



DISABILITY MANAGEMENT EMPLOYER COALITION

DMEC 2008 Employer Behavioral Risk Survey



DMEC White Paper Series



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DMEC 2008 Employer Behavioral Risk Survey

Abstract

The goal of this survey was to examine employer strategies, advancement, prevalence, and effectiveness in the area of Behavioral Risk Management. This paper represents the findings from two surveys: one that was conducted with employer members from the Disability Management Employer Coalition (DMEC) as a follow up to a survey conducted in 2006; and another first-time survey of employer members of the Partnership for Workplace Mental Health, a program of the American Psychiatric Foundation (APA). Responses indicate that behavioral risk management continues to be of importance; key stakeholders are embracing and moving the concept forward; and more metrics, resources and research are needed to support the effectiveness of this best-practice area.

Background

Behavioral Risk Management is a term that was coined by the Disability Management Employer Coalition in 2006 to describe a process in which disability management (DM) professionals could effectively assess, prevent and control losses within their organizations caused by behavioral, psychosocial, or mental health issues.

A number of research findings have underscored that underlying unresolved behavioral issues could, and do, complicate medical recovery and outcomes for disabled or absent employees in addition to strongly affecting productivity while at work. The first DMEC survey was conducted in 2006. In addition, an annual behavioral risk conference, programs and publications were undertaken to educate and raise awareness. The underlying premise of this methodology is to decrease claims and productivity loss, increase corporate profitability, and increase the quality-of-life for employees.

Just over 10 years ago, only the most innovative employers would attempt to review underlying behavioral issues to get at unresolved claims, difficult performance issues, high-frequency safety incidents, or unexplained productivity levels in employees. Work that initially was done by a handful of employers and mental health professionals produced rewarding results, but the time had not arrived, nor had the resources been identified, to make this a best practice in the industry.

Perceived Barriers

A turning point was reached beginning at the turn of the 21st century, fueled by the passage of time, improved technology, and advanced research resulting in the reduction of perceived barriers such as:

- **Stigma** related to having a mental health condition, receiving mental health treatment, or using psychotropic drugs.
- **Frustration** of disability and absence management professionals working in isolation who were unable to resolve complicated claims, knowing full well that “something” was going on beneath the surface.
- **Fear** of creating a stress claim – especially in Workers’ Compensation – as a result of investigating behavioral issues of a physical claim. The proverbial “opening Pandora’s Box” was traditionally the excuse for not exploring conditions that exacerbated the extent of an illness or injury or precluded recovery.
- **Lack** of qualified mental health providers who were enlightened regarding the inner workings of the workplace or who understood the value of return to work.
- **Lack of Support** and commitment from upper management for the pursuit of such innovative programs.
- **Lack of Practice Guidelines** based on hard data and cost-saving results.

Behavioral Risk is the review, analysis and implementation of processes to prevent and limit losses related to a psychological component of claims, absence, and productivity in the workplace.

Compelling Research and Statistics

We know that mental health concerns in the workplace have considerable economic impact, including lost productivity, additional health care costs, increased likelihood of a short term disability (STD) or long term disability (LTD) claim, greater number of accidents, poor decision-making and problem-solving skills, and diminished work interactions. Compelling statistics, as evidenced in some examples below, have now caused employers take pause and consider paying attention to the mind-body connections and behavioral implications for absence, claim frequency and severity, and presenteeism.

- 300% increase in mental health social security disability claims in the past decade.¹
- 9.4% of the US workforce suffers some type of depressive disorder, with major depression taking the highest toll on productivity at 8.4 hours per week. (Additionally) 69% of depressed people may not realize they're depressed, reporting unexplained physical symptoms as their only complaint.²
- 28-30% of US population has a mental health disorder, substance abuse disorder or both.³
- Mental illness ranks #1 among illnesses that cause disability in the US.⁴
- Empirical research has demonstrated that at least 64 percent of individuals with physical concerns (musculoskeletal, cardiac, etc.), or with extended LTD claims, experience psychological concerns that cause a delay in the improvement of physical health.⁵
- If an individual has anxiety or depression plus a physical illness, the anxiety and depression are more predictive of functional impairment over time than is the severity of the physical illness.⁶
- Companies with EAP's in place have a 21 percent lower absenteeism rate and a 14 percent higher productivity rate.⁷
- Psychiatric conditions may cost US employers an estimated \$344 billion annually in lost productivity and medical fees.⁸
- Stress accounts for 40% of employee turnover.⁹
- Depression/Mental Illness ranks as the number one cause of lost work days with 26 per year versus 17 for cancer and 15 for respiratory disorders.¹⁰
- A fundamental change in today's global economy demands cerebral not manual skills as the minds of employees do the heavy lifting. This shift "coinciding with an increase in brain-based illnesses like anxiety and depression, challenges the US, Canada, and countries around the world."¹¹

¹ Warren, P.A., The Management of Workplace Mental Health Issues and Appropriate Disability Prevention Strategies, Work Loss Data Institute, 2005, p. 6-7.

² JAMA, 2003

³ National Mental Health Association, 2002.

⁴ President's Freedom Commission on Mental Health, 2006.

⁵ Warren, P.A. Ibid

⁶ Langlieb, A.M., Kahn, J.P., "How Much Does Quality mental Health Care Profit Employers?", JOEM, Vol. 47, No. 11, November 2005

⁷ US Department of Health and Human Resources

⁸ Risk & Insurance Magazine, June 2005.

⁹ American Institute of Stress, Benefit News Online, May 9, 2006.

¹⁰ USA Today, April 4, 2008

¹¹ Spangler, N., "US and Canada Forum on Mental Health and Productivity Brings Stakeholders Together", Mental HealthWorks p. 7

Recent Advances

On many fronts reported progress has been made in the past couple of years in better understanding the interplay of the mental with the physical, including cutting-edge research and technological advances.

- Neuroimaging studies have shown physical changes in the brain associated with mental disorders which help to document a biological basis. Brain scans and markers are allowing instant detection and prevention of a number of mental health disorders, paving the way for objective findings.¹²
- A systematic program to identify depression and promote effective treatment significantly improves not only clinical outcomes but also workplace outcomes. The financial value of the latter to employers in terms of recovered hiring, training, and salary costs suggests that many employers would experience a positive return on investment from outreach and enhanced treatment of depressed workers.¹³
- An EAP study “Healthier, More Productive Employees: A Report on the Real Potential of Employee Assistance Programs” found that EAP utilization rates of only 4-6% can significantly reduce unscheduled absences. Utilization rates of 10-11% by two study groups had a notably lower STD claim incidence than that of the control group, opening the idea that higher utilization rates may be better than historical 3-6% rates.¹⁴
- A growing number of studies – and many more are under way – is making the biological connection, redefining the concept of mental illness as brain illness.¹⁵
- Evidence based guidelines have now been released and are in general use by practitioners, including the Management of Workplace Mental Health Issues and Appropriate Disability Prevention Strategies.¹⁶
- In 2006, The Partnership for Workplace Mental Health (a program of the American Psychiatric Foundation), initiated two significant studies: one utilizing an employer taskforce on disability and RTW assessing employer best practices; and a clinical committee to determine principles of treatment and to make clinical recommendations. A landmark pilot training program was initiated in April 2008 where Costco Warehouse began training its network of psychiatrists in workplace return to work.¹⁷

All of these advancements point to the fact that we are now at a tipping point; that we are poised with tools and resources to make even greater leaps in turns of integrating behavioral risk management.

Survey Design and Methods

The survey contained 39 questions, the majority of which were taken from the survey conducted in 2006. Three questions were deleted from the previous survey as they were not directly related to the scope of the survey. Ten new questions were added, eight of which were taken from a prior survey done by the APA Partnership for Workplace Mental Health (a joint study done in 2007 with DMEC on mental health return to work.)

The focus of the survey was to determine whether Behavioral Risk Management (a term defined in the survey) was an emerging trend and whether progress had been made in the two years since the first survey. Most questions were close ended making tabulation of results easier. Four were open-ended allowing for an opportunity to explore program design and unique elements or to provide survey mailing information.

¹² Mayo Clinic.com, November 7, 2006

¹³ Wang, P.S., Simon G.E., Avorn, J., et al, “Telephone Screening, Outreach, and Care Management for Depressed Workers and Impact on Clinical and Work Productivity Outcomes”, JAMA, September 26, 2007, Vol. 298, No. 12, p. 1401

¹⁴ “Healthier, More Productive Employees: A Report on the Real Potential of Employee Assistance Programs”, July 2007, The Hartford Life

¹⁵ Kershaw, S., “The Murky Politics of Mind-Body”, The New York Times, Week in Review, pp. 1 & 4.

¹⁶ Warren, P.A. Ibid

¹⁷ “Assessing and Treating Psychiatric Occupational Disability: New Behavioral Health Functional Assessment Tools Facilitate Return to Work; A Report from the Partnership for Workplace Mental Health, Taskforce on Disability and Return to Work” 2007

Part I: DMEC Membership

On February 12, 2008, email survey requests were sent to 215 separate companies that represent the employer segment of the DMEC membership base. To avoid duplicate answers, only one survey was sent to each organization. Of these, 71 were returned, providing a 33% return, 9% more than the 2006 survey. Supplier members were not included in this survey to eliminate bias in survey results. Surveys were accepted until February 29, 2008. *KeySurvey* was the software utilized to accept and tabulate results. A list of survey questions and responses is included as Appendix A.

Participant Profiles - DMEC Members

Of this first survey group, 48% were large employers (defined as more than 10,000 employees); 41% were mid-sized (1-10,000 employees); and 11% were small (less than 1,000). This closely approximates the composition of the DMEC membership and the respondents from the 2006 survey. It also reflects that disability and absence management is not just a purview of large companies, but something that has migrated down to smaller companies. This sampling of companies at various sizes means that such thinking is now prevalent in a broad spectrum of companies, not just the “super-sized” giants that were the initial innovators.

Survey respondents were asked what field they specialized in. The most prevalent were:

- Disability – 66%
- Workers’ Compensation – 65%
- Human Resources – 49%
- Absence – 48%
- Employee Benefits – 41%
- Wellness – 31%
- Safety – 24%
- Behavioral/EAP – 21%

Note: percentages don’t add up to 100 percent due to the option of choosing multiple areas of expertise.

This survey group was very willing to promote the concept with their peers. 24 respondents (34%) were willing to share results and information with others; 75% were interested in attending a two-day conference on the subject; and 34% wanted to be more involved in the further development of this special interest area. This underscores both the professional makeup of the DMEC membership and their willingness to support continued exploration and information sharing.

Survey Results and Discussion - 2008 DMEC

The strong message that came from the survey was that Behavioral Risk Management continues to be an important best practice area. Additionally, it may be moving beyond an emerging focus area to one that is showing signs of being ingrained in how employer’s think. Given the changes that have occurred in the last two years since the 2006 study, the field of behavioral risk is set to be supported and propelled by scientific research and technological advances.

However, like many other trends, the path appears not be a straight line as there were several shifts detected in the direction of this practice area. This may reflect the fact that employers still are “experimenting” with how to best accomplish their goal of increasing productivity and moving toward prevention.

Of the questions asked, a number of areas stand out as significant and are discussed in this report. A full comparison by question is included in Appendix A, Responses.

Behavioral Risk as an Emerging Concept

A resounding 100% of respondents affirm that behavioral risk is an important emerging area of concern for employers, representing an increase of 6% from the 2006 survey. Most of the increase was seen in the “yes” vote (89%) with fewer saying “maybe” (11%). No one said that the concept was not an emerging issue. This indicates a stronger statement about the role of this concept with fewer that are skeptical.

Employer Program Best Practices

The strength of integration of behavioral risk as a component remained steady as 31% of the employers included a behavioral complement into their integrated or coordinated program in both 2006 and 2008. The strong believers and practitioners of the early years appear to remain convinced of the value and need for such practices. However, some ground was lost with the group who are considering this aspect, falling from 19% to 4% and moving to a “not sure” position. It may be reflective of the increasing need to have ready access to metrics and other return-on-investment measures that will move the acceptance to a higher level going forward. The number that is “not integrating” has fallen by 9 points, suggesting some indecisiveness and “fence sitting” for those who are waiting for continued success and documented results before moving forward with an integrated behavioral component.

Best practice areas that have shown an **increase** over the two-year span include the following. Clearly employers are seeing the value of this early and targeted intervention.

- Expanded application of depression screenings up significantly to 35% of respondents (up by 26 %.)
- Increased use of a mental health professional (MHP) for disciplinary programs (up 11%.)
- Increased use of EAP on disability management committees (up 15%.)

A **decrease** in the use of the following practices was noted.

- Screening of STD and LTD was down by about 5% while the use in Workers’ Compensation remains steady at 32%. It may be that employers who outsource this function are not aware of the uses of behavioral screening given that anywhere from 15 to 24% are not sure if it occurs. Perhaps better communication and awareness would move these numbers to the positive column.
- A shift away from a treatment model (6+ visits) in the EAP was seen, moving towards a referral model (3-6 visits.) 11% fewer employers had a 6 (or more) visit model in 2008 than in 2006. The traditional 1-3 session model remained constant at 28%. This may be explained as a cost-cutting measure, or perhaps the expanded use of mental health benefits within a health plan.
- A 10% shift occurred in the provider of behavioral benefits from a carve-out to the health plan itself. It is not clear if these shifts are due to cost cutting measures or a sense that better services are obtained within a health plan.

Innovations in Behavioral Return to Work

When asked what return-to-work (RTW) programs provided the best behavioral results, there were a variety of answers, but the three most prevalent areas were:

1. Working with an EAP or MHP – of the 43 responses, almost half reported this as an effective measure.
2. 3-point communication (employee, treating physician, and company) – working towards an integrated and coordinated process with the goal of maintaining good contact and open dialogue with the employee to ensure a bond with the workplace and focus on RTW.
3. Fitness for duty evaluations – a standard for many companies.

General responses that indicated advanced thinking and prevention included:

- Parity with medical, mental and behavioral health plans.
- Significant promotion of EAP and constant vigilance on training regarding the normalization of stress-related disorders and mental/emotional issues.
- Early detection, self-identification and getting treatment before major or significant issues develop as a key component of the program.
- Training supervisors to understand behavioral aspects so they know how to interact in those situations. This helps to limit the fears they have which can lead to avoidance of RTW opportunities and early intervention.

Management Awareness and Acceptance

Management attention to the subject took a big jump in awareness in the 2006 survey but only a moderate increase in 2008. In 2006, 53% of upper management had changed their opinion regarding the need to review for behavioral issues during the period of 2001-2005. The shift to more understanding did increase in the two-year period of 2006-2008 by another 28% indicating that they continue to be more open to this concept.

More interesting to note is that of those who said **yes** to management changing their opinion; fully 100% are **more open** to the concept. This is up by 18% from the 2006 survey. It appears that of those who are open to exploring the value of this concept, all of them “get it” in terms of understanding the implications and potential for success. This is a very encouraging note for DM professionals who have worked (or continue to pursue) this avenue. Once you have opened the door to the idea, you have a good chance of gaining support.

Stigma

Stigma continues to be a challenge to disability management and human resource professionals alike when it comes to dealing with behavioral conditions. The reason for its stubborn continuance may be that the term “mental illness” itself implies a distinction from “physical” illness although the two are intimately related. Perhaps the use of terms like behavioral health or brain disorders will help.

Three separate questions were asked to get at the level of stigma and how it may have changed in the two-year period—having a psych problem, seeing a MHP, and taking prescription drugs. In terms of being diagnosed with a MH condition, there was an increase in the perception of stigma from 84% to 90%. However, when probed further, 41% felt that it was less of a stigma than it was two years ago. 42% felt it hadn’t changed intensity in the 2-year period. What also may be happening is the respondents are more realistic in their appraisal or this is reflective of a different cohort group.

Seeing a MHP continues to carry a stigma, with 72% saying that it is still prevalent, up from 67%. In spite of great strides in treatment and availability of professionals, and even the acceptance by highly visible personalities who receive treatment, we still see a prejudice against those with a mental health condition. Recent progress in documenting the biological basis for psychiatric problems appears not to have made an impression yet on DM professionals or the public at large.

In the United States over the last five years, research studies examining the link between physical brain abnormalities and disorders like severe depression and schizophrenia have begun to make a strong case that the disorders are not scary tales of minds gone mad but manifestations of actual, and often fatal, problems in brain circuitry. (NYT 3/30/08)

The greatest advancement, and one that may lead the way for the crumbling of other stigmas, is the taking of antidepressant medication. An 11 point shift (from 71% down to 60%) was voiced by the respondents. This shift can be partially explained by the widespread advertising and acceptance of anti-depressants. A study revealed by *USA Today* on March 4, 2008 stated that the huge dollars that have been put into prescription drug advertising has had big payoffs in terms to consumer demand and purchase of drugs. Fully 59% of the drugs advertised are related to mental health conditions. Perhaps it is the drug companies themselves that will assist in breaking down the walls that prevent treatment for depression and other mental health conditions.

Part II: APA Membership Survey

On April 1, 2008 the identical survey instrument was emailed to 70 individual employer members of the American Psychiatric Foundation's Partnership for Workplace Mental Health (APA) 33 member companies. 64 responses were received. Although this represents a duplication of answers of many companies, it does provide a broader perspective on practices even within companies. This group was sought to expand the number of respondents and increase the statistical significance by seeking answers from a broader audience to avoid bias in terms of knowledge gained through DMEC membership. In total, approximately 138 employers were questioned from both groups, although some duplication of respondents may have occurred.

Participant Profiles – APA Members

The size of APA employers was more equally distributed between the three categories with 39% large, 33% mid-size and 39% small. This gives a more even picture across employer size and again reflects the broad acceptance of this thinking. In terms of their areas of specialization, the respondents represented almost a total reverse in comparison to DMEC members. As it might be expected, behavioral and EAP responsibility top the list of this group's areas of responsibility.

- Behavioral/EAP - 44%
- Disability - 38%
- Wellness - 34%
- Human Resources - 30%
- Employee Benefits - 28%
- Absence - 18%
- Workers' Compensation - 17%
- Other - 16%

Only 9 respondents were willing to share their contact information which may be based on their unfamiliarity with DMEC. 77% were interested in attending a practical, educational conference on behavioral issues.

Survey Results and Discussion – 2008 APA

Similarities

The top six areas of close agreement between the two groups (as defined by a 3 point or less difference) were:

- Importance of this emerging area of concern (89% DMEC vs. 92% APA)
- Integrating a behavioral component into an integrated program (31 vs. 33%)
- Management's openness to behavioral risk if aware (same – 100%)
- All stigma questions
- Using a MHP for disciplinary problems (17 vs. 20%)
- Providing depression or anxiety screenings (35 vs. 38%)

Given that these questions covered the most critical areas of this best practice area, these correlations demonstrate the potential for advancement, viability and acceptance.

Differences

The strongest differences (10 points or more) were seen in the following areas and appear to highlight the variety of ways employers can approach prevention and early intervention, not a difficulty with the concept itself.

- WC review for underlying psych issues (32% DMEC vs. 20% APA)
- STD review for underlying psych issues (35 vs. 28%)
- LTD review for underlying psych issues (45 vs. 25%)
- Use of MHP to do case management on psych claims (25 vs. 34%)
- Use of telephonic case management by MHP (24 vs. 33%)
- EAP as a representative on the disability management team (41 vs. 31%)

Behavioral Risk as an Emerging Concept

A stronger positive response to this question was elicited by APA members, with 92% saying that this area is of concern for employers. As was the case with DMEC, no one said “no” however, a small 1.6% did say they weren't sure, possibly because they may not feel qualified to respond on behalf of all employers. This supports the contention that this best practice area is of concern to a wide range of employers, with or without a strong commitment to mental health.

Employer Program Practices

Many of the same types of best practices were in place and appear consistent with DMEC. The most popular best practice areas were:

- Use of mental health professional for case management – 39%
- Including a behavioral component to an integrated program – 34%
- Use of MHP for telephonic case management – 33%
- Including EAP or a MHP on a disability team – 31%
- Review STD claims for possible underlying psych issues – 30%

Innovations in Behavioral Return to Work

There were some interesting comparisons between the two groups in terms of how they approached return-to-work. Whereas DMEC members utilized EAP as their chief resource, APA members turned to transitional job modifications with EAP a close second. Each mentioned consultation with vocational rehabilitation and analysis of cognitive demands as their fourth and fifth most popular. The most interesting and unexpected result was that 7% of DMEC, versus 20% of APA members, said they had no activities in place. One would assume that the APA would be more sophisticated in their approach to psychiatric return-to-work with at least one best practice in place.

When asked what programs worked best, the results were similar. Top trends were:

- Use of a MHP (including EAP) in the process.
- Strong communications between treating physical, department/supervisor, and employee.
- Commitment to providing services early in the process – early interception and intervention.

A few programs that stood out in terms of an innovative approach included:

- Setting clear expectations and time frames for RTW planning up to and including a Continuing Care Agreement where employees agree to comply with the providers Plan of Treatment.
- Implementation of depression screening for all high-risk disability cases. This process improves employee's conversations with their doctors, and often results in an introduction to or change of medication. This also provides an external validation to the employee's experience.
- Linking EAP with Behavioral Health provider network so employees can continue with the same provider through the health plan if they want, allowing continuity of care.

Management Awareness and Acceptance

APA respondents were less enthusiastic about management's change in awareness over the last couple of years with just 23% saying yes, a 5% difference from DMEC. However, for those who did respond yes, fully 100% say they are more open. As has been noted previously, it appears that raising awareness brings strong support which means that education is an important tool for employer advancement in this best practice area.

Stigma

Both groups had strikingly similar responses for all three questions regarding stigma, indicating that stigma continues to be a challenge especially in either being diagnosed with a psychiatric condition (#1) or seeing a MHP (#2). Both groups agreed (61%) that there was a stigma involved in taking antidepressant medications, but this clearly was the area where stigma was the lesser problem. As mentioned previously, this is likely the result of continued and aggressive advertising by pharmaceutical companies and broader acceptance by the public.

Conclusions

We have just begun in terms of exploring the usefulness and long-range acceptance of this best practice area. Certainly a shift is occurring, as is evidenced by this study and through other structural changes in the industry. Probably the most significant is the increased activity by all three key stakeholders (employers, suppliers and physician groups) in moving forward to make this happen. Recently several medical associations have thrown their hat into the ring, supporting the need for

return to work and promoting the healing value of work including the ACOEM, APA and the American Academies. Training is already ongoing in the United Kingdom's medical schools and discussions have been broached for changes in the US, including Harvard.

Suppliers have responded to employer demand for more integration of claims personnel in red-flag cases by means of "warm transfers" and peer-to-peer consultations where behavioral issues are present. Resources have been brought in house including expanded use of brain-imaging as a screening device.

Employers are demanding more emphasis on RTW and increased productivity as both a profitability and human capital enhancement goal. What we are seeing is not merely a passing management theory, but a sizeable movement fueled by strong research, technological advancement and legislative change in terms of mental health parity that is working in concert towards a more humanistic approach to piecing together the mind-body relationship. Perhaps through the work of visionary employers, providers and suppliers we will reach a true integration of the mind and body in our lifetime.

Appendix A: Responses

Question	2006	2008	APA
Does your company provide behavioral health benefits?			
Yes	94.7%	94.4%	93.8%
No	5.3	5.6	6.2
Are behavioral benefits carved out and administered by other than the employee's health plan?			
Yes	45.5		
No	54.5		
Not sure	0		
Do your Workers' Compensation claim adjusters review for possible underlying psychological issues for physical claims?			
Yes	29.8	32.4	20.3
No	33.3	45.1	37.5
Considering	8.8	4.2	6.2
Not sure	28.1	18.3	35.9
Do your short-term disability claim adjusters review for possible underlying psychological issues for physical claims?			
Yes	40.4	35.2	28.1
No	33.3	43.7	34.4
Considering	3.5	5.6	1.6
Not sure	22.8	15.5	35.9
Do your long-term disability claim adjusters review for possible underlying psychological issues for physical claims?			
Yes	49.1	45.1	25
No	21.1	28.2	26.6
Considering	1.8	2.8	0
Not sure	28.1	23.9	48.4
Does your company utilize a "triage" or "red flag" system to identify potential problem claims or cases?			
Yes	59.6		
No	31.6		
Not sure	8.8		

Does your company utilize a mental health professional (MHP) to perform, or oversee, case management on psychological or psychiatric claims?			
Yes	36.8	25.4	34.4
No	49.1	46.5	42.2
Occasionally	12.3	21.1	3.1
Considering		2.8	1.6
Not sure	1.8	4.2	18.8
Do you utilize a MHP to do case management on physical claims with potential psychosocial issues?			
Yes	24.6	21.1	17.2
No	68.4	69	57.8
Not sure	7	9.9	25
Do you utilize a MHP to do case management for disciplinary problems?			
Yes	5.3	16.9	20.3
No	86	80.3	65.6
Not sure	8.8	2.8	14.1
If you use an MHP for any case management, does the MHP perform telephonic case management?			
Yes	33.3	23.9	32.8
No	52.9	19.7	21.9
Not sure	13.7	18.3	10.9
Doesn't apply		38	34.4
Does your company analyze accident or safety reports for underlying behavioral risk?			
Yes	36.8	35.2	39.1
No	47.4	46.5	40.6
Not sure	15.8	18.3	20.3
Do you currently include an EAP representative or other MHP on your Disability Management Team?			
Yes always		8.5	15.6
Yes on occasion		32.4	15.6
No	59.6	52.1	59.4
Considering	12.3	5.6	0
Not sure	1.8	1.4	9.4
Do you include an Employee Assistance Program (EAP) as part of the benefit package or health coverage for employees?			
Yes	96.5	97.2	89.1
No	3.5	2.8	10.9

Do you currently include a behavioral component to your integrated or coordinated program?				
	Yes	30.2	31	32.8
	No	34	25.4	18.8
	Considering	18.9	4.2	1.6
	Not sure	17	39.4	46.9
Does your EAP plan assess only or treat?				
	Assess only	23.6	33.3	28.1
	Assess and treat	72.7	60.9	64.9
	Not sure	3.6	5.8	7
How many visits does your EAP provide?				
	1 to 3	27.5	27.5	22.8
	3 to 6	31.4	44.9	49.1
	>6	41.2	27.5	29.8
Are Retirees able to access to the EAP?				
	Yes	21.8		
	No	50.9		
	Not sure	27.3		
Has management's opinion regarding the need to review behavioral issues changed in the last 5 years?				
	Yes	54.4	28.2	23.4
	No	14	39.4	48.4
	Not sure	31.6	32.4	28.1
If yes to the prior question, are they more open?				
	Yes	88.6	100	100
	No	2.9	0	0
	Not sure	8.6		
Do you think behavioral risk is an important emerging area of concern for employers?				
	Yes	82.5	88.7	92.2
	No	0	0	0
	Maybe	14	11.3	6.2
	Not sure	3.5	0	1.6
Do you think that there is still a stigma associated with having a psychological/psychiatric problem?				
	Yes	82.5	90.1	89.1
	No	17.5	9.9	10.9
If yes, do you think that the stigma is less of a problem than it was two years ago?				
	Yes		40.6	43.9
	No		42.2	40.4
	I am not sure		17.2	15.8

Do you think there is a “negative” stigma associated with seeing a mental health professional?			
Yes	66.7	71.8	73.4
No	33.3	28.2	26.6
Do you think there is stigma associated with taking antidepressant medication?			
Yes	70.2	60.6	60.9
No	29.8	39.4	39.1
Does your company provide depression or anxiety screenings for employees?			
Yes	8.8	35.2	37.5
No	80.7	59.2	53.1
Not sure	10.5	5.6	9.4

Question	2008	APA
How do you identify an employee who is at risk of experiencing a work absence due to a psychiatric disability? Check all that apply.		
Predictive modeling from claims data.	9.9%	6.2%
Employee’s self report or claim.	77.5	65.6
Depression screening (such as PHQ9) at intake point.	11.3	18.8
Data obtained from a health risk assessment tool.	22.5	23.4
Integration of plans that allows cross referrals to behavioral health providers.	29.6	25.0
Supervisor conversations with employees.	49.3	59.4
EAP warm transfer to STD/LTD/WC claims personnel.	28.2	31.2
No screening for this risk.	21.1	25.0
Does anyone in your company receive training to recognize and support employees who may be at risk for a behavioral health absence? Check all that apply.		
Employees themselves.	14.1	28.1
Corporate and field HR professionals.	40.8	43.8
Benefits service center teams.	18.3	10.9
Managers who directly supervise employees.	29.6	43.8
Senior management members.	8.5	14.1
No one receives mental health training.	49.3	37.5
Please describe the program or solution that you feel has produced the best behavioral return to work results in your company.		
Number of written responses	49	42

What RTW activities do you have in place to help employees with psychiatric disabilities RTW? Check all that apply.		
Analysis to determine the cognitive demands of the job in order to determine the potential stressors that may prevent RTW.	39.4	26.6
Development of any transitional job modification possibilities.	67.6	60.9
Consultation with a voc rehab counselor from either WC or disability provider.	45.1	34.4
Consider referral to EAP or depression disease management program.	78.9	57.8
Communications between you, your disability provider or EAP to develop job accommodations to enable the employee to RTW gradually.	59.2	57.8
None	7.0	20.3
Other	11.3	10.9
Do you have any requirement for an employee returning to work from a psychiatric disability? Check all that apply.		
Discussion and sign off on RTW program between employee and supervisor.	25.4	17.2
Any fitness for duty test to determine their ability to perform their job.	38.0	31.2
Training on any changes to their job since they have been absent.	23.9	29.7
Interim touch base meetings with the employee to determine if the RTW program is successful.	25.4	26.6
None	26.8	28.1
Other	22.5	26.6
What RTW barriers do you most often encounter with employees out of work due to a psychiatric illness? Check all that apply.		
Doctors advocating for the patient i.e, lack of RTW planning.	80.3	51.6
Unclear RTW full capacity timeframes.	73.2	59.4
Employees depending on their primary care physician and not seeking treatment with a behavioral health specialist.	70.4	76.6
Other	14.1	21.9

Some of the 39 questions were omitted from this recap as they were for administrative purposes only.

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**DISABILITY MANAGEMENT
EMPLOYER COALITION**

DMEC is the only nonprofit national trade association dedicated to the Integrated Absence and Disability Management profession. Its mission is to provide educational resources and to provide guidance in the areas of workforce disability, absence, health, and productivity. This mission is met through national, regional and local conferences, e-learning resources, training programs, publications, and practical tools.

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