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CONFERENCE ABSTRACT

FULL OUTCOME REPORT from the IBBIS randomized controlled trial [DK]: Integrated vocational rehabilitation and mental health care for people on sick leave due to anxiety and depression (N=611 participants, one year follow-up)

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Introduction

Anxiety and depression are common causes of long-term sick leave. Currently, lack of coordination of the relevant interventions, seems to entail confusion among sick employees, afflicting their recovery and return-to-work (RTW) process. A positive effect of integrating vocational rehabilitation (VR) and mental health care (MHC) is indicated by some studies, but not finally established. The aim of this study is to examine the efficacy of the integrated IBBIS intervention compared to current, non-integrated interventions.

Methods

Hypotheses: compared to currently provided interventions, providing 1) improved MHC or 2) integrating MHC with VR, can improve RTW.

In this 3-armed randomized controlled trial, 611 participants on sick leave were randomized to:

1: Treatment as usual (TAU, a heterogenous non-integrated combination of MHC in primary care and VR at municipalities)

2: Standard MHC (research project-delivered), and standard VR in municipalities, non-integrated

3: The IBBIS intervention: integrated vocational rehabilitation (VR) and mental health care (MHC)

Outcomes are time to stable return to work (RTW), at 6- and 12-month follow-up (FU), levels of depression, anxiety, perceived stress, and functional level at 6-month FU.

Researchers are per October 2019 still blinded to group allocation – hence group allocation is concealed as X, Y and Z.

Results

The three groups showed different RTW-patterns and different symptoms levels.

After 6 months group Z, compared to group Y, showed 64% faster RTW ($p=0.0033$), but worse symptom levels. Group Z compared to X, showed tendency to 31% faster RTW ($p = 0.072$), but no difference in symptoms.
After 12 months groups Z and X respectively, compared to group Y, showed 34% faster RTW ($p<0.035$), and group Z showed worse symptom levels, compared to group Y. All symptom-differences were small compared to the change over time in all groups.

Discussion

Different interventions yield different RTW rates, with faster RTW concurrent with worse symptom levels. This might be due to a higher symptom rise after fast RTW compared to slow RTW, perhaps because participants in early phases are still sick despite RTW, which is in line with previous studies. Seemingly there might be an inverse relationship between RTW and symptom levels.

Conclusion

Intervention composition affects recovery in different and complex and ways, and fast RTW is not consistently associated with better symptom and functional level – under some conditions, seemingly, the opposite is the case. All unblinded results will be presented.

Lessons learned

RTW does not consistently imply lower symptom levels. Group symptom differences were much smaller than the average general change (very low effect sizes) – we speculate a 3-month FU could have been relevant.

Limitations

Only researchers are blinded, but neither participants nor intervention providers ever were, which might produce bias. Difference between the integrated intervention and the other groups were not only integration, but also the content of the VR delivered. In the TAU group we lack information about MHC provided in primary care.

Suggestions for future research

Using mixed methods and more frequent measurements, the interplay between health, interventions and employment could be examined.