

Mental Health

in the workplace

situation analysis

United States



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INTRODUCTION

Population:
272.6 million
GDP per capita:
\$31,500 (est. 1998)
Unemployment:
4.5% (est. 1998)

Mental health problems are among the most important contributors to the global burden of disease and disability.

The ILO's activities promote the inclusion of persons with physical, psychiatric and intellectual disabilities into mainstream training and employment structures.

Mental health problems are among the most important contributors to the global burden of disease and disability. Of the ten leading causes of disability worldwide, five are psychiatric conditions: unipolar depression, alcohol use, bipolar affective disorder (manic depression), schizophrenia and obsessive-compulsive disorder.¹

The burden of mental disorders on health and productivity throughout the world has long been profoundly underestimated.² The impact of mental health problems in the workplace has serious consequences not only for the individuals whose lives are influenced either directly or indirectly, but also for enterprise productivity. Mental health problems strongly influence employee performance, rates of illnesses, absenteeism, accidents, and staff turnover.

The workplace is an appropriate environment in which to educate and raise individuals' awareness about mental health problems. For example, encouragement to promote good mental health practices, provide tools for recognition and early identification of the symptoms of problems, and establish links with local mental health services for referral and treatment can be offered. The need to demystify the topic and lift the taboos about the presence of mental health problems in the workplace while educating the working population regarding early recognition and treatment will benefit employers in terms of higher productivity and reduction in direct and in-direct costs. However, it must be recognised that some mental health problems need specific clinical care and monitoring, as well as special considerations for the integration or re-integration of the individual into the workforce.

Why should the ILO be involved?

Mental illness constitutes one of the world's most critical and social health problems. It affects more human lives and wastes more human resources than any other disabling condition.³ The ILO's activities promote the inclusion of persons with physical, psychiatric and intellectual disabilities into mainstream training and employment structures.

The ILO's primary goals regarding disability are to prepare and empower people with disabilities to pursue their employment goals and facilitate access to work and job opportunities in open labour markets, while sensitising policy makers, trade unions and employers to these issues. The ILO's mandate on disability issues is specified in the ILO Convention 159 (1983) on vocational rehabilitation and employment. No. 159 defines a disabled person as an individual whose prospects of securing, retaining, and advancing in suitable employment are substantially reduced as a result of a duly recognised physical or *mental impairment*. The Convention established the principle of equal treatment and employment for workers with disabilities.

Most recently, the ILO has recognised the need to promote increased investment in human resource development, which can help support employment productivity and growth. This focus pays particular attention to the human resource needs of vulnerable groups, which include individu-

als with mental health problems. As pointed out, employee mental health problems and their impact on an enterprise's productivity and disability costs are a critical human resource issue. Increasingly, employers, employers' organisations and international organisational bodies are recognising that the economic and social costs of mental health problems in the workplace cannot be ignored.

*In the ILO study, **Mental health in the workplace, situation analyses of Finland, Germany, Poland, the UK and the USA provide in-depth assessments of the impact of mental health concerns in the workplace to determine the scope of the problem in the open labour market.***

The purpose of the research

With a grant from the **Eli Lilly and Company Foundation**, the ILO conducted in-depth situation analyses in five countries. The five countries selected were Finland, Germany, Poland, UK, and USA. The primary purpose of these situation analyses was to conduct an in-depth assessment of the impact of mental health problems in the workplace in order to determine the scope of the problem in competitive employment. Related to this purpose was also the assessment of the specific ramifications of the impact of mental health problem for employees and enterprises such as workplace productivity, loss of income, health-care and social security costs, access to mental health services and good practices by employers.

An essential objective of these situation analyses is that the information collected and assessed may be used to create further educational materials and assist in designing programmes which can be used by governmental agencies, unions, and employers' organisations for mental health promotion, prevention, and rehabilitation.

The situation analyses were based primarily on a thorough literature review, including documents from government agencies, NGOs, employer and employee organisations, as well as interviews with key informants.

The case of the United States

Clinical depression is one of the most common illnesses affecting working adults. In the United States, major depression is a leading cause of disability. Yearly, in the US, approximately one in ten adults experiences a depressive disorder. Depression is a workplace health issue that significantly impacts the bottom line. Depression-related illnesses predominate in prevalence and cost over other traditional occupational health issues, such as substance disorders. It is estimated that depression costs the nation between \$30 and \$44 billion, with approximately \$200 million lost work days each year. Employers assume much of this financial burden both in direct treatment costs and through absenteeism, reduced productivity, and more frequent work-related accidents.

The following situational analysis examines the scope and impact of depression in the US workplace as well as the role of all social partners in addressing this issue. It was not the purpose of this situational analysis to provide an exhaustive description and assessment of every agency, organization, or institution involved in the above activities. Selected key agencies, groups, and institutions were highlighted with illustrations of how important it is for all the social partners to work together in order to be more effective. Although, the situational analysis is primarily concerned with the depressive disorders, these are often viewed within the context of overall mental health issues. This is due, in part, to the nature of the information which does not always distinguish between depression and overall mental health problems.

Clinical depression is one of the most common illnesses affecting working adults. In the United States, major depression is a leading cause of disability.

The situational analysis examines three major areas: Mental health at the national level; The role of government and the social partners; and Managing mental health in the workplace.

MENTAL HEALTH AT THE NATIONAL LEVEL examines the evolution of the disabilities rights movement; workplace myths and misunderstandings concerning mental illness; unemployment and disability; policy and legislative framework, and the economic burden of depression for the nation and the employer.

THE ROLE OF THE GOVERNMENT AND THE SOCIAL PARTNERS examines the implementation of law and policy by government agencies; the role of workers', employers' and non-governmental organizations, and selected noted academic institutions in the area of employment and psychiatric disabilities.

MANAGING MENTAL HEALTH IN THE WORKPLACE addresses work-family issues and their impact on productivity; and employee education regarding mental health promotion and mental illness prevention; and it provides illustrations of corporate experiences and innovations.

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GLOSSARY

The definitions and terms related to mental health are evolving and still subject to much debate. Terms are often used interchangeably, which can be confusing as well as inaccurate. It is therefore useful to attempt to define the vocabulary of mental health and to make distinctions. Specific countries use different terminology to refer to the same issue. In the five situation analyses of mental health in the workplace, the reports have remained faithful to the terminology used by the mental health community in each country. This glossary therefore includes definitions of these nation-specific terms. The following definitions and terminology are based on current usage by such organizations as the WHO and ILO, participating countries in the situational analyses, and the European Union.

This glossary is conceptually oriented and will give the reader the familiarity with the vocabulary of mental health, which is necessary to fully understand the situation analyses.

MENTAL HEALTH: Though many elements of mental health may be identifiable, the term is not easy to define. The meaning of being mentally healthy is subject to many interpretations rooted in value judgements, which may vary across cultures. Mental health should not be seen as the absence of illness, but more to do with a form of subjective well-being, when individuals feel that they are coping, fairly in control of their lives, able to face challenges, and take on responsibility. Mental health is a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity specific to the individual's culture.¹

MENTAL HEALTH PROBLEMS: The vast majority of mental health problems are relatively mild, though distressing to the person at the time, and if recognized can be alleviated by support and perhaps some professional help. Work and home life need not be too adversely affected if the appropriate help is obtained.² In the situation analyses, the terms mental health problems and mental health difficulties are used interchangeably.

MENTAL ILLNESS: Mental illness refers collectively to all diagnosable mental health problems which become "clinical," that is where a degree of professional intervention and treatment is required. Generally, the term refers to more serious problems, rather than, for example, a mild episode of depression or anxiety requiring temporary help.

The major psychotic illnesses, such as endogenous depression, schizophrenia, and manic depressive psychosis, would fall in this category and would be seen less often in the workplace.³ Mental illness is sometimes referred to as *psychiatric disability*.⁴ This term is used primarily in the United States.

MENTAL DISORDERS: Mental disorders are health conditions characterized by alterations in thinking, mood or behaviour (or some combination thereof) associated with distress and/or impaired functioning. Mental disorders are associated with increased mortality rates. The risk of death among individuals with a mental disorder is several times higher than in the population as a whole.⁵

DEPRESSION: Depression is an example of a mental disorder largely marked by alterations in mood as well as loss of interest in activities previously enjoyed. It affects more women than men, by a ratio of about 2 to 1. It is projected that up to 340 million people will suffer from depression in the near future. The risk of suicide is high amongst those suffering from depression. Yearly, over 800,000 deaths attributable to suicide are recorded worldwide: The majority of suicides are due to depression.⁶

There is a great deal of information about the different types, causes and treatments of depression. However, it is important to realize that depression is not simple. There are different types and different degrees of each type. There is a high degree of variation among people with depression in terms of symptoms, course of illness, and response to treatment, all indicating the complexity and interacting causes of this illness. The most common form of depression is chronic unipolar depression (clinical depression). This category of depression has been frequently discussed and written about in the popular media in recent years, primarily due to new modalities of treatment.

Other types of depression recognized at this time are:

- Acute Situational Depression
- Dysthymia
- Bipolar Depression (manic depressive disorder)
- Seasonal Affective Disorder (SAD)
- Post Partum Depression
- Depression secondary to other diseases or drugs.

MENTAL HEALTH PROMOTION: Mental health promotion is a multidimensional concept that implies the creation of individual, social, and environmental conditions, which enable optimal overall psychological development. It is especially focussed, among other concerns, on personal autonomy, adaptability, and ability to cope with stressors, self-confidence, social skills, social responsibility, and tolerance. Prevention of mental disorders could be one of its outcomes.⁷

MENTAL HEALTH PREVENTION: Prevention is based on specific knowledge about causal relationships between an illness and risk factors. Prevention results in measurable outcomes. Within the context of the workplace, prevention is concerned with taking action to reduce or eliminate stressors. *Prevention* and *promotion* are overlapping and related activities. Promotion can be simultaneously preventative and vice versa.⁸

POST TRAUMATIC STRESS DISORDER: PTSD or post-traumatic stress disorder can occur as an acute disorder soon after a trauma or have a delayed onset in which symptoms occur more than 6 months after the trauma. It can occur at any age and can follow a natural disaster such as flood or fire or a man-made disaster such as war, imprisonment, assault, or rape.

REHABILITATION: A process aimed at enabling persons with disabilities to regain and maintain their optimal physical, sensory, intellectual, psychiatric, and/ or social functional levels, by providing them with tools to change their lives towards a higher level of independence. Rehabilitation may include measures to provide and/ or restore functions or compensate for the loss or absence of a function or for a functional limitation. The rehabilitation process does not involve initial medical care. It includes a wide range of measures and activities from more basic and general rehabilitation to goal-oriented activities, for instance vocational rehabilitation.⁹

STRESS: Stress is defined as a nonspecific response of the body to any demand made upon it which results in symptoms such as rise in the blood pressure, release of hormones, quickness of breathe, tightening of muscles, perspiration, and increased cardiac activity. Stress is not necessarily negative. Some stress keeps us motivated and alert, while to little stress can create problems. However, too much stress can trigger problems with mental and physical health, particularly over a prolonged period of time.¹⁰

JOB STRESS: Job stress can be defined as the harmful physical and emotional response that occurs when the requirements of the job do not match the capabilities, resources, or needs of the worker. Job stress can lead to poor health and even injury. Long - term exposure to job stress has been linked to an increased risk of musculoskeletal disorders, *depression*, and *job burnout*, and may contribute to a range of debilitating diseases, ranging from cardiovascular disease to cancer. Stressful working conditions also may interfere with an employee's ability to work safely, contributing to work injuries and illnesses. In

the workplace of the 1990s, the most highly ranked and frequently reported organisational stressors are potential job loss, technological innovation, change, and ineffective top management. At the work unit level, work overload, poor supervision, and inadequate training are the top-ranking *stressors*.¹¹

The following are specific examples that may lead to *job stress*:¹²

The design of tasks. Heavy workload, infrequent rests breaks, long work hours and shiftwork; hectic and routine tasks that have little inherent meaning, do not utilize workers' skills and provide little sense of control.

Management style. Lack of participation by workers in decision-making, poor communication in the organization, lack of family-friendly policies.

Interpersonal relationships. Poor social environment and lack of support or help from coworkers and supervisors.

Work roles. Conflicting to uncertain job expectations, too much responsibility, too many "hats to wear."

Career concerns. Job insecurity and lack of opportunity for growth, advancement or promotion; rapid changes for which workers are unprepared.

Environmental conditions. Unpleasant or dangerous physical conditions such as crowding, noise, air pollution, or ergonomic problems.

BURNOUT: This term is used most frequently in Finland to refer to job stressors and the resulting mental health problems that may occur. It is defined as a three-dimensional syndrome, characterized by energy depletion (exhaustion), increased mental distance from one's job (cynicism) and reduced professional efficacy.¹³

MENTAL STRAIN: This term is used in the German situational analysis to refer to psychological stress that impacts everybody in all realms of life.

WORK ABILITY: Individuals' work ability is based on their, physical, psychological and social capacity and professional competence, the work itself, the work environment, and the work organization. This term is often used in Finland in the world of work.

JOB INSECURITY: Job insecurity can be defined as perceived powerlessness to maintain desired continuity in a threatened job situation or as a concern about the future of one's job.¹⁴

STIGMA: Stigma can be defined as a mark of shame, disgrace, or disapproval, which results in an individual being shunned or rejected by others. The stigma associated with all forms of mental illness is strong but generally increases the more an individual's behavior differs from that of the 'norm.'¹⁵

INTELLECTUAL DISABILITY: This disability is defined by a person's capacity to learn and by what they can or cannot do for themselves. People with this disability are identified by low scores on intelligence tests and sometimes by their poor social competence.¹⁶ The term mental retardation is also used to refer to a person with an intellectual disability and is the most common term used in the situation analyses.

DISABILITY MANAGEMENT: The process of effectively dealing with employees who become disabled is referred to as "disability management." Disability management means using services, people, and materials to (i) minimize the impact and cost of disability to the employer and the employee and (ii) encourage return to work of an employee with disabilities.¹⁷ It should be noted that the term "disability management" is not commonly used, despite the fact that practices understood to be within the scope of disability management processes are now taking place within enterprises of all sizes worldwide.¹⁸

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Part 1

Mental health at the national level

The evolution of the disability rights movement¹

Historically, the disability rights movement has consisted primarily of people with physical disabilities. Traditionally, people with psychiatric disorders stood apart from the larger disability rights community. Because of the disability rights movement's profound current impact on public policy and social awareness of all disabilities, mental health advocacy must be examined in the context of its evolution.

The disability rights movement in the U.S. developed slowly over the twentieth century. While some groups organized around a shared occupation related illness (e.g. miners with black lung disease), specific disability (e.g. The National Federation of the Blind) or other common ties (e.g. war veterans), the social isolation of many individuals with disabilities and their frequently low socioeconomic status hindered them from organizing.

Social changes which began in the 1960s inspired the vigorous growth of the disability rights movement. The movement embraced the values of equal opportunity and social integration advocated by people of color and women and appropriated the political activism of the civil rights, women's, and consumer movements. The concepts of self-determination and freedom of choice nurtured the idea of independent living. This model of coping with disability, in contrast to the medical dependence paradigm, provided a new framework for living with long-term disabilities.

Changes in the populations of people with disabilities in the U.S. also fostered the disability rights movement. Many adolescents and young adults joined the ranks of people with disabilities after the polio epidemic in the early 1950s and the Vietnam war in the 1960s and 1970s. More recently, an aging population and the relative increase in chronic medical illness have added to the number of people with disabilities. Medical and technological advances have lengthened life span and resulted in the survival of people with previously fatal diseases or congenital conditions. Discrimination, as opposed to physical impairment or personal attitude, has become an increasingly important issue in the lives of people with disabilities.

The recognition of discrimination as a key problem for people with disabilities fostered a sense of common identity which, in turn, furthered work in the public policy arena. Advocates documented discrimination and developed an arsenal of information which fueled their advocacy efforts. (See *Figure 1, page 2*)² The growing coalitions of people with psychiatric disabilities and their families share features with the broader disability rights movement, including social influences, an evolving sense of shared identity, and increasing involvement in public policy. Medical advances, such as deinstitutionalization and improved pharmacological treatment, have contributed to social and public policy trends. The civil rights and consumer movements of the 1960s and 1970s motivated some individuals with psychiatric disabilities, just as they motivated the larger disability rights movement, culminating in the passage of the Americans with Disabilities Act (ADA) in 1990. Beginning in the early 1970s, small groups of former patients fought against institutionalization and mental hospital

Mental health awareness must be viewed in the context of the disability rights movement.

Federal Laws Prohibiting Job Discrimination

Federal Equal Employment Laws

- Title VII of the Civil Rights Act of 1964 (Title VII), which prohibits employment discrimination based on race, color, religion, sex, or national origin;
- the Equal Pay Act of 1963 (EPA), which protects men and women who perform substantially equal work in the same establishment from sex-based wage discrimination;
- the Age Discrimination in Employment Act of 1967 (ADEA), which protects individuals who are 40 years of age or older;
- Title I of the Americans with Disabilities Act of 1990 (ADA), which prohibits employment discrimination against qualified individuals with disabilities in the private sector, and in state and local governments;
- Section 501 of the Rehabilitation Act of 1973, which prohibits discrimination against qualified individuals with disabilities who work in the federal government; and
- the Civil Rights Act of 1991, which provides monetary damages in cases of intentional employment discrimination.

Figure 1. Source: *The U.S. Equal Employment Opportunity Commission, www.EEOC.gov/facts*

abuses, as well as the perceptions of mental illness held by mental health professionals and the public.

While stigma and discrimination affect the lives of all people with disabilities, people with psychiatric disabilities suffer from some of the harshest manifestations. Fortunately, attitudes have changed significantly during the last decade, particularly towards those with less severe forms of mental illness such as the depressive disorders.

Common knowledge: Individuals' access to basic information

Major campaign organizations are increasing the public's awareness of mental illness.

The 1990s have seen a substantial increase in awareness, attention, and targeted action regarding mental illness and, specifically, depression. Many employers have increased their awareness of the significant presence in the workplace of valued employees who experience mental disorders, of the treatability of many of these disorders when properly identified, and of the impact these disorders have on the workplace and the employee. This has, in turn, led to the introduction of innovative approaches to managing mental health problems in the workplace. There has been particular emphasis on improving the management of depression, the most common mental disorder in the workplace.³

The national increase in attention and access to information is due in large part to specific organizations and campaigns. Although their goals and activities vary, they all assert the importance for people with psychiatric disabilities of employment or some meaningful activity. The following is a list of the most prominent organizations promoting awareness of depression and workplace integration. A description of these organizations and their activities is in the text of this document.

- **The Campaign on Clinical Depression**
- **National Mental Health Association**
- **DEPRESSION/Awareness, Recognition and Treatment Program (D/ART)**
- **The National Institute of Mental Health**
- **National Depressive and Manic Depressive Association**
- **National Alliance for the Mentally Ill**
- **National Mental Illness Screening Project**

A recent survey conducted by the National Mental Health Association (NMHA), one of the U.S.'s leading mental health advocacy organizations,

found that the public's understanding and awareness of depression and other mental disorders as a serious public health issue had increased substantially over the last ten years.⁴ According to the NMHA poll:

- Nine out of ten Americans say that health insurance companies should provide coverage for mental illness which is more than or equal to coverage provided for physical illness or injury.
- Nearly all those surveyed believe that it is important for people like themselves to be ready to deal with mental illness in their families.
- One in four surveyed have an immediate family member who is suffering from a mental illness diagnosed by a physician.
- 49% say their community mental health services are fair, poor, or very poor. People with mental illness in their family gave services a lower rating.

The NMHA survey results also revealed that many Americans still believe some of the myths surrounding mental illness and are uninformed regarding employment mental health benefits. For example:⁵

- 57% disagree with the fact that mental illness can be diagnosed as accurately as physical illness.
- 45% of those who do not currently have a family member with mental illness believe the myth that depression is a normal part of life that can be worked through without medication.
- In terms of employment and mental health services, 57% did not know that most companies offer workers mental health benefits as part of their health insurance programs.

Workplace myths and misunderstandings concerning mental illness

Many individuals who have had a mental illness such as depression report that coping with the stigma of mental illness is often worse than dealing with the illness itself. Depression is considered the most common serious brain disease in the U.S., and although education and the dissemination of accurate information for diagnosis and treatment are more widespread than in previous decades, it is still misunderstood as a moral weakness or stigmatized as a form of insanity.⁶

Stigmatization is a major factor that affects the success of vocational efforts.⁷ Central to this problem is the belief that the impact of mental illness limits the employment prospects of people with psychiatric disabilities. Less than two decades ago, employment was not considered an option for people diagnosed with mental illness; they were frequently informed by mental health professionals that they would never work again. People generally believed that psychiatric symptomatology was incompatible with employment. Today, there is a growing professional consensus that this is inaccurate, especially in the case of depression. The belief, however, is still common and affects not only employers but also the individuals with depressive disorders.

Many people are concerned about using their employee health benefits to obtain treatment for mental illness out of fear that their bosses and colleagues will learn about the problem and use it against them. It has been reported that many professional workers who either resign a job or take a

Coping with stigma is a major issue for people with mental illness.

medical leave of absence related to a mental illness episode (i.e. depression) experience difficulty maintaining a working, stigma-free relationship with their employer. Those returning to the same work environment find that performance and behavioral difficulties which initially interrupted work have altered employer perception of their professional abilities. Furthermore, the stigma of having this type of condition can be as overwhelming to the employee as it is to the employer.⁸

The following are major myths and facts regarding the impact of mental illness on the workplace:⁹

- **Myth 1:** Mental illness is the same as mental retardation.

Facts: The two are distinct disorders. A diagnosis of mental retardation is chiefly characterized by limitation in intellectual functioning as well as difficulties with certain daily living skills. In contrast, among persons with psychiatric disabilities, intellectual functioning varies as it does across the general population.

- **Myth 2:** Recovery from mental illness is not possible.

Facts: Long-term studies have shown that the majority of people with mental illnesses show genuine improvement over time and lead stable, productive lives. For many decades mental illness was thought to be permanent and untreatable. People with mental illness were separated from the rest of society through institutionalization in mental hospitals. As medications were discovered which helped to alleviate the symptoms of mental illness, there was a gradual evolution toward the provision of treatment and rehabilitation services in the community.

- **Myth 3:** Mentally ill and mentally restored employees (the term denotes when the disorder is effectively treated) tend to be second-rate workers.

Facts: Employers who have hired these individuals report that they are higher than average in attendance and punctuality and as good or better than other employees in motivation, quality of work, and job tenure. Studies reported by NIMH and the the National Alliance for the Mentally Ill (NAMI) conclude that there were no differences in productivity when compared to other employees.¹⁰

- **Myth 4:** People with psychiatric disabilities cannot tolerate stress on the job.

Facts: This oversimplifies the complex human response to stress. People with a variety of medical conditions, such as cardiovascular disease, multiple sclerosis, and psychiatric disorders, may find their symptoms exacerbated by high levels of stress. However, the source of personal and job-related stress varies substantially between individuals. Some people find an unstructured schedule to be very stressful while others struggle with a regimented work flow. Some people thrive on public visibility or high levels of social contact, while others require minimal interaction in order to focus and complete tasks. Workers with psychiatric disabilities vary in their response to stressors on the job. In essence, all jobs are stressful to some extent. Productivity is maximized when there is a good match between the employee's needs and working conditions, whether or not the individual has a psychiatric disability.

- **Myth 5:** Mentally ill and mentally restored individuals are unpredictable, violent, and dangerous.

Facts: The vast majority of these individuals are not dangerous or violent. Upon learning that an applicant has a mental illness, some employers may expect that the individual is likely to become violent. This myth is reinforced by portrayals in the media of people with mental illnesses as frequently and randomly violent. A scholarly review of the research liter-

The facts dispute major myths about mental illness in the workplace.

ature by Cornell University indicates that “none of the data give any support to the sensationalized caricature of the mentally disordered served up in the media.”

Although stigma and shame are still the dominant attitudes towards mental health and mental illness, there has been a dramatic shift in perception during the last ten years. Advancements and improvements in the legal system have had a positive impact on attitudes and knowledge relating to all disabilities and to mental illness in particular. This has, in turn, created a greater openness towards all mental health issues. Additional contributing factors include public and professional awareness that prolonged hospital stays can be disabling; advances in pharmacology; and a shift in focus from pathology to strengths and abilities. More importantly, a variety of service models have been developed and implemented over the past decade which are successful in helping people with a depressive illness and other mental illnesses secure and maintain employment.¹¹

Work, unemployment, disability and promotion of mental health

A review of studies on the mental and physical health effects of unemployment and the mechanisms by which unemployment causes adverse health outcome reveals a complex relationship.¹² There has been a serious debate about the direction of causality. Does unemployment cause a deterioration in health, both mental and physical? Are the sick more likely to become unemployed?

Cross-sectional and longitudinal studies have consistently found poorer psychological health in unemployed compared with employed people, for example:

- A U.S. prospective study clearly showed that men aged 35 to 60 years who became unemployed had higher levels of depression and anxiety than those who were employed.¹³
- A review of 46 epidemiologic studies on the impact of unemployment on health, published in the *Journal of public health policy* (1997), showed the relationship between unemployment, employment, and job loss and a variety of mortality and morbidity outcomes. “The evidence suggested a strong, positive association between unemployment and many adverse health outcomes,”¹⁴ it states.
- In a study reported in the *Journal of community psychology* (1994), an analysis of employed respondents not diagnosed with major depression at first interview revealed that those who became unemployed had over twice the risk of increased depressive symptoms and diagnosis of clinical depression than those who remained employed. The reverse causal path from clinical depression to becoming unemployed was not supported by the data. The unemployment rate in the respondents’ community at time of interview was not related directly to psychological depression but appeared indirectly with depression via its impact on the risk of becoming unemployed.¹⁵

In its most recent investigation into work and disability in the United States, the National Institute on Disability and Rehabilitation Research (NIDRR) stated that there is a deficit in the amount of national data on the employment status of people with disabilities which includes information on psychiatric disabilities.¹⁶ The current approach towards disability emphasizes people with disabilities acting independently in their own environ-

Work is at the very core of contemporary life for most people, providing financial security, personal identity, and an opportunity to make a meaningful contribution to community life.
(NAMI, 1996-1999)

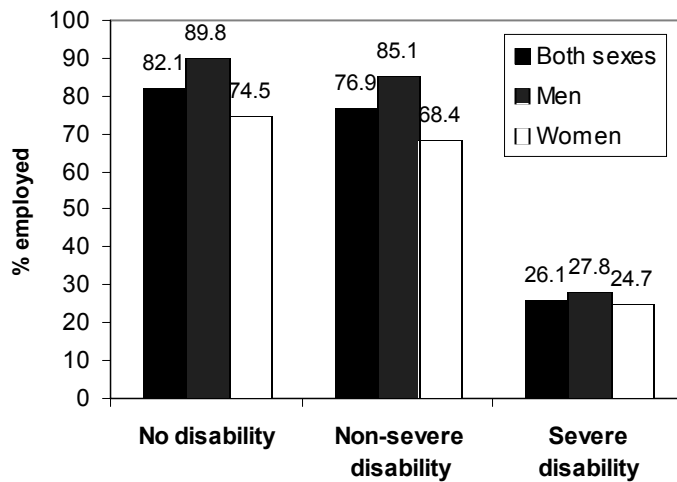
Re-employment has been shown to be one of the most effective ways of promoting the mental health of the unemployed.
(STAKES, 1999)

Fact: The National Institute of Mental Health estimates that there are more than three million adults aged 18 to 69 who have a serious mental illness. Estimates of unemployment among this group are between 70% and 90%, a rate higher than for any other group of people with disabilities in the U.S. Recent surveys report that approximately 70% of those with psychiatric problems rank work as an important goal. (NAMI, 1996-1999)

ment with the support necessary to deal pro-actively with opportunities and barriers. Employment is considered a key factor in achieving and maintaining independence. The topic of work and disability is important to persons with a disability as well as policy makers, advocates, unions, employers, and the general public. However, Katherine Seelman, Ph.D, Director of NIDRR, points out that due to lack of information, it is difficult "... to assess the numbers of people working at different types of jobs, in different social settings, with different degrees of disability and different types of accommodations."¹⁷

The following tables illustrate some of the significant findings by the NIDRR on work, disability, and mental disorders. This information provides an overall picture of disability in which depressive disorders are subsumed:¹⁸

Figure 2. Employment is lower for people with a disability and much lower for those with a severe disability.

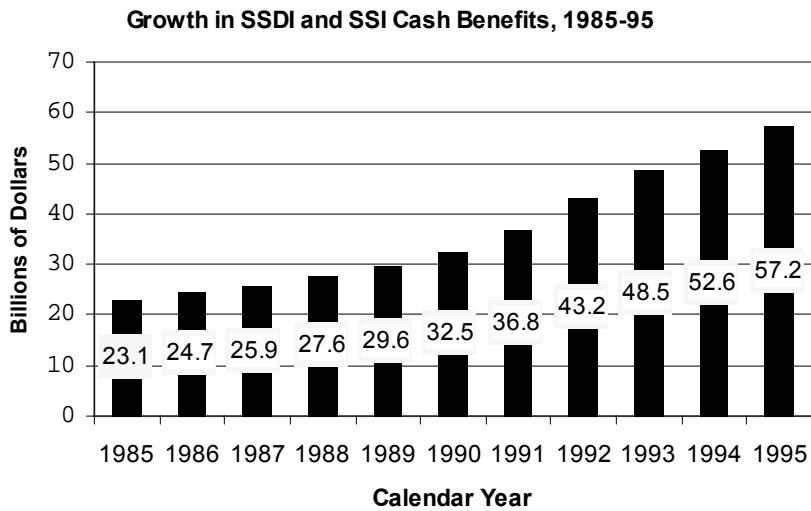


Source: McNeil (1997), *American with Disabilities: 1994-1995*.
<http://www.census.gov/hhes/www/disable.html>
 Survey: SIPP, 1994-1995

Figure 3 (see page 7). How many people with a work disability receive benefits from the Social Security Administration?

The social security administration has two insurance programs which provide benefits to working-age individuals with disabilities: Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI). These insurance benefits are federal government programs. SSDI provides monthly benefits to disabled workers and their dependents. An individual is eligible through compulsory tax on earnings. SSI provides income support to people over 65, blind or disabled adults, and blind or disabled children who have little or no income or other financial resources. SSI is need based.

Participation by working-age people in Social Security disability programs has grown from less than 4 million people in 1985 to 6.6 million in 1995. The U.S. General Accounting Office reports that the cost of cash benefits for disabled beneficiaries in 1995 was approximately \$60 billion.



Note: Includes SSDI benefits to disabled workers and federal-only SSI benefits to all SSI blind and disabled beneficiaries regardless of age.

Source: Annual Statistical Supplement to the Social Security Bulletin (Sept. 1996)

Figure 4. More than two-thirds of people with mental disorders have a disability.

People with mental disorders (23.5 million)			
Disability status	# in millions	% of U.S. population	% of people with mental disorders
Any disability	16.4	6.3%	69.8%
Functional disability	15.0	5.8%	63.8%
Work disability	6.1	2.3%	30.0%
Perceived disability	8.4	3.2%	35.8%
Disability program recipient	4.3	1.7%	18.3%

The recent National Health Interview Survey on Disability conducted by NIDRR estimates the extent of disability associated with mental disorders, using four definitions of disability:

Functional disability: any serious symptoms of mental illness that severely interfered with life for the past year, including limitations based on physical, sensory, and other impairments.

Work disability: limitation in or inability to work as a result of physical, mental, or emotional conditions.

Perceived disability: whether individuals consider themselves to have a disability or are considered by others to have one

Disability program recipient: anyone covered by Social Security insurance, special education and/or a disability pension.

Figure 5. Employment is lowest for people with mobility impairments; mental disability ranks second.

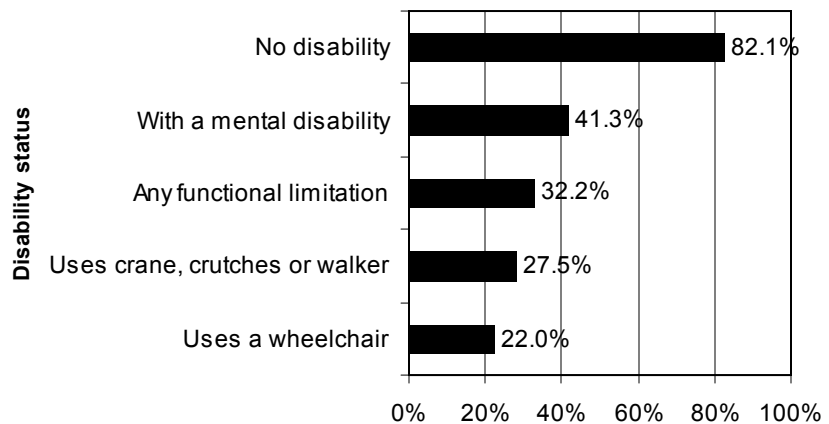
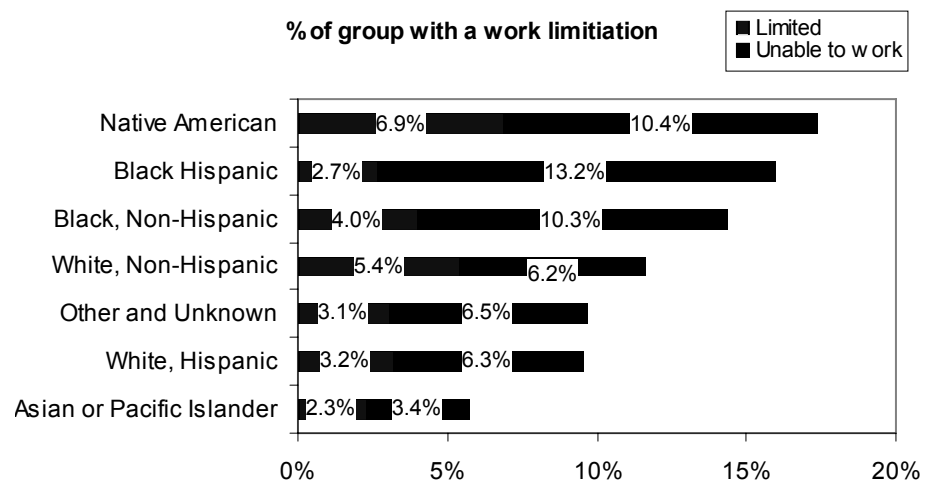


Figure 6. How is work limitation associated with race and ethnicity?

Native Americans report the highest rates of work limitation



The U.S. government is taking action to increase employment opportunities for people with disabilities.

Recently, U.S. President Clinton has taken new action to increase employment opportunities for people with disabilities. This includes creating a task force in 1998 to coordinate national policy for increasing employment of people with disabilities in all sectors of the economy; establishing new regulations in February 1999 to make work pay for people with disabilities receiving SSDI and SSI, by allowing them to earn more and still receive critical cash and medical benefits; issuing an executive order in June 1999 to expand hiring opportunities for people with psychiatric disabilities; and including in the 1999 federal budget a \$2 billion initiative to provide a \$1,000 tax credit for work-related expenses for people with disabilities.¹⁹

The Policy and Legislative Framework

There is a group of laws which reflect national policy and provide the legislative framework for effectively managing the impact of depressive disorders on the workplace. These laws do not focus specifically on depression but operate from the larger framework of all disabilities (as in the ADA), injuries (as in Workers' Compensation), and mandated leave provisions (as in the Family and Medical Leave Act).

To effectively manage an employee's medical problem, such as diagnosed depression, employers must have a coordinated program to handle leave time, medical expenses, accommodations, and return to work. Development of a comprehensive program by an employer must comply with:²⁰

- **The Americans with Disabilities Act of 1990 (ADA)**
- **The Family and Medical Leave Act of 1993 (FMLA) or any state leave law that is more favorable to employees than the FMLA**
- **Health insurance parity laws in mental health services**
- **State workers' compensation laws**

Unfortunately, these federal and state laws were enacted separately and with minimal consideration of other laws, leading to complications in compliance. However, according to the Bureau of National Affairs, most employers who understand the laws and make reasonable modifications of company policies and procedures can successfully comply as well as decrease expenses incurred due to sick leave, disability leave, or workers' compensation claims.²¹

The following summaries of the ADA, FMLA, workers' compensation laws, and mental health insurance parity laws are not intended to be comprehensive. They focus primarily on aspects of the laws which employers should understand in order to design and coordinate policy and procedures which will be in legal compliance.

AMERICANS WITH DISABILITIES ACT 1990 (ADA)²²

The Americans with Disabilities Act (ADA) is one of the most significant employment laws in U.S. history and a watershed in the history of disability rights:^{**} All employers with 15 or more employees, including for-profit and non-profit businesses, state and local governments, religious entities, and the United States Congress must comply with the ADA.

- The ADA outlaws discrimination against people with disabilities in nearly every domain of public life: employment, transportation, communication, recreational activities, and other areas of accommodation.
- Disability rights advocates celebrated passage of the ADA, hailing it as the most far-reaching legislation ever enacted against discrimination on the basis of disability.
- The preamble to the law, states that it covers 43,000,000 Americans. However, because of the increasingly inclusive definition of who is disabled, this number may be larger.

^{**} The ADA had overwhelmingly bipartisan support in Congress. Previous disability rights legislation had largely been ignored by the media, which showered attention on the ADA's passage and its early implementation. Executive branch agencies prepared required regulations. Businesses geared up for compliance and voiced concerns about the lack of guidance, cost, and the risk of litigation. A new industry emerged, marketing ADA expertise and technical assistance. ²³

EMPLOYMENT DISCRIMINATION OUTLAWED UNDER THE ADA

Title I of the ADA prohibits discrimination against a "qualified individual with a disability" with regard to job application procedures, hiring, training, compensation, fringe benefits, advancements, or any other term or condition of work. An employer cannot discriminate in any aspect of employment because of a job applicant's or employee's disability.²⁴

Key laws reflect national policy on managing the impact of depressive disorders on the workplace.

Example of Potential Compliance Issues under ADA and FMLA

An employee with a known psychiatric disability was hospitalized for two suicide attempts, which occurred within several weeks of each other. Under FMLA, the employee is entitled to up to 12 weeks leave for treatment and recovery. When the employee asked to return to work, the employer allowed him to return pending an evaluation of medical reports to determine his ability to safely perform his job. The individual's therapist and psychiatrist both submitted documentation stating that he could safely perform all of his job functions. Moreover, the employee performed his job safely after his return without reasonable accommodation. The employer, however, terminated the individual's employment after evaluating the doctor's and therapist's reports, without citing any contradictory medical or factual evidence concerning the employee's recovery. Under ADA, employees with known psychiatric disabilities cannot be terminated if they are able to perform their jobs. Without more evidence to the contrary, this employer cannot legally support his action. (BNA, *Policy & Practice Series*, 1996-1999)

The concept of reasonable accommodation is central to the ADA.

In addition, to the overall prohibition against discrimination, the ADA lists the following as discriminatory and illegal:²⁵

- limiting, segregating, or classifying a job applicant or employee based upon a disability that in any way adversely affects the employment opportunities or status of the individual;
- entering into contracts or other arrangements with third parties which have the effect of subjecting an employer's workers to discrimination based upon disability;
- utilizing any standards, criteria, or administrative methods which have the effect of discriminating based upon disability or which perpetuate the discrimination of others;
- excluding or otherwise discriminating against a job applicant or employee because of that person's association with a person who is disabled or a disability-based group;
- not making reasonable accommodation for the known disabilities of job applicants and employees.

WHAT IS NOT COVERED UNDER THE ADA.²⁶

The following are not required under the ADA:

- preferential treatment of job applicants or employees with disabilities;
- expensive accommodations or modifications of current workplace;*
- new recordkeeping or governmental reporting regulations;
- hiring or retention of unqualified individuals or providing an excuse for poorly performing or disruptive employees.

* The ADA requires, however, that employers make reasonable accommodations to the known physical or mental impairments of an otherwise qualified job applicant or employee who is disabled, unless the employer can prove the accommodation would create an undue hardship on the business. The concept of reasonable accommodations is key to the ADA.

THE ADA'S COVERAGE OF MENTAL ILLNESS

Psychiatric disabilities receive the same protection under the ADA as physical disabilities. Under the ADA, the term disability means: “(a) A physical or mental impairment that substantially limits one or more of the major life activities of an individual, (b) a record of such an impairment; or (c) being regarded as having such an impairment.”²⁷

Although the ADA clearly prohibits discrimination on the basis of a psychiatric disability, as legislation it has provided minimal guidance regarding the legal requirements. Mental illness was not discussed in legislative hearings and reports during passage of the law. The main regulatory commission never separately discussed mental illness. Therefore, the only legal rules concerning mental illness beyond the general principle of no discrimination have come from court decisions.²⁸

A complete analysis of court rulings and the regulatory commission's guidelines regarding the impact of the ADA on psychiatric disabilities and employment cannot be covered by this situation analysis. However, the following points are highlighted as relevant to understanding the nature and scope of the Americans with Disabilities Act.

What is a “mental impairment” under the ADA?

The ADA defines “mental impairment” to include “any mental or psychological disorder, such as...emotional or mental illness.” Examples of emotional or mental illnesses include major depression, bipolar disorder, anxiety disorders, schizophrenia, and personality disorders. The current edition of the American Psychiatric Association's *Diagnostic and statistical manual of mental disorders* (DSM-IV, now in the fourth edition) is relevant to identifying these disorders. The DSM-IV has been recognized as an important reference by courts and is widely used by U.S. mental health professionals for diagnostic and insurance reimbursement purposes.²⁹ However, not all conditions listed in the DSM-IV are considered disabilities or impairments for purposes of the ADA. The DSM-IV lists several conditions that the U.S. Congress explicitly excluded from the ADA's definition of disability.³⁰ Individuals with the following mental impairments are not considered legally disabled, and receive no protection under the ADA. However, these impairments may be disabilities under some state laws:³¹

- compulsive gambling
- kleptomania
- pyromania
- psychoactive substance use disorders, resulting from current illegal use of drugs*

*Also excluded as disabilities under the ADA are transvestism, transsexualism, pedophilia, exhibitionism, voyeurism, gender identity disorders not resulting from physical impairments and other sexual behaviour disorders.

Even if a condition is an impairment, it is not automatically a disability. To rise to the level of a disability, an impairment must substantially limit one or more major life activities:³²

- The major life activities limited by mental impairments differ from person to person. There is no exhaustive list of major life activities. For some people, mental impairments restrict major life activities such as learning, thinking, concentrating, interacting with others, caring for oneself, speaking, performing manual tasks, or working.³³

Psychiatric disabilities receive the same protection under the ADA as physical disabilities.

**An example of a court decision under the ADA:
Schmidt v. Safeway, Inc. 1994***

The lawsuit involved an employee with a known psychiatric disability requesting reasonable accommodation by stating that he could not do a particular job and by submitting a note from his psychiatrist. The court ruling stated that when an individual decides to request accommodation, the individual or his or her representative must let the employer know that he or she needs an adjustment or change at work for a reason related to a medical condition. To request accommodation, an individual may use "plain English" and need not mention the ADA or use the phrase "reasonable accommodation." (*BNA, Policy & Practice Series, 1996-1999*)

*Safeway is a large U.S. food store chain

- To establish a psychiatric disability an individual does not have to show that he or she is substantially limited in working. Working should be analyzed only if no other major life activity is substantially limited by an impairment.
- No traits or behaviours, in themselves, are mental impairments. For example, stress in itself is not automatically a mental impairment. Stress, however, may be shown to be related to a mental impairment, such as clinical depression. Similarly, behaviours like irritability, chronic lateness, and poor judgment are not mental impairments, although they may be linked to mental impairments.³⁴

Disclosure of disability under the ADA³⁵

Within this context, the idea of disclosure refers to an employee or potential employee revealing to a supervisor, human resource personnel, or direct employer that he or she has a psychiatric disability. Individuals with psychiatric disabilities often have questions about whether and when they must disclose their disability to their employers under the ADA. Workers have expressed concern about the potential negative consequences of disclosing a psychiatric disability in the workplace and about the confidentiality of information that they disclose. Under the ADA, employers must keep all information concerning the medical condition, including the psychiatric condition, of their applicants or employees confidential. This includes medical information which an individual voluntarily tells his or her employer. There are limited exceptions to the ADA confidentiality requirement. The following exception is most pertinent to an individual with a psychiatric disability:

Supervisors and managers may be told about necessary restrictions on the work or duties of employees and about necessary accommodations.

An employer may ask for disability related information, including information about psychiatric disability, only in the following circumstances:³⁶

- **Application Stage.** Though employers are prohibited from asking disability-related questions before making an offer of employment, an exception is made if an applicant asks that reasonable accommodation be made for the hiring process. If the need for this accommodation is not obvious, an employer may ask an applicant to provide documentation about his or her disability. The employer may require the applicant to provide documentation from an appropriate professional such as a psychiatrist, psychologist, psychiatric nurse, licensed social worker, or licensed professional counselor.

The ADA defines the circumstances in which an employer can ask disability-related questions.

- **After making an offer of employment, if the employer requires a post-offer, preemployment medical examination, or inquiry.** The employer may require a medical examination (including a psychiatric examination) or ask questions related to disability including questions about psychiatric disability if the employer requires all entering employees in the same job category to undergo the same examinations regardless of disability.

- **During employment, when a disability-related inquiry or medical examination of an employee is “job-related and consistent with business necessity.”** This requirement may be met when an employer has a reasonable belief, based on objective evidence, that an employee’s ability to perform essential job functions will be impaired by a medical condition or an employee will pose a direct threat due to a medical condition.

Requesting reasonable accommodation under the ADA ³⁷

An employer must provide a reasonable accommodation to the known physical or mental limitations of a qualified individual with a disability unless it can show that the accommodation would impose an undue hardship on the business. Of course, an employee’s decision to request reasonable accommodation may be influenced by his or her concerns about the potential negative consequences of disclosing a psychiatric disability at work. Reasonable accommodations for individuals with a psychiatric disability must be determined on a case-by-case basis because workplaces and jobs vary. Accommodations for individuals with psychiatric disabilities may involve some changes to workplace policies, procedures, or practices. Among the most common accommodations listed by experts and people with psychiatric disabilities are those that address symptoms or treatment side effects. These include use of part-time work; job sharing; more frequent breaks (for those who do not have the stamina for full time work); flexible hours (that take into account medication side effects such as early morning drowsiness); time off each week for clinical services; and limited night shift when symptoms or effects of medication interfere.³⁸

Employers must provide reasonable accommodations to qualified individuals with disabilities unless doing so would impose undue hardship on the business.

Mental health professionals, including psychiatric rehabilitation counselors, are able to make suggestions about particular accommodations and help employers and employees communicate effectively about reasonable accommodations.

Employees and employers have posed numerous questions about what constitutes a request for reasonable accommodation for a psychiatric disability. Since depression is the leading mental illness in the workplace, questions and concerns about reasonable accommodation for employees with depression are those most frequently raised by human resource personnel, employers, and insurance providers.

Mental Health Parity Act of 1996

Like the American with Disabilities Act, this is a landmark law which received unprecedented bipartisan support. It begins the process of ending the long-held practice of providing less insurance coverage for mental illnesses than for equally serious physical disorders. The following are key provisions:³⁹

- The law equates aggregate lifetime limits and annual limits for mental health benefits with aggregate lifetime limits and annual limits for medical and surgical benefits. Typical caps for mental illness coverage are

\$50,000 for lifetime and \$5,000 for annual, compared with a \$1 million lifetime and annual cap for other physical disorders.

- The law covers mental illnesses (i.e. mental health services as defined under the terms of individual plans); it does not cover the treatment of substance abuse or chemical dependency.

- Existing state parity laws are not preempted by the federal law. A state law requiring more comprehensive coverage would not be weakened by the federal law nor does the federal law preclude a state from enacting stronger parity legislation.

- The law has a small business exemption which excludes businesses with 50 employees or less. Consequently, this is not a comprehensive mandate and limits the number of employers required to provide mental health parity benefits.

- The principle beneficiaries of the law are persons with severe, persistent and disabling brain disorders, such as major depression and bipolar disorder, because they are, on average, more likely to exceed annual lifetime benefits.

The Mental Health Parity Act does not provide a comprehensive redress of the imbalance in health insurance coverage. However, it ensures that at least some insurance protection will be provided. It also provides the framework to continue building and expanding the scope of insurance coverage parity in mental health services. The most recent step in this regard is new legislation proposed and introduced into the U.S. Senate called the Mental Health Equitable Treatment Act of 1999. Among its provisions, this bill would eliminate the earlier mental health parity law's expiration date of September 30, 2001 and would reduce that measure's small business exemption from 50 employees to 25 employees, so more businesses would be covered by the requirement. Like the previous bill, it covers major depression and bipolar disorder.⁴⁰

Numerous government and non-government agencies and the vast majority of the American public support parity in the medical insurance coverage of mental health services.⁴¹ Recent studies indicate that health costs for employers have not been negatively effected by mental health parity laws.

FAMILY AND MEDICAL LEAVE ACT OF 1993 (FMLA)⁴²

The Family and Medical Leave Act (FMLA) provides employees with up to 12 weeks unpaid leave within a 12 month period, during which their jobs are protected. Unless the employee is unable to perform the essential functions of his or her job, employment is guaranteed. However, if the position is filled, the employee can be placed in a substantially equivalent job with the same pay and benefits.

Who is covered by FMLA?

An employee must be employed at least 12 months (not necessarily consecutively) to be eligible. He or she must have worked a minimum of 1,250 hours during the 12 months preceding the leave. Leave due to the serious health condition of a child, parent, spouse, or oneself is clearly defined in the law primarily as an injury, impairment, or physical or mental condition that involves either inpatient or continuing treatment by a health care provider. These conditions include mental illnesses resulting from stress. Substance abuse is covered only if the leave is to seek treatment from a health care provider.⁴³

The State of Connecticut recently signed into law sweeping measures to expand individual and group insurance coverage for mental health conditions on the same level as medical, surgical, and physical health conditions. The provisions of this new law make it one of the most equitable state laws covering mental health services in the United States. (NIMH, 1999 & NMHA, 1999)

WORKERS' COMPENSATION LAWS ⁴⁴

Workers' compensation laws are state laws. Since they vary between states, there are no exact unifying requirements for eligibility. Generally, the laws require an employer to insure or self-insure in order to make payments for all medical and rehabilitation expenses resulting from an on-the-job injury or job-related sickness.

Most workers' compensation claims are filed as a result of a physical injury. However, there are three types of mental claims, also known as stress claims, that can be filed under worker's compensation:

- **A physical-mental claim** describes a compensable physical condition that leads to a mental condition or disability.
- **A mental-physical claim** describes mental stress that results in a physical condition.
- **A mental-mental claim** describes mental stress that leads to a mental condition or disability.

All states in the U.S. compensate for physical-mental and mental-physical claims. Mental-mental claims are not compensated for in eleven states. The remaining states either have standards which vary within the state or have not set a judicial precedent for mental-mental claims.

Disputes concerning the extent of an injury or whether an injury or medical condition occurred on or off the job are heard by workers' compensation claims offices or, in some states, in court. Job-related mental health illnesses, as in the case of depression, are difficult to prove. However, workers' compensation claims for on-the-job stress related mental health conditions (i.e. clinical depression) are increasing.⁴⁵ According to the Director of the National Institute of Occupational Health and Safety (NIOSH), Linda Rosenstock, M.D., M.P.H.:⁴⁶

“The U.S. workplace has changed dramatically in the past decade and promises to continue to do so. With this transformation have come unprecedented demands on businesses and workers and the emergence of work stress as a significant occupational and public health concern.

The global economy is putting more pressure on businesses, which, in turn, put increased pressure on their employees. We need to develop strategies and processes that will value and protect worker health and well-being, help women and men be effective at their jobs and enhance organizational productivity.”

Disability under Workers' Compensation and the ADA⁴⁷

An individual who has received disability benefits under workers' compensation is not covered by the ADA unless the person has sustained a mental or physical impairment that substantially limits a major life activity. In many cases, the definition of disability under state workers' compensation laws differs from the definition under the ADA because state laws serve a different purpose. Workers' compensation laws are designed to provide needed assistance to workers who suffer many kinds of injuries including job-related depression, whereas the ADA's purpose is to protect people from discrimination on the basis of a disability.

IMPACT OF LEGISLATIVE FRAMEWORK ON POLICY IN THE WORKPLACE

Major laws and regulations applicable to businesses and employers can create problems in compliance. However, a comprehensive review of the

In 1960, a Michigan court upheld a compensation claim by an automotive assembly line worker who had difficulty keeping up with the pressure of the production line. To avoid falling behind, he tried to work on several assemblies at the same time and often got parts mixed up. As a result, he was subjected to repeated criticism from the foreman. Eventually, he suffered a psychological breakdown.

In 1995, nearly one half of the states allowed workers' compensation claims for emotional disorders and disability due to stress on the job. However, the courts are reluctant to uphold claims for what can be considered ordinary working conditions or just hard work.

disability management literature, which covers employers and consumers, indicates that employers and society as a whole benefit from laws such as the ADA, mental health parity laws, family and medical leave bills, and workers' compensation statutes.⁴⁸ Some key benefits:

- **People with disabilities win by gaining a better chance for productive employment.** There is a large pool of qualified individuals with disabilities who desire to work. An estimated 66% of people with disabilities are of working age. Although approximately 67 % of this group report the desire to work, well over 60% are not working.⁴⁹

- **Society wins because of reduced social security disability or other government aid payments and a corresponding increase in the number of employed taxpayers.** Most workers with disabilities become disabled while employed, leading to the rapidly increasing costs of workers' compensation, medical insurance, and social security disability pay. The literature shows that companies taking an active role in managing and accommodating worker disabilities, i.e. the economic impact of depression, can substantially reduce the business costs of disability.⁵⁰

- **Businesses win by finding a new source of qualified employees in times of a shrinking labor force.** Shortages are emerging in the U.S. labor market. Employment openings are expected to have risen approximately 19% from 1989 to 2000. However, the low birth rate from 1965 to 1980 has resulted in only 1.5 million new workers entering the workplace at a time when the estimated need for new workers is between 2 and 3 million. Extending employment opportunities to people with disabilities is an important way of finding new, qualified workers.⁵¹

Employers and society as a whole benefit from the ADA, mental health parity laws, family and medical leave bills, and workers' compensation statutes.

THE ROLE OF EMPLOYEE ASSISTANCE PROGRAMS (EAPs)

Employee assistance programs are company-sponsored programs designed to alleviate and assist in eliminating workplace problems caused by personal problems. These programs typically provide supportive, diagnostic, referral, and counseling or treatment services. Many EAPs began as occupational alcoholism programs and gradually evolved into broader-based efforts as employers recognized that alcoholism was not the only problem that could negatively affect job performance.

Although some EAPs continue to focus only on identifying and assisting workers who are substance abusers, most now offer a wide range of other services to help employees resolve personal and work-related problems. These services may include on-site, vendor-site, and telephone counselling; referral for psychological symptoms or mental health disorders (e.g. depression, stress, anxiety); marital or family-related issues; legal and financial problems; catastrophic medical problems (e.g. AIDS, cancer); eating disorders; pre-retirement planning needs, and career-related difficulties.⁵²

Employee Assistance Programs have been effected by changes in the legislative framework.⁵³As an employer develops programs to respond to federal and state policies as well as legislation, EAP work professionals* have had to become knowledgeable about the statutes and how they impact their company's employees and policies.⁵⁴

For example:

- **American with Disabilities Act.** EAPs may have to make an individual aware of his or her right to request an accommodation. Other EAP roles related to the ADA include: prevention of disability through early identification and appropriate referral; prevention of depression as a

secondary disability; consultation between supervisor and employee about reasonable accommodation; and employee education and manager training specific to disabilities related to mental disorders.

- **Workers Compensation.** EAPs can work with employees and management to prevent the circumstances leading to an accident or injury; facilitate early return to work and the prevention of secondary disabilities; and assist in identifying problems that may predispose employees to on the job accidents, injuries, and severe or persistent job-related stress.

- **Family and Medical Leave Act.** EAPs may inform an individual of his or her leave benefit as well as coordinate all other benefits under programs such as health insurance or workers' compensation. Other roles related to EAP services already in place include: counseling and referrals, consultation between a supervisor and employee about leave, and employee education and manager training specific to the FMLA.

- **Mental Health Parity Laws.** In addition, to the federal Mental Health Parity Act, many states have their own laws relevant to mental health parity. EAP staff should be aware of the impact of these laws on the scope of mental health services provided through their designated health insurance plans.

*EAP professionals regulate their profession under the National Employee Assistance Program Standards, recommended by the Employee Assistance Professional Association and the professional certification requirements of the Employee Assistance Certification Commission. Other than self-regulation, the profession is largely unregulated at the federal or state level, although professionals in a number of states have lobbied lawmakers to consider establishing state and federal licensing regulations. (BNA, 1996-1999)

The Economic Burden of Mental Illness Nationally

FACTS ABOUT MENTAL ILLNESS⁵⁵

The following facts regarding the scope of mental illness are important in order to fully understand its economic impact in the United States.

Mental illness facts for the U.S. (1996)

Annual office visits to physicians

- for mental disorders: 31.8 million
- for schizophrenic disorders: 1.9 million
- for depression : 4.7 million
- for anxiety: 4.3 million

Psychopharmacologic drug mentions in office practice: 81 million

Source: *Vital and Health Statistics Series 13, No. 134*,
<http://www.cdc.gov/nchswww/fastats/mental.htm>

- Mental illnesses are more common than cancer, diabetes, or heart disease.
- More than 40 million people have psychiatric impairments; of those 4 to 5 million are considered seriously mentally ill.⁵⁶
- One in every five families is affected by a severe mental illness, such as bipolar disorder, major depression, or schizophrenia.

The role of Employee Assistance Programs is expanding in the context of the legislative framework.

The treatment success rate for mental illness is high, particularly for major depression and bipolar disorder with rates ranging from 65% to 80%. Comparatively, the success rate for treatment of heart disease ranges from 41 to 52%.⁵⁷

- The leading reason for hospital admissions nationwide is a biologic psychiatric condition. At any moment, almost 21% of all hospital beds are filled with patients who have mental illness.

NATIONAL EXPENDITURES/ PUBLIC AND PRIVATE SECTORS

Although the economic impact of mental illnesses continues to be enormous, a new study that examines nationwide health care spending trends indicates that spending for mental health treatment declined over the last ten years as a share of national health expenditures. In part, this trend has been attributed to the impact of managed care for mental health services. For example, introducing managed care in Medicaid-funded* child mental health services resulted in cost reductions and shifts from inpatient treatment to less intensive treatment.⁵⁸ The study, *National expenditures for mental health, alcohol and other drug abuse treatment*, was the first in an annual series designed to track expenditures for treatment by the U.S. government.⁵⁹

*Medicaid is a state public insurance program based on income eligibility.

The research findings have been used to create a baseline to assess future trends in spending on mental health treatment. The following data presents a current overview of expenditures:⁶⁰

- The average annual growth of expenditures for treatment of mental illness was 7.3% annually between 1986 and 1996. Out of the total expenditures, an estimated \$46.9 billion (59.1%) comprised treatment by specialty providers. Specialty providers include psychiatric hospitals, mental health clinics, and specialty substance abuse clinics (\$33.2 billion), as well as psychiatrists, psychologists, counselors and social workers (\$13.6 billion).
- Hospital settings accounted for the largest share of mental health and alcohol and drug expenditures in 1996 (33.4%). The second largest share went to expenditures on independent practitioners (26.2%).

Public sector and private insurance expenditures⁶¹

- The public sector paid for the majority of treatments (54%). The public sector's share of expenditures has increased from 49% in 1986 to 54% in 1996.
- Among the public sector payers, state and local government sources other than Medicaid paid for the greatest share (18.7%), followed by Medicaid (18.2%) and Medicare (13.4%).
- Other U.S. federal government programs accounted for only 3.8% of all payments. Private insurance accounted for 29.8% of total mental health, alcohol and drug treatment expenditures. Out of pocket payment represents an estimated 16% of expenditures.

TRENDS AFFECTING MENTAL HEALTH TREATMENT COSTS

During the last five years two important trends have influenced availability and cost of treatment. They are health insurance parity for mental illness and managed care and its implications for mental health services.

Health insurance parity for mental illness

The Mental Health Parity Act of 1996 ends the long-held practice of providing less insurance coverage for mental illnesses than for equally

The price tag of mental illnesses in the U.S. is approximately \$81 billion, including direct costs (hospitalizations, medications) and indirect costs (lost wages, family caregiving, losses due to suicide).

(NAMI, 1998)

According to the Institute of Medicine, if loss of productivity to the U.S. economy is included, this figure can exceed \$249 billion per year.

(Employer's Guide to the ADA, 1995)

The U.S. Census Bureau has estimated that by the year 2000, total disability costs (physical and psychiatric) will exceed \$340 billion, double what they were at the start of the decade. (Watson Wyatt & WBGH, 1998)

serious physical disorders. The cost of paying for health insurance parity for mental illness has been one of the most hotly debated issues at the national and state levels. Despite vehement opposition by special interests who claimed that parity would be too costly for businesses, multiple studies show that the cost impact is minimal and that businesses are instigating policies to provide parity for their employees:⁶²

- The introduction of parity in combination with managed care results in, at worst, very modest cost increases. In fact, lowered costs and lowered premiums were reported within the first year of parity.
- Maryland reported a 0.2% decrease after the implementation of full parity at the state level.
- Rhode Island reported a less than 1% increase of total plan costs under state parity; Texas experienced a 47.9% percent decrease in costs for state employees enrolled in its managed care plan under parity.
- In a survey of New Hampshire insurance providers, no cost increases were reported as a result of a state law requiring health insurance parity for severe mental illnesses.
- A Congressional Budget Office federal cost estimate projected a 0.4% increase in premiums and a 0.16% increase in employer contributions for parity in annual and lifetime limits.
- A study conducted for NAMI by William Mercer Inc., one of the nation's leading human resources consulting organizations found that of the 300 American businesses polled, 85% were either in compliance or planned to make changes to comply with the Mental Health Parity Act by January 1, 1998.
- Seven out of ten of those same employers agreed that mental health parity is a reasonable national policy goal and that parity is important to their employees.

What is managed care?

Managed care began in the United States in the form of pre-paid group practices. These were developed to provide coordinated health care in a cost-effective way. The passage of the federal Health Maintenance Organization Act in 1973 spurred the growth of managed care. As health care costs escalated, employers and the public insurance programs increasingly considered managed care as a means of containing health care costs. By early 1998, 74% of those receiving their health insurance through their employers were enrolled in a managed care plan.⁶³

The concept of managed care is to combine the delivery of health care services with the financing of that care. By enrolling in a managed care plan, the consumer agrees to receive health care from a selected group of physicians, hospitals, and other service providers in exchange for paying a set fee each month for the services received. Managed care plans range in type from more restrictive to less restrictive models in terms of choice of medical providers, medical care, and services.⁶⁴ Managed care plans can dictate not only which procedures are covered but also how much insurance companies will pay for the procedures. While it is widely agreed that managed care has been cost effective, it has also been very controversial. According to *Health news*,⁶⁵ overall consumer dissatisfaction with managed care plans rose from 17% in 1997 to 22% in 1998. Consumer dissatisfaction was mainly related to poor customer service in terms of resolving problems, timeliness, and accuracy. Consumers are often caught in the middle of

The cost impact of health insurance parity for mental illnesses has proved minimal.

Managed care combines the delivery of health care services with the financing of that care.

By 1998, 74% of those receiving health insurance through their employers were enrolled in managed care.

disputes between physicians and health plans. Many physicians have reported that health care plan denials of tests or treatment have aggravated their patients' health status.⁶⁶

Managed care for mental health services

During the last five years there has been significant change in mental health care. The market has been altered by the growth of "carve-out" managed care plans that provide separate, specialized mental health coverage. This means that a consumer's managed care plan subcontracts mental health services to another company. Rand Corporation and UCLA Center on Managed Care for Psychiatric Disorders conducted three studies examining issues surrounding mental health benefits under managed care. The studies focused on the costs of mental health services under managed care and the implications of the 1996 parity legislation for cost and benefit design.⁶⁷

According to the studies:⁶⁸

Managed care has reduced the cost of delivering mental health services, but has resulted in significant consumer dissatisfaction.

- Unlimited mental health benefits under managed care cost virtually the same as capped benefits. The average increase was about \$1 per employee compared with costs under a \$25,000 cap, which was a typical limit in other existing plans. The study concluded that benefit caps on mental health coverage had little effect on employers' overall health care expenses. (See *Figure 7, page 21*)

- An even more comprehensive change required by some state laws (i.e. removing limits on inpatient days and outpatient visits) will increase costs by less than \$7 per enrollee per year.

- Despite increasing benefits, the switch to managed care led to a substantial reduction in costs for mental health care. Costs per covered member under fee for service coverage were high and rising at a rate of 20% annually. Following the transition in 1991, costs immediately fell 40% and continued to decline slowly over the following years. (See *Figure 2, page 21*)

- The switch to managed care did not reduce access to mental health care. The number of patients receiving mental health specialty care increased.

- Factors responsible for cost reduction were that fewer patients were hospitalized, the average length of stay was reduced, and the cost per inpatient day fell drastically. All of these trends began before the carve-out but were accelerated by managed care.

There has also been a litany of complaints specific to mental health services under managed care. The National Coalition of Mental Health Professionals and Consumers is an organization which addresses the negative impact of managed care on patients and practitioners in mental health care. The following are examples of problems which it has identified:⁶⁹

- Because managed care limits referrals to specialists, it forces many professionals to treat special problems for which they do not have the training or experience.

- In managed mental health, utilization reviewers often have limited experience and education. These reviewers routinely overrule and change the treatment decisions of greatly experienced specialists.

Figure 7. Unlimited mental health benefits do not cost significantly more than plans with limits

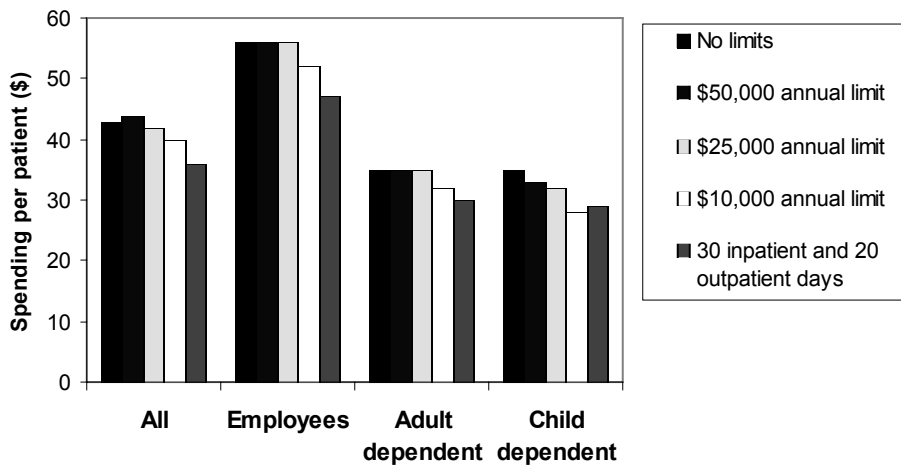
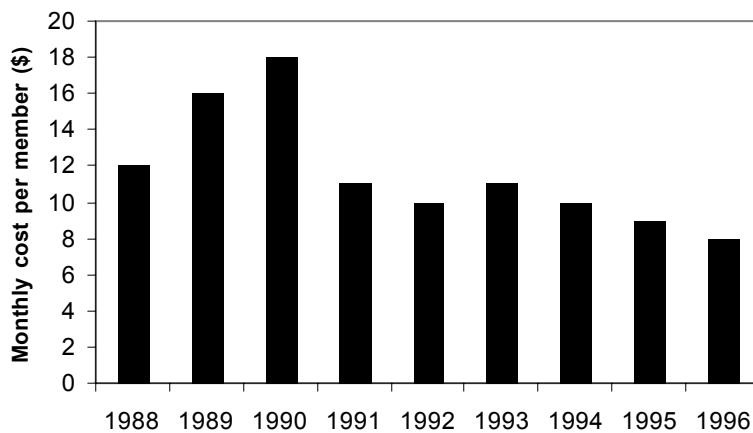


Figure 8. Mental health care costs fell under managed care carve-out plan



- Managed care often claims to provide all mental health services at times when it offers only ultra brief therapy, i.e. a short term treatment which is often ineffective depending on the mental illness.
- Managed care, particularly under the parity laws, often claims that mental health benefits are unlimited, when, in reality, hidden policies and rules make even ordinary treatment unavailable.
- Medication is frequently presented as if it is a complete treatment. Managed care often fails to inform patients of any treatment alternative outside of the plan.

Despite these problems, managed care, in some form, has been recognized by unions, employers, and government agencies as an organized system which can deliver cost-effective health care, incorporating benefit design features, financial incentives for providers, controls on unnecessary utilization, and emphasis on providing quality health care in the most efficient settings.

The employer and the workplace: The impact of depression

As stated, evidence indicates that depressive disorders are among the most common forms of mental illness in the U.S. population and consequently have a substantial impact on all sectors of the U.S. economy.

KNOW THE FACTS ⁷⁰

- Depression ranks among the top three workplace problems for employee assistance professionals, following family crisis and stress.
- The leading mental health (medical) and disability cost is related to depressive disorders.
- 3% of total short-term disability days are due to depressive disorders, and 76% of those cases are female employees.
- The annual economic cost of depression in 1995 was \$600 per depressed worker. Nearly one third of these costs were for treatment and 72% were costs related to absenteeism and lost productivity at work.
- Almost 15% of those suffering from severe depression will commit suicide.

HIGH COST OF DEPRESSION

It is estimated that depression costs the nation between \$30 and \$44 billion, with approximately 200 million lost work days each year.

Employers assume much of the financial burden associated with depression, both in direct treatment costs and through absenteeism, reduced productivity, more frequent safety risks, and the cost of inadequate or inappropriate treatment for depression related symptoms.⁷¹ In 1990, employers spent an estimated \$3,000 on each worker with depression. Research shows that for employers most of the cost associated with depression is due to absenteeism and loss of productivity, rather than treatment.⁷²

Estimates for national spending on depression range from \$30 to \$44 billion, with an estimated 200 million days lost from work each year.⁷³ Direct treatment costs accounted for \$12.4 billion, \$23.8 billion was borne by employers in the form of absenteeism and reduced productivity (an estimated \$12 billion for absenteeism alone), and \$7.5 billion was the cost associated with suicide mortality.⁷⁴ (See *Figure 9*)⁷⁵

Figure 9. Depression Costs Almost \$44 Billion Each Year

Cost element	% of total annual cost	Cost in billions of dollars
Direct treatment costs	28	12.4
Absenteeism	27	11.7
Lost productivity	28	12.1
Mortality costs	17	7.5

A Rand Corporation study showed that the impact of depression on day to day functioning is comparable to that of a chronic heart condition. Depression is responsible for more days in bed and more physical pain than hypertension, diabetes, and gastrointestinal problems.⁷⁶

Examples from Employers⁷⁷

The following facts regarding the scope of mental illness are important in order to fully understand its economic impact in the United States.

- **Westinghouse:** Prevalence rates for major depression were 17% for women and 9% for men.
- **Pacific Bell:** Depression accounted for 11% of all days lost from work during one year and resulted in half the total time lost due to mental health problems.
- **Wells Fargo Bank:** An employee survey at revealed that 30% to 35% of respondents were experiencing depressive symptoms. The incidence of clinical depression could be as high as 12% to 15%.

See Figure 10 page 24 and Figure 11, page 25, Medical Costs and Short Term Disability Data On a Disease by Disease Basis of a Fortune 100 Firm.⁷⁸

EMPLOYER CASE STUDY

A study of the medical and disability costs of depressive disorders was conducted at the First Chicago Corporation, examining data between 1989 to 1995. During this time, the First National Bank of Chicago was the eleventh largest bank in the United States, with over 15,000 employees worldwide. The study analyzed 12,400 employees, dependents, and retirees covered under the bank's self-insured medical plan. (As result of a merger in October 1998, First Chicago is now Bank One with approximately 100,000 employees. The information presented in this section was derived from pre-merger studies.)

The purpose of this study was to examine the economic costs of depressive disorders to First Chicago in terms of short-term disability rates, medical plan claims, and EAP services. Data analysis was made possible through the use of First Chicago's integrated health data management computer system.

According to First Chicago's Medical Director and EAP Directors, in the late 1980s and early 1990s, depression was taking an enormous toll on the company in terms of direct and indirect costs. Evidence included the following:⁷⁹

- The incidence of depressive disorders continued to increase.
- In terms of absenteeism and cyclical absences, depressive disorders had a powerful impact on disability rates. Depressive disorders surpassed other common chronic medical conditions such as heart disease and low back pain in the average length of the disability period. Additionally, an employee with a diagnosed depression was significantly more likely to return to disability status within 1 year than an employee with a chronic medical condition such as heart disease or high blood pressure.
- Between 1989 and 1992, depression exhibited the highest rate of 12 month recidivism among a group of common chronic disorders. One in four

individuals with depression had multiple bouts of short-term disability within a year of the initial disability. Other studies have also documented the chronicity or recidivism of depressive illnesses.⁸⁰

- Between 1989 and 1992, the average length of disability for depression was 40 days, which was longer than the average duration for many other chronic ailments, including low back pain, heart disease, high blood pressure, diabetes, and other mental health conditions.

- In terms of medical claims, an average of 11% of all First Chicago medical plan costs were connected to mental health. The cost for depression was the single largest component of mental health claims. Medical claims for depression were very high in 1991 totalling \$930,000, second only to \$1,200,000 for heart disease.

- Depressive illnesses accounted for more than half (52%) of all mental health medical plan claims for employees, spouses, and dependents. Although the cost figures establish the significance of depressive disorders in a corporate medical plan, a discussion of the study's findings stated, "...there is reason to believe that they represent an underestimate. Given the tendency by primary care physicians to misdiagnose depressive disorders and to substitute medical diagnoses for mental health problems, additional costs for depressive disorders are most likely hidden in claims for physical medicine."

- Employees with depressive disorders represented the largest group of those who requested EAP services. 19% of EAP intakes had diagnostic impressions of depressive disorders. Other leading diagnostic categories included substance abuse disorders (8%), anxiety disorders (7%), and adjustment disorders (6%).

Figure 10. Charting direct cost components: Look at the top three of the company's 10 most costly diseases: Outpatient medical payments are in a fairly close range, hospital payments are the biggest component of heart disease and cancer care, and short-term disability drives mental illness costs.

At First Chicago, women represented the majority (79%) of EAP clients with clearly stated depressive symptoms. The findings point to the role of depressive illnesses as a working women's health issue. There was a preponderance of women diagnosed with some type of depressive illness.

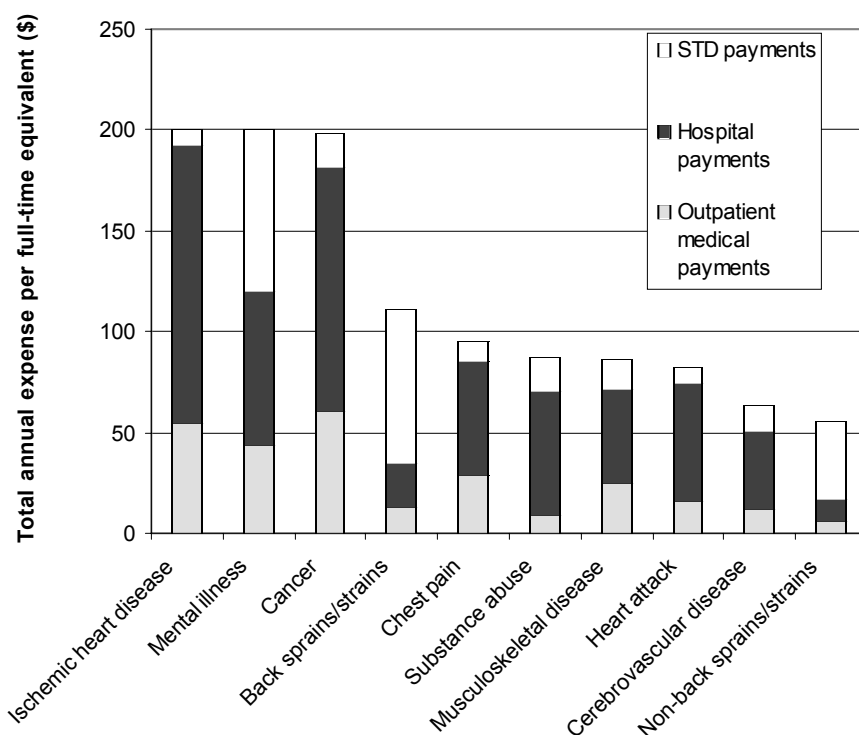
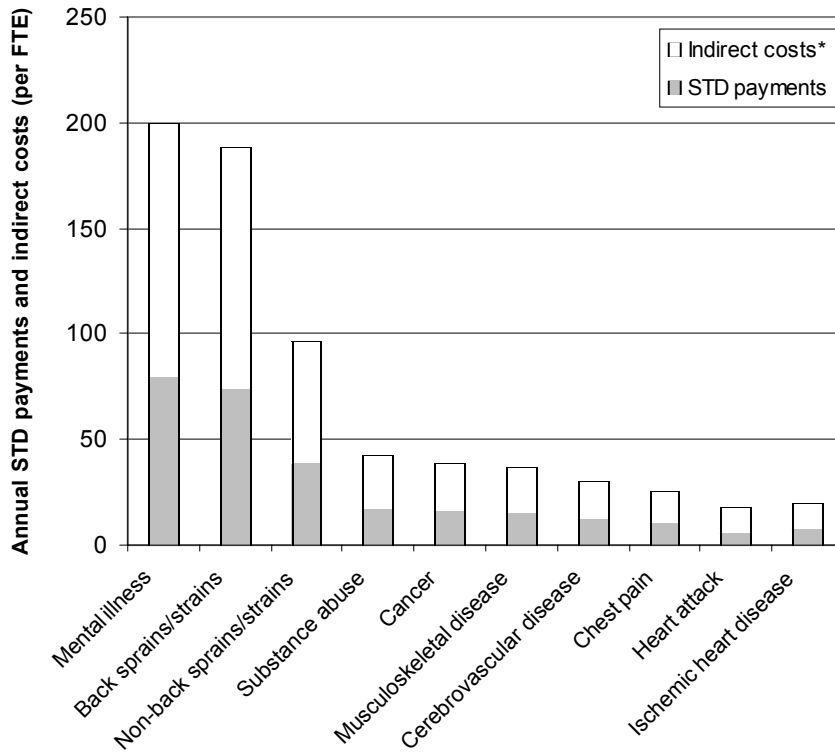


Figure 11. The total disability burden: Ranking the same 10 conditions according to the full burden of disability drops heart disease to the bottom of the list and reveals major indirect costs - administration, absenteeism, retraining and the like - for top-ranked mental illness and back sprains and strains.



*Based on industry standard of \$1.50 for every \$1 in disability payments.

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Part 2

The role of government and the social partners

Success and implementation of the laws that reflect national policy and provide the legislative framework for effectively managing the impact of depressive disorders on the workplace depend on numerous individuals and organizations. Employers and employees who educate themselves about the law and comply voluntarily are most important. Consumer, advocacy, and business organizations can assist employers and employees by providing technical assistance, materials, and other forms of educational outreach. State and local governments, which must also comply with the Americans With Disabilities Act, families and medical leave laws, workers' compensation and mental health parity laws, can further extend knowledge of and compliance with the legislative framework, by dovetailing their programs and business support activities with the law.¹

The role of the government

IMPLEMENTING LAW AND POLICY

Due to the fact that the Americans with Disabilities Act (ADA) is arguably the most significant employment law in U.S. history, particularly with its identification of psychiatric disabilities, this section will focus on ADA implementation and policy.

The U.S. federal government plays a critical role in interpreting, translating, and implementing the ADA. The ADA requires the federal government to prepare regulations and guidelines to implement the law; to enforce the law; to assist those with rights and responsibilities under the law; and to coordinate enforcement and technical assistance efforts.² The following are the primary government agencies and offices actively involved in enforcement, technical assistance, research, and dissemination of information for all psychiatric disabilities. Through their various activities, these agencies and offices offer support on mental health issues in the workplace to both employers and employees. Although the following organizations are the key government agencies in dissemination, technical assistance, and enforcement, they are not all equally involved in mental illness (e.g. depression) and employment. Some of their activities specific to depression and employment are subsumed under the larger framework of psychiatric disabilities and local community support.

- **US Equal Employment Opportunity Commission**
- **National Institute on Disability and Rehabilitation Research**
- **Center for Mental Health Services**
- **National Institute of Mental Health**
- **President's Committee for the Employment of People with Disabilities**
- **National Institute of Occupational Safety and Health**

U.S. Equal Employment Opportunity Commission (EEOC)

EEOC was established by law in 1964.* EEOC enforces Title I of the Americans with Disabilities Act (ADA). EEOC receives a large number of charges under the ADA alleging employment discrimination based on a psychiatric disability. These charges raise a wide range of legal issues

Key federal agencies interpret, translate, and implement the ADA.

“Cases involving individuals with alleged mental disabilities are frequently more complicated than those involving physical disabilities. Investigators may need more time to determine whether a mental impairment exists, whether a disability exists and whether an individual with a mental disability is qualified.”⁵

including, for example, whether an individual has a psychiatric disability as defined by the ADA and whether an employer may ask about an individual's psychiatric disability. People with psychiatric disabilities and employers have posed numerous questions to EEOC about this topic.³ There is a continual need for information and guidance because of the complexity of psychiatric disabilities and the general lack of knowledge (by the public) about these conditions. ⁴

One of the critical functions of EEOC is to provide enforcement guidance. This guidance is designed to:⁶

- facilitate the full enforcement of the ADA with respect to individuals alleging employment discrimination based on a psychiatric disability;
- respond to questions and concerns expressed by individuals with psychiatric disabilities regarding the ADA;
- answer questions posed by employers about how principles of ADA analysis apply in the context of psychiatric disabilities.

Emotional and psychiatric claims are now the leading reasons why people sue employers for on-the-job discrimination. Depressive disorders top the list of psychiatric disorders for mental health claims. In 1992, EEOC recorded 91 complaints based on emotional or psychiatric issues, 9% of the total. By 1997, the number had jumped to 2,789, representing more than 15% of the total, outnumbering claims based on AIDS, cancer, drug abuse, and back problems.⁷

*The Civil Rights Act of 1964 requires that EEOC enforce anti-discrimination laws. EEOC enforces Title VII of the Civil Rights Act, the Age Discrimination in Employment Act, section 501 of the Rehabilitation Act and the equal pay provisions of the Fair Labor Standards Act. EEOC is composed of five individuals (no more than three from one political party) with the chair and vice-chair appointed by the U.S. President.

Impact of EEOC Rulings on Mental Health Claims for Depressive Disorders

In the past, EEOC had ruled that plaintiffs could claim discrimination on the basis of a disability only if it affected their job performance. People who responded to antidepressants had their suits thrown out because when they responded to their medication, they no longer suffered job impairment and were not considered disabled.

Recently, EEOC changed its guidelines. Now mental health problems can be considered disabilities even if they do not hurt job performance. Under these new guidelines, companies must take requests for workplace accommodations based on mental health issues much more seriously.⁸

EEOC Case Example: Wood v. County of Alameda (N.D. California, 1995)

The court ruled on behalf of a plaintiff with anxiety and depression, ordering the county government to reassign the plaintiff to any vacant position for which she was qualified. Ms. Wood had previously received temporary disability benefits and was cleared to return to work, but not to her old job. She asked for the reasonable accommodation of reassignment to a vacant position, but the county claimed that it only assigned individuals to vacant positions in limited circumstances. The court found, however, that in fact the county government routinely reassigned employees and held that it discriminated against Ms. Wood by failing to make this option available to her.⁹

National Institute on Disability and Rehabilitation Research (NIDRR)

NIDRR* is the lead U.S. federal agency supporting disability research. Located within the Department of Education's Office of Special Education and Rehabilitative Services, NIDRR develops and implements long range plans for rehabilitation research, coordinates the work of all federal agencies supporting or conducting such research, and disseminates research results to businesses, professionals, and people with disabilities.¹⁰

The U.S. Congress has assigned NIDRR considerable responsibilities under the ADA. Specifically, 15 grantees receive funds from NIDRR to provide information, training, and technical assistance to businesses and agencies with duties and responsibilities under ADA. In addition to 10 regional Disability and Business Technical Assistance Centers, two National Peer Training Projects provide education about the ADA. While these ADA technical assistance activities include information on psychiatric disabilities, in general, they have had little impact on consumers and employers. Recognizing that more technical assistance is necessary, NIDRR recently provided funds for a resource center on psychiatric disabilities organized and coordinated by the Washington Business Group on Health (WBGH), a non-profit Washington based national health policy organization which represents numerous major American corporations and public systems in all segments of U.S. business and government, and one of the leading NGOs focusing on the impact of depression in the workplace.¹¹

*Historically, psychiatric disabilities have not been the prime focus of NIDRR's program; its research portfolio spans all disabilities. In 1992, approximately 5.6% of its annual budget went to psychiatric disabilities. However, recently NIDRR has increased its commitment to psychiatric disabilities. NIDRR, along with the Center for Mental Health Services, funds two rehabilitation and training centers that focus on severe and chronic mental disorders: Boston University's Center for Psychiatric Rehabilitation and Thresholds National Research and Training Center in Chicago, Illinois. Both of these rehabilitation and training centers have employment and mental illness among their focuses.

Center for Mental Health Services (CMHS)¹²

CMHS is the federal government's leading administrator of funds devoted specifically to mental health services. The largest portion of its budget funds mental health block grants, i.e. the federal support of community mental health and social service programs. With its focus on community services and consumer participation, CMHS has the potential to be a leading provider of services and technical assistance regarding employment, the ADA and psychiatric disabilities. Though employment issues have not been a top priority for CMHS, it does sponsor several programs and activities focused on employment. Among these, the Community Support Program (CSP), is perhaps most significant in terms of consumer advocacy and generating awareness of mental health issues.

The Community Support Program

CPS has concentrated primarily on people with severe psychiatric disabilities, who are not institutionalized but living and working in communities. It is a leader in federal support for the psychiatric consumer movement. For example, CSP funds two national consumer self-help centers: Project Share in Philadelphia, Pennsylvania and the National Empowerment Center in Lawrence, Massachusetts. Each center conducts technical assistance activities related to employment and reasonable accommodations specific to ADA compliance. For example, the National Empowerment Center conducted a national teleconference with consumers and consumer organizations in approximately 30 States to educate them about the ADA and to discuss how to ask for reasonable accommodations.

National Institute of Mental Health (NIMH)

NIMH* is the nation's top supporter of research on mental disorders. The vast majority of NIMH funding goes to basic biomedical and behavioral research and clinical studies. Services research is also part of NIMH's mandate, and NIMH supports studies examining disabilities and employment. To underscore the need for services research, the U.S. Congress mandated that 12% of NIMH's budget be dedicated to mental health services in fiscal year 1993 and 15% in subsequent years.¹³ NIMH has focused its support for services research on:

- general disability and psychiatric disability, including its characterization, assessment, and measurement;
- vocational rehabilitation, employment issues in general and the ADA in particular;
- public attitudes attached to mental disorders.

*NIMH has recently been reunited with the National Institute of Health. NIMH is a sub-branch of NIH

DEPRESSION Awareness, Recognition, and Treatment Program (D/ART)

One of the most successful initiatives sponsored by NIMH has been D/ART, which was initiated by the NIMH Division of Services and Intervention Research in 1985 to develop and implement a public campaign on depression.¹⁴ The major goals of this campaign were to fight the pervasive stigma and discrimination associated with mental illness; to sensitize the nation to the serious public health problem of unrecognized and untreated depression; and to develop literature on intervention and treatment for depression. D/ART activities included:¹⁵

- reviewing and assessing current knowledge of mental health issues;
- establishing a new set of public and private organizational connections;
- producing specialized print and media materials;
- developing media relations.

D/ART has been highly successful in de-stigmatizing and creating general public awareness regarding etiology, intervention, and treatment of depressive disorders. According to Isabel Davidoff, one of the founders of D/ART and currently Chief of the National Worksite Program in NIMH, D/ART was a major catalyst in the explosion of information and materials on depression in the general media. It also spurred the increased receptiveness of employers to recognizing the impact of depression on costs and performance. By the late 1990s, at least among larger employers, a substantial change had occurred in the understanding of depression and other mental health disorders. In 1997, D/ART was reconfigured as the National Worksite Program, which works almost exclusively with employers and organizations handling employment issues.

The National Worksite Program

The National Worksite Program, which began under NIMH in 1987, is a cooperative effort with the Washington Business Group on Health (WBGH). Its objectives are to sensitize employers nationwide to the public health problem of unrecognized and untreated depression and to stimulate the adoption of corporate policies and practices that promote early recognition, quality care, return to work, and on-the-job support for individuals with depressive illness. To achieve these objectives, the National Worksite Program activities have included :

Programs at NIMH sensitize the nation to the serious public health implications of unrecognized and untreated depression.

- the development and dissemination of a multifaceted human resources conceptual framework for managing depression in the workplace, and
- the broad dissemination of this approach nationwide through special meetings and conferences, on-site consultation, media activities, development of training materials, development and dissemination of informational materials; and participation in national corporate health, disability, and public policy activities.

Significant differences can be documented in the perception and management of depression in the workplace in the 12 years in which the National Worksite Program has functioned. In the 1980s, major employers generally did not fully recognize the impact of depression on costs and performance, were not aware of depression as a treatable illness, and saw cutting benefits as the solution to mental health problems and rising costs. By the 1990s, at least for larger employers, a substantial change had occurred in the understanding of depression and in the extent to which employers provide comprehensive services through benefit programs and health and human resource services.

The National Worksite Program has played a key role by serving as a leader and catalyst in the process for change. Noted achievements are:

- expanding understanding and awareness by bringing messages about the direct and indirect costs of depression to corporate America, health plans, the media, organizations, and employees;
- using effective education, consultation, and training to reach key decision makers in major corporations, business, and related organizations;
- conceptualizing, developing, and disseminating innovative approaches to improving the management of depression;
- providing science-based information about depression in the workplace to business and trade print and broadcast media at both national and local levels;
- collaborating with national organizations to expand the National Worksite Program's reach; and
- developing a corps of corporate senior executives as consultants, advisors, spokespersons, and opinion leaders.

[The Department of Health and Human Services \(DHHS\) White House Conference on Mental Health](#)

DHHS, through the National Institute of Mental Health, has launched a landmark five-year study of mental health in the United States which began on July 1, 1999. The new study, announced at the first White House Conference on Mental Health on June 7, 1999, will make fundamental contributions to understanding mental illness and to allocating resources for diagnosing, treating, and rehabilitating people with mental disorders, including all depressive disorders.¹⁷ The study will address issues of critical importance to public health, providing information on the duration of various mental disorders, the kinds of disability they produce, the links between socioeconomic status and mental health, and the relationship between types of mental illness and use of services. This information is a vital tool for planning and assessing public and private mental health services, as well as increasing the awareness and knowledge base of the public regarding mental illness. Specifically, this information will benefit

The National Worksite Program has significantly changed the perception and management of depression in the workplace.

employers, disability management specialists, and human resource and employee assistance program (EAP) personnel as they address the issues associated with the impact of depression in the workplace.¹⁸

President's Committee on the Employment of People with Disabilities (in the U.S. Department of Labor)¹⁹

The goal of the President's Committee is to develop employment opportunities for people with disabilities. Created in 1955, the President's Committee works with approximately 600 individuals representing employers, training and rehabilitation specialists, educators, labor leaders, medical and health professionals, service organizations, community leaders, as well as people with disabilities and their organizations and advocates.

The ADA has been a cause célèbre of the President's Committee. Prior to the ADA's passage the President's Committee helped to organize nationwide hearings on disability and discrimination. The testimony at these hearings provided key data on this type of discrimination and helped to propel the ADA's passage. Since the passage of the ADA, the President's Committee has maintained its support for this statute by organizing ADA employment summits and conducting a series of teleconferences across 50 states to review ADA implementation. Over the last five years, the President's Committee has concentrated on ameliorating the negative images and perceptions associated with psychiatric disabilities by forming organizations such as the Coalition Against the Discrimination of People with Psychiatric Disabilities and Job Accommodation Network.

The Coalition Against the Discrimination of People with Psychiatric Disabilities (CADPPD)

CADPPD involves 42 national leaders and numerous organizations concerned with media images of mental illness.

CADPPD work groups are developing language guidelines and position papers on such issues as civil rights, and it has prepared a list of workplace accommodations. The National Alliance for the Mentally Ill, the National Association of Psychiatric Survivors, the National Mental Health Consumers Association as well as mental health professional associations are represented in CADPPD.

Job Accommodation Network (JAN)²¹

JAN provides very practical services. It supplies information and referrals on workplace accommodations to employers, rehabilitation and social service counselors, and people with disabilities. JAN receives over 4,500 inquiries each month and represents one of the most comprehensive sources of information concerning job accommodations currently provided by the federal government. Prior to the passage of the ADA, JAN answered few calls concerning psychiatric disabilities. Currently, over 8 % of the calls each month focus on these conditions. It is estimated that approximately 41% of these psychiatric calls are from businesses. Since the passage of the ADA, JAN has begun to increase its in-house expertise on accommodating people with psychiatric disabilities. JAN also has a list of mental health services which provide useful information to employers, employee assistance programs, and human resource departments.

National Institute for Occupational Safety and Health (NIOSH)

NIOSH was established by the federal Occupational Safety and Health Act of 1970. It is part of the U.S. Centers for Disease Control and Prevention (CDC) and is in the Department of Health and Human Services. It is the

The goals of CADPPD define the fight against discrimination:²⁰

People with psychiatric disabilities must possess the same inalienable rights and responsibilities as all other human beings.

The mission of the Coalition is to eliminate discrimination against people with psychiatric disabilities. The purpose of the Coalition is to serve as a forum to share information, discuss policies and opportunities and to encourage cooperative action to achieve common goals.

only federal institute responsible for conducting research and making recommendations for the prevention of work-related illnesses and injuries. As part of its mandate, NIOSH is directed by Congress to study the psychological aspects of occupational safety and health, including stress at work. NIOSH works in collaboration with industry, labor, and universities to better understand the stress of modern work, the effects of stress on worker safety and health, and ways to reduce stress in the workplace.²²

AWARENESS OF DISCRIMINATION AND PROMOTING MENTAL HEALTH AND EMPLOYMENT

The U.S. federal government has a prominent role to play in the ADA's implementation and in generating national support for and awareness of mental health issues and employment. The law requires federal enforcement. Technical assistance and research are needed to guide and inform implementation. The ADA requires EEOC to enforce Title I, issue guidelines and regulations, and provide technical assistance. Several other federal agencies, NIDRR, CMHS, NIMH and the President's Committee, have supported technical assistance efforts concerning psychiatric disabilities and employment. The federal government is using these agencies to support efforts to create awareness and sensitivity regarding discrimination based on psychiatric disabilities.

The role of workers' and employers' organizations

To successfully change, design, and implement new policies and programs specific to the mental health issues of employees and, ultimately, ameliorate the economic burden of depression requires a combined effort by unions, workers and employers.

Today, unions represent approximately 13.9% of the U.S. workforce. This is down sharply from 35% in the 1950s. The decline in unionized companies is due, in part, to globalization as companies continue to close unionized factories and move overseas for lower costs including wages and benefits for workers. During the last ten years, the U.S. explosion in jobs has been in small business and high technology where unions have had minimal impact. Corporate America and its allies in the U.S. Congress continue to propose hostile legislation.²³ Recent trends, however, indicate that union membership is on the increase. For example, the service employees' union is expected to see its membership increase in 1999 by almost 200,000, to 1.3 million.²⁴ Whatever the trends in union membership, unions have had and continue to have significant impact on policy and legislation affecting workers and employees.

Literature from unions such as the broad-based AFL-CIO, illustrates their involvement in advocating for workers with disabilities.²⁵ In many cases, this involvement predates the Americans with Disabilities Act. Most of the union advocacy has been associated with physical disabilities, particularly work related physical injuries. However, with the increase in stress induced workers' compensation claims, there has been a growing recognition of mental health issues, and particularly of the impact of workplace violence on the mental health of employees.²⁶

UNION ADVOCACY FOR DISABILITIES

The following are examples of union advocacy for disabilities which would have included psychiatric disabilities:

Unions, workers, and employers must cooperate to reduce the economic burden of depression.

UAW literature states:³⁰

“Our union has never been simply concerned with how much money goes into a worker’s paycheck. We have always focused on the whole lives of our members and on issues that affect our entire society.

Companies need to pay attention to these issues affecting the lives of individual workers as well because problems that arise outside of work can easily impact workplace performance. Likewise, social issues such as violence and substance abuse can also spill over into worksites.”

- The Steelworkers, long before the ADA was enacted, used anti-bias clauses in collective bargaining contracts to prohibit discrimination against disabled workers. Issues dealing with disability discrimination are resolved through their grievance process, negotiated joint civil rights committees or the United Steelworkers Association (USWA) civil rights compliance procedure.²⁷

- The Association of Machinists and Aerospace Workers’ IAM CARES program is considered a model of what unions can do to aid their members with disabilities. This program, which was launched with a single federal grant in 1980, now includes 38 projects serving people with disabilities in 19 U.S. cities. IAM CARES services approximately 2,400 workers a year providing job assessment, job readiness, job development modification, job training, industrial evaluation, job placement, follow-up and support services.²⁸

- In the 1970s, the United Auto Workers (UAW) pioneered Employee Assistance Programs (EAPs) to assist workers with personal problems that could interfere with their health, job performance, and well-being. The UAW literature states that these programs have reduced absenteeism and utilization of sick and accident benefits by its members.²⁹ UAW continues to support family life issues at the bargaining table.

Unions have been actively involved in implementing the Americans with Disabilities Act (ADA). Susana Gomez of the AFL-CIO civil rights department states, “Many unions found that, as they suspected, the ADA has assisted disabled workers on the job and enabled other brothers and sisters to return to work.”³¹ For example, new contracts between management and unions should provide standards for handling job applicants and employees who are disabled. Sample contract language has been designed and developed by the International Association of Machinists and Aerospace Workers Union³² (see box page 34)

UNION ADVOCACY WHICH IMPACTS MENTAL HEALTH

- AFL-CIO continues to vigorously support the enforcement of Occupational Safety and Health Administration (OSHA) laws on workplace safety. Each year, more than 55,000 U.S. workers die and seven million are injured because of job hazards.³³ Clearly, a dangerous workplace not only impacts physical safety but also increases stress, and, in turn, may effect the mental health of workers.

- AFL-CIO supports OSHA’s guidelines for late-night workplace violence prevention programs. AFL-CIO would like to broaden these programs. The Inter-Union Workplace Physical Violence Coalition has expressed concern that only those retail stores open 24 hours may implement preventive programs, while those open after dark, even until 11pm, do not consider themselves night establishments.

- AFL-CIO has been a strong supporter of the Family and Medical Leave Act (FMLA) and continues to advocate for paid leave. Karen Nussbaum, director of the AFL-CIO Working Women’s Department, states, “What working people really need is paid leave and this group of Democrats and Republicans recommended that states look into schemes to provide paid leave.” A U.S. government report released on May 1, 1999 by the Commission on Family and Medical Leave characterizes the FMLA as “easy to administer, of low cost and usually involving very short leaves of 10 days or less.”³⁵

Sample Union Contract

1. **NONDISCRIMINATION.** The employers shall not discriminate against any employees covered by this agreement on the basis of disability, race, gender, religious belief, sexual preference or national origin.
2. **JOB RETENTION.** Both parties to this agreement will work cooperatively to retain in employment a worker who becomes disabled on or off the job. Both parties also agree to work together to facilitate the individual's return to work as soon as possible.
3. **REASONABLE ACCOMMODATION.** It will be the policy of (name employer) to make reasonable accommodations to the known limitations of a worker who has a disability. Such accommodations may include, but are not limited to such things as workstation modification; adaptation of work schedules and travel/transportation adjustment. The employee with a disability who is affected will be consulted on an accommodation. Any accommodation made will ensure that the work will be performed safely.
4. **RETRAINING AND/OR TRANSFER OF EMPLOYEE.** It shall be the policy of (name employer) that if an employee injured on or off the job is unable to return to his or her present job, the employer and the union will work together to make every effort to place the worker in another position for which he or she is qualified or can be qualified through training or accommodation.
5. **PROMOTION.** It will be the policy of (name employer) that promotions will be based on the ability to do the job and merit. This policy will apply to all employees, including those who have disabilities. Disability alone shall not be grounds for excluding a candidate from consideration.
6. **JOINT LABOR-MANAGEMENT COMMITTEE ON WORKERS WITH DISABILITIES.** A joint Labor-Management Committee on Workers with Disabilities shall be established. The Committee's functions will be to keep track of problems and recommend as well as review company policies and programs and recommend any necessary changes.

- The United Auto Workers (UAW) was a major supporter of the Mental Health Parity Act of 1996 and continues to advocate for comprehensive mental health benefits. UAW has continually been in the forefront of advocating a national health care program in the United States which would provide comprehensive and universal medical benefits.³⁶

THE IMPACT OF VIOLENCE ON THE WORKPLACE

Violence at work has been recognized as a health and safety issue by leading government agencies such as the National Institute for Occupational Safety and Health (NIOSH) and the National Institute of Mental Health, as well as by labor unions and international organizations. In 1996, the World Health Organization, at its 49th World Health Assembly, adopted a resolution which, in recognizing the serious implications of violence for the health and psychological and social development of families, communities, and countries, declared violence to be a leading worldwide public health problem.³⁷

Today, violence in the U.S. workplace is arguably the most serious stressor for the U.S. worker. NIOSH has found that an average of 20 workers are murdered each week in the United States. In addition, an estimated 1 million workers, 18,000 per week, are victims of non-fatal workplace assaults each year.³⁸ Most non-fatal workplace assaults occur in service settings such as hospitals, nursing homes and social service agencies. For workplace homicides, the taxicab industry has the highest risk, followed by liquor stores, detective/protective services, gas service stations, and jewelry stores.³⁹ Non-fatal workplace assaults result in more than 876,000 lost

National Institute for Occupational Safety and Health (NIOSH) data indicate that homicide is the second-leading cause of occupational death. The greatest number of deaths during the period of 1980-1992 occurred in the retail industry, followed by public administration.³⁴

PTSD or post-traumatic stress disorder can occur as an acute disorder soon after a trauma or have a delayed onset in which symptoms occur more than 6 months after the trauma. It can occur at any age and can follow a natural disaster such as flood or fire or a man-made disaster such as war or imprisonment, or assault or rape.

workdays and millions of dollars in lost wages. In addition, victims of violent crime may suffer undiagnosed post traumatic stress disorder (PTSD) for many years at great cost to their health and the healthcare systems.⁴⁰

According to Dean Kilpatrick, Ph.D. and Sherry Falsetti, Ph.D. in a report from the annual meeting of the Anxiety Disorders Association of America in May, 1995, titled *Stress signs often missed in victims of violent crime*, “Violent crimes like physical assault, homicide, and rape touch the lives of millions of Americans each year and produce persistent emotional effects, such as PTSD, which can last for many years.”⁴¹ Drs. Kilpatrick and Falsetti stated that the most common diagnosis that they found after a traumatic event was PTSD. They also found that 80% of patients coming in for treatment reported four or more physical reactions occurring at the same time which were diagnosed as panic attacks.

According to NIOSH, homicide is the second leading cause of death on the job and homicide is the leading cause of workplace death for women. However, men are at three times the risk of becoming victims of workplace homicides that women. Homicide is also the leading cause of death for workers under 18 years of age. The majority of workplace homicides are robbery related crimes (71%) with 9% committed by coworkers or former coworkers. Moreover, 76% of all workplace homicides are committed with a firearm.

EMPLOYERS’ ORGANIZATIONS

Although there are numerous employers’ organizations, two stand out in terms of their work on employment and mental health issues as well as their partnerships with governmental agencies.

Washington Business Group on Health (WBGH)

WBGH is a non-profit organization of approximately 300 employers. It was established in 1989 to assist employers with workplace strategies and health system practices that reduce the economic impact of depression and other mental disorders. The program is advised by a council of corporate leaders in human resources, employee assistance, medical, health and disability, health promotion, and work/life programs. WBGH has worked closely with the National Institute of Mental Health National Worksite Program in developing programs for employers that will reduce the impact of mental disorders, particularly depression, on both employer and employee⁴²

The U.S. Office of Technology Assessment provides the following description of WBGH’s mission and activities:⁴³ “...to provide information and technical assistance to employers, advocates, service providers, unions, and others to assist in achieving voluntary compliance with Title I of the ADA. Among the project’s goals: The creation of widespread awareness among employers about their responsibilities under the ADA; the establishment of a WBGH/ADA Resource Center consisting of a database of effective employer’s best practices and resource individuals and materials; the provision of information and technical assistance; the production and wide dissemination of a series of ADA mental health information briefs; and the production of an employer’s guide to accommodating individuals with mental disabilities in the workplace”

The Washington Business Group on Health has been an important resource for this document. Please refer to the bibliography for a complete list of its publications pertinent to depression and the workplace.

National Institute on Disability and Rehabilitation Research (NIDRR)

NIDRR is a governmental organization which works closely with WBGH on issues related to the Americans with Disabilities Act. For three years, NIDRR has provided funds for a resource center on psychiatric disabilities organized and coordinated by the Washington Business Group on Health.⁴⁴

National Business and Disability Council (NBDC)

NBDC, formerly the Industry-Labor Council, is the leading national corporate resource on all issues related to the successful employment and integration of individuals with disabilities into the U.S. workforce. It is the corporate resources unit of the National Center for Disability Services, an international organization based in New York, which promotes the interests of people with disabilities through educational, medical, and vocational rehabilitation. NBDC works with a wide range of Fortune 1000 corporations to assist with their disability-related employment issues.⁴⁵

NBDC's Executive Leadership Team plays a key role in the program. Members of this team are senior executives from major corporations who are promoting equal opportunities for people with disabilities in the business world. Participating corporations include: Merrill Lynch & Co., Microsoft Corporation, Sears, Roebuck & Co., United Parcel Service, and Mutual of America Life Insurance Company.

Historically, the National Business and Disability Council has focused primarily on physical disabilities. However, since employers of all sizes have begun to recognize the costly impact of depression-related disability claims as well as the legal ramifications of the Americans with Disabilities Act, NBDC also provides technical services regarding mental health issues in the workplace. According to NBDC's information officer, its primary focus is to respond to the needs of companies in terms of all aspects of the employment process regarding employees or potential employees with disabilities. Issues may include questions on the recruitment process, job analysis, reasonable accommodations, and employment law.⁴⁶

The role of non-governmental organizations

According to the U.S. Office of Technology Assessment "perhaps thousands" of consumer and professional groups for individuals with psychiatric disabilities and their families have been organized and formed across the nation. These non-governmental organizations are neither singular nor unified but rather coalitions of people who have joined together on the basis of need, advocacy, types of disorders, treatment, and experience.⁴⁷

At the national level, several groups have had a vital role in raising the awareness of mental health issues, eliminating stigma and discrimination, and advocating for appropriate legislation as well as the availability of jobs or meaningful activity. A defining characteristic of these organizations is that they work closely with governmental agencies, business groups, and corporate sponsors. The organizations that have figured prominently include:

National Mental Health Association (NMHA)

NMHA, established in 1909, is a nationwide network of mental health advocates seeking broad-based healthcare reform for all people with mental and emotional disorders. NMHA was founded by Clifford Beers. In 1908

It is in the interest of employers to reduce the impact of depression and other mental disorders on their employees.

Non-governmental organizations are vital in raising awareness of mental health issues and advocating for people with psychiatric disabilities.

Beers changed mental care forever with the publication of *A mind that found itself*, an autobiography chronicling his struggle with mental illness and the shameful state of mental health care in the U.S. This book had an immediate impact, spreading his vision of a massive mental health reform movement worldwide. Today, NMHA has a nationwide network of 330 affiliates, involving more than 400,000 volunteers serving over two million people. NMHA is actively involved in impacting policy developments at the federal level through state and federal government affairs departments.⁴⁸

NMHA public education programs are an integral part of its mission and strategic planning. Specific to depression, in 1993 NMHA launched a National Public Education Campaign on Clinical Depression to inform the American public of the symptoms of depression and provide information about treatment. As part of its Campaign On Clinical Depression, NMHA has focused on depression in the workplace, specifically describing the economic impact of depression, employees' attitudes towards depression, recognizing the symptoms, and where to go for help. This public education campaign continues to demonstrate positive results and acquire more support. For example, there are now numerous professional as well as government organizations which are partners in this campaign. They include the American Academy of Child and Adolescent Psychiatry, the American Psychiatric Association, the American Public Health Association, Business and Professional Women, the Employee Assistance Professionals Association, the National Black Nurses Association, the National Association of Hispanic Nurses, the National Medical Association, and the National Institute of Mental Health.⁴⁹

NMHA has also been advocating for parity of mental health benefits with other health coverage. NMHA was at the forefront of efforts to win passage of the Mental Health Parity Act of 1996. Current efforts are under way to gain broad-based parity which will cover a full range of mental health diagnoses.⁵⁰

The National Alliance for the Mentally III (NAMI)

NAMI is a nonprofit, grassroots, self-help support and advocacy organization of consumers and families and friends of people with severe mental illnesses, such as major depression, bipolar disorder, obsessive-compulsive disorder, and schizophrenia. Founded in 1979, NAMI has more than 208,000 members with approximately 1,200 state and local affiliates in the U.S. It also has affiliates in Puerto Rico, Canada, and American Samoa and has helped start sister organizations in Australia, Japan and the Ukraine. NAMI, working at the national, state, and local levels, provides education about mental illness, supports increased funding for research and advocates for adequate health insurance, housing, rehabilitation, and employment for people with psychiatric illnesses.⁵¹

NAMI has been a leader in the struggle to end discrimination and stigma against people with mental illness. It has begun a five-year major campaign called Campaign to End Discrimination. This campaign has support from many professional and government organizations such as: the American Managed Behavioral Healthcare Association, the American Psychiatric Association, the American Nurses Association, the National Coalition of Hispanic Health and Human Services Organizations, the National Institute of Mental Health, and the National Association of State Mental Health Program Directors.⁵³

This campaign has been funded, in part, by its founding sponsors: Abbott Laboratories, Bristol Squibb Company, Eli Lilly and Company, Janssen Pharmaceuticals, Inc., Magellan Health Services, Novartis Pharmaceuticals,

If people with mental illness are to receive the treatment, respect, and economic opportunities they deserve, we will have to change the behaviour and public policies of lawmakers and public officials. We will have to challenge the corporate policies of our nation's businesses and the attitudes of our nation's opinion leaders towards people with brain disorders.

Mission statement of NAMI's Campaign to End Discrimination⁵²

Pfizer, Inc., SmithKline Beecham, Wyeth-Ayerst Laboratories, and Zeneca Pharmaceuticals.

National Mental Illness Screening Project (NMISP)

NMISP is a nonprofit organization developed to coordinate nationwide mental health screening programs and to ensure cooperation, professionalism, and accountability in mental illness screenings. This organization grew out of the success of National Depression Screening Day, the community outreach and education program created by Harvard psychiatrist Douglas Jacobs, MD, in 1991, with the support of the American Psychiatric Association.⁵⁴

Media coverage for NMISP's programs has been extensive. Segments about the programs have appeared on television shows such as NBC Nightly News, Good Morning America, CBS, and the CNN Morning News. Print coverage has appeared in the *New York Times*, the *Washington Post*, *Sports Illustrated* and hundreds of local daily papers. NMISP programs include National Depression Screening Day and Interactive Telephone Screening Programs.

National Depression Screening Day (NDS)

NDS is held each year during Mental Illness Awareness Week, usually in October. It is designed to call attention to the illnesses of depression and manic-depression on a national level, to educate the public about their symptoms and effective treatments, to offer individuals the opportunity to be screened for the disorders at no cost, and, to connect those in need of treatment to the mental health care system. Media coverage for National Depression Screening Day has been unusually high. In 1998, it was estimated that National Depression Screening Day received more than 400 million print, visual, and audio media impressions⁵⁵

In 1998, NDS screened more than 90,000 people at more than 3,000 sites. Site participants included primary care physicians, employers, hospitals, colleges, shopping malls, and community based organizations such as YWCA/YMCA. National Depression Screening Day, the first mental screening program of its kind, has now amassed the largest database of any mental health research project. The National Institute of Mental Health, a sponsor of the program, has analyzed some 100,000 individual screening forms containing symptomatology, demographic, and mental health care treatment history questions.⁵⁶

According to Isabel Davidoff, Chief of the National Worksite Program at the National Institute of Mental Health, employers who have participated in this program have reported an increase in the detection of depression in their employees, which has resulted in earlier intervention, and a corresponding reduction in work days lost and short-term disability costs.⁵⁷ Employers' participation also fosters destigmatization of mental illness and encourages an atmosphere of openness regarding mental health problems.

The National Depression Screening Day has many professional and government organizations as sponsors and supporters. Some of these are: the American Psychiatric Association, the National Institute of Mental Health, the American Association of Retired Persons, the American Colleges of Health Association, the American Foundation for Suicide Prevention, the Employee Assistance Professionals Association, and Wellness Councils of America. Corporate funders have included: Abbott Laboratories, Eli Lilly and Company, Forest Laboratories, Parke-Davis, and Kaiser Permanente.

Employers' participation in mental health programs fosters destigmatization and openness regarding mental illness.

Interactive Telephone Screening Programs: The Employee Telephone Access Program (ETAP)

The National Mental Illness Screening Project offers employers and health care organizations two telephone screening programs which address education and early intervention regarding depression and alcohol problems. A core program offers depression screening and a comprehensive program provides depression and alcohol screening.⁵⁸ Briefly, ETAP provides employers with:

- an affordable, easy-to-implement strategy to educate employees and their families about the signs and symptoms of depression and alcohol problems and to motivate them to seek timely treatment;
- enhanced mental health benefit visibility and utilization of services through its anonymous and non-stigmatizing approach;
- significant cost savings through early intervention, a time when mental health treatment is most effective and least expensive;

Additional organizations should be noted for their emphasis on advocacy and education:

National Depressive and Manic-Depressive Association (NDMDA)

NDMDA, formed in 1978, identifies its primary objectives as education and self-help and support for people with serious mood disorders and their families. It has approximately 30,000 members sponsoring over 200 local groups, forums and lectures for professionals, a semiannual national conference, and several regional conferences. It publishes a quarterly newsletter, books, and other materials. NDMDA views major depression and manic-depression as biological illnesses that can be treated with medication and therapy.⁵⁹

National Mental Health Consumers' Association (NMHCA)

NMHCA was formed in 1985 as a network of local consumer groups engaging in a variety of advocacy, technical assistance, and self-help activities. NMHCA focuses on access to appropriate treatment, including medical interventions, and espouses a strong commitment to civil rights for people with psychiatric illnesses. Most of its approximately 1,000 members have serious psychiatric conditions. Many have experienced hospitalizations, involuntary treatment and reliance on the public sector.⁶⁰

Brazelon Center for Mental Health Law

Brazelon Center for Mental Health Law is a nonprofit legal advocacy organization. It is considered one of the leading national legal advocates for people with mental illness and mental retardation. Among other issues, the Brazelon Center focuses on protection against discrimination in housing, employment, and public services; reform of public systems to serve all individuals with mental disabilities in their communities; and improving access to the health care, housing, and support services of a consumer's choice. The Brazelon Center collaborates with local, regional, and national mental health advocacy and consumer organizations to reform public systems and encourage consumer participation in the design of new programs. Brazelon Center attorneys provide technical support for selected lawsuits with private lawyers, legal services programs, state protection, and advocacy organizations.⁶¹

In summary, people with psychiatric disabilities, their families, and mental health advocates have founded several national organizations and, over the last 10 to 20 years, have gained a voice in public policy, although not yet at the same level of leadership and political influence as those with physical dis-

A key message of the Employee Telephone Access Program is that depression and alcohol problems are not personal weaknesses, but illnesses which are treatable.

Early intervention in the treatment of depressive disorders reduces unnecessary and prolonged absenteeism and helps individuals attain optimal levels of functioning.

abilities. These groups express common concerns regarding the need for sustained employment, increased employer awareness of their work capabilities, and the problems of discrimination and stigma.⁶²

Noted academic institutions

The U.S. has numerous academic institutions that conduct research, organize conferences, and disseminate information on mental health as well as provide mental health services. These institutions often work closely with government agencies, such as the National Institute of Mental Health, the Center for Mental Health Services, the National Institute on Disability and Rehabilitation Research, and the National Institute for Occupational Safety and Health. They usually work in partnership with one another, often with the government agency funding a particular research study or conference. For example, the National Institute for Occupational Safety and Health recently sponsored the conference, Work, Stress and Health: Organization of Work in a Global Economy, in which many academic institutions and professional organizations participated.⁶³

It is not possible to provide a comprehensive list of every academic institution that engages in some type of research, training, or technical support in the field of mental health. The following academic institutions have been highlighted due to their extensive work in the area of employment and psychiatric disabilities:

Boston University, Center for Psychiatric Rehabilitation

Boston University's Center for Psychiatric Rehabilitation is the leading academic institution in research, training, and service dedicated to improving the lives of people with psychiatric disabilities. The Center is supported in part by the Center for Mental Health Services and the National Institute on Disability and Rehabilitation Research. The Center is noted specifically for developing the psychiatric rehabilitation model that is now being replicated and used in mental health facilities in the U.S. Briefly, this model is consumer-driven with an emphasis on independence and integration in the community through employment, education, and independent living.⁶⁴

Cornell University, NYS School of Industrial and Labor Relations

Through its Program on Employment and Disability (PED), Cornell conducts research, trains, and provides technical support in such areas as the Americans with Disability Act, Social Security disability work incentive programs, employment and disability policy, and vocational rehabilitation and supported employment. PED is partially funded for specific programs by the U.S. Department of Education, Rehabilitation Services Administration. For example, PED is involved in a long term training project for community rehabilitation program personnel. Topics in the training program include employment law, working effectively with employers and unions, and placement of individuals with psychiatric or physical disabilities in gainful employment.⁶⁵

Michigan State University (MSU), Office of Rehabilitation and Disability Studies

MSU is a leader in the field of disability management in the public and private sectors. Specifically, MSU focuses on assisting employers in addressing and minimizing disability-related costs in the workplace through resources and technical support. MSU tracks and develops program models for human resource managers and employment policy specialists in this area of disability management.⁶⁶

The influence on public policy of people with psychiatric disabilities and their advocates has grown significantly over the past two decades.

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Part 3

Managing mental health in the workplace

Work-family issues and their impact on productivity

Work and family concerns have emerged as key factors for competitive businesses in the United States.¹ More and more employers are aware and concerned regarding the link between family issues and job performance. According to the Family and Work Institute, a nonprofit research and planning organization committed to developing new approaches for balancing the changing needs of family and workplace productivity, “An interest in work-family issues is multidimensional: clearly, more CEOs today understand that the notion of keeping one’s personal problems at home is no longer possible or even advisable. They now see that attention to family related issues is a necessity of good business, an investment from which they have come to expect a healthy return.”²

Attention to the link between family and work performance includes an awareness of how mental well being can enhance or negatively impact productivity. Employers are realizing that mental health issues are intricately linked with family and job stressors which are often precursors to mental health problems such as depression. Consequently, work and family accommodations are being made with the full intention that they will yield a return on investment because that is what motivates companies to address these types of issues.³

Research conducted by the Family and Work Institute on 188 companies analyzed work-family programs in major corporations, among other issues. The study also identified “Four Friendliest Companies” using a family-friendly index rating. The companies were Johnson & Johnson (pharmaceuticals and consumer products), IBM Corporation (computers and information processing equipment), Aetna Life & Casualty Company (insurance and financial services), and Corning Incorporated (glass, building materials, and consumer products).

These companies had the following in common:⁴

- Good economic health; though in some cases their work-family policies were developed in reaction to a threat to their economic health.
- Long-term strategic thinking and planning went into their work-family agenda and is typical of the way they conduct business.
- Well-respected employee champions envisioned work-family initiatives as part of a business strategy that will result in a desirable work culture.
- Each company examined what its employees needed and wanted and which community resources could help address the problems identified.

When several dozen companies began offering family-supportive policies in the late 1970s, their efforts were viewed with skepticism as a passing fad. However, by the 1990s, initiatives to help employees cope with the dual stresses of work and home life are not only here, but increasingly championed as mainstream corporate activity.

(Family & Work Institute, 1991, p. 1, The Corporate Reference Guide)

CHARACTERISTICS OF COMPANIES MOST LIKELY TO PROVIDE WORK-FAMILY PROGRAMS AND POLICIES AND SUPPORTIVE WORK ENVIRONMENTS⁵

The Family and Work Institute identified a number of characteristics of employers most closely associated with supportive work-family programs and policies. The following are the top five predictors.

- **Industry** is the most frequent predictor of work-life support. Finance, insurance, and real estate services had the most supportive policies.
- **Company size** is the second most frequent predictor of work-life assistance and a supportive work environment. Larger employers (1,000 or more) are more likely to provide flexible work options, longer maternity leaves, paternity leaves, leaves for adoptive parents, and wage replacement during maternity leaves. Larger companies are more likely to provide elder care programs, employee assistance programs, and health care and wellness programs.
- **The proportion of top executive positions filled by women** is the third most frequent predictor. A company which has a larger proportion of top executive positions filled by women is associated with work-family programs. For example, 82% of companies with women in half or more of their top executive positions provide traditional flextime, compared with 56% of companies with no women in top positions. Six times as many companies with women in half or more of their top executive positions provide on- or near-site child care.
- **The proportion of top executive positions filled by minorities (African-Americans and Hispanics)** is an equally important predictor of work-family programs. Since the majority of companies have no top positions filled by minorities, the presence of even one or a few in top positions can have an impact. For example, more than 80% of companies with minorities in 25% or more of top executive positions offer traditional flextime versus 64% of companies with no minorities in key positions.
- **The percentage of women in a company's workforce** is also predictive of work-family assistance. When women are a larger proportion of the workforce, employers are more likely to provide a number of options such as job sharing, part-time work, longer maternity leaves, direct subsidies for childcare and care for children during school vacations.

See Figure 12, page 44 for the types and prevalence of work-family programs among the 188 companies surveyed.⁶

Employee Education for Mental Health Promotion and Mental Illness Prevention

Historically, the typical worksite health promotion program overlooked mental health needs. Fortunately this is changing. A 1992 survey indicated that 81% of all worksites with 50 or more employees have health promotion activities. The most frequently offered activities are injury prevention, exercise, smoking cessation, stress management, and alcohol and drug rehabilitation. In 1992, 25% of worksites offered programs on mental health, compared with 15% in 1985.⁷ Employers are investing more and more in programs to educate employees and their families about mental health problems. Taking into account U.S. regional differences, today, approximately 40% to 60% of worksites with 50 or more employees offer some type of mental health program. This is particularly true if stress man-

Education about the symptoms and treatment for depression increases the chance of prompt recognition of the illness, creates wiser health care consumers and helps reduce the stigma associated with depression.

(WBHG, 1994 and D/ART Worksite Prevention Program)

agement programs are considered part of a company's mental health program.

Figure 12. Types and prevalence of work-family programs

Rank	Program Description	% of companies offering program
1	Part-time schedules	87.8
2	Employee assistance programs	85.6
3	Personal days	77.4
4	Flextime	77.1
5	Personal leaves of absence	70.4
6	Child care resource and referral	54.5
7	Spouse employment assistance	51.9
8	DCAPs (dependent care assistance plans)	49.5
9	Job-sharing arrangements	47.9
10	Flexplace	35.1
11	Family, child care leaves for mothers*	28.0
12	Family counseling in relocation	26.9
13	Work-family seminars	25.7
14	Cafeteria benefits	25.1
15	Wellness/health programs	23.4
16	Elder care consultation and referral	21.1
17	Adoption benefits	15.7
18	Child care centers	13.0
19	Work-family management training	9.6
20	Work-family support groups	5.3
21	Corporate foundation giving	5.3
22	Family illness days	4.8
23	Discounts for child care	4.8
24	Sick child care	4.3
25	Work-family coordinators	3.2
26	Work-family handbooks	2.7
27	Long-term care insurance	2.1
28	Consortium centers for child care	1.6
29	On-site caregiver fairs	1.6
30	Vouchers for child care	1.1

Note: Ranking does not include disability leaves for new mothers, which are available in 100% of the companies surveyed.

*Family and child care leave policies for mothers that are also available to fathers are found in 22.3% of the companies and are extended to adoptive parents in 23.4% of the companies. Policies that include extended care for relatives are available in 16.0% of the companies. These variations are not counted separately in the above table

Three trends continue to drive the restyling of U.S. corporate health policies and programs:

- Health care costs are still rising at rates that outpace inflation, draining corporate resources and severely impacting the competitiveness of U.S. firms.⁸
- There is greater sensitivity on the part of employers about how individual health impacts organizational productivity.⁹

- The increasing visibility of the disability rights movement and the passage of anti-discriminatory legislation such as the Americans with Disabilities Act; and the influence of mental health insurance parity laws, family leave laws, and rising workers' compensation claims for job-related mental health problems.

“High quality, comprehensive and effective mental health benefits can be offered by major corporations providing that the benefits are carefully designed and managed.”

Wayne Burton, VP, Medical Director, The First National Bank of Chicago¹¹

In response to these trends, employers are implementing human resource policies and programs designed to support employees in maintaining or improving health and enhancing their ability to be productive. Employers have also responded to the growing societal awareness of the impact of mental illness and the legal ramifications of pursuing discriminatory and less than equitable employment policies.

Where depression is concerned, effective employer policies and programs stress early identification and appropriate treatment referral and encompass a continuum of interventions. Experience has shown that leadership from top management is critical to the successful implementation of these efforts which include:¹⁰

- employee education for health promotion and disease prevention
- management training
- employee assistance services
- benefit design and administration
- information management
- integration of corporate health related services

Case studies: Ford Motor Company and The First National Bank of Chicago

FORD MOTOR COMPANY’S TOTAL HEALTH PROGRAM¹³

The Ford Motor Company is a worldwide leader in automotive and automotive-related products and in various financial services. While there are more than 370,000 employees worldwide, the following Total Health Program applies only to 44,000 salaried employees working in the United States and employed by the parent company. A comparable program is made available to Ford hourly employees represented by the United Auto Workers through the UAW Ford Employee Support Services Program. UAW is one of the largest worker unions in the United States.

The Total Health Program is part of Ford’s major and ongoing change in corporate culture which began in the early 1980’s. The changes have directly affected the work environment by providing structure and support for employees so that they have greater involvement in planning and decision-making. These include encouraging managers to work with their employees in an interactive fashion which facilitates greater employee control and reduces uncertainty.

The Total Health Program is a combined employee assistance and health promotion program for salaried employees. One reason for integrating these programs was to reduce the stigma of seeking assistance for personal problems. Depression is one of many health and lifestyle concerns addressed by the program, reflecting the positioning of the program as a resource for personal, health, and lifestyle issues. Analysis of health care

“We need to get a firm grip on what depression is costing us and how many people are affected. Then we need to think of creative solutions beyond treatment.”

Bryan Lawton, Former VP, Director, Employee Assistance Services, Wells Fargo Bank¹²

claims data, employee assistance program utilization data, and health risk appraisal data showed that depression among Ford employees existed and needed to be addressed by Ford health-related programs.

Elements of Ford's Total Health Program include:

- **Health promotion programs.** Employees are offered a variety of health promotion activities: health risk appraisal, hypertension and cholesterol screening, education in nutrition, smoking cessation, exercise and stress management. Average participation rates are 65%. These health promotion activities serve a primary prevention function with respect to depression. In addition they frequently result in referrals to the counseling service.
- **Counseling services.** Counseling is available 24 hours a day, 365 day a year. It is strictly voluntary, confidential, and provided to employees and their families at no cost. Program promotional materials indicate that use of the counseling service will not affect an employee's job status in any way.
- **Supervisor Consultation Services.** Mental health professionals also provide training and assistance to supervisors, managers and personnel representatives in addressing unsatisfactory employee performance which may be related to employee personal problems such as depression. The training emphasizes that managers should not attempt to diagnose the presence or nature of personal problems which may underlie unsatisfactory job performance. Instead, the intervention focuses on measurable performance standards while advising the employee about the availability of the counseling services.

Examples of health promotion activities at Ford

Lunchtime talks on mental health topics are led by Total Health Counselors as a means of helping employees feel more comfortable in contacting the counselor when necessary. Topics have included: "Coping with the holidays", "Healthy relationships", and "Dealing with difficult people."

Bulletins on mental health topics are distributed periodically to all employees. Topics have included: "Everyone feels down sometimes" and "How many roles do you play?"

Posters promoting the Total Health Program and addressing issues such as depression and work-family relationships are displayed on a revolving basis.

Articles in Ford newsletters address issues such as depression, transitions, assertiveness, anger, parenting, substance abuse, and grief.

In person presentations by Total Health Counselors at company meetings provide mainstream exposure for the program.

THE FIRST NATIONAL BANK OF CHICAGO: QUALITY AND COST EFFECTIVE MANAGEMENT OF DEPRESSION¹⁴

The First National Bank of Chicago is the 11th largest bank in the United States, with over 15,000 employees worldwide. The following case study applies to the 12,400 employees, dependents and retirees covered under its self-insured medical plan. Following a 1998 merger, First Chicago is now Bank One with approximately 100,000 employees. The information was derived from pre-merger data.¹⁵

In 1983, mental health costs accounted for 14% of total medical plan costs. They ran a third only to women's health and musculoskeletal injury as a percentage of total medical costs. At that time, management decided that there should be no significant change in the liberal mental health benefits, and, consequently, a strategic program was designed and implemented to address specific mental health costs.

First Chicago's mental health quality and cost effectiveness program includes four major components:

- **Employee Assistance/Health Promotion Program.** A primary goal of the mental health program is to prevent long- and short-term disability by providing early intervention or prevention. Assessment, short-term counseling, and referral to community resources are obtainable at no cost. One of the main subject areas of health promotion is education regarding depression and other mental health issues. The Health Promotion Program provides primary prevention through education and serves as a conduit to the Employee Assistance Program.
- **Psychiatric hospital utilization review.** For certification of benefits, the patient's physician contacts the Bank's medical director by the sixth day of hospitalization. A mental health treatment report is submitted for any hospitalization anticipated to last more than ten days.
- **Consulting psychiatrists.** Psychiatrists serve the mental health program by reviewing the appropriateness of psychiatric hospitalization; assisting employees and dependents in obtaining appropriate care; and visiting treatment facilities where appropriateness of care is a concern.
- **Benefit plan design.** Changes were made in the mental health benefit plan to ensure that quality and cost effective options to inpatient care are available, e.g. partial hospitalization, evening outpatient chemical dependence programs, and outpatient day treatment. These options are especially important for the treatment of depression, which can be most often done in an outpatient setting. This also facilitates an earlier return-to-work of the employee, even on a part-time basis, which in turn reduces disability costs.

As a result of this program, there has been a significant decrease in inappropriate inpatient mental health care related to depression and other mental health diagnoses, while the availability of outpatient ambulatory services has been enhanced and improved. Between 1991 and 1995, the direct treatment costs for depressive disorders dropped from just under \$1,000,000 to a little over \$400,000. As a percentage of total mental health claims, the cost of depressive disorders fell from 62% in 1992 to 45% in 1995. Furthermore, indirect costs have not risen as direct costs have declined. The average duration of short-term disability cases for depressive disorders has remained relatively stable over the past several years. According to the Washington Business Group on Health, the key is in successful management to ensure appropriate and medically necessary treatment.

Additional corporate experiences and innovations

INFORMATION MANAGEMENT

Accessing company data on the prevalence, cost, treatment, efficacy, and attitudes regarding depression provides information about how to allocate corporate resources and design health and disability benefits to better manage the impact of depression in the workplace.¹⁶ For example:¹⁷

To fight rising mental health costs, Ford emphasizes early intervention and outpatient treatment.

The First National Bank of Chicago developed an integrated health data management system for its self-insured, self-administered program. The system includes data on health claims, short term disability, employee assistance program utilization, health promotion program participation, nursing visits, periodic health evaluation, and other medical information. As noted, this system enabled First Chicago to identify inappropriate use of inpatient mental health services.

Pacific Bell uses its health data management system to establish priorities, identify elements in its health program in need of change, simulate or project the impact of those changes, and provide standards for evaluating specific interventions.

Owens Corning is designing and implementing an integrated information system that will encompass medical, human resources, payroll data, and data on topics such as safety and industrial hygiene. The system protects employee confidentiality by giving different levels of clearance to different types of personnel. In addition, Owens Corning staff are setting overall health goals for the company and charging the local health teams at individual locations with initiating programs that will meet those goals.

According to Isabel Davidoff, Chief of the National Worksite Program, an integrated information management system can provide the impetus to better educate and train employees, managers, supervisors, and human resource staff in depression awareness, recognition, and treatment referral. It can also provide information for improvements in employee benefit plans. Information management systems have proved critical promoting best practices among companies.

EXPANDING THE ROLE OF EMPLOYEE ASSISTANCE PROGRAMS

In keeping with the purpose of the EAP to help employees address problems that negatively affect their performance, state-of-the-art EAPs are continually modifying their services to meet the changing needs of employees and the workplace.

Abbott Laboratories maintains an active Employee Assistance Program whose goal is to improve the quality of life for employees and families. A 1995 study conducted by Abbott showed that EAP services were cost-effective for mental health and substance abuse disorders as well as for reducing absenteeism and increasing productivity. Abbott has implemented a proactive disability management process through its EAP. Key components of the program are early identification of employees on short-term medical leave; case management throughout the medical leave; liaison between the company and health care providers; follow-up services for employees after their return to work.¹⁸

“When appropriate behavioral health services are not provided, it is expected that there will be an increase in medical utilization and costs, lost day and disability costs, and decreased productivity.” Burgess, et al, Investing in workplace productivity

Common services offered by EAPs in 120 companies surveyed

Alcoholism counseling	95%
Substance abuse counseling	92%
Mental health counseling	92%
Family and marital counseling	92%
Prevention of workplace violence	77%

Source: BNA (1996-1999)

WOMEN'S HEALTH PROGRAMS

Women comprise half of the U.S.'s workforce and experience more acute and chronic conditions such as depression, have more preventable diseases and, account for a higher percentage of physician visits.. Women also tend to utilize EAPs and promotional/preventive health programs more frequently when offered by their employers. Many employers have begun to offer programs and health plans that address women's specific health care needs.¹⁹

Johnson and Johnson is a leader in recognizing the impact of the overall mental and physical well-being of its employees on work. It has approximately 38,000 employees in the U.S., and one-half of them are women. Johnson and Johnson recently introduced a new integrated approach to medical, wellness, employee assistance, and disability management called Health and Wellness. Through its Wellness and Employee Assistance Programs women have been provided additional support for physical and mental health issues, as well as work and family benefits that may ease the stress level for many women. These include: on-site Child Development Centers which provide care for children from six weeks through accredited kindergarten; child/family leaves of up to one year including benefits continuation; flexible work schedules that allow employees to tailor their working hours to suit their family needs and responsibilities; accessible preventive health services such as routine mammograms, pelvic exams and pap smears; accessible counseling services for emotional disorders, stress and other lifestyle personal issues.²⁰

Practical suggestions for small business

Often smaller businesses (less than 50 employees) cannot afford to have a specific Employee Assistance Program or medical and rehabilitation experts on staff. However, the model that is used by many large employers can be adapted to a small setting. Based on reported experiences by the smaller employer, the *Employer's guide to the Americans with Disabilities Act* offers the following suggestions for managing and reducing disability costs:²¹

- The personnel or human resource director or other appropriate officer of the company should visit the employee who is on a medical/disability leave as soon as practical to demonstrate concern and encourage an early return to work.
- Always try to return the worker to his or her old job, even if an accommodation or flexible work time is required. This minimizes complications to the employee, reduces stress which may trigger a reoccurrence of depressive symptoms, and maximizes the company's advantage of having a trained employee.
- Use community resources. State or local rehabilitation agencies and support groups may aid in a successful return to work with minimal or no expense to the business.
- If necessary, ask your workers' compensation, health or disability insurance company for resources and assistance for reasonable accommodations.
- Make a special effort to inform the employee's physician or mental health professional regarding requirements of the job and possible changes and accommodations.

Strategies developed by large corporations for managing and reducing disability costs can be adapted to the needs of smaller businesses.

A CASE EXAMPLE: DISABILITY CASE MANAGEMENT AT ABBOT LABS

The following psychiatric disability case illustrates the benefits of an effective disability management program. An office assistant in her early thirties was a divorced single mother with two children. Her manager, having observed her recent problems with concentration and productivity, referred the employee to Abbott's EAP.

Due to the severity of the employee's condition, the EAP recommended that she be placed on medical leave. The employee, who had a history of childhood abuse and symptoms of depression, had been under the care of a psychiatrist and therapist. These providers were not responsive to the EAP's request for additional evaluation and more intensive outpatient treatment. Therefore, with the employee's agreement, she was referred to in-network providers, a psychiatrist and psychologist team, who quickly determined that she needed more timely intensive care. Her medications were modified and she began partial hospitalization treatment. The EAP case manager also arranged for the employee to receive financial assistance through a company program, which helped to reduce her level of stress.

After seven weeks, the woman had stabilized and was returned to work. However, shortly thereafter, she had a relationship break-up, and quickly slipped back into a crisis mode, including suicidal ideation. The employee was again placed on medical leave and her providers admitted her into an inpatient program. After a few days in the hospital, the employee stabilized again, returned to partial hospitalization, and began attending a depression support group.

Within six weeks time, the employee returned to work for the second time. This time, she was eased back into the work routine, beginning on a part-time basis, and slowly increasing her work hours. Within a month, she returned to full-time work. The EAP case manager maintained contact with her after the return to work, and also worked with the employee's manager to ensure a successful transition back to work. This employee has since demonstrated positive progress with a good prognosis.

Over a ten-month period, the EAP had made a total of 163 contacts with the employee, providers, and company personnel. This investment in support has enabled an employee who had been a probable candidate for long-term disability to remain productive. (Burgess, et. al.: Investing in workplace productivity, 1999)

SPECIFIC STEPS AN EMPLOYER CAN TAKE TO HELP AN EMPLOYEE RETURN TO WORK AFTER TREATMENT FOR DEPRESSION

1. Inform the attending physician of the exact duties of the job before the physician makes a final decision on return to work.
2. In consultation with the individual's physician, encourage an early return to work. The longer an employee is out of work due to treatment, the more the employee will worry about losing his or her job. Furthermore, the longer a person is away from the job, the more mentally detached he or she will become. An early return is best for no other reason than decreased disability pay, health insurance payments, or workers' compensation payments.
3. Consider gradual return to work. Allowing part-time work for several weeks may help reduce stress, leave time for additional medical counseling and allow the worker to quickly get back into a normal routine. Flextime, temporarily changed duties that involve less job-related stress, or other flexible arrangements may be helpful. However, there should be a clear understanding between the employee and the employer as to the details of the return to work program: expected length of time special accommodations will be granted, what day-to-day flexibility is allowed, the exact duties of the employee, and who will supervise the worker.

4. Other possible stress reducing accommodations include:

- altering the pace of work;
- lowering the noise level at work;
- providing water, tea, or soda and crushed ice to combat a dry mouth caused by some medications;
- extra encouragement and praise of job performance, but only if warranted and not obviously excessive;
- while taking steps to reduce stress, avoid babying the employee.

Over protection or excessive concern may harm a person's mental adjustment even more than lack of caring or concern;

- be sure the employee is treated as a member of the team and not excluded from social events, business meetings, or other activities relevant to the employee's job position. (Adapted from Frierson, 1995)

The changing employer role

Today, it is clearly recognized that employers benefit from an employee base that is healthy. Traditionally, employers have provided health care benefits, but as the financing of health care services continues to change in the U.S. and costs continue to explode more attention is being focussed on employers as active purchasers of care.

The Washington Business Group on Health has identified the following questions pertinent to the role of employers in the mental health area:²²

- What are the effects of company policies and procedures on the mental health of employees?
- What is the appropriate employer role in support of chronic, long-term catastrophic care for employees and their families?
- What is the appropriate employer role in supporting employees through unavoidable life crises (such as a death of a spouse or child), which impact job performance and may, in fact, represent the appropriate intervention point to prevent a disabling illness?
- When is the insurance model the most appropriate vehicle for employer sponsored mental health care? What are other alternatives?

Specific to their role as health care purchasers, employers are asking:

- What is the cost-benefit of a specific service?
- What are the effects of the restriction or elimination of mental health benefits?
- Is early intervention for depression and other mental disorders cost-effective?
- How should results of the latest research on depression and other mental disorders be incorporated into company policy?

To address these questions effectively, there must be a collaboration between the public and private sectors. The key role of the government and social partners, such as government agencies, non-government agencies, and unions in working with employers to implement and evaluate policy and legislation has been addressed earlier in this paper.

Exploding costs have led employers to play an increasingly proactive role in evaluating and purchasing health care services.

CONCLUSION

Clinical depression is one of the most common illnesses affecting working adults. Yearly, approximately one in ten American adults experiences a depressive disorder. Moreover, there is much evidence that there is a substantial degree of co-occurrence among medical, psychiatric, and substance abuse disorders. For example, depression occurs in up to two-thirds of patients who have suffered a heart attack and up to 25 % of cancer and post-stroke patients.¹ Depression is a major occupational health issue that needs to be addressed. It is a workplace health issue that significantly impacts the bottom line. In this situation analysis, the literature revealed that depression-related illness predominated in prevalence and cost over other traditional occupational health issues, such as substance abuse disorders.²

Clinical depression is a major workplace health issue.

Employers are beginning to recognize its implications for productivity, and, fortunately, there are effective treatments which lead to positive long-term results.

Employers of all sizes are beginning to recognize that depressive disorders often constitute their single highest mental health (medical) and disability cost. Employers experience expensive consequences of depression through absenteeism, lower productivity, disability, accidents and the inappropriate use of medical services.³ A large percentage of employers understand the relationship between health and productivity and are improving their management strategies by developing and implementing programs supportive of work/family/life issues, such as flextime, part-time schedules, child care benefits, personal leave, wellness health programs, and family counseling. As illustrated in this report, innovative employers have developed practices in conjunction with their health and human resource systems for managing both the direct and indirect cost consequences of mental illness in general and of depressive disorders in particular.⁴ To recap briefly, these employers are encouraging early recognition, appropriate and cost-effective care management, accommodations, and timely return to work. This is especially evident with the larger employer (over 1,000 employees) who is more apt to have the resources in terms of time, staff and capital expenditures. It is important to note, though, that smaller enterprises (under 50 employees) can partially implement aspects of these programs without incurring financial costs.

In spite of the many advances in the workplace in understanding mental illness and the implementation of preventive and promotional programs, many employers remain unaware and, perhaps, unconcerned about the overall impact of depression on their enterprises. For example, failure to recognize and treat co-occurring illnesses such as depression and heart disease, may lead not only to serious consequences for the employee but can ultimately contribute to increased health care costs, excess absenteeism, and unnecessary disability. From the standpoint of the the worker, although there are many interventions, effective medications, and legal recourse, there are barriers to recognition and treatment, including fear of stigma, under-recognition of symptoms by health care providers, limitation on insurance coverage, and inadequate or inappropriate treatment. Unfortunately, without access to recognition and treatment of a depressive disorder, the protection and requirements of laws such as the American with Disabilities Act become moot for many employees.

Despite increasing attention in the media, on the part of federal and state government agencies, campaigns by consumer and mental health advocacy organizations, technical support provided by NGOs and academic institu-

Numerous reports in the literature suggest that rates of depression among women, and especially among working women, are increasing. One suggested hypothesis for this increase has been that women experience stress from their work on the job and at home, and the combined effect can result in psychological strain and depression. (Griffin, Ph.D., Johns Hopkins School of Public Health; paper presented at the Work, Stress and Health Conference, 1999)

tions, the U.S. Office of Technology Assessment (USOTA) has stated that the current level of guidance, technical assistance, and research activities is still inadequate to optimally assist employers and people with mental illness in terms of implementation of effective management models and the legislative framework. To address these issues, USOTA recommends that the appropriate government agencies (e.g. the Center for Mental Health Services and the National Institute on Disability and Rehabilitation Research) expand current ties, and work more closely with mental health advocacy organizations, employee assistance programs, other human resource professionals, and private and state-affiliated care providers. Some of these activities would include:

- developing professional training materials on mental health management and disseminating them at national and regional meetings sponsored by federal government and professional organizations;
- expanding the activities of the National Worksite Program to include more small- and mid-size companies; and
- providing more information on the various laws and pertinent judicial rulings in the form of materials and training sessions for EAPs, other human resource offices, and mental health advocacy organizations.

In this analysis, the literature indicates that clinical depression, unlike other illnesses tends to be concentrated in individuals of working age between ages 25 and 44. While they may have short-term or long-term periods of disability, clinically depressed employees typically remain employed, often struggling with their symptoms for months or years. The good news about depressive disorders is that effective treatments are available, and according to NIMH there is an 80% success rate utilizing medication, psychotherapy, or a combination of both. For example, a recent study concluded that antidepressant drug therapy effectively lowers rates of job absenteeism in depressed workers. Researchers found that once patients began drug therapy, within six months rates of absenteeism declined from over 5.5 days/month to 1.5 days/month.⁵ The Washington Business Group on Health in its *Executive summary: Investing in workplace productivity* states: "These treatments lead to positive long-term results - results much better than for many serious physical maladies, from back pain to cancer."

In conclusion, as the United States evolves towards a more information-based economy, increased pressure is placed on a company's employees to supply a competitive edge. It is not surprising that more and more cases of disability are related to slowly developing chronic conditions such as depression and work-induced stress. Mental illnesses such as the depressive disorders, either as occupational disabilities or disabilities arising outside the workplace, are a concern for workers, employers and government bodies alike.

NOTES

INTRODUCTION

1. Murray, C. and Lopez, A. eds: *The Global Burden of Disease*, Harvard School of Public Health; WHO and World Bank, 1996, p. 21; WHO, Department of Mental Health, Feb. 2000.
2. *Mental Health: A Report of US Surgeon General*, Chap. 5, Jan. 00.
3. Jansen, M.: Emotional disorders and the labour force, prevalence, costs, prevention and rehabilitation. *International Labour Review*. ILO 1986, p. 605.

GLOSSARY

1. WHO *Programme on Mental Health*. 1998, <http://www.who.int>; WHO. *Mental Health*, Fact Sheet 130. August 1996; *Mental Health: A Report of the Surgeon General*. U.S.N.
2. *ibid.* and *The Undefined and Hidden Burden of Mental Health Problems* WHO Fact Sheet 218, April 1999.
3. *Mental Health: A Report of the Surgeon General*. *op.cit.*
4. Sim, Foo Gaik: *Integrating Women and Girls with Disabilities into Mainstream Vocational Training: A Practical Guide*, ILO, 1999.
5. *Introduction to mental health issues in the EU*. STAKES. Finland 1999. *Mental Disorders in Primary Care: A WHO Educational Package*. WHO. 1998 (Reference tool for symptoms and diagnoses)
6. *Five Common and Disabling Mental and Neurological Problems*. www.who.int, Jan. 2000. *Mental Health* WHO
7. Hosman, C.M.H, Jane-Llopis, E.: *Effective Mental Health Promotion and Mental Disorders Prevention*, European International Union for Health Promotion and Education, 1999.
8. Pender, N.J.: *Health Promotion in Nursing Practice*. pp. 51-57, Appleton and Lange, 1996. Clemens and Jane-Llopis, *op.cit.*
9. UN Standard Rule; Code of Practice: Management of Disability Related Issues unpublished, ILO.
10. Pender: *op. cit.*, pp 124, and 235-237.
11. Liam, Vivien: *Moderating the effects of work-based support on the relationship between job insecurity and its consequences*. *Work and Stress*, 1997 Vol.11 (3), 231- 266.
12. U.S. National Institute for Occupational Safety and Health (NIOSH). *Stress At Work*, prepared by a NIOSH Working Group, 1998. <http://www.cdc.gov/niosh>
13. Kalimo, R.: 1999, *The Challenge of damaging work and stress for human resources. The case of Finland*. The Finnish Institute of Occupational Health. In print.
14. Liam: *op.cit.*
15. *The Undefined and Hidden Burden of Mental Health Problems*. WHO Fact Sheet No. 218, April 1999.
16. Sim: *op. cit.*, p. 12.

17. Frierson, J.: *Employer's Guide to The American With Disabilities Act*. BNA Washington D.C. 1995. p. 317.
18. Code of Practice: Management of Disability-Related Issues in the Workplace. ILO, unpublished.

PART 1: MENTAL HEALTH AT THE NATIONAL LEVEL

1. Behney, et al.: *Psychiatric Disabilities, Employment and the Americans with Disabilities Act Background Paper*, US Office of Technology Assessment, pp. 15-20, 1997; McCarthy,(ed.) "Understanding and Working with Disability Rights Groups," *Complete Guide to Employing Persons with Disabilities*, Chap.11, 1985.
2. The US Equal Employment Opportunity Commission, www.eeoc.gov/fact.
3. Burgess,et al.: *Investing in Workplace Productivity, Innovations in Managing Indirect Mental Health Costs*, Washington Business Group on Health & NIMH, 1999. Refer to entire source.
4. National Mental Health Association(NMHA), *NMHA Poll Shows Myths & Misunderstanding Still Surround Mental Illness*, NMHA News Release, June 5,1999.
5. Ibid.
6. Fitter: "Depression In the Office," *Boston Herald*, 1995. Originally written by author for Boston Herald. www.well.com/user/fsquared/depress.html National Institute of Mental Health (NIMH), "Depression Affects Your Employees," "What Can a Supervisor Do," "The Invisible Disease-Depression," www.nimh.nih.gov , May, 1999.
7. National Institute On Disability & Rehabilitation Research(NIDRR), *Strategies to Secure and Maintain Employment for People with long-term Mental Illness*, pp. 1-3, Vol XV, (10) 1993.
8. PRS Disability Management, *Mental Illness in the Workplace*, April, 1999. See web site for more information www.psychdismgmt.com on PRS Disability Management, a leading organization in psychiatric disability management.
9. Cornell University, School of Industrial & Labor Relations, *Employing & Accommodating Workers with Psychiatric Disabilities*, January 1994; Frierson, *Employer's Guide to The Americans With Disabilities Act (2nd Edition)*, pp. 257-259, 1995.
10. National Alliance for the Mentally Ill (NAMI), NAMI Fact Sheet. www.nami.org July, 1999.
11. NIDRR, pp. 3-6.
12. Mathers & Schofield: "The health consequences of unemployment:the evidence," *MJA* 1998: 168: 178-82 Dooley, et al., "Depression & Unemployment:panel findings from the Epidemiologic Catchment Area study." *Amer. J.Comm. Psy.*, 1994 Dec 22(6): 745-65; Turner, "Economic context and the health effects of unemployment." *J HealthSocial Behavior*, 36, 1995: 213-229.
13. Linn et al.: "Effects of Unemployment on mental and physical health," *Am J Public Health* 1985; 75:502-506 cited in Mathers, "The health consequence of unemployment: the evidence," *MJA*, 1998, p. 3.
14. Jin, R. L. et al.: "The impact of unemployment on health: "A review of the evidence"*J. of Public Health Policy*, 18 (3), 1997: 275-301.
15. Dooley, et al.:1994.
16. Stoddard, et al.: *Chartbook on Work and Disability in the United States, 1998*, ppiii-3, US Dept. of Education, NIDRR, for full text see www.ed.gov/offices/OSERS/NIDRR/pubs.html.

17. Ibid, p. iii.
18. Ibid, pp. 5,11, 28, 34.
19. GLADNET, Work Incentives for Persons with Disabilities, Oct. 20, 1999.
20. Frierson: Chapter 9, pp. 287 -335; NAMI, "The Mental Health Parity Act of 1996:Summary of the Law," July 1999 . For full text see www.nami.org/update/parity96.html.
21. Frierson, see Chapter 9 for detailed explanation.
22. Behney et al: Chapter 1 Executive Summary; Frierson, p. 3; The Bureau of National Affairs, Inc.(BNA) Policy and Practice Series:EEOC: Psychiatric Disabilities and the ADA, 1996- 1999.
23. Behney, et al.: pp. 1-2.
24. Frierson, J.: pp. 3-5; Behney et al., Chapter 2 pp. 10-13.
25. Frierson, J.: pp. 4-5.
26. Ibid, p. 5.
27. BNA, pp. 2-3; Frierson, J., p. 250.
28. Frierson, J.: p. 259-260; BNA pp. 4-18 - entire series demonstrates this point.
29. BNA, p. 2.
30. Ibid.
31. Frierson, J.: p. 250.
32. BNA, pp. 3-4.
33. Ibid.
34. Ibid.
35. Behney, C. et al.: "Disclosing a Psychiatric Disability to an Employer," pp. 38-42..
36. BNA, "Disclosure of Disability", pp. 6-8.
37. BNA, "Requesting Reasonable Accommodation," pp. 9-14.
38. Behney, C., et al.: pp. 45-49.
39. NAMI, "The Mental Health Parity Act of 1996," July 1999; " Mental HealthParity Act to Take effect at Midnight," December 1997.
40. Health News: Dr. Koop's Community, April 15, 1999"Senators unveil scaled back mental health bill."
41. NAMI, "The Mental Parity Act of 1996," July 1999.
42. Frierson, J.: pp. 292-298
43. Ibid. & GLADNET, 1999
44. Frierson, J.: pp. 299-302; BNA Policy and Practice Series 1996-1999: Workers' Compensation General Provisions.

45. National Institute for Occupational Safety and Health (NIOSH), Stress At Work, DHHS (NIOSH) Publication No. 99-101, 1998. Full text at www.cdc.gov/niosh/stresswk.html.
46. Ibid, p. 3.
47. Frierson, J.: pp. 300-301
48. BNA Policy and Practice Series, 1996-1999; Burgess et al., refer to full document; Vaccaro,V, Depression:Corporate Experiences and Innovations, D/ART Program, NIMH, Washington Business Group on Health, 1994.
49. Frierson, J.: pp. 334-335
50. Burgess, A, et al.; Vaccaro, V., 1994, Frierson: pp. 334-335.
51. Frierson: pp. 334-335
52. BNA Policy and Practice Series, 1996-1999: Counseling and Employee Assistance Programs.
53. Ibid.
54. D/ART Worksite Program, NIMH, Washington Business Group on Health(WBGH), In Good Company: Developing EAP Strategies for Clinical Depression. A series of educational/training materials distributed by WBGH.
55. NAMI, Facts About mental illness, 1999, full text at www.nami.org/fact
56. NIDRR, 1993, p. 1.
57. NAMI, 1999.
58. NIMH, NIMH Press Office, "New Study on Financing Mental Health Parity in Managed Behavioral Health Care," July 13,1998.
59. Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Mental Health Services,. "Mental Health Services Shift Toward Greater Consumer Participation,"1998. SAMHSA is a public health agency in the U.S. Dept. of Health and Human Services and is the federal government's lead agency for improving the quality and availability of substance abuse prevention, addiction treatment and mental health services in the U.S. See internet site for more information www.samhsa.gov.
60. Ibid.
61. Ibid.
62. UCLA/Rand Center for Research on Managed Care; William Mercer, Inc., Senate Report No. 104-368, cited in NAMI, "Cost Data on Parity for Mental Illness, 1999.
63. AARP/Managed Care A Consumer's Guide, pp. 1-5. 1999. See text at internet site www.aarp.org/monthly.
64. Ibid.
65. Health News: Dr. Koop's Community, 1999.
66. Medical Tribune News Service, 1999; CNN-HMO's: The Cost of Cutting Prices, May 23, 1997. www.cnn.com/HEALTH.
67. Sturm, R.: "How Expensive is Unlimited Mental Health Care Coverage Under Managed Care," JAMA, November 12,1997; NAMI, "Cost Data on Parity For Mental Illness," July, 1999.
68. Sturm, R.: 1997.

- 69 Miller,I., Ph.D., “Eleven Unethical Managed Care Practices Every Patient Should Know About (with emphasis on mental health care);” The National Coalition of Mental Health Professionals and Consumers, Inc., August, 1998.
- 70 National Mental Health Association (NMHA), *Fact Sheet: Depression in the Workplace*,1999. For more information see internet site:www.nmha.org/ccd/support/factsheet.
71. Conti D.J., Burton W.H.: “The Economic Impact of Depression in a Workplace.” *JOM*, 1994; 36: 983-988. D/ART National Worksite Program & Washington Business Group on Health (WBGH), *Managing the Impact of Depression in the Workplace: An Integrated Approach*,1995. Vaccaro, V., 1994, pp. 1-6.
72. D/ART National Worksite Program & WBGH, 1995, p.3.
73. Ibid & Vaccaro,V,. 1994, p. 2.
74. Conti D.: et al., 1994, p. 983. D/ART National Worksite Program & WBGH, 1995, pp. 4-5.
- 75 D/ART National Worksite Program &WBGH, p. 4. (Adapted from Greenberg, PE et. al. “The Economic Burden of Depression in 1990.” *J Clin. Psychiatry*.1993;54:405-418).
76. Vaccaro, V., 1994, p. 4.
77. Ibid. pp. 6-7
78. Greenberg, P.: “Tackling costs one disease at a time,” *Business & Health*, May, 1999, p. 2.
79. Conti, D.J, 1994, pp. 285-286. D/ART National Worksite Program & WBGH, pp. 7-9. Burgess,A., 1999, pp. 18-22.
80. Arc. Gen. Psychiatry, 1992.

PART 2: THE ROLE OF GOVERNMENT AND THE SOCIAL PARTNERS

1. Behney, et al.: op.cit.,pp. 61-63.
2. Behney, et al.: op.cit.,pp. 70-71.
3. Behney, et al.: op.cit.,p. 64 & The Bureau of National Affairs, Inc.,(BNA)Policy and Practice Series: EEOC: Psychiatric Disabilities and the ADA, p. 1.
4. Behney, et al.: pp. 64-66.
5. Ibid, p. 64.
- 6 BNA Policy and Practice Series: op.cit.,pp. 1-2
7. New York Times, “Employment Discrimination Suits:Mental Health Claims Now Top the List,” December 14, 1998, <http://www.depression.com/news>. & Moss,K. et al.: Assessing Employment Discrimination Charges Filed by Individuals with Psychiatric Disabilities Under the Americans With Disabilities Act. *Journal of Disability Policy Studies*, Vol.9 (1), 1998.
8. New York Times, ibid. and BNA Policy and Practice Series, op.cit, pp. 1-6.
9. BNA Policy and Practice Series, op.cit., p. 10.
10. Behney, et al.: op.cit., pp. 66.
11. ibid.

12. Ibid, pp. 67-68. (All information on CMHS based on this source.)
13. Ibid, pp. 68-69., & NIMH, Depression Research at the National Institute of Mental Health:Fact Sheet, April 13,1999: See web site <http://www.nimh.nih.gov/> .
14. NIMH, National Worksite Program (1987-1999), Chapter 5. (Document from Isabel Davidoff, Chief of the National Worksite Programn, NIMH)
15. *ibid.*
16. *ibid*, (refer to entire chapter)
17. NIMH, Press Release: National Institute of Mental Health Launches Landmark Study of Mental Health in the U.S. June 7, 1999. See web site: <http://www.nimh.nih.gov/events/prlandmark.htm>.
18. *ibid.*
19. Behney et al.: *op.cit.*, pp. 69-70
20. *Ibid*, p. 70.
21. *Ibid*, & Frierson: *op.cit.*, p. 165.
22. National Institute for Occupational Safety and Health (NIOSH), *Stress at Work*, Feb. 1999 , pp.1-3, see web site: <http://www.cdc.gov/niosh>
23. Greenhouse,S.: “Labor, Revitalized With New Recruiting, Has Regained Power and Prestige,” *New York Times*, October 9, 1999.
24. *ibid.*
25. Parks, J.: Unions helping to make disabilities act work. *AFL-CIO News*- July 31, 1995; O’Neil,C.: Family Leave Act Causes no strain, *AFL-CIO News*-May 16,1996; Parks,J.:Sweeney: Union Strength can lift disabled workers, *AFL-CIO News* -June 7, 1996.; AFL-CIO, Summary of Job Safety and Health Protections Threatened by 105th Congress, April 1998. See web site <http://www.aflcio.org>
26. National Institute For Occupational Safety and Health (NIOSH): NIOSH Report Addresses Problem of Workplace Violence. Suggest Strategies for Preventing Risks, Press Release, July 8, 1996; NIOSH, Violence in the Workplace:Public Health Summary, July 16, 1996.; NIOSH, Violence in the Workplace:Homicide in the Workplace, 1996.; NIOSH,Violence in the Workplace:Nonfatal Assaults in the Workplace, July16, 1996. See web site <http://www.cdc.gov/niosh/violpr.html>
27. Parks, J.: Unions helping to make disabilities work. *AFL-CIO News*- July 31,1995.
28. *ibid.*
29. United Auto Workers (UAW),Bargaining 1999 -Q&A on UAW Bargaining in ‘99- Family: UAW Work and Family Programs. August 1999. See web site <http://www.uaw.org>
30. *ibid.*
31. Parks, J.: Unions helping to make disabilities act work, *AFL-CIO News*, July 31,1995.
32. Frierson: *op.cit.*, p. 348 (adapted for this document)
33. Rosier, S.: Tighter rules sought to prevent workplace violence at night. *AFL-CIO News*, August 23, 1996.

34. *ibid.* & NIOSH Report Addresses Problems of Workplace Violence, Suggests Strategies for Preventing Risks, July 8, 1996.
35. O'Neil, C.: Family Leave Act causes no strain, *AFL-CIO News*, May 16, 1996.
36. UAW, *op.cit.*
37. Chappell, D. & Di Marino, V.: "Part I: Understanding Violence at Work", Violence at Work, pp. 3-6
38. *Ibid.*, & NIOSH, *op. cit.*
39. NIOSH, *op.cit.*
40. Sabbagh, L.: "Stress Signs Often Missed in Victims of Violent Crime," The Medical Post, 1995. (Reported from the annual meeting of the Anxiety Disorders Association of America.)
41. *ibid.*
42. Burgess, et al.: *op. cit.*
43. Behney, et. al: *op.cit.*, p. 66
44. *ibid.*
45. National Business and Disability Council (NBDC), Mission Statement, August, 1999. See web site <http://www.businessdisability.com>
46. NBDC, August 1999 - telephone interview with Information Officer
47. Behney: *op.cit.*, pp. 16-17.
48. NMHA, More About NMHA and the Mental Health Movement, July 1999. See web site <http://www.nmha.org>
49. *ibid.*
50. *ibid.*
51. NAMI, NAMI Fact Sheet. July, 1999. See web site <http://www.nami.org> & Behney, *op. cit.* pp. 17-18 (see for additional information)
52. NAMI, Campaign to End Discrimination, July 1999. See web site <http://www.nami.org/campaign/index.htm>
53. *ibid.*
54. National Mental Illness Screening Project, July 1999. See web site <http://www.nmisp.org>
55. *ibid.*
56. *ibid.*
57. Isabel Davidoff, NIMH, July 1999 telephone interview.
58. NMISP, Interactive Telephone Screening Programs, July 1999. See web site <http://www.nmisp.org/phone.htm>

59. Behney et. al.: op. cit., p17.
60. *ibid.*
61. Brazelon Center For Mental Health Law, Who We Are What We Do what We don't Do. July 1999. See we site <http://www.brazelon.org> & Behney et al.: op.cit.
62. Behney et al.: op.cit., pp. 18-19.
63. Work Stress & Organization of Work in a Global Economy, sponsored by NIOSH and American Psychological Association, March 11-13 1999.
64. Boston University Center for Psychiatric Rehabilitation. See web site <http://gopher1.bu.edu/SARPSYCH>
65. Cornell University, School of Industrial and Labor Relations, Program on Employment and Disability. See web site <http://www.ilr.cornell.edu/ped>
66. Michigan State University, Office of Rehabilitation and Disability Studies. See web site <http://ed-web3.educ.msu.edu/ord/>

PART 3: BEHAVIORAL RISK MANAGEMENT IN THE WORKPLACE

1. Galinsky et al.: The Corporate Reference Guide To Work -Family Programs, pp. 9-18, 1991.; Galinsky et al.: The 1997 National Study of the Changing Workforce, 1997.; Greenberg, Tackling costs one disease at a time. *Business & Health*, May 1999.
2. Galinsky et al.: op. cit.,p. 111.
3. *ibid.*
4. Galinsky, et al.: op. cit., Chapter 4 “The Four Friendliest Companies”, pp. 45-80.
5. Galinsky & Bond: The 1998 Business Work-Life Study Executive Summary.
6. Galinsky et al.: The Corporate Reference Guide to Work- Family Programs, p. 87.
7. Vaccaro: Depression Corporate Experience and Innovations, pp. 1-2, 1994.
8. *Ibid*, p.6.
9. *ibid.*
10. WBGH & NIMH (D/ART National Worksite Program) , Managing the Impact of Depression in the Workplace: An Integrated Approach. pp. 5-6.
11. Vaccaro: op. cit., p. 18.
12. *Ibid*, p. 20.
13. *Ibid*, pp. 8-10.
14. Burgess, et al.:Investing in Workplace Productivity,pp. 18-21.
15. Conti, et al.: The Economic Impact of Depression in a Workplace pp. 983-984.
16. WBGH & NIMH, Managing the Impact of Depression in the Workplace:An Integrated Approach, p.6.
17. Burgess et al.: op. cit., pp. 17-31

18. Ibid, p. 22.
19. Muchnick-Baku: Corporate Strategies for Womens Health Survey Results and Case Studies, 1997.
20. Ibid, pp. 23-26.
21. Frierson: op.cit., pp. 331-332.
22. Vaccaro: op.cit.: p. 31.

CONCLUSION

1. Burgess, et al.: op. cit., "Recognize Co-Occurrence of Illnesses," p. 46.
2. Conti, et. al.: op. cit. pp. 983-984.
3. WBGH & NIMH, Managing the Impact of Depression in the Workplace: An Integrated Approach.
4. Burgess et al.:op cit.
5. Reuters Health, Antidepressants Reduce Number of Missed Work Days, July 9, 1999. Originally published in the July 1999 issue of the *Journal of Occupational and Environmental Medicine*. Croghan, et al.: "Cost Effectiveness of Antidepressant Medications." *The Journal of Mental Health Policy and Economics*, 1, 109-117. 1998.

This page has been left blank intentionally.

BIBLIOGRAPHY

AFL-CIO: Mission and Goals of the AFL-CIO, Summary of Job Safety and Health Protection Threatened by 105th Congress. July, 1999. <http://www.aflcio.org>

Bernard Arons, M.D., Director: Summary of Presentations: Parity in Coverage of Mental Health Services in an Era of Managed Care (Project on the Decade of the Brain). Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Dept. of Health and Human Services,, June 1997. <http://leweb.loc.gov/loc/brain/summary>

Clyde Behney,Laura Hall, Jacqueline Keller (Project Staff): Psychiatric Disabilities, Employment, and The Americans With Disabilities Act Background Paper, U.S. Office of Technology Assessment, 1997. <http://www.eeoc.gov/docs/psych.pdf>

James Bond, Ellen Galinsky, Jennifer Swanberg: The 1997 National Study of the Changing Workforce. (No.2 1997) Families and Work Institute, NY,NY 1998. <http://www.familiesandwork.org>

The Bureau of National Affairs Policy and Practice Series: The Bureau of National Affairs, Inc. 1996-1999, Washington D.C. <http://www.bna.com> (The Bureau of National Affairs, Inc. is the oldest wholly employee-owned company in the United States. BNA is a leading publisher of print and electronic news and information reporting on development in health care, business, labor relations, law, economics, taxation, environmental protection, safety and other public policy and regulatory issues. BNA produces more than 200 news and information services and numerous dailies, including the Daily Report for Executive and Daily Labor Report.)

The Bureau of National Affairs: Bulletin to Management Series. 48(3,14); 49 (3, 8, 25, 26, 39, 30); 50 (3). The Bureau of National Affairs, Inc. 1996-1999. Washington, D.C. <http://www.bna.com>

Angela Burgess, Isabel Davidoff, Veronica Goff: Investing in Workplace Productivity: Innovation in Managing Indirect Mental Health Costs. Washington Business Group On Health National Institute of Mental Health National Worksite Program, March, 1999.

Duncan Chappell & Vittorio Di Martino: Violence at Work, International Labour Organization,Geneva, 1998.

Daniel Conti, Ph.D. & Wayne Burton MD.: "The Economic Impact of Depression in a Workplace." JOM, Vol.36, (9) September, 1994, pp. 983-989

Mary Ellen Copeland: The Depression Workbook: A Guide for Living With Depression and Manic Depression. New Harbinger Publications,Inc., Oakland,CA., 1992.

Thomas Crogan et.al.: "Cost-Effectiveness of Antidepressant Medications". The Journal of Mental Health Policy and Economics, 1. 109-117 (1998)

Isabel Davidoff: National Worksite Program (1987-1999), Chapter 5. National Institute of Mental Health, Division of Services and Intervention Research, Bethesda, MD

DEPRESSION, Awareness, Recognition, and Treatment, National Worksite Program (D/ART), Washington Business Group on Health and National Institute of Mental, Health.: Managing the Impact of Depression in the Workplace: An Integrated Approach, Washington D.C., 1995

Mary Jane England,MD.: "Capturing Mental Health Costs Offsets". Health Affairs March/April, 1999.

James Frierson: Employer's Guide To The Americans With Disabilities Act, Second Edition. Bureau of National Affairs, Inc., Washington D.C., 1995.

Ellen Galinsky & James Bond: The 1998 Business Work-Life Study A Source Book, Families and Work Institute, NY, NY, 1998. <http://www.familiesandwork.org>

Ellen Galinsky, Dana Friedman, Carol Hernandez: The Corporate Reference Guide to Work Family Programs, Families and Work Institute, NY,NY, 1991. <http://www.familiesandwork.org>

James Gemignani.: “ Best Practices That Boost Productivity.” Business & Health, March, 1998.

Ron Goetzel, Ph.D. et.al.: “Association of IBM’s “A Plan for Life” Health Promotion Program with Changes in Employees’ Health Risk Status.” Journal of Occupational Medicine, 36 (9), September 1994 pp. 10-16

Steven Greenhouse.: “Labor, Revitalized With New Recruiting Has Regained Power and Prestige”, New York Times, Oct. 9,1999

Health News: Dr. Koop’s Community: Senators Unveil Scaled Back Mental Health Bill. April 15,1999.

Deborah Holmes & Dana Friedman: The Changing Employer-Employee Contract: The Role of Work-Family Issues, paper prepared for the 1995 Work-Family Conference sponsored by Families and Work Institute, NY, NY.

Elise Lipoff et. al. (eds): The Annual Review of Disability Management 1991. Washington Business Group on Health & Institute for Rehabilitation and Disability Management, Washington, D.C., 1991.

Colin Mathers and Deborah Schofield: “The Health Consequences of Unemployment: The Evidence.” The Journal of Australian Medical Association, 1998: 168: 178-182.

Henry McCarthy (ed.): Complete Guide to Employing Persons with Disabilities .Human Resource Center, Albertson, NY, 1985.

K. Moss & M.C. Johnsen: Employment Discrimination and the ADA: A study of the Administrative Complaint Process. Journal of Disability Policy Studies, 9 (1), 1998.

Sonia Muchnick-Baku: Corporate Strategies for Women’s Health: Survey Results and Case Studies. Washington Business Group on Health, Washington D.C. Spring, 1997.

National Alliance for the Mentally Ill (NAMI): Cost Data on Parity for Mental Illness; Campaign to End Discrimination;NAMI Fact Sheet; Some Questions You May Have about the New Federal Parity Law. July, 1999. <http://www.nami.org>

National Business & Disability Council: The NBDC is the leading resource for corporations that are hiring, working with and markeing to people with disabilities: “Over 22 years of expertise....”; Birch Awarded Industry Labor Council 1997 Employee of the Year. August 1999. <http://www.businessdisability.com>

National Institute of Mental Health (NIMH): New Study on Financing Mental Health Parity in Managed Behavioral Health Care. Washington, D.C., National Institute of Mental Health, July 13, 1998.

National Institute of Mental Health Series on Depression: The Effects of Depression in the Workplace; What To Do When an Employee is Depressed; What Can a Supervisor Do? Depression Affects Your Employees; The Invisible Disease-Depression. <http://www.nimh.nih.gov>

National Institute for Occupational Safety and Health (NIOSH): NIOSH Press Release: Workplace Violence - NIOSH Report Addresses Problem of Workplace Violence, Suggests Strategies for Preventing Risks; Public Health Summary; Homicide in the Workplace; Nonfatal Assaults in the Workplace; Risk Factors and Prevention Strategies , July 1996. <http://www.cdc.gov/niosh/violabst.html>

National Institute for Occupational Safety and Health (NIOSH): Stress At Work, prepared by a NIOSH Working Group, 1998. <http://www.cdc.gov/niosh>

National Institute for Occupational Safety and Health (NIOSH): Violence in the Workplace, June, 1997. <http://www.cdc.gov/niosh>.

National Mental Health Association (NMHA): Best & Worst Practices in Private Sector Managed Mental Healthcare; More About NMHA and the Mental Health Movement; NMHA Poll Shows Myths

& Misunderstandings Still Surround Mental Illness; NMHA Lauds Connecticut Legislature, Governor for Approving Full Mental Health Parity Legislation; Depression in the Workplace, July 1999. <http://www.nmha.org>

National Mental Illness Screening Project: Doctors Discovering Depression; National Depression Day Expands to Primary Care Offices; Interactive Telephone Screening Programs: Workplace Program Employee Telephone Access Program, July, 1999. <http://www.nmisp.org>

Colleen O'Neil: "Family Leave Act Causes no Strain," AFL-CIO News May 16, 1996. <http://www.aflcio.org>

James Parks: "Sweeney: Union strength can lift disabled workers," AFL-CIO News - June 7, 1996. <http://www.aflcio.org>

James Parks: "Unions helping to make disabilities act work," AFL-CIO News July 31, 1995. <http://www.aflcio.org>

Nola Pender: Health Promotion in Nursing Practice (Third Edition). Appleton & Lange, Simon & Schuster, 1996.

"Post Traumatic Stress Disorder," The Harvard Mental Health Letter, June (Part I), July, 1996 (Part II). <http://www.mentalhealth.com/mag>

Rehab Brief: Strategies..Employment..Mental Illness. Strategies to Secure and Maintain Employment for People with Long Term Mental Illness. National Institute on Disability and Rehabilitation Research, Office of Special Education and Rehabilitative Services, Department of Education Washington, DC. Vol. XV, No. 10 (1993) ISSN:0732-2623. <http://www.cais.com/naric/rehab>

Reuters Health: Antidepressants Reduce Number of Missed Work Days, July 9, 1999. <http://www.depression.com/news>

Sharolyn Rosier: "Tighter rules sought to prevent workplace violence at night," AFL-CIO, August 23, 1996. <http://www.aflcio.org>

Leslie Sabbag: "Stress Signs Often Missed in Victims of Violent Crime", The Medical Post, May 9, 1995.

STAKES (National Research and Development Centre for Welfare and Health in Finland): Working Life, Employment policy and Promotion of Mental Health in Finland - European Conference on Promotion of Mental Health and Social Inclusion, Tampere 10-13 October, 1999. <http://www.stakes.fi/mentalhealth>

Susan Stoddard, Lita Jans, Joan Ripple, Lewis Kraus: Chartbook on Work and Disability in the United States, 1998. Prepared for. U.S. Department of Education National Institute on Disability and Rehabilitation Research, Washington, D.C.. InfoUse, Berkeley, CA.

Roland Sturm: "How Expensive Is Unlimited Mental Health Care Coverage Under Managed Care?." JAMA: 278 (18), pp. 1533-1537, 1997.

UAW: Q&A on UAW Bargaining in '99: Health Care: Meeting the challenge of cost and quality; Bargaining 1999 - Q&A on UAW Bargaining in '99 - Family; Issues: Our Action Program Health Care Reform. August, 1999. <http://www.uaw.org>

Veronica Vaccaro: Depression :Corporate Experiences and Innovations, published for the DEPRESSION Awareness, Recognition and Treatment National Worksite Program, a cooperative initiative of the National Institute of Mental Health and the Washington Business Group on Health, Washington, D.C. 1994

Otto Wahl, Ph.D.: Media Madness: Public Images of Mental Illness, New Brunswick, NJ: Rutgers University Press, 1995.

Watson Wyatt Worldwide and Washington Business Group on Health: Staying At Work: Increasing Shareholder Value Through Integrated Disability Management, Third Annual Report. Washington D.C., 1999

This page has been left blank intentionally.

ANNOTATED BIBLIOGRAPHY

Clyde Behney, Laura Hall, Jacqueline Keller (Project Staff). Psychiatric Disabilities, Employment, and the Americans With Disabilities Act Background Paper, U.S. Office of Technology Assessment, 1997. <http://www.eeoc.gov/docs/psych.pdf>.

This study by the U.S. Office of Technology Assessment examines efforts under the American with Disabilities Act (ADA) in the area of psychiatric disabilities and employment and reviews data that may assist future implementation. This assessment has two major goals. The first is to compare ADA's employment provisions with what is known about mental disorder-based or psychiatric disabilities. The second goal is to review federal activities relevant to the ADA, employment and psychiatric disabilities. This report presents the following information: 1) provides an overview of the ADA requirements and the political and legal antecedents; 2) presents discussion of the ADA's definition of disability and its potential impact on people with psychiatric disabilities. A description of psychiatric disabilities, their prevalence, common symptoms, and treatment, associated functional limitation, and their impact on employment is also presented; 3) examines many of the critical requirements of Title I of the ADA, including disclosure, qualification standards, reasonable accommodations, and the issue of direct threat. The ADA's potential impact on mental health benefits is also discussed; and 4) reviews federal enforcement, technical assistance, and research support related to the ADA, psychiatric disabilities, and employment.

James Bond, Ellen Galinsky, Jennifer Swanberg. The 1997 National Study of the Changing Workforce, (No.2 1997) Families and Work Institute, NY, NY 1998. <http://www.familiesandwork.org>

This report is based on a major survey of a representative sample of U.S. workers focusing on what is actually occurring at work and in their personal lives. Based on lengthy interviews with thousands of wage and salary earners across the United States, it provides a view of workers today as well as a comparison with the last 20 years. The survey was designed in part to parallel the U.S. Labor Department's 1977 Quality of Employment Survey. From the changing roles of men and women to the characteristics of work most related to loyalty, retention, and job satisfaction, this report addresses employers, policy-makers, labor organizations researchers and anyone who works.

The Bureau of National Affairs Bulletin to Management Series, Vol. 48 (3,14); 49 (3, 8, 25, 26, 39, 30); 50 (3). The Bureau of National Affairs, Inc. 1996-1999. Washington D.C. <http://www.bna.com>

This series examines the impact of job stress on the employee health. issues discussed: Causes of job stress; declines in employee commitment as job stress builds; job stress and lost productivity; impact of firing an employee (the second leading source of workplace stress); worker loyalty; mental disability, reasonable accommodations, and court rulings; the "crunch" of work/family demands on employees; staffing shortage on the rise; and EEOC's guidelines on psychiatric disabilities.

The Bureau of National Affairs Policy and Practice Series. The Bureau of National Affairs, Inc. 1996-1999, Washington D.C. <http://www.bna.com>

The Bureau of National Affairs, Inc. is the oldest wholly employee-owned company in the United States. BNA is a leading publisher of print and electronic news and information reporting on development in health care, business, labor relations, law, economics, taxation, environmental protection, safety and other public policy and regulatory issues. BNA produces more than 200 news and information services and numerous dailies, including the Daily Report for Executive and Daily Labor Report. BNA's Policy and Practice Series covers the following: The Personnel/Human Resources Dept; Counseling and Employee Assistance Programs; Work Life Benefits; Health Promotion, Wellness and Medical Programs and Services; Video Display Terminals; Mental Health and Substance Abuse; Eldercare Programs and Services; Workers' Compensation General Provisions and Psychiatric Disabilities and the ADA.

Angela Burgess, Isabel Davidoff, Veronica Goff. Investing in Workplace Productivity: Innovation in Managing Indirect Mental Health Costs. Washington Business Group On Health National Institute of Mental Health National Worksite Program, March, 1999.

Employee health has long been seen as a key component of productivity, although it has traditionally been evaluated only in terms of the direct cost of providing health benefits. Increasingly, corporations are realizing that there are significant indirect costs in the form of lost work time and impaired performance created by poorly managed or unrecognized employee health problems. To deal with this issue and help large employers meet the productivity challenge, the National Worksite Program, a cooperative initiative of the Washington Business Group on Health (WBGH) and the National Institute of Mental Health (NIMH), sponsored an executive briefing on Investing in Workplace Productivity: Managing Indirect Mental Health Costs in the spring of 1997. This report, based on the executive briefing, is organized into three parts: 1) a presentation of health and productivity from the perspective that employee benefits function not as a cost center but as a catalyzing force for promoting human and intellectual capital; 2) case studies of four innovative corporations that are successfully managing both the direct and indirect costs of mental illnesses; 3) a review of the issues to be considered when focusing on a health and productivity approach and recommendations for more effective management of corporate mental health costs and programs. Four corporations are profiled: Bank One, Abbott Laboratories, Owens Corning, and Digital Equipment Corporation.

Duncan Chappell & Vittorio Di Martino. Violence At Work International Labour Office, Geneva, 1998.

This ILO report was designed to provide a basis for understanding the scope and nature of workplace violence and to suggest ways of preventing it in the future. It highlights best practices and successful methods of prevention, illustrating the positive lessons to be drawn from such experience. The report is divided into three parts: Part I examines violence at work. It covers the changing profile of violence; the commitment of the ILO in this area; an analysis of data displaying patterns and trends; areas and occupations most affected; vulnerable situations and groups; the social and economic costs of violence for individuals; the enterprise and the community. Part II examines different types of response to violence at work and identifies the best solutions. It includes an analysis of legislative and regulatory interventions; adoption of existing legislation; emergence of specific legislation; growing attention to prevention strategies; new collective agreements to combat workplace violence; an analysis of policies and guidelines. Part III considers the key lesson to be drawn; highlights the main messages; and suggests specific and practical action based on successful experience.

Daniel Conti, PhD & Wayne Burton MD. The Economic Impact of Depression in a Workplace., JOM, Vol.36, (9) September 1994 pp. 983-989

Epidemiological studies hold that depressive disorders are among the most common forms of mental illness in the population and should produce a substantial economic impact upon corporate America. A study of the medical and disability costs of depressive disorders was conducted at the First Chicago Corporation (pre Bank One merger). In this analysis, short-term disability data, medical plan costs and Employee Assistance Program referral data for depressive disorders were compared with selected common chronic medical conditions. The average length of disability and the disability relapse rate were greater for depressive disorders than for the comparison medical groups. Depressive disorders were also found to have the largest medical plan costs of all mental health diagnoses. Finally, depressive disorders proved to be the most common Axis-I-level diagnosis encountered in the Employee Assistance Program. These findings have important implications for medical benefit plan designs, disability plan management and occupational health professionals' training. The observed higher prevalence of these disorders in women force their recognition as a women's health issue.

Mary Ellen Copeland. The Depression Workbook. A Guide for Living with Depression and Manic Depression. New Harbinger Publications Inc., Oakland, CA. 1992.

Presents a detailed overview of the history, causes and treatment of mood disorders as well as offering step-by-step self help guidance for taking responsibility for your own wellness; finding appropriate men-

tal health professionals; building a support system; avoiding conditions that exacerbate mood swings; and using relaxation, diet, exercise, therapy, and pharmacology to assist in stabilizing moods. The author has bipolar disorder and has spent much of her life learning to understand and cope with her illness. She tells her story as well as sharing the thoughts and insights of 120 individuals with diagnosed mood disorders from around the country who participated in a survey she conducted.

Thomas Crogan et.al., *Cost-Effectiveness of Antidepressant Medications*, *The Journal of Mental Health Policy and Economics*, 1. 109-117 (1998)

Antidepressant medications have been shown to effectively relieve symptoms, improve interpersonal and occupational functioning and reduce disability from coexisting medical conditions. The aim of the study reported in this article was to determine the probability that relapse or recurrence of depression can be prevented by appropriate antidepressant choice; determine the cost associated with relapse or recurrence of depression; and determine the relative cost-effectiveness of alternative antidepressants. This paper furthers the debate regarding the relative cost-effectiveness of antidepressant medications and the findings suggest several ways that policy makers can improve the care of depressed individuals at minimal additional cost. Specifically, the findings highlight the importance of adherence to current recommendations regarding the length of antidepressant treatment and suggest several methods for improving this important outcome.

Mary Jane England, MD. *Capturing Mental Health Costs Offsets*. *Health Affairs* March/April, 1999.

The issues underlying health care financing and delivery improvements are complex. Diverse financial, regulatory, market, professional, and clinical factors continue to influence efforts to improve quality. Multiple strategies are needed to make these improvements. This article addresses two such strategies. First, the cost model applied in mental health research needs to be expanded. The real value of mental health and substance abuse services cannot be demonstrated by examining only medical costs offsets. Indirect costs and metrics associated with functioning and life activities, work performance and disability also must be incorporated into the model. Second, employers must continue to play an important role in assessing health system performance through innovative collaborations with the delivery systems.

In recent years the most compelling evidence causing employers to change health benefits has come from disability costs and related indirect cost. Clinical depression is a case in point. Approximately 70% of the adults with depression are in the labor force. Spending for depression in 1993 was almost \$44 billion. Almost \$24 billion was employers' costs associated with lost work time and productivity. Compared with other prevalent conditions, depression often has the longest average length of disability and the highest probability of a second disability leave within one year. This article explores some of the guidelines and issues involved in employer management of mental health costs.

James Frierson, *Employer's Guide to The Americans With Disabilities Act* (Second Edition), The Bureau of National Affairs, Washington D.C., 1995.

This book is a practical guide to compliance with the Americans with Disabilities Act (ADA). It combines a coverage of the law's requirements and recommendations for conforming to the law with materials explaining various disabilities, methods of accommodating disabilities, and example costs of accommodation devices. Highlighting Chapters 8 & 9 : Chapter 8 focuses specifically on mental illness, examining the various types of mental illness; the ADA's coverage of mental illness; case decisions involving mental illness; and EEOC regulations. Chapter 9 "Managing Disabilities: The ADA, FMLA and Workers' Compensation Laws" provides material to aid employers in coordinating compliance with the ADA, Family and Medical Leave Act and Workers' Compensation laws. Potential major conflicts in complying with all three laws are explained and solutions are given. This book attempts to address not just legal compliance, but rather effective legal compliance that benefits employers just as much as employees.

Ellen Galinsky & James Bond. The 1998 Business Work-Life Study A Source Book, Families and Work Institute, NY, NY, 1998. <http://www.familiesandwork.org>

The 1998 Business Work-Life Study is one of the first and most comprehensive studies of how U.S. companies respond to the work-life needs of their employees. Developed to complement the 1997 National Study of the Changing Workforce, this new study looks at a representative sample of companies with 100 or more employees and examines an array of work-life programs, policies and other components of a supportive workplace. These include flexible time and leave programs; dependent care assistance; health care and policies that promote economic security. This Sourcebook also examines which companies are most likely to be "family-friendly". Answers include those in the finance, insurance and/or real estate industries, those that are larger and, most interesting of all, those that have more women and minorities at the very top.

Ellen Galinsky, Dana Friedman, Carol Hernandez. The Corporate Reference Guide to Work Family Programs, Families and Work Institute, NY, NY, 1991. (<http://www.familiesandwork.org>)

The Guide provides a comparative analysis of personnel policies in 188 Fortune 1,000 companies surveyed across 30 industries. It draws upon extensive research conducted by the Families and Work Institute including over 30 research projects on the stresses and satisfaction associated with balancing work and family or personal responsibilities; the productivity repercussions of these problems; and evaluations of the impact of family-responsive initiatives. In addition, the Guide profiles the four companies with the highest Family-Friendly Index scores, analyzing how they came to excel; describes the typical stages of development of corporate work-family programs; and presents 76 model initiatives on a range of work-family options.

James Gemignani, *Best Practices That Boost Productivity*, Business & Health, March 1998.

Programs and practices designed to boost workers' wellbeing are almost always good for the bottom line. This article examines the challenge of employers to improve the productivity, profitability and health of the vast majority of employees, those who come to work every day but do not always perform optimally or up to par. Based on a study of 16 Fortune 500 firms, it examines practices that contribute to worker health and wellbeing, and, ultimately improved productivity. Along with identifying specific practices and strategies to achieve similar results, the research uncovered 10 themes that best practice firms have in common.

Deborah Holmes & Dana Friedman. The Changing Employer-Employee Contract: The Role of Work-Family Issues, paper prepared for the 1995 Work-Family Conference sponsored by Families and Work Institute, NY, NY.

The theme of the 1995 annual work and family conference, co-sponsored by the Families and Work Institute and The Conference Board in New York, New York, is the changing contract between employers and employees. Responding to global growth, technological advances and economic realities, many businesses have decided to change. There is also mounting evidence that U.S. workers are changing what they want from their work experience. They want more meaningful work, more control over their hours, and flexibility in how the work is accomplished. They want a better quality of life and their employer's acknowledgment of them as a whole person. The one thing that employees never want is job insecurity and loss of benefits. Under those conditions few people take advantage of flexibility when it is offered. In a survey of 80 large companies by Rodgers and Associates, fewer than 2 % of workers use job sharing, telecommuting, or part-time options, even though most of those companies had policies allowing these practices. The workers can not use them because there is too much work and too many penalties, perhaps even job loss, if they do.

This paper and the related conference attempt to explore work-family issues not only as an outcome of or response to business changes, but as an actual catalyst to some of these changes. If it is accepted that employees' desires for flexibility, meaningful work and trusting relationships at work pre-date the concepts of re-engineering, then there might be a more balanced view of the changing employer-employee contract.

Henry McCarthy (ed.) Complete Guide to Employing Persons with Disabilities. Human Resource Center, Albertson, NY, 1985.

This book is written as a practical reference manual for managers involved in implementing corporate programs of equal employment opportunity for individuals with disabilities. It is based on the premise that the affirmative action principles and procedures established by various US laws represent not only legal requirements but basic policies of sound personal management. Although, this book was published in 1985 and there have been a number of new laws since, it still provides a useful reference tool for employing people with disabilities as well as an historical perspective on US employment laws specifically for individuals with disabilities.

Sonia Muchnick-Baku, Corporate Strategies for Women's Health: Survey Results and Case Studies, Washington Business Group on Health, Washington D.C., Spring 1997.

This was a project of the Washington Business Group on Health (WBGH) developed to promote knowledge of and commitment to women's health care services among large employers. The report is based on a survey of large employers and aims to determine how they are addressing women's health needs. Case studies are presented highlighting five innovative corporate programs. The survey results are: 1) managed care options consistently provide routine coverage for the widest array of services, particularly in the areas of preventive screening and health promotion for women; 2) women's health care services receiving the most attention are breast cancer screening and prenatal services; 3) mental health and substance abuse services are widely covered, but full parity for mental health coverage is rare; and 4) employers commonly make educational materials and company policies available for sexual harassment and work-site violence, but rarely for family violence.

Nola Pender. Health Promotion in Nursing Practice. (Third edition), Appleton & Lange, Simon & Schuster, 1996.

Organized around a conceptual framework, the book offers analyses of various definitions of health and presents models for understanding health protecting/promoting behaviors. The author also presents intervention strategies and effective assessment tools that enable health practitioners to assist individuals, families, and groups in their quest for healthier lifestyles. Health Promotion also examines health protection/promotion programs in a variety of settings, hospitals, ambulatory, home, and community (eg. worksite health promotion). Part IV Strategies for Prevention and Health Promotion: The Action Phase and Part V Sociopolitical Strategies and Future Directions for Prevention and Health Promotion focus on worksite prevention/promotion programs and stress management models.

Rehab Brief: Strategies..Employment..Mental Illness. Strategies to Secure and Maintain Employment for People with Long Term Mental Illness. National Institute on Disability and Rehabilitation Research, Office of Special Education and Rehabilitative services, Department of Education Washington, DC. Vol.XV, No. 10 (1993) ISSN:0732-2623. (<http://www.cais.com/naric/rehab>)

In September 1992, The National Institute on Disability and Rehabilitation Research (NIDRR) convened a Consensus Validation Conference concerning employment for people with long-term mental illness. It was the consensus of that conference that much more can and should be done to improve and expand employment opportunities for people with psychiatric disabilities. This Rehab. Brief summarizes findings of this conference.

Four elements of the vocational rehabilitation process were identified as important in effectively helping people with long term mental illness obtain employment: the practitioner, the process, the program, and the principles. A variety of program approaches exist today, many emphasizing "real-work" for "real-pay" in community settings. Research strongly indicates the effectiveness of such programs in reducing hospitalizations and increasing job acquisition, job retention, and earnings. This report also examines the impact of stigma on the success of vocational efforts. Issues that negatively and positively affect employment are also discussed.

Veronica Vaccaro, Depression :Corporate Experiences and Innovations, published for the DEPRESSION Awareness, Recognition, and Treatment National Worksite Program, a cooperative initiative of the National Institute of Mental Health and the Washington Business Group on Health, Washington D.C. 1994.

This report responds to the need for employers to adopt more effective health policies and programs. The costly impact of depression can be reduced with better management of corporate resources to encourage early interventions; direct individuals to appropriate and cost-effective care; and provide a supportive work environment during treatment. The purpose of this report is to assist employers in this process by presenting an overview of the knowledge base about depression and by featuring case studies from major U.S. corporations with innovative and exemplary human resource strategies. This report provides the following: 1). It alerts employers to the problem of untreated depression. 2). It identifies current issues affecting mental health care. 3).It initiates discussion of corporate and public policy implications. 4) It provides models for employer action And 5).It generates questions for further investigations.

Otto Wahl,PhD. Media Madness: Public Images of Mental Illness. New Brunswick, NJ:Rutgers University Press, 1995.

This book addresses and exposes the rampant inaccuracies about mental illness in newspapers, magazines, movies and books . It goes far in explaining where the errors are and in educating and sensitizing the reader to the frequent inaccuracies. Many mainstream references are provided in the text and illustrations that indicate the common belief that mental illnesses are fair game for humor, an excuse for murderous behavior, and an explanation for diminished intelligence. Of equal or even greater danger is the plethora of inaccuracies present in the print and electronic news media. The author shows that those with mental illnesses are frequently presented as their illnesses: they are schizophrenics, manic depressives, or multiple personalities rather than persons with an illness or disorder.

In addition to the text and illustrations, there are extensive notes representing the author's comprehensive research. Three appendices are included listing movies, television shows, and books that have mental illness or psychiatric references, many of which are inaccurate or disparaging. Although it concentrates on the U.S. media, it is an excellent reference for any anti-stigmatization campaign conducted in other parts of the world.