TOWARDS AN ENHANCED UNDERSTANDING OF FACTORS INVOLVED IN THE RETURN-TO-WORK PROCESS OF EMPLOYEES ABSENT DUE TO MENTAL HEALTH PROBLEMS

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ABSTRACT

The purpose of this study was to reach a better understanding of the factors involved in the work reintegration process among employees of the Quebec Civil Service who were absent from work because of a mental health problem, as certified by a medical doctor. A qualitative approach was used based on data obtained from interviews. Analysis of the data allowed researchers to reconstruct these people's experience at various stages of the process of work reintegration, their interpretation of these events, and their responses to the difficulties they met. The results support the notion that the inability to work and return to work are constructs that relate not only to employees' health, but also to management practices that influence the work reintegration process. Support from colleagues and superiors, improvement in the conditions that contributed to the work interruption, a progressive return to work, and better cohesion between absence management practices and support measures are key factors in ensuring that the employee returns to work and remains in the workplace.

Mental health problems constitute one of the principal causes of absence from work. There has been a marked increase in this phenomenon in recent years (Banham, 1992; Conti & Burton, 1994; Gabriel & Liimatainen, 2000; Karttunen, 1995; Nystuen, Hagen, & Herrin, 2001; Vézina, 1996; Vézina & Bourbonnais, 2001). Claims related to psychological health represent the most rapidly increasing disability costs for a number of disability insurance companies (e.g. Standard Life, Sun Life; Conseil de gestion du régime d'assurance invalidité, 2004). The same is true in Quebec, where the Commission de la santé et de la sécurité du travail [Health and Workplace Security Commission] (CSST) has seen its total expenses for work-related injuries linked to stress, professional burnout, and other psychological factors increase from $5.8 million in 1995 to $14.3 million in 2004 (CSST, 2006). In Canada,

losses in productivity attributable to depression total $4.5 billion annually (Stephen & Joubert, 2001). In recent decades, the workplace has undergone considerable upheaval, with consequences for individuals' ability to work and maintain their employment, as well as for their mental health. According to Vinet, Bourbonnais, and Brisson (2003), the dizzying rise in absences from work due to mental health problems and the resulting proportional increase in group insurance premiums bear witness to the range and depth of this crisis.

Mental health problems serious enough to warrant absence from work often require long periods of convalescence, with a higher risk of relapse (Conti & Burton, 1994; Druss, Schlesinger, & Allen, 2001). Studies have demonstrated that the duration of a work disability following depression is approximately two and a half times longer than that caused by other illnesses (Gabriel & Liimatainen, 2000). According to Dewa, Goering, Lin, & Paterson (2002), 76% of workers with psychological problems will return to work, 8% will go on long-term disability, and 16% will leave their employment. Despite the extent of the problem, research focused on assisting workers to return to work and keeping them there has been scarce.

Several studies on workplace reintegration have examined the workplace health of workers who were victims of accidents or work-related injuries. While not centred on psychological health, this research has given rise to insights that are potentially useful in this area. Research in the field of rehabilitation has succeeded the biomedical approach that often concentrated on individual factors of an illness, and now integrates more factors related to the workplace environment in analyzing the work integration process. Readaptation to the work environment must be analyzed as a social reality, well beyond the boundaries of a strictly medical approach (Baril, Martin, Lapointe, & Massicotte 1994; Roberts-Yates, 2003). In particular, management practices affecting absence and the psychosocial work environment may have significant effects on the return to work and likelihood of remaining in the job (Baril et al., 2003; Durand, Loisel, Charpentier, Labelle, & Nha Hong, 2004; Durand, Vachond, Loisel, & Berthelette, 2003; Franche et al., 2005; Loisel, Buchbinder et al., 2005; Loisel, Durand et al., 2001; Roberts-Yates, 2003).

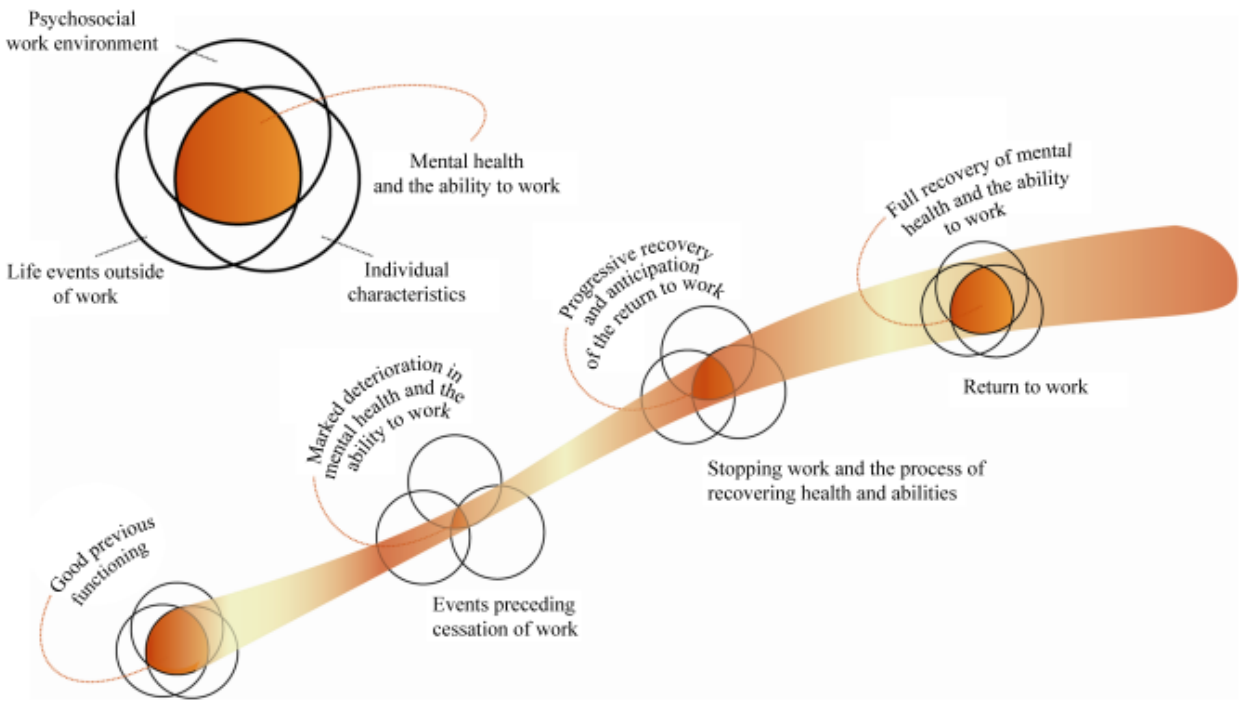
According to Loisel et al. (2001), the effectiveness of a work integration program is contingent on a well-documented analysis of opportunities to return to work and of obstacles present in the work environment, from the employee's work situation to the overall organization of the work environment and, if possible, to the external context in which it evolves. Also, aspects of the employee's medical history, indemnification process, professional path, and personal life experience should be considered in an analysis of the phenomenon (Baril et al., 1994, 2003; Lippel et al., 2006).

In the current economic context, characterized by an increased incidence of psychological health problems in the workplace, we need to rethink our previous emphasis on individual characteristics and to observe more closely the real impact of work on the individual's capacity to adapt. To help employees return to work and remain in their positions, Van der Klink et al. (2003) recommend adding consideration of the psychosocial work context to the individual cognitive-behavioural clinical approach. Along the same lines, Nieuwenhuijsen, Verbeck, Siemerink, & Tummers-Nijsen (2003) revealed that better communication between managers and employees was associated with a full return to work for employees who were not depressed. According to the authors, superiors needed to stay in regular contact with employees on sick leave and hold a follow-up meeting upon their return.

Our previous work has led to the development of a model allowing for the elaboration and more precise definition of aspects that facilitate vulnerable workers' work integration and their remaining in their positions (Saint-Arnaud, Saint-Jean, & Rhéaume, 2003; see Figure 1). These dimensions cover events prior to leaving work, the process of restoring employees' capacities, and practices in the work environment that encourage or impede reinstatement and remaining in their jobs. In this model, mental health and work capacity are defined by the dynamic interaction of individual characteristics, the psychosocial work environment, and stressful events in life outside of work. The individual characteristics not only integrate such factors as age and sex, but also personal dimensions linked to physical and mental health, particularly the person's psychiatric history. The psychosocial work environment integrates the structural and the human dimensions of work. The structural dimensions concern the specific content of the task. In other words, they determine "what to do," "how to do it," and "how much to do" in a given time. The human dimensions concern the social relationships at work, more specifically, the modes of interaction and communication between persons, whether vertical (superiors and subordinates) or horizontal (colleagues). Life events outside of work refer to social factors (support from those close to the person, the family context, etc.) that can affect a person's mental health and capacity to work.

Figure 1

Model of the Dynamic of Factors Involved in the Process of Work Withdrawal and Reintegration



The interaction in space and time among the three dimensions (individual characteristics, events in life outside of work, and the psychosocial work environment) permit an understanding of a period of good functioning preceding that of a marked deterioration in mental health and work capacity. The goal of our study was to better comprehend the factors involved in the process of reintegration into the workplace of persons who were absent following a mental health disorder. This study explores work absence, return to work, and remaining in the job by tracing employees' experiences, in particular, factors that led to leaving work, as well as conditions supporting their work integration.

METHODOLOGY

This study uses a qualitative method based on interviews with Quebec public service employees who were absent due to a mental health problem. This methodology has proven to be particularly fruitful in analyzing complex phenomena and gaining access to employees' subjective interpretation of their experiences (Desmarais, 1989). According to Hagner and Helm (1994), understanding the phenomena sufficiently to develop a successful rehabilitation program must start with the experience that the persons lived through.

In total, 37 Quebec public servants, absent between 1998 and 2001 due to a medically certified mental health disorder, were interviewed. Participants were recruited through information flyers distributed by employee services, a number of organizations and departments, and various medical consulting offices and clinics. They were recruited in such a way as to ensure a range of cases by age, gender, employment, and length of absence to paint a more complete picture of the situation (Kaufman, 1996; Pires, 1997). Interviews averaging 90 minutes in length were recorded with the respondents' consent, then transcribed word for word. The study received ethical approval from a university ethics board.

In an attempt to better understand what the workers go through in the reintegration process, two principal types of analysis were used based on our objectives and the data that were gathered. First, the manifest content was analyzed using steps proposed by L'Écuyer (1990) and Bardin (1993) concerning the identification of themes and the definition of units of classification, the process of categorization and classification, the comparative analysis of data, and the interpretation and validation of results. Following identification of the categories of themes, we used Nvivo software to code the data. This groundwork enabled us to develop a grid to analyze the thematic content and apply it to the body of data collected in terms of (a) events leading up to the work interruption, (b) factors related to stopping work and the process of regaining health and the ability to work, and (c) conditions of returning to work or prolonging the absence. The data were then analyzed in order to pinpoint the convergences and divergences as well as variations and particularities within the corpus.

Second, inspired by the theories of Glaser and Strauss (1967) and Strauss and Corbin (1990), an interactive process was also used for the data collection and analysis as it allowed us to explore new subjects of interest (themes) that emerged from the interviews and set them into the analytical framework by means of a continuous comparison between the categories of themes and the data collected. The interviews were therefore conducted at different stages in order to introduce the data processing and analysis gradually as the data were collected. Lastly, a detailed transverse analysis of the data allowed us to build a consistent model of the results as a function of the research object.

FINDINGS

Participants

In total, 25 women and 12 men from 12 organizations or departments of the Government of Quebec were interviewed. The distribution of participants by employment categories was as follows: 5 managers, 11 professionals, 14 technicians, 6 office workers, and 1 worker (see Table 1). The age ranged from 26 to 56, with an average of 44 years. Nine participants were absent for less than 6 months, 17 were absent between 6 and 12 months, and 11 were absent for more than 12 months. At the time of the interview, 23 of the 37 participants had returned to work.

Table 1

Distribution of Employees Interviewed According to Employment, Gender, Length of Absence, and Outcome of the Reintegration Process (Return or Non-Return to Work)

Category of employment	Gender	Length of absence and final outcome of the process of reintegration (return or non-return to work)						Total
		Less than 6 months		6 to 12 months		More than a year		
		Return	Non-return	Return	Non-return	Return	Non-return	
Worker	M					1		1
	F							
Office worker	M							
	F	3		1		2		6
Technician	M				1		1	2
	F		2	3	4	1	2	12
Professional	M	1		1	1	1	1	5
	F			3	2	1		6
Manager	M	2		1		1		4
	F	1						1
Total		7	2	9	8	7	4	37

Events Preceding Cessation of Work

We were able to identify three overriding factors that contributed to illness and led to stopping work: (a) stressful life events outside of work, (b) the presence of an individual psychopathology characterized by psychiatric disorders, and (c) risk factors related to the psychosocial work environment.

Some participants faced stressful events in their personal lives, outside of their employment context. The death of a loved one, or assuming responsibility for a sick parent or child, are examples of

experiences that contributed to a fragile state of health. A number of people commented on the empathy and support of colleagues and superiors during these tragic events. These participants generally stayed in contact with the latter during their time away from work. Moreover, maintaining this connection and having such a supportive environment seemed to facilitate the process of returning to work. Knowing that they could rely on a supportive workplace allowed them to positively anticipate returning to work and remaining in their jobs.

> After the death of my wife (suicide), my manager told me, "Take the time you need. I know you have been through a lot. It's okay." That means, if you are upset and it affects your performance, I will not consider you a bad employee. His flexibility was encouraging. (Charles, professional)

Others faced stressful events such as conjugal violence, difficult divorces, and financial problems. Although these experiences may erode one's health, they did not seem to evoke as much empathy in the work environment as the case of a serious illness or the death of someone close, especially when work performance was affected. As Cathie, a technician, states, "My boss told me that it was not up to him to solve my personal problems. He was not understanding."

A reduced pace at work, an inability to shoulder one's customary full workload, or even a change in behaviour with colleagues and superiors, all have a significant impact in the work milieu. Someone who cannot handle his or her assigned tasks must have good reasons, especially when this inability affects the workload of others. Therefore, psychosocial problems seem not to generate as much empathy from the workplace, and people experiencing such problems are often seen as not being able to "manage" their personal problems. Despite similar indicators and symptoms (insomnia, poor concentration, irritability, etc.) between those absent from work because of an illness or the death of someone close and those absent due to psychosocial factors, these two groups do not leave their work environments in the same way.

Some participants had a history of more severe psychiatric disorders (manic depressive psychosis or major depression) that led to a period of hospitalization and extended absence (more than a year) from the workplace. Beyond clinical problems, these employees experienced significant difficulties in reintegrating into the workplace due to the negative image that was associated with their leaving work. The progression of the illness affected their ability at work and in some cases led to unusual behaviour that had a damaging effect on the workplace. Practically no connection was maintained with colleagues and superiors during the absence from work. Furthermore, their absence was longer and their return to work more difficult than those without severe psychiatric disorders. A number of employees expressed concerns about the negative judgments of colleagues and superiors upon their return to work.

> The relationship is not an easy one. Sometimes I have mood swings. I almost get to the point of getting mad at somebody or at the employer. How can I put it? I understand that it is not necessarily coming from the employer, but from my mental state. I always manage to come back and explain myself. (Claude, technician)

Finally, difficulties related to the psychosocial work environment emerged as important factors in contributing to the deterioration of employees' health and stopping work. Work overload and reorganization of the workplace, pressures to perform, lack of recognition for their efforts, job insecurity,

conflictual relations with colleagues or a superior, and risks associated with certain trades are workplace-related factors identified as impacting employees' psychosocial health.

> I worked very hard, very hard. I arrived at seven o'clock in the morning, and left at six. I took work home and I worked weekends. I felt able to do it and I was not aware that I was getting exhausted. I made myself sick, and I got sick. (Claudine, manager)

It is noteworthy that a number of workers feared returning to the same working conditions that led them to leave. Few had any control over factors that could improve their working conditions, fostering a negative anticipation of the return to work. For people who stayed away after a conflict with colleagues, the idea of coming back to work evoked great anxiety: "But the idea of returning to that milieu, I kept imagining myself with two colleagues, and the idea of going back just floored me. In fact, I could have gone back much sooner" (Cassandra, technician).

Stopping Work and the Recuperation Process

Employees resisted stopping work due to a mental health problem, particularly if they had never had any mental health issues and previously felt well-adjusted at work. There are still many prejudices surrounding mental health problems, and frequently workers reacted very negatively to the idea of leaving work due to such an illness. When explaining their reluctance to seek medical advice and leave work, participants discussed their fear of being perceived as weak and unable to cope with the pressures of life:

> The people who worked for me told me, "You are worn out, stop, you should stop it." But I toughed it out, I endured because my pride kept me at work. I knew I was tired. I knew I should do something, but I did not dare ask for it. It was forbidden. You have to be strong. Men don't ask for things like that, and they don't cry. Sickness was for women, then for the weak. (Christian, manager)

Treatment principally consisted of taking medication, generally antidepressants. Rest was the first step in the process of recovery. Along with medical supervision, a number of people also pursued psychotherapy at the suggestion of the attending physician or the person responsible for employee assistance. Clinical interventions focused on the development of individual adaptation strategies. Few interventions involved an analysis of the psychosocial work environment and risk factors in the workplace.

Employees were apprehensive about the illness and afraid of returning to work too soon, conditions that were not conducive to successful reintegration. For a number of participants, this anxiety was raised at each meeting with their doctor, not knowing from one doctor's appointment to another whether their absence would be extended and wondering how the doctor could assess the extent of this distress that was not very visible compared to a physical ailment.

> If someone had told me, "Take your time!" I would have perhaps recovered more quickly. I would have caught my breath. I wanted to be reassured, to hear someone say, "This will pass, the doctor will not send you back to work in three months. It's going to take a certain amount of time." It seems to me that I would have recovered more quickly. As it was, I kept up the stress by returning too quickly. (Christian, manager)

Management practices with regard to absences also generated anxiety and concern. The employer's or the insurer's demands by mail or telephone for precise dates of return, or even the frequency

with which workers must file medical reports, were sources of disturbance and worry. Furthermore, administrative letters contesting the date of return prescribed by the doctor elicited heated reactions.

> I knew that I was not able to go back, but I always had to get the doctor's okay every two or three weeks. The fact of having to get permission every time I saw the doctor, knowing that I could not return to work, was a stress that I lived through every time. I told myself, "Okay, is he going to make me go back to work after one month, two months?"—knowing that it was not the answer. (Christina, manager)

Some employers also required participants to submit to examination by psychiatric experts. These demands for expert opinions were puzzling since there was no forewarning or explanation for the reasons underlying these demands. While in principle, such a demand for medical expertise would only validate the diagnosis and treatment proposed by the patient's own doctor, this measure was perceived by several participants as a questioning of the genuineness of their illness and of their integrity. Some were deeply hurt by these measures, interpreting them as a form of non-recognition of their health problems. Having to meet an external expert harmed the relation of trust with their employer and, in certain cases, gave rise to indignation and bitterness that undermined the process of reinstatement.

> I was ill at ease. I felt like a thief. I had the impression that I had to justify my status as an invalid. I had the impression that there was a lack of trust—as if they thought I was abusing the system. I am so used to being "clean" in everything I do. I make great demands of myself, and the fact that there was some doubt did not go down well with me. It was my reputation, and it was not acceptable. I want it to be unsullied. (Carine, professional)

Return to Work and Support Offered

Most participants expressed apprehension about going back to work. Therefore, it is not surprising that a gradual return to work, an approach designed to facilitate the progressive readaptation of the individual to his or her work, was an option favoured by participants; they perceived this as a way to mitigate the impact of returning to work on their health. Most often, gradual return to work was implemented on the advice of the employee's doctor or a counsellor in human resource management. Most participants returned to work for two or three days a week for several weeks. Nonetheless, after this period, few managed to get back to their regular "cruising speed." Conscious of their fragile health at the time of the return, these employees often used the maximum time allowed for a gradual return to work (6 months). Perhaps this lengthy process is an indication of the difficulty employees experience in going back to work even when it is gradual. Further research is warranted on the question, "To what extent does a gradual return encourage an employee to eventually return to work full-time and remain in the job?"

Analysis of the interviews allowed us to understand the tension between, on the one hand, the goal of reintegrating the employee through a gradual return and, on the other, the goal of maximizing productivity. These two goals were contradictory, thus negating the benefits of a gradual return. Indeed, employees had to cut short their gradual return to work due to the numerous tasks that awaited them. This study found that gradual return to work can be effective only if the work context is favourable. That is, a progressive return to work is meaningful and beneficial for the reintegration and

readaptation process when the workload and responsibilities also increase gradually. However, because the work context is so focused on performance-oriented goals, it is difficult for colleagues and superiors to offer genuine support for reintegration.

> They told us, "Pay attention!" But that wasn't it—it wasn't enough. . . . It is as though they expected the person to take charge of it. . . . Even if they had told us to pay attention [to our health], that they were going to lighten [the employee's workload]. . . . But it wasn't the case. (Claudine, manager)

The absence of support in the workplace also characterized Camille's experience. She revealed that her new job and heavy workload diminished her capacity to work and harmed her general health. Her colleagues adopted a rather contradictory attitude towards her, which had the effect of adding to the pressure. She perceived the warm welcome of her work colleagues upon her return as a double-edged sword:

> Everyone told me, "Listen, take your time coming back and everything." That was the language they used. But, on the other hand, in their actions it was completely different because in the hallways and the elevators, on the escalators, in the meeting rooms, even in the washrooms, "Ah, you're back? Wow! We were really waiting for you. We wanted you back. Have you seen the minutes of the committee on such a such a date that talks about . . . all that?" (Camille, technician)

This study reveals that few employees witnessed an improvement in their working conditions, either through a lightening of the workload or a redefinition of tasks, by the time of their return to work. Many employees who were still absent from work at the time of the interview were anxious and pessimistic about returning to the same working conditions.

> Just imagine returning to work with someone who is not able to take the pressure when one is in a crazy situation in the public service. Then the managers are measured by the output of their employees, and they get a bonus. So they put pressure on us. It's incredible! It was a big part of my anxiety, returning to work. (Clarence, technician)

Another technician expressed similar concerns. "I want to see what she is going to offer me—something different. But if she puts me back in the same position as before, it is certain that I won't be able to come back." If this were the case, this technician would consider taking a year of unpaid leave.

Although some employees returned to the same job, despite the difficulties previously experienced, the overriding majority changed employment or envisaged doing so. They felt that it was not possible to improve conditions in their current positions. One technician who did attempt to return to a high pressure position was soon caught up in the frantic rhythm that had caused her illness in the first place. "I began to be exhausted, and I said, 'I am back in the same rat-race as I was before, nothing has changed, I don't even take breaks, and I leave late.'"

DISCUSSION

A variety of events—stressful occurrences outside of work, mental disorders, and risk factors related to the psychosocial work environment—were associated with deterioration in health and withdrawal from work. These factors had different effects on the employee's relationships with colleagues and superiors and the support that they offered. While becoming "sick" after a tragic event—perceived

as a socially acceptable response that could happen to anyone—elicited support from peers and superiors, this was not the case for those experiencing difficulties due to more serious mental disorders or difficult conditions at work. This phenomenon suggests that, beyond biological aspects or individual characteristics, there is a social construct of illness. Colleagues' and superiors' more or less favourable interpretations of an illness seemed to determine the support and welcome offered to the absent employee.

Certain causes of absence are considered more valid than others, and some sicknesses are more easily accepted (Baril et al., 1994; Roberts-Yates, 2003). As Roberts-Yates stresses, workers find themselves obliged to justify the authenticity of their claim when it is viewed with suspicion and doubt by their employer, colleagues, friends, and family.

Workers had difficulty with management procedures governing absence, and with demands for expert medical opinions. According to certain authors, the lack of cohesion in medical-administrative practices and support measures may have a negative impact on returning to work and remaining in the position (Baril et al., 1994; Stock, Deguire, Baril, & Durand, 1999). Roberts-Yates (2003) observes that workers perceive this treatment and readaptation as a process over which they have no control. The employers' demand that employees consult medical experts led to misunderstanding, frustration, anxiety, and hostility on the part of the workers. These various disputes exacerbated the workers' symptoms and undermined their motivation to return to work. Furthermore, Franche et al. (2004) stress that it is not obvious to workers that they should comply with these management practices at the very time when they are most vulnerable. Cooperation and respect between employers and employees are essential to build a climate of confidence in which the program to return to work will succeed (Baril et al., 2003).

Conditions under which people leave work affect the way they anticipate their return. Those who were supported throughout their period away from work, both by colleagues and superiors, anticipated the return to work positively. Even if they experienced a certain level of anxiety at the idea of going back to work, the support offered by people in their work environment helped them overcome their fears. This positive anticipation was especially marked for those who maintained contact with their work environment throughout their absence. Their relations with colleagues or superiors were determined, on one hand, by the prevailing affinities before stopping work and, on the other hand, by the recognition and acceptance of the reasons for their absence by those around them.

It is interesting to note that the nature of relations with colleagues and superiors has an impact on people's degree of positive anticipation toward return to work. Those who were supported throughout their absence seem to have entertained positive images of the workplace, and this nourished the idea that coming back to work was returning to an environment that is beneficial for mental health. According to Baril et al. (2003), social relationships at work are a source of motivation to return to work when the worker is respected by his or her superiors and colleagues. Workers who are appreciated in their work environment are also more inclined to return rapidly. On the contrary, those who experienced an upset in their social relations at work did not harbour a positive image of the workplace.

Despite the important role of colleagues and superiors in the process of anticipating the return to work, the working conditions awaiting the employee determine the manner in which he or she views the future. Anticipation of a return to working conditions that are difficult and particularly risky for one's psychological well-being seems to influence the process of reintegration. People are less likely to feel ready to return to work when they know that the work demanded of them is unchanged. Thus, a number of employees are faced with a situation they perceive as unresolved. The way in which work is seen during an absence is a major determining factor in subsequent actions. In research on musculoskeletal problems related to work, it has become increasingly clear that transformations perceived as possible affect the perception of reality. Workers who believe they can change things are more likely to see their musculoskeletal problems dissipate (Daniellou, 1999). Along the same lines, psychodynamic studies have shown that the impossibility of imagining things unfolding differently has a negative effect on mental health (Carpentier-Roy & Vézina, 2000; Dejours, 1993).

Finally, public servants' return to work is characterized by significant mobility. Given the impossibility of changing the psychosocial work environment that contributed to the deterioration in their health and their stopping work, people change their employment. Transferring jobs within the same organization may be a risky solution in the absence of preventive action to improve the work environment and organizational culture.

CONCLUSION

The inability to work due to a mental health problem, and the return to work, are influenced by management practices and the process of work integration. The support of colleagues and superiors, more cohesive medical-administrative practices and support measures, the possibility of affecting changes in the conditions that contributed to the withdrawal from work, and a gradual return to work that takes into account the demands of the job, are dimensions that should be considered to ensure a return to work and to encourage the retention of employees absent due to mental health problems.

RÉSUMÉ

Le but de cette étude est de mieux comprendre, à l'aide d'une méthodologie qualitative basée sur des données d'entrevues, les facteurs impliqués dans le processus de réintégration au travail d'employés et d'employées de la fonction publique québécoise qui s'étaient absentés en raison d'un problème de santé mentale, tel que certifié par un médecin. L'analyse des données d'entrevues a permis de reconstruire la trajectoire des personnes en tenant compte de leur expérience vécue, de leur interprétation des événements et de leurs réponses face aux difficultés rencontrées. Les résultats soutiennent que l'incapacité de travail et le retour au travail ne sont pas seulement fonction de l'état de santé mais également une construction déterminée par des pratiques de gestion qui influencent le processus de réinsertion professionnelle. Le soutien des collègues et du supérieur(e), l'amélioration des conditions ayant contribué au retrait du travail, un retour progressif et une meilleure cohésion entre les pratiques de gestion de l'absence et les mesures de soutien sont des facteurs-clés pour assurer le retour et le maintien en emploi.

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