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Mental Illness in the Workplace

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Introduction

- Jacqueline Agnew introduces Martina Lavrisha

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Section A

Global Burden of Disease

Headlines in January and February 2009

- Headlines on UPI and Yahoo! News in January and February 2009
  - Sailor killed in murder-suicide
  - Murder-suicides may be “tip of iceberg”
  - Job woes blamed for LA murder-suicide
  - Army suicides at record high, passing civilians
  - Army reports alarming rise in suicides last month
  - Mike Whitmarsh, former beach volleyball Olympian, dies at 46
    - Autopsy shows Whitmarsh committed suicide with carbon monoxide from car exhaust

Global Burden of Disease

Cardiovascular Conditions	18.6%
Mental Disorders	15.4%
Cancer	15.0%
Others	51%

Source: Murray and Lopez. (1996). *Global burden of disease.*

Illnesses with Highest Economic Burden on Employer

- Chronic illnesses with highest economic burden on employer
  - Hypertension: $392 per eligible employee per year
  - Heart disease: $368
  - Depression and other mental illnesses: $348
  - Arthritis: $327

Source: Goetzel et al., (2004).

Incidence of Mental Illness in the U.S.

- 26.2 percent of Americans ages 18 and older, or one in four adults (57.7 million Americans), will experience a form of mental illness in a given year (NIMH, 2004)

Cost of Mental Illness in the U.S.

- The cost of mental illness in both the private and public sectors in the U.S. is $205 billion
- Direct treatment costs are $92 billion, with $105 billion due to lost productivity, and an additional $8 billion resulting from crime and welfare costs related to the illness
- The cost of untreated and mistreated mental illness to American businesses, the government, and families has grown to $113 billion annually

Rice and Miller. (1998).

Hospital Costs of Mental Health Disorders in 2006

- One out of every five hospital stays (21.3 percent) had either a principal or secondary diagnosis of a mental health condition
- Medicare and Medicaid were the payers for 6 out of every 10 mental health stays, while private insurance paid for slightly more than 2 out of 10 of these stays
  - Slightly less than 1 out of 10 mental health stays were uninsured
- Mood disorders and schizophrenia were responsible for 82 percent of all mental health hospitalizations
- For individuals 65 years and older, dementia and associated cognitive disorders were the most common cause of mental health hospitalizations (50%)

Source: AHRQ. (2008).

Hospital Stays: Mental Health vs. All Diagnoses

- Characteristics of hospital stays for mental health compared to all stays, for all age groups, 2006

All hospital stays		
	Mental health principal diagnosis	All diagnoses
Number of hospital stays	1,350,700	39,450,200
Mean length of stay (days)	8.2	4.6
Mean charge per stay (dollars)	$15,400	$24,000
Mean charge per day (dollars)	$1,900	$5,200
Percent admitted from the ED	49.3%	43.8%
Percent admitted from another hospital	6.2%	3.5%
Percent admitted from long-term facility	3.6%	1.3%

Source: AHRQ, Center for Delivery, Organization, and Markets, Healthcare Cost and Utilization Project. Nationwide inpatient sample, 2006.

Barriers to Treatment

- Only 25–40% of individuals with symptoms seek treatment as unsure of which type of provider to initiate treatment with or do not have insight into their illness

- Cost—uninsured, smaller companies may opt to not offer mental health benefits

Barriers to Treatment

- Access—mental health providers not taking insurance due to low reimbursement rates, specialists found more in urban settings, transportation, lack of mental health providers in remote areas, office hours conflict with work schedule, difficulty navigating insurance and disability systems

- Stigma—viewed as personal weakness or defect; educational bias, competing priorities for lower income individuals

- Employment implications (military, security clearances)

Diagnostic and Treatment Options

- Approximately 25–50% of individuals with mental illness are seen by their primary care physician or practitioner, 25–40% of individuals see a psychiatrist or mental health provider, and the remainder may see other alternative providers (clergy, acupuncturist, massage therapist)

- Diagnosis is made based on presence of specific symptoms in DSM-IV, absence of organic (brain tumor) or other medical conditions (thyroid d/o, vitamin deficiency), side effect of medication(s)

- The earlier the treatment, the better the outcome
  - Research has shown that a combination of medications/therapy is most effective

Up-front Costs

- Cost of comprehensive psychiatric evaluation ($400–600), more frequent visits in first six months (co-payments), medications ($16 per prescription), therapy sessions ($100–250)

- Cost of primary care MD/NP/PA visits based on complexity (co-payments or out of pocket)

- May see longer duration of symptoms if treated by primary care as more likely to misdiagnose, order inadequate dosages of medications, and are less likely to explore suicidal thoughts (40% of suicide victims saw their primary care within a month of the event) (Pomerantz, 2005)

Increased Costs

- Increased costs with decrease in coverage or increased symptoms
  - A 30% cost reduction in mental health services at a large Connecticut corporation triggered a 37% increase in medical care use and sick leave by employees using mental health services, thus costing the corporation more money rather than less (Rosenheck et al., 1999)
  - Langlieb (2005) noted that if depressed employees were also highly stressed, they spent 147% more on health care than those who were depressed alone (based on the findings of a 1998 study of 46,000 employees)

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Section B

Mood Disorders

Mood Disorders

- Depression
- Bipolar disorder
- Dysthymia
- Seasonal affective disorder

Depression

- Depression is a major public health problem, and increasing the number of Americans with depression who receive treatment is an important public health goal and a national objective of Healthy People 2010 (DHHS, 2000)

Prevalence of Depression in U.S.

- Depression affects 14.8 million adult Americans, or about 6.7% of the U.S. population age 18 and older in a given year and is the leading cause of disability for individuals ages 15–44 (NIMH, 2008)

Effects of Depression in Working Adults

- In the U.S., clinical depression has become one of the most common illnesses, affecting 1 in 10 working-age adults, resulting in a loss of 50 working days per depressed worker each year when untreated

- In 2000, employers spent $26 billion in direct costs and lost an additional $51.5 billion for absenteeism and reduced productivity

Source: Greenberg et al. (2003).

Depression: DSM-IV Criteria

- Five or more of the following symptoms in the past two consecutive weeks:
  - Depressed mood
  - Loss of interest/pleasure
  - Guilt or worthlessness
  - Sleep disturbance
  - Psychomotor agitation or retardation
  - Appetite change (increase or decrease)
  - Concentration difficulties
  - Energy loss
  - Suicidal ideation

Benefits of Depression Treatment for the Employer

- When depression management included in health plan, productivity increased over 6%, absenteeism declined by 28%, with a savings of $2,601 per each depressed employee (Rost, 2004)

- Other studies have shown depression treatment yielding cumulative savings of $2,898 per 1,000 workers over five years and an additional net savings of $4,633 per 1,000 workers (from reduced absenteeism and employee turnover rates) by the second year of treatment (Wang et al., 2006)

Unhappiest Cities (*Business Week*, 2009)

Rank	State
1	Portland, Ore.
2	St. Louis, Mo.
3	New Orleans, La.
4	Detroit, Mich.
5	Cleveland, Ohio
6	Jacksonville, Fla.
7	Las Vegas, Nev.
8	Nashville, Tenn.
9	Cincinnati, Ohio
10	Atlanta, Ga.

Bipolar Disorder: DSM-IV Criteria for Mania

- Four or more of the following symptoms in the last week
  - Feeling unusually “high,” euphoric, or irritable
  - Needing less sleep
  - Talking a lot or feeling unable to stop talking
  - Being easily distracted
  - Having lots of thoughts/ideas going through your head at one time
  - Doing things impulsively with negative consequences (money, sex, business)
  - Feelings of greatness
  - Making lots of plans for activities or feeling the need to keep moving

Rates and Costs of Bipolar Disorder

- Bipolar disorder affects more than 5.7 million adult Americans every year, or 2.6 percent of the U.S. population aged 18 and older (Kessler, Chiu, Demler, and Walters, 2005)
- Higher rates (close to 50%) of suicide attempts reported, with 19% succeeding (Jamison, 2000)
- Individuals with bipolar disorder have a higher rate of substance abuse or dependence—the ECA study found that approximately 56% of patients with bipolar disorder abused or were dependent on drugs, and approximately 44% had comorbid alcohol abuse (Regier et al., 1990)
- Comorbid alcoholism also increases the attempted suicide rate (38% vs. 21% lifetime rate) among individuals with bipolar disorder (Potash et al., 2000)
- Lifetime cost of bipolar disorder based on a 1991 study was $45 billion, with lost productivity and early death accounting for $38 billion (Wyatt and Henter, 1995)

Treatment of Mood Disorders

- Antidepressants, mood stabilizers, antipsychotics, anxiolytics, sedatives
- Therapy—cognitive, behavioral, family, group, phototherapy, TMS, VNS
- Support groups

Treatment of Mood Disorders

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- Therapy—cognitive, behavioral, family, group, phototherapy, TMS, VNS
- Support groups
- ECT
- Exercise
- Nutrition

Anxiety Disorders

- Single phobia (agoraphobia, claustrophobia)
- Social anxiety disorder
- Post–traumatic stress disorder
- Generalized anxiety disorder
- Panic disorder
- Obsessive-compulsive disorder

Rates and Costs of Anxiety Disorders

- Approximately 40 million American adults ages 18 and older (18.1%) in a given year have an anxiety disorder (Kessler, Chiu, Demler, and Walters, 2005)
- Anxiety disorders are highly treatable, yet only about one-third of those suffering from an anxiety disorder receive treatment
- Having multiple types of anxiety disorders (PTSD, phobia, panic disorder) increases risk of suicide (Sareen et al., 2005)
- The direct costs of treating anxiety disorders is $42 billion a year

Treatment of Anxiety Disorders

- Anxiolytics, antidepressants
- Therapy—cognitive behavioral, desensitization, EFT
- Support groups
- Relaxation techniques, stress management
- Exercise

Suicide

- Suicide rates are on the rise worldwide—WHO estimates that 1.53 million people will die from suicide in 2020, averaging 1 death every 20 seconds and one attempt every one to two seconds (Bertolote and Fleischmann, 2002)

Suicide

- Suicide took the lives of 32,439 Americans in 2004 (NIMH, 2009)
- 86 suicides daily; 1 suicide every 17 minutes, annual rate of 10.9 per 100,000
- More people die from suicide than from homicide—in 2000, there were 1.7 times as many suicides as homicides
- Overall, suicide is the 11th leading cause of death for all Americans, and is the third leading cause of death for young people aged 15–24
  - Rates of completed suicide are highest among the elderly over 85—elderly adults have suicide rates close to 50% higher than the nation as a whole
- 2008 suicide rates in the Army are at all time high—20.2 per 100,000 soldiers, Marine Corps rates, at 19 per 100,000 troops, are also higher than national rates (AP, 2009)

Suicide by Gender, Race

- Males are more than four times more likely to die from suicide than are females; however, females attempt suicide three times more often than males
- 52% of suicides in 2005 were committed with a firearm (men use firearms more readily while females choose poisoning)
- In 2005, white males accounted for 72% of all suicides
  - Together, white males and females accounted for over 90% of all suicides (U.S. Suicide Statistics, 2005)
- Between 1999 and 2005, there was an increase in the overall suicide rate, especially in whites aged 40–64, with white women experiencing the largest annual increase of 3.9 percent, and the rate among white men rose 2.7 percent annually (Hu et al., 2008)
- From 1979–1992, suicide rates for Native Americans (American Indians and Alaska Natives) were about 1.5 times the national rates
  - There was an increased number of suicides among young male Native Americans during this period, as males 15–24 accounted for 64% of all suicides by Native Americans (APA, 1999)

States with Highest Suicide Rates, 2005

- U.S. Suicide Statistics (2005)

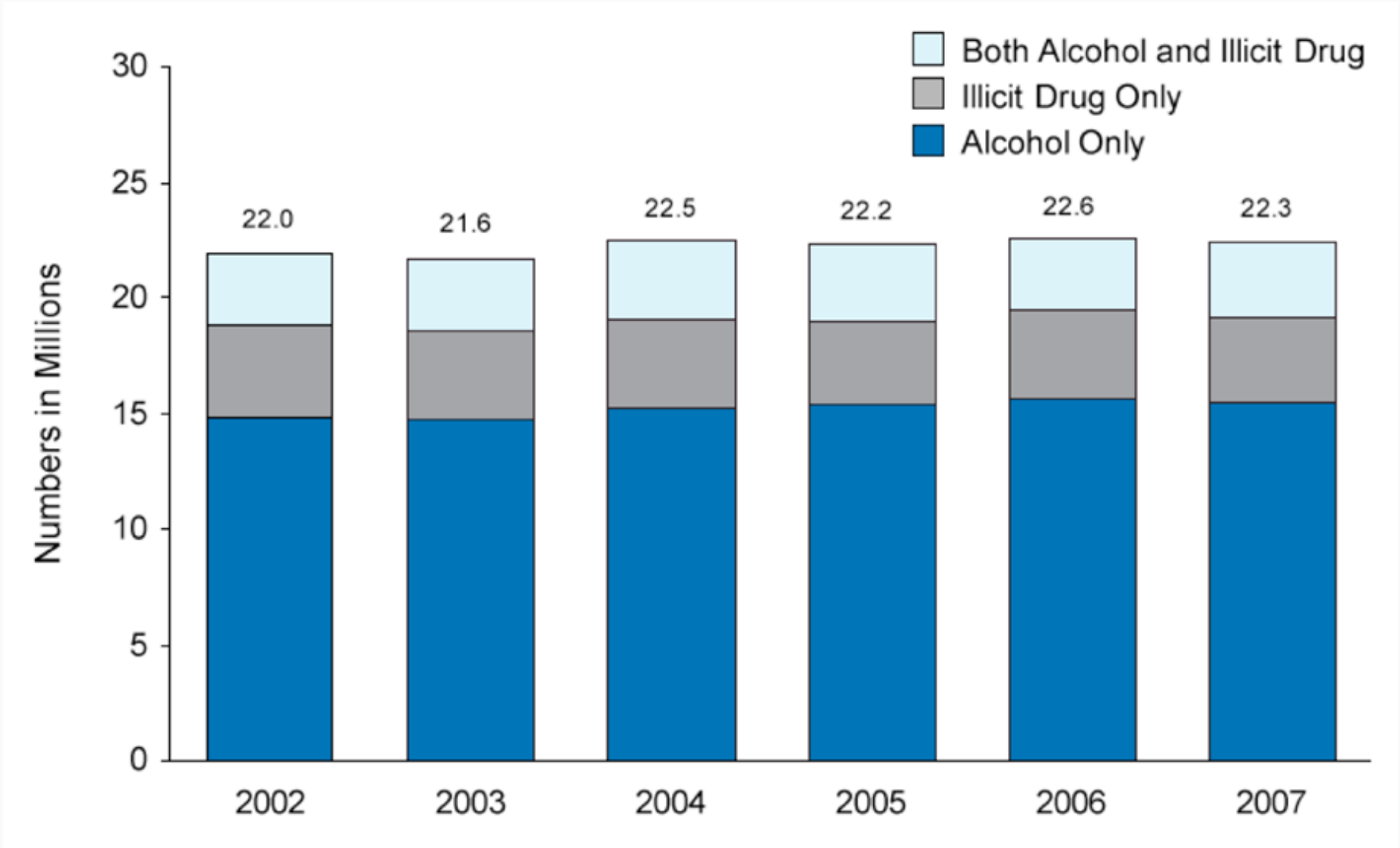
Rank	State	Number	Rate
1	Montana	206	22.0
2	Nevada	480	19.9
3	Alaska	131	19.7
4	New Mexico	342	17.7
4	Wyoming	90	17.7
6	Colorado	800	17.1
7	Idaho	228	16.0
8	Arizona	945	15.9
9	South Dakota	121	15.6
10	Oregon	560	15.4

Substance Abuse and Dependence

- Substance abuse and dependence

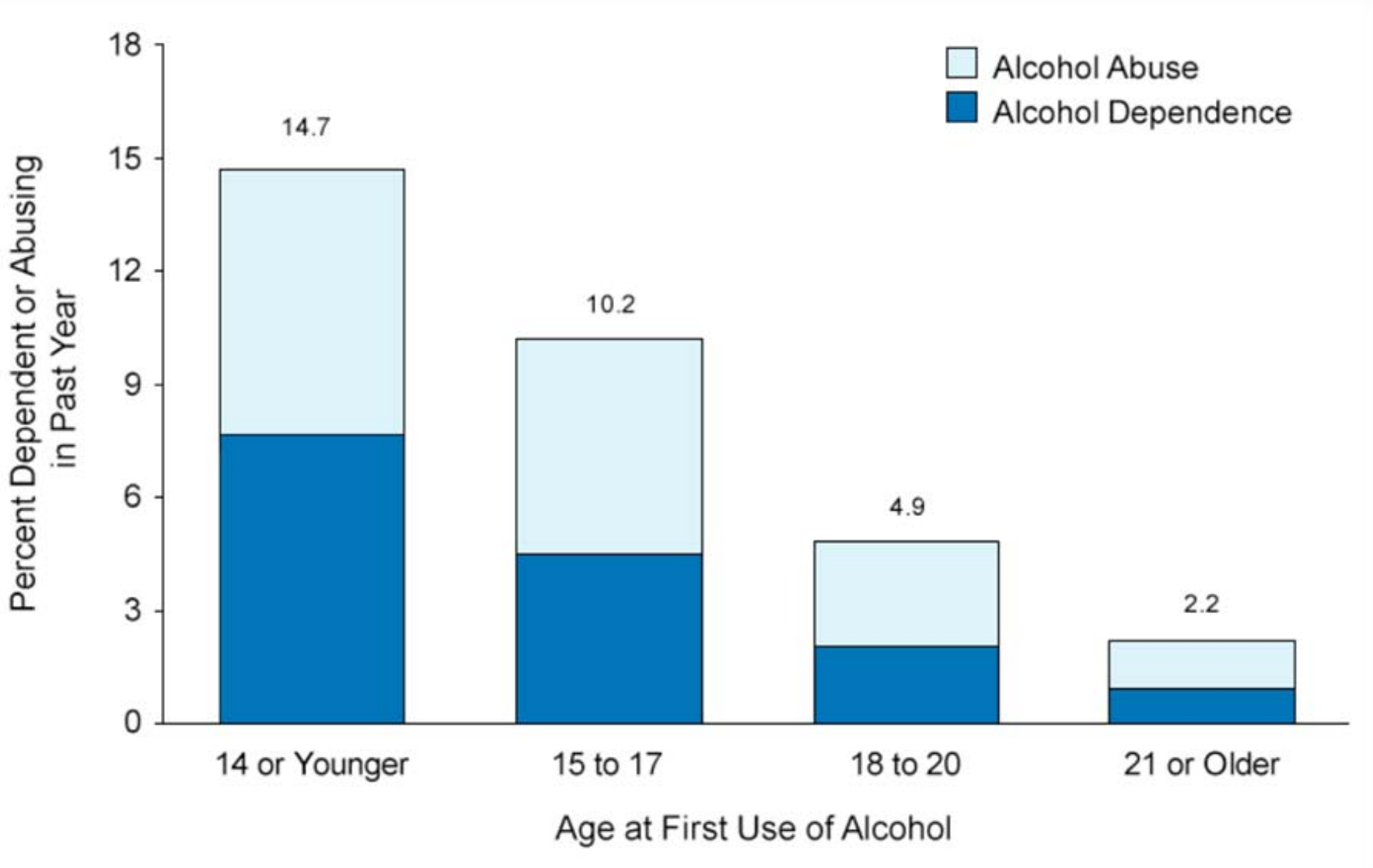
Substance Abuse and Dependence

- Substance dependence or abuse in the past year among persons aged 12 or older: 2002–2007 (SAMHSA, 2008)



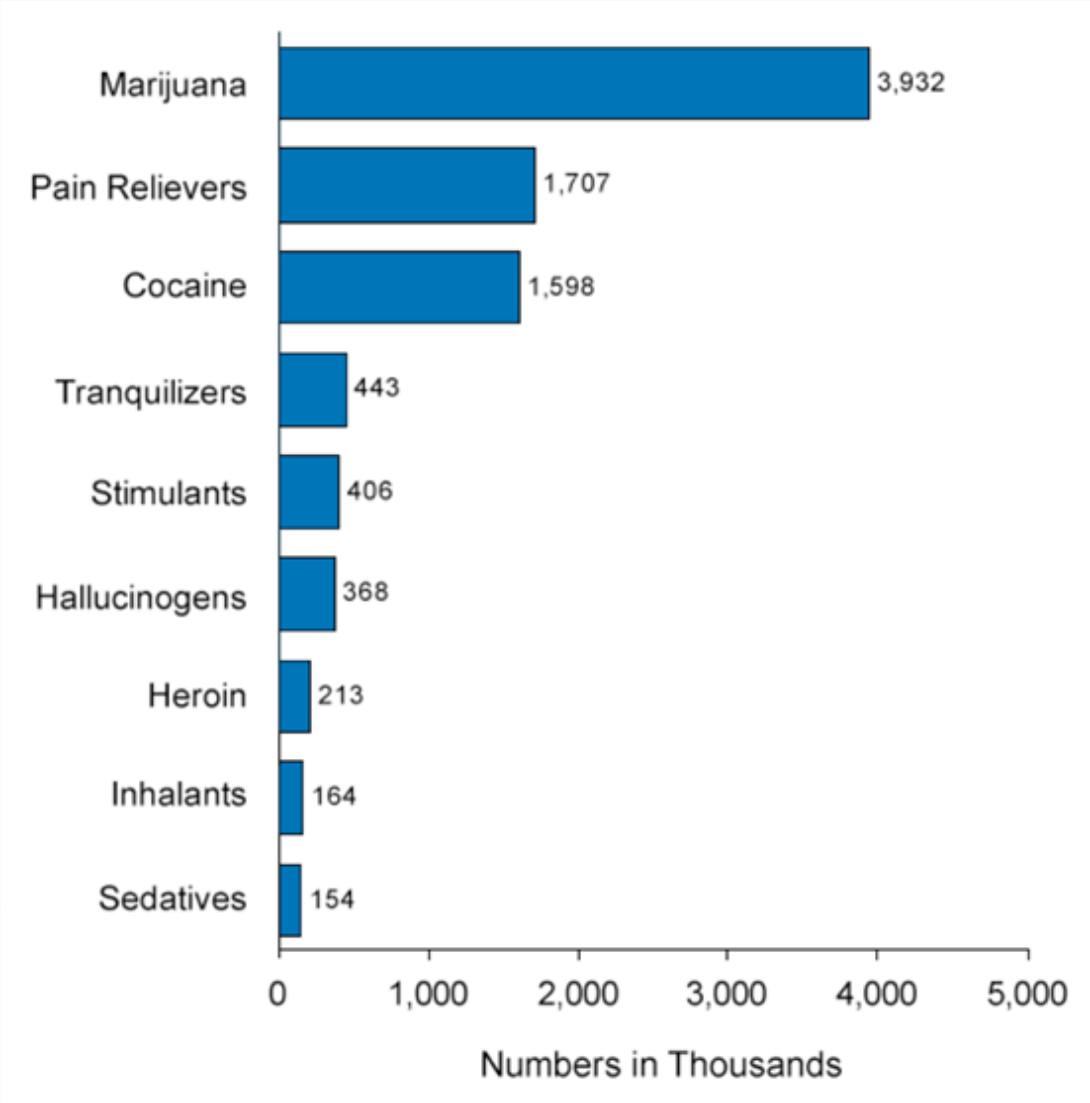
Substance Abuse and Dependence

- Alcohol dependence or abuse in the past year among adults aged 21 or older, by age at first use of alcohol: 2007 (SAMHSA, 2008)



Substance Abuse and Dependence

- Dependence or abuse of specific illicit drugs in the past year among persons aged 12 or older: 2007 (SAMHSA, 2008)



Substance Abuse and Comorbid Psychiatric Disorder

- Rates of alcohol/substance abuse and comorbid psychiatric disorder
  - In individuals with an alcohol disorder, 37% also have a mental disorder
  - In individuals with other substance abuse disorders, 53% have a coexisting mental disorder
  - If addicted to one substance, odds are seven times greater than general population to have another addiction (Regier et al., 1990)

Substance Abuse Treatment

- Medications: antidepressants, mood stabilizers, methadone, bupronorphine, Revia, Antabuse
- Support groups: AA, NA
- Harm reduction approach
  - Reduce harm by providing clean syringes to reduce risk of HIV, hepatitis
  - Overdose prevention—providing intramuscular Narcan and educating adults with addictions on appropriate use with opiate overdose

Legislation Mandate

- The Drug-Free Workplace Act of 1988
  - Requires any organization that receives a federal contract worth $100,000 or more to establish a drug-free workplace policy
  - It also requires all organizations receiving a federal grant of any size to maintain such a policy

Source: SAMHSA. (2004).

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Section C

Public Health Approach to Mental Illness in the Work Setting

Primary Prevention

- Openly recognizing mental illnesses
  - World Mental Health Day (October 10)
  - Sponsoring “Out of the Darkness Walk” to raise awareness and funds for suicide prevention
  - National alcohol screening day (April)
  - National depression or national anxiety screening days (October 8)
  - Offering courses on stress management, anger management, problem solving, communication skills, addictions
  - Offering incentives to join a gym
  - Offering employee assistance program (EAP)

Secondary Prevention—Treatment

- Be aware of symptoms
  - If someone's performance is down, increased absence from work, difficulty concentrating, decreased attention to hygiene, bizarre behavior, exaggerated response to a stressor or change within the organization, referral to EAP or mental health is advised
  - Goal of treatment is to stabilize symptoms and prevent relapse (absence of symptoms for 4–9 months)
  - Can refer to network of providers through insurance carrier, contracted mental health providers, suicide hotline (1-800-273-TALK), drug treatment, FMLA
  - Support workplace accommodations to enhance productivity

Tertiary Prevention

- The maintenance phase of treatment is maintaining the highest level of functioning through medications, therapy, vocational rehabilitation, workplace accommodations, social services, methadone or other substance-maintenance treatment, nutrition, and stress management

Work Accommodations for Depressed

- Reduce distractions in the work area
- Increase natural lighting or provide full-spectrum lighting
- Allow the employee to work from home and provide necessary equipment
- Allow for frequent breaks
- Divide large assignments into smaller tasks and goals
- Restructure job to include only essential functions

Source: ODEP. (2008).

Work Accommodations for Anxiety Disorder

- Recognize that a change in the office environment or of supervisors may be difficult for a person with an anxiety disorder
- Refer to counseling and employee-assistance programs
- Provide a self-paced work load and flexible hours
- Allow employee to work from home during part of the day or week

Source: ODEP. (2008).

Work Accommodations for Substance Abuse

- Allow use of paid or unpaid leave for inpatient medical treatment
- Allow use of paid or unpaid leave or flexible scheduling for counseling or to attend support meetings
- Allow modified daily schedule
- Provide a self-paced workload
- Reassign to a less stressful job

Source: ODEP. (2008).

Conclusion

- Mental illness is likely to be encountered in the occupational health setting as one in four American workers are likely to experience a mental illness during their lifetime

- Research has shown there is benefit to the inherent up-front costs of psychiatric treatment by reducing the duration of symptoms, improving productivity, and reducing the burden to society

- Strategies to improve the mental health of all employees include open discussion of mental health and illness, early detection and referral of suspected mentally ill workers, and employer support of reintegration through accommodations in the workplace

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Section D

Q & A with Jackie Agnew

Q & A with Jackie Agnew

- What are some of the things an employer can do to make a layoff as easy as possible for an employee?

Q & A with Jackie Agnew

- What dilemmas are faced in working with someone with mental illness?

Q & A with Jackie Agnew

- How do you go about finding employee assistance programs?

Q & A with Jackie Agnew

- What are some workplace interventions?

Q & A with Jackie Agnew

- What is World Mental Health Day?