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Original article

A 5-year prospective study of predictors for functional and work disability among primary care patients with depressive disorders



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ABSTRACT

Objective: To study prevalence of and predictors for functional and work disability among primary care (PC) patients with depressive disorders in prospective long-term follow-up.

Methods: The Vantaa Primary Care Depression Study followed up prospectively 137 patients with depressive disorders for 5 years with a life chart. Information on level of functioning in general and in different dimensions, employment, sick leaves and disability pensions were obtained from interviews and patient records.

Results: Level of functioning and work ability were strongly associated with time spent depressed and/or current severity of depression. Patients who belonged to the labour force at baseline spent one-third of the follow-up off work due to depression; two-thirds were granted sick leaves, and one-tenth a disability pension due to depression. Longer duration of depression, co-morbid disorders and having received social assistance predicted dropping out from work.

Conclusion: Duration of depressive episodes appears decisive for long-term disability among PC patients with depression. Patients spent one-third of the follow-up off work due to depression, and remaining outside the labour force is a common outcome. Psychiatric and somatic co-morbidities, education and socio-economic means influence the level of functioning and ability to work, but are not equally important for all areas of life.

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1. Introduction

Major depressive disorder (MDD) is worldwide the fourth leading illness causing functional disability and days lost from work, resulting in considerable costs often exceeding those for chronic medical conditions [5,22,31,41,46]. To prevent disability due to MDD, knowledge of risk factors is important. Although most depressive disorders are encountered there [32], risk factors for disability in PC have remained little investigated.

Knowledge about risk factors for overall functional and work impairment among patients with depression is mostly derived from either retrospective or short-term prospective studies in psychiatric, occupational health care, and general population settings [1,5,7,8,14–16,18,21,29,30,28,37,38]. In MDD patients in psychiatric settings, low level of functioning and poor ability to work are associated with severity, recurrent course, partial remission and

long duration of depression, plus psychiatric and somatopsychiatric co-morbidities; in addition, patients with older age, poor social support, living alone, high neuroticism or hopelessness, low self-esteem and early onset of illness appear to be at greater risk for disability [29,28,37,38]. In a long-term study of psychiatric MDD patients, time spent in major depressive episodes (MDEs) during the follow-up was the strongest predictor of disability pension, but older age, low education, introversion, somatic illness and subjective inability to work were also relevant [14]. The importance of depression for disability has also been highlighted in general population and occupational health care studies. Disability of subjects with depression is associated with co-morbidity, older age and low education; work-related factors, such as periodic employment and high workload, are also likely of importance [1,7,8,16,18]. In PC studies, onset of depression is associated with 1.8-fold physical and 23-fold social disability [25]; patients who recover are more often employed than those who do not [35]. PC patients with depressive disorders have higher levels of functional impairment and worse social functioning than patients with chronic medical conditions [46]. In a cross-sectional study, we found overall level of functioning largely similar between depressive outpatients in PC

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and secondary-level psychiatric care [44]. Nevertheless, due to selective help-seeking and referral patterns plus consequent differences in patient characteristics, generalizability of findings concerning prevalence and risk factors for disability from depression in other settings to PC remains uncertain.

To our knowledge, there are no published prospective long-term cohort studies of risk factors for disability of representative samples of depressive PC patients. With life-chart methodology, we obtained longitudinal information on course of depression and ability to work over a 5-year period. To explore risk factors for both functional and work disability, we investigated all comorbid mental disorders, medical co-morbidity, plus psychosocial and socio-economic factors. We hypothesized functional impairment, sick leaves and disability pensions due to depression to be highest among those with more severe depression, longer time spent in MDEs, psychiatric and somatic co-morbidities and adverse psychosocial or socio-economic circumstances.

2. Subjects and methods

The Vantaa Primary Care Depression Study (PC-VDS) is a naturalistic prospective cohort study on depressive disorders. The pertinent Ethics Committee approved the baseline and the 5-year follow-up protocols. The PC-VDS is a collaborative research project between the National Institute of Health and Welfare, the University of Helsinki and the City of Vantaa, Finland. Details of the baseline methodology [43] and of the 18-month [45] and 5-year [26] follow-ups have been reported elsewhere.

2.1. Screening and baseline evaluation

Screening for depression was based on stratified sampling within two representative catchment areas, with 63,400 inhabitants, served by 30 general practitioners with a population-based responsibility. Altogether 373 of 1119 patients aged 20–69 years screened in general practitioners' waiting rooms on randomly selected days with the primary care evaluation of mental disorders (PRIME-MD) [39] had a positive screen. The presence of at least one core symptom of MDD according to the Structured Clinical Interview for DSM-IV Axis I Disorders (SCID I/P) [11] was then confirmed by telephone. All of the 175 potentially eligible patients were interviewed face-to-face using the SCID I/P with psychotic screen. Inclusion criteria were current:

- MDD;
- dysthymia;
- subsyndromal MDD with two to four depression symptoms (minimum one core symptom) and lifetime MDD;
- minor depression (MinD) otherwise similar to subsyndromal MDD, but without MDD history.

Distress or functional impairment was required for all. Dysthymia was regarded as subsyndromal MDD or MinD according to a positive or negative history of MDD. Patients who refused to participate (15%) did not differ significantly in age or gender from those who consented. The diagnostic reliability for current MDD and current subsyndromal diagnoses was excellent ($\kappa = 1.0$) [43].

Current and lifetime psychiatric disorders were assessed with SCID-I/P and SCID-II [10,11]. Observer scales included the 17-item Hamilton Depression Rating Scale (HAM-D) [13]. Self-report scales included the 21-item Beck Depression Inventory (BDI) [2], the Beck Anxiety Inventory (BAI) [4], the Beck Hopelessness Scale (HS) [3] and the Perceived Social Support Scale - Revised (PSSS-R) [6]. A self-report questionnaire, medical records and an interview were used for chronic medical illnesses. Lifetime course of depression

was reconstructed from the interviews and medical and psychiatric records [43]. Psychosocial and socio-economic factors were assessed in the interviews and with self-report questionnaires. Subjective work ability was divided into categories fully capable, decreased capacity and incapable. Social assistance in Finland is a last resort for income security; municipalities' welfare offices will offer financial assistance when the income and resources are insufficient to cover necessary daily expenses. It effectively reflects severe economic difficulties. Patients were divided into those who had received social assistance at least once and those who had not.

2.2. Follow-up

After baseline, patients were investigated at 3, 6 and 18 months [45] and at 5 years [26]. BDI and other self-report scales were used at 3 months, and current state of depression was investigated by telephone at 6 months. Current state of depression was investigated face-to-face at 18 months by SCID-I/P, and all psychiatric disorders at 5 years with SCID-I/P and SCID-II. At both time-points, the above-mentioned scales and all medical and psychiatric records were used. In addition, at 5 years, the alcohol use disorders identification Test (AUDIT) was used [33].

Of the 137 patients initially included in the study, 127 (93%) participated in the 18-month and 112 (82%) in the 5-year follow-up. Patients remained in the cohort until they were censored due to change of diagnosis (4%) or death (4%) after the last interview. The median time for the 5-year interview was 62.9 (mean 63.3) months. Dropouts did not differ from participants in age, gender or baseline depression severity. Baseline and 5-year characteristics of the 111 depressive patients (81%) followed up for 5 years are shown in Table 1.

2.3. Life-chart

At 18 months and 5 years, sick leaves and disability pensions granted for depression were assessed and placed on the life-chart. Disability pension in Finland can be granted after 300 sick leave days. Depression and substance use disorders (dependence or abuse) were diagnosed in face-to-face interviews with the SCID-I/P to determine timing and duration of episodes of depression (full remission, partial remission and MDEs) and substance abuse. In addition, data were gathered from all medical and psychiatric records. These were integrated into a graphic life-chart [26,45].

2.3.1. Measurement of functional outcome

Information on employment, retirement, disability pensions and sick leaves during the follow-up was collected in the interviews, with self-report questionnaires and from patient records.

The Social and Occupational Functioning Assessment Scale for DSM-IV (SOFAS) [12] was used at all interviews. SOFAS scores of 40 to 50 represent the range from major to serious, 60 to 70 moderate to some, and 80 to 90 slight impairment to good functioning.

In addition to SOFAS, at 5 years, we used the Sheehan Disability Scale (SDS) [34], a self-reported outcome measure for assessing functional impairment in three domains: work/school activities, social activities and family life. For each dimension, the patient rates the extent of impairment over the previous week due to their symptoms on a 10-point visual analogue scale. Only patients employed (54/111) were included in work/school and only patients married/cohabiting (57/111) in family life analyses.

2.4. Statistical analysis

Baseline and 5-year characteristics were compared using the paired-samples *t*-test or Wilcoxon or McNemar tests. Patients who were employed or unemployed, or granted sick leave or disability

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