



DISABILITY MANAGEMENT EMPLOYER COALITION

DMEC 2010 Employer Behavioral Risk Survey



DMEC White Paper Series



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DMEC 2010 Employer Behavioral Risk Survey

Abstract

This report provides a summary and an analysis of the 2010 Disability Management Employer Coalition's biannual survey which tracks employer strategies, advancements, prevalence and effectiveness, in the area of Behavioral Risk Management. These findings build on the results from 2006 and 2008 studies, providing an opportunity to identify changes in employer trends. The data indicates employers' commitment to the subject matter and the emergence of specific best practices related to EAP services and Mental Health Professional (MHP) engagements. Further to this great progress, additional enhancements are possible, and employers and the markets that serve them are well positioned to transition programs towards best-in-class offerings.

Background

The Disability Management Employer Coalition (DMEC) coined the term Behavioral Risk Management in 2006 and established a stage for open discussions related to behavioral absence and productivity initiatives through their annual behavioral risk conference and related programs. The core philosophy is to assess behavioral risk in a unique way in order to decrease claim and productivity loss, increase corporate profitability, and increase the quality of life for employees.

Mental health and behavioral health conditions are unique as they may or may not have a physical ailment attached. Often management processes and insurance policies lack the necessary support for behavioral health treatment. In addition, mental conditions can sometimes mask as physical disorders which translate into longer absences as primary care physicians, and ideally MHPs, determine the accurate diagnoses and appropriate treatment. Mental health conditions also frequently co-occur with physical health conditions – and when these comorbidities occur, work loss can grow markedly. As an example, the Work Loss Data Institute shows that the expected median disability duration for a lumbar sprain is 10 days. The expected median disability duration for lingering depression with anxiety is 26 days. Combined, the expected median disability duration jumps to 153 days¹.

Although researchers have completed a considerable number of studies in this area, there is still a negative stigma attached to these types of cases. Recent legislation, however, has shown a newly recognized need for mental health benefits. Specifically, the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) which became effective for most plans on January 1, 2010, essentially requires health plans to offer equitable benefits (in terms of deductibles, co-pays, visitation limits, etc.) for mental health coverage and medical/surgical benefits.

While regulations such as the MHPAEA demonstrate a need to address behavioral health risks, they still may be overshadowed by other health-related initiatives that are either more often or more easily tied to costs. Wellness, for instance, is a prevalent trend in the industry and as one survey respondent noted, their company's management was more focused on weight control/reduction support programs than mental health programs despite the fact that they have "2.5 times the level of claims in STD for depression than the carrier's book of business" with the rationale being that obesity is driving medical costs.

In most cases, leveraging a mental health professional is beneficial for the employer and the employee. There is a subject matter expertise that a specialized clinician can provide where others often fall short.

¹ Work Loss Data Institute "ODG Announces Comorbidity Calculator" April 1, 2010.

² U.S. Department of Labor. Fact Sheet The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) January 29, 2010.

Barriers

Similar to the 2008 environment, the following perceived barriers to behavioral health management continue to challenge employers:

- **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 knowledgeable 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 practical guidelines for employers** based on hard data and cost-saving results.

Compelling Research and Statistics

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. The increasing body of knowledge and supporting statistics, (as evidenced in some examples below,) has caused employers to consider paying attention to the mind-body connections and behavioral implications for absence, claim frequency and severity, and presenteeism.

- Major Depressive Disorder is the leading cause of disability in the U.S. for ages 15-44³.
- An estimated 26.2 percent of Americans ages 18 and older — about one in four adults — suffer from a diagnosable mental disorder in a given year⁴.
- Nearly half (45 percent) of those with any mental disorder meet criteria for 2 or more disorders, with severity strongly related to comorbidity⁵.
- Serious mental illnesses (SMIs), which afflict about 6% of American adults, cost society \$193.2 billion in lost earnings per year⁶.
- The number of people accounting for expenses for mental disorders almost doubled from 19.3 million to 36.2 million from 1996 to 2006⁷.

“The usual tools that are used for conflict resolution or communication skills for employee improvement or self development are not always effective and a different set of skillsets/tools are required.”

³ The World Health Organization. The World Health Report 2004: Changing History, Annex Table 3: Burden of disease in DALYs by cause, sex, and mortality stratum in WHO regions, estimates for 2002. Geneva: WHO, 2004

⁴ Kessler RC, Chiu WT, Demler O, Walters EE. Prevalence, severity, and comorbidity of twelve-month DSM-IV disorders in the National Comorbidity Survey Replication (NCS-R). Archives of General Psychiatry, 2005 Jun;62(6):617-27.

⁵ Kessler RC, Chiu WT, Demler O, Walters EE. Prevalence, severity, and comorbidity of twelve-month DSM-IV disorders in the National Comorbidity Survey Replication (NCS-R). Archives of General Psychiatry, 2005 Jun;62(6):617-27

⁶ “Tallying Mental Illness Costs” TIME Magazine. May 9, 2008.

⁷ The Five Most Costly Conditions, 1996 and 2006: Estimates for the U.S. Civilian Noninstitutionalized Population.

- Lost productive time among U.S. workers due to depression is estimated to be in excess of \$31 billion per year⁸.
- Behavioral health issues cause 217 million missed workdays annually⁹.
- Nearly two-thirds of depression-related productivity losses are due to presenteeism¹⁰.
- Employees in the depression group have 44% more lost time than employees who had no depression treatment during their disability leave which cost employers \$3,408 more per case¹¹.
- Depression was identified as the most costly health condition among a group of 10 large employers when combining costs from medical, pharmacy, absenteeism, and presenteeism (work time loss due to a health condition.)¹²

Survey Design and Methods

DMEC's 2010 Behavioral Risk Survey is similar to prior surveys conducted in 2008 and 2006. The 2010 survey contains 35 questions, 4 less than in 2008; however, the content was comparable since some questions were combined. The primary goal of the study remains: to determine what progress is being made as it relates to Behavioral Risk Management.

The survey sample has been different in each survey time period and the intent is to take an overall pulse on the market rather than detail tactical changes at specific organizations. As such, the survey was primarily closed-ended, but allowed for explanations where appropriate.

Survey Statistics

The survey was released during the period of February 23 through March 12, 2010 through the Survey Monkey online survey tool to five organizations besides DMEC employer members (see following participant matrix). A total of 1,063 surveys were sent out and 114 were completed for a response rate of 11%.

DMEC	Partnership for Workplace Mental Health (VA)	Mid-America Coalition (KS)	Midwest Business Group on Health (MBGH) (IL)	Center for Health Value Innovation (MO)	Employer Healthcare Alliance (OH)
163	450	60	60	300	30

⁸ Munce SE, Stansfeld SA, Blackmore ER, Stewart DE. The Role of Depression and Chronic Pain Conditions in Absenteeism: Results From a National Epidemiologic Survey. *J Occup Environ Med.* 2007 Nov;49(11):1206-1211.

⁹ Segal/Sibson Perspectives: How to Improve the Behavioral Health of an Organization. October 2007.

¹⁰ "IBI Research Finds Employers Severely Underestimate the Prevalence and Lost Productivity Costs of Depression." Integrated Benefits Institute. May 28, 2009.

¹¹ Ibid.

¹² Health and Productivity as a Business Strategy: A Multiemployer Study. *JOEM* Volume 51, Number 4, April 2009

Participant Profiles

Participants were recruited from an expanded population. In addition to the DMEC membership, participants included employers from the American Psychiatric Association (APA)'s Partnership for Workplace Mental Health network and four other US healthcare coalitions. Although the survey sample in 2010 may be somewhat different from 2008, participants' employers were of similar sizes. Small groups (less than 1,000 employees) represented 11% of respondents in 2008 and 14% in 2010. Similarly, large employers (over 10,000 employees) represented approximately 48% of respondents in 2008 and 41% in 2010. This not only represents the survey population, but also reflects DMEC membership overall. By structuring the survey to target employers of all sizes, we were able to distinguish trends by size where they existed.

In terms of location, the Mid-West continued to have the most significant concentration of respondents, represented by 39.6% of respondents in 2008 and 41.6% of respondents in 2010. The South had the smallest representation at 7.5% in 2008 and 14.3% in 2010. Unlike the 2008 survey respondents, whose employers were concentrated in professional services (33.8%) and manufacturing (29.6%), the 2010 respondents' employers were primarily engaged in health care and social assistance (23.2%) and manufacturing (17.9%).

When asked their field of specialty, participants were able to select any and all applicable responses. Regardless of employer size, Human Resources, Disability, and Workers' Compensation are the primary answers. Below summarizes all responses:

Human Resources – 53%	Wellness – 23%
Disability – 40%	Occupational Health – 20%
Workers' Compensation – 35%	Risk Management – 16%
Absence – 32%	Safety – 14%
Employee Benefits – 31%	Disease Management – 6%
Behavioral/EAP – 27%	Labor Relations – 5%

Overall survey participants were very open to learning more about this important topic of behavioral health. An overwhelming 75.5% indicated they would be interested in attending a two-day practical conference. Some, 30%, were willing to share successful strategies with other members through a conference presentation, chapter meeting, speakers' bureau, case study, or special interest group.

Survey Results and Discussion

Prior surveys indicated that all firms consider behavioral risk as an important emerging area of concern. The 2010 survey results support DMEC's theory from 2008 with 61.8% believing behavioral risk is an important emerging area of concern with another 27.5% indicating "maybe."

The 2010 data reveals that employers of all sizes are interested in Behavioral Risk Management; however, smaller employers may not have as much of a focus. Small (under 1,000) and mid-sized (1,000-10,000) employers utilize a behavioral component in their program to a lesser degree (35.7% and 37.8% respectively) as compared to 65.0% for large employers. This may be due to the fact that smaller employers have a lower incidence rate and therefore may not immediately see the value in Behavioral Risk Management. Having said that, it is very promising to see how many small employers have fully functioning disability and absence management programs. Approximately

43% of small employers, compared to 31% for the entire survey sample, stated they have a “fully integrated/coordinated offering.” This is notable because integrated and coordinated programs are often able to streamline processes and integrate more program elements like behavioral needs.

Looking at overall statistics in 2010, 47.3% of respondents indicated “Yes,” they include a behavioral component in their integrated or coordinated disability/absence management program. This is a favorable increase from the 2008 survey where 31% provided a “Yes” response indicating the growing importance of this focus area.

Providing Behavioral Health and Related Programs

As expected, all employers surveyed in 2010 provide health coverage for mental health care with a high percentage, 70.5%, carving it within their medical plan compared to 20.5% that have a separate “carve-out” behavioral health plan. The utilization of a separate behavioral plan has decreased from 34.3% in 2008, which is appropriate given consolidation in the market, as well as the increasing ability of standard health plans to provide strong behavioral health benefits. Regardless of whether care is provided from a primary health plan or a separate program, employers are continuing to embrace programs related to behavioral health issues. The survey documents 92.7% of respondents having substance use disorder coverage, 53.6% providing disease management or case management for chronic pain conditions, and 52.7% offering disease management or case management for depression. Some respondents also noted providing STD leave for behavioral health, though LTD provisions for this leave are limited due to the need for objective medical findings.

Over time, the popularity of employee assistance programs (EAP) has increased in the market and their value to employers has grown. Within our 2010 and 2008 survey group(s), EAPs were offered by 97.2% of organizations. Although smaller organizations are less likely to offer an EAP, at 85.7%, the penetration with our survey group is high. Firms of all sizes seem to consistently provide external EAP programs which have been coordinated by 65.4% of survey respondents in 2010; however, larger firms are more likely to establish an internal EAP due to the complexities of program set-up and the ongoing costs as a function of overall EAP incidents/visits. Regardless of size, EAPs are most often used for employee consultation and coaching with 79.6% of respondents indicating their programs provide these services. From there, other common uses of EAP services for the overall survey group are employee treatment (75%), management consultation/coaching (69.4%), and management training (61.1%). When examining the number of EAP visits provided, 51.9% (up from 44.9% in 2008) of respondents in 2010 cite offering between 3 and 6 visits within their EAP program. Another 21.7% offer 1-3 visits and 13.2% offer more than 6 visits.

Screening and Behavioral Health Triggers

One of the most critical aspects of a best-in-class Behavioral Risk Management program is early intervention which is directly linked to proactive screenings and established triggers. As one respondent noted “with improved data integration we can see the lost productivity from comorbid behavioral health problems that we previously suspected. The risk was there before the physical ailment, and addressing the behavioral health risk with an otherwise healthy employee is much more effective.”

Perhaps the most telling information about EAPs from the survey data is that employers ranked EAPs as the most significant program element for return to work efforts (65.3%). Engaging the employee through the EAP can create an intimacy that strengthens communications and fosters a return to work focus from the beginning of the absence. This survey suggests that employers without EAP programs, as well as those that do not take advantage of their EAP services, should reconsider their approach.

Overall screening for psychological or psychosocial issues has remained strong with 41.1% of firms in 2010 noting they actively screen for mental health conditions. When asking employers what they screen for, substance use disorders are the most common, cited by 37.6% of respondents. In addition, screenings for depression were noted by 25.7%, and stress or anxiety was documented by 24.8%. Somewhat disappointing is that 35.6% of respondents indicated they do not screen for stress, anxiety, substance use disorder, depression or child/spousal/senior abuse.

The current results indicate that employers that do screen use all programs and processes available to them including short term disability (STD), performance reviews, workers' compensation, long term disability (LTD), and safety. Although the survey percentages show a decrease in LTD and workers' compensation screenings and a slight increase in STD screenings, this does not appear to be a widespread trend and could potentially signal more attention being placed in the short term which is typically more impactful. Tools leveraged for screening include:

- Supervisor communication – 46.6%
- Review by other case management professionals – 43.8%
- Case management review or judgment – 38.4%
- Red flags – 35.6%
- Review by MHP – 34.2%
- Other screening tools – 15.1% (Some respondents noted the Patient Health Questionnaires PHQ-2, PHQ-9, the U.S. Preventive Services Task Force[USPSTF] tool, internal company developed tools, and online Health Risk Assessments [HRAs])

Return to Work (RTW)

When asked about return to work programs in place to assist employees with mental health/psychiatric disabilities, 2010 responses were similar to 2008. The most popular activities continue to be:

- Referrals to EAP or other programs
- 3-point contact; communication between organization, provider and employee
- Fitness for duty (FFD) or transitional job modifications

Programs offering the best behavioral and mental health RTW results reflect the value of the EAP, as well as the advantages of early intervention and communication:

- Use of EAP – 65.3%
- Promotion of EAP services – 58.9%
- Communication to employees and supervisors – 46.3%
- Early intervention and identification – 45.3%

Employees returning to work after psychiatric cases should expect fitness for duty assessments which are used by 35.6% of organizations. In addition to FFD, employers cite:

- Discussions and sign off on RTW program between employee and their supervisor – 21.8% (a decrease from 25.4% in 2008)
- Training on any change to their job since they have been absent – 16.8% (decrease from 23.9% in 2008)
- Interim “touch base” meetings with the employee to determine if the RTW program is successful – 19.8% (decrease from 25.4% in 2008)

One respondent noted “with improved data integration we can see the lost productivity from comorbid behavioral health problems that we previously suspected. The risk was there before the physical ailment, and addressing the behavioral health risk with an otherwise healthy employee is much more effective.”

Employers surveyed indicated the most significant barrier to RTW initiatives for behavioral health conditions is employees' dependency on their primary care physicians and not seeking treatment with a Mental Health Professional (MHP). This was referenced by 71.7% of respondents in 2010 and 70.4% of respondents in 2008. This supports the need for better and earlier engagement from a MHP.

Use of a Mental Health Professional

In most cases, leveraging a MHP is beneficial for the employer and the employee. There is a subject matter expertise that a specialized clinician can provide where others often fall short. Given this, many organizations are beginning to include MHP or EAP providers within their disability management teams. In 2010, 31.1% of surveyed firms included them within the team; this figure is higher for larger organizations (52.5%) compared to small and mid-sized groups (28.6%). Although this is a decrease from the prior analysis, there was an increase in organizations that said they always involve a MHP or EAP provider from 8.5% in 2008 to 11.7% in 2010.

Growth in the use of MHPs for psychological or psychiatric claims was significant with 62.9% of firms using MHPs in 2010 compared to 48.1% using them in 2008. Of those, 35.4% always use a MHP, with the remaining 64.6% using them occasionally.

For further insight, DMEC asked employers to respond to how MHPs are used in the case management process. Increases were noted in all categories that were common to the 2008 and 2010 survey, further underscoring the effectiveness of this case management tool.

Note: respondents were asked to check all that apply which yields percents of greater than 100

	2008	2010
Psychiatric and psychological claims	25.4%	62.9%
Face-to-face consultation	N/A	37.1%
Physical claims with potential underlying psychosocial or psychiatric issues	21.1%	35.5%
Telephonic consultation	23.9%	35.5%
Referral source to identify areas of concern	N/A	35.5%
Disciplinary or performance problems	16.9%	27.4%
Safety reports	N/A	11.3%

In physical cases, use of a MHP as a means to screen for possible underlying psychological or psychosocial issues has also increased. In 2008 only 25.4% of organizations used a MHP to screen, while 34.2% are now utilizing a MHP's expertise to fully examine underlying comorbidities. This is seen as a reflection of successful outcomes and increased availability of MHPs with workplace expertise.

Training and Communications

Unfortunately, 41.3% of firms in 2010 do not provide any training to identify “at risk” employees. Although a strong opportunity exists for improvement, this is a favorable decrease from the 2008 survey which indicated 49.3% of respondents did not provide mental health training to identify these employees. As one respondent whose organization has taken steps to provide training states, “The usual tools that are used for conflict resolution or communication skills for employee improvement or self development are not always effective and a different set of skillsets/tools are required.” The overall lack of training, however, translates into employees primarily self reporting absences due to a psychiatric disability. Other ways employers uncover work absences due to psychiatric disabilities are:

- EAP “warm transfer” from STD/LTD/WC claims personnel to EAP – 37.9% (increase from 28.2% in 2008)
- Integration/coordination of plans that allows cross referrals or “warm transfers” to behavioral health providers – 25.2% (decrease from 29.6% in 2008)
- Data obtained from a health risk assessment tool – 18.4% (decrease from 22.5% in 2008)
- Depression screening at intake point – 8.7% (decrease from 11.3% in 2008)
- Predictive modeling from claims data – 2.9% (decrease from 9.9% in 2008)

In 2010, 47.3% of respondents indicated “Yes,” they include a behavioral component in their integrated or coordinated disability/absence management program. This is an increase from the 2008 survey where 31% indicated the growing importance of this focus area.

Although there is a gap to fill related to “at risk” training, employers are taking education surrounding wellness and work/life seriously. One new area of analysis in 2010 was gathering insight regarding educational programs offered by employers. As you will see below, wellness/health promotion is most common and has surpassed traditionally rooted safety communications. DMEC is interested in tracking this growth in the next survey.

Note: respondents were asked to check all that apply, which yields percents of greater than 100

	2010
Wellness/health promotion (exercise, nutrition, relaxation)	91.1%
Safety	85.1%
Stress management/resilience training	76.2%
Communication skills	72.3%
Diversity	70.3%
Conflict resolution	67.3%
Work-life balance	60.4%
Substance abuse	53.5%
Depression, anxiety, bipolar disorders	38.6%

Stigma

Behavioral conditions continue to have a stigma attached to them, which is an ongoing struggle for employees suffering from illnesses as well as employers and health providers trying to treat them. Often a mental illness is overlooked in comparison to a physical illness, even though they are directly related and can each exacerbate the other.

Although the percent of respondents who believe a stigma exists is higher in 2010 than 2008, a large percentage also feels there is a decrease from two years ago. Depending on the category, only 5.9% to 11.8% believe the stigma has increased over the past two years:

	Stigma Increased	Stigma Decreased	Stigma Stayed the Same
Having a psychological/psychiatric problem	9.8%	23.5%	60.8%
Seeing a MHP	5.9%	36.6%	44.6%
Taking psychotropic/mental health prescriptions	11.8%	29.4%	46.1%
Utilizing EAP services	7.9%	36.6%	38.6%

Further to these statistics, throughout the survey, many respondents commented on the recognized costs of psychotropic/mental health prescriptions (such as antidepressants), an identifiable link between mental health and productivity and a focus on a “doing more with less” kind of workplace mentality that has arisen due to recent economic conditions. That these items were frequently referenced suggests that not only has current research and literature increased awareness of these issues, but also that economic pressures have contributed to bringing these topics to the forefront.

Management Awareness and Acceptance

Much of this stigma within an organization is derived from the overall corporate culture. When asking survey respondents how their upper management views behavioral health issues, most (71.6%) feel their opinion has not changed in the last two years. Of the remaining, 24.5% believe they have become more open and only a small percentage (3.9%) believes upper management has become more closed. These results are promising overall and in line with what was captured in 2008; however the realities of the significant economic issues of the 2008-2010 recession may have distracted upper management’s attention from behavioral risk implications. DMEC expects to see resurgence in the attention to these factors in the next survey.

Conclusion

This subject matter is vast and complex and DMEC’s survey work is just beginning to collect and analyze perceptions regarding Behavioral Risk Management. DMEC is encouraged by the commitment by many organizations and their upper management teams and feels strongly that the dedication to integration in the industry will highlight the need for more customized solutions toward behavioral health.

As employers continue to benchmark and track return to work, health, and productivity, a spotlight will shine on this subject matter and the market expertise that exists. This is

Wellness is a prevalent trend in the industry and as one survey respondent noted, their company’s management was more focused on weight control/reduction support programs than mental health programs despite the fact that they have “2.5 times the level of claims in STD for depression than the carrier’s book of business.”

demonstrated through suppliers already responding to employer demand through pre-determined Behavioral Risk Management triggers that prompt additional intervention.

As one respondent noted, “expectations in the US for work performance, tools such as blackberries that tend to increase demand over easing demand, and... current economic trends” are just a few reasons why the complexity of our lives has become more intense. With that, the line between “work” and “non-work” becomes grayer. So too is the distinction between physical and behavioral conditions. We expect to see this blurring of the lines result in a more comprehensive approach to not only absence and return to work, but the overall treatment of physical and behavioral conditions in an individualized yet streamlined and integrated manner.

Appendix A: Questions and Responses

Answer Options	Response Percent
1. Does your company have an integrated/coordinated disability and absence management program?	
Yes, fully integrated/coordinated	31.0
Yes, partially integrated/coordinated	39.8
No	19.5
Considering	3.5
Not Sure	6.2
2. Does your company currently include a behavioral component to your integrated or coordinated disability/absence management program?	
Yes	47.3
No	34.8
Considering (please explain in comment area)	6.3
Not Sure	11.6
3. Does your company provide health insurance coverage for mental health care?	
Yes	100.0
No, if no skip to question 5	0.0
4. If yes, who provides behavioral health benefits?	
Carve In (included as part of a medical plan)	70.5
Carve out (managed by a behavioral health plan)	20.5
Other	3.6
Not sure	5.4
5. Does your company offer any of the following programs?	
Disease management or case management for depression?	
Yes	58
No	35
Considering	8
Not sure	9
Disease management or case management for chronic pain conditions (arthritis, back pain, fibromyalgia, or other)?	
Yes	59
No	39
Considering	7
Not sure	5
Substance abuse coverage?	
Yes	101
No	7
Considering	0
Not sure	1

Answer Options	Response Percent
6. Does your company offer an Employee Assistance Program (EAP)?	
Yes	97.2
No	2.8
Not sure	0.0
7. If yes, are services provided by:	
Internal EAP	17.8
External EAP	65.4
Combination	15.9
Other (please describe)	0.9
8. Does your EAP offer any of the following programs? Check all that apply.	
Management training	61.1
Management consultation/coaching	69.4
Employee training	56.5
Employee consultation/coaching	79.6
Referral only	26.9
Employee treatment	75.0
Automatic disability claim referral	10.2
Safety department review of accident records	9.3
Other (please describe)	14.8
9. How many visits does your EAP provide?	
1-3 visits	21.7
3-6 visits	51.9
7-20 visits	13.2
Other (please specify)	13.2
10. Do you identify or screen for possible underlying psychological or psychosocial issues?	
Yes	41.1
No	39.3
Considering	4.7
Not sure	12.1
Doesn't Apply	2.8
11. If yes, what areas do you screen? Check all that apply.	
LTD	22.8%
STD	35.4%
Workers' Compensation	26.6%
Performance	34.2%
Safety	22.8%
Doesn't Apply	34.2%
Other (please describe)	11.4%

Answer Options	Response Percent
12. If yes, how do you screen? Check all that apply.	
Red flags	35.6
Supervisor communication	46.6
Case management review or judgment	38.4
Screening tool (describe below)	15.1
Review by Mental Health Professional (MHP)	34.2
Review by other case management professional (ex. Occupational Health; claims adjuster, etc.)	43.8
Doesn't Apply	34.2
Other (please describe)	
13. How does your company 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	2.9
Employees self-report or claim	56.3
Depression screening (such as PHQ9) at intake point	8.7
Data obtained from a health risk assessment (HRA) tool	18.4
Integration/coordination of plans that allows cross referrals or "warm transfers" to behavioral health providers	25.2
EAP "warm transfer" from STD/LTD/WC claims personnel to EAP	37.9
No screening for this risk	31.1
Other (please describe)	7.8
14. Does your company utilize a MHP to perform, or oversee, case management on potential psychological or psychiatric claims?	
Yes, always	17.0
Yes, occasionally	31.1
No – we use non-mental health case managers	12.3
No – no one does case management	22.6
Considering	1.9
15. If yes, in what ways do you utilize the MHP to do case management? Check all that apply.	
Psychiatric or psychological claims.	62.9
Physical claims with potential underlying psychosocial or psychiatric issues	35.5
Disciplinary or performance problems	27.4
Safety reports	11.3
Face-to-face consultation	37.1
Telephonic consultation	35.5
Referral source to identify areas of concern	35.5
Other (please specify)	9.7
16. Do you currently include an EAP representative or other MHP on your Disability Management Team?	
Yes, always	11.7
Yes, occasionally	19.4
Considering	3.9
No	63.1
Not sure	1.9

Answer Options	Response Percent
17. 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	10.6
Corporate and field HR professionals	28.8
Benefits service center teams	9.6
Managers who directly supervise employees	29.8
Senior management	9.6
No one receives mental health training	41.3
Not sure	13.5
Other (please specify)	12.5
18. Does your company offer any of the following educational programs? Check all that apply.	
Stress management/resilience training	76.2
Depression, anxiety, bipolar disorders	38.6
Conflict resolution	67.3
Communication skills	72.3
Work-Life balance	60.4
Diversity	70.3
Wellness/health promotion (exercise, nutrition, relaxation)	91.1
Safety	85.1
Substance abuse	53.5
19. Do you screen for any of the following? Check all that apply:	
Stress or anxiety	24.8
Substance abuse	37.6
Depression	25.7
None	35.6
Child/Spousal/Senior abuse	3.0
None	23.8
Other (please describe)	
20. Has upper management’s opinion regarding the need to review behavioral issues changed in the last two years?	
Yes, become more open (please specify below)	24.5
Yes, become more closed (please specify below)	3.9
Not changed	71.6
Other (please explain)	
21. Do you think behavioral risk (as defined in the opening statement) is an important emerging area of concern for employers?	
Yes (please explain)	61.8
No	3.9
Maybe	27.5
Not sure	6.9
Explanation	

Answer Options	Response Percent
22. Is there a stigma associated with any of the following and how has it changed in the last two years?	
Having a psychological/psychiatric problem	
Increased	10
Decreased	24
Stayed the Same	62
No Stigma	6
Seeing a MHP	
Increased	6
Decreased	37
Stayed the Same	45
No Stigma	13
Taking psychotropic/mental health prescriptions	
Increased	12
Decreased	30
Stayed the Same	47
No Stigma	13
Utilizing EAP services	
Increased	8
Decreased	37
Stayed the Same	39
No Stigma	17
23. What return-to-work (RTW) activities do you have in place to help employees with mental health/psychiatric disabilities return to work? Check all that apply.	
Analysis to determine the cognitive demands of the job in order to determine the potential stressors that may prevent RTW	38.2
Development of any transitional job modification possibilities	55.9
Consultation with a vocational rehabilitation counselor from either WC or disability provider	37.3
Consider referral to EAP or depression disease management programs	67.6
Communications between you, your disability provider or EAP to develop job accommodations to enable the employee to RTW gradually.	49.0
Job coach (before or during RTW process)	11.8
Engage in the interactive process	50.0
None	13.7
Other (please explain)	5.9
24. Do you have any special requirements for an employee who returns to work from a psychiatric disability? Check all that apply.	
Discussion and sign off on RTW program between employee and their supervisor	21.8
Fitness for duty test/exam to determine their ability to perform their job	35.6
Training on any changes to their job since they have been absent.	16.8
Interim "touch base" meetings with the employee to determine if the RTW program is successful.	19.8
None	33.7
Not sure	5.9
Other (please explain)	22.8

Answer Options	Response Percent
25. What RTW barriers do you most often encounter with employees out of work due to a psychiatric/behavioral illness? Check all that apply.	
Doctors enabling or overprotecting patients	63.6
Doctor's lack of RTW planning	60.6
Doctor's unclear RTW full capacity timeframe	61.6
Difficulty developing transitional duty options	46.5
Employees depending on their primary care physician and not seeking treatment with a MHP	71.7
Workplace issues other than actual illness (e.g. supervisor or co-worker conflict, resistance to accommodations)	65.7
Personal stressors	51.5
Other (please describe)	10.1
26. Which of the following program elements or solutions do you feel have produced the best behavioral/mental health RTW results in your company? Check all that apply or explain your unique program.	
Use of EAP	65.3
Use of MHP or behavioral case manager	33.7
Mandatory referral	16.8
RTW committee	9.5
RTW coach or advocate	23.2
Parity of benefits (mental and physical)	28.4
Promotion of EAP services	58.9
Early intervention and identification	45.3
Vendor integration or coordination	23.2
Communication to employees/supervisors	46.3
Transitional duty options	37.9
IME with RTW mindset	20.0
Engaging in the interactive process	41.1
Other (please describe)	

Answer Options	Response Percent
27. What is the primary business of your company or organization?	
Accommodation & Food Services	0.0
Administrative/Support/Waste Management/Remediation Services	1.1
Agriculture, Forestry, Fishing, Hunting & Mining	0.0
Arts, Entertainment & Recreation	1.1
Construction	1.1
Educational Services	8.4
Finance & Insurance	10.5
Health care and Social Assistance	23.2
Information	2.1
Management of Companies and Enterprises	1.1
Manufacturing	17.9
Other Services (except Public Administration)	3.2
Professional, Scientific, & Technical Services	5.3
Public Administration	7.4
Real Estate, Rental and Leasing	0.0
Retail Trade	2.1
Transportation and Warehousing	6.3
Utilities	8.4
Wholesale Trade	1.1
Other	
28. Please indicate the total number of employees in your company.	
< 500	10.0
500 – 999	4.0
1000 – 2499	11.0
2500 – 4999	16.0
5000 – 7499	8.0
7500 – 10000	10.0
10000 – 24999	17.0
> 25000	24.0
29. Please identify your field of specialty. Check all that apply.	
Human Resources	53.0
Disability	40.0
Absence	32.0
Workers' Compensation	35.0
Risk Management	16.0
Employee Benefits	31.0
Wellness	23.0
Behavioral/EAP	27.0
Safety	14.0
Disease Management	6.0
Occupational Health	20.0
Labor Relations	5.0
Other	

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**DISABILITY MANAGEMENT
EMPLOYER COALITION**

The Disability Management Employer Coalition (DMEC) is a non-profit organization that provides educational resources to employers in the areas of disability, absence, health, and productivity. The primary goal of DMEC is to assist employers in developing cost-saving programs, encouraging responsive market products, and returning employees to productive employment. Visit www.dmec.org for more information about educational publications and events.

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