

► **Consumer Health: The Next Generation of Managed Care**

Depression in the Workplace: *Negative Effects, Perspective on Drug Costs and Benefit Solutions*

by Mark Riotto

► **Depression is a relatively common disease that has more impact on employers' health care costs and workplace productivity than many chronic medical conditions.** *This article describes the costs of depression, both direct and indirect, and discusses effective employer strategies for dealing with depression in the workplace.* ◀

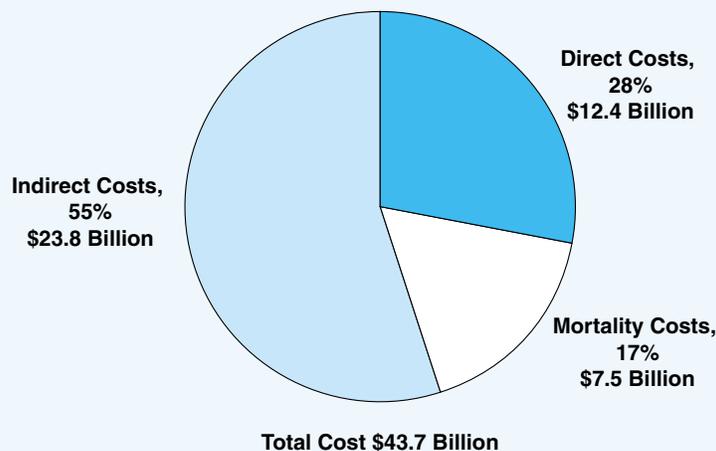
Major depressive disorder is a costly and debilitating disease that can have detrimental effects on quality of life, job productivity and family relationships, as well as pose a substantial risk for mortality. Depression is a relatively common disease, affecting almost 20% of adults in the United States at some point during their lives.[1] According to the National Institute of Mental Health, an estimated 17 million Americans experience serious depression each year. Research shows that at least one in ten men and one in five women will have a major depressive disorder during his or her lifetime.

Despite its high prevalence, depression remains largely misunderstood, underrecognized and dramatically undertreated.[2] Patients with depression utilize significantly more health care services, leading to health care costs that can be twice as much as for those without depression. A 1995 study conducted at the Center for Health Studies, Group Health Cooperative of Puget Sound, Seattle, Washington reported that the mean annual cost per patient with depression (\$4,246) was significantly higher than for patients without depression (\$2,371).[3]

For employers, these findings point to a substantial impact on health care costs and workplace productivity. The negative effects of depression on functioning and well-being are greater than for many common chronic medical conditions.[4] According to a recent study, combined direct and indirect costs of depression in the United States totaled \$43.7 billion in 1990.[5] Since then, the estimated total costs have soared to between \$50 and \$60 billion. Direct costs—those primarily related to the diagnosis and treatment of the condition, including hospitalization, primary care, outpatient care, pharmaceuticals and rehabilitation—account for only about one-fourth of total costs for depression. The rest is attributed to indirect costs, which are those associated with lost productivity, missed workdays, and lost lifetime earnings as a result of suicide. (See the figure.) One study showed annual costs for lost productivity and absenteeism to exceed \$3,000 per employee with depression.[6] Based on six-month prevalence rates for major depression, the cost of depression in the United States in

FIGURE

**Direct and Indirect Costs of Depression
in the United States in 1990**



Source: Greenberg et al., 1993.

terms of lost time in the workforce is estimated to be more than 172 million days each year.[6]

“Moderate depression plays a major role and impact in lowering employee productivity,” says Larry Shoner, M.D., vice president of health services at Lucent Technologies in Murray Hill, New Jersey. “If we’re going to optimize productivity, this is one of the major issues with which we are going to have to deal in corporate America today. People are overwhelmed and highly stressed, not just from greater intensity and expectations at work, but with additional problems at home.”

In fact, depression may be as costly as common physical diseases. In a well-known study, First Chicago Corporation (now Bank One) reported direct costs of about \$927,000 in mental health claims and an estimated \$1.2 million in heart disease claims over a one-year period.[7] Depression accounted for more than half of the medical plan dollars paid for mental health problems. The First Chicago Corporation study reported that depression is associated with more disability days per episode (40 versus 29 days on average) and higher 12-month relapse rates (26%) than

chronic medical diseases such as hypertension (11%) and heart disease (8%). Only diabetes was associated with a relapse rate similar to that for depression.

Sophisticated data collection methods have allowed employers to become savvier in addressing mental health issues. The Employers Health Coalition, a group of 146 employers in the Tampa, Florida area that provides health benefits for 350,000 workers and their dependents, is working with physicians, hospitals and health plans to develop “best practice” treatment guidelines and to improve patient outcomes, according to the coalition’s president and chief executive officer, Frank Brocato. In 1998, the Employers Health Coalition implemented Healthy People/Productive Community, a three-year survey project. The survey, sent to 20,000 employee households in the Tampa Bay area, was designed to measure the impact of the top ten diseases on employee productivity and absenteeism. A total of 6,215 households completed the survey, which pinpointed not only the effect of certain diseases on absenteeism in the workplace but also, more importantly, on-the-job impairment due

TABLE

Negative Impact of Depression

| Measure | Depression Rank (Out of Ten) | Diseases With Greater Negative Impact |
|---|-------------------------------------|--|
| Impact on the individual | 2nd | Heart problems |
| Impact on the community | 1st | None |
| Patient satisfaction with the health care process | 9th | Hepatitis |
| Days lost to impairment (4-week period) | 2nd (5.4 days) | High-risk pregnancy |
| Days lost to productivity (4-week period) | 2nd (6.2 days) | High-risk pregnancy |
| Overall prevalence in the workplace | 3rd (9.1%) | Allergies, hypertension |

Source: Tampa Bay Employers Health Coalition.

to the diseases or the medications prescribed for the diseases. Lost productivity attributed to impairment while on the job was shown to be five to 20 times greater than that due to absenteeism. The results of the survey also showed that depression is one of the most costly diseases. (See the table.)

“We wanted to find out from the patient perspective about these diseases and how they were treated in the delivery system process,” says Brocato. “The information will help providers and payers improve patient care and help employers enhance worker productivity.” Based on the survey results, the Employers Health Coalition will work with providers and health plans to develop action plans to reduce the impact of these diseases and disorders on employee productivity and absenteeism through prevention, education and clinical practice patterns. Participating employers will use individual company data to improve their return-to-work programs and reduce operating costs.

BENEFITS OF TREATMENT

Data from clinical studies indicate the wide range of benefits resulting from the identification and treatment of patients with mental disorders. Although most patients with depression respond to antidepressant therapy, major depression is unrecognized or misdiagnosed in

about 50% to 75% of affected individuals. In addition, about 30% of patients are poorly compliant with treatment, and about 20% do not get their prescriptions filled. Depression recurs in 80% of patients, and chronic depression occurs in 15% to 20% of patients.[8] According to the American Psychiatric Association, about 15% of patients with depression die from depression-related suicide.

The stigma that society continues to attach to mental disorders makes it difficult to identify people with depression. “Historically, there has been a reluctance on the part of people to speak about their [mental health] problems, even if they recognize them themselves,” says Marcia L. Comstock, M.D., principal of Comstock Consulting Group in Wayne, Pennsylvania. “Mental health issues are not as readily discussed as physical health issues.”

Dr. David Satcher, the surgeon general of the United States, stated in a recent report on mental illness that more than one in five adults in the United States have a mental health disorder in any given year and that half of all Americans have such a disorder at some time in their lives. Most of them, however, never seek treatment; the study found that many people with mental disorders do not realize that effective treatments exist, or they fear discrimination because of the stigma attached to mental illnesses.

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“The new Surgeon General’s report is an attempt to say that we need to acknowledge that this is a common problem, it is a problem for which there is good treatment, and we need to make sure that people understand that there are ways to identify the symptoms in themselves and others and help them get treated,” Dr. Comstock points out.

Approximately half of all primary care physicians may intentionally misdiagnose depression for patients who meet diagnostic criteria for the disease because of their uncertainty about the diagnosis or complications with reimbursement for services related to a diagnosis of depression.[9] These practices lead to an improper diagnosis code for 31% of patients. In addition, data that indicate a high rate of somatization associated with physical symptoms also show that depression is often misdiagnosed.[10] This apparent discomfort and unfamiliarity with psychiatric diagnoses in the primary care setting, specifically with depression, may account for the fact that up to 60% of patients with a psychiatric illness have never received professional psychiatric care.[1]

Although several studies have documented the impact of depression in the workplace, programs to assist employees with depression are not as readily available as disease management programs for medical illnesses. When depression is correctly diagnosed and treated, however, the success rate is 85%.

The advent in the past decade of newer antidepressant agents, such as selective serotonin reuptake inhibitors (SSRIs) has focused renewed attention on major depressive disorders. Antidepressant pharmacotherapy has been shown to effectively reduce health care utilization and costs and possibly the rate of suicide attempts.[2] About three dozen antidepressants are currently available in the United States, but the most commonly prescribed are the SSRIs and tricyclic antidepressants (TCAs). Drugs in these two classes have been shown to be effective in the treatment of depression. Both of these classes of drugs alleviate symptoms of depression, and therapy with either an SSRI or TCA can also reduce health care utilization, the rate of absenteeism and the level of impairment at work.[11]

Although therapy with both SSRIs and TCAs is effective in relieving symptoms of depression, SSRIs have several advantages compared with TCAs. SSRIs are associated with significantly fewer adverse effects, offer better tolerability and allow easier administration.[12] SSRIs do not cause the well-known increase in body weight that is associated with TCAs, and the relative absence of sedation compared with TCAs is likely to translate into improved work performance. Studies have shown that antidepressant therapy with an SSRI results in improved management of depression, a greater likelihood of receiving adequate doses, and longer duration of therapy with the original drug compared with TCA-based therapies.[13]

The introduction of SSRIs resulted in a marked shift in the recognition and treatment of depression. An eight-year study at a 390,000-patient health maintenance organization (HMO) in the Northwest reported that the use of antidepressants has tripled since SSRIs were introduced, probably because physicians have become increasingly familiar with the need to accurately diagnose and treat depression.[14] As anticipated, SSRIs, as a new therapeutic class, exhibited the fastest rate of growth in prescriptions, although the number of prescriptions of all classes of antidepressants increased. This rapid increase in the utilization of SSRIs produced a great deal of debate over the cost-effectiveness of these new drugs compared

with older generations of antidepressants such as TCAs, as well as compared with each other. (See sidebar.)

DEPRESSION IN THE WORKPLACE

Employees who feel extremely stressed and depressed have health care expenses nearly 1½ times more than those who report neither of these psychosocial factors, according to a study in which researchers tracked health risk factors and medical expenditures over a multiyear period for 47,500 active employees of six large organizations. These findings are intriguing, considering other reports that even a modest increase in the amount spent on prevention programs targeting psychological disorders could have a significant impact on medical treatment costs.[15]

Due to the fact that depression has such a significant impact in the workplace, and because treatment has far-reaching medical and economic benefits for both the patient and the employer, many companies are starting to recognize the need to improve access to psychiatric services. The Mental Health Parity Act, which went into effect in January 1998, stipulates that annual and lifetime benefits for mental health services must be equal to benefits available for medical and surgical care. Under this law, mental health services are defined by individual insurance plans. While the Mental Health Parity Act represents important legislation, it does not mandate that employers offer mental health benefits. Other limitations are that it contains no conditions on deductibles, copayments, or limits on days or visits. In addition, small employers with 50 or fewer employees are exempt.

Prior to implementation of this law, many employers argued against parity for mental health care services, saying the law would lead to dramatically higher health care costs. In effect, the law contains a clause that exempts employers if compliance causes their health care costs to rise by more than 1%. The law, however, has not produced the cost increases many employers feared, according to the National Alliance for the Mentally Ill. This organization cites data from the National Advisory Mental Health Council that show that full compliance costs less than 1% of annual health care costs

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and that compliance with the act within a managed care environment can produce overall cost savings of up to 50%. Data from the Rand Corporation show that annual costs to comply with the Mental Health Parity Act total about \$1 per employee under managed care. Data from certain states with mental health parity laws demonstrate similar situations with slight increases or even cost savings following implementation of parity laws. Mental health parity laws have also been enacted in 32 states as of November 2000.

Employee benefit managers can play a significant role in limiting the impact of depression in the workplace by contracting for mental health benefits and developing employee assis-

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Mark Riotto has written numerous articles on depression and anxiety disorders for leading medical journals and trade publications. He has also worked as editor of a leading market research magazine serving the pharmaceutical industry and as a reporter for national magazines targeting allied health professionals.

Cost Comparison of Antidepressants

Studies on economic outcomes of antidepressant therapy show an offset effect in favor of the selective serotonin reuptake inhibitors (SSRIs) when compared with older antidepressant classes, namely the tricyclic antidepressants (TCAs). These data show that the higher purchase price of SSRIs is largely offset by reduced utilization of other health care services due to fewer adverse effects, less switching of drugs, decreased need for dosage adjustments and fewer cases of treatment failure compared with TCAs. The end result is lower overall treatment costs for SSRI therapy. One of the earlier studies to compare total treatment cost when using an SSRI or a TCA included more than 700 patients from a large health maintenance organization (HMO).¹ The overall direct treatment cost per patient after one year was more than \$300 lower in the SSRI group than in the TCA group. Other studies have reported similar findings in favor of the newer antidepressants.²

Based on these reports and the widespread use of SSRIs as first-line antidepressants, the focus has now shifted to evaluating cost among the SSRIs. However, head-to-head comparisons of costs for SSRI treatment are limited in number, so assessment of cost centers on factors known to influence treatment cost. Drug purchase price, which is typically reported as average wholesale price, is one of these factors, but it is difficult to compare because contract terms or rebates may affect the final cost. When comparing direct price, Celexa® (citalopram) is the least expensive SSRI approved for the treatment of depression, followed by Paxil® (paroxetine) and Zoloft® (sertraline). Prozac® (fluoxetine), the first SSRI on the market, is the most expensive. The SSRIs have similar prices for all tablet strengths, except for Prozac, which costs more for higher capsule strengths.

Among the other factors that may influence cost of antidepressant therapy is dose titration, which is defined as the need to adjust a patient's dose. Dose titration is critical when analyzing the costs associated with SSRIs because it involves not only drug costs, particularly if more than one tablet or capsule is needed to achieve the effective dose, but also costs for follow-up physician visits and pharmacist dispensing. A large study funded by the Food and Drug Administration analyzed antidepressant use over eight years in more than 18,000 patients enrolled in a large group model HMO and reported that Paxil was the least likely of the SSRIs to require dose titration or multitablet therapy.³ Less than half of patients taking Paxil required adjustment to a higher dose, whereas about three-fourths of those taking Prozac had their dosages increased. According to the study authors, Zoloft was associated with the highest average daily dose and cost.

Another large-scale study demonstrated the effect of dose titration on drug costs in more than 2,300 patients.⁴ Paxil had a significantly lower rate of dose titration compared with other SSRIs. The important observation from this study is that direct drug costs were significantly higher among patients taking Prozac compared with those taking Paxil or Zoloft because Prozac was more frequently prescribed at higher doses that required two or more capsules (the manufacturer of Prozac has since introduced a 40-mg capsule, but this capsule strength costs about the same as two 20-mg capsules). Costs for hospitalizations, physician visits and laboratory tests were statistically similar for the three SSRIs, whereas the more expensive drug costs in patients taking Prozac resulted in higher overall treatment costs compared with those taking Paxil or Zoloft.

Duration of antidepressant therapy is another key contributor to treatment costs for depression. It is well documented that longer treatment reduces the risk of relapse of depression, so current treatment practices are designed to increase the amount of time that patients remain on their antidepressant medication, even if they are feeling better. Many programs are in use to improve patient education and ultimately compliance with the prescribed treatment regimen.

Managed care organizations use these data and their own internal cost models to evaluate which antidepressants represent the best options for formulary placement, a decision that usually places great emphasis on cost and value when multiple products are available. For instance, Paxil fares well for key cost drivers because it is associated with one of the least expensive purchase prices, a low rate of dose titration (which may mean fewer physician visits for dose adjustments),

and a low need for multitablet therapy. According to the market research company Scott-Levin Associates in Newtown, Pennsylvania, Paxil is included on almost all managed care formularies and is the preferred SSRI on about 85% of formularies; the SSRI with the second-highest level of preferred formulary status is Zoloft, at about 65%.

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tance programs (EAPs) for depression. These programs may reduce the economic burden for employers and improve the health of a substantial portion of the workforce.

Employee benefit managers may want to evaluate the effectiveness of their health care providers in diagnosing and treating depression, and a simple understanding of the economics of depression treatment may help in these efforts. Pharmaceutical costs have increased more rapidly than other health care costs for employers, who may then believe that the vendor must be doing something wrong and it is therefore appropriate to take steps necessary to "stop the bleeding." However, in many cases, urgent cost-management approaches are not the most effective way to solve the problem. Employee benefit managers can assist employees and their dependents in receiving proper health care by providing access to the most cost-effective medications. Although the health plan may recommend a pharmacy benefit design, it is the employer's financial responsibility to decide what is most beneficial for its employees.

Because the newer SSRIs are more expensive than the older generation TCAs, employers have specifically targeted SSRIs and other expensive drugs for cost management. Multitiered copayments are now used to allow employers and employees to share medication costs. In the past, most health plans would charge a copayment of \$5 for a 30-day supply of medication, regardless of the cost of the drug to the health plan. Some had a two-tiered plan that required a higher copayment of \$10 for a brand-name drug when a generic equivalent was available. Today, new drugs not on the "standard formulary" can require a copayment of up to \$25. Depending on how a plan classifies SSRIs, they can fall into any of these higher categories. Formulary and copay issues regarding SSRIs are expected to have greater importance later this year when the first generic version of an SSRI reaches the market—A generic version of Prozac is anticipated in August 2001.

Employers contract with pharmacy benefit managers or carve out managed care firms for behavioral health care to manage costs. However, employers often confuse cost with price.

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The price charged as premiums or per-member-per-month fees usually reflects the aggregate claims experience of the members. However, claims are only one manifestation of the financial exposure of purchasers. All expenses related to the disease over time are the true statement of costs, not the prices paid. This is especially true in relation to depression because of its high indirect costs. In reality, reducing medical costs may inadvertently increase expenses when taking into account the effects of disability and reduced productivity, whereas proper treatment of depression will likely improve productivity (as much as 25% in one study), reduce absenteeism, and decrease overall health care utilization and costs.[11, 16]

Given the costs of depressive disorders in general and the potentially high costs of severe forms of depressive disorders in particular, mental health benefit plans (and now managed care mental health programs) must reduce barriers to early intervention and treatment. Benefit plans that contain mental health costs through such changes as high front-end deductibles and arbitrary benefit limits, or through managed care programs that provide coverage for only the most severe forms of a disorder, may generate higher costs in the long run.

Employers can use their influence to help people in need. They can distribute information through a variety of communications me-

dia on the signs and symptoms of depression. They can teach supervisors how to deal with people with depression—not to counsel them, but to provide clear feedback that their performance has weakened and their behavior has changed, hopefully influencing them to seek help. Employers should make EAP services available for little or no out-of-pocket costs to the employee.

STRATEGIES FOR DEALING WITH DEPRESSION IN THE WORKPLACE

After First Chicago Corporation (now Bank One) completed its study of corporate costs for health care for its employees, mental health was found to be the second most expensive treatment category (13.9% of the company's total health care costs). Corporate management realized that it was necessary to promote early intervention for people with depression, but illnesses such as depression and anxiety (which represented 68% of the company's behavioral health incidences and 73% of the behavioral health care absentee days) were not openly discussed in the 1980s. The company initiated an educational campaign, sending out newsletters and brochures to managers and employees, according to Dr. Wayne Burton, corporate medical director of Bank One. Training managers to spot key identifiers of troubled employees was especially important, he notes.

“We tried to reduce the stigma and educate managers so employees would feel comfortable approaching them before they had to take off work and go into the hospital,” he explains. “At the same time, mental health benefits were expanded to be more accessible, with more options like outpatient care and evening programs.”

These progressive policies brought mental health issues out into the open, encouraged employees to consult a professional before they needed hospitalization, and allowed for early intervention and drug therapy. Approximately 3,000 (3%) of Bank One's covered employees become new users of the mental health program each year. Behavioral health costs have declined dramatically as a result of early treatment; by 1996, the mental health share of total health care costs decreased from almost 14% to less than 5%.

“Bank One (First Chicago) began to deal with the issue of depression in the workplace many years ago; they set the precedent,” says Dr. Marcia L. Comstock. “They also developed an integrated database that allowed them to collect and identify information. They could track total treatment costs, lost workdays and short-term disability. They were able to identify the total cost of depression—direct and indirect.”

Dr. Comstock was formerly corporate medical director and assistant vice president of health services at Conrail, whose operations were recently consigned to Norfolk Southern and CSX railroads. Dr. Comstock explains that, in the past, industries such as the railroad focused largely on issues of substance abuse in their perceived responsibilities for worker health and wellness. While at Conrail, Dr. Comstock and her team dealt with mental health issues by trying to identify any behavioral or mental health problem that had an impact on an employee.

“We created a means where we had an integrated field team, a health services team, which was composed of a health service manager, a nurse who was both a case manager and a certified occupational health nurse, a case manager who did strictly medical management, an EAP specialist, and a health promotion specialist.”

If a member of this team identified an employee with a problem, he or she would attempt to determine whether there were other issues such as mental health problems and would then refer the employee to the proper specialist.

“We tried to take a very holistic approach to the health continuum and make sure employees had the resources available to them,” says Dr. Comstock. “We had to do this in a very confidential way, with no risk to the individual. There are ways of trying to protect the privacy of the individual in dealing with an issue for which people are not very likely to come forth. Some employees chose to take advantage of this program, and some didn’t. If there is a screening program in a company for diabetes or high blood pressure, people will come forth and participate. I don’t think that is likely to happen with depression.”

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“At Lucent, we have a very strong employee assistance program within our 22 clinics nationwide, and the physicians and nurses have their ears tuned to all illnesses. When we’re doing a disability management case interview with a patient, if any clues surface concerning appetite, mood or sleep irregularities, we have the nurses or physicians discuss the case with the EAP representative.”

Although controlling health care expenditures at Lucent Technologies is a big issue, Dr. Shoner emphasizes the need for striking a balance. “If you try to limit healthcare expenditures too much, you may be limiting direct costs, but your indirect costs will rise. For example, if we decrease access to the providers, we end up losing more on the productivity side. The goal we’re trying to reach, and it is very vague and intangible, is appropriate health care.”

“Although our vendors for medications have a number of programs that carefully monitor patients, our approach is to try to educate our employees to be able to speak with the providers and understand what their options are, and have them involved in the process of picking the appropriate option. I believe that if we can educate employees as to what is good and appropriate care, and provide resources to help them find out that information, they can rely on our clinics.”

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One of the pilot programs at Lucent Technologies is the Mayo Nurse Care Line, which employees can call in an effort to address what is appropriate treatment in a particular situation. “If they understand that a surgical procedure involves risks, is expensive, and they know the advantages and disadvantages of the outcome, they’re going to be better able to make the appropriate decision and will be happier because of their involvement. I don’t believe you can have all these cutout templates that say ‘this is what you do with situation X, Y, or Z.’ There are so many variables in the human being, and I think each case needs individual attention. The person best able to handle that is the employee himself, as a patient,” says Dr. Shoner.

In addition, Lucent Technologies has partnered with a pharmacy benefit management company that keeps corporate officials well informed of drug prices and works on appropriate ways to manage drug costs. “When it comes to costs for drugs to treat depression, I would say that pharmacies stick tightly to guidelines. I think that, overall, we’re undertreating depression. The SSRIs are among our most prescribed drugs. They are certainly near the top of our health care medication costs. I’ve been in discussions about whether we’re paying too much, and I counter that we’re paying too little,” Dr. Shoner states.

Dr. Shoner says health care plans have not been reluctant to provide SSRIs, despite their higher cost. “I think there are advantages of SSRIs over tricyclics. Although SSRIs are more expensive, I think compliance with them is better, though response to them may be similar. My experience with the SSRIs shows that people tolerate them much better, and they don’t need to make as many return visits to the doctor. I don’t prescribe tricyclics anymore, with very few exceptions. In my estimation, the SSRIs are the first-line drugs for depression.”

Realizing the importance of a communications media program to acquaint workers with the signs and symptoms of depression, health care officials at Lucent Technologies are working with the company’s mental health provider to set up some programs on a national basis.

“We have had several of our clinics conduct depression-screening programs featuring qualified speakers, and e-mails are sent to employees to bring their attention to them. We purchase two products from the Mayo Clinic—their *Mayo HealthQuest* newsletter, as well as Mayo-Online, which is cobranded with Lucent. Both of these have a self-assessment quiz about depression, and some hints on what to do about it, as well as articles in our newsletter. Both refer to our national vendor for mental health as well as our EAPs.”

Supervisory training programs are important in spotting problems of depression. Dr. Shoner says the company conducts some supervisory training programs that address depression. “We’re expanding our communications programs in a number of areas in terms of our health promotion. We have a special EAP booklet that we give to our new supervisors; it gives them special advice on identifying symptoms and when to contact EAPs.”

Hughes Electronics, in El Segundo, California, employs 17,000 people worldwide and is addressing depression-related issues in its workforce. Dr. Pam Hymel, director of Medical Services and Benefits, points out that depression is the number one cause of lost workdays at the company. “It is a big deal,” she says. “Depression is not necessarily the most expensive medical disability with which we deal, but it is the one that causes the most lost days from work.”

Hughes uses several strategies to deal with depression. At its larger sites in southern California, the company has internal EAP programs staffed with a number of EAP counselors who are available to work with both employees and management on any kind of issue. Individual counseling, as well as business group or operations unit intervention, is available.

“We have EAP counselors on-site who conduct training, in addition to our organizational effectiveness people who present programs on management and business process training,” says Dr. Hymel. “Much of what goes on, especially depression that stems simply from a poor work environment, can be traced to employee-supervisory interaction.”

A disability management program is an important strategy used at Hughes Electronics. If an employee is absent from work for more than seven calendar days, they must call the disability management department to be eligible for benefits. “Our disability managers make sure that when someone is out due to a diagnosis of depression, they’re getting appropriate treatment and have been referred to our mental health center,” Dr. Hymel explains. “We are contracted with a national professional organization and have an insured mental health program sponsored by the Mental Health Network. An employee can call the Mental Health Network directly if they feel they need counseling because of depression, or they can be referred through our EAP. If their personal physician orders them to take a few days off from work because they are suffering from depression, our disability managers catch the fact that this person may need counseling. They work to get them referred to the appropriate health care professional so they are put into the health care system as quickly as possible to get treatment.”

“Our objective is to get people treated and back to work,” says Dr. Hymel. “The bottom line is that this is the most cost-effective way of dealing with this kind of disability.”

This is the first year that Hughes Electronics has used a pharmacy management program to monitor drug costs for the treatment of depression. “For people on our PPO plan, we have a pharmacy management program; employees pay 20% of the price of a medication, and we pick up the rest, with a cap of \$50 per

“Employers should hold health plans and behavioral health managed care companies accountable for the outcomes produced in treating people with depression.”

prescription. Thus, we now have a program through which we can begin to track which drugs are being prescribed and the prices we’re paying. We have not tried to restrict the usage of medications.”

Depressive disorders are clearly a major occupational health issue that should be addressed. Corporations must recognize that depressive disorders are most likely the single highest mental health and disability cost. However, these costs can be managed effectively by integrated response measures that contain elements of rational benefit design, managerial training and provision for early appropriate intervention.

Employers should hold health plans and behavioral health managed care companies accountable for the outcomes produced in treating people with depression. Employers deserve to have this information in return for the premiums paid. However, it is widely acknowledged that Health Employer Data and Information Set information is insufficient and misleading in terms of evaluating outcomes of depression interventions. The Foundation for Accountability has produced a measurement set for major depressive disorder that has been well received by researchers and consumers, but this set is not as widely recognized as the Health Employer Data and Information Set.

Major depressive disorder is a costly and debilitating disease that can have detrimental effects on quality of life and job productivity. An important part of dealing with this problem in the workplace is for employers to understand the seriousness of depression and appreciate its devastating effects on the individual as well as the toll it takes on productivity. The challenge is to ensure early recognition of symptoms and access to appropriate interventions, including EAPs, to reduce the burden of depression and bring those affected back into a productive workplace situation as rapidly as possible. ◀

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