Best Practices in Depression Disease Management

Insights from The Shepell•fgi Research Group

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Executive Summary

EAP providers are frequently called upon to offer their customers depression/anxiety identification, treatment and disability claims prevention/duration reduction. The belief is that, as specialists in mental health, EAPs are an appropriate route through which employers can identify individuals experiencing depression/anxiety, provide help, and reduce the risk of difficult-to-resolve disability claims.

However, confidential Employee Assistance Programs are inherently limited in what they can do on each of these fronts. The clinical networks, protocols and practices used by EAPs, which address the vast majority of employee emotional, family and health and productivity issues very well, are generally inadequate to deal with serious mental health and addictions issues. EAP providers themselves have long recognized this, and have established alternate routes of risk assessment and referrals to external resources to appropriately manage these cases while retaining the integrity of the EAP service delivery model as a voluntary, confidential resource for employees who self-refer for help on a wide range of issues.

EAP providers that seek to offer a truly effective depression disease management program—one that has an impact on an individual's recovery and an organization's disability claims incidence and costs—must build a specialized infrastructure to deliver that service and must be prepared to work closely in an alliance with the employer, the disability claims manager, the client and the client's treating physician. Without this model and structures to support it in place, the risk to the employer and to the individual is high: everything from delayed and inappropriate diagnosis leading to chronic depression or relapse and unnecessarily extended claims duration to confidentiality breaches and legal action should such cases not be handled properly.

Best practices in depression/anxiety identification, treatment and case management require support at the individual and organizational level that extend beyond the well-established EAP business and service delivery model. These are outlined in this White Paper, and employers, disability insurers, benefits consultants and other stakeholders in employee health and wellness are encouraged to evaluate their current practices against these guidelines.

The Issues

EAPs rely on individual self-identification and offer, in return, a confidential resource for employees (and their family members, usually) to help resolve the issue that the individual presents. Most high-quality EAPs offer a risk assessment at intake and a more comprehensive clinical assessment during the first counselling appointment to identify the risk of depression, addictions or other serious mental health issues. The best practice in EAP assessment is to ensure that the risk of harm to self or others can be identified immediately so that appropriate referrals to emergency services are made; and secondarily, where depression, anxiety, major mental health or addictions issues emerge during the counsellor's face-to-face assessment, that these clients are referred to appropriate community resources for treatment. In most cases, the EAP's short-term, solution-focused model is not adequate to deal with cases of moderate to severe mental illness (depression, anxiety, addictions, etc.), which generally require psychopharmacological support, a specialized form of therapy and extensive case and medical coordination.

Fundamental within this process, which has developed as a way to ensure the right level of care is applied at the right time and that emergency risks are quickly and effectively responded to, is the fact that EAPs can only 'identify' depression/anxiety as an issue if the individual experiencing the problem picks up the telephone and calls. This leaves many at-risk individuals in an organization vulnerable to being undiagnosed, untreated and at risk of disability if they choose not to self-identify to the EAP. In particular, because EAPs are a workplace tool and primarily reach those at work, it leaves out those at greatest risk who may already be absent from work or on disability leave due to mental/nervous disorders. This is no fault of the EAP or the EAP provider—rather, it is an artifact of the EAP structure as a confidential, voluntary resource.

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It is not that the EAP is unavailable to individuals absent from work; it is simply that these individuals are involved in treatment and a care plan through what is usually a separate system—the disability management system. While these people *could* call the EAP, they generally *don't*. Even if they do, EAPs are not 'built' to interface well with disability case management systems unless protocols and infrastructures, including training of EAP counsellors and the employer's or their insurer's case managers has been implemented to allow for seamless cross-referrals and information sharing between the two systems.

If an individual is assessed with moderate to severe depression, the options for treatment within the EAP are limited. EAPs provide a very specific form of help: short-term (e.g., typically 6 to 8 sessions) of what is known as "solution-focused" therapy. This type of therapy, practiced by clinicians qualified as social workers or with Master's-level degrees in adult education/psychology, is entirely appropriate to address the broad range of issues that may be presented to the EAP: from parenting troubles through to marital difficulties; coping with life transitions to general stress management.

To best address depression/anxiety, however, one needs a different skill set. At the least, a background in mental health treatment/psychiatric settings–which some, but not all social workers have–is imperative. Secondly, the preferred psychotherapeutic approach for optimal clinical outcomes for depression/anxiety is cognitive-behavioural therapy (CBT). This is a methodology that, again, some social workers practice, but not all do.

Thus, the match between the clinician and the client becomes imperative. Individuals presenting with depression to an EAP, even if they can be offered the type of therapy required and to the extent required, must be streamed to the appropriate clinician, and that clinician must be provided with the training, supervision and protocols appropriate to deal with an issue that requires extensive coordination with external resources, including the client's treating physician and, in most cases, a disability case manager.

Without training, communication protocols and consent/clinical referral processes in place and well-understood by all parties, the counsellor dealing with the depressed individual has no choice but to practice within the traditional boundaries of EAP short-term therapy. Even if extended to 10 or 12 sessions, he or she will be constrained in their ability to effect an outcome that achieves the disability prevention goals of both the individual and the organization.

- approximately 8% of adults will experience major depression at some time in their lives
- only one-third of patients experiencing depression seek help within the first year of exhibiting symptoms; some wait up to 10 years before seeking help
- while four out of five people with depression can be successfully treated within weeks, the fact remains that of those who seek treatment, many remain undiagnosed or receive either incorrect medication or inadequate doses
- depression results in an estimated $1.5 billion dollars of lost productivity each year and is now the second leading cause of long-term worker disability in Canada

(Public Health Association of Canada, 2003; Statistics Canada, 2005; American Psychiatric Association, 2001)

These factors greatly increase the risk of moderate to severe depression/anxiety emerging into a disability claim. Should an individual being treated within the EAP end up on disability, confidentiality parameters actually *prevent* the EAP counsellor from sharing information with the case manager, unless very specific protocols have been established in advance. Without these, everyone ends up frustrated: the clinician, who is doing his/her best to help the individual navigate the resources available; and the

disability case manager and employer, who may seek information from the EAP provider that cannot be provided without appropriate consents and protocols in place for the sharing of personal health information.

What's worse, the individual may be subjected to more of what is likely a long history of delays, misdiagnoses, and ineffective treatments. Inevitably, this leads to unnecessary suffering and extended absence duration than should occur if appropriate assessment, treatment and a care plan was in place early.

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Within this context, it becomes obvious why anti-depressants are among the highest costs for organizations (because they are prescribed in a vacuum and treatment compliance is invariably low); why mental/nervous disorders are among the top three disability claims categories in all organizations; and why these claims are the most likely to extend to long-term disability cases, from which it is very difficult to help the individual recover and return to productivity.

Another difficulty that must be managed is the training and orientation of the clinician providing the depression counselling. Where the individual has first presented to the EAP with depression, and then moves into a disability/absence situation, a shift must occur: the clinician treating the individual, and the client him/herself, need to "switch gears" from being in a voluntary, confidential setting where the client's goals have been identified and the action plan in place to achieve them, to a mandated program that the individual—now a "claimant"—is required to attend to maintain eligibility for disability benefits; where information about the individual's progress and functional abilities will be provided to a third party; and where the focus of counselling is now specifically directed to the return-to-productivity goal.

Such a shift requires: a different clinical practice and methodology; different clinical supervision and communication protocols; a different triage and access route for the client; obtaining consent and communicating with multiple parties to the claim differently; and an extensive amount of policy/protocol coordination to protect the client and the employer from the risk of privacy breaches and legal liability.

Lest the foregoing be misconstrued to imply that EAPs are not doing what they ought to do, exactly the opposite is the case. The axiom: "you must correctly identify the problem before you can solve it" is useful here. EAPs do exactly what they should do to treat the vast majority of personal, social, family and other challenges that are presented to them and indeed, to treat many of the depression cases that are self-presented to them. The problem is that the EAP—the program itself—should not be used

as a disability management system. Too often in the past that is what has been asked of them and some EAP providers have attempted to mold their EAP into that shape, with problematic consequences. It is not the ***EAP*** that needs to change; it is the ***EAP provider***. It is not the EAP that needs to "treat depression better"—it is the EAP provider that must be able to leverage their clinical resources in new ways to fulfill their organizational customers' mental / nervous disability management requirements.

To do this, EAP providers must set up a separate treatment program, access route and coordinated approach to dealing with depression/anxiety cases that almost invariably will interface with the disability case management system. Moreover, this "separate-from-EAP" system needs to be available to those who probably would not approach the EAP on their own, but rather will be more often referred in to counselling by a disability case manager.

While reframing the identification and treatment of depression/anxiety as a disability prevention and disease management issue brings new challenges to EAP providers, it is vital to best serve the interests of employers, disability case managers and clients.

The Best Practice Solution

By viewing depression from the lens of disease management rather than "employee assistance," the provider is freed from the inherent limitations of the EAP structure to ensure that processes to identify, treat and manage serious mental health cases are in place to support the clinical and business objectives of all parties in the process: the client, the clinician, the case manager and the employer.

- If the EAP provider's intake system is to be used to screen for depression, special protocols must be in place and training delivered to ensure that anyone self-presenting with depression is triaged to a comprehensive clinical assessment that uses a clinically-valid and reliable tool and offers appropriate information to the case manager regarding prognosis, treatment recommendations and a care plan;
- The EAP must be leveraged to reach those it can through communications that raise awareness of depression, educate employees and managers about it, and encourage those experiencing symptoms to call the EAP for help. This maximizes the self-referral route for depression (from there, structures need to be in place to offer a referral to the right ***type*** of help based on the assessed level of depression);
- Counsellors must be specially selected, trained and supervised to deliver cognitive behavioural therapy with a return-to-work focus;
- A psychometric tool should be used to inform the care plan. It should offer the counsellor and client

diagnostic, treatment compliance and physician-to-physician contact to ensure that psychotherapy is coordinated with medical therapy for best clinical outcomes—furthermore, it should be well-integrated within the counselling process and used as a motivational and progress measurement tool;

- Counsellors delivering depression psychotherapy must be prepared to provide information to the case manager regarding the individual's treatment, functional abilities, attendance or progress in treatment ensuring that appropriate consents are received if and when the case progresses to disability absence;
- Counsellors must have the expertise to work effectively with those who are mandated to attend treatment as a condition of benefits payment;
- The program must be implemented with adequate training for the case manager and employer's Occupational Health personnel. Protocols should be aligned with the employer's disability management policy and practices;
- A clear firewall must be maintained between the information provided by the counsellor as part of the case management plan and that used by the case manager in adjudicating the claim so that claims decisions are defensible;
- Program implementation must be customer-specific so that the employer's case manager (either its own Occupational Health or its insurer's) receives appropriate support to refer into the program and manage these high profile and potentially costly cases.

Implementing Depression Disease Management: *Questions to Ask*

While complex and requiring a shift of focus and practice, implementing an effective, best-practice depression disease management program is eminently do-able. The following are the questions employers, benefits consultants and key stakeholders in employee health and wellness should ask to verify that the provider's approach to identifying and treating depression and anxiety employs disease management best practices:

- What depression assessment tool is used, when and by whom? What information does it provide, when and to whom? Is it integrated within the counselling process, or applied separately?
- Does the tool offer a care plan and physician-to-physician consultation to ensure medication dosages are appropriate and psychopharmacological treatment is integrated with the counselling? How often is the tool used during the course of treatment? How are results

communicated to the individual client, the client's treating physician, and the case manager, for what purpose(s) and by whom?

- Is an appropriate course of therapy suited to the complexity of moderate to severe depression/anxiety available? If these sessions are to be included as EAP utilization, will additional charges be applied? If not, how is the provider funding this more extensive level of service?
- What clinical management processes are in place to ensure that these high profile cases are conducted in such a way as to avoid confidentiality breaches and optimize clinical outcomes?
- What training and selection processes have been developed and executed to ensure that counsellors are appropriately qualified, trained and supervised to deliver mental health counselling with a return-to-work focus, in alignment with the case management program and with individuals who are mandated to attend as a condition of disability benefits payment?
- How does the counsellor interact with the disability case manager? How does the provider ensure that this interaction is seamless; that consents are in place; and that communication protocols respect the customer's short-term disability policies and protect the client's personal health information at all times?
- Given the limitations of self-referral to the EAP for depression (and given that most individuals using EAP are at work), how will the availability of this service be promoted to individuals off work as a result of mental/nervous disorders? In other words, how will depression counselling, medical co-ordination and treatment be extended to those at most risk?
- What protocols are in place to ensure depression counselling is integrated with case management / return-to-work processes and the customer's attendance, short and long-term disability policies? How are the various parties involved in claims management trained and supported during program implementation and on an ongoing basis?
- What kind of reporting is provided, to whom, and what is the consent mechanism to ensure that breaches of privacy do not occur? What outcomes are reported, to whom, to ensure that treatment is achieving the return-to-work goal and, more broadly, the case management and duration reduction objectives?
- What systems and support are available to ensure effective communication between the employer's occupational health disability case managers (internal or external), the counsellor, the treating physician and the client? What support is available for program set-up, communication and reporting at the organizational level?

Focus On The Objectives

The bottom line is to remain focused on the key objectives of any employer-based disease management and disability prevention program:

1. Is the individual being supported appropriately to return to productivity in the workplace?
2. Are the activities aligned with the employer's disability policy and processes?
3. Ultimately, will the solution in place reduce the risk of mental/nervous disability and, where the individual is already absent as a result of mental/nervous disability, reduce the duration of that disability by offering appropriate care?

With gaps in the public health system and inherent limitations of the EAP model, combined with the rising costs and incidence of disability impacting organizations, it behooves employers, their insurers and their benefits consultants to evaluate very carefully who is doing what to address these issues, and hold their providers to the highest standards with respect to best practices in the area of depression disease management.

THE SHEPELL·FGI RESEARCH GROUP
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