



## M E M O R A N D U M

February 26, 2016

To: Management Labor Advisory Sub-committee on Counseling Services for Injured Workers

From: Lori Lee Graham  
Operations Manager

Subject: General Research for Worker Counseling Services

On January 8, 2016 the Subcommittee on Counseling Services for Injured Workers met to explore potential options to allow injured workers access to counseling services related to injury on the job, but possibly outside of the accepted claims process typically used in workers' compensation systems. During that discussion information was requested on various topics specifically Employee Assistance Program (EAP) usage for state employees, costs related to the state EAP program, information about the Oregon Medical Association employee assistance program, and any assessment tools that are being used by organizations to help identify employees that may be suffering from depressive symptoms.

Below is a brief discussion of the information requested.

### **State of Oregon EAP**

The State of Oregon EAP is managed through the Public Employees' Benefit Board (PEBB). PEBB maintains a single contract with Cascade Centers, Inc., for all EAP services. Any agency wishing participate in the program is allowed to do so, but at this time, participation is not mandated. If an agency chooses to participate, a monthly fee per full-time employee position is paid by the agency regardless of usage. The amount of the fee is based upon the number of visits allowed. The state contract allows for either 3 or 5 sessions per event, with event being defined as any circumstance that contributes to the employee's personal and emotional concerns that if left untreated would impact the employees work performance.

### **EAP Usage by State Employees**

PEBB reports that for 2014 there were 4,215 total individual users of EAP services. The report states that this is 8.8% of the members entitled to the service. The usage number includes usage by:

1. State employees alone (3,096);
2. Dependents only (517); or
3. Both employees and dependents (602).

For convenience, the member profile summary for same time period indicating the service usage is attached.

### **Oregon Medical Association EAP**

According to the Oregon Medical Board, the Oregon Medical Association (OMA) does not have an assistance program for their members. However, there are four medical societies in Oregon that offer assistance to their members:

- Medical Society of Metropolitan Portland Physician Wellness Program
- Lane County Medical Society Physician Wellness Program
- Oregon Health and Science University Wellness Program
- Hazelton Treatment Program for Health Care Professionals (Newberg, OR)

The Lane County Medical Society's Physician Wellness Program was the first in the nation sponsored by a medical society to provide psychological care to physicians. In addition to traditional appointments, the program also provides a 24/7 support line. The program and is being duplicated across the nation. Created by Candice Barr, CEO of the Society, it is funded by soliciting contributions by the major health care systems, grants and physicians themselves. Physicians are allowed 8 visits per year at no cost, no insurance is billed and a brief paper record is kept. Since mid-2012, 8% of the society's members have used over 240 visits.

### **Assessment Tools**

One of the most widely used instruments for measuring the severity of depression is Beck's Depression Inventory (BDI). The BDI is a 21 item, self-report rating inventory designed to determine if someone is experiencing depression. The assessment is written for individuals between the ages of 13 and 80. A copy of one form of the test is attached for review and consideration.

Outside of the BDI, there are various assessment tools available online for self diagnosis. Mental Health America offers several assessment tools for varying concerns as does COPE-Inc. Copies of the Mental Health America Depression Self assessment and the COPE-Inc. Stress Test self assessment are attached for your convenience. In addition, COPE-Inc. provides a management EAP referral form which is also attached.

**State of Oregon Employee Assistance Program General Statistics  
Program Year 2014**

| <b>Member Profile Summary</b>  |             |
|--|-------------|
| <b>Provider Identified Problem</b>   | <b>YTD</b>  |
| Alcohol/Substance Abuse  | 56          |
| Anger Management   | 20          |
| Anxiety  | 170         |
| Career   | 20          |
| Depression   | 176         |
| Divorce Adjustments  | 57          |
| DOT SAP Evaluations  | 3           |
| Family   | 295         |
| Financial  | 6           |
| Grief  | 117         |
| Habit Control (Eating)   | 5           |
| Habit Control (Gambling)   | 1           |
| Habit Control (Other)  | 9           |
| Habit Control (Smoking)  |             |
| Home Ownership Program   | 123         |
| Legal  | 8           |
| Life Adjustment  | 145         |
| Marriage/Relationship  | 459         |
| Medical/Physical   | 16          |
| Military Life  | 1           |
| No Session Used – List Given or Case closed due to N/s, CX, or No Schedule | 380         |
| Other mental/emotional   | 67          |
| PTSD   | 52          |
| Stress Due to Reorganization   | 3           |
| Stress Management  | 167         |
| Waiting for provider to answer/active case open                            | 444         |
| WFL/Child Care   | 18          |
| WFL/Elder Care   | 28          |
| WFL/Financial  | 230         |
| WFL/ Identity Theft  | 4           |
| WFL/Legal  | 793         |
| WFL/Resources  | 131         |
| WFL/Will Kit   | 24          |
| Work Related   | 86          |
| Work Stress  | 100         |
| Workplace Violence   | 1           |
| <b>Total</b>   | <b>4215</b> |

| <b>Who is Being Served</b> |             |
|----------------------------|-------------|
| Both                       | 602         |
| Dependent Only             | 517         |
| State EE Only              | 3096        |
| <b>Total</b>               | <b>4215</b> |

Attachment: Sample BDI Inventory

BECK DEPRESSION INVENTORY

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Please circle the number next to the sentence which best describes your symptoms for the past seven days. Choose only one sentence under each letter.

- |    |   |  |    |   |  |
|----|---|--|----|---|--|
| A. | 0 | I do not feel sad.   | K. | 0 | I am no more irritated now than I ever am.   |
|    | 1 | I feel sad.  |    | 1 | I get annoyed or irritated more easily than I used to.                                   |
|    | 2 | I am sad all the time and I can't snap out of it.                  |    | 2 | I feel irritated all the time now.   |
|    | 3 | I am so sad or unhappy that I can't stand it.                      |    | 3 | I don't get irritated at all by the things that used to irritate me.                     |
| B. | 0 | I am not particularly discouraged about the future.                | L. | 0 | I have not lost interest in other people.  |
|    | 1 | I feel discouraged about the future.                               |    | 1 | I am less interested in other people than I used to be.                                  |
|    | 2 | I feel I have nothing to look forward to.                          |    | 2 | I have lost most of my interest in other people.   |
|    | 3 | I feel that the future is hopeless and that things cannot improve. |    | 3 | I have lost all of my interest in other people.  |
| C. | 0 | I do not feel like a failure.                                      | M. | 0 | I make decisions about as well as I ever could.  |
|    | 1 | I feel I have failed more than the average person.                 |    | 1 | I put off making decisions more than I used to.  |
|    | 2 | As I look back on my life, all I can see is a lot of failure.      |    | 2 | I have greater difficulty in making decisions than before.                               |
|    | 3 | I feel I am a complete failure as a person.                        |    | 3 | I can't make decisions at all anymore.   |
| D. | 0 | I get as much satisfaction out of things as I used to.             | N. | 0 | I don't feel I look any worse than I used to.  |
|    | 1 | I don't enjoy things the way I used to.                            |    | 1 | I am worried that I am looking old and unattractive.                                     |
|    | 2 | I don't get real satisfaction out of anything anymore.             |    | 2 | I feel that there are permanent changes in my appearance that make me look unattractive. |
|    | 3 | I am dissatisfied or bored with everything.                        |    | 3 | I believe that I look ugly.  |
| E. | 0 | I don't feel particularly guilty.                                  | O. | 0 | I can work about as well as before.  |
|    | 1 | I feel guilty a good part of the time.                             |    | 1 | It takes an extra effort to get started at doing something.                              |
|    | 2 | I feel guilty most of the time.                                    |    | 2 | I have to push myself very hard to do anything.  |
|    | 3 | I feel guilty all the time.  |    | 3 | I can't do any work at all.  |
| F. | 0 | I don't feel I am being punished.                                  | P. | 0 | I can sleep as well as usual.  |
|    | 1 | I feel I may be punished.  |    | 1 | I don't sleep as well as I used to.  |
|    | 2 | I expect to be punished.   |    | 2 | I wake up 1 to 2 hours earlier than usual and find it hard to get back to sleep.         |
|    | 3 | I feel I am being punished.  |    | 3 | I wake up several hours earlier than I used to and cannot get back to sleep.             |
| G. | 0 | I don't feel disappointed in myself.                               | Q. | 0 | I don't get more tired than usual.   |
|    | 1 | I am disappointed in myself.                                       |    | 1 | I get tired more easily than I used to.  |
|    | 2 | I am disgusted with myself.  |    | 2 | I get tired from doing almost anything.  |
|    | 3 | I hate myself.   |    | 3 | I am too tired to do anything.   |
| H. | 0 | I don't feel I am any worse than anybody else.                     | R. | 0 | My appetite is no worse than usual.  |
|    | 1 | I am critical of myself for my weaknesses or mistakes.             |    | 1 | My appetite is not as good as it used to be.   |
|    | 2 | I blame myself all the time for my faults.                         |    | 2 | My appetite is much worse now.   |
|    | 3 | I blame myself for everything bad that happens.                    |    | 3 | I have no appetite at all anymore.   |
| I. | 0 | I don't have any thoughts of killing myself.                       | S. | 0 | I have lost much weight, if any, lately.   |
|    | 1 | I have thoughts of killing myself, but I would not carry them out. |    | 1 | I have lost more than 5 pounds.  |
|    | 2 | I would like to kill myself.                                       |    | 2 | I have lost more than 10 pounds.   |
|    | 3 | I would kill myself if I had the chance.                           |    | 3 | I have lost more than 15 pounds.   |
| J. | 0 | I don't cry anymore than usual.                                    |    |   | I am purposely trying to lose weight by eating less.<br>Yes _____ No _____               |
|    | 1 | I cry more now than I used to.                                     | T. | 0 | I have not noticed any recent change in my interest in sex.                              |
|    | 2 | I cry all the time now.  |    | 1 | I am less interested in sex than I used to be.   |
|    | 3 | I used to be able to cry, now I can't cry even though I want to.   |    | 2 | I am much less interested in sex now.  |
|    |   |  |    | 3 | I have lost interest in sex completely.  |

**COPE Inc. Self Assessment Stress Test**

- |     |  |           |
|-----|--|-----------|
| 1.  | Have you noticed a change in your usual sleeping habits such as sleeping more, or an increased difficulty in falling or staying asleep?                                    | Yes<br>No |
| 2.  | Do you have difficulty concentrating on work activities for a long period of time?   | Yes<br>No |
| 3.  | Have you noticed changes in your typical eating habits or a change in your appetite?   | Yes<br>No |
| 4.  | Have you noticed an increase in physical symptoms such as upset stomach, headaches, or neck/back pain?   | Yes<br>No |
| 5.  | Do you find it hard to relax and have fun?   | Yes<br>No |
| 6.  | Have you found yourself more easily frustrated by co-workers or family members?  | Yes<br>No |
| 7.  | Do you feel you have had inadequate time to accomplish or balance your work and family responsibilities?   | Yes<br>No |
| 8.  | Have you noticed any changes in the way you use alcohol or prescription medicine, or have you started using other drugs?   | Yes<br>No |
| 9.  | Have you found yourself less motivated to do activities which you previously looked forward to?  | Yes<br>No |
| 10. | Have you (or someone close to you) suffered a significant loss? i.e., death of a loved one, separation or divorce, loss of a pet, loss of a home, loss of a job, etc.)     | Yes<br>No |
| 11. | Have you experienced a major life adjustment in the past six months such as changing jobs, ending a significant relationship, or purchasing a home?                        | Yes<br>No |
| 12. | Have you had any difficulty in the past six months meeting all of your financial responsibilities in a timely manner?  | Yes<br>No |
| 13. | Has your work environment changed significantly in the past six months, either through physical differences, changes in staffing, or the overall culture of the workplace? | Yes<br>No |
| 14. | Have you found yourself in need of legal representation or with general legal questions?   | Yes<br>No |
| 15. | Have you found yourself concerned with child care options?   | Yes<br>No |
| 16. | Have you been concerned with "acting out" behavior by your child/adolescent?   | Yes<br>No |
| 17. | Are you the primary care-giver of an aging parent/loved one or having difficulty finding elder-care resources?   | Yes<br>No |
| 18. | Has the majority of time you spend with your spouse or significant other been less enjoyable than you would like?  | Yes<br>No |
| 19. | Does communication with your co-workers leave you feeling frustrated or misunderstood?   | Yes<br>No |
| 20. | Have you experienced a traumatic event in your workplace, (i.e. incidence of workplace violence, death of an employee, etc.)   | Yes<br>No |
| 21. | Are you concerned about the alcohol or substance use of a family member?   | Yes<br>No |

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**Employee Assistance Program  
Supervisory Referral Form**

**General Instructions:**

The purpose of this form is to provide information to the Employee Assistance Program (EAP) regarding the reason for your supervisory referral.

It is *essential* that you complete *all* of the information requested to the best of your knowledge. Please limit your responses to objective fact as opposed to hearsay and/or assumptions. This information will serve as a means of assessing the employee's problem, will help the EAP to determine the steps necessary in assisting the employee in alleviating his or her problems, and will be used to measure outcomes regarding the effectiveness of the EAP supervisory referral process in terms of helping to minimize employee problems.

An EAP Staff member will follow-up with you by phone in six (6) months to complete a follow-up survey which allows COPE to determine the effectiveness of the referral process, the outcomes related to EAP services, and whether or not any additional steps are necessary at this time in assisting the employee in alleviating his or her problems.

*It is recommended that you review the contents of this form with the employee prior to referring him or her to the EAP.*

\*\*\* Note: This form should **ONLY** be completed by the person making the referral. \*\*\*

*(Please Print In Ink or Type)*

Referral Date \_\_\_\_\_

Employee's Name: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ (optional)

Home Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ EOD: \_\_\_\_\_

Position Title: \_\_\_\_\_ Grade: \_\_\_\_\_

Department / Agency: \_\_\_\_\_

Employee's Work Location: \_\_\_\_\_

Shift: \_\_\_\_\_ To: \_\_\_\_\_ Days Off: \_\_\_\_\_

Referred By: \_\_\_\_\_

Title: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Office Address: \_\_\_\_\_

Fax Number: \_\_\_\_\_

REASON(S) FOR REFERRAL

Please complete all of the sections below, basing your responses on the employee's performance in the past six months. If sufficient space is not available, please attach a supplemental sheet.

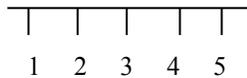
**ATTENDANCE**

\_\_\_\_\_ The employee does not have a problem with attendance.

\_\_\_\_\_ The employee has a problem with attendance as evidenced by the consistent presence of one or more of the following:

- Extended lunch periods
- Frequently away from work station
- Significant number of days absent
- Late occurrences
- Unusual excuses for absences
- Early departures

Please rate the severity of this problem on a scale from 1 to 5 based on behavior observed during the past six months. (*1 = extremely severe, 2 = moderately severe, 3 = somewhat severe, 4 = troublesome, 5 = could become troublesome if behavior continues*)



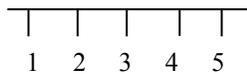
**JOB PERFORMANCE**

\_\_\_\_\_ The employee does not have a problem with job performance.

\_\_\_\_\_ The employee has a problem with job performance as evidenced by the consistent presence of one or more of the following:

- Lower quality of work
- Erratic work patterns
- Decreased productivity
- Failure to meet schedules
- Increased errors
- Impaired judgment/memory/concentration

Please rate the severity of this problem on a scale from 1 to 5 based on behavior observed during the past six months. (*1 = extremely severe, 2 = moderately severe, 3 = somewhat severe, 4 = troublesome, 5 = could become troublesome if behavior continues*)



**BEHAVIOR / CONDUCT**

\_\_\_\_\_ The employee does not have a problem with behavior / conduct.

\_\_\_\_\_ The employee has a problem with behavior / conduct as evidenced by the consistent presence of one or more of the following:

- Avoids Supervisor or Co-workers
- Unusually sensitive or hostile to advice or constructive criticism
- Loss of interest or enthusiasm
- Less communicative
- Frequent mood swings
- Threats of violence and/or harm to others
- Disregard for safety of Supervisor/Co-workers
- Unusually critical of Supervisor/Co-workers
- Inability to get along with coworkers, customers, managers

Please rate the severity of this problem on a scale from 1 to 5 based on behavior observed during the past six months. (*1 = extremely severe, 2 = moderately severe, 3 = somewhat severe, 4 = troublesome, 5 = could become troublesome if behavior continues*)

|   |   |   |   |   |
|---|---|---|---|---|
|   |   |   |   |   |
| 1 | 2 | 3 | 4 | 5 |

**REASON(S) FOR REFERRAL**  
*(Continued)*

Please **CIRCLE** the appropriate answer:

- YES NO Have the above observations been discussed with the employee?  
YES NO Have these observations been recorded/documented and filed?  
YES NO Has a corrective and/or warning interview taken place?

If 'YES', when did the interview take place? \_\_\_\_\_

**What were the results of the interview? (e.g., Letter of Warning, suspension, etc.):**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- YES NO Has the manager discussed with the employee the need to receive confirmation of EAP participation and asked the employee to sign a release for that purpose?

Comments and/or Additional Information:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
*Signature of Referring Person*

\_\_\_\_\_  
*Date*

My manager has discussed the contents of this form with me. I understand that the Employee Assistance Program (EAP) counselor will inform my manager whether or not I have contacted the EAP and met with a counselor. Only this information will be provided to my manager. This information will be given whether or not I have signed a Release of Information form.

\_\_\_\_\_  
*Employee's Signature*

\_\_\_\_\_  
*Date*

Employee Assistance Program  
COPE, Incorporated  
Phone: (202) 628-5100 or 1-800-841-7406  
Fax: (202) 628-5111  
Email: eap@cope-inc.com  
Web: www.cope-inc.com

Attachment: Mental Health America Depression Screening

**Mental Health America Depression Screening**

Over the last 2 weeks, how often have you been bothered by any of the following problems?

Please note, all fields are required.

|   |                    |                         |                     |
|---|--------------------|-------------------------|---------------------|
| 1. Little interest or pleasure in doing things  |                    |                         |                     |
| Not at all  | Several days       | More than half the days | Nearly every day    |
| 2. Feeling down, depressed, or hopeless   |                    |                         |                     |
| Not at all  | Several days       | More than half the days | Nearly every day    |
| 3. Trouble falling or staying asleep, or sleeping too much  |                    |                         |                     |
| Not at all  | Several days       | More than half the days | Nearly every day    |
| 4. Feeling tired or having little energy  |                    |                         |                     |
| Not at all  | Several days       | More than half the days | Nearly every day    |
| 5. Poor appetite or overeating  |                    |                         |                     |
| Not at all  | Several days       | More than half the days | Nearly every day    |
| 6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down                          |                    |                         |                     |
| Not at all  | Several days       | More than half the days | Nearly every day    |
| 7. Trouble concentrating on things, such as reading the newspaper or watching television                                    |                    |                         |                     |
| Not at all  | Several days       | More than half the days | Nearly every day    |
| 8. Moving or speaking so slowly that other people could have noticed  |                    |                         |                     |
| Not at all  | Several days       | More than half the days | Nearly every day    |
| Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual                       |                    |                         |                     |
| Not at all  | Several days       | More than half the days | Nearly every day    |
| 9. Thoughts that you would be better off dead, or of hurting yourself   |                    |                         |                     |
| Not at all  | Several days       | More than half the days | Nearly every day    |
| 10. If you checked off any problems, how difficult have these problems made it for you at work, home, or with other people? |                    |                         |                     |
| Not difficult at all  | Somewhat difficult | Very difficult          | Extremely difficult |