

# Depression: The Untold Story

Plan sponsors and benefits providers can reduce the impact of mental illness by focusing more on the rapid treatment of depression

More employers are taking concrete steps to support the mental health of their employees, to reduce the widespread costs associated with mental illness and to improve productivity in the workplace. Without doubt, these efforts deliver positive results for the individual, the business and greater society.

But are we overlooking an essential piece of the puzzle, which can dramatically improve efforts specifically to help employees diagnosed with depression?

A growing body of clinical evidence suggests this to be the case. In a nutshell, too many people with depression are not getting the right treatment soon enough. The longer it takes to arrive at effective treatment, the lower the likelihood of recovery. Indeed, only about a quarter of those treated today get full relief from their symptoms as well as regain the functionality they enjoyed prior to becoming ill.<sup>1</sup>

On the flip side, when treatment is monitored and adjusted within the first four weeks—an approach referred to as “early optimized treatment”—recovery rates improve significantly and the risk of relapse drops. Keeping in mind that depression is a leading cause of disability leaves, it appears that employers would benefit from including early optimized treatment as an objective when putting together programs for mental health.

Yet what role can employers realistically play? Early optimized treatment appears to be a call to action for physicians and other healthcare providers. As with any effort to support health, however, the workplace can play a significant role in raising awareness and reducing stigma. Benefit plan designs can also evolve to remove current potential barriers.



“Early optimized treatment is everything. It can prevent people from becoming chronically ill with depression, which is a disaster for everyone, including employers. We can all play a part in better supporting people right out of the block as soon as that first prescription is written,” says Dr. Diane McIntosh, a psychiatrist in Vancouver, who joined employers, insurance carriers and benefits advisors for a roundtable discussion on mental health hosted by *Benefits Canada* in March.

## Current efforts

Before determining how to incorporate early optimized treatment into mental health strategies, participants in the roundtable agree it's necessary to take stock of current efforts. First and foremost, insurance carriers at the table unanimously agree that more plan sponsors recognize the need for—and feasibility of—a strategy in the first place. “More plan sponsors are understanding the costs of mental illness in their own workplace. And they are seeing that random acts of support, whether they be for mental or physical wellness, may not lead to results. Having a strategy is critical,” says Dr. Marie-Hélène Pelletier, a psychologist and assistant vice-president, workplace health, at Sun Life Financial.



The increased availability of resources targeted to the workplace—such as the Mental Health Commission of Canada’s National Standard of Canada for Psychological Health and Safety in the Workplace, supplemented by a wide range of tools from health organizations and insurance carriers—helps with the development of a strategy. And while larger employers are more likely to be active due to the greater availability of internal resources, smaller employers are also taking note.

“Smaller employers may be more in the early phase of this journey. I’m seeing more are building mental health initiatives as an integral part of their wellness programs. While in some cases these can be considered ‘random acts,’ there is a growing sense of having to start somewhere and building from there,” says Carolyn Zinken, registered nurse and consultant, benefit services, at benefits consulting firm CBA Canada.

Where broader-scale strategies are in place, roundtable participants report concurrent efforts in the following areas: awareness raising to reduce stigma, resilience training for all staff, targeted training for managers and improved case management for those on disability. “People are returning to work sooner and we’ve seen a drop in the recurrence of disability leaves,” says Georgia Pomaki, PhD, mental health specialists leader at Manulife. She adds: “When it comes to mental health in particular, more so than physical health, there is no ‘easy fix.’ The case management team needs to include mental health specialists who, right from the first day of the claim, help guide plan members through an individual recovery and return-to-work plan.”

## Closing gaps for depression

While the strides made in disability management are important, roundtable participants suggest that more can be done to support employees with depression while they’re still at work—with the goal to prevent, or at least significantly reduce the duration of, disability leaves.

On the clinical side, early optimized treatment can play a vital part in achieving that goal. “The whole premise of early optimized treatment is that patients should see an improvement within the first two to four weeks. That time frame really improves their

chances of being able to stay at work, or at least come back to work sooner,” says Dr. Jeff Habert, a family physician in Thornhill, Ont. “I’ve seen a big difference in outcomes between patients who follow the steps of early optimized treatment and those who don’t.” (See sidebar for more on early optimized treatment.)

How can workplace mental health strategies help communicate the benefits of early optimized treatment? First, by emphasizing the benefits of early detection and quick treatment as part of existing efforts to reduce stigma and train managers.

When it comes to reducing stigma, members of the roundtable stress that equal attention must be paid to the self-stigma often felt by those who have depression, as to the stigma that can be present among those who do not have the disease. “Personal stigma may prevent people with depression from accessing treatment or even being good to themselves. This is a major challenge,” says Pomaki.

“People with depression may feel a lot of shame, and the depressed mind may perceive things differently, which can lead to hesitation or even resistance to treatment,” agrees Dr. Pelletier. “This takes us back to management training, peer support programs and civility in the workplace—employers cannot underestimate the positive impact they can have when employees with depression feel they are supported.”

Peer support can be especially impactful, agrees Dave Gallson, associate national executive director of the Mood Disorders Society of Canada (MDSC). “The employer’s best resource is employees who have gone through mental health issues, who can be champions in the workplace to share their stories and be part of committees to implement policies and programs. You might be surprised by how willing employees will be to step forward, once you create the right environment.”

To create the right environment, non-profit organizations stand ready with a wide range of programs, including the popular “Elephant in the Room” anti-stigma campaign from MDSC ([www.mdsc.ca](http://www.mdsc.ca)). “We’re helping hundreds of organizations across Canada. It doesn’t have to be complicated, and it doesn’t have to cost a lot of money. Contact us,” urges Gallson.

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By intercepting and  
optimally treating depression  
earlier [‘early optimized treatment’],  
there is the potential to reduce,  
sometimes by many years, the substantial  
morbidity, mortality and functional  
impairment associated with this illness.”

Dr. Diane McIntosh,  
Psychiatrist

## A closer look at communication

Some key messages to communicate as part of general efforts to reduce stigma and raise awareness of early optimized treatment include:

- Mental illness is a physical condition that affects the brain; it is not an “emotion” that can be “controlled” by willpower alone.
- Like other physical conditions, mental illness can be successfully treated with medications as well as counselling.
- People with depression can start feeling better in as little as two weeks with the right treatment.

While general communication efforts should use simple language and avoid clinical terms, employers and insurers can get into a bit of detail with educational vehicles. “A lot of carriers send newsletters to their clients, as well as produce newsletters on behalf of clients to send to plan members, and these could include an article about depression and early optimized treatment in simple terms,” suggests Sherry Peister, a pharmacist and chair of the board at Green Shield Canada.

Rachel Chan, national wellness manager at Rogers Communications agrees that employers can take that extra step to educate plan members about best practices for treatment. “There is so much information out there. We can help make sure that employees get the most up-to-date information from the subject matter experts.”



This is especially relevant when it comes to early optimized treatment for depression, since it will take time for the medical profession to adopt this approach for treatment. “We can equip our employees with the latest information so that they are confident enough to self-advocate [when meeting with healthcare professionals,]” says Chan.

Down the road, targeted communications sent directly to consenting plan members can also raise awareness and nudge behaviours. For example, the sub-mission of a claim for an antidepressant would trigger a text or email with positive messaging about the benefits of following up with a doctor or pharmacist after trying the medication for two weeks. “There is an openness to this form of communication,” says Dr. Pelletier. “Employees are telling us they expect their employers to support them with their physical, financial and mental health, and there is clearly a growing preference to be communicated to via electronic means, with information that is tailored to personal situations.

## Changes to plan design

Plan sponsors and insurance carriers can be more tactical about facilitating early optimized treatment through the following plan-design measures:

## ANATOMY OF DEPRESSION

Scientists continue to build the case that depression is a physical condition—and if treated too late or sub-optimally, can result in changes to the brain that prevent full recovery and increase the risk of relapse.

“Depression can be caused by many factors but ultimately it leads to a brain injury. That injury, which is the result of inflammation, causes physical changes to the brain. Brain cells can be damaged or destroyed by depression, and that can be seen on a brain scan such as an MRI,” says Dr. Diane McIntosh, a psychiatrist in Vancouver. “Most people do not get that, even among physicians. Yet once you understand that, the whole picture changes as far as treatment.”

Those brain changes result in symptoms that can cause feelings of sadness or worthlessness, lack of motivation and difficulty with concentration and decision-making. These symptoms, in turn, contribute to higher rates of nonadherence to treatment and eventually treatment failure.

The degree of brain injury is related not only to the severity of the depression to begin with, but also to the amount of time it takes to find an effective treatment. Changes to the brain not only increase the risk of relapse, but also can lead to co-morbidities such as anxiety.

## Alleviate financial barriers

To encourage continued therapy, increase annual coverage for services beyond the typical amounts set aside in employee assistance programs, paramedical benefits or healthcare spending accounts. Patients often require more than a handful of sessions and may need to try different providers, and lack of coverage can be a big barrier, notes Gallson.

## Simplify access to antidepressants

Ensure that prior authorizations and tiered formularies do not delay adjustments to treatments for depression; under early optimized treatment, physicians may need to switch or add drugs several times during the first two to four weeks after starting the initial course of treatment.

## Implement trial prescriptions for antidepressants

Encourage pharmacists to dispense an initial 14-day supply of antidepressants by enabling them to bill for the service, which would include following up with the patient and, if changes to the medication are required, consulting with the physician.

## Better yet, offer pharmacist coaching as a standard benefit

“Pharmacists can play a big role because patients come to us with their prescriptions. We can follow up with the patient and use the standardized assessment tool to evaluate symptoms, then work with physicians as required,” says John Papastergiou, a pharmacist and owner of two Shoppers Drug Mart pharmacies in Toronto. “There would need to be a structure, which would include training to make sure pharmacists carry out the steps of early optimized treatment, and reimbursement for the service,” he adds. Such a benefit would be well worth the investment, adds Dr. Habert. “Paying a fee to pharmacists is more cost-effective than having a person persist with depression for years because they were not treated optimally early in their depression.”



Left to right: **Rachel Chan**, Rogers Communications; **John Papastergiou**, Shoppers Drug Mart; **Maria Fraga**, Manulife; **Dr. Jeff Habert**; **Sherry Peister**, Green Shield Canada; **Georgia Pomaki**, Manulife; **Carolyn Zinken**, CBA Canada; **Dave Gallson**, MDSC; **Dr. Marie-Hélène Pelletier**, Sun Life; **Ken Bowman**, RBC Insurance; **Dr. Diane McIntosh**; **Kathleen Ballantyne**, Employee Life Health Trust for AEFO members; **Gail Enever**, OTIP

## Once patients are stable, don't allow switches

Some drug plan designs encourage or require that brand-name drugs be changed or switched to generic drugs, which cost less. As well, when there are multiple generic options they are generally treated as interchangeable, which means that pharmacies may dispense different generics to the same patient over time. However, clinical studies show that any switching of antidepressants, for reasons not related to health, is more likely to cause adverse effects than switching in other categories of drugs. Ideally, brand-name antidepressants should be “grandfathered” or exempt from mandatory generic substitution policies, and pharmacies should not be able to switch between generics. “Patients should always receive the same antidepressant medication whether it’s branded or generic. They shouldn’t be switching around because we’re seeing that patients often suffer due to switches,” says Dr. Habert.

## Attention insurance carriers

Participants at the roundtable also suggest the following measures specifically for insurance carriers:

- In forms used by physicians for disability claims, replace the request for a “global assessment of functioning” score, which is outdated, with a request for the “PHQ-9” (Patient Health Questionnaire for depression) score, to encourage physicians to adopt this assessment tool that can be used as part of early optimized treatment.
- Sponsor continuing education programs for physicians and pharmacists on the benefits and steps of early optimized treatment.

## WHAT IS EARLY OPTIMIZED TREATMENT FOR DEPRESSION?

Currently, most physicians use a “start low, go slow” approach with patients taking an antidepressant for the first time. Traditional teaching recommends that they begin with the lowest effective dose and give that a trial of six to eight weeks before adjusting treatment, if required.

However, research increasingly shows that patients who remain on an ineffective or poorly tolerated treatment for more than four weeks are at greater risk of delayed or incomplete recovery. In fact, when symptoms improve two to four weeks after starting treatment, patients have a much better chance of recovery.<sup>2</sup>

“Conventional thinking is that it takes four to eight weeks for an antidepressant to work, but that’s not true. If something is not happening within two to four weeks, then it’s not going to, and you need to try something else,” stresses Dr. Diane McIntosh, a Vancouver psychiatrist. Adds Dr. Jeff Habert, a family physician in Thornhill, Ont.: “If patients do not improve by 20% in the first two to four weeks, the chance of remission is less than 10%.”

Using the approach of early optimized treatment, the physician books a follow-up appointment to occur two to four weeks after the start of an antidepressant. If the patient does not report enough of an improvement in symptoms at that time, the physician may increase the dose (if the drug is well tolerated), change the drug or add another therapy. Follow ups continue every two to four weeks until symptoms are clearly improving.

The success of early optimized treatment largely relies on the use of objective assessment tools that can measure progress based on scores recorded over a period of time. The PHQ-9 (Patient Health Questionnaire for depression) is one such tool. “We are able to objectify the treatment of depression. This makes it easier not only for doctors, but also for patients. They become more confident and engaged. Just as you measure blood sugar for diabetes, you can measure depression, and the goal is to treat to a target score,” says Dr. Habert.

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<sup>1</sup> Sheehan DV, Harnett-Sheehan K, Raj BA. The measurement of disability. *Int Clin Psychopharmacol*. 1996;11(Suppl 3):89-95.

<sup>2</sup> Habert J, Katzman MA, Oluboka OJ, et al. Functional recovery in major depressive disorder: focus on early optimized treatment. *Prim Care Companion CNS Disord*. 2016;18(5): doi:10.4088/PCC.15r01926.