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General introduction
Chapter 1

Workers without a permanent employment contract and mental ill health

Sick-listed workers without an employment contract: a vulnerable position in the labor market

Sick-listed workers without an employment contract have a vulnerable position in the labor market. To illustrate this, let us consider the following cases:

Danny (43 years old) has worked for several years in a small construction company, located in the east of the Netherlands. When the economic recession worsens, the company receives fewer and fewer new projects. As a result, Danny has to wait longer and longer until he receives his salary, and he often receives less money than was agreed on. Finally, the company goes bankrupt and Danny loses his job. He applies for an unemployment benefit, and starts looking for a new job. However, his previous experience makes Danny feel very insecure about his ability to work. Moreover, the job opportunities are very limited due to the economic recession. As he receives less income than before, Danny can no longer meet his financial obligations, such as paying the rent for the house he shares with his wife and two kids. This causes a lot of stress, which in turn leads to relationship issues between Danny and his wife. Danny feels as if he has lost his old self. As his financial debts increase, his wife decides to leave him. Consequently, Danny becomes even more depressed.

Barbara (38 years old) has worked as a temporary agency worker in several administrative jobs in Amsterdam. She feels most confident in her work when there is a certain daily routine. Therefore, every start at a new company goes along with several challenges, such as finding the best route to work, meeting new colleagues and getting new tasks or responsibilities. Barbara often experiences feelings of anxiety when facing this kind of challenges, but she has not yet succeeded in finding a permanent job. She also feels anxious to lose her job. She fears to make a mistake and to be fired. To avoid making mistakes she checks and double checks her work. In the past, her GP diagnosed an Obsessive Compulsive Disorder.
Further, she lacks social support from a partner to help her with these complaints. Recently, Barbara started in a new position at a large IT firm. She has to work together with people from different departments, and it feels as if every day she is getting new tasks and responsibilities. Facing these kinds of challenges, her anxiety complaints become worse. After a few weeks, she decides that she is too sick to continue working. Very soon she is replaced by another temporary agency worker.

Danny and Barbara, both having no (permanent) employment contract, experience mental health problems. A recent study indicated that the unemployed, like Danny, have an increased risk of (mental) illness, such as a depressive or an anxiety disorder [1]. Moreover, unemployment seems to be both cause and consequence of mental ill health, resulting in a vicious circle [1,2]. Mixed findings have been reported on the relationship between non-permanent employment and (mental) ill health [3]. A qualitative study of Bosmans et al [4] illustrates how temporary (agency) employment can affect (mental) health negatively, resulting from a high job insecurity, low benefits and poorer prospects, as was the case for Barbara, but also positively, through high flexibility, learning opportunities and freedom of choice. Furthermore, research has indicated that non-permanent workers are not sick-listed more frequently than regular employees [5], or even less often [3,6]. Nevertheless, once they get sick, both non-permanent and unemployed workers appear to have a more vulnerable position in the labor market, compared to permanent employees. Sick-listed non-permanent workers seem to be at risk for longer disability episodes, compared to sick-listed permanent employees [7]. In case their employment contract ends during sickness absence, which was the case for Barbara, the lack of a workplace to return to obviously becomes a major obstacle for return to work (RTW) [8,9]. This absence of a workplace to return to is also a major obstacle for RTW of sick-listed unemployed workers, like Danny. Moreover, long-term sick-listed workers who have no (longer an) employment contract often experience a worse health condition and encounter more psychosocial barriers for RTW compared to long-term sick-listed employees, such as language difficulties, debts, legal proceedings, relationship problems, addiction, social isolation, a lack of social support and care issues [9]. Comparable problems were experienced by
Danny and Barbara. Finally, long-term sick-listed workers without an employment contract are more often low-skilled and have less work experience compared to long-term sick-listed employees [8]. All these characteristics illustrate the more vulnerable position in the labor market of sick-listed workers without an employment contract. For this vulnerable group of workers good occupational health care (OHC), including facilitation of RTW, is very important.

**Occupational health care in the Netherlands: lack of return to work interventions for sick-listed workers without an employment contract**

In the Netherlands, the Sickness Benefits Act executed by the Dutch Social Security Agency (SSA) provides a social security safety net for sick-listed workers without an employment contract, such as sick-listed unemployed workers, temporary agency workers and workers with an expired fixed-term contract. According to this act, workers like Danny and Barbara can file a sickness benefit claim at the SSA, while in many other countries sick-listing is only possible when an individual is employed. When this claim is approved, the SSA is responsible for the provision of a supportive income, ie, sickness benefit payment. This sickness benefit equals maximally 70% of the last wage. In 2014, about 91 800 sick-listed workers received a sickness benefit from the Dutch SSA. Many sickness benefits provided by the Dutch SSA are granted on the grounds of mental health problems (about 40%) [9].

In the absence of an employer, the SSA is responsible for OHC. Sickness absence counseling and vocational rehabilitation are provided by a team of OHC professionals, consisting of an insurance physician, a labor expert and a RTW coordinator. Communication and cooperation with other healthcare providers often remains limited. The insurance physician is responsible for analyzing the medical issues and for advising the sick-listed worker about recovery and RTW. The labor expert provides vocational support and helps to identify RTW options, resulting in a RTW action plan. The RTW coordinator monitors the full vocational rehabilitation process. Some of these actions, such as the medical problem analysis and formulating a RTW action plan, are obligatory and dictated in the Dutch Improved Gatekeeper Act. In addition, the sick-listed worker can be referred to specialized support, such as work disability-oriented treatment to facilitate recovery of
health, or additional vocational rehabilitation support to reduce the distance to the labor market and/or to facilitate RTW [9]. OHC and sickness benefit payment by the SSA end once the worker reports that he/she is no longer sick or the insurance physician establishes full recovery of workability for the last job of the worker. In the absence of a workplace to return to, ending of OHC and sickness benefit payment can occur without actual RTW of the worker. During the second year of sickness absence, OHC and sickness benefit payment may also end if the insurance physician establishes recovery of workability for adjusted work with earnings equal to the worker’s last job. After 18 months of sick-listing, the sick-listed worker can apply for a long-term disability benefit (disability pension) at the Dutch Institute for Employee Benefit Schemes. This is the same as for sick-listed employees.

OHC for sick-listed workers without an employment contract is always complicated by the absence of a workplace to return to and will therefore often not be as successful as OHC for sick-listed employees. Nevertheless, there is still plenty of room for improvement [9]. To illustrate, in 2008 a Dutch cohort study comparing long-term sick-listed workers without an employment contract with long-term sick-listed employees showed that only 53% of the sick-listed workers without an employment contract reported that they had received RTW guidance, compared to 86% of the sick-listed employees. More specifically, the obligatory medical problem analysis and RTW action plan was reported by respectively 22% and 23% of the sick-listed workers without an employment contract, compared to respectively 67% and 63% of the sick-listed employees [8]. In 2011, another Dutch cohort study among long-term sick-listed workers without an employment contract revealed that the Dutch SSA could improve its OHC by facilitating suitable work, by paying more attention to the biopsychosocial barriers for RTW of these sick-listed workers, and by improving the sick-listed workers’ participation and responsibility in the RTW process [9]. In this same period, a study by Vermeulen et al [10] showed promising results of a participatory RTW program for unemployed and temporary agency workers, sick-listed 2–8 weeks due to a musculoskeletal disorder. This new RTW program contained many elements as were suggested in the aforementioned cohort study [9]. The participatory RTW program was based on a successful RTW program for sick-listed employees with low back pain [11-13], consisting of a stepwise process to jointly identify and solve obstacles for RTW, resulting in a consensus-based RTW action plan. Vermeulen et al [10] were the first who studied the
effectiveness of this program in the absence of a workplace to return to. Placement in a temporary (therapeutic) workplace with ongoing sickness benefit was added to the original protocol to overcome this major obstacle for RTW. The program resulted in a shorter median duration until sustainable RTW with or without continuing benefits, compared to usual OHC by the Dutch SSA [10].

Although the study of Vermeulen et al [10] showed promising results for these workers with musculoskeletal disorders, evidence-based RTW interventions for a comparable group of workers with mental health problems are still lacking, despite the high prevalence of this type of health complaints. Therefore, it seems worthwhile to investigate whether a similar RTW program would also lead to an improvement in RTW of workers without an employment contract, sick-listed due to mental health problems. However, because the sickness benefit payment might continue during placement in a (therapeutic) workplace, the participatory RTW program evaluated by Vermeulen et al was considered more costly compared to usual care, from the social insurer’s perspective [14]. For this reason, it also seems worthwhile to investigate whether the focus could be shifted from placement in a temporary (therapeutic) workplace with ongoing supportive benefit to direct placement in a competitive job.

The international context: increase of flexible employment and mental health related sickness absence

In the last decennia flexible forms of employment, such as temporary employment, globally expanded [3,15]. In Europe, the economic recession of 2008 further stimulated this growth [3]. In the same period mental ill health has become a growing cause of sickness absence and labor market exclusion world-wide [16], resulting in enormous societal costs [16] and individual suffering [17,18]. Mild to moderate mental disorders, such as depressive, anxiety, and stress-related disorders, have been the most common disorders. Because of their high prevalence, these common mental disorders (CMDs) have a large impact on the societal burden [16].

Due to the large impact of CMDs, there has been a growing attention in the international literature for the development and evaluation of interventions that aim to enhance RTW of workers who are sick-listed due to a CMD [19-29]. Nevertheless, the majority of these
RTW interventions do not take into account the changing labor market and assume the presence of a workplace to return to. Furthermore, the mental healthcare sector has not yet been a real partner in the RTW process of sick-listed workers with a CMD [16]. Employment issues are often not addressed (adequately) by healthcare providers, although these issues may have an important effect on mental health. Initiatives from the mental healthcare sector that do facilitate RTW have an almost exclusive focus on patients with the most severe mental disorders [16]. A well-known initiative in this regard is supported employment. Key to this evidence-based approach is direct placement in a competitive job, based on the sick-listed worker’s preferences. Other characteristics are intensive collaboration between healthcare providers and employment specialists, and ongoing support for the sick-listed worker and employer during placement in a competitive job. According to the OECD, similar RTW programs need to be developed to address vocational needs of sick-listed workers with a CMD [16]. This illustrates that also from an international perspective there is a need for RTW interventions aimed at workers sick-listed due to a CMD, including those without an employment contract. Moreover, there seems to be a need for RTW interventions that facilitate RTW and incorporate the mental healthcare sector as a partner in the RTW process, ie, through an integrated care approach.

Need for more knowledge about factors that influence return to work

In order to improve RTW of workers without an employment contract, sick-listed due to a CMD, knowledge about factors that influence RTW is needed. The aforementioned studies on OHC for workers without an employment contract [9,10] demonstrate some intervention characteristics that may be effective in improving RTW of these workers. However, to develop adequate RTW policy it is also important to investigate what characteristics of sick-listed workers are likely to influence their RTW. Systematic reviews of the literature reveal that RTW of sick-listed workers with mental health problems is associated with disorder-related characteristics (eg, duration and severity of the disorder), demographic characteristics (eg, age) and work-related characteristics (eg, employment status) [30-32]. Studies included in these reviews most often studied the relationship between RTW and disorder-related factors. This means that knowledge about the influence of non-disorder
related factors is still limited. Furthermore, little is known about the influence of all these factors on RTW in the long run, because of the cross-sectional nature of many of these studies [32]. Therefore, further research is necessary to study longitudinal associations between a broad range of factors and RTW of sick-listed workers with mental health problems. Knowledge about these factors will assist in the development and evaluation of suitable RTW interventions.

Aim of this thesis

The main aim of this thesis is to improve RTW of workers without an employment contract, sick-listed due to a CMD. The sub objectives of this thesis are:

1. To get a broad understanding of factors that in the long run influence sustainable RTW of sick-listed workers with a common mental disorder (CMD).
2. To develop a new participatory supportive RTW program for workers without an employment contract, sick-listed due to a CMD, based on a participatory RTW program, integrated care and direct placement in a competitive job.
3. To evaluate the execution of this new program in practice.
4. To evaluate the effectiveness and cost-effectiveness of the new program in shortening the duration until first sustainable RTW in a competitive job.

To reach these aims associations are studied between biopsychosocial factors and sustainable RTW of sick-listed workers with a depressive and/or anxiety disorder, by using data of a large Dutch cohort study (sub objective 1). Further, a randomized controlled trial (RCT) titled “The Co-WORK study” is carried out, in which the new participatory supportive RTW program is compared with usual OHC for Dutch sick-listed workers without an employment contract (sub objective 2, 3 and 4).
General introduction

Outline of this thesis

The thesis is organized as follows:

- **Chapter 2** reveals which biopsychosocial factors in the long run are associated with sustainable RTW of sick-listed workers with a depressive or anxiety disorder.
- **Chapter 3** describes the design of the Co-WORK study, including the development of the participatory supportive RTW program and the design of the (cost-)effectiveness and process evaluation.
- **Chapter 4** describes a process evaluation of the new program. This evaluation shows whether the components of the new program were realized in practice and in accordance with the protocol. In addition, the recruitment of participants and professionals and its reach, perceived barriers and facilitators for implementation of the new program, and satisfaction of the sick-listed workers and professionals who participated in the program are evaluated.
- **Chapter 5** provides further insight into the execution of the new program in practice, by presenting stakeholders’ perceptions of the function(s) of the new program, and of barriers and facilitators for a successful execution of the program within the Dutch social security sector.
- **Chapter 6** presents the effectiveness of the new program in reducing the duration until first sustainable RTW in competitive employment, compared to usual OHC by the Dutch SSA. Also the effectiveness of the program on secondary outcomes including average working hours, duration until RTW in any type of employment, sickness benefit duration, and perceived physical and mental health and functioning, is presented in this chapter.
- **Chapter 7** describes the economic evaluation of the new program, including a cost-effectiveness, cost-utility and return-on-investment evaluation.
- This thesis closes with a general discussion of the main findings, in **chapter 8**.
References

General introduction


Chapter 1


