Randomised trials on return-to-work programmes for major depressive disorder

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In many industrialised countries, the high prevalence and/or increasing trends in disability and work loss due to depressive disorders are worrying. For example, in Finland almost one in every three new work disability benefit recipients is disabled for work because of mental health problems. A common disorder such as depression, with a lifetime prevalence of up to 25% for women and 12% for men, would justify primary prevention programmes. Although such programmes have proven helpful for some conditions such as cardiovascular diseases, evidence for primary prevention of depression is limited, although many of the risk factors for depression have been identified as modifiable.

While this lack of evidence is not a sufficient reason to abandon well-designed primary prevention programmes, it does provide health professionals and authorities with an incentive to focus preventive efforts on disability due to major depressive disorder through secondary prevention strategies.

In recent years, there has been considerable interest in the evaluation of the potential benefits from secondary prevention of work disability. Since the 1990s, many innovative rehabilitation programmes for sick-listed employees have been developed. The so-called Sherbrooke model, which aims at an early return to work (RTW) through integration of the workplace in the treatment programme, was first applied to low back pain. Evidence now indicates that this type of workplace-based intervention is more effective than usual healthcare interventions for reducing sick leave and preventing work disability among employees with musculoskeletal disorders.

The Sherbrooke model has recently been modified to fit the Dutch healthcare and compensation system, labelled as collaborative or integrated care, and tested in various sick-listed populations. It has proven effective in low back pain and patients with chronic hand eczema, but the evidence is inconclusive for distress. The differences in the effectiveness of the workplace component on the RTW outcome in these interventions still raise questions. The underlying mechanisms of successful RTW programmes remain far from being fully understood.

In this issue of the journal, two randomised controlled trials (RCT) from The Netherlands expand our knowledge of the benefits of RTW interventions targeting depressive disorders in occupational settings. Both studies have included employees with major depressive disorder and have selected them based on sick leave status.

The trial conducted by Vlasveld et al was carried out within a large occupational health service. Altogether 14 595 employees on sickness absence due to mental disorders between 4 and 12 weeks were first screened for depressive symptoms with a questionnaire. A total of 20% responded. Thereafter a research assistant interviewed 1551 employees by telephone. Employees who met the DSM-IV criteria for major depressive disorder according to the structured interview and consented (n=139) were included. They had moderate-to-severe symptoms (eg, about 50% suffered from general anxiety). The study evaluated the effectiveness of the collaborative care intervention, provided by an occupational physician care manager. The intervention was compared to usual care and contained the following elements: 6–12 sessions of problem solving treatment, manual-guided self-help, a workplace intervention and, depending on patient preference, prescription of antidepressant medication according to a treatment algorithm. The workplace intervention aimed at reaching consensus about the RTW plan, and consisted of a workplace assessment and work adjustments. The role of the occupational physician care manager was that of a process mediator and the employer and the employee together pointed out barriers for RTW and made a plan for implementation of the solutions. Nevertheless, adherence to the intervention was low: 40 employees visited the occupational physician care manager, but the workplace intervention was applied to only 5 employees. In comparison to usual care (61 employees), the intervention group (65 employees) had a shorter time to response, with a difference of 2.8 months, but no difference was found on time to remission or depressive symptoms as continuous measure. With a mean of 190 days in the collaborative care, and 210 days in the usual care, the groups did not differ significantly from each other in the duration until full RTW during the 12-month follow-up. However, as stated by the authors, the study was probably underpowered for RTW.

The other RCT by Hees et al was conducted in an academic medical centre. Potential participants (n=227) were referred by occupational physicians from several local occupational health services and were eligible (n=117) if they were diagnosed with a major depressive disorder (at least 3 months) according to DSM-IV criteria and absent from work for at least 25% of their contract hours at least 8 weeks. At baseline, more than two-thirds of the participants were depressed for more than 6 months, a high proportion were absent from work for more than 3 months with a median duration of 5 months, and more than half had had at least one previous depressive episode. The study compared the effectiveness of adjuvant occupational therapy (TAU+OT; n=78) to treatment as...
usual (TAU; n=39) in an outpatient university clinic. Employees were required to work at least 2 hours per week when starting the OT intervention, which focused on a fast RTW and improving work-related coping and self-efficacy. It consisted of 18 sessions and was provided by two experienced occupational therapists. Adherence to the adjuvant OT was good: 66 participants (85%) completed it. During the 18-month follow-up, the groups did not significantly differ in their overall work participation, but the participants in the TAU+OT group did show greater improvement in depression symptoms and increased probabilities of long-term symptom remission and long-term return to work in good health. Yet the differences between the median number of days until partial RTW (86 days) and full RTW (44 days) were in favour of the adjuvant OT. One potential explanation for the lack of statistical significance, as stated by the authors, may be insufficient power due to the high variability in the duration until RTW.

These two Dutch RCTs show promising results by targeting RTW programmes to sick-listed employees with major depressive disorder whose symptoms may endanger their ability to continue working. Both interventions led to faster recovery of symptoms and the mean or median number of days for RTW was in both trials in favour of the intervention. Yet it must be stressed that neither of the trials shows convincing results concerning enhanced RTW. Both studies seem to have been insufficiently powered.

Both interventions tried to establish an environment with good contacts between the healthcare providers and the workplace and/or occupational health professionals. However, this did not succeed too well in the other trial and maybe these interventions will not be easily replicated in other settings or countries either. Treatment and sickness certification are separated from each other in the Dutch social security legislation, and the occupational physicians by definition play a central role in the guidance of sick-listed employees, unlike many other countries. Nevertheless, these studies should be considered by both researchers and occupational health practitioners who have to promote meaningful, effective and evidence-based prevention policies for major depressive disorder. In view of the results of these studies, further research will obviously be needed to define the optimal strategies for secondary prevention of work disability in major depressive disorder and the means to identify the employees who can best benefit from them.

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