OPTIMIZING DEPRESSION CARE: OPPORTUNITIES FOR THE EAP

Tony J. Kreuch, Psy.D., CEAP
Sandia National Laboratories
Albuquerque, NM

Depression is a major workplace concern with significant impact on employee productivity, attendance and "presenteeism" and often affects the company bottom line in areas such as cost impact, employee morale, worker turnover and affected families. However, despite the frequent challenge of depression in the workplace, EAPs are often not well-equipped to fully address these employees. Often, the individual will either be directed to a 24 hour call center or seen briefly onsite by an EAP professional and referred to a treating provider without a full assessment or comprehensive approach. Diagnostic practices may be informal without use of validated tools and without a full assessment of risk or identification of appropriate level of care. However, the EAP may be ideally placed within an organization to have a significant positive impact on this condition. This article will summarize my recommendations regarding EAP strategies for optimizing assessment and care for employees who are struggling with depression. I will also briefly review a working model for the assessment and treatment of depression that we have developed at my company using best practices and a collaborative model for tracking outcomes.

Depression in the Workplace: An Epidemic That Affects the Bottom Line

It is by now well understood that the depressive disorders have a significant impact on society. Available data (Kessler, 2003) indicate that Major Depressive Disorder is the leading cause of disability in the United States for individuals aged 15-44 with a median age of onset of 32 years old. Depressive disorders affect approximately 15 million adults (6-7%) age 18 and older annually and suicide is considered to be the 10th leading cause of death. Unfortunately, there is a significant "services gap" with depressive disorders in that only 22% of those diagnosed receive adequate and effective treatment. Additionally, depression is predicted to be the leading cause of occupational disability by the year 2020. On average 12% of US workers report a history of treatment for depression. Workers with any history of diagnosed depression miss an additional 68 million days of work annually and the estimated cost to the employer per episode of depression ranges from $5,000 to over $25,000 (Gallup, 2013). There are approximately $26 billion in direct costs and $51 billion in indirect costs to employers associated with depressive disorders (Kessler, 2003). The data are compelling and support the need for efforts at more comprehensive and effective responses to depression at the workplace.

Towards a Model of Comprehensive Care for Depression at the Worksite

Any worksite screening for depression should ideally include the following components: *assessment of depression with differential diagnosis; employee functional status; impact on work performance including absenteeism and productivity; risk assessment.*

Depression Assessment. It is important for the EAP Professional to "ask the right questions" and conduct a comprehensive interview that includes historical, social/interpersonal, medical and substance use information in order to differentiate health conditions and/or substance use that might be misinterpreted as depression. Not all individuals with depressive disorders necessarily report feelings of sadness or low mood. As such, thoroughly questioning symptom areas such as changes in sleep, appetite or energy levels, changes in usual activity levels, poor concentration, feelings of despair or guilt is important. Use of well- validated measures such as the Patient Health Questionnaire – 2 (PHQ-2) for initial screening and the Patient Health Questionnaire-9 (PHQ-9) for confirmation of diagnosis are recommended (Kroenke, 2001, 2003).

Employee Functional Status. Evaluation of employee functional status can be completed with instruments such as the Stanford Presenteeism Scale-6 (2001) or the newer Workplace Outcome Suite (2013), both of which can provide a level of current work engagement including time away from work and ability to maintain focus on work tasks when on the job. Additionally, the clinician should inquire as

to whether or not the employee has been experiencing any significant changes in behavioral functioning while at work. Questions such as: "Are you finding yourself more withdrawn or less social at work?" "Are you having difficulty getting along with co-workers and/or getting your work done?" "Has your supervisor discussed concerns about you or your work with you?", should be asked. Sometimes, depending on circumstances, a supervisor will be involved and may actually make a direct referral to the EAP out of concern for the employee. Obtaining the appropriate level of consent and release is crucial in these situations but can ultimately often be a very effective pathway for getting an employee appropriate help.

Risk Assessment. Evaluation of potential for self-harm is a crucial aspect of any depression assessment, whether that assessment is part of a worksite based program or not. The EAP clinician should inquire as to whether or not the employee has had any prior history of suicidal thinking or attempt, if there is any family history of depression or suicidality, and clarify current status with respect to intent and available means (Do you have any firearms or other weapons at home? What is your level of access to these weapons or pills?). The PHQ-9 includes a question on suicidality. Finally social support status should be evaluated. Does the employee live alone or with family and what is the quality of relationships at home? Evaluation of level of risk in context of the employee's job and work duties should also be thoroughly completed. Many jobs include activities that are connected to safety, whether it be public safety (e.g. airline pilots, law enforcement, fire fighters) or safety of others at the worksite (e.g., power plant workers) and depressive disorders frequently impact cognitive functions such as judgment, ability to reason, problem-solve and respond adequately.

Endpoint Assessment Best Practices Recommendations. Once a diagnosis of depression has been confirmed by the EAP Professional, then best practices treatment is ideally coordinated (American Psychiatric Association, 2010). For mild to moderate depression, including Major Depressive Disorder or Persistent Depressive Disorders (DSM-V), counseling alone is often indicated. Cognitive Behavior Therapy (CBT) is a well-validated therapeutic approach for depression and has been effectively used as a stand-alone treatment for many years. Interpersonal and dynamic approaches have also been shown to be beneficial (American Psychiatric Association, 2010). For moderate to severe depressive disorders, in particular when the individual is experiencing impairments in functionality in areas such as sleep, appetite, motivation and concentration (along with suicidal thinking), antidepressant medications are often recommended. First line pharmacological treatment currently includes a trial of one of the so-called SSRIs (Selective Serotonin Reuptake Inhibitors) such as fluoxetine, sertraline or escitalopram, or one of the SNRIs (Combination Serotonin-Norepinephrine Reuptake Inhibitors (venlafaxine, Cymbalta, Pristiq), or bupropion (Wellbutrin) which is a combination dopamine/norepinephrine reuptake inhibitor. Sleep aids, such as zolpidem (Ambien) or Lunesta might be used short-term, in addition to a short-term anxiolytic such as lorazepam (Ativan) or clonazepam (Klonopin). Older antidepressants such as Trazodone or Elavil are also at times used for sleep. Excellent resources for learning more about antidepressants include web sites such as Epocrates or the National Institute of Mental Health.

Patient education is also included in the best practices model since the antidepressants frequently have side effects (gastrointestinal problems, sexual side effects, headache, dizziness and suicidal thinking). This last potential effect is rare and typically reported in younger populations (adolescents) but given the possible impact on an individual already depressed it is important to review as the person starts on medication. Finally, a collaborative care approach in which all providers involved are in communication regarding the individual's care including approaches, goals and targeted outcomes is crucial. Taking this collaborative care best practice aspect of depression care to the "next level" includes using assigned Care Managers once treatment has begun.

One Effective Model: Onsite Depression Screening & Treatment Program at Sandia National Laboratories

Sandia National Laboratories is a major research and development laboratory that is part of the U.S. Department of Energy Nuclear Weapons Complex and has approximately 9,500 employees. Our EAP is uniquely positioned within an active Occupational Medicine Program that offers a range of services including management of chronic conditions such as hyperlipidemia and diabetes, wellness, and an urgent care clinic for acute medical disorders. We were long aware of the potential impact of depression on our workforce and in 2008 we initiated development of an onsite program after completing a needs and risk analysis and reviewing best practices care currently in use such as the DIAMOND Initiative (2008) and the STAR*D Project (2007). The result was the initiation of our Onsite Depression Program which has recently completed its 5th full year in operation. The critical elements of the program include: *Collaborative Care, including use of Onsite Care Managers; Ongoing Psychiatric Consultation; Initial Screening; Clinical Confirmation of Diagnosis; Treatment (or referral) Using Best Practices Care for Depression; Ongoing Outcomes Tracking.*

Care Managers. Our Care Managers are onsite health educators who complete a seven session depression training program. They are assigned to the patient at the outset of treatment and provide a point of contact and support for continuity of care and follow-up for program outcomes.

Psychiatric Consultation. We utilize a consulting psychiatrist who provides valuable input regarding our cases including treatment, recommendations and additional referral options. This combination of care manager collaboration and the use of the consulting psychiatrist are important aspects of the program.

Initial Screening. We use the Patient Health Questionnaire -2 (PHQ-2) for initial screening. This occurs within one of our clinics as part of the standard medical assessment and is voluntary. The PHQ-2 items ("Over the past two weeks I have had little interest or pleasure in doing things" and "Over the past two weeks I have felt down, depressed or hopeless") are highly sensitive to depressive disorders. Scores at or above 3 are considered to be significant and a referral to a clinician is initiated.

Clinical Confirmation/Treatment. A positive PHQ-2 triggers a referral to either one of our onsite medical providers or the EAP for a full evaluation. The PHQ-9 is used as part of this assessment and a diagnosis is either confirmed or ruled out with a PHQ-9 score above 5 and clinical confirmation. The patient can at that point elect to obtain care onsite with our internal providers, obtain referrals for offsite care or decline care. If treatment is chosen (either onsite or offsite) then the individual is entered into the program and assigned a Care Manager. Best practices care for depression is followed, per APA.

Program Outcomes. Outcomes are tracked using the PHQ-9 at pre-treatment, 6 months post-remission and 12 months post-remission. To date (as of June 2014) we have screened approximately 400 employees, with 235 eventual enrollees. We have had 161 either "complete" the program (to 12 month remission PHQ-9) or complete post-measures if not reaching remission. Analysis of 103 cases with complete data revealed a remission rate of over 70% and the following PHQ-9 Mean Scores: Pre-treatment 13.8 Six-Month Remission 3.8 Twelve-Month Remission 3.0. These scores reflect a significant reduction in PHQ-9 scores at the $p<.001$ level and our additional data analysis indicated that factors such as age, gender or site or type of treatment were not significant contributory variables with respect to PHQ-9 score reductions.

Summary

The findings from our program self-study are encouraging. We have demonstrated positive outcomes with a combination of a high rate of remission and PHQ-9 data. Our view is that it is the comprehensive, integrated nature of the program which has made it successful. We recognize that our self study does not include a control group and has not been replicated but the initial results are encouraging. Future goals

include inclusion of productivity and absenteeism/presenteeism measures for additional outcomes tracking.

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