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Collaborative care for major depressive disorder in an occupational healthcare setting

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Summary
Randomised controlled trial to evaluate the effectiveness of collaborative care in a Dutch occupational healthcare setting: 126 workers on sick leave with major depressive disorder were randomised to usual care (n = 61) or collaborative care (n = 65). After 3 months, collaborative care was more effective on the primary outcome measure of treatment response (i.e. reduction in symptoms of ≥50%) on the Patient Health Questionnaire-9 (PHQ-9). However, the groups did not differ on the PHQ-9 as a continuous outcome measure. Implications of these results are discussed.

Declaration of interest
C.M.v.d.F.-C.: payment for a presentation at the International Journal of Integrated Care conference, grants for collaborative care trials for anxiety (from The Netherlands Organisation for Health Research and Development, ‘ZonMw’) and for return to work (from Achmea), and payment from Eli Lilly for a lecture on diabetes and depression. H.J.A.: fee from the Trimbos Institute for consulting on the statistical analyses and comments on the draft manuscript.

Evidence-based treatments for major depressive disorder are available, yet show disappointing results in daily practice. To improve depression outcomes, a primary care treatment model, collaborative care, has been developed in the USA. Key elements of collaborative care are: continuous monitoring of symptoms, collaboration between healthcare professionals and access to a consultant psychiatrist. Moreover, the role of a care manager is introduced, who coordinates care, assists in the management of major depressive disorder and monitors treatment progress. Currently, extensive evidence supports the effectiveness of collaborative care, and new research projects are studying the effectiveness of collaborative care in other countries, populations and healthcare settings.1,2 In this study, collaborative care was evaluated in a Dutch occupational healthcare setting (trial registration: ISRCTN78462860).3

Major depressive disorder is a prevalent condition in Dutch occupational healthcare settings. Dutch workers with major depressive disorder are absent eight to nine times more often than their colleagues without major depressive disorder.3 In the Netherlands, occupational physicians play a central role in the care of workers on sick leave. However, because treatment and sickness certification are separated in the Dutch legislation, there is a lack of communication and collaboration between occupational physicians and the curative sector.5 Furthermore, access to treatment in specialised mental healthcare is often hampered by waiting lists. Therefore, occupational physicians aim to play a more prominent role themselves in the care of workers on sick leave with major depressive disorder.6 In the present study, the effectiveness of collaborative care, applied by occupational physician–care managers, is examined for workers with depression on sick leave.

Method
In this randomised controlled trial (RCT), the effectiveness of a collaborative care treatment for major depressive disorder was compared with usual care. Computer-generated randomisation took place at participant level. In both groups, participants received sickness guidance as usual by their company’s occupational physician, however, only participants allocated to the intervention group also received collaborative care from an occupational physician–care manager. The study protocol, including a power calculation and the method of masking, is described in greater detail elsewhere.3,7

Results
Of 14,595 workers approached, 2955 (20.2%) filled in the screening questionnaire, of whom 52.5% (n = 1551) screened positive for depression (online Fig. DS1). Subsequently, 1425 workers were excluded and 126 participants were included and randomised in the usual care group (n = 61) or collaborative care group (n = 65). Three months after baseline, 98 participants filled in the questionnaire. Almost two-thirds (62%) of the collaborative...
The present study showed that collaborative care, applied in the occupational healthcare setting, was more effective than usual care in terms of response to treatment among individuals on sick leave with major depressive disorder. However, for depressive symptoms as a continuous outcome measure, no effect for collaborative care could be found. In post hoc analyses, collaborative care was found to be more effective than usual care among those with moderately severe depression. However, these latter results are secondary and need to be interpreted carefully and confirmed in future research.

Interestingly, a significant effect was found for the dichotomous outcome measure, whereas this was not the case for the continuous one. As previously described by Poirier et al., this discrepancy can be explained by the variation in the PHQ-9 scores: collaborative care participants were overrepresented in the groups with a large decrease in symptoms and with no improvement or a slight increase in symptoms, whereas usual care participants were in the majority in the group with a moderate decrease of symptoms. Although response is an internationally recognised outcome measure, these results can be interpreted as modest since an effect on the continuous outcome measure is lacking.

The innovation in this study is the new role of the occupational physician as care manager in the treatment of major depressive disorder. Training and close supervision were given to them, which, together with the web-based tracking system, made it easier for them to adopt their new role. However, a substantial number of the participants did not visit the occupational physician—care manager. Waiting lists, that had to be operated during the study, suboptimal implementation of collaborative care during the study, further implementation of collaborative care is not yet justified. Future research needs to confirm whether collaborative care has added value for individuals with at least moderately severe depression (PHQ-9 ≥15).

References


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