



# Return-to-Work Following Depression: What Work Accommodations Do Employers and Human Resources Directors Put in Place?

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Published online: 23 July 2018  
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## Abstract

The magnitude of economic and social costs related to common mental disorders has a profound impact on the workplace. Returning to work following depression is, therefore, a major issue for all stakeholders involved (employee, employer, human resources director, union, physician, etc.). Considering their role in the organization, Human Resources Directors (HRD) and employers have a decisive impact on the return-to-work (RTW) process. *Purpose* This study aims to determine which RTW accommodations are implemented, following depression, by one of the central stakeholders: HRD and employers. *Methods* 219 HRD/employers participated in a semi-structured telephone interview about RTW of employees after depression. From that interview, the question related to this article was: Do you put in place work accommodations for employees after a sick leave due to depression (yes or no)? If their response was positive, we asked: If yes, what were the work accommodations? *Results* 170 HRD/employers specified accommodations. The most common categories identified were related to: work schedule, task modifications, job change and work environment change. Accommodations directly related to the employee or the colleagues were considerably less mentioned and those concerning other RTW stakeholders, including supervisor, were almost absent. *Conclusion* Our results suggest that accommodations directly related to work aspects seemed to predominate in our sample of HRD/employers when an employee returned-to-work following depression. The relational aspect and the involvement of the different stakeholders are also not prioritized to accommodate the RTW. These results contrast with employer best practice guidelines for the RTW of workers with common mental disorders.

**Keywords** Return to work · Depression · Disability leave · Employer · Work accommodation

## Introduction

The magnitude of depression is such that it causes deleterious effects on people, organizations and society. Depressive disorders (major depressive disorder/depressive episode and dysthymia) are estimated to affect 322 million people worldwide with 7.5% of all years lived with disability in 2015 [1]. In that context, major depressive disorder is one

of the central contributors to disability, worldwide [2, 3]. Major depressive disorder represents a significant economic burden estimated at \$210 billion in the United States in 2010 [4]. Presenteeism (reduced productivity at work) and absenteeism (reduced work hours and missed days from work) account for almost half of these costs (48–50%) [4].

The detrimental effects of depressive disorders on work performance are well described in the literature [5–7]. Workers with depression, compared to workers without depression, will have more lost productive time (e.g. start work later or leave sooner, redoing a job, working slower than usual, tiredness at work) caused by personal health difficulties [8] and organizational problems [9]. The lost productive time (LPT) by workers with depression is estimated to cost United States employers around \$44 billion per year compared with \$13 billion per year for none depressive workers [8]. Diminished productivity while at work (presenteeism) accounts for the majority (81%) of that LPT cost [8]. Based on 55 industries (8235 employers) in western

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Pennsylvania, Wulsin et al. [10] showed that depression rates change depending on the workplace (6.9–16.2%; the general rate was 10.45%) [10], supporting the role of workplaces in depression. According to this study, work stress, exigent clientele interactions and less demanding physical work seem to contribute to the high rates of depression in the industries studied [10]. Humanly and economically impacting the workplace, work disability challenges employers to act promptly for the benefit of their employees and their organization.

Work disability conceptualization by researchers influences all aspects of their research and their focus on individual or organizational variables [11]. However, a certain common ground exists in the literature concerning work disability, defined “as a relational concept resulting from the interaction of multiple dimensions that influence each other through different ecological levels”, as circumscribed by Lederer et al. [11]. Defining work disability as a multifaceted dynamic construct emerging from interactions between individual, organizational and societal levels expands our understanding of all aspects involved which influence the disability [11].

A best practices review on how to manage common mental disorders, including depressive disorders, includes many studies on workplace-based intervention [12–15] which focus mainly on clinical interventions. More specifically, the employer best practice guidelines for mental health disability, with versions created in Canada, the United Kingdom and Australia, underline the notion of work accommodations in the sustainable return-to-work and all advise employers to have a clear disability policy with precise roles and responsibilities for stakeholders, a procedure for disability leave and to provide work accommodations [16]. Comparing scientific literature, grey literature and stakeholder feedback from both, Williams-Whitt et al. [17] attest to the consensus around the worth of work accommodations in the RTW process. RTW process in which work accommodations have an important role can be divided into six distinctive steps: (1) time off and recovery period; (2) initial contact with the worker; (3) evaluation of the worker and his job tasks; (4) development of a return-to-work plan with work accommodations; (5) work resumption, and (6) follow-up of the return-to-work process [18]. Not surprisingly, providing work accommodation is one of the most endorsed practices from the guidelines and best practices review to facilitate the RTW and stay at work of the employee [12, 16–19]. The Americans with Disabilities Act (ADA) of 1990 and the ADA Amendments Act (ADAAA) of 2008 established important laws requiring employers to provide reasonable accommodations to employees with either physical and/or mental disabilities, unless doing so creates undue hardship for the employer [20]. To implement these work accommodations, senior management’s endorsement in

granting the supervisor the latitude to decide on required accommodations is fundamental [18]. Also contributing to the success of work accommodations implementation is the establishment of a common vision of sustainable RTW for the employee among all the stakeholders involved in the return (e.g. employee, supervisor, colleagues, union, physician, insurer) [21]. Furthermore, increasing awareness of stakeholders to reduce stigma about mental health disorders [22] will help employees to disclose their work accommodations needs [23].

According to the scientific literature, work accommodations (i.e. work adjustments, job accommodations, work modifications) for common mental disorders encompasses providing accommodations to overcome difficulties during the RTW (e.g. lack of stamina, poor concentration, reduced organization capacities, more difficult learning process) and facilitating relational aspects at work (e.g. supervisor relationship, relationships with colleagues, peer support group program) [24–27]. Our understanding of work accommodations encompasses a broader perspective by adding relational aspects outside of the work environment (e.g. physician, insurer and other health professionals) and the involvement of RTW stakeholders (employee, supervisor, colleagues, union, physician, insurer) in the work accommodation plan. Furthermore, work accommodations should be malleable, well adapted to the needs of the worker and address the organization’s challenges [18]. Even if work accommodations are agreed upon practices, in the past 20 years, few studies have addressed work accommodation implementation and outcomes in workplaces for people with mental illness, including depression [28]. Even less is known about the Human Resources Directors’ (HRD)/employer’s work accommodation practices following depression, specifically. Yet, HRD/employers are central to the work accommodation process and are the main resource identified by supervisors to assist them in this process [29]. The literature specifies the work accommodations contributing to RTW and stay at work (SAW) success for employees with common mental disorders, but does empirical knowledge find its way into workplace practices?

This is the purpose of this Canadian study which specifies the RTW accommodations implemented following depression by one of the central stakeholders: HRD and employers.

## Methods

This study is part of a broader research project carried out in Quebec (Canada) which portrays the reality of four central stakeholders implicated in the RTW process of employees on sick leave due to depression: the employees diagnosed with depression [30], the union representatives [31], the supervisors [32] and the HRD/employers. This study aims

to depict the practices of HRD/employers when it comes to work accommodations after depression. Different sources were used for identifying potential participants: a list of the major Small and Medium-size Enterprises in Quebec, the *Centre patronal de santé et sécurité au travail du Québec*, the *Association paritaire pour la santé et la sécurité du travail—secteur affaires municipales*, the *Ordre des conseillers en ressources humaines agréés*, *Les 500 au Québec* and the *Registraire des entreprises au Québec*. From that list, the research coordinator contacted the HRDs of the larger organizations and the employers for the smaller sized businesses. Two inclusion criteria were required for participating in this study: (1) speaking French or English and (2) being a HR director or the employer of the organization. This study was approved by the ethics committee of the Université de Sherbrooke. The HRD/employers participated in a 45- to 60-min semi-structured telephone interview, in which most of the questions came from the Bayle interview [33] adapted to the Quebec context. This study is based specifically on the section of the interview concerning work accommodations. The question of interest was: *Do you put in place work accommodations for employees after a sick leave due to depression? (yes or no)?* If their response was positive, we asked: *If yes, what were the work accommodations?* The verbatim was coded using Gallagher descriptive analysis method [34]. Repeated readings of the verbatim were used to create work accommodations categories. Next, a categorical analysis grid was created to facilitate the quotation of each specific work accommodation. To improve interrater reliability of coding, the quotation using the categorical analysis grid was carried blindly by two coders (MFB, MC). The interrater agreement was at 94%. The few disagreements were discussed until consensus.

## Sample Description

There were 219 respondents—HRD ( $n = 150$ ) and employers ( $n = 69$ )—in this study. The majority were women ( $n = 163$ ; 74.4%), men represented just 25.6% of our sample ( $n = 56$ ). The average age was 41.3 years ( $SD = 10$  years) and 89% of our sample had a university diploma ( $n = 195$ ). Organizations were mostly in Montreal ( $n = 134$ ; 61.2%) or outside Montreal ( $n = 85$ ; 38.8%). Most of them came from tertiary ( $n = 161$ ; 73.5%) or secondary sectors ( $n = 55$ ; 25.1%). Of the HRD/employers, 170 confirmed that their organization put work accommodations in place for employees returning to work after a sick leave due to depression.

As presented in Table 1, the 170 respondents who provided work accommodations were not different by gender, title or region from the 49 individuals who did not answer affirmatively the question: *Do you put in place work accommodations for employees after a sick leave due to depression*

**Table 1** Respondent's description

Variable	n = 219 n (%)	n = 170 n (%)	n = 49 n (%)	p
Gender				0.59
Men	56 (25.6)	42 (24.7)	14 (28.6)	
Women	163 (74.4)	128 (75.3)	35 (71.4)	
Age				0.04*
20–30 years	36 (16.4)	27 (15.9)	9 (18.4)	
31–40 years	65 (29.7)	53 (31.2)	12 (24.5)	
41–50 years	71 (32.4)	48 (28.2)	23 (46.9)	
51–60 years	47 (21.5)	42 (24.7)	5 (10.2)	
Education				0.001**
University	195 (89.0)	159 (93.5)	36 (73.5)	
Other	24 (11.0)	11 (6.5)	13 (26.5)	
Economic sector				0.001**
Secondary	55 (25.1) <sup>a</sup>	33 (19.6) <sup>a</sup>	22 (45.8) <sup>a</sup>	
Tertiary	161 (73.5)	135 (80.4)	26 (54.2)	
Size of the organization				0.001**
5–99	38 (17.4)	23 (13.5)	15 (30.6)	
100–499	90 (41.1)	66 (38.8)	24 (49)	
> 500	91 (41.6)	81 (47.6)	10 (20.4)	
Title				0.06
Human resources director	150 (68.5)	122 (71.8)	28 (57.1)	
Employer	69 (31.5)	48 (28.2)	21 (42.9)	
Region				0.32
Montreal	134 (61.2)	107 (62.9)	27 (55.1)	
Outside Montreal	85 (38.8)	63 (37.1)	22 (44.9)	

*n* number of respondents

\* $p < 0.05$ ; \*\* $p < 0.001$

<sup>a</sup>Due to missing data, the average is not always at 100%

(yes or no)? Group differences were significant for age ( $\chi^2 = 8.55$ ;  $df = 3$ ;  $p < 0.04$ ); education ( $\chi^2 = 15.69$ ;  $df = 1$ ;  $p < 0.001$ ); economic sectors ( $\chi^2 = 13.49$ ;  $df = 1$ ;  $p < 0.001$ ) and size of the organization ( $\chi^2 = 14.14$ ;  $df = 2$ ;  $p < 0.001$ ). More precisely, the 49 respondents who did not answer affirmatively were mostly in the 41–50 years old bracket (46.9%); came from both economic sectors; had 20% less university degrees and counted 27% fewer organizations over 500 employees when compared to the 170 respondents (see Table 1).

## Results

### Work Accommodation Categories

The principal categories of work accommodations for employees following a depression retrieved from HRD/

employer's answers were related to *work schedule* (category 1, 96.47%), to *the tasks* (category 2, 48.82%) and to *job change and work environment* (category 3, 37.65%). Categories directly related to *the employee* (category 4, 18.82%), the *colleagues/work team* (category 5, 10.59%), the *supervisor* (category 6, 2.94%) were mentioned less frequently. The category related to *human changes* was also less mentioned (category 7, 8.24%). Moreover, the categories related to other stakeholders of the RTW, *physician* (category 8, 5.29%), *mental health professionals* (category 9, 4.71%), *employment counselor/rehabilitation consultant* (category 10, 1.18%), were found to be underrepresented. The category related to *stakeholders* was reported by one respondent (category 11, 0.59%). The categories related to *temporary assignment* (category 12) and *other accommodations* (category 13) were named by 2.35% of the participants (Table 2).

### Work Accommodations Implemented

HRD/employers named specific work accommodations implemented in their practices for employees following depression. Each work accommodation mentioned was linked to a category above (Table 2). The most frequently implemented work accommodations retrieved were: Arrange, modify, reduce working schedule/flexible schedule (in category 1, 50.59%), gradual RTW/prolong the gradual RTW (in category 1, 42.94%), modify/reorganize/lighten the tasks/reduce the workload (in category 2, 41.18%), realize, allow a change of job (in category 3, 18.24%) and make changes to the work environment (in category 3, 9.41%). It is worth mentioning that few implemented work accommodations were from the employee category. The main ones included were: train, update, coach the employee/refresh knowledge, guide and assist in tasks/information day (5.89%), respect and show flexibility according to the capacities, needs and limitations of the employee (3.53%) and meet the employee (2.94%). The remaining work accommodations mentioned by HRD/employers were less implemented (less than 7%).

### Discussion

This study aimed to determine which RTW accommodations following depression are put in place by one of the central stakeholders: HRD/employers. Our findings provide a better understanding of the work accommodations implemented by HRD/employers, dedicated to employees returning to work after a sick leave due to depression. The most common work accommodation categories identified by HRD/employers related strictly to some aspect of the work: work schedule, task modifications, job change and work environment change. These results align with the recent scoping

review from McDowell and Fossey [28], and are congruent with Bolo et al.'s study [26] about work accommodations received by employees with mental disorders. For example, these two studies indicated that reduced work hours and modified job duties were among the most commonly implemented work accommodations for people with mental disorders. In addition, Bolo et al. [26] reported that provision of services from an Employee Assistance Program and access to a peer support group also figured highly among the accommodations employees received. In the Schultz et al. study [24], however, employers had the most experience with other types of work accommodations for employees with mental disorders. For example, more accommodations oriented toward employee needs and their functional limitations, illustrated by open communication with managers, praise and reinforcement, written instructions, extra training time, allowing phone calls for support and having flexible leave for health issues.

More precisely, the accommodations most often implemented by HRD/employers in our study were arrange/modify, reduce work schedule/flexible schedule (50.59%) and allowing gradual return/prolong the gradual RTW (42.94%). These types of accommodations are recognized as effective if combined with gradually increasing tasks, respecting workers' limitations [35, 36], and if they are implemented in a supportive work context [37]. Several studies showed that the beneficial effects of work accommodations could be jeopardized if they were interpreted by colleagues as unfair [38, 39], if they negatively impacted colleagues, generating resentment [40] or if they took place in a work environment where high performance expectations limit social support at work [37]. Almost half of the HRD/employers in our study realized that modified/reorganized/lighten the tasks/reduce workload helped employees return to work after a sick leave due to depression. According to Brenninkmeijer et al.'s [41] longitudinal cohort study of employees sick listed due to mental health problems, changing/modifying the work task has a positive effect on the course of depressive symptomatology. However, it remains important to consider job strain (high job demands and low job control) when it comes to changing/modifying the tasks [42]. For example, modification of tasks or change of job and/or environment could be beneficial if they reduce job strain strongly associated with the development of depressive symptoms among employees [43–45]. Thus, implementing work accommodations focused on the work task with specific attention on job strain could significantly reduce the risk of depression [46] and, thereby, prevent relapses among employees returning to work following depression.

Our results are in line with Williams-Whitt et al.'s [17] observation that employer interventions are mainly motivated by the medical work disability paradigm, with less consideration of the biopsychosocial paradigm recognized

**Table 2** Categories and work accommodations

	n (%)
Category 1. Accommodations related to schedule	
1.1 Gradual return-to-work (RTW)/prolong the gradual RTW	73 (42.94)
1.2 Arrange, modify, reduce working schedule/flexible schedule (e.g., no night shifts)	86 (50.59)
1.3 Avoid overtime	2 (1.18)
1.4 Encourage taking leave (paid or not paid)/take time off from the leave bank/taking back the time off	3 (1.76)
Total	164 (96.47)
Category 2. Accommodations related to task	
2.1 Modify/reorganize/lighten the tasks/reduce workload	70 (41.18)
2.2 Break up, divide tasks	11 (6.47)
2.3 Reduce productivity expectations/reduce or remove sales objectives	2 (1.18)
Total	83 (48.82)
Category 3. Accommodations related to job change and work environment	
3.1 Rearrange, adjust the workstation	5 (2.94)
3.2 Make changes to the work environment (e.g. change of department, unit, work station location, relocation)	16 (9.41)
3.3 Realize, allow a change of job (reassignment, transfer, less stressful position)	31 (18.24)
3.4 Enable teleworking (working from home)	6 (3.53)
3.5 Adapt/avoid job rotation	2 (1.18)
3.6 Reduce the amount of travelling required for the job	3 (1.76)
3.7 Create a rest area	1 (0.59)
Total	64 (37.65)
Category 4. Accommodations concerning the employee	
4.1 Respect and show flexibility according to the capacities, needs, limitations of the employee	6 (3.53)
4.2 Solicit the employee's participation so that he communicates his needs, gets involved	1 (0.59)
4.3 Train, update, coach the employee/refresh of the knowledge, guide and assist the employee in tasks/information day	10 (5.89)
4.4 Offer support, accompany the employee	3 (1.76)
4.5 Value, recognize, encourage the employee	3 (1.76)
4.6 Meet the employee (e.g., evaluate if he is ready to return to work)	5 (2.94)
4.7 Conduct follow-ups with the employee/establish a follow-up program	4 (2.35)
Total	32 (18.82)
Category 5. Accommodations concerning the colleagues/work team	
5.1 Sensitize the work team about depression	1 (0.59)
5.2 Solicit the collaboration, implication, communication (or the discretion) of the colleagues	3 (1.76)
5.3 Encourage the team to offer support to the employee	2 (1.18)
5.4 Promote team work/tasks sharing	2 (1.18)
5.5 Offer twinning with a colleague/employee sponsorship	6 (3.53)
5.6 Allow supernumerary replacement/add a colleague so the employee is not alone	4 (2.35)
Total	18 (10.59)
Category 6. Accommodations concerning the supervisor	
6.1 Support, equip, accompany/offer coaching to the supervisor	1 (0.59)
6.2 Meet/conduct follow-ups/speak with the supervisor	2 (1.18)
6.3 Solicit the collaboration of the supervisor	1 (0.59)
6.4 Encourage the supervisor to meet with his employee/to welcome him	1 (0.59)
Total	5 (2.94)
Category 7. Accommodations related to human changes	
7.1 Supervisor change (if related to the absence)	3 (1.76)
7.2 Team change	6 (3.53)
7.3 Clientele change	4 (2.35)
7.4 Remove staff supervision	1 (0.59)
Total	14 (8.24)

**Table 2** (continued)

	n (%)
Category 8. Accommodations concerning the physician	
8.1 Respect physician recommendations	4 (2.35)
8.2 Provide a flexible schedule for consultation with the physician	5 (2.94)
Total	9 (5.29)
Category 9. Accommodations concerning mental health professionals	
9.1 Involve a mental health counselor	1 (0.59)
9.2 Set up telephone follow-ups with a nurse specialized in work place	1 (0.59)
9.3 Set up meeting with a social worker	1 (0.59)
9.4 Refer the employee to the employee assistance program/refer to psychological services	3 (1.76)
9.5 Allow psychologist session as often the employee needs	1 (0.59)
9.6 Provide external services to help at home/help with family life	1 (0.59)
Total	8 (4.71)
Category 10. Accommodations concerning employment counselor/rehabilitation consultant	
10.1 Set up meetings with employment counselor, involve him	1 (0.59)
10.2 Involve a rehabilitation consultant	1 (0.59)
Total	2 (1.18)
Category 11. Accommodation concerning stakeholders (three and more)	
11.1 Establish a gradual RTW in collaboration with the Insurer and the physician, collaborate with them	1 (0.59)
Total	1 (0.59)
Category 12. Accommodations related to temporary assignment	
12.1 Transfer to a temporary office job	2 (1.18)
12.2 Offer a temporary assignment	2 (1.18)
Total	4 (2.35)
Category 13. Other accommodation	
13.1 Encourage to take a walk	1 (0.59)
13.2 Facilitate retirement	2 (1.18)
13.3 Encourage family support	1 (0.59)
Total	4 (2.35)

*n* number of respondents who mentioned the work accommodation, %  $n/170$  (total of respondents who provide work accommodation)

to most effectively prevent and manage work disability [17]. As formulated by the International Classification of Functioning, Disability and Health (ICF), disability is considered to be an interaction between individuals with a health condition, and personal and environmental factors [47]. This broader definition of disability and the duty by law in Canada and in the United States to put in place reasonable work accommodations for employees with disability (which is restricted only by undue hardship for employers) [48, 49], tends to open workplace practices to a wider range of accommodations less centered on strict aspects of work. Undue hardship is defined by the ADA National Network as “action requiring significant difficulty or expense when considered in light of a number of factors”. These factors include “the nature and cost of accommodations in relation to the size, resources, nature, and structure of the employer’s operation” [50]. As illustrated in the jurisprudence in Quebec (Canada), work accommodations related to psychosocial work environment (e.g., reducing psychological strain, providing

respectful working relationships, adapting the work to the capacities of the employee), are now requested [9]. As formulated by Laflamme [9], “By implementing measures to change the psychosocial work environment, accommodation not only promotes access to and retention of employment among people with mental disorders, but also opens the way to first stage prevention for the benefit of all.”

First, in this study, key actors of the RTW (employee, colleagues, supervisor, union, physician) have been neglected in HRD/employer practices. However, best practice guidelines (BPGs) [23, 51–53] recommend their involvement and collaboration to achieve sustainable RTW. Achieving sustainable RTW requires that the different interests of stakeholders are overcome [21], along with potential barriers for their collaboration (e.g. lack of communication, role conflict, mistrust) [40]. Furthermore, BPGs [23, 51–53] address which actions should be taken by key actors of the RTW process, and recommend that the RTW plan and work accommodations are adapted to the needs and functional capacity of the

employee. In this vein, the employee remains central to the work accommodation planning and his/her active involvement is essential to the RTW process according to the BPGs [23, 51–53] and the literature [18, 31]. Unexpectedly, less than 4% of HRD/employers mentioned work accommodation related to show flexibility according to the capacities, needs and limitations of the employee. One explanation might be the lack of knowledge of HRD/employers about specific symptoms of depression that persist [54], even during the RTW. For example, cognitive difficulties are the most important perceived barrier to RTW of workers on sick leave due to common mental disorders [55] and persistent cognitive difficulties affected numerous workers during their RTW [56]. In that context, we cannot expect a complete remission of depressive symptoms when returning to work, which emphasizes the need to involve the employee and clearly define his functional limitations to ensure work accommodations are adapted to his/her needs. In addition, providing employer training about reasonable accommodations for employees with common mental disorders could optimize their practices [57].

Second, the importance of welcoming and support from colleagues during the RTW of the employee is encouraged by BPGs [23, 52, 53]. Also, their participation in work accommodation planning, considering that some work accommodations could impact them is well described in the literature [58, 59]. However, in our study less than 2% of HRD/employers solicited collaboration/implication communication or discretion from colleagues and no one referred to their involvement in the discussion of work accommodations. Yet, beyond social support, colleagues can also be involved in task sharing, twinning or coaching the employee to facilitate the resumption of work after a sick leave.

Third, supervisors play a substantial role in the employee's RTW and BPGs [23, 51–53] recommend his/her active participation in the RTW process (e.g. clarifying with the employee the barriers of the RTW, establishing the RTW plan; implementing work accommodations; monitoring the RTW process; supporting the employee). The supervisor's attitude [30, 60], support [61], empathy [31], competencies [62], and their intention to take measures to facilitate the return [32] or their pressure during the RTW [32] have a decisive impact, positive or negative, on the RTW and stay at work outcomes. Surprisingly, only 3% of HRD/employers implemented work accommodations that involved the supervisor. A possible hypothesis for this lack of involvement of colleagues and supervisor in work accommodations is that working relationships and social support at work are not conceptualized as work accommodations by HRD/employers, while natural supports in the workplace are essential for facilitating the RTW of people with a mental disorder [63]. Potentially, HRD/employers considered these relational aspects (working relationship

and social support) to be the responsibility of the supervisor who works closely with the employee and who is more aware of the team dynamic and productivity goals. This hypothesis is supported by Negrini et al's study [32], where supervisors' responses to the Work Accommodation and Natural Support Scale (WANSS) [64] demonstrated that they do indeed take on the responsibility of implementing work accommodations centered on relationship needs, take time to assist/orient the employee, provide rewards or recognition and provide emotional support for the employee during the RTW of employees following a depression.

Fourth, BPGs [23, 51–53] considered the Union representative as a key actor that could facilitate the employee's return to work (e.g. providing information about RTW possibilities; collaborating to the RTW plan with stakeholders; supporting the employee). No participant in this study mentioned the implication of the Union when asked about work accommodations. This situation could potentially be explained by the unclear roles and responsibilities the Union's representatives have in the RTW process and the variability in their means to be involved with the employee after a sick leave due to depression [31]. Neglecting the involvement of key actors (employee, colleagues, supervisor and Union) not only prevents access to facilitators of the RTW and SAW, but also may lead to missed critical issues (psychosocial factors, relational aspects, persistent symptoms, job strain, impact on the colleagues, etc.) that could jeopardize the RTW process and increase the risks of relapse.

There are both strengths and limitations to this study. To our knowledge, this is the only study that determines what work accommodations are implemented by HRD/employers, specifically for employees returning to work after depression. This qualitative descriptive analysis provides a comprehensive understanding of workplace practices, of what HRD/employers prioritize and how they conceptualize work accommodation for employees who return to work after depression. It also contrasts employer practices with scientific literature on the subject and depicts, once more, the need to fill the gap between workplace and research. However, this article also has limitations that are important to understand. First, our sample comes mainly from large organizations located in the greater catchment area of Montreal (QC, Canada), so our results may not represent the reality of smaller companies or those located in other cities. Nevertheless, a pool of 170 organizations, including 38.8% of our sample from outside Montreal, allows us to clearly identify major orientations related to this research theme. In addition, not using a questionnaire systematically, like the WANSS [64] to specify the answers of HRD/employers about implemented work accommodation, may have reduced the diversity of accommodations named in this

study. However, proceeding accordingly allowed us to minimize the influence of social desirability in our participants' responses.

In terms of clinical implications, residual symptoms of depression during the employee's RTW may be difficult to observe for the HRD/employers, risking late discovery of the difficulties experienced by the employee. In that context, having efficient work accommodations implemented not only facilitates the employee's RTW, but also acts as a preventative practice to minimize worsening of the psychological condition and reduce eventual relapses. However, non-disclosure of the diagnosis by the employee due to the fear of being stigmatized makes work accommodation planning considerably more complex [63]. In addition, the lack of awareness among employees and HRD/employers of effective work accommodations after a depression limits the scope of possible work-based interventions.

Moreover, the HRD/employers are not usually equipped to properly identify the functional limitations of their employees following their RTW. Similarly, the employee's physician, concentrating primarily on the improvement of depression to determine work resumption, does not specifically evaluate the functional limitations of the employee. Furthermore, physicians generally know very little about their patient's job requirements and even less about the mental charge it requires. Therefore, without appropriate knowledge of functional limitations and work abilities, the implementation of work accommodations could remain unpredictable. Accurate assessment of functional limitations and work abilities could greatly improve work accommodations planning. Proper training of physicians in this regard offers an interesting opportunity to optimize the RTW process. However, considering that evaluation of functional limitations and work abilities is presently a rare practice for mental disorders, improving the knowledge of key stakeholders—employees, supervisors, HRD/employers, physicians—about the most prevalent functional limitations during the RTW following depression could serve as a solid foundation for work accommodation planning. Improving knowledge about specific types of work accommodations deemed to be effective in overcoming functional limitations after depression would help to ensure better outcomes in the RTW process. For example, implementing accommodations such as offering a quieter work environment, breaking up and writing down the tasks to be completed and gradually increasing responsibilities, can be helpful for the employee with cognitive difficulties.

On the other hand, work demands and work relationships as psychosocial factors at work are strongly linked to the onset and development of depressive symptoms. Prevailing psychosocial factors at work from before the employee's absence could still impact him/her during work resumption. The employee may avoid pointing out the genuine

psychosocial issues related to his sick leave (e.g., job strain, lack of recognition, conflicts with the team or the supervisor), fearing negative consequences, being judged or that nothing will change. Thereby, deleterious psychosocial factors at work become vectors favoring absenteeism and presenteeism problems in workplaces. Addressing those psychosocial issues at work, therefore, requires more complex involvement of employers, compared to actions carried out strictly on the job (e.g., gradual return to work, reduction of workload).

To conclude, this study depicts with a substantial sample which work accommodations are put in place by HRD/employers for employees specifically returning to work after depression. Our study brought to light that accommodations directly related to work aspects—work schedule, modifications of the tasks, job change and work environment change—seem to predominate in HRD/employer practices. Even if these practices could be beneficial for the employee, they do not encompass crucial aspects of a sustainable RTW. Scientific literature and employer best practice guidelines for the RTW of employees with common mental disorders emphasize the importance of psychosocial factors at work and the involvement of stakeholders to optimize the RTW process. Our article, thus, underlines the need to reunite workplace practices with empirical knowledge to reduce the substantial personal, societal and economic costs associated with work disability for common mental disorders. To act directly on absenteeism and presenteeism in the workplace, we must broaden the planning of work accommodations. Optimizing HRD/employer practices in this regard will benefit all employees and organization's profitability and sustainability.

**Funding** This work was supported by a funding grant from the Canadian Institutes of Health Research (CIHR). Grant Number: 201386.

## Compliance with Ethical Standards

**Conflict of interest** Marie-France Bastien and Marc Corbière declare that they have no conflict of interest.

**Ethical Approval** All procedures performed in studies involving human participants were in accordance with the ethical standards of the Sherbrooke University (human research ethics committee).

**Informed Consent** Informed consent was obtained from all participants included in the study.

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