Mental Health Works

Fourth Quarter 2010

PPG Industries Drills Down on Depression and Productivity Factors

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Partnership for Workplace Mental Health™

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Dear Reader:

Welcome to the latest issue of *Mental Health Works*. In this issue, we update readers on progress made by PPG Industries, since we first featured their work in 2004. PPG continues to drill down on workplace stress and depression to better understand their effects on employees. Their employee data were included in two recent studies, one on depression severity predictors, and the other on the health effects of the caregiver role. This article shows why we are so pleased to count PPG's corporate medical director Dr. Alberto Colombi among the members of the Partnership for Workplace Mental Health's Advisory Council!

This edition of *Mental Health Works* also brings you an employer innovation from the West Coast. Puget Sound Energy, headquartered in Bellevue, Washington, has taken steps to direct attention to the ways mental and cognitive functioning affects employees' behavior and work performance. The utility company put new services, procedures, and forms in place to facilitate discussion with providers and supervisors around these issues, with the goal of keeping people employed and productive.

We also want to be sure employers are kept informed about a major development affecting clinical care. The American Psychiatric Association recently released a new clinical practice guideline for the treatment of depression. The new version includes new evidence-based recommendations on the use of antidepressant medications, depression-focused psychotherapies, and somatic treatments such as electroconvulsive therapy. It is encouraging to see how science has progressed our understanding of the best ways to treat depression.

And as part of our ongoing commitment to share useful tools and practical information with employers, you'll also find articles sharing recent work by the Integrated Benefits Institute and the National Business Group on Health.

As always, please let us know your feedback and story ideas by e-mailing us at **mhw@psych.org** or calling us at 703-907-8561.

Sincerely,

Alan A. Axelson, MD

Co-Chair, Partnership for Workplace Mental Health Advisory Council

William L. Bruning, JD, MBA

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Mental Health Works

Partnership for Workplace Mental Health™

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Positive Approach Keeps People Working

A Washington-Based Utility's Cognitive and Behavioral Accommodations

BY NANCY SPANGLER, MS, OTR/L

Photo courtesy of Puget Sound Energy

Many employers in the United States are facing increases in sickness and disability-related absences. Mental and cognitive health issues are major contributing factors. For example, depression-related worker productivity losses are projected to be nearly $2 billion per month in the United States (Birnbaum et al., 2010). The work loss costs of attention deficit hyperactivity disorder (ADHD) in working adults and their family members are also substantial (Birnbaum et al., 2005). Approximately one-fifth of childhood cases of ADHD may have a comorbid learning disorder, and difficulties with learning may persist into adulthood (McCann & Roy-Byrne, 2000).

Puget Sound Energy (PSE), headquartered in Bellevue, Washington, has taken steps to address ways in which mental and cognitive functioning affect employees' behavior and work performance. The utility has put new services, procedures, and forms in place to facilitate discussion with providers and supervisors around these issues, with the goal of keeping people employed and productive.

Puget Sound Energy is Washington State's oldest local energy utility, serving more than 1 million electric customers and nearly 750,000 natural gas customers, primarily in the Puget Sound region of Western Washington. PSE's service area is home to some of America's most recognized and respected businesses, including Boeing, Microsoft, Amazon.com, Weyerhaeuser, Starbucks, Costco, and Nordstrom.

Approaches to Cognitive and Behavioral Restrictions

Employers frequently have services and procedures in place for employees who become injured on the job or who develop physical disabilities. Accommodation for these physical impairments is common in workplaces, but accommodation for mental or cognitive impairments is less common. "Employees with psychiatric, cognitive, or behavioral impairments often present a challenge for employers since their impairments may be less visible than physical impairments and frequently are misunderstood," says Jenny Haykin, M.A., C.R.C., integrated leaves and accommodation consultant for PSE since 2007. She commonly sees examples of unaccommodated learning disabilities that result in presenteeism—workers who are on the job but less productive. Presenteeism is more costly to U.S. businesses than medical costs or work absence, and depression is one of the highest contributors to presenteeism (Goetzel et al., 2004).

Haykin gained experience in this area when she was previously employed as a disability services team lead with King County government, another Washington State employer,

which has 13,500 employees. While working at King County, she found that methods for addressing employees' physical impairments were far more advanced than those for addressing mental impairments. For example, evaluation forms were available to help obtain documentation from an employee's physician or clinician regarding a worker's specific physical limitations. Obtaining documented limitations was the first step in the process of identifying potential reasonable accommodations to address the physical impairment. However, no forms were available for mental impairments, and documentation of specific restrictions was rarely provided.

Forms to Facilitate Accommodation

Haykin spearheaded an effort to develop forms and procedures that would facilitate accommodations for King County workers with diagnosed mental, behavioral, cognitive, or learning impairments. She worked with the King County's team of vocational rehabilitation counselors and area psychiatrists to develop the following forms for healthcare providers to assess the worker's capacities and limitations when evaluating or treating employees with cognitive and psychiatric conditions:

- The Cognitive and Behavioral Capacities Evaluation form lists a variety of job demands for the health care provider to review and respond to. **This form can be downloaded here**.
- The Cognitive and Behavioral Job Analysis form is used to document the cognitive and behavioral requirements specific to an employee's job. **This form can be downloaded here**.
- Both forms are based on the same cognitive and behavioral capacities, so they may be used separately or in conjunction with one another. Haykin continued utilizing these forms at PSE as a step in the accommodation process for employees with cognitive and/or behavioral limitations.

Puget Sound Energy is a recent addition to the Partnership's Employer Innovations online database.

Consultant Role

Haykin frequently serves the role of educating healthcare providers, vocational rehabilitation counselors, human resource professionals, and workplace supervisors on the use of the forms, the importance of assessing and documenting employees' abilities and limitations, and the therapeutic value of work. She also trains managers and supervisors on making reasonable work accommodations and using available resources to help employees.

Cognitive and behavioral impairments may first surface in the form of a work performance deficit – the employee shows up late, misses deadlines, or has difficulty completing tasks. The initial discussion is often between the employee and his or her supervisor. Haykin encourages supervisors to document work performance problems and to share objective observations that explain in clear terms what the issues are. Supervisors should explain to an employee why his or her behaviors or other

performance issues are not acceptable and should communicate performance expectations. At the same time, supervisors should be supportive and ask what, if anything, would help the employee prevent these behaviors from occurring in the future, without presuming that there is any disability. Haykin reinforces that once an employee has indicated a cognitive or behavioral medical or learning issue, the supervisor must not ask questions about conditions or treatments. Instead, discussions should be about work restrictions documented by the employee's provider, including whether they are temporary or permanent and what reasonable accommodations may help reduce the restrictions.

Some employees, when informed of behavioral or performance concerns, see for the first time how their condition is affecting them at work. They may then seek evaluation and treatment if they have not done so previously. Once a cognitive impairment or other mental disability is diagnosed and documentation about limitations is received, accommodation options can be considered and reviewed for possible implementation.

Process Description

The procedure for using the forms begins when it becomes known that an employee has a cognitive or behavioral medical issue or a learning disability. The employee or a vocational rehabilitation counselor, case manager, or human resources representative (all with permission from the employee) then provides information to the healthcare provider or learning disability specialist on the nature of the employee's job. This step may include providing the Cognitive and Behavioral Job Analysis. At the same time, information about work performance concerns and specific questions are provided. These details help the healthcare provider or learning disability specialist better understand what is expected of the employee at work and what information the employer will need in order to facilitate potential accommodations with the employee for successful performance. Haykin has found that employees are open to allowing this exchange of information with their healthcare provider or specialist, with the understanding that it facilitates review of performance or behavioral issues through an accommodation process, where otherwise the review would be solely disciplinary.

The Cognitive and Behavioral Capacities Evaluation form seeks the provider's opinion on the employee's capacity in comprehension, memory, learning ability, information

Case Scenarios:

Office worker — surfing the Internet, unable to stay on task. Accommodations may include coaching on organizational and focusing skills from a local learning disabilities association.

Office clerk — engaging in extreme germ-avoidant behaviors. Worker may be provided assistance to help learn new job tasks and ways to minimize interruptions, thus reducing the stressors that resulted in the unusual behaviors. Accommodations may include setting precise routines for performing work.

Project manager with memory deficits — unable to report verbally on project details in unstructured staff meetings. Accommodations may include providing questions in advance and allowing referral to notes.

Repairman — avoided completion of Commercial Driver's License exam due to phobia of driving large trucks (not an essential job function). Accommodation may include waiver of the exam and job readjustment to allow driving small trucks.

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processing, task completion, and work behaviors. For example, is the employee able to remember written instructions, maintain emotional control under stress, direct others in complex tasks, or respond effectively to emergencies? This information is then used by the accommodation consultant (typically a vocational counselor) in working with the employee's supervisor to make specific adjustments in job tasks to accommodate the employee's disability and allow optimal work performance. One PSE employee recently reported to Haykin, "I had depression and bipolar disorder. PSE had resources to accommodate my restrictions. Before I couldn't function and was on disability leave, now it's working really great."

Supportive and Accountable Work Culture

Haykin notes that PSE has a unique work culture where people are accountable for respectful behavior toward one another. All employees are trained in the company's code of ethics, which is posted on PSE's website, and targeted refresher training is provided regularly. The utility's anonymous ethics hotline is available 24 hours a day. Instances when workers do not treat other people respectfully are promptly investigated and addressed.

The company also places a priority on clear and timely communication. For example, when there are organizational changes, workers are informed as quickly as possible with as much information as can be disclosed. The company's employee assistance and wellness programs support adjustment to change as well. Haykin, who holds a master's degree in organizational psychology, suggests that the positive work culture may play a role in PSE's high success rate in keeping people employed and getting them back to work after injuries or impairments. Many people are with the utility for their entire career, and family members from multiple generations work for the company.

Nancy Spangler, MS, OTR/L, president of Spangler Associates, Inc., and consultant to the Partnership for Workplace Mental Health, is a prevention and health management specialist in the Kansas City, Missouri area.

SOURCES:

Birnbaum, H. G., Kessler, R. C., Kelley, D., Ben-Hamadi, R., Joish, V. N., & Greenberg, P. E. (2010). Employer burden of mild, moderate, and severe major depressive disorder: mental health services utilization and costs, and work performance. *Depression and Anxiety,* 27(1), 78–89. doi:10.1002/da.20580

Birnbaum, H. G., Kessler, R. C., Lowe, S. W., Secnik, K., Greenberg, P. E., Leong, S. A., & Swensen, A. R. (2005). Costs of attention deficit-hyperactivity disorder (ADHD) in the US: excess costs of persons with ADHD and their family members in 2000. *Current Medical Research and Opinion,* 21(2), 195–206. doi:10.1185/030079904x20303

Goetzel, R., Long, S., Ozminkowski, R., Hawkins, K., Wang, S., & Lynch, W. (2004). Health, absence, disability, and presenteeism cost estimates of certain physical and mental health conditions affecting U.S. employers. *Journal of Occupational and Environmental Medicine,* 46(4), 398–412.

McCann, B. S., & Roy-Byrne, P. (2000). Attention-deficit/hyperactivity disorder and learning disabilities in adults. *Seminars in Clinical Neuropsychiatry,* 5(3), 191–197.

What Are You Doing About Workforce Depression?

While Manageable, It's Probably a Bigger Problem than You Think

BY WILLIAM MOLMEN, JD

Most employers likely are in the midst of their due diligence in determining how best to participate in the new post-reform healthcare environment. As part of that review, employee benefits professionals must ask themselves, "For my company, are benefits and health programs an investment or simply to be regarded as a cost?"

To answer that question, employers must recognize the true costs of ill health in the work environment. This is especially true for the major cost driver — depression. Recent research by the **Integrated Benefits Institute** (IBI) and others broadens the investment discussion by avoiding a sole focus on paid benefits to demonstrate the business impact of depression-related lost time and lost productivity. As part of that research, IBI members offer insights for employers into how best to use the results to manage depression in the workforce.

Beyond Paid Benefits

When employers think of "value," most often the discussion centers around the amounts paid in benefits, premiums, or administrative charges because, for most employers, that's all the data available. To make matters worse, they know little about the effects of specific medical conditions because this level of information often can't be retrieved from insurers or program administrators — much less condition-specific absence data.

The focus on medical treatment costs dramatically underestimates the true workforce cost impact of various medical conditions and, worse, understates the potential savings available from focused interventions. Research co-authored by IBI and published last year in the ***Journal of Occupational and Environmental Medicine*** (JOEM) reports on the costs, by chronic condition, of medical and pharmaceutical claims combined with lost-productivity costs based on employee-reported lost time for six employers (Loeppke et al., 2009). Lost-productivity costs also reflect such research-based employer costs as unrealized output; overstaffing, temporary workers, or overtime to cover sick-day absences; and stress on team members required to pick up the slack (see Nicholson et al., 2006).

The *JOEM* research found that for every $1 of medical and pharmacy costs there are $2.3 dollars of health-related lost productivity from absence and presenteeism (being at work but under-performing due to the health condition). This calculation does not include paid lost-time wage replacement benefits. For some conditions, the ratio of lost productivity to medical/pharmacy costs can be as high as 20:1.

Integrated Benefits Institute
IBI is a nonprofit organization that provides employers and their supplier partners with resources for demonstrating the business value of health. IBI's programs, tools, and expert member networks advance understanding about the link between, and the impact of, health-related productivity on corporate America's bottom line.

Depression Management — What's at Stake?

Depression is a huge driver of total health-related workforce costs. The 2009 *JOEM* research reported that of the 25 chronic conditions studied, diagnosed depression was the top medical-condition driver of such total costs. For depression cases, lost productivity from lost time was three and one-half times higher than medical and drug costs for treatment, and total depression-related costs were 35% higher than the number 2 condition, which was obesity.

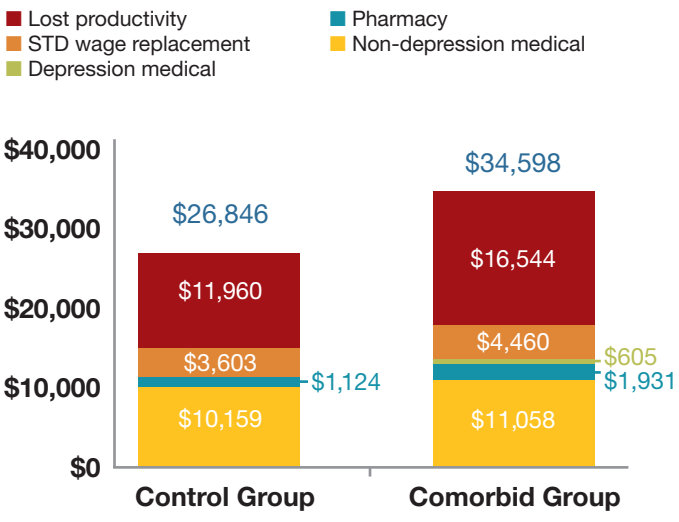
Recent research by IBI (Gifford, Parry, & Jinnett, 2009) demonstrates the daunting challenge that workforce depression presents to employers.

In IBI's experience, depression costs rise to a level of concern for employers when they are associated with an expensive claim for short-term disability (STD). Our research shows, however, that the broader issue is likely to be how depression acts as a costly, aggravating, and potentially unnoticed comorbid condition. The research suggests several surprising results that should cause employers to take a closer look at managing depression in their workforce.

Short-Term Disability With and Without Depression

Employers aren't wrong in pointing to the adverse effects of depression on disability. But most employers may not go far enough in recognizing these effects and investing in resources to manage them. For example, when IBI analyzed a sample of 45,171 employees with STD claims (using claims data supplied by Ingenix), we found that STD claims with depression had significantly more lost time than STD claims without depression, after appropriate research controls. IBI then estimated the dollar value of that disability-related lost productivity, based on the research by Nicholson et al. (2006). IBI's methods are detailed in IBI's depression research report (Gifford, Parry, & Jinnett, 2009).

TOTAL STD COSTS BY COMPONENT



When we also consider lost-productivity costs and wage-replacement payments, we get a far different view of total employer costs than if we looked only at medical and pharmaceutical costs. This difference is demonstrated in the figure, which compares full-cost results for two samples of STD cases from a research database supplied by Ingenix. Both groups consist of STD cases where no depression treatment occurs within the study period prior to the onset of STD.

We controlled for demographic and health characteristics so that the only analytic difference between the samples is the presence of a post-STD diagnosis of depression in the comorbid group.

Two results stand out. First, lost-productivity costs exceed the medical/pharmacy costs in each group. Second, though depression-related medical

treatment for the comorbid group totals only $605, total costs for the group with depression are $7,752 higher than those for the group with no depression.

We can't say whether depression caused these additional costs or whether the more serious nature of the illness resulted in an added depression condition. What we can say is that the existence of depression after an STD claim occurs *is a marker* for the need to pay special attention to the management of this type of STD claim and the associated depression, given what is at risk.

Depression Isn't Just About Short-Term Disability

When we combined our STD analysis with self-reported data from the Health and Work Performance Questionnaire (HPQ) database, we found that lost time associated with depression amounts to only 19% of health-related lost days for depressed employees (Integrated Benefits Institute, 2009b). More than 80% of the lost time comes from sick-day absence and presenteeism.

The next generation of the HPQ, **HPQ-Select**, is now managed by IBI in partnership with Ronald Kessler, PhD, of Harvard Medical School, who developed the original HPQ with the World Health Organization. The database includes information on 27 self-reported chronic health conditions, including depression, together with data on prevalence, treatment by a healthcare professional, and related lost time from absence and presenteeism.

IBI's analysis finds that 28% of employees report depression, but only 30% of those who report the condition currently receive professional depression treatment. An IBI analysis of the 129,552 individuals in the HPQ-Select database, performed for this article (Integrated Benefits Institute, 2009c), drives home the potential impact of comorbid conditions in combination with depression. When depression exists, there are, on average, an additional six conditions impacting the depression sufferer's health. The top-10 conditions comorbid with depression are: 57% with allergy, 48% with back/neck pain, 47% with anxiety diagnosis, 45% with fatigue, 39% with headache, 32% with migraine, 31% with obesity, 28% with sleeping problems, 28% with arthritis and 27% with other chronic pain.

These results, in total, should drive home the need for employers to view depression — a leading driver of health-related lost productivity and treatment and pharmacy costs — more broadly than its effects on medical claim costs or even added disability.

What Does the Research Mean to You?

IBI invited experts from among its employer and supplier members to suggest ways to meet the challenges and costs of workforce depression and other behavioral issues in the workforce that the research identified.

Here are the highlights of the experts' tips:

- Promote a corporate culture in your company that effectively manages stress and

behavioral issues, communicates that orientation, and fosters and promotes early identification of potential depression cases for intervention.
- Establish disability management/return-to-work programs that move disabled workers and your operations management away from a "disability paradigm."
- Engage a disability supplier that will aggressively manage psychiatric disabilities and get beyond the disability diagnosis on the doctor's report. The supplier should look at claims horizontally, e.g., probe for family and social or work/life issues when talking to claimants.
- Integrate, either internally or through a single or coordinated vendors, clinical and system capabilities across all your benefits initiatives and programs.
- Collect and monitor data to identify trends, results, and needed program improvements.
- Fine-tune mental health benefits and treatment as a productivity instrument (and not just grudgingly meet the minimal requirements for compliance with mental health parity requirements).
- Include an employee assistance program (EAP) as part of the benefits package offered to your employees and promote earlier EAP intervention to avoid or reduce medical and disability costs, absence, and presenteeism.

One Employer's Experience

In June 2009, IBI focused on Nationwide's employee depression management initiatives in an **IBI *Employer Insight*** (Integrated Benefits Institute, 2009a). Nationwide's cross-benefit program is part of an integrated absence management effort.

Initiatives include a direct offer of depression assistance embedded in the health risk assessment, placing a counselor in each of 10 clinics nationwide, referring employees to EAP counseling to head off depression concerns when it becomes apparent that a chronic illness has resulted in or is likely to result in disability, cross-training all occupational health or disability management nurses on depression screening tools and on how to approach depression issues, and allowing all Nationwide nurses caring for associates to refer employees to an assistance program with no need for a formal transfer.

Quoted on the program's results, Kathleen Herath, Assistant Vice President for Employee Health & Productivity at Nationwide, noted that the productivity improvement was "amazing." "We would have expected improvement, but clearly [the nursing referral intervention program] was successful. In addition, the nurses have intervened on the appropriate associates, picking up the right people."

Moving Ahead

IBI's research illustrates what many leading employers believe but may not be able to quantify: Ignoring mental health is costly. IBI prepared a **90-second video** to highlight this point in a simple message.

In this time of tightening resources and reevaluation of the goals of healthcare, wellness, and prevention, senior management needs to know where best to invest valuable

resources to improve human capital assets and improve quality of life and workforce engagement. Focused research and measurement and modeling tools, such as those offered by IBI, can show employers where interventions can generate the greatest health return.

William Molmen, JD, is General Counsel of the Integrated Benefits Institute, a nonprofit research, measurement, and forum organization he helped found in 1995. Mr. Molmen directs the Institute's forum function. Learn more about IBI by visiting www.ibiweb.org. To request a copy of the research and expert tips, contact ***info@ibiweb.org***

SOURCES

Gifford, B., Parry, T., & Jinnett, K. (2009). *The full costs of depression in the workforce.* Retrieved from Integrated Benefits Institute website: http://ibiweb.org/do/PublicAccess?documentId=959

Integrated Benefits Institute. (2009a). Depression management and outcomes measurement. *IBI Employer Insights.* Retrieved from Integrated Benefits Institute website: http://ibiweb.org/do/PublicAccess?documentId=961

Integrated Benefits Institute. (2009b). *Health and Work Performance Questionnaire (HPQ)* database. San Francisco, CA.

Integrated Benefits Institute. (2010). *HPQ-Select database.* San Francisco, CA.

Loeppke, R., Taitel, M., Haufle, V., Parry, T., Kessler, R. C., & Jinnett, K. (2009). Health and productivity as a business strategy: A multiemployer study. *Journal of Occupational and Environmental Medicine,* 51(4), 411–428.

Nicholson, S., Pauly, M. V., Polsky, D., Baase, C. M., Billotti, G. M., Ozminkowski, R. J., . . . Sharda, C. E. (2005) How to present the business case for healthcare quality to employers. *Applied Health Economics and Health Policy,* 4(4), 209–218.

Nicholson, S., Pauly, M. V., Polsky, D., Sharda, C. E., Szrek, H., & Berger, M. L. (2006). Measuring the effects of work loss on productivity with team production. *Health Economics,* 15(2), 111–123.

PPG Industries Drills Down on Depression and Productivity Factors

Recent Research Builds the Case for Employer Programs and Benefits

Photo courtesy of PPG

PPG Industries is a global supplier of coatings, glass, fiberglass, and chemicals. Based in Pittsburgh, Pennsylvania, the company employs more than 34,000 employees at 50 production sites in the United States and 120 locations worldwide.

BY NANCY SPANGLER, MS, OTR/L

Mental Health Works **first featured PPG Industries in 2004**. At the time, the company was several years into an effort to increase employee education about depression and to improve coordination of employees' mental health care. Corporate Medical Director Alberto M. Colombi, MD, MPH, worked with PPG Industries' health plans to encourage depression screening in primary care and appropriate referral to mental health specialists. PPG added questions to their health risk appraisal process about both depression and the stressors that may contribute to depression. The company also integrated data from a variety of sources to determine how mental health affected not only health care costs, but also such areas as work productivity, absence, disability, and turnover. The results at that time in terms of improved patient screening and care coordination were encouraging.

Currently, the company continues to drill down on workplace stress and depression to better understand their effects on employees. PPG employee data were included in two recent studies, one on depression severity predictors and the other on the health effects of the caregiver role. "Better understanding of the specific issues our workers face will help us to target our interventions appropriately," says Colombi.

Colombi and his colleagues (Allen, Hyworon, & Colombi, 2010) set out to learn how various person- and work-related characteristics affect depression severity and, in turn, how depression severity affects health and work performance. To summarize a few findings from this comprehensive study, general health, work attendance, and work performance were all affected negatively as depression severity increased. Employees with mild depression (as measured by the Patient Health Questionnaire) had the largest combined productivity loss due to the greater overall prevalence of mild depression. Adverse effects of personal issues and financial concerns were the strongest predictors for higher levels of depression severity. In mild stress, a predisposition toward stress (measured by scoring on a defined stress risk assessment) was the most potent predictor, followed by having a stressful (versus satisfactory) job, a job at risk for minimal stimulation, and a higher number of lifestyle risk behaviors.

The caregiver study (**MetLife Mature Market Institute, 2010**) was prompted by the recognition that aging workers were taking on caregiving tasks for elderly family members. This eldercare role was found to be associated with higher chronic health

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conditions (such as depression, hypertension, and diabetes), higher health care costs, greater work absence, and negative influences on work. In addition, employees in eldercare roles tended to have higher levels of risky coping strategies, such as smoking, and they were more likely than non-caregivers to neglect their own health.

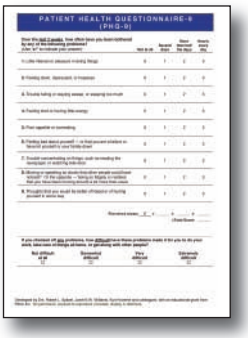
Both studies suggested ways for employers to target changes in workplace programs and benefits to address these issues. Regarding depression and contributing stressors, Colombi comments,

> The economic impact on productivity loss for mild depression is very relevant. We need to have an understanding of the spectrum from mild to severe depression and diversity of interventions to match each level. At one end of the spectrum, there is severe depression, where early detection screening and high quality clinical tools are very relevant. On the other end of the spectrum, organizational and work cultural strategies become more relevant for addressing mild depression and stress precursors.

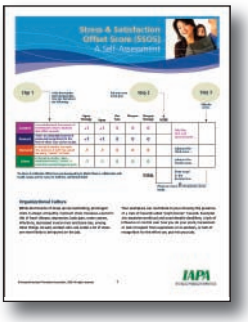
HRA Depression and Stressors Questions

PPG Industries added questions to their health risk appraisal process about both depression and the stressors that may contribute to depression.

Depression: PPG used the Patient Health Questionnaire (PHQ-9); to access the tool and scoring instructions, visit http://www.phqscreeners.com.



Stressors: PPG used the Stress & Satisfaction Offset Score (SSOS); to access the tool and scoring instructions, visit http://www.iapa.ca/pdf/fd_ssos.pdf.



In terms of support for caregivers, the report suggests work/life balance benefits may be valuable. These include paid time off, telecommuting, and flexible schedules. In addition, wellness programs are encouraged to support and incentivize caregivers to build positive coping skills, develop healthy lifestyle habits, and access appropriate preventive health checks.

PPG is currently designing an educational and training plan for addressing some of these factors that contribute to stress and depression. Plans include a series of analyses on depression as a comorbid condition of several chronic diseases and a series of webinars on stress resilience, sleep hygiene, and caregivers' health promotion needs.

Nancy Spangler, MS, OTR/L, president of Spangler Associates, Inc., and consultant to the Partnership for Workplace Mental Health, is a prevention and health management specialist in the Kansas City, Missouri, area.

SOURCES

Allen, H., Hyworon, B., & Colombi, A. (2010). Using self-reports of symptom severity to measure and manage workplace depression. *Journal of Occupational and Environmental Medicine,* 52(4), 363–374.

MetLife Mature Market Institute. (2010). The MetLife study of working caregivers and employer healthcare costs. Retrieved from http://www.metlife.com/assets/cao/mmi/publications/studies/2010/mmi-working-caregivers-employers-health-care-costs.pdf

New Guidelines on the Treatment of Major Depressive Disorder

The American Psychiatric Association (APA) released a **new clinical practice guideline for the treatment of patients with major depressive disorder** on October 1, 2010. The new guideline updates a previous version published 10 years ago and includes new evidence-based recommendations on the use of antidepressant medications, depression-focused psychotherapies, and somatic treatments such as electroconvulsive therapy. The guideline addresses other topics as well, including alternative and complementary treatments, the treatment of depression during pregnancy, and strategies for treatment-resistant depression.

"The five-year process of intense review, discussion, and thoughtful revision-making has led us to today's release of new guidelines that we believe will improve patient care," said Alan J. Gelenberg, MD, chair of the work group that drafted the guidelines. "We are hopeful these guidelines will lead to improved lives for many patients."

The work group led by Gelenberg was made up of APA members with extensive research and clinical expertise in the assessment and treatment of major depressive disorder. The group reviewed more than 13,000 articles published from 1999, when the search from the previous edition ended, to 2006. Draft versions of the guideline underwent extensive review by more than 100 stakeholders, including experts from the field of psychiatry, allied physician organizations, patient advocacy groups, and members of APA. More than 1,000 comments were submitted. Each comment was reviewed by the work group and APA's Steering Committee on Practice Guidelines; substantive revisions were made in response to comments. In 2009, an independent panel of depression treatment experts without ties to industry reviewed the guideline specifically for potential bias, and the final guideline was approved by the APA Board of Trustees.

A few key changes in the new guidelines include:

- **Rating Scales:** The guideline recommends potentially using a clinician- and/or patient-administered rating scale to assess the type, frequency, and magnitude of psychiatric symptoms in order to tailor the treatment plan to match the needs of the particular patient.
- **New Strategies for Treatment-Resistant Depression:** The guideline explains that electroconvulsive therapy has the strongest data supporting it as a treatment for patients who do not respond to multiple medication trials. Transcranial magnetic stimulation and vagus nerve stimulation have also been added as potential treatments for these patients. Monoamine oxidase inhibitors, known as MAOIs, are also an option.
- **Exercise and Other Healthy Behaviors:** The guideline cites randomized, controlled trials that demonstrate at least a modest improvement in mood symptoms for patients who engage in aerobic exercise or resistance training. Regular exercise may also reduce the prevalence of depressive symptoms in the

general population, with specific benefit found in older adults and individuals with co-occurring medical problems.

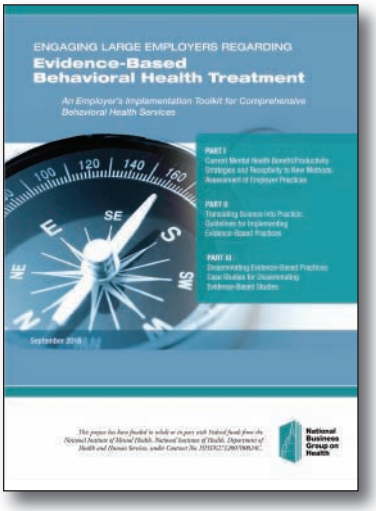
- **Maintenance Treatment Recommendation Strengthened:** The guideline recommends that after the continuation phase, maintenance treatment should be considered, especially for patients with risk factors for recurrence. Maintenance treatment should definitely be provided for patients with more than three prior depressive episodes or chronic illness.

APA President Carol A. Bernstein, M.D., highlighted the new guideline in her **October 1 *Psychiatric News* column**. She emphasized the independent panel review, which was conducted to assure that the guideline was free of potential bias.

Visit the APA at **www.psych.org** and **www.HealthyMinds.org**.

Engaging Large Employers Regarding Evidence-Based Behavioral Health Treatment

BY WENDY I. SLAVIT, MPH, CHES



Employers continue to express concerns about controlling costs and improving employee health. As a result, they have implemented strategies for their general medical plans and pharmacy plans. Employers collect and analyze data for these plans in order to see where they can make improvements in cost and quality. Mental and behavioral health continues to be a substantial business challenge for employers. Behavioral health disorders are associated with more days of work loss and work impairment than many other chronic conditions (e.g.., diabetes, asthma, and arthritis). Approximately 217 million days of work are lost annually due to productivity decline related to behavioral health disorders, costing United States employers $17 billion each year. Furthermore, mental disorders are the leading cause of disability in the U.S. and Canada for people ages 15 to 44 years.

In addition to claims for behavioral health care, costs due to behavioral health problems significantly impact other costs such as productivity, employee assistance programs (EAPs), disability, general medical, and other pharmaceutical claims. While most employers have developed strategies to reduce behavioral health costs, few employers make use of strategies to manage behavioral health treatment quality.

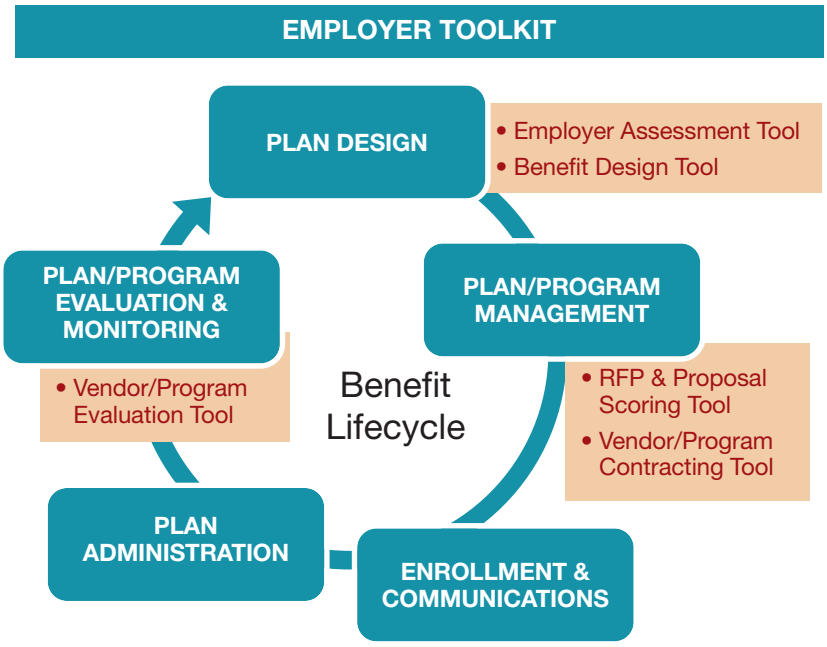
According to Helen Darling, President of the National Business Group on Health (Business Group), "Employees need to be healthy physically and psychologically to perform at their highest potential. Employers benefit from ensuring that their employees and their dependents have access to effective, evidence-based behavioral health services and to care that is appropriately coordinated."

Employers are seeking ways for employees and dependents to receive better coordination of care and access to effective evidence-based behavioral health services. In order to address these needs, the Business Group, in collaboration with The National Institute of Mental Health (NIMH), recently released a behavioral health implementation toolkit for employers entitled *Engaging Large Employers Regarding Evidence-Based Behavioral Health Treatment*.

The Business Group's objectives ranged from assessing employers' general knowledge of behavioral health disorders to identifying evidence-based practices and implementation strategies that employers use to provide coverage and programs to address these disorders. **Engaging Large Employers Regarding Evidence-Based Behavioral Health Treatment** focuses on integrated behavioral health services that are offered through health plans, disability management, EAPs, and other health and productivity programs.

To develop the toolkit, the Business Group convened an advisory group, the National Leadership Committee on Behavioral Health (NLCBH), whose membership included professionals from academic research and those with practical corporate experience in the behavioral health field. Members had experience and knowledge in general medical, behavioral health, and pharmacy benefit design and administration; EAPs; Family Medical Leave; short- and long-term disability; and wellness/health promotion.

The Business Group, with input from NLCBH and NIMH, identified practice recommendations for employers that included: best practices, evidence-based practices, and implementation and evaluation strategies. The primary areas of concern used to frame the recommendations include:



- General medical and behavioral health benefits design;
- Business partner relationships and benefit administration activities;
- Disability management protocols and operations;
- EAP design and administration activities;
- Overall behavioral and general medical plan integration; and
- General medical and behavioral health benefits evaluation protocols.

The elements of toolkit correspond with the stages in an employers' benefit lifecycle: plan design, plan/program management, enrollment and communications, plan administration and plan/program evaluation and monitoring. Recommendations give specific guidance for each stage of the lifecycle, including how to structure benefits, language

for request for proposals (RFPs), methods for scoring RFPs, summary plan descriptions (SPD) language, contract language, and vendor evaluation strategies.

The toolkit includes:

- Results of a survey of large employer behavioral health plan design and administration practices;
- Findings from interviews with leading behavioral health benefit consultants and behavioral health management companies;
- Detailed guidance for implementing evidence-based practices in disability management programs, EAPs, and employer health benefit plans, including general medical, pharmacy, and behavioral health benefits;
- Case studies that identify barriers, obstacles, and successful strategies for implementing the toolkit's guidance; and
- Evaluation and program monitoring tools.

Employers are at a critical juncture to improve care coordination and implement integrated evidence-based behavioral health services. The toolkit is designed to help employers take action and provide practical tools to facilitate these processes. The Business Group's Engaging Large Employers Regarding Evidence-Based Behavioral Health Treatment is available at: **www.businessgrouphealth.org/benefitstopics/et_mentalhealth.cfm**.

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SOURCES:

American Academy of Family Physicians. (2001). *Mental health care services by family physicians (position paper)*. Retrieved from http://www.aafp.org/x6928.xml

Kessler, R. C., Greenberg, P. E., Mickelson, K. D., Meneades, L. M., & Wang, P. S. (2001). The effects of chronic medical conditions on work loss and work cutback. *Journal of Occupational and Environmental Medicine,* 43(3), 218-225.

Lustman, B.J. & Clouse, R.E. (2005). Depression in diabetic patients: The relationship between mood and glycemic control. *Journal of Diabetes and Its Complications,* 19, 113-122.

National Center on Quality Assurance. (2004). *State of health care 2004: Industry trends and analysis*. Retrieved from http://www.ncqa.org/Portals/0/Publications/Resource%20Library/SOHC/SOHC_2004.pdf

Sharp, L. K., & Lipsky, M. S. (2002). Screening for depression across the lifespan: A review of measures for use in primary care settings. *American Family Physician,* 66(6), 1001–1008.

U.S. Department of Health and Human Services. (1999). *Mental health: A report of the Surgeon General — executive summary*. Rockville, MD: Author.

World Health Organization. (2004). *The world health report 2004: Changing history, annex table 3: Burden of disease in DALYs by cause, sex, and mortality stratum in WHO regions, estimates for 2002*. Geneva, Switzerland: Author.

Save the Dates

2011 IBI/NBCH Health & Productivity Forum

February 28-March 2, 2011, The Fairmont San Francisco, San Francisco, CA

The **Integrated Benefits Institute** & **National Business Coalition on Health** — two nationally-recognized non-profit organizations focused on workforce health and its broad impact on worker productivity and quality of life are partnering to host the 2011 IBI/NBCH Health and Productivity Forum. The program will provide employers, their supplier-partners and other health and productivity stakeholders a unique learning environment. The goal is to foster objective discussion and evaluation of the latest practical approaches to investing in and promoting workforce health and productivity.

For more information, visit the **Forum website**

6TH Annual Disability Management Employer Coalition (DMEC) Behavioral Risk Management in the Workplace Conference

March 23-25, 2011 at the Newport Beach Marriott, Newport Beach, CA.

Attendees of the **Disability Management Employer Coalition** conference have the opportunity to hear first- hand about the latest advancements and strategies in workforce behavioral risk management, plus learn about successful, innovative program models from some of the country's top employers.

Registration is open at the **DMEC website**. Partnership subscribers are eligible to receive a $50 discount off individual registration. Contact **conference@dmec.org** or call 800.789.3632 for more information.

2011 AOTA Annual Conference & Expo

April 14-17, 2011, Philadelphia, PA

Pre-Conference Institutes: April 13
Early Registration Deadline: February 16
Regular Registration Deadline: April 4

The American Occupational Therapy Association (AOTA) is the national professional association which represents the interests and concerns of occupational therapy practitioners and students of occupational therapy services. AOTA educates the public and advances the profession by providing resources, setting standards, and serving as an advocate to improve health care. AOTA is based in Bethesda, MD. For more information, visit the **AOTA website**.

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