Work-focused treatment of common mental disorders and return to work: a comparative outcome study
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Record Status
This is a critical abstract of an economic evaluation that meets the criteria for inclusion on NHS EED. Each abstract contains a brief summary of the methods, the results and conclusions followed by a detailed critical assessment on the reliability of the study and the conclusions drawn.

CRD summary
This study evaluated the effectiveness and costs of work-based cognitive-behavioural therapy (CBT), to help return to work, for employees on sick leave with common mental disorders. The authors concluded that focusing more and earlier on work-related aspects in CBT could accelerate return to work, without hindering symptom recovery. The study was methodologically robust, and appropriate adjustments were made. The findings were reported thoroughly, and the authors acknowledged the need for more detailed costing. The conclusions were appropriate.

Type of economic evaluation
Cost-effectiveness analysis

Study objective
This study evaluated the effectiveness and costs of work-based cognitive-behavioural therapy (CBT), to help return to work, for employees on sick leave with common mental disorders.

Interventions
Standard CBT was compared with work-based CBT. Standard CBT consisted of 12 sessions that focused on identifying the problem and reducing the symptoms, followed by one or more modules, chosen in dialogue with the employee, for the remaining sessions. Modules could incorporate work-based issues, if employees chose to address them, but the protocol was not focused on work-based issues. Work-based CBT integrated work-related homework and exercises into the standard CBT, and framed psychological issues around how they might relate to returning to work. Return to work was the focus of work-based CBT, and was incorporated from the start.

Location/setting
The Netherlands/out-patient care.

Methods
Analytical approach:
The economic evaluation was conducted alongside a quasi-experimental study, in association with a large mental health centre. Four departments, in different geographical locations, were split between standard and work-based CBT, with patients assigned to a department by their geographic proximity. Participants were followed up at one, three, six, and 12 months after initial assessment. The authors stated that the perspective was that of the employers.

Effectiveness data:
Participants were recruited from a large out-patient mental health centre. The common psychological problems included Adjustment Disorder, and Mood Disorder; Major Depressive Disorder, and Post-Traumatic Stress Disorder were excluded. The study recruited 208 out of 250 eligible employees; 79 for standard CBT and 89 for work-based CBT were analysed. The primary effectiveness data were time to full return to work, and time to partial return to work. Relapses were measured. The percentages of employees fully resuming work within three, six, and 12 months were reported. Secondary effectiveness measures related to mental health status, such as stress, depression, and anxiety. Multi-level statistical modelling was used for missing data and to measure whether individual therapists correlated with mental health outcomes. Survival analysis was undertaken to show differences in return to work status over time. Baseline differences were tested for statistical significance, and differences were adjusted for using statistical modelling.
Monetary benefit and utility valuations:
Not relevant.

Measure of benefit:
The measures of benefit were the effectiveness outcomes.

Cost data:
The analysis focused on the costs of paying employees on sick leave. The cost of a day of sick leave was estimated from a private consultancy report on sick leave in Europe. The number of days until full return to work were calculated from the study, and then averaged by intervention. The costs were reported in Euros (EUR).

Analysis of uncertainty:
The data were reported with measures of variance, and some tests for statistical significance were conducted.

Results
The proportion of patients who had fully resumed work at one year was not statistically significantly different (p>0.05) between interventions, but at three and six months follow-up there was a statistically significant difference, in favour of work-based CBT (p<0.05).

Patients receiving work-based CBT had a statistically significant better chance of full or partial return to work. Median full return to work was 65 days earlier, and median partial return to work was 12 days earlier, for work-based compared with standard CBT.

Patients receiving work-based CBT were more likely to return to work earlier, but they were also more likely to relapse (15.7% work-based versus 7.6% standard CBT; p=0.10), and they took more steps to return to work fully, indicating a more gradual return to work.

The individual therapist had no significant effect on treatment efficacy. No statistically significant differences were found between interventions in the resolution of mental health problems.

Employers paid an average EUR 16,727 for employees receiving standard CBT and EUR 13,085 for those receiving work-based CBT; a difference of EUR 3,642 in favour of work-based CBT.

Authors' conclusions
The authors concluded that focusing more and earlier on work-related aspects in CBT could accelerate return to work, without hindering symptom recovery, benefiting employees, employers, and care providers.

CRD commentary
Interventions:
The interventions were thoroughly described and appear to have been appropriate.

Effectiveness/benefits:
It was not entirely clear how patients were allocated to their treatment group. The authors indicated that this was based on geographic proximity to a therapist. They appropriately tested for and adjusted for baseline differences, and tested for the effects of individual therapist on effectiveness. This might have captured some of the differences in treatment effectiveness, due to geographic location, but a test for whether location affected the results, does not appear to have been conducted. Generally, reporting of the methods was good, and the effectiveness measures were thoroughly described and appear to have been appropriate.

Costs:
The study only evaluated and reported the cost savings to the employer, which was the objective of the study. It was not clear if the work-based treatment entailed no additional costs; there were no extra contact hours, for example. The authors acknowledged that additional costs could have been incorporated, including productivity costs, costs for replacement workers, intervention costs, insurance payments, other health care use, and individual wages (as opposed to averages). The inclusion of such costs could change the amount of savings to the employer. The methods used to
calculate the costs were transparent and seem to have been appropriate.

Analysis and results:
The authors conducted appropriate statistical analyses, and the results were generally well reported. Not all the results were reported with comparisons for statistical significance between interventions, but the general direction of the effects was clear. Multi-level modeling was used to account for missing data, assuming that they were missing at random. Further analysis of uncertainty could have been undertaken, using bootstrapping, which could give a likelihood that patients would return to work at given time points, and a likelihood of work-based CBT being superior, both of which would be valuable for decision makers. The authors compared their results with those of other similar studies, and gave a thorough evaluation of the differences. They acknowledged that to reach firmer conclusions on cost-effectiveness, additional analysis, including more complete costs, was necessary.

Concluding remarks:
The study was methodologically robust, and appropriate adjustments were made for initial imbalances. The findings were reported thoroughly, and the authors indicated the need for more detailed costing. The conclusions were appropriate.

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