	A	B	C	D	E	F	G	H	I	J	K	L
1	1ste auteur publicatie (jaar)	mate van bewijs	type onderzoek	populatie	cases	controls	uitkomst-maat	resultaten	conclusie	opmerkingen		
2	Uitgangsvraag 1. Welke werkgebonden factoren veroorzaken depressie?											
3	Theorell *in press*	A1	systematic review van N=59 (N=19 high-quality; cohort- of population based nested case control-) onderzoeken, median follow-updduur 3 jaar; search 1990 - mei 2013	werkenden in Finland (N=11), Denemarken (11), VS (8), Canada (7), Nederland (5), VK (5), Zweden (4), België (3), Frankrijk (3) en Italië (1)	with depressieve symptoms N=19; n=	no depressive symptoms n=158.251; N studies		work related risk factor		quality of evidence according to GRADE		
4					53.985	10		high psychological demands		low; limited confidence	hoge psychische belasting	
5					197.682	14		job strain (high demands & low decision latitude)		moderate	werkstress (hoge taakeisen i.c.m. weinig beslissingsruimte of regelmogelijkheden)	
6					11.419	2		passive work		low; limited confidence	passieve werktaken	
7					34.554	5		time pressure		low; limited confidence	werkdruk	
8					27.136	3		imbalance effort-rewards		low; limited confidence	disbalans geleverde inspanning vs. ontvangen beloning	
9					50.935	8		low social support from supervisor		low; limited confidence	weinig sociale steun van werkgever	
10					82.772	17		low work social support		low; limited confidence	weinig sociale steun op het werk	
11					27.170	6		low social support from co-workers		low; limited confidence	weinig sociale steun van collega's	
12					9.242	2		unfavorable team climate		low; limited confidence	slechte werksfeer	
13					59.340	2		unfavorable social capital at work		low; limited confidence	gering sociaal kapitaal	
14					33.589	5		percieved social or distributive injustice		low; limited confidence	ervaren onrechtvaardigheid	
15					33.589	5		procedural injustice;		low; limited confidence	sociale onrechtvaardigheid; procedureel	
16					30.761	3		relational injustice		low; limited confidence	sociale onrechtvaardigheid; relationeel	
17					13.732	3		conflicts		low; limited confidence	conflicten	
18					9.692	2		with superiors		low; limited confidence	met superieuren	
19					9.692	2		with co-workers		low; limited confidence	met collega's	
20					15.173	3		bullying		moderate	gepest worden	
21					15.382	4		little opportunity for personal development		low; limited confidence	geringe ontwikkelingsmogelijkheden	
22					24.833	7		job insecurity		low; limited confidence	baanonzekerheid	
23					13.107	6		high number of weekly working hours / overtime		low; limited confidence	lange werkdagen/weken	
24					x	x		lange opsomming (in het Engels) van risicofactoren waarvoor in het SR onvoldoende evidence werd gevonden		very low; no evidence		
25	Beseler 2008	B	case control study with adequate adjustment for covariates	USA farmers from Agricultural Health Study, recruited 1998-1997, year of information collection not specified	n=**534**; self-report of depression (physician-diagnosed, that required medication and/or "shock therapy")	n=**17.051**; no self-report of depression	**OR** (±95% CI)	self-report of **exposure** i.e. life time use of 50 pesticides, and exposure to solvents and heavy metals; multiple logistic regression analysis of cumulative exposure levels for the totals sample adjusted for covariates (only significant results for most adjusted model)	* significant OR; ** significant OR>2	study selected by Theorell; study quality according to GRADE: **moderate**		
26							**1.37** (1.11 - 1.69)	exposure to solvents other than gasoline	* aannemelijk verband tussen blootstelling aan oplosmiddelen en ontstaan van depressie			
27							**1.11** (0.87 - 1.42)	life time days of pesticide exposure >752	* aanwijzingen voor een verband tussen blootstelling aan pesticiden en depressie			
28							**2.57** (1.74 - 3.79)	diagnosed with pesticide poisoning	** zeer aannemelijk verband tussen ooit pesticidevergifting en ontstaan van depressie			

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29							**2.05** (0.76 - 5.54)	ever used herbicides	onduidelijk verband tussen (ooit) gebruiken van herbiciden en depressie			
30							**2.05** (1.29 - 3.27)	ever used insectides	** zeer aannemelijk verband tussen het ooit gebruiken van insecticiden en depressie			
31							**1.24** (1.01 - 1.53)	ever used fungicides	* aannemelijk verband tussen ooit gebruiken van fungicide en het krijgen van depressie			
32							?	heavy metals				
33	Aydin 2003									depressieve klachten als gevolg van blootstelling aan kwik sluit per definitie de diagnose MDD uit		
34	Langford 1999									depressieve klachten als gevolg van blootstelling aan kwik sluit per definitie de diagnose MDD uit		
35	Morrow 2000									depressieve klachten als gevolg van blootstelling aan organische oplosmiddelen sluit per definitie de diagnose MDD uit		
36	Reif 2003									depressieve klachten als gevolg van blootstelling aan organische oplosmiddelen sluit per definitie de diagnose MDD uit		

1ste auteur publicatie (jaar)	mate van bewijs	type onderzoek	populatie	uitkomstmaten	resultaten	conclusie	opmerkingen
Uitgangsvraag 2: Welke belemmeringen ervaren werkenden met een depressieve stoornis? Welke mogelijkheden en oplossingen zien zij?							
Milward, 2005	+/-	kwalitatief	19 wkn	RTW interview	verschillende rollen	ziekterol, indentiteit	Gestructureerde interviews bij wkn met depress
Sallis, 2013		kwalitatief	7 wkn	Interview	3 thema's: interactie depressie en werk, ziektegedrag, orgnisatie en epressie		

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1ste auteur publicatie (jaar)	mate van bewijs	type onderzoek	populatie	meet-instrument	variabelen	uitkomstmaten	resultaten	conclusie	opmerkingen
Uitgangsvraag 3: Welke beperkingen in het functioneren in een arbeidssituatie zijn bij patiënten met een depressie te verwachten? Hoe kunnen de arbeidsbelastbaarheid en de arbeidsmogelijkheden van werkenden met een depressieve stoornis - betrouwbaar, valide, transparant en aanvaardbaar - worden vastgesteld?									
Mintz 1998	A	ge-integreerde meta-analyse		Hamilton, BDI	affectieve beperkingen (distress, interesseverlies, onvrede met het werk); functionele beperkingen (verzuim, productiviteits-verlies, conflicten) work performance / presenteeism (moeite met time management, - interpersoonlijk werkeisen, - met "output tasks")			affectieve beperkingen zijn meer (eerder en langer) aanwezig, ongeacht de ernst van de depressieve klachten; werkhervatting hoeft niet te wachten alle symptomen in remissie zijn; work performance* van patiënten met depressie is slechter dan die van RA-patiënten, (* timemanagement, mentale taakeisen, interpersoonlijke werkeisen, "output tasks"	
Lerner 2004	B	prospectief cohortonderzoek; 18 mnd follow-up	employees without intention to stop working						
Adler 2006	C	observationeel, longitudinaal onderzoek	werkende patiënten in de eerste lijn		affectieve beperkingen (distress, interesseverlies onvrede met het werk)			werkende patiënten in de eerste lijn met depressie ervaren significant ernstigere beperkingen in time-mangement, mentale en interpersoonlijke werktaken en output tasks dan werkende patiënten met RA of geen depressie	
Dewa 2013	D	kwalitatief, beschrijvend onderzoek	clinicians'	experiences	work disability assessment			gap in knowledge about factors that affect succesful functioning in general and work in particular	

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Arbeidsbeperkingen met betrekking tot rijgeschiktheid									
Brunnauer 2006	C		n=100 in-patients who met the DSM-IV criteria for MDD prior to discharge; Jan 2004 - March 2005; Germany			clinically relevant psychomotor function related to car-driving abilities (reactivity, stress tolerance, selective attention)	16% severe impairment (unfit to drive); 60% mild to moderate (indication for individual counseling taking into account compensational factors); 24% without clinically relevant disturbances	with SSRI and mirtazipine better test performances then TCA; no difference between venlafaxine and TCA	
Brunnauer 2008	B	RCT	n=40 patients with DSM-IV-TR MDD prior to discharge; June 2004 - June 2006; Germany	Act and React Testsystem ART-90, and Wiener testsystem	n=20 reboxetine; n=20 mirtazipine	visual perception, reactivity, stress tolerance, concentration, and vigilance		no significant differences between treatment groups; improved driving ability skills - after 14 days of pharmacotherapy treatment selective attention and reactivity, lower frequency of accidents in risk simulations	
Ramaekers 2003	B	SR of 9 crossover placebo-controlled studies and 1 double-blind baseline-controlled study				vehicular "weaving" (SD of lateral position during 1 hour in normal traffic)	changes in SDLP after acute doses of sedating antidepressants comparable to those seen in drivers with blood alcohol concentration of 0.8 mg/mL or more, after one week of treatment performance returned to normal.		

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Wingen 2005	B	RCT double blind 3-way cross-over		Road Tracking Test with assessment of SDLP after 2, 9 and 15 days of treatment	n=18 evening dose escitalopram 10mg, mirtazipine 30mg, or placebo			subjects with mirtazipine perform less well on driving test as compared to placebo during acute treatment period but not aon days 9 and 16 of treatment	
Bulmash 2006	C	open trial	n=18 outpatient with MDD; n=29 controls; Canada	30-min simulated driving performance; Epworth Sleepiness Scale		steering reaction time, and number of crashes	after correction for age and sleepinesss, patients with MDD showed significant lower steering reactions and a increased number of crashes compared to controls		
Shen 2009		open trial	n=28 MDD patients (DSM-IV) university hospital, Ontario , Canada; n=14 mirtazipine 30mg a.n. during 30 days; June 2005 to January 2006	computerized driving simulator test and Maintenace of Wakefullness Test at baseline, days 2, 9, 16, and 30		road position and fewer crashes, no improvement in control group		linear improvement on road position and fewer crashes, no improvement in control group	
Brunnauer 2015	B	RCT	n=20 depressive inpatients with agomelatine; n=20 inpatients with venlafaxine; n=20 healthy subjects; Germany	psychomotor tests (reactivity and stress-tolrance) at baseline, day 14 and 28, plus on-road driving test by licensed instructor		steering reaction time, and number of crashes	no difference between treatment groups; improved psychomotor skills at day 28, however not reaching the performace level of healthy subjects; 72.5% labeled fit to drive		
LESA (NHG+) rijgeschiktheid	A1								
NVP 2014	A1	EBM richtlijn Adviesnota Rijgeschiktheid							

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Trimbos, 2013	1			nvt	nvt	nvt	Richtlijn	Multidisciplinaire Richtlijn	Nationaal gebruikt
DSM-V	1	verzameld expert o	nvt	nvt	nvt	nvt	Manual	Diagnostisch standaard werk	Internationaal gebruikt
Allen Francis	4	expert opnion		nvt	nvt	nvt	nvt	Leerboek diagnostiek psychiatrie	internationaal gebruikt, pragmatisch
Feico Zwerver	4	RCT	40 verzekeringsartse	Performance Indicator	VA, PI,	PI-scores	Training in toepassen	Ontwikkelde implementatiestrategie	Context UWV
G. De Vries 2012	4	kwalitatief	41 wkn,BA, leidingg.	concept mapping, interviews		statements	3 clusters:Persoon, we	per cluster aanbevelingen voor inter	nuttig voor uitvoering in prktijk
A. Hamar 2009	3	review	artikelen			artikelen	acute en lange termijr	depressie is geaassocieerd met cogniteve beperkingenen	
Wisenthal 2013	4	expert opnion					cognitive work harden	work hardening is well-established ir	deze interventie slaat brug tussen zorg en werk
Endo 2012	3	decriptive	540 wkn	sickness abecence syst	ziekteverzuim	verzuim na RTW	Kaplan Meyer curve R	bijna helft wkn heeft recidiverend ve	wkn 8,5 jaar gevolgd
Koopmans 2008	3	descriptive	alle ned wkn	registratie ziekteverzui	verzuimperiodes	ziektevrzuim tgv dep	KaplanMeyer gemidde	Ziekteverzuim met depressieve symp	wkn gevolgd over periode van
Guico_Pabia 2011	3	beschrijvend	3530 patients	HRSD voor depressie	SDS voor functioneren	HRDS score en functi	Significante relatie tus	Relatie aangetoond tussen ernstvan	depressie en functioneren
J Spijker 2004	3	beschrijvend	6778 NEMESIS	CIDI voor depressie	MOS-SF-36 voor functioneren	scores op CIDI en MC	Na langer herstel van	Functioneel herstel blijft achter bij h	Nederlands onderzoek
Kruijshaar 2003	3	beschrijvend	NEMESIS	CIDI voor depressie	MOS-SF-36 voor functioneren	scores op CIDI en MC	Associatie ernst depre	Relatie aangetoond tussen ernstvan	Nederlands onderzoek

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Uitgangsvraag 4: Welke interventies hebben bewezen een effect (of géén effect) op werkfunctioneren, terugkeer in werk of instroom in arbeidsongeschiktheidsregelingen?									
interventies voor het ontstaan van depressie (preventie)									
Gereardts 2014ab	B	RCT	n= niet verzuimende werknemers van 5 grote Nederlandse bedrijven met depressieve klachten	web-based guided self-help		depressive symptoms; work functioning assessed by Health and Work Performance Questionnaire short- and long-term	short term: long term:	no difference	
interventies ná het ontstaan van depressie									
systematic reviews									
Furlan 2010	A1	SR of N=12; 10 RCT + 2 non-RCT	working age individuals with mild or moderate depression various countries	workplace-based interventions that could be implemented and/or facilitated by the employer	no intervention OR care as usual	work outcomes	short term: long term:	as all evidence was graded as very low no intervention can be recommended	quality of evidence according to GRADE **very low**
Nieuwenhuijsen 2014	**A1**	SR of (c)RCTs	**werkenden met depressie(ve klachten)**			**absenteeism** ***work functioning***	SMD (±95%CI)		**quality of evidence GRADE**
interventies gericht op de werkplek									
Nieuwenhuijsen 2014	A1	RCTs (3)	**n=251** workers with MDD, **3** studies; multicomponent work-directed program (1), and adjuvant occupational therapy (2)	work-directed plus clinical	clinical intervention alone	days of sickness absence *work functioning*	medium term (follow-up 3-8 mo.) SMD -0.40 (95%CI: -0.66 - -0.14) *SMD -0.31 (95%CI: -0.79 - 0.16)*	moderate effect size	**moderate** downgrade 1 level
Lerner 2012	A2	RCT	n=79 (**72** completed) employees with MDD and/or dysthymia, WLQ productivity loss ≥5% in past 2 weeks and age 18 to 62 years; recruitment 6 months, follow-up 4 months. Workplace setting State Government Maine, USA	n=52 (**47** completed); **multicomponent work-focused program;** Work and Health Initiative intervention provided over the phone by EAP counsellors ≥8-weeks program with 1-hour sessions every 2 weeks; with work coaching and modification, care coordination, and cognitive-behavioral strategies (co-creation of care plan for dealing with functional problems, reviewing specific assigments and progress at each session). Electronic feedback on depression and advise to seek care	n=27 (**25** completed); **care as usual**: primary care, specialty care, behavioral health programs, and/or standard EAP services. Electronic feedback on depression and advise to seek care	WLQ Work Absence Module self-reported **time** missed **from work** in past 2 weeks because of health or medical care *WLQ; 4 dimensions of performance*	SMD -0.66 (95%CI: -1.15 - -0.16) *SMD -0.58 (95%CI: -1.08 - -0.09)*	significant less days off work in medium-term with multi-component work-focused program	high risk of performance and detection bias; loss-to-follow-up intervention group 9.6% **moderate** QoE acc. to GRADE (together with Hees 2013, and Schene 2006)

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Hees 2013	A2	RCT	**n=117** out-patients with MDD (DSM-IV) ≥3 months, *or* absent from work for ≥8 weeks, and ≥25% contract hours due to depression, with work, substantially (>25%) contributing to depression, reducing productivity, or hindering RtW; age 18 to 65 years; recruitment December 2007 - October 2009, follow-up 18 months. Academic psychiatric practice in Amsterdam, Netherlands	n=**39** (34 completed); **adjuvant occupational therapy (OT)** i.e. 18 sessions (9 individual, 8 group sessions and 1 with the employer) with 2 experienced occupational therapists; including psycho education, supportive therapy and cognitive behavioural interventions (supervised by an experienced senior psychiatrist) plus frequent communication with occupational physician and treating resident psychiatrist (employees ≥2 hours/week at work at start OT), if needed pharmacotherapy according to protocolised algorithm	n=**78** (66 completed); **care as usual** i.e. 19 visits including psycho education, supportive therapy and cognitive behavioural interventions (supervised by an experienced senior psychiatrist), if needed pharmacotherapy according to protocolised algorithm	average number of hours of **absenteeism** over each 6-months period; **sick leave duration** due to depression - from start of treatment until partial (increment of ≥5 hours during ≥4 weeks) and/or full contract hours) RtW *self-report records of work efficiency (2-point scale), and on 3 WLQ subscales (output, time management, and mental-interpersonal)*	medium term (follow-up 3-8 mo.) *SMD -0.09 (95%CI: -0.48 - -0.29)* long term (follow-up 18 mo.) *SMD -0.25 (95%CI: -0.63 - -0.14)*		high risk of performance and detection bias; loss-to-follow-up intervention group 13% **moderate** QoE acc. to GRADE (together with Lerner 2012, and Schene 2006)
Schene 2006	A2	RCT	n=**62** MDD out-patients (regular referrals, also from OPs; DSM-IV, BDIscore >15), or absent from work for >10 weeks, < 2 years, and clinically estimated contribution of work to the onset and/or continuation of depression of >50%; age > 18 years; recruitment ?? 200? - ?? 200?, follow-up 42 months. Academic psychiatric practice in Amsterdam, Netherlands	n=**30**; **adjuvant occupational therapy (OT)** i.e. 4-week diagnostic phase (5 visits with occupational history, video observation in a role-played work situation, contact with OP, and written plan for work reintegration), 24-week therapeutic phase with 12 individual sessions (preparation of work reintegration, contacting the work place en if possible starting to work), weekly 2-hour group sessions [8-10 patients] with elaboration of individual issues and theme discussions [being passive, stress on work place, personal bounds and limits, powerful and powerless, perfectionism, conflicts and prevention]	n=**32**; **treatment as usual** according to APA Guideline and antidepressants if indicated and accepted by patients, according to standardized stepwise drug treatment regimen or algorithm	total number of hours workes during 6-months periods, up to 42 month; time from t1 to partial or full return to work	**together with Hees 2013**; medium term (follow-up 3-8 mo.) SMD -0.30 (95%CI: -0.61 - 0.01) long term (follow-up 18 mo.) SMD -0.19 (95%CI: -0.49 - 0.12)	non-significant small differences between groups	high risk of performance, detection, and attrition bias; loss to follow up 20% in intervention and 25% in control group at 24 weeks **moderate** QoE acc. to GRADE (together with Hees 2013, and Lerner 2012)
Nieuwenhuijsen 2014	A2	RCT (1)	**n=126** workers with high level depressive complaints	work-directed plus clinical	work-directed care alone	days of sickness absence	SMD -0.14 (95%CI: -0.49 - 0.21)	**not** significantly fewer days off work with collaborative care	**moderate** downgrade 1 level
Vlasveld 2013	A2	RCT	n=139 (**126** completed) workers on 4 tot 12 weeks sickness absence diagnosed by OP as due to a mental disorder, with high score on PHQ depression subscale, and who subsequently met DSM-IV criteria for MDD with MINInterview administered by telephone. 22-months recruitment period, 12-months follow up; large occupational health service (ArboNed) in the Netherlands	n=69 (**65** completed); work-directed plus clinical care; **collaborative care** i.e. 6-12 sessions of PST aimed at teaching PS skills (focussing on cognitive restructuring, RtW, and healthy lifestyle), manual-guided self-help, a workplace intervention, and (based on patient's preferences) antidepressant medication according to treatment protocol, with ongoing supervision and psychiatric supervision to OP-casemanagers	n=70 (**61** completed); work-directed **care as usual** by OP in occupational health care setting	**primary:** days until lasting (≥4 wks), and full RtW; **secundary:** total number of sickness absence (during 12 mo. follow-up)	**prim:** non-significant between treatment-group difference: 190 (SD 120) vs. 210 (SD 124) days **sec:** non-significant between treatment-group difference: 198 (SD 120) vs. 215 (SD 118) days	non-significant but less sickness absence with collaborative care intervention	48.8% vs 49.2% with comorbid generalized anxiety disorder; *in intervention group 40/65 visited OP-CM; 5 had workplace inter-vention; 19 used anti-depressant, for 7 patients psychiatrist consultation of OP-CM,* high risk of performance bias; no loss to follow up in sickness absence data **moderate** QoE

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Nieuwenhuijsen 2014		c-RCT (1)	**n=40** workers with MDD	work-directed	alternative work-directed	days of sickness absence *depressive symptoms*	SMD 0.45 (95%CI: -0.00 - 0.91) *SMD -0.18 (95%CI: -0.84 - 0.49)*	later RtW in exposure-based group? Inconclusive	**very low** downgrade 3 levels
Noordik 2013	B	cluster-RCT	n=160 workers (37 with depressive disorder DSM-IV); recruitment November 2006 - December 2007, follow-up 12 months. Occupational health care, Netherlands	n=75 (**18** with depressive disorder) **exposure based return to work intervention** with practice guideline based occupational health care as usual, and gradual exposure in vivo to more demanding work situations structured by a hierarchy of tasks evoking increasing levels of anxiety, stress, or anger	n=85 (**19** with depressive disorder) practice guideline based occupational health **care as usual**	**time-to-full RtW** (number of days from first day of sick leave to the first day of full RtW, lasting ≥28 days without recurrence of sick leave)			high risk of selection, performance, and attrition bias; loss to follow up 11% in depressed subgroup **very low** QoE acc. to GRADE
gezondheidszorg-interventies; farmacotherapie									
Fernandez 2005	A2	RCT	n=293; (**n=163** employed) major depressive disorder patients (DSM-IV) from 44 general practices in 8 European countries	n=**76** employed (11% with long-term sickness absence) SSRI **escitalopram** daily 10mg during first two week, at week 2 or 4 increase to 20mg/day possible at the investigator's discretion	n=**87** employed (11% with long-term sickness absence) SNRI **venlafaxine** daily 75mg during first two weeks, at week 2 or 4 increase to 150mg/day possible at the investigator's discretion	average length of **sickleave per week** during 8 weeks of study; personal communication days of sick leave during the 8-weeks study period			high risk of attrition bias **moderate** QoE acc. to GRADE
Romeo 2004	B	RCT	n=177 **(94** employed) outpatients with depressive episode DSM-IV (checklist 17-HAM-D score >18); >18 years; recruitment from general practitioners' practices; follow up 24 weeks. Scotland, UK	n=84 (**n=49** employed) SSRI **paroxetine** (week 1-4 20mg/day, week 5-24 optional increase to 30 mg/day at discretion of investigator)	n=93 (**n=45** employed) SNRI **mirtazepine** (week 1-4 30mg/day, week 5-26 optional increase to 45 mg/day at discretion of investigator)	total mean **days lost** due to illness in 24 weeks			high risk of attrition bias (loss to follow up 14% and 6%) **low** QoE acc. to GRADE
Wade 2008	B	RCT	n=295 (**186** paid employment or self-employed), outpatients with MDD (DSM-IV-TR), age 18-65 years; recruited in psychiatric and primary care settings, from September 2005 to September 2006, follow up 24 months, multinational trial.	n=144 (**85** paid employment or self-employed) SSRI **escitalopram** daily 10mg during first 2 weeks, 20mg for remaining period	n=151 (**91** paid employment or self-employed) SNRI **duloxetine** daily for the 24 weeks	mean per patient sick leave duration in **days** *impairment assessed by the Sheehan Disability Scale*			high risk of attrition bias (loss to follow up 24.4%) **low** QoE acc. to GRADE

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Miller 1998	B	RCT	n=635 (**451** employed) outpatient DSM-III-R chronic major depressive disorder, recruitment from referrals from physicians or mental health prefesionals, media advertising, and word of mouth. Age 21 to 65 years. Follow up 12 weeks. 12 outpatient centers in USA	n=426 (**n=??** employed) SSRI **sertaline** (week 1-3 50mg/day, then weekly titration in 50mg/day increments with a max of 200mg/day	n=209 (**n=??** employed) TCA **imipramine** (week 1 50mg/day, week 2 100mg/day, week 3 150mg/day, then weekly titration in 50mg/day increments with a max of 300mg/day	**hours worked** per week (12 weeks); *SAS work composite, and LIFE work functioning*	*SMD -0.05 (95%CI: -0.16 - 0.06)*	*no difference*	lost to follow up 2% **low** QoE acc. to GRADE
Fantino 2007	A2	RCT	n=280 (**189** employed) patients with major depressive disorder patients (DSM-IV and MADRS score ≥ 30) from general or psychiatric practices in France	n=138 (**n=89** employed) SSRI **escitalopram** daily 10mg during first week, 20mg for remaining 7 weeks	n=142 (**n=100** employed) SSRI **citalopram** 20mg daily during first week, 40mg for remaining 7 weeks	**days** of sick leave during the 8-weeks study period			low risk of bias **moderate** QoE acc. to GRADE
Nieuwenhuijsen 2014		RCT (1)	n=**61** workers with MDD	TCA orMAO	placebo	**days** of sickness absence *work functioning*	SMD 0.48 (95%CI: -0.05 - 1.00) *SMD -0.58 (95%CI: -1.11 - -0.05)*		GRADE quality of evidence **very low;** downgrade 3 levels
Agosti 1991	B	RCT	n=**61** outpatient DSM-III depressive disorder, recruitment unclear, New York, USA	**n=38** increasing dose of either TCA or MAOi (phenelzine 60-90mg/day, imipramine 200-3000mg/day, or L-deprenyl 40mg/day) during 6 weeks	**n=23** 4 tot 6 placebo pills/day	**hours worked** in past week (at baseline and 6 weeks), *work functioning assessed by LIFE employment scale (semi-structured interview that tracks episodes of psychiatric functioning during the week in 5 areas) administered by the treating physician (at baseline and 6 weeks)*	SMD 0.48 (95%CI: -0.05 - 1.00) *SMD -0.58 (95%CI: -1.11 - -0.05)*	with antidepressants (non-significantly) less hours worked, *significant better work functioning*	loss-to-follow up 29.5% **very low** QoE acc. to GRADE
gezondheidszorg-interventies; psychotherapie									
Nieuwenhuijsen 2014	A1	RCT (3)	**n=326** workers with depressive disorder, **3 studies;** in a workplace setting (1,) and in primary care (2)	cognitive-behavioral therapy by telephone (1) or online (2)	no intervention OR care as usual	(follow-up 3-8 mo.) **days** of sickness absence *depressive symptoms*	SMD -0.23 (95%CI: -0.45 - -0.01) *SMD -0.56 (95%CI: -0.76 - -0.36)*	significant but small effect sizes	**moderate** downgrade 1 level for n<400

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Bee 2010	B	RCT	n=53 workers (**n=12** with depression) absent from work with mild to moderate mental health difficulties for 8 to 90 days authorised by GP' certificate , recruitment over 10 months (HR mailed potential participants a study infomation pack), follow-up 3 months; **workplace setting** (large communication compagny),UK.	n=26 (n=**5** with depression) **telephone CBT**, delivered over 12 weeks by one or two registered graduate mental health workers	n=27 (n=**7** with depression) **usual care**, primary and occupational health services	self-reported actual **working hours** in last 4 weeks; *self-rated work performance and productivity*			high risk of performance and detection bias, no loss-to-follow-up in subgroup of depressed workers **moderate** QoE acc. to GRADE (together with Hollinghurst 2010, and McCrone 2004)
Hollinghurst 2010	B	RCT	n=297 (**n=180** with employment) **primary care** patients with new episode of depression (≥ 14 BDI12 and CIS-R positive); age 18 to 75 years; recruitment October 2005 - February 2008, follow-up 8 months. From 55 general practices in Bristol, London and Warwickshire, England.	n=149 (n=**97** employed) **online CBT** in addition to usual care (10 sessions of 55 minutes to be completed witin 4 months)	n=148 (n=**83** employed) **usual care from GP** while on 8-months waiting list	number of working **days lost** because of depression (time off work) over 8 month; *total SAS-score ('work outside home' not seperately reported)*			high risk of performance, detection, and attrition bias; loss-to-follow-up intervention group 50% **moderate** QoE acc. to GRADE (together with Bee 2010, and McCrone 2004)
McCrone 2004	B	RCT	n=274 (**n=170** with employment, ?? with depression) **primary care** patients recruited by GP waiting room screening and GP referrals (GHQ-12 ≥4); diagnosis (ICD) depression, mixed anxiety/depression or anxiety disorder (CIS-R ≥12), age 18 to 75 years, recruitment period ?, follow up 6 months. UK	n=97; **computerised CBT**: interactive, multimedia, feedback to patient and GP after each session, 15-minutes introductory video, 8x 50 minutes session of CBT, with homework between sessions	n=74; **care as usual by GP** (f. ex. medication, practical or social help, referral to counsellor, practice nurse, mental health professional)	number of **days** of absence from work (certified by GP) during 8 months; *Work and Social Adjustment Scale score*			high risk of performance, and detection bias; sick leave data were part of cost data (available for both baseline and follow-up periods in 95% of the patiens: loss-to-follow-up 5%) **moderate** QoE acc. to GRADE (together with Bee 2010, and Hollinghurst 2010)
Nieuwenhuijsen 2014	B	RCT (1)	MDD patients, employed or student	psychodynamic therapy	solution-based therapy	**days** of sickness absence short / long term	SMD -0.91 (95%CI: -1.62 - -0.19) / SMD -4.61 (95%CI: -5.84 - -3.39)		**low** downgrade 2 levels

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Knekt 2013	B	RCT	n=326 (n=263 employed or student, n=78 employed or student and with depression) outpatients from psychiatric services, 20 to 45 years and with longstanding disorder (DSM-IV anxiety or mood disorder >1 year) causing dysfunction in work ability; recruitment period June 1994 to June 2000, follow-up 5 years. Helsinki region, Finland.	n=101 (**n=42** employed or student); **short-term psychodynamic psychotherapy** (20 weekly sessions over 5 to 6 months); n=128 (**n=97** employed or student); **long-term psychodynamic psychotherapy** (2 to 3 times a week, for up to 3 years)	n=97 (**n=60** employed or student); protocolized **solution-focused therapy** (brief, focal, transference-based therapy, one session every 2-3 weeks, <= 12 session s over =< 8 months, by	number of **sick-leave days** during last 3 months; *SAS-work; the work-subscale of the social adjustment scale*			high risk of performance, detection, and attrition bias; loss-to-follow-up 39% at one year, 52% at five years **low** QoE acc. to GRADE
Nieuwenhuijsen 2014	B	RCT (1)	**n=78** CMD patients with employment and new episode of depression	CMHN	usual GP care	**days** of sickness absence *depressive symptoms*	SMD 0.22 (95%CI: -0.36 - 0.79) *SMD 0.22 (95%CI: -0.31 - 0.75)*		**low** downgrade 2 levels
Kendrick 2005	B	RCT	n=247 (n=173 with employment, **n=78?** with employment *and* depression) community mental health service (CMH) patients from local NHS trusts, with a new episode of anxiety, depression, or reaction to life difficulties (symptoms ≥4 weeks, <6 months, GHQ-12 >3) symptoms duration, recruitment period unknown, follow-up 26 weeks. From community mental health, UK	n=90 (**n=60** employed); protocolized **problem-solving treatment** (initial 1-hour session plus five 30-15 minutes follow-up sessions) **by CMH nurse**	n=79 (**n=59** employed); **generic treatment** (initial 1-hour session plus five 30-15 minutes follow-up sessions) by CMH nurse; n=78 (**n=54** employed); **usual care by GP** (asked not te refer patients to a psychological therapist during study period unless absolutely necessary)	number of **days** off paid work			data for depressed subsample was provided by personal communication; high risk of performance, detection, and attrition bias; overall loss-to-follow-up 26% **low** QoE acc. to GRADE
gezondheidszorg-interventies; psychotherapie en farmacotherapie									
Nieuwenhuijsen 2014		RCT (1)	n=**57** persons with stable employment, MDD and new episode of care	psychodynamic therapy combined with antidepressant medication (TCA)	supportive care + TCA	(follow-up 7-12 mo.) **days** of sickness absence	SMD -0.02 (CI: -0.15 - 0.12)		GRADE quality of evidence **very low;** downgrade 3 levels for risk of bias and small number
Burnand 2002	B	RCT	n=95 (n=**57** with stable employment), outpatient with new episode of care, MDD (DSM-IV + HDRS ≥20); age 20-65 years; community mental health centre in francophone Switzerland	n=35 (n=**25** with stable employment) **psychodynamic psychotherapy** (individual sessions by nurse, frequency not fixed), and TCA clomipramine 25mg per day, gradually increasing to 125mg on 5th day (refusal or side effects 20 to 40 citalopram per day), during 10 weeks	n=39 (n=**32** stable employment) **supportive care** (with empatic listening, guidance and support) and TCA clomipramine 25mg per day, gradually increasing to 125mg on 5th day (refusal or side effects 20 to 40 citalopram per day), during 10 weeks	**days** of sickness absence in 10 weeks			stratified randomisation (personality disorder, previous DD, gender); unclear risk selection bias, high risk of performance, detection, and attrition bias (loss to follow up 22%) GRADE quality of evidence **very low**

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Nieuwenhuijsen 2014	B	RCT (3)	persons with depressive disorders, **3 studies** in primary health care setting	enhanced primary care combined with antidepressant medication	care as usual	(follow-up 7-12 mo.) **days** of sickness absence	SMD -0.02 (CI: -0.15 - 0.12)	inconclusive	GRADE quality of evidence **low;** downgrade 2 levels for low quality (in 3) and inadequate study allocation (in 1 study)
Rost 2004	B	RCT	**n=326** employed patients, with MDD (from 2-stage screening procedure), age ≥18 years; from 12 community primary care practices across the USA	n=**158 enhance care** (high quality depression treatment by trained primary care team; within one week after initial visit with physician return visit with nurse care manager (education about treatment, addressing treatment barriers, checklist fot physician's review, scheduling of next appointment), during 5-7 weeks, monitoring for 1 year	n=**168 usual care**; regular primary physicians care	total number of work **hours** lost due to illness or doctor visits over past 4 weeks *subjective rating productivity on scale 0-10*			high risk of selection, detection, and attrition bias (loss-to-follow-up 27% at one year) GRADE quality of evidence **low**
Schoenbaum 2001	B	cluster-RCT (at hospital level)	**n=1356** patients with probable depressive disorder (intended to use clinic fot next year), ≥18 years, in 46 primary care clinics in 6 community-based managed care organisations, USA	n=**913 quality care program (i.e. QI meds** *or* **QI therapy)** with 2-days training of local practice team and resources (f. ex. education pamphlets and videotapes, patients tracking forms, guideline-concordant clinical manuals and pocket reminder cards) to initiate and monitor QI programs care (QI meds: monthly telephone contacts with nurse specialist to support adherence for 6 *or* 12 months; QI therapy: protocolised, individual and group CBT by practice therapist)	n=**443 usual care**; mailing of practice guidelines to primary care professionals	**days** worked during 24 months follow-up			high risk of selection, performance, and detection bias (loss to follow up 15% at 2 yrs) GRADE quality of evidence **low**
Simon 1998	B	RCT	n=156 MDD patients (n=± 115 employed) with probable depressive disorder (intended to use clinic fot next year), age 18-80 years, large primary care clinics in managed care setting, USA	n=80 (±63 employed) **multifaceted care** aimed to increase likelihood that treatment would be conform primary care depression guidelines (components: 1) written and videotaped patient education material, 2) increased frequency follo-up visiits during first 8 weeks, 3) physicians advice on pharmacotherapy changes, 40 monitoring side-effects, and - 2 subgroups with psychiatrist-liaison vs. psychologist-liaison collaborative care	n=76 (±52 employed) **usual care**; any service normally avialable, including pharmacotherapy, and referral	number of **days** of missed work or school out of last 90			high risk of detection, and attrition bias (loss to follow up 17%, and 21%) GRADE quality of evidence **low**
Nieuwenhuijsen 2014	A2	RCT (1)	n=**604 persons with depressive disorder** in managed care setting	**psychological intervention combined with antidepressant medication**; telephone outreach and care program	**care as usual**	(follow-up 12 mo.) **days** of sickness absence *on-the-job* ***performance***	SMD -0.21 (CI: -0.37 - -0.05) *SMD 0.50 (CI: 0.34 - 0.66)*	small difference between intervention groups	GRADE quality of evidence **high**

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Wang 2007	A2	RCT	**n=604** employees covered by a managed behavioral health plan, identified in a 2-stage screening process as having depression - at least moderate depression severity. USA.	n=**304**; structured telephone intervention; **telephonic outreach and care management program** that encouraged workers to enter outpatient treatment (by systematically assessment of needs for treatment, both psychotherapy and anti-depressant medication), monitored and supported treatment adherence, and - for those declining in-person treatment - a structured psychotherapy intervention by telephone	n=**300**; **care as usual** patients were advised to consult a clinician and could recieve any normally available insurance benefit of service (e.g. psychotherapy), just *not* additional telephone care management components	**effective** weekly **hours worked** (i.e. product of job retention [0 for those not working], relative hours among the employed, and on-the-job preformance among the employed), **actual weekly hours worked** among employed (6, 12 mo); **job retention** (6, 12 mo); ***HPQ on-the-job performance*** *(10-pts scale) (6, 12 mo)*	**at 6 mo**: 42.0 (15.4) vs 40.1 (15.6); 1.8 h/w (-0.8 - 4.4), p=0.18 **at 12 mo**: 42.3 (13.4) vs 39.5 (13.7); 21.1 h/w (-0.4 - 4.5), p=0.09; *at 6 mo: 0.8 (0.2) vs 0.7 (0.2); 0.2 (-0.2 - 0.5), p=0.35 at 12 mo: 0.8 (0.2) vs 0.7 (0.2); 0.2 (-0.2 - 0.6), p=0.40*		70.7 vs 77.7% women; high risk of performance and detection bias (loss to follow up 14.5%, and 10%) GRADE quality of evidence **high**
interventies in de gezondheidszorg; bewegingstherapie									
Nieuwenhuijsen 2014	A2	RCT (1)	n=**65 workers with depressive disorder;** data from 1 trial	**strength training**	**relaxation**	**days** of sickness absence *depressive symptoms*	SMD -1.11 (CI: -1.68 - -0.54) *SMD 0.50 (CI: 0.34 - 0.66)*	large difference between interventions in sickness absence but not symptom reduction	GRADE quality of evidence **low**
	A2	RCT (2)	n=**180? workers with depressive disorder;** data from 2 trials with 3+2 treatment arms	**aerobic training**	**relaxation / stretching**	**days** of sickness absence *depressive symptoms*	SMD -0.06 (CI: -0.36 - 0.24) *SMD 0.50 (CI: 0.34 - 0.66)*	no difference between interventions in sickness absence and depressive symptoms	GRADE quality of evidence **moderate**
Krogh 2009	B	RCT	n=165 **(n=92** employed, and with depression) outpatients meeting ICD-10 criteria for unipolar depression, referred by a medical doctor or psychologist, 18 to 55 years; recruitment period January 2005 to July 2006, follow-up 12 months. Greater Copenhagen area, Denmark	n=55 (n=**32** employed); supervised **strength training** (designed to increase muscle strength, circuit-training program with 6 exercises on machines involving large muscle groups); n=55 (n=**25** employed); **aerobic training** (designed to increase fitness, program with 10 different exercises using large muscle groups); twice a week, during 4 months, 32 sessions	n=55 (**n=35** employed) **relaxation training** (designed to avoid muscular contractions or stimulation of the cardiovascular system, program with 3 different relaxation, light balancing and breathing exercises for 50 to 80 minutes)	self-reported percentage of **days absent** from work during last 10 working days at 4 and 12 months			high risk of performance, detection, and attrition bias; loss-to-follow-up 22% at one year GRADE quality of evidence **low**

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Krogh 2013	B	RCT	n=115 **(n=68** employed) patients from various clinical settings with MDD (DSM-IV with MINI, and HAM-D17 >12), referred by a medical doctor or psychologist, 18 to 60 years; recruitment period September 2008 to April 2011, follow-up 3 months. Greater Copenhagen area, Denmark	n=56 (**n=36** employed); **aerobic training** (designed to increase fitness as measured by maximal oxygen uptake, program with 10 minutes low-intensity warming-up, followed by 30 minutes high intensity training [up to 80% maximum uptake] on cycle ergometer, and 5 minutes cooling-down), three times a week for 3 months, 36 sessions	n=59 (**n=32** employed); **stretching excercise** (designed as an attention control group with the same level of social interaction and contact with health care professionals), program with 10 minutes low-intensity warming-up, followed by 20 minutes of streching, and 15 minutes of various low intensity excercises, three times per week for 3 months for a total of 36 sessions	self-reported percentage of **days absent** from work during last 10 working days at 3 months			high risk of performance; loss-to-follow-up 16.1%, and 10.2% at 3 months GRADE quality of evidence **moderate**
recent interventie onderzoek, anders dan systematic review									
Hellerstein 2015	C	pilot study	n=16; participants in a MDD pharmacotherapy trial with good response but remaining unemployed. State New York, USA.	12-week individual manual driven behavioral activation therapy with a goal return to work	-	hours of work-related activity and hours of paid work, at 24 wks	d= 0,83 and 0,54	preliminary evidence of efficacy of a work-targeted psycho-therapy to remediate vocational impairment	14 (85%) completed the 12-weeks intervention
interventies tegen terugval bij depressie									
Arends 2014a	A2	RCT	SHARP trial werknemers met CMD (waaronder een klein deel depressie)			uitblijven van terugval in verzuim			uitgebreide beschrijving in rapport over prioritering MDR - incl deel ppn met MDD

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Uitgangsvraag 5: Welke factoren hebben een gunstige of ongunstige invloed op de prognose van a) functioneren in werk, b) terugkeer in werk of opnieuw uitvallen, en c) instroom in uitkeringen of regelingen voor arbeidsongeschiktheid?										
Arends 2014b	Predictors of recurrent sickness absence among workers having returned to work after sickness absence due to common mental disorders	B	prospective cohort study	n=158 patients sick listed due to OP's diagnosis of common mental disorder (SHARP trial)	(Baseline) questionaires and administrative data	6 and 12 months after RtW	recurrent sickness absence (longitudinal logistic regression analysis with backward elimination)	predictors: compagny size >100 (OR 2.59, 1.40-4.80), conflicts with supervisor (OR 2.21, 1.21-4.04); having => 1 chronic disease (OR 0.54, 0.30-0.96)		gemengde groep CMD (niet aangegeven hoeveel % met depressie)
Brenninkmeijer 2008	Depressed and absent from work: predicting prolonged depressieve symptomatology among employees	B	longitidunal cohort study	patiënten sick listed for 12-20 weeks due to mental health problems (INVENT cohort)	screening questionnaire, and standardized telefonische interviews	n=555; screening questionnaire 42%, 93% first interview, 79% second interview, n=436 participated in second interview; Follow-up van 1 jaar na inlcusie	Work resumption (zowel full als partial), depressive symptoms, work-related characteristics and actions by employer	laag opleidingniveau en kostwinnerschap zijn verbonden met een ongunstiger verloop van de ziekte; werkhervatting en aanpassing van taken zijn belangrijk . Deels of volledige verhervatting toont relatie met gunstiger verloop van ziekte (kan ook andersom zijn).		
Brouwers 2009	Predicting Return to Work in Employees Sick-Listed due to Minor Mental Disorders	B	prospectieve cohort; aug 2001-juli 2003; inclusie bij 70 HAP'n, Almere	n = 194 patiënten met 'minor mental disorders', al verzuimend of direct na het consult	vragenlijsten en telefonisch interview	volledige werkervatting 3 maanden 38%, na 6 maanden 61%	volledige werkhervatting na 3 of 6 maanden	voorspellers: ernst klachten; langbestaande klachten voor ziekmelding; lang verzuim voor zoeken van hulp; hoge scores op 4DKL somatisatie e/o angst at baseline of depressie op 3 maanden	exclusie patiënten met matig ernstige en ernstige depressieve stoornis	

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Cornelius 2011	Prognostic factors of long term disability due to mental disorders: a systematic review	A1	systematisch review met 7 hoge kwaliteit cohort-onderzoeken		gezondheids-, persoonlijke en externe factoren vlgs ICFmodel		doorgaand verzuim (no RtW); arbeids-ongeschiktheid	voorspellers: sterk bewijs leeftijd >50 jaar langdurend verzuim en blijvende arbeids-ongeschiktheid; beperkt bewijs: man, hoog opleidingsniveau, eerder verzuim, negatieve verwachtingen t.a.v. herstel, lage SEK, werkeloosheid, kwaliteit/continuiteit BGZ, opstelling leidinggevende		depressie en angststoornissen zijn als gezondheidsfactor verbonden met meer verzuim en AO-heid (net als stressgerelateerde stoornis, rug- en schouderpijn
Cornelius 2014	Predictors of functional improvement and future work status after the disability benefit claim: a prospective cohort study.	B	Prospective cohort study (october 2009 - april 2011)	n = 375 (response rate van 24,3%) (n=310 voor work status analyse), disability claimants (data uit PREDIS gebruikt)	Self reported vragenlijsten en structured psychiactric interviews	1 jaar	functional improvement en work-status at follow up	Voorspellers voor toekomstig werk status: werk status at baseline, contact met medisch specialist, en Loss of Earning Capacity <80%		Kijkt specifiek naar voorspellers als patienten al ziektegeld ontvangen
de Graaf 2011	Verzuim door psychische en somatische aandoeningen bij werkenden	A1		NEMESIS-2 Nederlands bevolkings-onderzoek				werkenden met depressie verzuimen extra 22,8 dagen per jaar		

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Ebrahim 2013	Association of Psychotherapy with Disability Benefit Claim Closure among Patients Disabled Due to Depression	B	retrospectief cohort-	claimanten bij Canadese inkomensverzekeraar (n=259.510) wegens kortdurende (<±27wk; n=172.425 geincludeerd) of blijvende (tot 65jr; n=55.530 geincludeerd) arbeids-ongeschiktheid a.g.v. depressie (ICD-	aanbieden van psychotherapie	Cox-regressie	afsluiten van de claimperiode	het ontvangen van psychotherapie hangt samen met een langere periode short-term disability claim (=verzuim) en kortere periode long-term disability claim (=arbeidsongeschiktheid); ook een hogere leeftijd, vrouw zijn, hoger salaris, diagnose van recidief episode depressie, een tweede psychische of somatisch aandoening leidden tot langer short-term disability claim period. Hogere leeftijd, primaire diagnose van recidiverende depressie en een	Cox-regressie
Endo 2013	Recurrence of sickness absence due to Depression after Returning to Work at Japanese IT Company	C	descriptief retrospectief cohort-	n=540 Japanse werknemers bij 1 onderneming die hervatten na een verzuimperiode a.g.v. een eerste depressieve episode (apr 2002-mrt 2008); follow-up 8,5 jaar		8,5 jaar	recurrence of sickness absence due to depression after work	na 8,5 jaar follow up was bij 49,3% herhaald ziekteverzuim opgetreden, vooral in de eerste 2 jaren en bij 85,2% binnen de eerste 3 jaren na werkhervatting	Onderzoek uit Japan, representatief voor NL?	
Koopmans 2008	Sickness absence due to depressive symptoms	B	decriptief prospectief; observational; survival analysis	Nederlandse werknemers - aangesloten bij ArboNed n=9.910 verzuimepisodes ten gevolge van depressieve stoornis in periode		104 weken	verzuimduur (dagen)	24% langer dan een jaar; gemiddeld verzuim (mediaan) onder mannen 200 (179), onder vrouwen 213 (201); relatief lang verzuim in onderwijs en overheid (232;242), commerciële sector (213;219), gezondheidssector (212;214); onder ouderen en bij		

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Flach 2013	Identifying employees at risk of job loss during sick leave	C	retrospectief	n=4132 employees on sick leave; geregistreerd van Mei 2004 tot Januari 2006	Verzameling van data (retrosepctief ingevoerd) door 75 getrainde OHP's.		OR voor job loss during sick leave berekend in logistic regression models	Job loss during sick leave is associated with mental disorder, a history of sick leave due to these disorders, lack of co-worker and supervisor support, job insecurity, and working as a civil servant or a	were divided into mood disorder, anxiety disorder, stress disorder, somatoform disorder and
Lerner 2004	The Clinical and Occupational Correlates of Work Productivity Loss Among Employed Patients With Depression		longitudinal observational cohort study	N = 246 employees with depression (recruited tussen 2001 en 2003) and N = 143 controls.	Questionaires, multi regressie		health related productivity loss		
Lerner 2010	Work Performance of Employees With Depression: The Impact of Work Stressors	A2	longitudinal cohort study	N = 286 depressed employed adults (18-62) en 193 controls. Recruited tussen februarie 2001 tot maart 2003	Baseline questionaire via email. Questions over the phone by research assistant. Followup questionaires via post.	18 maanden	Work performance	Depression symptoms are related to work absences and impaired work performance.	
Lagerveld 2010	Factors Associated with Work Participation and Work Functioning in Depressed workers: A systematic review	A1	systematisch review met hoge kwaliteit cohort-onderzoeken	N=25; N=19 work participation, N=11 work functioning, N=5 both; depressed workers	systematisch literatuur-onderzoek		work participation; work functioning	WP: Sterke evidence voor relatie tussen duur depressie en work disability. Matig evidence voor relatie tussen ergere depressie, aanwezigheid van co-morbiditeit en work disability. WF: Matig evidence voor relatie tussen ergere depressieve symptomen en meer limitations voor werk en matige	
Mäntyniemi 2012	Job strain and the risk of disability pension due to musculoskeletal disorders,	A2	prospectief cohort-onderzoek	n=69,842; 48,598 repondents to survey, follow up from 2000 to 2002	high job strain; HR/unit, adjusted for demographics, work unit and	mean 4.6 years; 2,572 (4%) were granted disability pension	disability pension	no consistent pattern found for disability pension due to depression	

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Slebus 2007	Prognostic factors for work ability in sicklisted employees with chronic diseases	A1	systematisch review met hoge kwaliteit cohort-onderzoeken	AMI: N=7; cLRP N=2; MDD N=0	systematische literatuursearch jan 1990-juli 2006			geen relevante onderzoeken die prognostische factoren t.a.v. werkhervatting en arbeidsongeschiktheidsuitkeringen voor patiënten met depressie		
Vemer 2013	Let's get back to work: survival analysis on the return-to-work after depression	C	prospectief longitudinaal onderzoek	n=122 cohort uit interventie- en kosten-utiliteits-onderzoek van Vlasveld 2013 en Goorden 2014	Vragenlijsten		Tijd tot volledige RTW (ziekteverzuim-dagen)	ernst van de depressieve klachten (PHQ-9) en gezondheids-gerelateerde kwaliteit van leven maten (EuroQol-5D en SF-36) voorspellen verzuimduur; vrouwen, patiënten met partner maar zonder kinderen en ouderen meer tijd tot volledige werkhervatting; full-time job and patients with more decision latitude leidt ook tot langere tijd tot RTW. Management		