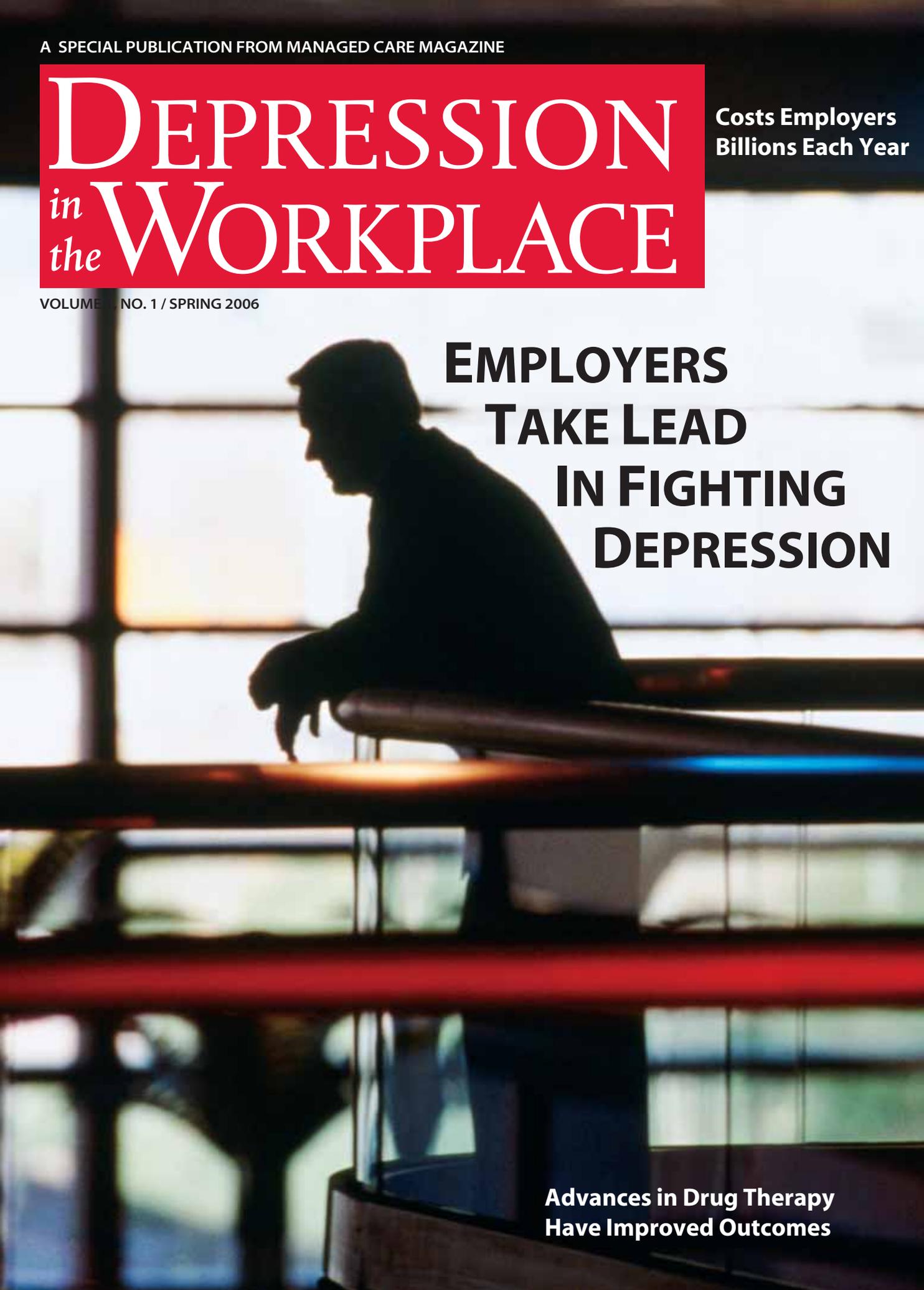


A SPECIAL PUBLICATION FROM MANAGED CARE MAGAZINE

DEPRESSION *in the* WORKPLACE

Costs Employers
Billions Each Year

VOLUME NO. 1 / SPRING 2006

A silhouette of a person sitting on a railing, looking out a window. The person is in profile, facing left. The background is a bright window with a grid pattern, creating a high-contrast scene. The person's shadow is cast on the railing.

EMPLOYERS TAKE LEAD IN FIGHTING DEPRESSION

Advances in Drug Therapy
Have Improved Outcomes

DEPRESSION in the WORKPLACE

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The Toll of Depression

Even though depression is common and treatable, it remains a significant problem for employers. Employees suffering from depression will feel its effects in the workplace, irrespective of the actual characteristics of the work environment. The disease will affect their productivity and ability to function in the workplace. It can impair judgment and overall job performance. The inability to concentrate fully or to make decisions can lead to injuries, mistakes, and accidents.¹

Overall, medical utilization costs for patients with depression are significantly higher than for those without depression, and have been related to greater use of medical services rather than psychiatric services.²



CHRISTOPHER V. GOFF, JD, MA

This serious problem is exacerbated by the fact that while effective treatments for depression are available, many people don't seek them and, if they do, they are not particularly successful at maintaining long-term freedom from the illness. Often, depressed employees will not seek treatment because they fear the effect it will have on their jobs and are concerned about confidentiality. They also might be unaware that they have depression or might be concerned that their insurance is inadequate to cover costs. The difficulty of keeping depression in remission also is well known, with a key problem being that many patients discontinue their medications too soon.

More than three quarters of benefit managers believe that the cost to their companies in lost productivity because of depression is greater than the cost of treating this condition, but only 11 percent facilitate employee screenings.³ And screenings are but one element of dealing with this problem.

We have divided this publication into three parts: The first part outlines and quantifies the effects of workers' untreated depression; the second describes the current state of therapy; and the third covers many of the techniques and resources that employers may use to help their employees overcome their depression. Many employers, for example, are working through their employee assistance programs (EAPs) to remove the stigma associated with the disease and to offset the significant cost differential between encouraging the depressed employees to seek treatment and not doing so.

Concerted efforts to identify and treat depression among employees and their families can only have a salutary effect on those who suffer personally, as well as on their peers in the workplace and on overall productivity within an organization.

Christopher V. Goff, JD, MA
CEO, Employers Health Purchasing Corp. of Ohio

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DEPRESSION *in the* WORKPLACE

Vol. 1, No. 1
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Clare Miller

Introductory Message

From Christopher Goff, JD, MA

Opposite

The chief executive officer of the Employers Health Purchasing Corp. of Ohio discusses why employers are increasingly proactive in helping employees combat depression.

Actual Cost of Depression Is Not Obvious

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Indirect costs account for more than two thirds of depression's financial burden on employers, in stark contrast to many other diseases.

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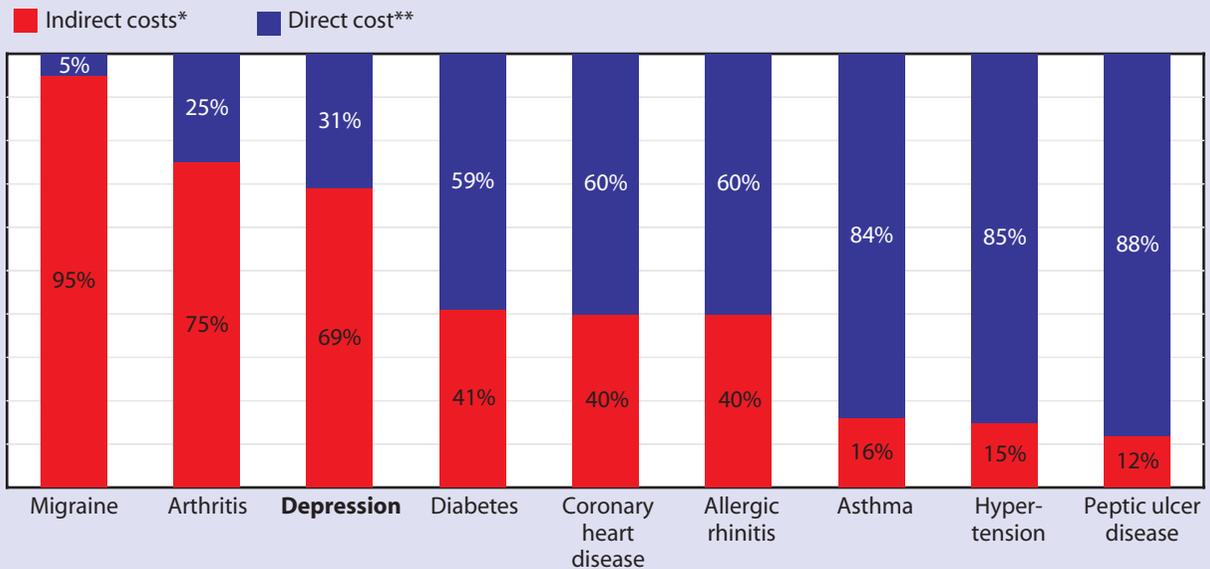
Innovative businesses around the country are screening and educating employees and are enlisting the help of primary care physicians.

A SPECIAL PUBLICATION FROM MANAGED CARE MAGAZINE

Actual Cost of Depression Is Not Obvious

How different illnesses compare in ratio of direct to indirect costs

Lost productivity, rather than treatment costs, is a main concern.



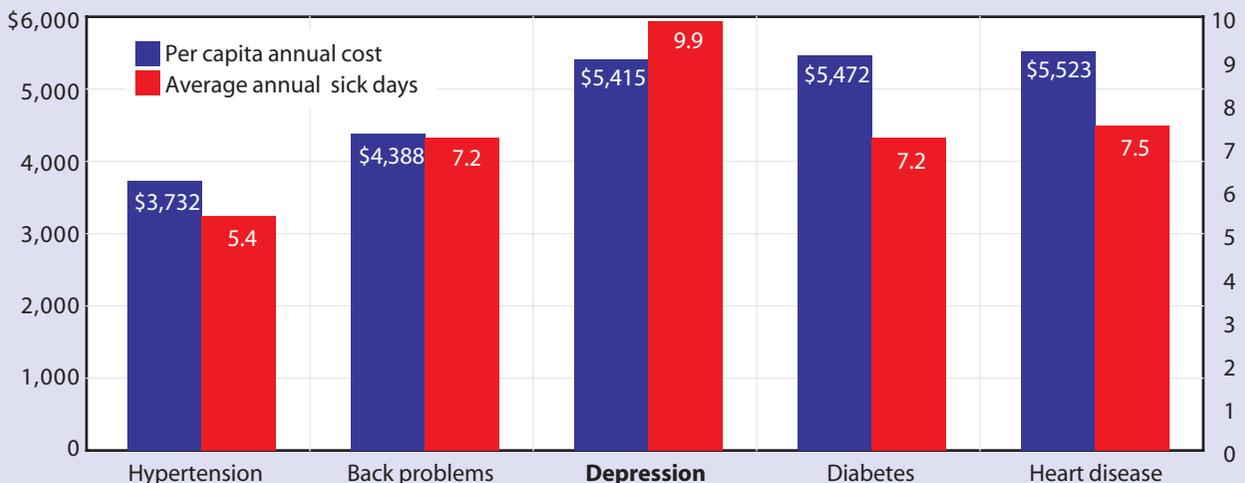
Source: Sullivan, J. Promoting Health and Productivity for Depressed Patients in the Workplace. *J Manag Care Pharm.* 2005;11(3 Suppl):S12-5.

*Indirect costs include lost productivity due to absenteeism, disability, premature mortality, and lost wages.

**Direct costs include hospitalization, physicians, drugs, and other medical expenses.

Greater per-capita costs and more sick days

The per-capita annual cost of depression is significantly more than that of hypertension or back problems, and comparable to that of diabetes or heart disease. People with depression also have more sick days than people suffering from other conditions.

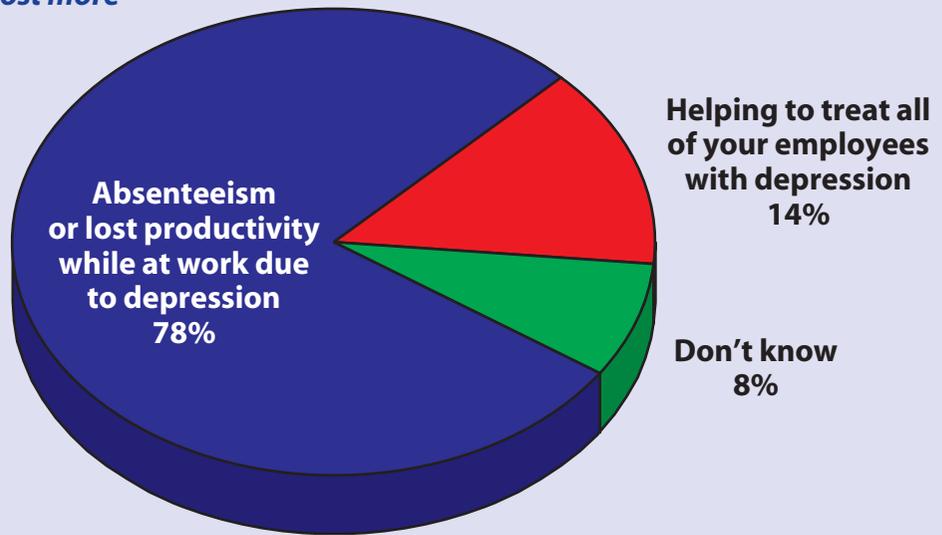


Source: Druss, BG, Rosenheck RA, Sledge WH. Health and disability costs of depressive illness in a major U.S. corporation. *Am J Psychiatry.* 2000;157(8):1274-8.

Is Depression Education Needed?

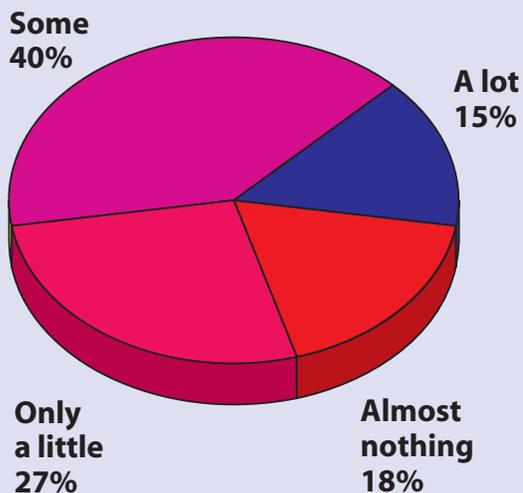
Benefit managers believe that the costs of treating depression are less than the costs imposed by the disease itself.

Asked which would cost more

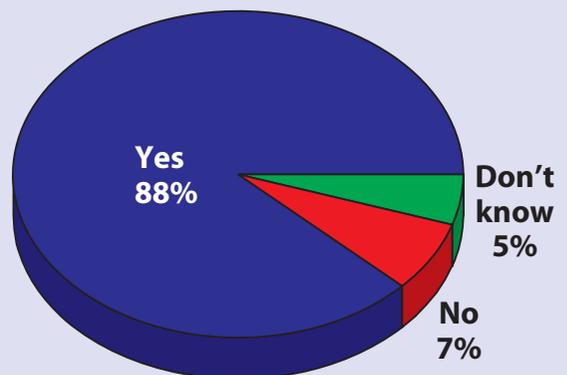


Lack confidence in their knowledge of depression

Benefit managers' confidence level



Overwhelmingly, employees who reported having stayed out of work or had other difficulty completing their work because of depression felt that their performance improved after receiving treatment.



Source: Public Opinion Strategies, A Study of Depression in the Workplace, conducted on behalf of University of Michigan Depression Center, January/February 2004

Depression Is Prevalent and Pernicious, Costing Employers Billions Each Year

The effect is in such areas as job turnover, lowered productivity, increased absenteeism, and higher benefit costs

EXTENT OF THE PROBLEM

This article reviews and, to the extent reported in the research literature, quantifies the economic burden of depression on employers, for although depression can keep a person from even attempting to become employed, more than 7 of 10 persons with depression are active in the workforce. Most, if not all, are not working at their capacity.

By Martin Sipkoff

Depression has a profound adverse effect on businesses, employers, and employees. The economic burden is staggering, with estimates running as much as \$51.5 billion a year in lost productivity. An additional \$26.1 billion is spent for medical treatment.¹

“The cost of depression in the workplace is surprising to many employers, [but] it should not be, given the prevalence of untreated depression in this country,” says Ronald Kessler, PhD, a professor of health care policy at Harvard Medical School.²

Kessler and colleagues have extensively studied the effect of depression on workplace productivity, absenteeism, and presenteeism, defined as “workers being on the job but, because of medical conditions, not fully functioning.”³ Kessler’s seminal, comprehensive study of the extent of depression in this country — involving 9,090 randomly selected people, one of the largest studies of depression ever conducted — was published in the June 18, 2003 issue of the *Journal of the American Medical Association*. He concluded that “[M]ajor depression is a common disorder, widely distributed in the population, and usually associated with substantial symptom severity and role impairment.”⁴

Few get satisfactory treatment

“Over half the people surveyed with depression had severe depression, and only 10 percent were

considered mild,” says Kessler. “Yet just one in five received adequate treatment. We found that less than half of them were even getting minimal treatment.”²

More than 70 percent of people diagnosed with depression are employed, and depression results in 400 million lost work days a year, according to Keith Dixon, PhD, president of Cigna Behavioral Health.⁵ In the private sector, Dixon noted, depressed employees use, on average, more than \$4,000 per year in medical services versus less than \$1,000 per year used by employees without depression, making depression a significant element of health care costs.

“While direct treatment costs should concern us, the indirect costs of untreated depression are a more serious issue. These indirect costs show up as absenteeism, poor productivity, flawed decision-making, accidents, turnover, failed projects, faulty products, poor customer service, poor teamwork,” Dixon said. “Depression is a huge drag on industrial productivity. Companies in our economy now need to compete globally, and the direct and indirect costs of depression are serious threats to our economic security in a vastly altered competitive landscape.”⁵

The prevalence of depression makes its effect on productivity especially pernicious, according to Peter Mills, MD, chief health officer for vieLife, an international health risk assessment and research organization. “The impact of depression on pro-

ductivity and overall health care costs is huge. It's underestimated, if anything. The work of Ron Kessler and others shows that depression is at the top of the list in adversely affecting productivity, especially presenteeism," says Mills.⁶

More evidence

Kessler's work is mirrored in several other studies in recent years. Bernard Bloom, PhD, of the University of Pennsylvania says that about 18 million people have had at least one episode of depression and sustain a lifetime risk of having another episode of about 17 percent. According to Bloom, depression affects between 1 percent and 3 percent of the U.S. population during any six-month period; has a lifetime incidence of more than 15 percent; affects nearly twice as many females as males; recurs at least once among 50 percent of persons, within 10 years of the initial episode; recurs a third time among 90 percent of persons with two previous episodes; has a 40 percent relapse rate within 15 weeks among persons with three or more lifetime episodes; has a relapse rate of 65 percent within the first year, if untreated, among recurrent depressives; and, is the primary psychiatric disorder suffered by at least 60 percent of suicide victims, accounting for about 16,000 deaths annually.⁷

Persons with depression tend to have multiple comorbidities, with substantial effects relative to suffering and cost. Many depressed persons shun treatment, losing work days and performing inadequately on the job. These factors add up to enormous human and economic costs, states Bloom.⁷

Depressive disorders pose a major occupational health challenge, with implications for productivity, competitiveness, absenteeism, insurance benefits utilization, and medical care costs. "Employers — the primary health care payer in the United States — are concerned about increased health-benefit costs. . . . [However] most employers are unaware of how often depression contributes to worker disability, the extent of its indirect costs, and the availability of effective treatment options."⁷

What is depression?

According to the National Institute of Mental Health, a "depressive disorder is an illness that involves the body, mood, and thoughts. It affects the way a person eats and sleeps, the way one feels about oneself, and the way one thinks about things."¹⁷

These are the three most common types of depressive disorders, varying in symptoms, severity, and persistence:

Major depression manifests through a combination of symptoms that interfere with the ability to work, study, sleep, eat, and enjoy once-pleasurable activities. Such a disabling episode of depression may occur only once but more commonly occurs several times in a lifetime. "Approximately half of the persons who reported *major* depression were in the labor force," according to research by Lynn Elinson, PhD, and colleagues at Westat, a research organization in Rockville, Md.^{9,17}

Dysthymia is less severe than major depression and involves long-term, chronic symptoms that do not disable, but keep one from functioning well or from feeling good. Many people with dysthymia also experience major depressive episodes at some time in their lives.¹⁷

Bipolar disorder is also called manic-depressive illness. It is not as prevalent as other forms of depressive disorders, and is characterized by cycling mood changes: severe highs (mania) and lows (depression).¹⁷

Indirect costs can come from lowered productivity by co-workers and from an increase in the number of accidents. They can also include paying overtime to other employees, paying replacement workers, and paying to hire and train these replacements.⁸

Direct and indirect costs vary based on degree of depression, but all forms of depression have an adverse effect on productivity, including absenteeism and presenteeism.⁹

All forms of depression result in a significant degree of job turnover. Debra Lerner, PhD, and colleagues at the Institute for Clinical Research and Health Policy Studies at Tufts-New England Medical Center recently studied the effect of depression on employment by specifically focusing on employed individuals with depression.

They reported on unemployment rates among participants at the six-month follow-up and, among those employed, rates of job retention (sustained employment in the same job) versus job turnover (leaving a job), as well as health-related presenteeism and absenteeism.

Lerner found that at the six-month follow-up, persons with depression had more new unemploy-

ment: 14 percent for persons in the dysthymia group, 12 percent for persons in the major depression group, and 15 percent for persons in the group with both dysthymia and major depression, compared with 2 percent for persons in a control group and 3 percent for persons in the rheumatoid arthritis group.

“Among participants who were still employed, those with depression had significantly more job turnover, presenteeism, and absenteeism,” said Lerner.¹

Younger Workers

Elinson’s research shows that the prevalence of depression in the workplace is exacerbated by the demographic make-up of those workers suffering from the disease who maintain employment. He and colleagues from University of Pittsburgh School of Medicine found that, compared with nonworking depressed persons, working depressed persons tended to be younger, to be male, to be better educated, to have a higher income, to live alone or with a non-relative, and to live in an urban or suburban location. They less often perceived themselves as unable to work or as disabled and were healthier and less impaired by social, cognitive, and physical limitations than their nonworking counterparts.⁹

Another factor affecting younger workers is the devastating effect depression can have within family constellations. Experts estimate that caregivers of family members with dementia or major depression suffer from depression themselves at nearly three times the national rate. A study by researchers at the University of Bridgeport found that 22 percent of caregivers compared to 8 percent of non-caregivers reported frequent anxiety and depression.¹⁰

“An acute or chronic illness in a spouse, parent, or a child will almost certainly affect how one spends one’s time, for instance missing work or giving up leisure activities in order to pro-

vide direct care, emotional support, or transportation to the doctor,” wrote Kenneth M. Langa, MD, PhD, of the University of Michigan Health System. “In addition, a growing body of research suggests that illness in one family member may also have important effects on the health and happiness of other family members.¹¹

Depression review looks at several companies

The costs of depression are borne disproportionately by businesses, according to Katherine A. Durso, PhD, a senior consultant at Ingenix, a research company in Eden Prairie, Minn. Employers pay almost two-thirds of the \$80 billion price tag for treatment of depressive disorders each year, according to Durso¹⁸, and related symptoms, such as reduced concentration and motivation, fatigue, and pain, add substantial productivity losses to the direct medical costs.¹⁸

Durso reviewed seven employers’ medical and drug claims, examining the extent to which workers and dependents sought treatment for depression over a two-year period, ending in 2003. The population was national Ingenix clients in either the service, manufacturing, and transportation industry, with various medical vendors and health plans, and more than 300,000 employees, spouses, and dependents under 65.

The review found that about 7 percent of the population was treated for depression during the two years. The claimants were predominantly employees (56 percent), followed by spouses (29 percent). On a cost-per-episode basis, the 10- to 19-year-old age group was the most expensive. Claimants ages 30 to 39 and 40 to 49 each had more than a quarter of the total depression episodes, as well as more than 25 percent of the depression-related costs. About half of the benefits paid were for prescription drugs. Hospital admissions accounted for only 13 percent of the total paid.

The amount paid for medical and drug benefits for depression treatment was \$968 per claimant. However, the total medical and drug costs for all conditions for which people with depression were treated was much higher: \$8,103 per claimant, compared to the total population average of \$4,258 per claimant for all diseases and disorders.

“Clearly, not all of the comorbidities of these depression claimants are actually associated with the depressive disorder. But a number of recent studies have called attention to the association between depression and long-term painful and treatment-resistant conditions,” reported Durso. She found that the two highest cost comorbidities of depression were musculoskeletal and gastrointestinal disorders, followed by cancers, injuries and neurological disorders.

“Some of the highest costs related to depression are the indirect costs, primary among them productivity losses,” wrote Durso, adding that “the real problem is ‘presenteeism,’ people at work but limited in their ability to produce or participate....”

Insidious effect

The effect of depression on work performance is as insidious as it is prevalent, causing significant variation and decreases in output throughout a single day. Phillip Wang, PhD, of the division of pharmacoepidemiology and pharmacoeconomics at Brigham and Women's Hospital in Boston and a professor at Harvard Medical School, studied what he terms the "moment-in-time work performance" associated with depression.

Wang and colleagues assessed the work performance of 105 airline reservation agents and 181 telephone customer service representatives, paging each five times a day to prompt the workers to record their work performance in a diary. Seven conditions — allergies, arthritis, back pain, headaches, high blood pressure, asthma, and major depression — occurred often enough to be studied.

Wang noted that "major depression was the only condition significantly related to decrements in both of the dimensions of work performance assessed in the diaries: task focus and productivity. These effects were equivalent to approximately 2.3 days absent because of sickness per depressed worker per month of being depressed." The researchers concluded that "studies based on days missed from work significantly underestimate the adverse economic effects associated with depression."¹²

There are several reasons why the economic burden of depression is so significant, according to Wang. First, depression is among the most commonly occurring chronic diseases in both the labor force and the general population.

Second, as many researchers have found, depression is associated with substantial loss in productivity, much of which results from the fact that depression has an earlier age of onset (typically late 20s) than other common diseases affecting individuals before or during their prime working years.

Third, depression is a chronic disease and its deleterious effects on educational and professional attainment further add to this substantial loss in productivity.

Fourth, despite the availability of effective treatments that lead to improved clinical and work outcomes, only a minority of people with depression receive adequate treatment, at an appropriate dosage and for sufficient duration.¹³

The adverse economic impact of depression is in

fact significantly aggravated by lack of treatment. Wang writes that "the economic burden of depression persists, partly because of the widespread underuse and poor quality use of otherwise efficacious and tolerable depression treatments. Recent effectiveness studies conducted in primary care have shown that a variety of models, which enhance care of depression through aggressive outreach and improved quality of treatments, are highly effective in clinical terms and in some cases on work performance outcomes as well."¹³

Depression is a chronic disease for which there is potential room for improvement in cost savings to the employer and benefit to the employee, says Steven Avey, MS, RPh, executive director of the Foundation for Managed Care Pharmacy in Alexandria, Va.¹⁴

"A majority of the lost productive time (LPT) costs that employers face from employee depression is invisible and explained by reduced performance while at work," says Walter F. Stewart, PhD, MPH, in a study conducted when he was director of the AdvancePCS Center for Work and Health in Hunt Valley, Md. "Use of treatments for depression appears to be relatively low. The combined LPT burden among those with depression and the low level of treatment suggests that there may be cost-effective opportunities for improving depression-related outcomes in the U.S. workforce."¹⁵

In the workplace

Depression is a risk factor for heart disease, high blood cholesterol, high blood pressure, chronically elevated levels of stress hormones, stroke, and low levels of day-to-day functioning. "Depression itself has a negative impact on personal activities, interpersonal relationships, and quality of life," says Sally Lusk, PhD, RN, professor emerita at the University of Michigan School of Nursing.¹⁶ In a review of existing studies, she notes the following barriers to effective management of depression in the workplace:

- Stigma employees feel may be associated with the diagnosis.
- Lack of motivation to seek care because of the shame about needing care.
- Ignorance about treatment available.
- Lack of confidence in employee's physicians.
- Deficiencies in primary care physician train-

ing related to mental health problems.

- Health care system shortcomings¹⁶

These barriers notwithstanding, research demonstrates that productivity losses related to depression appear to exceed the costs of effective treatment. Wang, in measuring moment-in-time productivity loss, notes that “an important implication of these results is that the cost effectiveness of depression treatment from the perspective of the employer might be substantially greater than previously thought.” Wang wrote that “data from two nationally representative general population samples of workers suggest that depression treatments . . . in recent effectiveness trials would lead to decreases in work loss and work cutback that would yield a value of \$1,100–\$1,800 in salary equivalents per year of treatment. These savings exceed the average costs of depression treatment, even though they focus exclusively on absenteeism.”¹²

Research under way

But “employers are consequently reluctant to accept indirect evidence of cost-effectiveness. As a result, efforts to increase employer enthusiasm for expanded depression treatment will require effectiveness trials to be carried out that estimate the cost-effectiveness from the employer’s perspective of usual care as well as the perspective of enhanced depression care.”¹²

A new effectiveness trial known as the Work Outcomes Research and Cost-Effectiveness Study, sponsored by the National Institute of Mental Health, is under way to obtain such estimates. “This trial as well as future initiatives aimed at evaluating cost-effectiveness from the employer’s perspective need to consider not only the effects of absence because of sickness but also the effects on work performance in order to capture the full extent to which depression affects work performance and the full extent to which depression treatment has value for the employer,” states Wang.¹²

Researchers and health plan leaders believe that, as employers grow increasingly aware of the need to control overall health-related costs, they will seek solutions for the loss of productivity endemic to depression.

Dixon summed it up: “The employer is no longer passive in our health care system, but is driving

fundamental change. Health care has simply become too expensive — and health has become too important to productivity — for the employer to take a back seat.”⁵

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Advances in Drug Therapy Have Improved Outcomes

Physicians are having success in treating depression by following best practices in the use of newer pharmaceuticals

By Bruce Flickinger

Medical care for depression has increasingly emphasized pharmacologic therapy. Agents such as selective serotonin reuptake inhibitors (SSRIs) and serotonin and norepinephrine reuptake inhibitors (SNRIs) have fewer side effects than first-generation medications and are being adopted widely by physicians.¹

Employers, looking for ways to get the most value for their health care investment, are beginning to recognize the value of spending more when there is a return on that investment. While drug acquisition costs are important and could help determine

TREATMENT OPTIONS

This article provides an overview of the evolution of both the medications for and approaches to treating depression, and how effectively they have been applied in the workplace, and how the implementation of best practice and quality improvement programs among primary care providers can assure long-term success of these therapies among patients.

availability in the formulary, even more important is drug tolerability, because if the patient doesn't stay on the medication and then gets worse, overall utilization costs will increase substantially.²

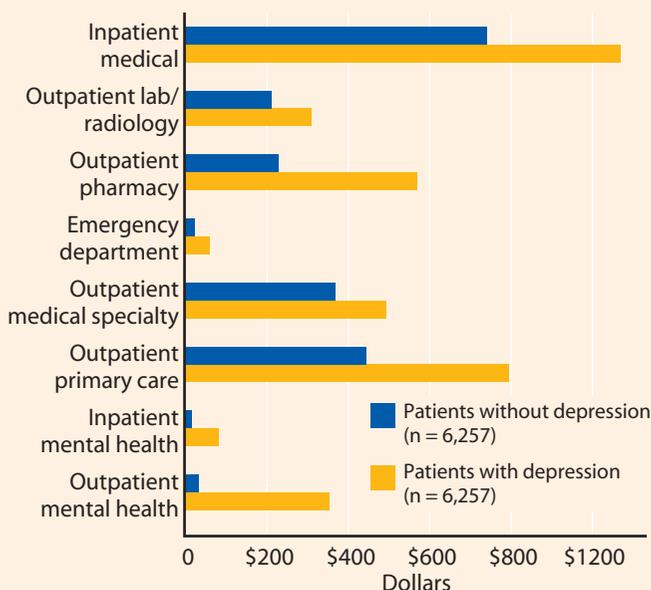
The classes of currently prescribed antidepressants are found on the next page. According to the Pharmaceutical Research and Manufacturers of America (PhRMA), 23 antidepressants currently are in development pipelines.

Whatever the diagnosis and treatment recommended, second and third medication options often must be considered. Some research indicates that less than half of those suffering major depressive episodes achieve remission with the first antidepressant provided and that one third of all patients suffering depression have a chronic condition.³

Adherence is critical

Research indicates that monotherapy regimens were the most commonly used treatment strategy by MCOs, even where multiple regimen changes could be required to achieve successful treatment,

FIGURE 1 Increased utilization and costs in patients with depression compared with patients without depression over 12 months (mean dollars)*



Total health care costs:

Patients without depression: \$2,371 Patients with depression: \$4,246

*P < .001 for all cost categories.

Source: Panzarino PJ, et al.¹¹

and that physicians and MCOs need to monitor patients and be open to necessary regimen changes.³

Frequent problem

Physicians and MCOs also must work together to develop improved strategies to monitor and detect patients with depression who do not comply with their antidepressant regimen.

A frequent problem is that nearly half of all patients who reach the point of getting help stop taking their medications prematurely.

Clinical guidelines for the treatment of depression recommend the continuation of antidepressant medication for four to nine months after the resolution of depressive symptoms. Nevertheless, premature discontinuation can reach as high as 44 percent as soon as three months after initiation of antidepressant treatment.

A substantial portion of patients who fail to achieve remission are likely to be suffering from treatment-resistant depression (TRD). Researchers found that when monotherapy provided at the

Medications commonly used to treat depression

Tricyclics — From the 1960s through the 1980s, tricyclics were the first line of treatment for major depression. They include amitriptyline, desipramine, imipramine, and nortriptyline. Most of these medications affect two chemical neurotransmitters, norepinephrine and serotonin. Although the tricyclics have been shown to be as effective in treating depression as the newer antidepressants, their side effects usually are more unpleasant.⁸ For that reason, tricyclics generally are used today as a second- or third-line treatment. Common side effects caused by these medications include dry mouth, blurred vision, constipation, difficulty urinating, worsening of glaucoma, impaired thinking, and tiredness. Tricyclics can also affect blood pressure and heart rate.

Monamine oxidase inhibitors (MAOIs) — These include isocarboxazid, phenelzine, and tranylcypromine. Researchers believe that MAOIs relieve depression by preventing the enzyme monoamine oxidase from metabolizing the neurotransmitters norepinephrine, serotonin, and dopamine. Also used extensively from the 1960s through the 1980s, MAOIs are effective for some people with major depression who do not respond to other antidepressants, and also are effective for treating panic disorder and bipolar depression. MAOIs are used less commonly than the other antidepressants because they can have serious side effects, and because patients need to avoid certain medications and foods that contain high levels of tyramine.

Selective serotonin reuptake inhibitors (SSRIs) — These include citalopram, escitalopram, fluoxetine, paroxetine, and sertraline. SSRIs appear to relieve symptoms of depression by blocking the reabsorption of serotonin by certain nerve cells in the brain. This leaves more serotonin available, which

enhances neurotransmission and improves mood. These medications have been shown to have fewer side effects than other antidepressants, with similar cost effectiveness;¹ elsewhere it has been reported that antidepressant therapy with SSRIs is more cost effective than treatment with tricyclics when overall health care utilization and expenses are considered.¹¹ Side effects associated with SSRIs include dry mouth, nausea, nervousness, insomnia, sexual problems, and headache.

Serotonin and norepinephrine reuptake inhibitors (SNRIs) — These include venlafaxine and duloxetine. Venlafaxine, in particular, has performed well compared with other antidepressants in terms of efficacy and cost effectiveness, and it has minimal side effects.¹² SNRIs are generally second line and not as well tolerated as SSRIs. Common side effects caused by these medications include nausea and loss of appetite, anxiety and nervousness, headache, insomnia, and tiredness, but side effects tend to be less than those of the tricyclics.

Norepinephrine and dopamine reuptake inhibitors (NDRIs) — The primary drug in this category is bupropion. Common side effects in patients taking NDRIs include agitation, nausea, headache, loss of appetite, and insomnia. They also can cause increased blood pressure in some patients.

Combined reuptake inhibitors and receptor blockers — Drugs in this category include trazodone, nefazodone, maprotiline, and mirtazapine. This class of drugs, too, has been shown to be effective, particularly when in combination with psychotherapy.⁵ Common side effects of these medications are drowsiness, dry mouth, nausea, and dizziness. People with liver problems should not take nefazodone, and people who have seizures should not take maprotiline.

Only 25 percent of patients with depression receive appropriate psychopharmacological or psychosocial treatment

maximum manufacturer-recommended doses has failed to provide remission in depression, the diagnosis should be confirmed, psychotherapy should be added, and psychosocial factors should receive attention. Changes in medication, or augmentation with a second antidepressant or certain other drugs, may improve outcomes.³

There is much evidence to suggest that coordinated care programs incorporating some form of psychotherapy have high rates of success in assuring long-term remission among depressive patients. Current best practices recognize that any form of psychotherapy, including some short-term (10–20 week) therapies, can help depressed individuals, particularly in concert with pharmacological treatments.

At least one study has shown greater treatment success with combination therapy.⁵ Other work has reviewed the role cognitive therapy specifically might play in improving remission rates and decreasing relapse and recurrence rates, and Beck reported that the technique has been shown to be effective in reducing symptoms and relapse rates, with or without medication, in a wide variety of psychiatric disorders.⁶

Some therapies

Two of the short-term psychotherapies that research has shown helpful for some forms of depression are interpersonal and cognitive/behavioral therapies. Interpersonal therapists focus on the patient's disturbed personal relationships that both cause and exacerbate the depression. Cognitive/behavioral therapists help patients change the negative styles of thinking and behaving that are often associated with depression. A third form of therapy, psychodynamic, focuses on resolving the patient's conflicts.

These therapies are often reserved until the depressive symptoms are significantly improved. Other studies of minimizing relapse and recurrence have found a combination of medication and psychotherapy to be effective.⁷

Segal found that concurrent psychotherapy is as effective as monotherapy for the treatment of mild-

to-moderate depressive disorder and could be more effective in cases where depression is more severe.

Emphasis on primary care

As new medications and therapeutic approaches become widely incorporated on the one hand, the responsibility and preparedness of primary care — the likely point of entry for patients seeking treatment for depression — become cause for some concern on the other.⁸ Managed care organizations, which generally discourage referral to specialty care, are shifting treatment of mood/anxiety disorders to primary care, and, by some counts, almost half of all patients with affective disorders (characterized by a consistent, pervasive alteration in mood, thoughts, emotions, and behaviors such as attention-deficit hyperactivity disorder and bipolar disorder) are seen initially in primary care settings. While the literature is mixed on the effectiveness of depression treatment in the primary care setting, at least one study indicates that while most primary care physicians should know how to treat depression, only 25 percent of patients with depression receive appropriate psychopharmacological or psychosocial treatment.⁹ Stafford surveyed the literature and found evidence questioning the success of treatment in the primary care setting, but also concluded that the predominant use of SSRIs suggests that primary care physicians are adopting new therapeutic strategies for depression.⁸ Still, undertreatment seems to be the norm, and this study also found a disturbingly high rate of benzodiazepine use that is inconsistent with current treatment guidelines. The benzodiazepine class has been shown to be effective in treating anxiety, but has demonstrated limited effectiveness in treating depression.⁸

In one quality-of-care study for depressive and anxiety disorders in the U.S., researchers found that during a one-year period, 83 percent of adults with a probable depressive or anxiety disorder saw a health care provider, and only 30 percent received appropriate treatment.⁹ Among subjects who visited primary care providers only, 19 percent received what would be considered appropriate care.

The authors say there are many factors that contribute to why people who need care do not receive it, including perceived need, willingness to accept care, insurance coverage, detection by providers, and knowledge and beliefs among providers about effective treatment. Their findings “support efforts to improve care through either public education or quality improvement interventions.”

Quality improvement programs

One study found that quality improvement programs for depressed primary care patients can improve health outcomes for 6 to 28 months, but that effects for longer than 28 months are unknown.¹⁰ They sought to assess how quality improvement programs for depression affect health outcomes, quality of care, and health outcome disparities at 57-month follow-up.

Primary care practices in the study were randomly assigned to usual care or to one of two programs supporting quality improvement teams, provider training, nurse assessment, and patient education, plus resources to support medication management or psychotherapy for six–twelve months. They found that combined quality improvement programs for medications and therapy, relative to usual care, reduced the percentage of participants with probable disorder at five years by 6.6 percentage points.

A priority

Given this, some feel that one of the most important changes that now must happen in managed care is a relaxation of current restrictions on the number of patient visits allowed to treat mental illness or depression.² The logic is that the extra time spent with difficult patients will improve the overall treatment success rates, which also would benefit from expanded access to credentialed psychotherapists. Again, some believe that while it is not for all patients, the option needs to be available.

The thinking is that if physicians are educated and if adaptable algorithms for treatment can be generated, then the most costly options in the treatment of depression will be used judiciously.

Clearly, both employers and their health care providers seek cost-effective means of treating de-

pression, but these measures involve a fairly concerted investment in order to assure a healthy, effectively functioning employee in the long run.

While a gap exists between what is known about depression and what actually is applied in the clinical setting, this can be offset by best-practices programs and quality-improvement initiatives that focus on long-term freedom from the disease and emphasize better awareness among primary care providers and their patients, appropriate pharmaceutical regimens, and, when needed, pharmacological treatments combined with psychotherapy.

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Employers Take Lead In Fighting Depression

Innovative businesses around the country are screening and educating employees, and enlisting the help of primary care physicians

By MargaretAnn Cross

Depression is taking a huge toll on American workers and companies. However, advancements in treatment as well as new evidence that battling depression in the workplace is good for business are reshaping how employers view the disease.

The potential benefits of launching a depression initiative, for example, stacked up quickly at Sprint, the communications giant, once human resources executives began investigating the disease.

The company participated in a course offered by the Mid-America Coalition on Health Care in

which a psychiatrist explained depression to employers. Then, Sprint ran information about the age of its employees through an online depression productivity calculator (<http://www.depressioncalculator.com>) to understand the costs of the disease within its employee population — and the potential savings it could realize by improving treatment. The company also looked at just how much it was spending on pharmaceuticals for the condition. This spring, Sprint rolled out a depression awareness and education program, building on its previous success in areas such as cancer, low-back pain, diabetes, and asthma.¹

Sprint and other employers in the Kansas City



PHOTOGRAPH BY ROB CRANDALL

“Companies need to ask, ‘What are we already paying for that we can make the most of?’” says Clare Miller, director of the Partnership for Workplace Mental Health. If you have a great benefit — market it.

area have taken on depression individually and collectively through the Mid-America Coalition's Community Initiative on Depression. The five-year project has created lasting change in the way primary care physicians are reimbursed for treating depression in Kansas City. Realizing that physicians were not screening for depression because they thought they would not be paid for their time, employers asked insurers to educate physician office managers on how to code a visit so that a screening test would be covered. "It was less a matter of changing policy than of communicating with one another," says William L. Bruning, president of the Mid-America Coalition on Health Care, an organization that coordinates health care efforts between employers, health care providers, labor representatives, and local government in Kansas City.²



The cost of anti-depressant drugs is just one of a full range of factors that employers need to look at, says William L. Bruning, president of the Mid-America Coalition on Health Care.

what is known nationally about employee understanding of depression and mental health benefits in the workplace.² Fifty percent of employees, for instance, said they would be willing to seek help for depression through an employee assistance program, if it was available.³

Initially, however, Kansas City employers were skeptical that depression warranted their efforts and that they could have an impact on the disease, Bruning says. "Seven out of eight employers at first voted to focus on diabetes. When we started back in 2000, there was a lot less discussion nationally about depression."²

The Kansas City project is just one example of how employers around the country are taking the lead in addressing depression in the workplace. In some cases, companies are purchasing programs from disease management vendors, health plans, and pharmacy benefit managers. In others,

Increasing interest

The project also led to a major survey of employees at 13 large companies that has contributed to

they are working with one another and a variety of community organizations to put together employee

and physician education programs and other interventions. Not-for-profit advocacy groups and disease management vendors have developed many resources to assist employers (see "Resources," p. 19).

What employers are realizing is that this is an area in which they can make a difference.

Employers spent \$26.1 billion for depression care in 2000, and the disease cost an additional \$51.5 billion in absenteeism and productivity losses.⁴ Managers believe that depression is the leading inhibitor of worker productivity, according to a survey by the University of Michigan Depression Center.⁵

TABLE 1 What employees have to say

Depression and work

While 50 percent of employees know how to use company resources, just 36 percent would feel comfortable talking to a supervisor about the disease

Know how to use company mental health resources	50% agree
Most depressed people can handle their work	53% agree
I know the difference between depression and a sad mood	73% yes
I would feel comfortable talking with my doctor about depression	92% yes
I would feel comfortable talking with my colleague about depression	36% yes
I would feel comfortable talking with my supervisor about depression	29% yes

Source: *Journal of Occupational and Environmental Medicine*, 2005³

Getting help for depression

Employees say they would seek assistance from the following people and organizations

Clergy	31%
Primary care physician	76%
Psychiatrist	43%
Employee resources	50%
Friends and family	70%
Community resources	26%
Health plan	34%
Handle on my own	53%

Source: *Journal of Occupational and Environmental Medicine*, 2005³

Three basic steps

The three most important — and most practical — steps that employers can take when it comes to depression is to educate workers in an attempt to counter the stigma of depression, give employees easy access to depression resources and care, and ensure that primary care physicians are being paid for screening for depression, said Alberto M. Colombi, MD, MPH, corporate medical director of PPG Industries, a glass and chemical products manufacturer based in Pittsburgh. “There are a thousand important things employers can do when it comes to depression, but my advice is to make sure these three things are done first, and then tackle the other 997.”⁸

PPG undertook an 18-month program designed to improve care for its depressed population. With Medstat, a health information company, and Caremark, a pharmacy benefit manager, PPG

charted depression’s large impact on its expenses by examining medical literature as well as PPG’s own medical, prescription, and absenteeism data.⁸

In designing the depression program, PPG first brought all of the stakeholders together, including its pharmacy benefit manager, health plan, and behavioral health carve-out. PPG then worked with its partners to train care managers, create work-site interventions, and reach out to primary care physicians.

Specific goals included training primary care physicians to use depression screening tools and making sure employees who were prescribed antidepressants stayed on the medication for at least six months to ensure that its effectiveness could be assessed. Outreach to primary care physicians included the distribution of informational packets and preprinted pre-

scription pads, which was done by Highmark Blue Cross Blue Shield. PPG also sought to get depressed patients actively engaged in their care.²⁷

In measuring the success of its effort, PPG found that the number of employees visiting a depression Web site operated by Magellan Health Services tripled from 2002 to 2003. The number of employees using a Web-based screening tool also rose to 42 from 5, and the number of employees contacting the company’s employee assistance program rose to 157 from 42.

The company saw a 30 percent increase in the number of depression cases opened by its employee-assistance program, to 82 from 63. Increased productivity at work was also recorded through an employee survey (see “Employees Find Success Through EAP” on page 16).²⁷

More than half of people with depression say that they have been so sick they have not been able to come to work, and 1 in 5 depressed individuals say the disease interferes with their productivity.⁵ Another recent study suggests that lost productivity related to major depression translates into the equivalent of 2.3 lost days of work each month.⁶

The door is wide open for employers to have an impact, mainly because the condition often goes untreated, and even when it is diagnosed, follow-up care for depression is often insufficient.⁷

Setting the stage for employees to seek treatment as soon as they notice the signs of depression is one way employers can help. More than 90 percent of employees surveyed correctly recognized the symptoms of depression,³ but 3 out of 4 depressed individuals do not seek treatment right away.⁵ That is important because 88 percent of those who have been treated say that the help they received improved their work performance.⁵

Lingering stigma associated with depression may be what is stopping employees from getting help

sooner.⁸ Individuals have concerns about how their career might be affected if coworkers learn about their condition.⁵ Supervisors also cite a lack of training in dealing with the issue among their employees,⁵ providing another opportunity for improvement. A strong workplace focus on depression makes both employees and managers feel better about dealing with the disease. Within companies that earned high rankings for best practices in depression, 90 percent of depressed employees felt satisfied with their jobs, and 85 percent were satisfied with the potential for advancement with their current employer⁵ (see “Best Practices for Employers,” on page 18). In addition, increasing the number of contacts with care managers along with counseling about medication side effects is likely to result in increased compliance with pharmaceutical therapies.⁹

Large employers do a good job of putting benefits for depression in place, and employees are generally aware of what is available to them.^{3,5} Thirty-six states require health plans to offer the same

benefits for mental health care as they do for other medical conditions.¹⁰ Nevertheless, only a third of companies specifically offer depression education programs⁵ and just 4 percent of major U.S. employers offer depression disease management programs, compared to 84 percent for heart disease.¹¹

The best approach to getting started is for companies to make the most of what they already have in place, advises Clare Miller, director of the Partnership for Workplace Mental Health, a coalition of trade organizations, employers, and government agencies that work to provide behavioral health resources to employers.¹²

“Companies need to ask, ‘What are we already paying for that we can make the most of?’” Miller says. “For example, if a company has an employee assistance program, is it marketing that to employees? If you have a great benefit, and if people aren’t utilizing it or people aren’t being diagnosed, it’s not as helpful as it could be.”¹²

Companies that ask employees to take health risk assessments, for instance, should ensure that the HRA screens for depression — and then has a mechanism for personal follow-up, suggests Jaan Sidorov, MD, medical director of care coordination at Geisinger Health Plan.¹³ In addition, employers should ensure that the disease management programs they have in place for other chronic conditions routinely screen their patients for depression, because depression is often associated with chronic conditions such as diabetes and low-back pain.^{13,14}

Nurse advocates

Sprint used existing resources by expanding its Sprint Alive! health promotion program to include depression. The company sent postcards to employees’ homes that said, “In any given year, about 10 percent of all Americans suffer from depression. Would you recognize the symptoms?” The postcard invited employees to call the Sprint Alive! phone line, which is staffed with nurse advocates. The employer also sponsored lunchtime education programs on depression and broadcast a program over the Web that could be viewed at employees’ workstations.¹

Sprint and other companies involved in the Kansas City depression initiative recently advised

TABLE 2 Employees find success through EAP

Participants in PPG Industries’ employee-assistance program said counseling sessions helped them improve function at home and work

How much did your ability to function at work change since your counseling sessions began?

Much improved	16.5%
Improved	45.5%
Stayed about the same	38.0%
Deteriorated	0.0%

How much did your ability to function at home change since your counseling sessions began?

Much improved	24.5%
Improved	62.0%
Stayed about the same	13.0%
Deteriorated	0.0%

Source: *Journal of Managed Care Pharmacy*²⁷

executives who visited the region that they could replicate the program in their own companies. Their advice included finding out what their company’s mental health benefit actually covers (employers in Kansas City compared their benefits and found them to be very similar), educating managers and supervisors about depression, and accessing local and national mental health organizations for educational materials.^{1,2} Such materials are available from the Partnership on Workplace Mental Health and the National Institute of Mental Health.

Many organizations offer disease management programs, which have evolved over time. Today, it is important that a program incorporate an integrated approach, says Alex R. Rodriguez, MD, chief medical officer for behavioral health at Magellan Health Services, a company that offers employee assistance as well as behavioral health programs. For instance, an employee assistance program can be a strong entry point into depression care, Rodriguez says.¹⁵

Cigna Healthcare expected to begin operating its Well Aware Depression Management program in January, with a focus on integrating the company’s behavioral health, pharmacy, and medical management components.¹⁶ And United Behavioral HealthCare has announced plans to bolster its depression programs with a comprehensive approach

Seventy-eight percent of benefit managers believe that lost productivity and absenteeism cost a company more than treating all of a company's depressed patients.

at the start of the year. The program, designed to help employers identify more employees who could benefit from depression treatment, will incorporate depression screening and education into such areas as employee assistance programs, disease management programs for chronic conditions, disability programs, and self-help Web sites.¹⁷ Caremark, the pharmacy benefit manager, has also introduced a new depression disease management program, building on its experience with depression in other areas. For more than six years, for instance, the company has offered employers a program that monitors physicians' prescribing habits as related to depression, with about 80 companies using that program today. Caremark also has long screened for depression in other disease management pro-

grams, such as those it offers for diabetes and heart disease. The new depression specific disease management program is focused on newly diagnosed patients and is meant to ensure that patients are treated according to standard guidelines.¹⁸

And in November 2005, Aetna introduced its own depression management program in the Mid-Atlantic and Southwest, emphasizing screening at the primary care physician level, using a standardized measurement tool, and a program of reimbursing physicians for this service, and training them in screening technique.¹⁹

When evaluating vendor programs in depression, employers can look for endorsements from such organizations as the National Committee for Quality Assurance and URAC, both of which offer

States, federal government aim to improve mental health care

As employers battle depression in the workplace, state governments, federal government agencies, and industry groups are setting their own agendas for improving care.

Oregon, in October, became the 36th state to require health plans to provide the same level of coverage for mental health that they provide for other medical illnesses. Oregon's law will go into effect in January 2007 and includes treatment of substance abuse in its equal coverage mandate, according to the American Psychiatric Association. It also requires that employers of all sizes comply with the law.¹⁰

The less-extensive federal Mental Health Parity Act prohibits many or most health plans from putting lower annual or lifetime caps on mental health benefits than the caps on other medical

and surgical benefits, according to the Centers for Medicare & Medicaid Services.²⁸

"Parity is an important step in how our country deals with mental illness, but it doesn't solve everything," says Clare Miller, director of the Partnership for Workplace Mental Health, a coalition of organizations, employers, and government agencies that work to provide behavioral health resources to employers.¹² Individuals must know about the benefits and have unfettered access to them in order for such laws to be meaningful, she says.

A federal agency this summer issued a report on how the government can improve the country's mental health system. The Substance Abuse and Mental Health Services Administration's plan, titled "Transforming Mental Health in America.

The Federal Action Agenda: First Steps," outlines how the government should coordinate its efforts but requests no new funding, the APA reported. The report sets the agenda for implementing the goals of President Bush's 2003 New Freedom Commission on Mental Health.²⁹

Shortly after the release of the report, a coalition of 16 national mental health advocacy organizations, including the APA, issued a list of action items for the federal government, titled "Emergency Response: A Roadmap for Federal Action on America's Mental Health Crisis," according to the APA. "The Action Agenda and the CMHR roadmap were complementary documents and together can serve to bring about needed changes to the country's mental health system," said Charles S. Konigsberg, director of the coalition.²⁹

Best practices for employers

In a survey by the University of Michigan Depression Center, managers and employees said they believed the following would be effective workplace practices for depression.

The company:

- Ensures that employees have appropriate access to outpatient care and a broad continuum of services, settings, and providers.
- Provides information to employees to help them understand the health care system and the benefits available to them for the treatment of depression.
- Provides information to employees on symptoms of depression and the importance of seeking care.
- Has employee screening or early detection mechanisms for depression.
- Has guidelines for job accommodations, including time to participate in therapy and other mental health programs, for those with depression.
- Has supervisor training to help them identify, manage, and assist employees with depression.
- Has a return-to-work plan for employees who have been absent due to depression.

Source: University of Michigan Depression Center, 2004⁵

disease management accreditation. URAC standards for such programs are not disease specific, but they emphasize evidence-based practice, collaborative relationships with providers, consumer education, and shared-decision making with consumers.²⁰ NCQA standards assess program content, patient service, practitioner service, clinical systems, measurement and quality improvement, and program operation. Of the more than 30 disease management vendors accredited by the NCQA, three have received accreditation for depression programs: CorSolutions, Health Integrated, and Kaiser Permanente Care Management Institute.²¹

Employers should keep depression treatment in mind when selecting a health plan as well. The NCQA's Health Plan Employer Data and Information Set, or HEDIS, includes depression measures. The quality standards examine how health plans manage antidepressant medication, calling for 12 weeks of filled prescriptions during the acute phase of treatment and six months of filled prescriptions for ongoing care. They also look at follow-up contacts with individuals after a diagnosis (at least three contacts with the primary care physician during a 12-week acute care phase) and after a hospi-

tal stay (contacts within seven days and 30 days). In 2004, 74.4 percent of health plans followed up with patients within 30 days of a hospital stay, but only 20.3 percent provide at least three follow-up contacts after a mental health diagnosis.²²

Measuring quality with eValue8

Measuring the quality of depression care today is done by looking at the process a health plan follows, rather than outcomes, explains Dennis White, interim director of the eValue8 program for the National Business Coalition on Health. "With diseases such as diabetes, we can look at someone's hemoglobin A_{1C} levels and know that members are receiving good care, but with depression, there is no such silver bullet." The organization's eValue8 program is a universal health plan evaluation tool used by 12 coalitions and additional companies around the country.²³

Depression is one of four conditions covered in eValue8's disease management module. The program asks health plans questions related to identification of members with depression, use of proper treatment guidelines, member support, physician support, the plans' participation in collaborative projects within communities, and the coordination of care between emergency departments and other providers.²³

Vendors also should be reviewed for privacy practices and compliance with the Health Insurance Portability and Accountability Act. Disease management providers should be able to collect information, give personal feedback to employees based on their diagnoses, and report aggregate data about an employee population to the employer.¹³

While employers have many options in designing depression initiatives and selecting vendors, it is similarly challenging to set expectations for the desired results of a program. Disease management efforts often improve the rate of depression diagnoses, especially if they include a screening component, and the quality of care depressed employees receive.⁷ Yet they do not appear to reduce actual medical costs,²⁴ resulting instead in employees visiting doctors more often and filling more prescriptions.⁷ A recent review of eight diverse clinical tri-

Resources

National Mental Health Association
2001 N. Beauregard Street, 12th Floor
Alexandria, VA 22311
703/684-7722
www.nhma.org

The National Mental Health Association's Web site provides educational material and resources, including information on specific medications. It also covers advocacy efforts.

**National Institute of Mental Health
Public Information and Communications Branch**
6001 Executive Boulevard, Rm. 8184, MSC 9663
Bethesda, MD 20892-9663 U.S.A.
1-866-227 NIMH (6464)
www.nimh.nih.gov

The NIMH Web site offers access to research, educational material, and information on outreach programs such as its Real Men Real Depression campaign. The institute also holds meetings around the country to disseminate information on mental health issues.

**Partnership for Workplace Mental Health
American Psychiatric Foundation**
1000 Wilson Blvd.
Suite 1825, Arlington, VA 22209-3901
703-907-8673
www.workplacementalhealth.org

The partnership offers a range of materials, including educational brochures for employees and a free newsletter that highlights employers' efforts to improve mental health care. The Web site also features links to related organizations, including the Ameri-

can Psychiatric Association, and tools such as the depression calculator.

The Mid-America Coalition on Healthcare
1 West Armour Blvd.
Suite 204
Kansas City, Missouri 64111
816-753-0654
www.machc.org

The National Business Coalition on Health

The coalition provides depression resources for consumers, human resources managers, and medical and mental health professionals. Tools for managers include a self-assessment that can be used to evaluate a company's depression management policies and a ready-to-use presentation on depression.

Productivity Impact Model
www.depressioncalculator.com

Last year, the U.S. Chamber of Commerce worked with the American Psychiatric Association, the Pharmaceutical Research and Manufacturers of America, the Institute for Health and Productivity Management, and the Mid-America Coalition on Healthcare to develop the Productivity Impact Model, which is also called the depression calculator. The tool enables employers to view what effect improved treatment of depression could have on its bottom line. The program examines an employer's population by age, estimates how many employees in each age group are likely to be affected, and projects savings based on reduced absenteeism as well as a reduction in direct medical costs.

als for depression disease management found that program expenses ranged from \$51 to \$5,549 per participant and resulted in a negative return-on-investment that averaged 35 cents for every dollar spent, without considering productivity impacts.²⁴

It is necessary with depression, therefore, to take a broad view of the overall cost of depression, especially as it relates to absenteeism and productivity.

DM and productivity

Many researchers have quantified the overall costs of depression, including its impact on productivity, but it is generally agreed that more work needs to be done to explore the cost-effectiveness

of targeted depression programs as they relate to productivity in the workplace.²⁴ Two years ago, a literature review of studies on the effectiveness of disease management programs did not identify any studies that measured the potential cost savings resulting from improved treatment.⁷

But today, studies have begun to measure the outcomes of depression initiatives using productivity measures. A recent examination of an integrated care model that included screening for depression, care management, and therapy demonstrated cost savings associated with productivity and absenteeism. In 2005 dollars, the program cost \$297 per year per treated depressed employee. Over two years, the program resulted in an average reduction

of 12.3 days of absenteeism, with an annual value of \$648 per participating employee. The program also resulted in an average productivity increase of 8.2 percent, or \$1,982 per treated employee.⁹

A cost-effectiveness study in which five large employers are measuring the effects of screening tens of thousands of employees and offering depression outreach treatment, sponsored by the National Institute for Mental Health and titled "Outreach and Treatment for Depression in the Labor Force," is scheduled to be completed in 2006.^{25,26}

But even without specific data, many understand the potential for improving depression care. Seventy-eight percent of benefit managers believe that lost productivity and absenteeism cost a company more than treating all of a company's depressed patients.⁵

In Kansas City, thinking about depression has come a long way, says Bruning of the Mid-America Coalition. "The way that employers looked at it in the beginning of this initiative was simply as the cost of antidepressant drugs; it was a formulary issue. And now they understand that they need to look at a full range of factors, including disease management programs, employee-assistance programs, the mental health benefits they provide, adherence to treatments, and how depression relates to productivity. They've gotten much more sophisticated in dealing with depression in the workplace."²

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