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[Intervention Review]

Interventions to improve return to work in depressed people

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ABSTRACT

Background

Work disability such as sickness absence is common in people with depression.

Objectives

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

Search methods

We searched CENTRAL (The Cochrane Library), MEDLINE, Embase, CINAHL, and PsycINFO until April 4th 2020.

Selection criteria

We included randomised controlled trials (RCTs) and cluster-RCTs of work-directed and clinical interventions for depressed people that included sickness absence days or being off work as an outcome. We also analysed the effects on depression and work functioning.

Data collection and analysis

Two review authors independently extracted the data and rated the certainty of the evidence using GRADE. We used standardised mean differences (SMDs) or risk ratios (RR) with 95% confidence intervals (CI) to pool study results in studies we judged to be sufficiently similar.

Main results

In this update, we added 23 new studies. In total, we included 45 studies with 88 study arms, involving 12,109 participants with either a major depressive disorder or a high level of depressive symptoms.

Risk of bias

The most common types of bias risk were detection bias (27 studies) and attrition bias (22 studies), both for the outcome of sickness absence.

Work-directed interventions

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Work-directed interventions combined with clinical interventions

A combination of a work-directed intervention and a clinical intervention probably reduces sickness absence days within the first year of follow-up (SMD -0.25, 95% CI -0.38 to -0.12; 9 studies; moderate-certainty evidence). This translates back to 0.5 fewer (95% CI -0.7 to -0.2) sick leave days in the past two weeks or 25 fewer days during one year (95% CI -37.5 to -11.8). The intervention does not lead to fewer persons being off work beyond one year follow-up (RR 0.96, 95% CI 0.85 to 1.09; 2 studies, high-certainty evidence). The intervention may reduce depressive symptoms (SMD -0.25, 95% CI -0.49 to -0.01; 8 studies, low-certainty evidence) and probably has a small effect on work functioning (SMD -0.19, 95% CI -0.42 to 0.06; 5 studies, moderate-certainty evidence) within the first year of follow-up.

Stand alone work-directed interventions

A specific work-directed intervention alone may increase the number of sickness absence days compared with work-directed care as usual (SMD 0.39, 95% CI 0.04 to 0.74; 2 studies, low-certainty evidence) but probably does not lead to more people being off work within the first year of follow-up (RR 0.93, 95% CI 0.77 to 1.11; 1 study, moderate-certainty evidence) or beyond (RR 1.00, 95% CI 0.82 to 1.22; 2 studies, moderate-certainty evidence). There is probably no effect on depressive symptoms (SMD -0.10, 95% CI -0.30 to 0.10; 4 studies, moderate-certainty evidence) within the first year of follow-up and there may be no effect on depressive symptoms beyond that time (SMD 0.18, 95% CI -0.13 to 0.49; 1 study, low-certainty evidence). The intervention may also not lead to better work functioning (SMD -0.32, 95% CI -0.90 to 0.26; 1 study, low-certainty evidence) within the first year of follow-up.

Psychological interventions

A psychological intervention, either face-to-face, or an E-mental health intervention, with or without professional guidance, may reduce the number of sickness absence days, compared with care as usual (SMD -0.15, 95% CI -0.28 to -0.03; 9 studies, low-certainty evidence). It may also reduce depressive symptoms (SMD -0.30, 95% CI -0.45 to -0.15, 8 studies, low-certainty evidence). We are uncertain whether these psychological interventions improve work ability (SMD -0.15, 95% CI -0.46 to 0.57; 1 study; very low-certainty evidence).

Psychological intervention combined with antidepressant medication

Two studies compared the effect of a psychological intervention combined with antidepressants to antidepressants alone. One study combined psychodynamic therapy with tricyclic antidepressant (TCA) medication and another combined telephone-administered cognitive behavioural therapy (CBT) with a selective serotonin reuptake inhibitor (SSRI). We are uncertain if this intervention reduces the number of sickness absence days (SMD -0.38, 95% CI -0.99 to 0.24; 2 studies, very low-certainty evidence) but found that there may be no effect on depressive symptoms (SMD -0.19, 95% CI -0.50 to 0.12; 2 studies, low-certainty evidence).

Antidepressant medication only

Three studies compared the effectiveness of SSRI to selective norepinephrine reuptake inhibitor (SNRI) medication on reducing sickness absence and yielded highly inconsistent results.

Improved care

Overall, interventions to improve care did not lead to fewer sickness absence days, compared to care as usual (SMD -0.05, 95% CI -0.16 to 0.06; 7 studies, moderate-certainty evidence). However, in studies with a low risk of bias, the intervention probably leads to fewer sickness absence days in the first year of follow-up (SMD -0.20, 95% CI -0.35 to -0.05; 2 studies; moderate-certainty evidence). Improved care probably leads to fewer depressive symptoms (SMD -0.21, 95% CI -0.35 to -0.07; 7 studies, moderate-certainty evidence) but may possibly lead to a decrease in work-functioning (SMD 0.5, 95% CI 0.34 to 0.66; 1 study; moderate-certainty evidence).

Exercise

Supervised strength exercise may reduce sickness absence, compared to relaxation (SMD -1.11; 95% CI -1.68 to -0.54; one study, low-certainty evidence). However, aerobic exercise probably is not more effective than relaxation or stretching (SMD -0.06; 95% CI -0.36 to 0.24; 2 studies, moderate-certainty evidence). Both studies found no differences between the two conditions in depressive symptoms.

Authors' conclusions

A combination of a work-directed intervention and a clinical intervention probably reduces the number of sickness absence days, but at the end of one year or longer follow-up, this does not lead to more people in the intervention group being at work. The intervention may also reduce depressive symptoms and probably increases work functioning more than care as usual. Specific work-directed interventions may not be more effective than usual work-directed care alone. Psychological interventions may reduce the number of sickness absence days, compared with care as usual. Interventions to improve clinical care probably lead to lower sickness absence and lower levels of depression, compared with care as usual. There was no evidence of a difference in effect on sickness absence of one antidepressant medication compared to another. Further research is needed to assess which combination of work-directed and clinical interventions works best.

PLAIN LANGUAGE SUMMARY

What are the best ways to help people with depression go back to work?

What is depression?

Depression is a common mental health problem that can cause a persistent feeling of sadness and loss of interest in people, activities, and things that were once enjoyable. A person with depression may feel tearful, irritable, or tired most of the time, and may have problems with sleep, concentration, and memory.

Depression may affect people's ability to work. People with depression may be absent from work (off sick), or feel less able to cope with working.

Going back to work

Reducing depressive symptoms may help people with depression to go back to work. Treatments include medications and psychological (talking) therapies, or a combination of both. Changes at the workplace could also help, such as:

changing a person's tasks or working hours;

supporting them in a gradual return to work; or

helping them to cope better with certain work situations.

Why we did this Cochrane Review

Work can improve a person's physical and mental well-being; it helps build confidence and self-esteem, allows people to socialise, and provides money. We wanted to find out if workplace changes and clinical programmes could help people with depression to return to work.

What did we do?

We searched for studies that looked at whether workplace changes and clinical programmes affected the amount of sick leave taken by people with depression. Clinical programmes included: medicines (anti-depressants); psychological therapies; improved healthcare by doctors; and other programmes such as exercise and diet.

Search date: we included evidence published up to 4 April 2020.

What we found

We found 45 studies in 12,109 people with depression. The studies took place in Europe (34 studies), the USA (8), Australia (2) and Canada (1).

The effects of 'care as usual' were compared with those of workplace changes and clinical programmes to find out:

how many days people with depression were on sick leave

how many people with depression were off work;

people's symptoms of depression; and

how well people with depression could cope with their work.

What are the results of our review?

Our main findings within the first year of follow-up, for workplace changes or treatments compared with usual care, are listed below.

Workplace changes combined with a clinical programme:

probably reduce the number of days on sick leave (on average, by 25 days for each person over one year; 9 studies; 1292 participants);

do not reduce the number of people off work (2 studies; 1025 participants);

may reduce symptoms of depression (8 studies; 1091 participants); and

may improve ability to cope with work (5 studies; 926 participants).

Workplace changes alone:

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may increase the number of days on sick leave (2 studies, 130 participants);
probably do not lead to more people off work (1 study; 226 participants);
probably do not affect symptoms of depression (4 studies; 390 participants); and
may not improve ability to cope with work (1 study; 48 participants).

Improved healthcare alone:

probably reduces the number of days on sick leave, by 20 days (in two, well-conducted studies in 692 participants, although not in all 7 studies, in 1912 participants);

probably reduces symptoms of depression (7 studies; 1808 participants); and

may reduce ability to cope with work (1 study; 604 participants).

Psychological therapies alone:

may reduce the number of days off work, by 15 days (9 studies; 1649 participants); and

may reduce symptoms of depression (8 studies; 1255 participants).

We are uncertain if psychological therapies alone affect people's ability to cope with work (1 study; 58 participants).

How reliable are these results?

Our confidence in these results is mostly moderate to low. Some findings are based on small numbers of studies, in small numbers of participants. We also found limitations in the ways some studies were designed, conducted and reported.

Key messages

Combining workplace changes with a clinical programme probably helps people with depression to return to work more quickly and to take fewer days off sick. We need more evidence to assess which combination of workplace changes and clinical programmes works best.

Improved healthcare probably also helps people with depression to take fewer days off sick.