Employees with common mental disorders: from diagnosis to return to work
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Summary
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Common mental disorders are associated with limitations in many domains of life, including limitations in work productivity and sickness absence. Occupational physicians play a key role in the management of return to work of those employees who are absent from work. However, the quality of these rehabilitation activities has hardly been investigated, despite the extensive time spent on these activities by occupational physicians. The main aim of this thesis is to contribute to quality improvement of occupational rehabilitation of employees with common mental disorders. The first way to attain this goal is to measure the quality of the process of occupational rehabilitation and to relate this to return to work. Secondly, this thesis focuses on generating scientific knowledge and evaluating practical tools for occupational physicians, aimed at the diagnoses, clinical manifestations and prognosis of common mental disorders.

In Chapter 2, a self-report questionnaire, the Depression Anxiety Stress Scales (DASS), is evaluated for use in occupational health care. The psychometric properties and the diagnostic ability of the DASS were tested in our population of employees with common mental disorders. In this study, we found support for the internal consistency, the construct validity, and criterion validity of the DASS. The diagnostic ability of the DASS was tested by applying a cut-off score for the depression and the anxiety scales and comparing these scores with a diagnosis derived by a clinical interview. This study revealed that the DASS showed low posterior probabilities of a depression or anxiety disorder for those employees with scores below the cut-off point. However, the DASS also showed relatively low posterior probabilities of a depression or anxiety disorder for employees with scores higher than the cut-off point. These results suggest that the DASS can be helpful in ruling out the possibility of an anxiety disorder or depression in a population of employees with common mental disorders. However, the diagnosis of employees with scores above the cut-off point should be corroborated by a clinical interview.

Chapter 3 concerns one of the clinical manifestations of common mental disorders; irrational beliefs. In this chapter, the irrational beliefs in our cohort of employees with common mental disorders are examined. We investigated whether patients with different types of common mental disorder differed in their level, type and stability of irrationality. A self-report questionnaire, the Irrational Belief Inventory (IBI), was used to examine irrationality from baseline until one-year follow-up. The second aim of this study was to examine whether a change in irrational beliefs in these diagnostic groups was related to
symptom recovery. This study showed that irrational beliefs differed between different diagnostic groups in level, but not in type. Employees with a depression had lower levels of irrationality compared to employees with anxiety disorders, but higher levels than the group with adjustment disorders. The group with adjustment disorders had levels of irrationality at baseline which were comparable to normal controls. Furthermore, the magnitude and direction of change in irrational beliefs was related to the magnitude of recovery of depressive, anxiety, and stress symptoms over time. These findings suggest that occupational physicians can conduct similar cognitive interventions for all common mental disorders. Furthermore, cognitive interventions seem most appropriate for employees with a depression or anxiety disorder.

Chapter 4 involves the prognosis of employees with common mental disorders in our cohort study. We developed a clinical prediction rule using information that is potentially available to an occupational physician during the first consultation. Possible predictors were entered into a multivariate Cox’s regression model with time until return to work as outcome measure. Predictive of a poor prognosis were older age (>50 years), pessimistic recovery expectations of the patient, medium or high educational level, and a diagnosis being depression and/or anxiety disorder. By assigning each of those predictors one point if present, a simple prediction rule was constructed that showed acceptable discrimination. Even though caution is required when generalising these results to external populations, the use of this prediction rule could help identify potentially unfavourable cases.

Chapter 5 of this thesis studied supervisory behaviour as a predictive factor for return to work. We conducted interviews with 85 supervisors of employees in our cohort study. These interviews took place six months after the onset of sickness absence. Three aspects of supervisory behaviour during the period of absence were measured: communication with the employee, promoting gradual return to work, and consulting with other professionals. These three indices were related to time to return to work using Cox’s regression analysis. It was shown that positive supervisory behaviour during the occupational rehabilitation of the employee can enhance return to work. However, the relationship between supervisory behaviour and return to work seemed more complex than we had hypothesised. In fact, the study showed that consulting with other professionals, such as human resource managers or psychologists, by supervisors was related to a longer time until return to work, regardless of the severity of depressive symptoms. Yet, frequent communication between supervisor and employee during the return-to-work process was associated with favourable return-to-work rates in employees with low levels
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of depressive symptoms. For employees with high levels of depressive symptoms, frequent contacts were not related to return to work.

Chapter 6 describes the results of a retrospective cohort study of a 100 employees absent from work due to adjustment disorders. An audit of medical files was conducted to assess the quality of occupational rehabilitation, using the method of performance indicators. This study also addressed the question whether high quality was related to better outcome. One aspect of quality, namely adequate continuity of care, was related to a shorter time until both a first return to work and full recovery. Adequate interventions aimed at the organisation, for instance conferring with the supervisor, were related only to a shorter time until a first return to work. We did not find a relation between overall quality of care, indicated by the sum of the performance indicators, and return to work.

The study described in Chapter 7 further validated content validity of a set of performance indicators by means of an expert round. Content validity was established for 10 out of 11 performance indicators by conducting a structured assessment of the expert opinions. This Chapter also reports on the use of these performance indicators in our cohort study of employees with common mental disorders. This revealed that high overall quality of occupational rehabilitation was associated with a shorter time until return to work. Furthermore, the prospective cohort study found adequate interventions targeted at the curative sector to be inversely related to outcome, whereas a correct evaluation of work disabilities was related to better outcome. We found no effect of occupational rehabilitation on symptom reduction, and poor quality of care was associated with higher patient satisfaction.

Chapter 8 addresses the main findings of this thesis and elaborated on the following methodological features: the observational design of the studies, the generalisability of the findings, the use of performance indicators, and the analysis of predictors of return to work. Next, the implications for occupational health practice are presented. Occupational physicians are advised to adhere to the practice guidelines. The implications for the use of the generated scientific knowledge and the evaluated practical tools are also discussed. For instance, occupational physicians are advised to assess information on the patient’s expectation of the duration of the absence. On the level of the professional organisation of the occupational physicians, we recommend to include employees in the process of guideline development and refinement. The main recommendation for employers is that they should incorporate quality of occupational rehabilitation in their choice for an
occupational health service. Whenever an employee is absent from work due to common mental disorders, their supervisor is encouraged to frequently contact them.

High quality of care, as determined by adherence to practice guidelines, is related to a shorter time until return to work. Interestingly, no relation was found between quality and symptom levels, while an inverse relation with patient satisfaction was demonstrated. With regard to future research, we advise to address the relation between guideline adherence of occupational physicians and patient satisfaction. Especially, the role of the communication skills of the occupational physicians should be incorporated in this type of study. Two directions for future intervention studies are recommended: the experimental manipulation of the recovery expectations of employees and the development and evaluation of a training in managing return to work for supervisors.