Primary Health Care Research & Development 2018; **19:** 107–109
doi:10.1017/S1463423617000482

REVIEW ARTICLE

Cochrane Review Summary: Interventions to improve return to work in depressed people

Daksha Trivedi

Senior Research Fellow, Centre for Research in Primary and Community Care, University of Hertfordshire, Hatfield, UK

First published online 9 August 2017

Key words: depressive disorder; disability; intervention; occupational health; workplace

Review question

To assess the effectiveness of interventions aimed at reducing work disability in employees with depressive disorders.

Relevance to primary care and nursing

Primary health care professionals including specialist nurses have a vital role in the clinical, therapeutic, care management and monitoring of depression (National Institute for Health and Clinical Excellence, 2016).

Characteristics of the evidence

This Cochrane review contains 20 randomised controlled trials (RCT) and three cluster RCTs involving 5996 participants (Nieuwenhuijsen *et al.*, 2014). Included studies targeted adults 17 years and over who were employees or self-employed with either a major depressive disorder or significant depressive symptoms. Diagnosis was based on the criteria of the Diagnostic and Statistical Manual, the Research Diagnostic Criteria or the International Classification of Disease. Depressive symptoms were assessed by validated self-report instruments. Workers with a co-morbidity from other common mental disorders (such as anxiety) were included.

Studies examined interventions conducted in occupational health settings, primary care or outpatient care settings. These included (1) work-directed interventions as part of the clinical treatment or as a stand-alone intervention. They all aimed at reducing work disability and supporting workers to cope with depression at the workplace. (2) Clinical interventions, that is, treatment of depressive disorder which did not focus on work, and included antidepressant medication, psychological therapies and physical interventions that used exercise. Studies were conducted in the United States ($n=7$), United Kingdom ($n=6$), the Netherlands ($n=4$), Denmark ($n=2$) and one each in Switzerland, France and Finland. One study was conducted in altogether eight European countries. Studies that did not report depressive disorder as a primary diagnosis, or involved workers with bipolar disorders or depressive disorders with psychosis were excluded.

Treatment comparisons are shown below.

Summary of key evidence

Nine studies were of low risk of bias and 14 were high risk. The quality of evidence was judged using GRADE (The Grading of Recommendations Assessment, Development and Evaluation). Outcomes were reported in the medium term (last follow-up assessment between one and 12 months after inclusion) and long term (last follow-up assessment more than 12 months after inclusion). Primary outcome was mean days of sickness absence and secondary outcomes included depression, work functioning and employment status after a period. Significant effect sizes are reported as standardised mean difference (SMD) for continuous data with 95% confidence intervals

Correspondence to: Dr Daksha Trivedi, Senior Research Fellow, Centre for Research in Primary and Community Care, University of Hertfordshire, College Lane, Hatfield AL10 9AB, UK. Email: d.trivedi@herts.ac.uk

(CI). Data were pooled in a meta-analysis where appropriate.

(1) Work-directed interventions

Moderate-quality evidence suggested that work-directed intervention in addition to clinical care (occupational therapy and multi-component work intervention incorporating work modification and support) reduced sickness absence in the medium term (SMD −0.4; 95% CI −0.66 to −0.14; three studies, $n = 251$) with no effect on depressive symptoms or in the long-term. Enhancing the clinical care in addition to regular work-directed care showed no effect on any outcome compared with work-directed care alone. Evidence from one low-quality study evaluating enhanced regular care by occupational physicians with exposure-based return to work programme compared with regular occupational physician support showed no significant effect on any outcome.

(2) Clinical interventions

Antidepressants

Three studies evaluating selective serotonin reuptake inhibitors (SSRI) compared with selective norepinephrine reuptake inhibitors on reducing sickness absence reported inconsistent results. Only one study reported improved work function. SSRI compared with tricyclic antidepressants showed no effect on these outcomes, whereas one study found that SSRI (escitalopram) compared with another SSRI (citalopram) reduced sickness absence (SMD −0.31; 95% CI −0.54 to −0.07).

Psychological

Moderate-quality evidence from three studies ($n = 326$) showed that telephone or online cognitive behavioural therapy was more effective in reducing sick leave than usual primary or occupational care in the medium term (SMD −0.23; 95% CI −0.45 to −0.01).

Psychological combined with antidepressants

Low-quality evidence from two studies ($n = 969$) showed that enhanced primary care did not significantly reduce sickness absence in the medium term or in the long term (one study). High-quality evidence from one study ($n = 604$) reported that a structured telephone outreach and care management programme was more effective in reducing sickness absence than usual care (SMD −0.21; 95% CI −0.37 to −0.05).

Exercise

One low-quality study ($n = 65$) of supervised strength exercise reduced sickness absence compared with relaxation (SMD −1.11; 95% CI −1.68 to −0.54). Aerobic exercise compared with relaxation and stretching had no significant effect (two studies, $n = 180$).

Implications for practice

Work-directed interventions combined with a clinical intervention can be effective in reducing sickness absence. Enhancing occupational or primary care with cognitive behavioural therapy and structured telephone outreach with care management that includes medication have the potential to reduce sick leave, but the number of studies is small.

Implications for research

More studies are required on addition of work-directed interventions to clinical care. Including occupational outcomes to clinical intervention studies will provide better knowledge on reducing sickness absence and improving outcomes in workers who have depression. Standardised and validated measures of sickness absence are needed.

Acknowledgements

The author is a member of the Cochrane Nursing Care Field (CNCF).

Financial Support

This research received no specific grant from any funding agency, commercial or not-for-profit sectors.

Conflicts of Interest

None.

References

National Institute for Health and Clinical Excellence 2016: Depression in adults: recognition and management. Clinical guideline [CG90]. Retrieved 30 May 2017 from https://www.nice.org.uk/guidance/cg90.

Nieuwenhuijsen, K., Faber, B., Verbeek, J.H., Neumeyer-Gromen, A., Hees, H.L., Verhoeven, A.C., van der Feltz-Cornelis, C.M. and **Bültmann, U.** 2014: Interventions to improve return to work in depressed people. *Cochrane Database of Systematic Reviews*, Issue 12, Art. No. CD006237. https://doi.org/10.1002/14651858.CD006237.pub3.