

## Depression-from remission to functional recovery

van der Feltz-Cornelis, C.M.; Volker, D.; Vlasveld, M.C.

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# Depression – from remission to functional recovery

C. van der Feltz-Cornelis<sup>1,2,3</sup>; D. Volker<sup>1,2</sup>; M. Vlasveld<sup>2</sup>

<sup>1</sup>Tranzo Dept., Tilburg University, Tilburg, the Netherlands; <sup>2</sup>Trimbos Instituut, Utrecht, the Netherlands; <sup>3</sup>Clinical Center for Body, Mind and Health, GGz Breburg, Tilburg, the Netherlands

## Keywords

Depression, remission, absenteeism, return to work

## Summary

Depression occurs frequently in the general population and in the workplace and it leads to significant work absenteeism. Treatments aimed at improvement of depressive symptoms do not automatically lead to functional recovery in terms of return to work, and if they do, there is generally a long time lag. Several approaches have been suggested to improve return to work, that generally imply that the sick-listed employee should not wait for remission before resuming work, but rather try to return gradually. Personal as well as work factors influence the outcome of such a process, so that this approach has interpersonal as well as workplace implications that should be addressed at the same time as personal factors and the depressive symptoms.

## Schlüsselwörter

Depression, Remission, Arbeitsfernbleiben, Rückkehr zur Arbeit

## Zusammenfassung

Depression kommt oft in der allgemeinen Bevölkerung und am Arbeitsplatz vor, und es führt zu signifikantem Arbeitsfernbleiben. Auf die Verbesserung depressiver Symptome gerichtete Behandlungen führen nicht automatisch zu funktioneller Wiederherstellung in Bezug auf die Rückkehr zur Arbeit, und wenn sie es tun, gibt es allgemein eine große Zeitverzögerung. Mehrere Herangehensweisen sind vorgeschlagen worden, die Rückkehr zur Arbeit zu verbessern, die allgemein andeuten, dass der Erkrankte Arbeitnehmer nicht auf eine Remission warten sollte bevor er die Tätigkeit wieder aufnimmt, sondern eher versuchen sollte, allmählich zurückzukehren. Persönliche sowie Arbeitsfaktoren beeinflussen das Ergebnis solch eines Prozesses, sodass diese Annäherung zwischenmenschliche sowie Arbeitsplatz-Implikationen hat, die zur gleichen Zeit beachtet werden sollten.

Depression – von der Remission zur funktionellen Wiederherstellung

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One of the problems in psychiatry is the enormous social impact of mental disorder for the individual as well as society. Patients with mental disorders often have problems with general functioning, in personal relationships as well as at the workplace, and this often leads to loss of work for them (1). Moreover, once they lose their job due to a mental disorder, this produces stigma and diminishes their chances to re-enter the working population greatly (2) As depressive disorder is a common mental disorder that generally occurs in people who are still in their productive years, and that takes quite a while before remission occurs, if any, depressive disorder is a common cause for loss of work and remaining jobless thereafter. (3, 4) This situation should be tackled because of the obvious burden to individuals, their families, em-

ployers, and society at large, including economic costs (5). However, although several attempts have been made to address this issue, from a societal perspective (6–8), at community level (9), at general health care level (10–13), at occupational health care level (11, 14, 15), as well as from the perspective of psychiatry (16, 17), there are still several problems to be addressed as the results are inconclusive so far.

## Problem: How to achieve remission from depression?

Although depressive disorder is a common mental disorder, adequate diagnosis and treatment of the disorder is

not self-explanatory. Patients with depressive disorder often do not report their depressive symptoms directly when they visit their family doctor; generally, they present with physical symptoms (18, 19). Also, recognition of depressive disorder by the family doctor is limited (20) and this is also the case for the occupational physician. To improve recognition, several scales for assessment of, amongst others, depressive symptoms have been developed in these settings (21, 22). However, these scales are not commonly used. But even in case of adequate recognition and treatment of depression, the course of depressive disorder tends to be protracted, with relatively low recovery rates, lower remission rates, and frequent relapse (23–27). Recovery from depression is therefore limited (28) especially in case of co morbid physical symptoms or disorders (29–31). Although physicians seem to prescribe antidepressants for the right indications (32), their effect may still be limited in terms of achieving remission in many, therapy resistant cases (33, 34). Cognitive Behavioral Therapy has been suggested to diminish relapse (35) but is not a suitable treatment for everybody, since it requires active engagement, cognitive abilities including good concentration, and quite an amount of discipline to do the assignments, which may all be lacking or diminished especially in depressed patients who called in sick maybe because of that. Other barriers to optimal treatment are lack of active monitoring of treatment outcomes and poor adherence to treatment guidelines by professionals as well as patients. Enhanced depression care has been suggested to address these problems, as it combines several effective treatment modes i.e. in a collaborative care model in an easily accessible health care setting such as primary care (36). Enhanced depression care increases the systematization and organization of care by providing closer follow-up on symptoms and adherence to treatment. However, in a recent collaborative care study with good treatment response for depression in the primary care setting, remission rates were still low, albeit higher than in usual care. Remission rates were in the range of 6–13% in usual care and 21–37% in collaborative care, which may suggest that depressive disorder is not easy to treat and that if a patient experiences depressive disorder, it may be too optimistic to expect remission as regular outcome of treatment (37).

## Recommendations

Systematic attention should be paid to the possibility of depression by occupational or general physicians in their patients, whether they present with psychological or physical symptoms. When occupational or general physicians or psychotherapists start treatment, they should be

aware of the need for a sustained effort, both by the physician and the patient. Enhanced depression care such as i.e. Disease management programs (38) have shown potential, as well as collaborative care models, especially if there is structural psychiatric consultation available (39–42). However, chances are high that remission will not be a lasting outcome of depression treatment, even if treatment is adequately provided. Therefore, the question should be addressed if functional recovery in terms of return to work can be attained earlier than only after remission of depressive symptoms.

## Problem: how to improve return to work in treatment for depressive disorder?

For a long time, optimism existed not only regarding the expected outcome of treatment for depressive disorder in terms of depressive symptoms, but also for functional recovery in terms of return to work. The idea was that if the depression was properly treated, and the patient would take enough rest, return to work would occur as well. However, research shows that this optimism is unwarranted as treatment does not automatically lead to return to the workplace (43), and if it occurs, there is often a long time lag. Hees e.a. showed that there is an association between improvement of depressive symptoms and work functioning in persons receiving clinical depression treatment, but also suggested that treatment focused on qualitative functioning in the workplace may accelerate depression recovery; so, recovery at the workplace and improvement of depressive symptoms may be interrelated (44). Return to work however depends on other factors as well, such as co morbid physical disorders, personal factors and work related factors (45). For example, supervisor behavior (46) and high work pace and work load are work related factors influencing return to work (47). To sum it up, long-term remission of depression is predominantly predicted by diagnostic factors, but return to work is predicted by personal and work related factors as well (48).

Therefore, treatment should not only address the depressive symptoms, but also how to return at the workplace and this approach may be quite independent of addressing the depressive symptoms (17, 49). Combined interventions aimed at both remission as well as return to work have been developed in specialty mental health settings for clinical treatment of depression, as mentioned above; they have been developed in the primary care setting, by way of psychiatric consultation to the occupational physician and family physician (16); and they have been developed as collaborative care model in the occupational health setting (15). Providing occupational physicians with psychiatric consultation showed to be a prom-

ising approach in accelerating return to work of workers with common mental disorders (16). A more elaborate form of collaboration between occupational physicians and psychiatrists was applied within a collaborative care model, with trained occupational physicians fulfilling the treatment role and closely monitoring treatment outcomes. However, adherence to the protocol was low in the occupational physicians as well as in the workers, suggesting that having occupational physicians fulfilling the treatment role is yet a bridge too far (15). In the specialty mental health setting, adjuvant occupational therapy was examined twice. In the first study, adjuvant occupational therapy resulted in a reduction in work-loss days (17), however in the second study a shorter and improved version of the occupational therapy did not show significant benefit for improving overall work participation (49). This discrepancy in study findings may be explained by societal changes in the Netherlands that have occurred after the first study, such as legislative changes and changes in attitudes among health professionals (49). In addition, studies among workers with common mental disorders and stress-related disorders suggest that in order to promote return to work, work-focused cognitive-behavioral therapy (CBT) may be effective and that it may be particularly helpful to focus on the cognitions of workers with respect to return to work „while having symptoms“ (8).

Research also showed that trying to accelerate return to work in sick listed employees who have not yet recovered from depression completely can actually prolong time to full return to work, if it implies steadily accumulating exposure at the workplace in persons who still are (partially) depressed (50). Thus, simply starting return to work earlier while still being under treatment for depression can be too rigorous and counter-effective and should not be done without close monitoring of depressive symptoms relapse as well as actual work performance.

The optimal approach that combines depression treatment with addressing personal factors and self efficacy regarding return to work of the employee, as well as with interventions aimed at improving the work setting and the behavior of the supervisor, has not yet been established. Such a treatment model may also have to differ depending on country as the organization of care and the handling of sickness leave protocols in companies, as well as related legislation, differ greatly between countries.

## Recommendations

Interventions aimed at return to work in sick-listed employees with depressive disorder should both address the depressive symptoms and improve conditions in order to establish return at the workplace. These should be separate

interventions focusing on either the depressive symptoms, or return to work, provided by separate specialists in that matter, who should work closely together (17, 51). Integration of the organization of such combined care would be desirable and was proven feasible i.e. in the specialty mental health setting (16), in the primary care setting (52) and in the occupational health care setting (15). The employee should receive specific support to address his or her self-efficacy and cognitions regarding return to work, as simply resuming work earlier may be counterproductive; thus, close monitoring of the symptoms as well as progress of return to work is needed in order to achieve optimal results without setbacks.

It is time now to develop combined interventions that also involve coaching of the work supervisor or manager in order to improve return to work, aimed at adaptation of work and improvement of understanding and support in the workplace (53). The specific organization of such models may depend on the country and health care system as well as the level of integration with company provided care, because of variation in occupational health services. However, the idea that simply treating mental disorder will automatically lead to return to the workforce has not been confirmed so far. It is deemed necessary to develop multidisciplinary approaches for that (54).

Future directions for innovation and research in this field may also include blended e-health interventions that address cognitions of the sick listed employee regarding return to work, that direct the occupational physician in providing or monitoring depression treatment, and that facilitate monitoring and managerial efforts to improve swift recovery and return to the workplace (55). Such a combination of regular treatment, a web based decision aid for the professionals involved, and web based treatment of the cognitions of the sick listed employee regarding return to work combined with monitoring of depressive symptoms as well as progress in terms of return to work, may be an efficient and cost effective treatment model that warrants further exploration in research.

## Summary

Awareness is rising that absence from work in depressive disorder presents a huge burden to individuals, their families, employers and society. Depression treatment is best provided in some form of enhanced care, such as collaborative care, however even then remission of the disorder does not always occur. Return to work of employees with depressive disorder should be addressed earlier than that, preferably in some form of integrated treatment together with the treatment of the depressive symptoms, and with close monitoring of the symptoms as well as progress

of return to work. Treatment aimed at return to work should therefore complementarily address personal factors and work related factors in a multidisciplinary manner. Organization of such a treatment model may differ depending on the country. Blended e-health models may be of benefit to improve efficiency, adherence and costeffectiveness, but this still has to be established in future research.

#### Conflict of interest

In the last three years, the employer of Prof. Dr. van der Feltz-Cornelis received grants for an independent investigator initiated trial from Eli Lilly and from ACHMEA, a social insurance company. The employer received fees for lectures of Prof. Dr. van der Feltz-Cornelis from Eli Lilly and from a social insurance company, UWV. Prof. Dr. van der Feltz-Cornelis received royalties for books on the topic of psychiatry.

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#### References

- Lerner D, Adler DA, Chang H, Lapitsky L, Hood MY, Perissinotto C et al. Unemployment, job retention, and productivity loss among employees with depression. *Psychiatr Serv* 2004; 55 (12): 1371-1378.
- Alonso J, Buron A, Bruffaerts R, He Y, Posada-Villa J, Lepine JP et al. Association of perceived stigma and mood and anxiety disorders: results from the World Mental Health Surveys. *Acta Psychiatr Scand* 2008; 118(4): 305-314.
- Henderson M, Harvey SB, Overland S, Mykletun A, Hotopf M. Work and common psychiatric disorders. *J R Soc Med* 2011; 104(5): 198-207.
- Terluin B, van Rhenen W, Anema JR, Taris TW. Psychological symptoms and subsequent sickness absence. *Int Arch Occup Environ Health* 2011; 84(7): 825-837.
- Pincus HA, Pettit AR. The societal costs of chronic major depression. *J Clin Psychiatry* 2001; 62 (Suppl 6): 5-9.
- van der Hoek W. Prognose van depressie in het kader van de claimbeoordeling voor de nieuwe WAO. *Tijdschrift voor Bedrijfs- en Verzekeringsgeneeskunde* 2006; 14(4):161-166.
- van Oostrom SH, Anema JR, Terluin B, Venema A, de Vet HC, van MW. Development of a workplace intervention for sick-listed employees with stress-related mental disorders: Intervention Mapping as a useful tool. *BMC Health Serv Res* 2007; 7: 127.
- van Oostrom SH, van MW, Terluin B, de Vet HC, Knol DL, Anema JR. A workplace intervention for sick-listed employees with distress: results of a randomised controlled trial. *Occup Environ Med* 2010; 67 (9): 596-602.
- Dumesnil H, Verger P. Public awareness campaigns about depression and suicide: a review. *Psychiatric Services (Washington, D C)*, 2009 Sep; Vol 60 (9): 1203-1213.
- Von KM, Katon W, Unutzer J, Wells K, Wagner EH. Improving depression care: barriers, solutions, and research needs. *J Fam Pract* 2001; 50(6): E1.
- Bakker IM, van Marwijk HW, Terluin B, Anema JR, van MW, Stalman WA. Training GP's to use a minimal intervention for stress-related mental disorders with sick leave (MISS): Effects on performance Results of the MISS project; a cluster-randomised controlled trial. *Patient Education Counseling* 2010; 78(2): 206-211.
- Buijs P, Anema JR, Evers M, van Dijk F, van der Klink J. How general practitioners can manage work-related psychological complaints. Design and pilot of a guideline: a contribution towards solving a huge problem. *European Journal of General Practice* 2006; 12(1): 38-41.
- Buijs PC, van Dijk FJH, Evers M, van der Klink J, Anema H. Managing work-related psychological complaints by general practitioners, in coordination with occupational physicians: a pilot study. *Ind Health* 2007; 45: 37-43.
- Vlasveld MC, Van der Feltz-Cornelis CM, Adèr HJ, Anema JR, Hoedeman R, van Mechelen W et al. Collaborative care for major depressive disorder in an occupational healthcare setting. *British Journal of Psychiatry* 2011; 200(6): 510-511.
- Vlasveld MC, Van der Feltz-Cornelis CM, Adèr HJ, Anema JR, Hoedeman R, van Mechelen W et al. Collaborative care for sick-listed workers with major depressive disorder: A randomised controlled trial from the Netherlands Depression Initiative aimed at return to work and depressive symptoms. *Occup Environ Med* 2013; 70 (4): 223-230.
- Van der Feltz-Cornelis CM, Hoedeman R, de Jong FJ, Meeuwissen JAC, Drewes HW, Van der Laan NC et al. Faster return to work after psychiatric consultation for sicklisted employees with common mental disorders compared to care as usual. A randomized clinical trial. *Neuropsychiatr Dis Treat* 2010; 6: 375-385.
- Schene AH, Koeter MW, Kikkert MJ, Swinkels JA, McCrone P. Adjuvant occupational therapy for work-related major depression works: randomized trial including economic evaluation. *Psychol Med* 2007; 37(3): 351-362.
- Kroenke K, Spitzer RL, Williams JB, Linzer M, Hahn SR, deGruy FV et al. Physical symptoms in primary care. Predictors of psychiatric disorders and functional impairment. *Archives of Family Medicine* 1994; 3(9): 774-779.
- Kroenke K, Jackson JL, Chamberlin J. Depressive and anxiety disorders in patients presenting with physical complaints: clinical predictors and outcome. *Am J Med* 1997; 103(5):339-347.
- Kroenke K, Taylor Vaisey A, Dietrich AJ, Oxman TE. Interventions to improve provider diagnosis and treatment of mental disorders in primary care: A critical review of the literature. *Psychosomatics* 2000; 41(1): 39-52.
- Terluin B, van Marwijk HW, Ader HJ, de Vet HC, Penninx BW, Hermens ML et al. The Four-Dimensional Symptom Questionnaire (4DSQ): a validation study of a multidimensional self-report questionnaire to assess distress, depression, anxiety and somatization. *BMC Psychiatry* 2006; 6: 34.
- Kroenke K, Spitzer RL, Williams JB. The PHQ-9: validity of a brief depression severity measure. *J Gen Intern Med* 2001; 16(9):606-613.
- Dunn JD, Tierney JG. A step therapy algorithm for the treatment and management of chronic depression. *Am J Manag Care* 2006; 12(12 Suppl): S335-S343.
- Gaynes BN, Rush AJ, Trivedi M, Wisniewski SR, Balasubramani GK, Spencer DC et al. A direct comparison of presenting characteristics of depressed outpatients from primary vs. specialty care settings: preliminary findings from the STAR\*D clinical trial. *Gen Hosp Psychiatry* 2005; 27(2): 87-96.
- Gaynes BN, Rush AJ, Trivedi MH, Wisniewski SR, Balasubramani GK, McGrath PJ et al. Primary Versus Specialty Care Outcomes for Depressed Outpatients Managed with Measurement-Based Care: Results from STAR\*D. *J Gen Intern Med* 2008; 551-560: 551-560.
- Fava M, Detke MJ, Balestrieri M, Wang F, Raskin J, Perahia D. Management of depression relapse: Re-initiation of duloxetine treatment or dose increase. *J Psychiatr Res* 2006; 40(4): 328-336.

27. Lin EH, Katon WJ, Vonkorff M, Russo JE, Simon GE, Bush TM et al. Relapse of depression in primary care. Rate and clinical predictors. *Arch Fam Med* 1998; 7(5): 443-449.
28. Fava GA, Ruini CHIA, Belaise CARL. The concept of recovery in major depression 2007; 37.
29. Iosifescu DV, Nierenberg AA, Alpert JE, Papakostas GI, Perlis RH, Sonawalla S et al. Comorbid medical illness and relapse of major depressive disorder in the continuation phase of treatment. *Psychosomatics* 2004; 45(5): 419-425.
30. Huijbregts KM, van der Feltz-Cornelis CM, van Marwijk H, de Jong FJ, van der Windt DA, Beekman A. Negative association of concomitant physical symptoms with the course of major depressive disorder: A systematic review. *Journal of Psychosomatic Research* 2010; (In press).
31. Huijbregts KM, van Marwijk HW, de Jong FJ, Schreuders B, Beekman AT, van der Feltz-Cornelis CM. Adverse Effects of Multiple Physical Symptoms on the Course of Depressive and Anxiety Symptoms in Primary Care. *Psychother Psychosom* 2010; 79(6):389-391.
32. Cameron IM, Lawton K, Reid IC. Appropriateness of antidepressant prescribing: an observational study in a Scottish primary-care setting. *Br J Gen Pract* 2009; 59(566):644-649.
33. Fawcett J. Antidepressants: partial response in chronic depression. *Br J Psychiatry Suppl* 1994;(26):37-41.
34. Halfin A. Depression: the benefits of early and appropriate treatment. *Am J Manag Care* 2007; 13(4 Suppl):S92-S97.
35. Hollon SD, DeRubeis RJ, Shelton RC, Amsterdam JD, Salomon RM, O'Reardon JP et al. Prevention of relapse following cognitive therapy vs medications in moderate to severe depression. *Arch Gen Psychiatry* 2005; 62(4):417-422.
36. Beekman ATF, Van der Feltz-Cornelis CM, Van Marwijk HWJ. Enhanced care for depression. *Curr Opin Psychiatry* 2013; 26(1):7-12.
37. Huijbregts KM, de Jong FJ, van Marwijk HW, Beekman AT, Ader HJ, Hakkaart-van RL et al. A target-driven collaborative care model for Major Depressive Disorder is effective in primary care in the Netherlands. A randomized clinical trial from the depression initiative. *J Affect Disord* 2012.
38. Neumeyer-Gromen A, Lampert T, Stark K, Kallischnigg G. Disease management programs for depression: a systematic review and meta-analysis of randomized controlled trials. *Med Care* 2004; 42(12): 1211-1221.
39. Gilbody S, Bower P, Fletcher J, Richards D, Sutton AJ. Collaborative care for depression: a cumulative meta-analysis and review of longer-term outcomes. *Arch Intern Med* 2006; 166(21): 2314-2321.
40. Bower P, Gilbody S, Richards D, Fletcher J, Sutton A. Collaborative care for depression in primary care. Making sense of a complex intervention: systematic review and meta-regression. *British Journal of Psychiatry* 2006; 189: 484-493.
41. Archer J, Bower P, Gilbody S, Lovell K, Richards D, Gask L et al. Collaborative care for depression and anxiety problems. *Cochrane Database Syst Rev* 2012; 10: CD006525.
42. Woltmann E, Grogan-Kaylor A, Perron B, Georges H, Kilbourne AM, Bauer MS. Comparative effectiveness of collaborative chronic care models for mental health conditions across primary, specialty, and behavioral health care settings: systematic review and meta-analysis. *Am J Psychiatry* 2012; 169(8): 790-804.
43. Nieuwenhuijsen K, Bültmann U, Neumeyer-Gromen A, Verhoeven AC, Verbeek JH, Van der Feltz-Cornelis CM. Interventions to improve occupational health in depressed people. *Cochrane Database Syst Rev* 2008; (2): CD006237.
44. Hees H, Koeter M, Schene AH. Longitudinal relationship between depressive symptoms and work outcomes in clinically treated patients with long-term sickness absence related to major depressive disorder. *J Affect Disord* 2013; doi:10.1016/j.jad.2012.12.007. (Epub ahead of print).
45. Lagerveld SE, Bultmann U, Franche RL, van Dijk FJ, Vlasveld MC, van der Feltz-Cornelis CM et al. Factors Associated with Work Participation and Work Functioning in Depressed Workers: A Systematic Review. *J Occup Rehabil* 2010.
46. Nieuwenhuijsen K, Verbeek JH, de Boer AG, Blonk RW, van Dijk FJ. Supervisory behaviour as a predictor of return to work in employees absent from work due to mental health problems. *Occup Environ Med* 2004; 61(10):817-823.
47. Nieuwenhuijsen K, Noordik E, van Dijk FJ, van der Klink JJ. Return to Work Perceptions and Actual Return to Work in Workers with Common Mental Disorders. *J Occup Rehabil* 2012; (Epub ahead of print).
48. Hees H, Koeter MW, Schene AH. Predictors of long-term return to work and symptom remission in sick-listed patients with major depression. *J Clin Psychiatry* 2012; 73(8): e1048-55.
49. Hees H, De Vries G, Koeter M, Schene A. Adjuvant occupational therapy improves long-term depression recovery and return-to-work in good health in sick-listed employees with major depression: results of a randomised controlled trial. *Occup Environ Med* 2012; (Epub ahead of print).
50. Noordik E, van der Klink JJ, Geskus RB, De Boer MR, van Dijk FJ, Nieuwenhuijsen K. Effectiveness of an exposure-based return-to-work program for workers on sick leave due to common mental disorders: a cluster-randomized controlled trial. *Scand J Work Environ Health* 2012; pii: 3320. doi: 10.5271/sjweh.3320. (Epub ahead of print).
51. van der Feltz-Cornelis CM, Hoedeman R, de Jong FJ, Meeuwissen JA, Drewes HW, Van der Laan NC et al. Faster return to work after psychiatric consultation for sicklisted employees with common mental disorders compared to care as usual. A randomized clinical trial. *Neuropsychiatric Disease And Treatment*, 2010; Vol 6, pp 375-85 Electronic Publication 2010.
52. Van der Feltz-Cornelis CM, van Oppen P, Adèr H, van Dyck R. Randomised Controlled Trial of a Collaborative Care Model with Psychiatric Consultation for Persistent Medically Unexplained Symptoms in General Practice. *Psychother Psychosom* 2006; 75(5): 282-289.
53. De Vries G, Koeter MW, Nabitz UW, Hees H, Schene AH. Return to work after sick leave due to depression; a conceptual analysis based on perspectives of patients, supervisors and occupational physicians. *J Affect Disord* 2012; 136(3):1017-26.
54. OECD. Sick on the job? Myths and realities about mental health and work. OECD Publishing, 2012.
55. Volker D, Vlasveld MC, Anema JR, Beekman ATF, Hakkaart-van Roijen L, Brouwer EPM et al. Cost-effectiveness of a blended e-health module on return to work embedded in collaborative occupational health care for common mental disorders, compared to care as usual. Design of a multi-center cluster randomized controlled trial. *Neuropsychiatr Dis Treat* 2013; (In press).

#### Correspondence to

Prof. Dr. van der Feltz-Cornelis  
Full professor of social psychiatry  
Tranzo dept., Tilburg University. PO Box 90153  
5000 LE Tilburg, The Netherlands  
E-Mail: c.m.vdrFeltz@tilburguniversity.edu