BJPsych | The British Journal of Psychiatry (2012)
200, 442–443. doi: 10.1192/bjp.bp.111.103598

Editorial

Better care for depression in the workplace: integrating occupational and mental health services†

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Summary
People with depression in the workplace are less productive and at risk of losing their job. Many never work again. Intervention should ideally begin before sickness absence occurs and early return to work should be the focus of care. This will require closer integration of primary care, mental health and occupational health services.

Declaration of interest
None.

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Common mental disorders such as depression may cause misery and hardship to people with these conditions and to their carers and families. Alongside this personal impact, depression also results in lost productivity and blunts the competitive edge of companies who rely on a healthy workforce. In times of economic downturn, those with depression may be among the first workers to be shed. Individuals with depression may slide rapidly from paid employment to welfare, which has financial and emotional consequences. Many who lose a job through depression will never re-enter the workforce.[1] The journey from work to welfare via depression is a vicious circle.

The case to intervene is compelling. Traditionally, primary care and specialist mental health services have been left to 'pick up the pieces' when depression eventually leads to sickness absence or enforced worklessness. This is unfortunate, since worklessness compounds the sense of failure among individuals with depression. Workplace-based services provided by occupational health have traditionally not provided treatment for people with depression who remain at work.[2] Their role has been to signpost workers who are depressed to services within the National Health Service and to manage sickness and 'return to work' when things go wrong. Where workplace care has been offered, this has largely been for 'stress' rather than case-level depression[3] or has involved 'broad brush' interventions (such as employee assistance programmes or counselling) with more limited evidential support for their benefits in the treatment of depression.[4] A study published in this issue of the *Journal* provides an alternative approach that bridges the historical but artificial divide between occupational health and health services. Vlasveld and colleagues[5] present an important trial conducted in The Netherlands of an intervention designed and delivered in the workplace for those with clinical depression who are still at work.

What do we know about the link between work and depression?

The link between depression and work is complex and causal associations are often difficult to prove. However, it is well established that certain aspects of work and the workplace are detrimental to psychological well-being and may increase the chances of developing clinical depression, especially among vulnerable individuals. Epidemiological insights have emerged over two decades from a range of cohorts. These have been usefully summarised by Stansfeld & Candy[6] who quantified associations between workplace factors and common mental disorders (including depression). Predictors of distress include lack of decision authority (odds ratio (OR) = 1.2, 95% CI 1.1–1.4); job insecurity (OR = 1.3, 95% CI 1.1–1.7) and job strain (OR = 1.8, 95% CI 1.1–3.1). One of the most robust predictors of depression in the workplace is 'effort–reward imbalance' (OR = 1.8, 95% CI 1.5–2.4); an elegant description that captures overwork for poor pay, with limited employment rights and job insecurity. Once depression emerges (for whatever reason), then the chances of sickness absence are several times higher than in the rest of the workforce, and the prospects of early retirement through ill health are increased. Once employees take sickness absence for depression and, potentially, lose contact with the workplace, it is much more difficult to get them back to work. Employing or retaining workers with depression becomes less attractive to employers since workers with sickness-absence due to mental ill health are seven times more likely to have further absence than those with physical health-related sick leave.[7,8] The protection of disability and discrimination legislation is likely to be partial.

What are the economic and workforce implications of depression?

Given what we know about employment and depression, what are the implications for employers and society? A 2007 report by the Sainsbury Centre for Mental Health suggests that the proportion of sickness absence that can be attributed to common mental health conditions could be in the region of 40%.[1] For the UK working population this equates to 70 million days lost to mental health problems each year. But what of those with depression who remain in the workplace? Occupational psychologists have introduced the term 'presenteeism', defined as 'the lost productivity

†See pp. 510–511, this issue.

that occurs when employees come to work ill and perform below par because of that illness'.[9] In the case of depression, this may involve poor concentration, reduced attention span and low motivation. These clinical features are likely to make those with depression the least productive in the workforce. Research is beginning to emerge that quantifies the implications of presenteeism. Reworking USA data, the Sainsbury Centre for Mental Health estimates that the costs of presenteeism were likely to be '1.8 times as important as absenteeism'.[1] The total costs of common mental disorders (absenteeism, presenteeism and staff turnover) may be nearly £26 billion.

The case for intervention in the workplace

The case for offering appropriate interventions to those with depression who are still in the workplace is therefore compelling.[2] The link between depression, welfare and productivity was central to the Layard report and the subsequent expansion of psychological services in the UK through the Improving Access to Psychological Therapies programme.[10] There is preliminary evidence that this programme has helped people come off benefits and return to work.[11] However, there has been no expansion of services specifically targeted at those at work. The recent report by Dame Carol Black and David Frost on health, work and employment[12] makes specific recommendations on the improved provision of health assessment and intervention in the workplace, and support for early return to work before problems become ingrained. How might this work? The trial by Vlasveld and colleagues in The Netherlands presents a possible model.[5]

Collaborative care for depression in the workplace

The trial by Vlasveld *et al*[5] builds upon a burgeoning literature relating to collaborative care and case management for depression. Some psychiatrists in the UK may be unfamiliar with this intervention, which combines telephone support, low-intensity psychological therapy, medication management and symptom monitoring using the principles of care that underlie the management of all long-term conditions.[13] Our own reviews have shown this to be an effective and efficient means of delivering care,[13] and the evidence base to support collaborative care in depression is substantial compared with that for other widely advocated therapies such as cognitive–behavioural therapy and counselling. Further, Vlasveld and colleagues' trial[5] builds upon an emerging literature that has shown that collaborative care may also be effective in improving employment outcomes and may be 'cost-saving' in terms of improved productivity and reduced absenteeism.[14] The Dutch trial expands this evidence base by showing that effective care for depression can be transferred into the workplace using occupational health case managers who liaise with general practitioners and mental health specialists where necessary. The results show that depression is effectively treated and their results are in line with the findings of other trials using this model of care. Of course, enthusiasm must be moderated as this was a relatively small trial with limited statistical power and the results require large-scale replication, including a more detailed analysis of sickness absence and cost-effectiveness in the UK, and an exploration of ways in which the intervention might need modification to maximise the impact in workplace settings. Challenges might also arise in adapting this model of care beyond The Netherlands where there is a greater tradition of integration between employers and healthcare providers. Assuming further positive results, we would suggest that this is a feasible model for the delivery of better care for individuals with depression in the workplace and a closer integration between primary care, mental health services and employers as envisioned in recent reports.[1,12] Collaborative care is an intervention that can be delivered by a range of healthcare professionals, and occupational case managers may be ideally suited to this role.[2]

Concluding comments

The current economic downturn has focused minds on cuts in mental health services and the impact that this may have on service provision and patient outcomes. However, we should not underestimate the potentially important role that mental health services have in supporting the workforce, reducing the impact of depression on the performance of the UK economy, and reversing the vicious circle between work and depression.

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First received 8 Dec 2011, final revision 16 Apr 2012, accepted 16 Apr 2012

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https://doi.org/10.1192/bjp.bp.111.103598 Published online by Cambridge University Press