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Supported employment adapted for people with affective disorders—A randomized controlled trial

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ABSTRACT

Background: While effective vocational methods for gaining employment exist for people with schizophrenia and similar conditions, no evidence exists with regard to people with affective disorders. We aimed to study the effectiveness of a newly developed Individual Enabling and Support (IES) model adapted for the target group and compared to traditional vocational rehabilitation (TVR).

Methods: An assessor-blinded randomized controlled trial (RCT) with a parallel design was performed. Sixty-one participants received IES or TVR. The primary outcome was employment rate at 12-month follow-up. Secondary vocational outcomes, depression severity, and quality of life were also studied. Trial register number is ISRCTN93470551.

Results: IES was more effective for employment compared to TVR (42.4% vs. 4%; difference 38%, 95% CI 0.12–0.55). Significant group differences were present in secondary vocational outcomes (hours and weeks employed, time to employment), and depression severity. The IES-group had significantly lowering in depression scores and increased quality of life scores during the intervention period.

Limitations: This RCT was limited by the small sample size due to restriction of recruitment to middle-sized cities within geographically diverse sites in southern Sweden. Larger trials are needed, also in primary health care and employment services settings.

Conclusions: IES is more effective than TVR for attaining employment and improving depressive symptoms. On a societal level, IES closes the time and service gap between treatment and employment, and thus lowers sick-leave costs.

1. Introduction

Mental health problems such as affective disorders are recognized as the major cause of sick-leave and unemployment (Harvey et al., 2009; OECD, 2013). Having depression affects the entire lifestyle, including work (Adler et al., 2006; Lerner and Henke, 2008). The costs are high for the individual and society (Eaton et al., 2008; Murray et al., 2012; Social Insurance Report, 2015:11; OECD, 2011). Between 1997 and 2005, the costs of depression doubled to 3.5 billion Euros in Sweden. The primary costs are due to sick-leave and early retirement (Sobocki et al., 2007). Sick-leave rates are still increasing for men and women (Social Insurance Report, 2015:11). In Europe, depression is responsible for 7.2% of the total burden of disability adjusted life years (DALY) in women (Wittchen et al., 2011). People with depression have the longest periods of sick-leave among high risk groups (Swedish Government Official Reports, 2011; OECD, 2011, 2013). Research in this area tends to focus on symptom-reduction in healthcare settings, separate from the work setting and vocational outcomes (Joyce et al., 2016). The need to develop new interventions that address the difficulties persons with depressive symptoms have with gaining and keeping employment are needed (Lauber and Bowen, 2010; Joyce et al., 2016; Martin et al., 2012; Henderson et al., 2011).

Randomized controlled trials (RCT) have shown that the evidence-based place-then-train model of supported employment (SE) is more effective than traditional vocational rehabilitation (TVR) for people with severe mental illness in relation to vocational outcomes, e.g., gaining employment. This is the case for individuals with schizophrenia or other psychoses (Bond et al., 2008, 2012, Burns et al., 2007).

Abbreviations: ASRS, Adult ADHD Self Report Scales; AUDIT, Alcohol Use Disorders Identification Test; IES, Individual Enabling and Support; IPS, Individual Placement and Support; ISRCTN, International Standard Randomized Controlled Trial Number; KEDS, Karolinska Exhaustion Disorder Scale; MADRS-S, Montgomery-Åsberg Depression Self Rating Scale; MANSA, Manchester Short Assessment of Quality of Life; PES, Public Employment Service; SE, Supported Employment; SEFS, Supported Employment Fidelity Scale; SIA, Social Insurance Agency; TVR, Traditional Vocational Rehabilitation.

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Furthermore, a more complex intervention, performed by professionals in various services, i.e., the SE team, services of systematic medication management, behavioral health services, and health insurance services, was also effective for people with schizophrenia, major depression and bipolar disorder as compared to TVR (Drake et al., 2013). TVR refers to services that are performed as a stepwise rehabilitation chain, (the train-then-place model), in which several welfare agencies are involved (Corrigan, 2001, Bejerholm et al., 2011). Treatment is typically seen as a prelude to vocational rehabilitation, and not integrated into vocational rehabilitation. In Sweden, SE according to the Individual Placement and Support model (IPS) was more than three times as effective for attaining employment when compared to TVR (Bejerholm et al., 2015). Participants experience IPS as providing hope, tailored support, decreasing stigma, and increasing feelings of empowerment (Areberg and Bejerholm, 2013). The overwhelming evidence for SE for people with SMI (Bond et al., 2012) is reflected in the National Guidelines of Psychosocial Interventions for Persons with Schizophrenia and Similar Conditions (National Board of Health and Welfare, 2011).

In contrast, no effective intervention with the aims of supporting mental health and employment exists specifically for people with affective disorders (Joyce et al., 2016; Swedish Government Official Reports, 2011; Furlan et al., 2012; Audhoe et al., 2010). Affective disorder is an overarching concept, and includes depression and bipolar disorders. The rationale for including depression and bipolar disorder in this study is our focus on depression severity, and that depressive episodes in bipolar disorder affect work capacity and return-to-work to a greater extent than do manic episodes (Tse et al., 2014; Gilbert and Marwaha, 2013). Recently, SE was adapted to better fit the target group. This is called the Individual Enabling and Support (IES) model. IES is based on high-quality support (Modini et al., 2016), and the idea that special attention should be given to the initial and enabling parts of the intervention (Linder et al., 2009).

Work motivation is inversely related to depression severity among people with mental health problems who enter vocational rehabilitation (Bejerholm and Areberg, 2014; Johanson and Bejerholm, 2016). Work motivation and depressive symptoms predict sick-leave, while motivational strategies enhance engagement in therapy (Zuckoff et al., 2008). Therefore, strengthening motivation begins the enabling part of the IES. The next strategy targets functional cognitive strategies, i.e., thoughts, attitudes and behaviors related to work issues (Rose et al., 2012; Naidu et al., 2016). Cognitive strategies enable useful thinking strategies that diminish depressive thoughts, promote the return-to-work process, and support initial strategies. Sick-leave is not identical with having mental health problems at work. It can also be understood from a work and life-balance perspective, and an unbalanced lifestyle has been identified as related to sick-leave and depression (de Vries et al., 2012; Åkerstedt et al., 2009). The ability to optimize time use in relation to functioning and well-being is central to the understanding of problems related to employment; optimizing time might also be the solution to healthy functioning and well-being at work (Hellerstein et al., 2015; Christiansen, 2005). The IES model integrates motivational, cognitive, and time-use strategies with SE, and delivers them as a comprehensive strategy.

Despite the fact that affective disorder is a major concern, research on this target group tends to evaluate vocational interventions only in relation to mental health outcomes instead of mental health and vocational outcomes. So far, interventions typically do not support mental health, work aspirations, and work performance at the same time (Joyce et al., 2016). While effective SE approaches exist for those with severe conditions, the IES model is developed to integrate motivational, cognitive, and time-use strategies for a better fit for persons with affective disorders.

1.1. Purpose and hypothesis

The overall aim was to determine the effectiveness of IES, as compared to TVR, for persons with affective disorders. The primary outcome was difference in employment rate at 12-month follow-up. Secondary vocational outcomes were hours worked per week, number of weeks worked, total working hours, income, and time to employment, and data on internships, education, and prevocational activities or training were included as well. Depression severity and quality of life were other secondary outcomes. We hypothesized that IES-participants would have a higher employment rate and better vocational outcomes compared with TVR-participants at 12-month follow-up. We also expected to find fewer symptoms and improved quality of life among IES-participants.

2. Methods

2.1. Study design

This was a parallel, randomized, controlled trial (RCT) of two intervention groups (IES and TVR). Participants were recruited from four geographically diverse outpatient settings (Eslöv, Burlöv, Landskrona, Ängelholm) in the County Council of Skåne in southern Sweden. The interventions lasted 12 months, which corresponded to a recent trial (Burns et al., 2015). The trial started in December 2011. Recruitment was estimated to last at least 12 months. The duration of the project was ≤2.5 years. The RCT design was based on the CONSORT guidelines for non-pharmacological interventions (Moher et al., 2012), has Trial Number Register ISRCTN93470551, and was approved by the ethics board at Lund University, Lund, Sweden (Dnr 2011-544).

2.2. Participants

Eligibility criteria were having 1) a depressive episode (ICD-10 F32), recurrent depression (F33.0, F33.1), bipolar disorder (F31), or F30 (includes depressive episodes), as diagnosed by the team psychiatrist according to the International Classification of Diseases 10th edition (World Health Organization, 1992), 2) aged 18–63, 3) ability to communicate in Swedish, 4) expressing interest in employment, 5) has not been employed during the past year, 6) receiving mental health services, and 7) attended a research information meeting. Exclusion criteria included 1) severe drug/alcohol abuse, 2) somatic illness or physical disability that impeded work, factors which could potentially interact between the causal factor (IES) and outcome (employment). Potential participants picked-up leaflets in the waiting room, visited a project web-page, or read advertisements in a daily paper. They then attended research information meetings or received information individually. Any time after attending a research meeting, patients could hand in their written consent. The meetings occurred twice a month at each site, and explained the interventions, inclusion criteria, RCT-design, randomization issues, and ethical issues of approval.

2.3. Interventions

2.3.1. Individual Enabling and Support

IES is guided by an employment specialist who works closely with the participant in relation to the outpatient team, family, Social Insurance Agency (SIA), Public Employment Service (PES), and employers (Bejerholm, 2016). The professional role requires high-quality, empathetic counseling corresponding to ten IES principles (which do not need to be carried out in any particular order): 1) handling change and developing motivational and cognitive strategies, 2) having a time-use pattern that supports work-life balance, 3) integration of IES with mental health treatment, 4) competitive employment as a primary goal, 5) eligibility based on client choice,