their workplace. These contradictory demands from senior management were a source of confusion, making it increasingly difficult to meet the management's expectations. Without clear guidelines from senior management and the health department, the direct supervisors each implemented practices that they considered to be appropriate based on the demands made of them and on their own values and priorities, as attested by the different ways they viewed their roles and responsibilities. "*There are no clear guidelines concerning these cases of absence. There has never been any discussion about how to deal with them. We deal with them sort of intuitively, based on what we think is right."* The results demonstrated that while some direct supervisors set up activities to prepare for the return to work of employees, others did very little, believing that this was not their role or feeling overwhelmed by the issue. In fact, it was noted that some supervisors saw their role as involving the prevention and management of absences while others thought that this was the role of the occupational health service and human resources departments. *"It's the health department that's responsible for supporting the worker in the return-to-work process. I don't have the time or the skills to do it."* Moreover, some supervisors focused on the individual at work, his/her well-being, satisfaction, recognition, and mental health, while other supervisors were more oriented toward tasks and employee performance. The results also showed that supervisors were often unsure about contacting the worker during his/her absence, wondering whether they should call, what they should say, how the call would be perceived and what they were supposed to know. Communications with the health department, which managed the medical-administrative aspects of absences, were not standardized in the organization. Some supervisors rarely or only occasionally communicated with the health department regarding each case of absence, whereas others did so regularly or systematically*. "There are some employees off work that I don't even know. What am I supposed to say to them if I call?"* Lastly, it was observed that practices to prevent absences were very rare and often limited to actions aimed at supporting workers on an individual basis.

The analysis of interviews conducted with the direct supervisors also made it possible to identify the different ways in which absences for mental health reasons were interpreted. Some supervisors considered that most absences due to a mental health problem were related to personal or family problems or behavioural disorders. Other supervisors believed that many of the absences were caused by high-conflict relations at work.

"I would say that most cases of mental health absence in my department have been the result of meetings regarding disciplinary action."

"Problem employees make up between about 3 and 5% of the staff, but otherwise, I think it's important to realize that people want to work, to contribute, be useful and help out. If they can't, it's because something isn't right, so it's important to look at the workload and the work climate within teams."

Some direct supervisors held the view that many workers were abusing the wage-insurance system and were even cheating the system. *"I have people who are always sick in the summer. It's people who obviously don't want to work in the summer, it's obvious, they go get a doctor's note but they're not really very sick."* Some held strong prejudices which reinforced their distrust of workers who were absent from work. This climate of distrust and suspicion influenced the practices they used to manage absences which thus involved more control, less openness and less flexibility. Moreover, referral to medical assessment was used by some managers to contest the reason for absence (medical diagnosis) or the length of absence and thus to tightly control absences.

Others emphasized the worker's duty to take responsibility, to take charge of his/her work-life balance and return to work. Very few direct supervisors associated the workers' mental health problems with the difficulties experienced in the work context. Nevertheless, difficult working conditions, increased workload and the flagrant lack of staff were cited by the majority of supervisors. Although they hardly made the link between the effects of deteriorating working conditions on the health of workers, they nevertheless managed to make this link for themselves. "*You have to recognize that there are tons of supervisors who go on sick leave.*" Several supervisors referred to their workload which was increasing continuously, with large teams to manage in a difficult work context marked by the lack of human and financial resources. They did not have time to follow up on absent workers and only dealt with the most urgent files. These conditions hampered the adoption of practices to support workers on sick leave.

"*We'd like to take into account what the employees tell us, to listen to them and make use of what they have to say, because they have useful things to say, they have good ideas. If an employee has been off work and then tells us about aspects that could help us carry out prevention so that such a thing won't happen again, well we should pay attention and use their ideas.*"

Occupational Health Officers

The occupational health department included officers responsible for the medical-administrative follow up of cases of workers receiving disability insurance, medical referees under contract with the organization, and a manager. Workers on sick leave for mental health reasons who were followed up by the occupational health department had to submit a medical certificate and a disability insurance form filled out by their attending physician, indicating their diagnosis, treatment and the scheduled return-to-work date.

The interviews conducted with the key stakeholders in the occupational health department showed that their practices served contradictory missions. It was observed that the occupational health officers had to manage the medical-administrative aspects of absences in a context marked by pressure to reduce the rates of absence. The low target rates for absence requiring disability insurance set by government authorities were deemed to be unreasonable by the interviewed stakeholders in this group and put even more pressure on the department.

Thus, these officers had to respond to demands to control absences in order to reduce the costs associated with disability insurance. "*Our role is to make sure that it costs the least possible, we can't hide this fact. And we have to take drastic measures to achieve this."* However, the stakeholders in the occupational health department were also receiving the message from senior managers that they should give the individuals time to recover. "*The most important person is the one who is off work. I need to work with this person."* They were asked not to put pressure on the workers during their absence and to support them.

To serve these two missions, the occupational health officers implemented practices aimed at both reducing disability insurance costs and supporting the workers on sick leave. To meet this dual goal, these practices were based on an attempt to distinguish those who were "genuinely sick" with mental health problems from those affected by other organizational factors who were considered to be "feigning" illness. Workers on sick leave who had received a diagnosis related to mental health problems were thus judged by the occupational health officers, in collaboration with some direct supervisors, based on a determination between two types of absences: absences pertaining to

mental illness versus absences pertaining to relational conflicts, disciplinary measures or problems related to personal life. *"A lot of cases that are medicalized shouldn't be, such as problems involving work relations or personality conflicts."* The stakeholders in the health department adapted their support or control practices based on this determination, giving rise to different practices for the different individuals who were absent from work. Thus, from the outset, some workers were given more support and more time to recover and had access to additional sessions under the employee assistance program (EAP). Other workers received telephone calls putting them under greater pressure, and were questioned and challenged regarding their treatment and health status. Referrals to undergo medical assessment were frequent, mainly in order to validate the diagnosis of the attending physician, to ensure that the medication and treatment plan were adequate and to review, if necessary, the scheduled return-to-work date. In general, it was the occupational health officers who decided to refer the workers for medical assessment, based on their own judgment or on certain pieces of information received from the direct supervisors questioning the legitimacy of the sick leave.

"*In cases of mental health, you notice pretty quickly, subjectivity prevails over objectivity, but when we see the notes from the attending physicians, whether they're general practitioners or specialists, very often no objective mental health examination has been carried out."*

"*It's not because we have doubts about the disability but we want to ensure that people are getting the right treatment and we also want to know the prognosis in terms of return of work; should we expect a very long absence?" "There is a shortage of staff. We have to find ways to keep our people, when they're on disability leave, to use them."*

Thus, nearly 50% of workers who were absent for mental health reasons were subject to a medical re-assessment at the request of the health department. When a referral was made, medical assessment was compulsory and the report of the medical referee and his/her recommendation for a return to work at an earlier date than that of the worker's physician (30% of cases) could only be contested at the medical arbitration level, a medical-legal procedure that was used from time to time and whose verdict was final, without the possibility of appeal. According to the health department, the use of medical assessment allowed the occupational health officers to respond to the mission of reducing the rates of absence, by bringing back to work sooner those whose diagnosis and return date were reviewed by a medical referee, and to offer the "genuinely sick" the services of physicians specialized in psychiatry which were not easily accessible in the public health network.

The fact of always having to deal with paradoxical missions represented an important challenge to stakeholders in the health department with regard to managing absences and the return-to-work process. They had to reconcile the contradictory demands made on them, namely, offering support and giving workers time to recover while also reducing rates and lengths of absence.

"*We have to manage the medico-administrative aspects of absences, we have quotas to respect which are set by the ministry, we are under pressure to reduce absenteeism, but at the same time we feel pressure not to push these people!"*

Moreover, the high rates of absence and the growing complexity of mental health problems among the staff led to work overload which, in these officers' view, made it more difficult for them to adopt supportive practices. According to the individuals in this department who were interviewed, the application of set rules restricted more individualized interventions. In their view, all these

difficulties contributed to the negative image that workers had of the health department since the practices of following up on absences gave rise to controversial reactions. This image hampered the development of a program aimed at a more supportive role played by members of the health department.

Union and Worker Representatives

The last group of key stakeholders interviewed represented the various recognized trade unions within the organization. These stakeholders were not in charge of managing absences or the return-to-work process, but were responsible for supporting the worker over the course of his/her absence and return to work, while ensuring that all other workers were protected. Workers often turned to them for assistance, sometimes in distress or completely at a loss. At the individual level, these stakeholders supported the workers in any steps they might take during their absence from work, received workers' complaints, assisted them in their procedures, acted as intermediaries between workers and the health department, and informed workers of their rights, responsibilities and obligations. At the collective level, they could negotiate the arrangements needed for the return to work of some workers with the health and labour relations departments, while ensuring that the collective agreement was complied with. They also made policy representations to senior management in order to denounce practices they deemed to be abusive following complaints by workers.

"The employee called to ask me what was going on, if the way things were going was normal, and to find out about his rights. Because they are in a vulnerable position, they get asked questions [by the health department] and they wonder how far it should go. How much information they should give about their medication or their diagnosis. They're asked: "When are you coming back? What kind of medication are you taking?" There is also the assessment from the health department which creates a lot of dissatisfaction among the employees."

The referral to medical assessment and the obligation to return to work sooner in spite of the recommendations made by the attending physician were highly controversial. Despite support from the union, very few workers opted to go to arbitration following a medical assessment requested by the employer because they felt unable to fight for the recognition of what they considered to be their right.

"They [the workers] didn't feel good, they didn't feel comfortable, they didn't feel accepted either. In the end, they came back to work, they gave in and stopped fighting. They came back while they were still vulnerable even though their family physician had told them to remain on sick leave. They came back so they wouldn't have to fight against the system."

In cases of conflict or violence at work, the employee involved was not systematically defended by the union officer. Usually, the employer found out about the situation first and dealt with it through disciplinary measures. It was only after this that the employee contacted the union officer to report the situation.

"We had a nurse who was off work because of a burnout. The trigger, the big trigger was her relationship with the direct supervisor. There was a lot of violence between them. More and more, the women are having trouble keeping themselves from exploding."

The union conducted its own investigation. If it turned out that the employee in question was violent and witnesses could attest to it, he/she was not defended by the union. For the union, it

was clear that the high-conflict dynamics at work could lead to mental health problems whereas for the health department, sickness absence as a result of a relational conflict was more often than not considered to be the expression of a form of employee resistance.

Discussion

The analysis of workplace practices and paradigms shows that the organization under study was at the centre of a complex system made up of various groups of stakeholders with different practices and cultures, and in which the stakeholders made decisions and sometimes took actions based on different goals and purposes. According to Contandriopoulos et al. (2000), the capacity of a system to achieve its goals depends on the degree of coherence among its various parts. This coherence was assessed based on an analysis of the roles and responsibilities, mechanisms for action and decision making, resources, and principles and values of each group of stakeholders involved in the process of managing absences and supporting the return to work. One of the first findings of this study was that contradictions existed not only between the groups of stakeholders but also in the discourse within groups of stakeholders, and even that of single stakeholders.

The roles and practices of senior managers with regard to support and assistance in the return-to-work process mainly involved ensuring that the organization's policies and practices on absence management were transmitted, in particular to middle managers, i.e. the direct supervisors. Senior management showed an interest in the health of workers and the development of a support-based approach to the return to work. Senior managers were also responsible for monitoring the costs of absence in their department and reducing them. Moreover, they had to support and equip the direct supervisors in carrying out their mission. The analysis of the values and principles conveyed by the senior managers highlighted the existence of dissimilar approaches and perspectives within the departments. Thus, in the database of interviews with this group of stakeholders, there were both elements which reflected an approach based on supporting individuals and elements which revealed an approach based on controlling and regulating absences. These two approaches coexisted not only among the leaders in the same organization, but also within the discourse of single individuals. These differences generated contradictory practices among the stakeholders and also contributed to creating confusion among the direct supervisors and occupational health officers who were charged with carrying out the senior management's expectations.

The values and principles conveyed by the direct supervisors with regard to managing absences and the return-to-work process reflected their difficulty interpreting the expectations of senior management. This difficulty resulted in a multitude of principles guiding diverse practices among this group of stakeholders. Thus, within the same organization, different practices and skills were used based on how the issue was viewed. Caught in this cluster of increased demands, the direct supervisors were thus confronted with a contradictory order, "*take care of your employees but their performance will be assessed based on your ability to control their absences.*" Some direct supervisors felt overwhelmed by the whole situation and tended to withdraw from others and act in isolation in order to protect themselves from the risks related to these contradictory demands: it became "every man for himself," and there was a hesitation to share their difficulties. As for the workers, they became more suspicious and no longer wished to contact their direct supervisor during their absence. Such individual withdrawal makes it increasingly difficult to shift away from an "individualizing" and "psychologizing" representation of mental health problems at work toward a multicausal paradigm which takes the complexity of the phenomenon into account. Numerous studies now recognize that most of the factors which hamper return to work or job retention are less associated with illness and more related to environmental and psychosocial factors (Loisel et

al., 2001; Waddell, Burton & Main, 2003; St-Arnaud et al., 2007). This broader understanding of the causes of work disability makes it possible to move from a biomedical approach centered on illness and its treatment to a psychosocial approach which takes into account the complexity of individuals in the workplace. In fact, in recent years, workplaces have undergone major changes which have affected workers' mental health and their capacity to retain their jobs. A great proportion of workers who have been absent from work due to mental health problems stopped working because of difficulties experienced in their work context (St-Arnaud et al., 2007; Cohidon et al., 2009). Based on this perspective, it is still particularly difficult and risky for a worker to return to work following a mental health problem if the work-related risk factors are not taken into account (Brenninkmeijer et al., 2008). Although the direct supervisors cited work as the likely cause of mental health problems, it was nevertheless difficult for them to make the link with their own managerial practices (Brun, 2009).

The direct supervisors undeniably had a strategic role to play in assisting and supporting the return-to-work process, in particular in helping the worker identify the elements in the work environment that could be changed to facilitate the return to work and ensure job retention. It was a sizeable challenge for the direct supervisors to be heard by senior management and to be supported in their practices of assisting the return to work. In this regard, several studies have favoured the implementation of training programs aimed at helping supervisors to better grasp the importance of their role and of the factors related to work organization from the perspective of mental health at work (Nieuwenjuijsen, Verbeck, De Boer, Blonk & van Dijk, 2004). Training activities could contribute to facilitating the shift away from a paradigm of absence control toward a paradigm based on the support of individuals (Shaw, 2005). However, focusing on training programs without taking into account the limits of the policies of senior management and the challenges of contradictory demands, is likely to increase the pressure put on the direct supervisors and maintain a vicious cycle rooted in a primarily defensive social relationship wherein, fearing they will not be heard, people do not share their concerns. The role of the direct supervisor, considered to be central in the practices of supporting the return to work, cannot be performed properly without consistent support from the rest of the organization and especially from senior management.

The occupational health officers were among the first to intervene in the action chain. They were responsible for managing the disability insurance file. They also followed up on workers' absences and implemented a number of measures related to medical assessment and monitoring the treatment plan. In addition, they were responsible for supporting workers during their absence; in many cases, they were in fact the first to contact the workers. The occupational health officers also had to provide support to the direct supervisors who sometimes consulted them about managing absences and during the return-to-work process. Caught in the interface between the need to support workers and the demands of managers to reduce the costs of absence, they had to juggle divergent expectations. They were also encouraged by senior management to support the absent workers while under strong pressure to reduce the absence rates. According to Baril et al. (2003), a major challenge for occupational health officers is to gain the worker's trust while maintaining their credibility with managers and other stakeholders. A neutral and independent position, free from the medical, legal and administrative issues, is essential for them to carry out their work. Baril et al. (2003) maintain that it is better to separate the duties related to controlling absences from those based on support for health recovery and return to work. Despite this distinction, the credibility of return-to-work support programs can be compromised. Indeed, maintaining stakeholders with opposing roles within the same organization can lead to confusion over the real intentions of the organization.

These contradictory expectations were also reflected in the relations with the managers who, depending on their own outlook and principles, had demands that were either more focused on support-based practices or more focused on increased control of the reasons for absence and the length of withdrawal from work by some employees. It was seen above how referral to a psychiatric assessment made it possible to draw a line in this grey area linked to carrying out such a contradictory mission. However, the dual role of the health department, even when it was mediated by the decision of a medical referee, discredited its practices. Workers and their union representatives became more suspicious and reduced their degree of collaboration. In this respect, Baril et al.'s studies (2003) have shown that legal recourse diminishes the relationship of trust and hampers the return-to-work process. Although in principle, a request for medical assessment aims at validating the diagnosis and treatment suggested by the attending physician, this measure is generally perceived by the workers as questioning the veracity of their illness and their integrity (Baril et al., 2003; St-Arnaud et al., 2006). It also appears that workers are less motivated to return to work when they feel that the organization's motivation is essentially economic in nature. These control practices clash with the attitude of respect, responsiveness, openness and empathy advocated by the support-based approach encouraged by management. The health practitioners are pushed to focus on performance and organizational effectiveness with regard to human resource management to the detriment of an approach centred on the health and well-being of employees. According to Emery and Giauque (2005), managerial principles centred on goals based on performance, efficiency and effectiveness are increasingly creating numerous paradoxes for public organizations.

Conclusion

This study highlights the stakeholders' values and practices based on highly divergent, even contradictory types of rationality. The study in fact reveals that senior management wavered between an economic rationality, dominated by a reasoning centered on insurance and a major concern with the high costs generated by sickness absences, and a human and subjective rationality, concerned above all with health and well-being at work. The presence of these different types of rationality in the same organization and the lack of clear guidelines from senior management consequently led to a situation wherein each of the groups of stakeholders was faced with paradoxical practices which had to be juggled. It is interesting to note that although senior management was clearly in favor of an approach based on the support of individuals and the organization, it nevertheless acknowledged that different and often contradictory approaches were maintained within its organization.

This study conveys the importance of not underestimating the presence of paradoxical challenges within an organization. The commitment of senior management to adopt a support-based approach in line with a human and subjective rationality is not enough to obtain the participation of all groups of stakeholders. Senior management must ensure that its demands and requirements, with regard to the entire staff, are fully consistent with its commitment. However, such a practice cannot be put forward without bringing to light the numerous challenges that exist. One major challenge involves recognizing the role of work and psychosocial factors in workers' mental health and job retention. Thus, the support-based approach is in line with a systemic perspective which recognizes the need to act not only at the level of the individual but also at the level of work and the conditions in which it is performed, whereas the control-based approach is behind the deployment of measures related to control and the biomedical follow up of absent workers.

This action research conducted in the workplace led the organization to undertake: (1) to develop a reference framework that defines the support-based approach put forward by the organization, and (2) to collaborate with the various groups of stakeholders in describing and clarifying their roles and responsibilities related to the process of supporting the return to work. This study also highlighted the need to appoint a person responsible for ensuring the interface between the different roles of the stakeholders so as to foster collaboration and consistent practices. Managers, unions, workers, human resources managers, medical resource persons and insurers must work together and take consistent actions at each step of the return-to-work process.

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