FEATURE ARTICLE
Continuing Education

Managing Workplace Depression

An Untapped Opportunity for Occupational Health Professionals

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Managing major depression represents one of the greatest untapped occupational health opportunities in American business and industry. Despite well established research indicating the significant negative effect depression has on both individual and organizational health and dozens of intervention studies demonstrating highly successful treatment options, most U.S. employers remain unresponsive (Conti, 1994; Druss, 2000; Druss, 2001; Goetzel, 1998, 2002; Kessler, 1999; Simon, 2001; Stewart, 2003; Williams, 1999). The National Worksite Health Promotion Survey (Association for Worksite Health Promotion, 1999) found only 12% of companies (n = 1,544) offered programs to address depression at the worksite. Similarly, a 2001 survey conducted by the National Center for Brain Research and the Society for Human Resource Management estimated only 5% of more than 400 responding companies were currently using a comprehensive approach to address worker depression (The Benfield Group, Employee Health Management eNews, personal communication, March 28, 2002).

This is not to say nothing is available to employees who are depressed. Many employers offer mental health benefits, employee assistance programs (EAPs), health promotion or wellness programs, and screenings for depression (National Institute of Mental Health, 1995b). However, the fast growing prevalence and costs associated with employee depression seem to suggest these efforts are not enough to address the problem adequately.

Dozens of articles have been published in academic, medical, and business health trade journals during the past 15 years on the etiology of depression and its devastating effects in the workplace (Conti, 1994; Druss, 2000; Goetzel, 1998, 2002; 2003; Goldman, 1999; Johnson, 1997; Kessler, 1999; Regier, 1988; Riotto, 2001; Russell, 1998; Simon, 2001; Stewart, 2003; Vernarec, 2000; Williams, 1999). Although far less abundant than approaches for managing physical illness, literature during the past 15 years has provided numerous examples of worksite models, case studies, and guidelines for more effectively addressing depression (Conti, 1994; Dunnagan, 2001; Goetzel, 2002; Goff, 1993; Putnam, 2003; Regier, 1988; Riotto, 2001; Vacarro, 1991). So why are the vast majority of U.S. employers virtually ignoring the issue of workplace depression? Perhaps the reason has less to do with answering the "why?" and the "how to?" questions and more to do with the stigma associated with addressing mental health issues, especially at work.

To that end, the primary focus of this article is not to define depression or discuss its symptoms and treatment modalities. Rather, the intent of this article is to provide occupational health professionals with strategies for overcoming organizational, individual, and even occupational barriers that prevent employers from reaping the substantial benefits associated with a proactive approach to managing workplace depression.

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ORGANIZATIONAL BARRIERS

It is unlikely occupational health professionals need to be convinced of the need for aggressive approaches to addressing workplace depression. However, lack of verbal, political, and financial support from an organization's management may prevent occupational health nurses from assisting employees with depression and thus, reducing costs. Goetzel (2002) lists employer information gaps, lack of data to justify increased investment in employee mental health programs, and employers' ambiguous role in depression management as common organizational barriers to effectively addressing workplace depression. Thus, the first step in overcoming organizational barriers to addressing depression is to build a compelling case that:

- Educates employers about the negative effect depression has on business outcomes.
- Establishes depression initiatives as an investment, rather than an additional expense.
- Clarifies the employer's role in providing comprehensive programs addressing depression in the workplace.

Educating Employers

Depression is not a personal weakness, but a complex and serious illness involving body, mood, thoughts, and behavior. Left untreated, depression can become chronic and lead to devastating consequences for the individuals who experience it, their families, and the organizations in which they work (Goetzel, 2002; National Institute of Mental Health, 1995a; Sheffield, 1998; Simon, 2001).

The several types of depressive disorders include bipolar disorder (i.e., manic and depressive moods alternating), dysthymic disorder (i.e., chronic depression), and major depressive disorder—the most common disorder (National Institute of Mental Health, 1995a). The causes of depression are somewhat elusive. However, most researchers agree depression can result from one or a combination of factors including chemical imbalances in the brain, personality characteristics, genetic vulnerabilities, and situational events (Goetzel, 2002).

Why Is Addressing Depression So Important?

The answer to this question can be summed up for business leaders in three words: prevalence, cost, and treatment.

Depression is prevalent. Major depression is predicted to be the second leading cause of disease burden in the United States by the year 2020. Currently, it affects 19 million Americans each year (National Institute of Mental Health, 1995b). Nearly 70% of adults with depression are younger than 45, and more than 70% of those are actively employed (Anderson, 1993). The National Institute of Mental Health (1995b) estimates 1 in 20 workers is depressed at any given time.

Depression can affect anyone, even the most productive, bright, and creative individuals in the work force. However, the general consensus of most epidemiological research is that:

- Women experience depression twice as often as men.
- Younger individuals struggle more with depression than older individuals.
- White individuals have a slightly greater risk of experiencing depression than Black individuals.
- Poor individuals have higher rates of depression than individuals who are more economically stable.
- Separated or divorced adults are more likely to become depressed than married or never married adults (Blazer, 1994).

Depression is costly. The costs associated with depression, both human and economic, are well established in the literature. In terms of human health and quality of life, depression can be as debilitating as any major chronic illness. Frequently, individuals who are depressed experience comorbidities such as anxiety, substance abuse, or physical illness leading to further deterioration of well being (Williams, 1999). In addition, depression has also been found to be a risk factor for heart disease, high cholesterol, and high blood pressure (Goetzel, 2002). An estimated 15% of individuals with major depression commit suicide (Long, 1999).

The effect of depression often extends beyond the individual with depression. Employees who come to work depressed can lower the morale of their coworkers, increasing the risk turnover and general organizational discontent (Goetzel, 2002). In survey of 146 employers in the Tampa Bay area, depression was ranked first of the top 10 diseases affecting employee health and productivity for having the most negative effect on the community. This suggests coworkers, friends, family members, and indeed, society as a whole experience a reduced quality of life when individuals in their midst are depressed (Riotto, 2001).

From an economic perspective, the costs associated with workplace depression can be sub-categorized into employer paid health care costs and lost productivity. Simon (1995) found employees who were depressed generated nearly twice the annual health care claims as their coworkers without depression. Greenberg (1996) estimated a worker with depression costs an employer $6,000 per year.

Most recently, a 1998 landmark study of more than 46,000 employees conducted by the Health Enhancement Research Organization (HERO) found depression to be the most costly of the top 10 modifiable risk factors in the workplace in relation to annual health care costs. The HERO researchers estimated each employee with depression generated approximately $3,189.01 per year in health care costs compared to $1,679.31 per year for employees without depression. In addition, employees with depression who were also stressed generated approximately 147% more in health care costs than employees who were not depressed (Goetzel, 1998).

The greatest cost associated with depression, and the major issue occupational health practitioners can use to convince management to do more about workplace depression, is lost productivity. This includes short term disability, workers' compensation, absenteeism, and on-the-job impairment, also referred to as "presenteeism" (Druss, 2000; Goetzel, 2002; Kessler, 1999; Simon, 2001; Stewart, 2003). In fact, depression is one of the top five health issues associated with work loss and cutback.

Of these top five conditions, including panic, ulcers, chronic sleep problems and autoimmune diseases, depression is the most prevalent (Rossi, 2001).

Greenberg (1996) estimated the annual salary equivalent costs associated with work loss and cut back caused by major depression costs U.S. employers $33 billion per year. Kessler (1999) found workers with depression had 1.5 to 3.2 more short term disability days per month than their coworkers without depression. The estimated monthly salary equivalent associated with this lost productivity was $182 to $395 per employee with depression.

The greatest and most insidious costs associated with depression and productivity are not caused by absenteeism, but by presenteeism—employees with depression who continue to come to work and underfunction as a result of their symptoms. Although difficult to observe and measure, Stewart (2003) estimated more than 80% of an organization's total lost time caused by depression was "invisible and explained by reduced performance while at work." In another study, the productivity of workers with depression declined 20% because of lack of focus, inability to make decisions, apathy, fatigue, and low self confidence (Greenberg, 1993).

When compared with other chronic illnesses far more commonly addressed by occupational health professionals, Druss (2000) found the total costs associated with workplace depression as expensive as hypertension and roughly twice as expensive as diabetes and back problems. Only costs associated with heart disease, because of its high prevalence and average cost per employee, were higher than depression.

Contrary to what many organizational leaders may perceive, evidence suggests costs associated with depression are highest prior to diagnosis and treatment. Mayo Clinic researchers found workers with untreated depression were generating an average $850 per month in health care costs because of repeated visits to their primary care provider and the emergency department. They were complaining of the physical symptoms of depression or anxiety including headaches, insomnia, chest pains, abdominal pain, and joint pain. After diagnosis, monthly health care costs immediately declined (Nesse, 1998). With accurate diagnosis and appropriate treatment, productivity will also improve (Simon, 2001).

Depression is highly treatable. More than 80% of those who receive appropriate treatment for depression experience either symptom relief or elimination, many times within weeks (Elkin, 1989). Traditionally, treatment consists of pharmaceutical intervention, psychotherapy, or a combination of both. Success rates are fairly consistent across all three modalities (National Institute of Mental Health, 1995a). In addition, recent research indicates complementary and alternative treatments such as exercise therapy, yogic breathing techniques, light therapy, acupuncture, and homeopathic treatments are effective in relieving depression (Zuess, 2003).

Unfortunately, even with the availability of highly efficacious treatment options, only one third of individuals suffering from depression ever get appropriate care (Young, 2001). Barriers that may prevent insured workers from accessing expeditious and effective treatment for depression include stigma, inability to recognize signs and symptoms, lack of resources or awareness thereof, cumbersome or poor quality mental health plans, and under-diagnosis in primary care settings (Druss, 2001; Glozier, 1998; Goetzel, 2002; Goff, 1993; Goldman, 1999; Simon, 2001).

Establishing Depression Initiatives as an Investment

Most employers, rightfully, want to know if investing in employee mental health programs will save the organization money. According to the research, the answer to this question is yes. In an often cited study of Banc One employees, Conti (1994) found that even though the pharmaceutical costs of treating workers with depression increased, overall health care costs were significantly less following implementation of a comprehensive depression program.

However, the greatest return on investment with depression initiatives is regained productivity. Simon (2001) suggests 45% to 98% of the costs of depression treatment could be offset with restored job performance alone. In a review of both controlled and uncontrolled depression treatment studies, researchers observed the "synchronous" relationship between severity of depression and work impairment was such that as the symptoms of depression were relieved, productivity almost immediately increased. Assuming a cause and effect relationship, Simon concluded any relief in depressive symptoms could lead to improved work performance.

Clarifying the Employer's Role in Addressing Depression

The employer's role is never to diagnose depression nor to mandate assessment or force treatment. However, given the serious economic effect of depression on the workplace, many researchers strongly suggest it is not only appropriate, but imperative, that companies begin to design and implement more aggressive responses to this serious employee health issue (Conti, 1994; Goetzel, 2002; Goff, 1993; Putnam, 2003; Simon, 2001; Stewart, 2003). Still, many business leaders may be reluctant to implement programs because of concerns about employee relations and legal issues. They may fear staff will view their efforts related to workplace depression as overly intrusive, leaving the organization vulnerable to employee complaints, union issues, and legal liability (Goetzel, 2002).

The relationship between an organization's management and its employees is one of the most crucial factors in determining the success of any worksite depression initiative. In short, employees must believe the company genuinely cares about their well being if they are to feel safe in seeking help for their depression at work. If the current corporate culture is one of mistrust, anger, and hostility, employers might be better served to work on repairing their relationships with staff before attempting to address employee depression.

Legally, there are three important points to remember:

- An employer cannot ask a prospective employee about past or current bouts of depression.

Conditions for Identifying and Treating Employee Depression

- Participation in any worksite sponsored depression assessment is voluntary, includes a signed informed consent, and is strictly confidential.
- All assessments are scored promptly and an emergency plan is in place to respond immediately to employees at high risk for suicide.
- All employee data related to depression are stored separate from human resource records and reported in aggregate only.
- All staff members working with the worksite based depression initiative are aware of the organization's confidentiality and Health Insurance Portability and Accountability Act (HIPAA) compliance policies.
- Programs and services are available either at the worksite or as part of the mental health benefit plan (or both) to help employees with depression.
- Participation in worksite based depression treatment programs is voluntary and strictly confidential.

- Employees are never obligated to reveal their depression unless they are requesting some accommodation because of their illness.
- Employers are obligated under the American Disabilities Act to reasonably accommodate any known employee who is depressed (National Institute of Mental Health, 1995a).

However, there is no law prohibiting an organization from identifying and treating employee depression under the conditions noted in the Sidebar (above).

In addition, although supervisors cannot diagnose and treat depression nor discriminate against staff whom they know are depressed, it is not illegal for supervisors to approach employees about changes in work performance, listen to employees' concerns, and suggest resources for help. The National Institute of Mental Health (1995b) suggests all supervisors:

- Learn about depression and the available resources for help.
- Recognize when employees are struggling at work because of the possibility of depression related symptoms and refer appropriately.
- Always maintain the employees' confidentiality and privacy.

Involving supervisors in worksite depression initiatives, understandably, may to be of concern to occupational health practitioners. Traditionally, employee health issues and human resources issues have been kept separate to protect both employee and employer from discrimination and liability. Most supervisors are in frequent contact with their staff and many have established trusting relationships with them. As a result, supervisors can be a valuable referral source for depression programs and services if they are trained in what to look for, aware of the resources to access for help, and respectful of their professional boundaries when talking to an employee who may be depressed.

At the organizational level, busy employers short on time and expertise may be tempted to leave the work of addressing employee depression to the existing health plan or outsourced EAP—this could be a costly decision. When employers become more directly involved in workplace depression initiatives—whether in the form of implementing a health promotion sponsored education or awareness campaign, hiring an internal employee assistance provider or occupational health nurse, or assigning someone in the company to work collaboratively with existing outsourced health benefits providers—they are in a better position to closely monitor the quality of mental health programs and other benefits their employees receive.

Quality issues concerning health benefits deserve close scrutiny because they not only can delay treatment, but also exacerbate the problem and cost the company more money (Druss, 2001). Potential problems can include managed care organizations prescribing older, less effective medications because they are less expensive; a lack of coordination of care between mental and physical health providers caused by separate health care plans; and generally inadequate coverage for mental illness (Goldman, 1999). In addition, EAP vendors that are paid a contractual fee regardless of utilization and outcomes may not be motivated to increase identification and treatment of workers with depression.

Finally, employers who become more involved in managing workplace depression can serve as catalysts for system wide collaboration. Historically, depression screenings, EAP programs, mental health benefits, occupational health services, and health promotion initiatives working in isolation have not been an adequate solution to the problem. Benefits of integration may include:

- Pooling human and budgetary resources with which to implement the initiative.
- Reducing duplication of efforts.
- Presenting a consistent message to employees about depression.
- Developing more resources for employees to access for mental health care, which is, perhaps, the most valuable.

INDIVIDUAL BARRIERS

Having quality employer-sponsored mental health programs and services to address depression does not guarantee employees will use them. As mentioned previously, individual barriers such as stigma, inability to recognize the signs and symptoms, lack of motivation, fear of being labeled "unstable" or "incompetent," and ignorance about treatment options can prevent workers with depression from reaching out for help. The ideas listed in the Sidebar on page 126 may be helpful in addressing these barriers.

OCCUPATIONAL BARRIERS

Some occupational health nurses may be hesitant about initiating a more aggressive response to employee depression because of limitations they believe are inher-

Tips for Overcoming Barriers to Using Mental Health Programs

- Provide ongoing organization-wide trainings to build awareness of what depression is and how it can be treated. To maximize participation, incorporate trainings into leadership development courses, staff in-services, continuing education classes, wellness lunch 'n' learns, departmental meetings, and new employee orientation. To soften the stigma, consider adopting an "other" perspective. Instead of educating employees with depression about how they can help themselves, educate all employees about how they can be more helpful to "others" who are or may be depressed. The "other" perspective accomplishes three things. It provides valuable information to individuals who typically want to be more helpful to their friends, coworkers, and family members who may be depressed. It provides a non-threatening vehicle for delivering information to individuals who are depressed. It teaches an entire work force how to help address employee depression, as opposed to a handful of employee health practitioners.
- Launch a long term internal marketing campaign to help debunk the myths about depression, encourage workplace discussion of mental health issues, and promote programs and services to access for help. Choose a common theme; logo; or simple, easy to remember message and communicate it through brochures, flyers, emails, payroll stuffers, bulletin boards, videos, Intranet sites, screen savers, give-aways and guest speakers.
- Highlight testimonials of high profile formal or informal leaders in the organization who, despite having experienced depression in the past, have been successful in the workplace and have maintained the respect of their peers. If local accounts are not possible, consider substituting with stories of famous successful individuals who have been depressed.
- Evaluate all existing and newly developed mental health programs and services to ensure they are user friendly. Are the hours of operation and location of services optimal for employee access? Are there steps in the utilization process that could be simplified or eliminated?
- Encourage mental health providers to be highly visible and relational in the organization. Employees who feel they already have a connection with the company's social worker, counselor, or employee assistance program provider may be more likely to access that provider when they are feeling depressed. Thus, organizations that outsource their mental health services may want to ensure external vendors are committed to spending ample amounts of "face time" building relationships with employees to boost utilization.

ent in their professional training or job description. Occupational health nurses may feel ill equipped to handle psychosocial issues or uneasy about crossing boundaries and "stepping on the toes" of already existing mental health programs and services in the organization. They may have experienced past difficulties accessing all necessary health care information when case managing employees with depression. In addition, the reactive nature of most occupational health work may prevent some practitioners from thinking in a more proactive manner when it comes to managing depression.

Williams (1999) asserts the case management process for employees with depression should be no different than the process for case managing employees with other health conditions. Williams suggests the role of the occupational health nurse is to:

- Ensure quality, cost effective treatment is provided.
- Work with the employees' health care providers to coordinate care and evaluate level of function.
- Closely monitor employees taking psychotropic medications for unpleasant side effects and compliance.
- Maintain the employee's at-work status or return the employee to work as soon as feasible.

Occupational health professionals are in a unique position within an organization to do far more than case manage already identified employees with depression. In fact, occupational health professionals may be in the best position of all employee health related practitioners to use the strategies presented in this article and take a leadership role in convincing U.S. employers that a stronger, more proactive workplace response to depression is sorely needed. First, because the loss of productivity is the major cost associated with depression in the workplace, occupational health nurses are perhaps the most obvious practitioners within an organization to convince management to act on this issue. Secondly, because occupational health professionals are skilled at case managing and coordinating care across many disciplines, they may be the most familiar with various treatment options and resources to access for help. This multidisciplinary experience could also prove valuable in designing more integrated and comprehensive programs and services. Finally, their education and expertise may provide occupational health professionals with a higher level of credibility with organizational leaders than their colleagues in counseling, social work, or health promotion.

CASE STUDY

Mercy Medical Center–North Iowa is a multiple site health care network consisting of a 350 bed acute care facility and 9 affiliated rural hospitals, primary care clinics, long term care facilities, and hospice units throughout a 16 county area in North Iowa. Nearly 90% of the health care system's 2,800 employees are women.

Mercy's award winning "Beyond Bootstraps" depression initiative was a collaborative effort between the hospi-

tal's wellness program called "Kailo," occupational health services, the EAP, and leadership development. The 2 year campaign resulted in statistically significant reductions in depressive symptoms among participants and demonstrated cost savings to the organization (Putnam, 2003).

An Opportunity to Improve

Early self report data from the Kailo research and development phase in 1997 indicated 51% of Mercy employees had experienced depression within the past 6 months ($n = 253$). This information, combined with findings from the HERO study (Goetzel, 1998) indicating depression is such a costly risk factor in the workplace, prompted program developers to enlist the hospital's Continuous Quality Improvement (CQI) process to explore how Mercy could be more proactive in addressing employee depression. The CQI team included representation from Kailo, occupational health, EAP, marketing, behavioral services, clinical nursing, education, leadership development, human resources, and women's services. For ease of discussion, the resulting Beyond Bootstraps initiative is divided into two levels—education and awareness (Level I) and intervention (Level II).

Level I: Education and Awareness

First, program developers presented the business case to Mercy senior leaders to garner their support in moving forward with a more aggressive strategy for addressing depression. Second, a licensed independent social worker and internal EAP provider were recruited to deliver depression training sessions to Mercy managers and supervisors through the hospital's leadership development program and a series of depression awareness presentations through the Kailo wellness program. Third, health educators and wellness staff provided inservices to all line staff and offsite personnel at monthly departmental meetings. Finally, all depression trainings ended with an internally produced music video. The purpose of the video was to reinforce the didactic information provided in the trainings with an emotional appeal to employees to be more tolerant and understanding of their friends, coworkers, and family members who may experiencing depression.

A destigmatizing marketing campaign, including brochures, flyers, email scripts, bulletin boards, health fair displays, and newsletter articles was used to support the educational efforts. Mercy employees were gently reminded through marketing materials featuring various photos of a bassett hound and a pair of boots that bootstrap theories—"those feel-good phrases and get-a-grip attitude that sometimes accompanies them"—may be well intentioned, but are an ineffective strategy for dealing with depression. The campaign's consistent message suggested "It's time we move Beyond Bootstraps and learn how to really help when someone we know is depressed."

In total, 90% of Mercy's leaders participated in a supervisor specific training ($n = 360$) and 57% of employees ($n = 1,385$) participated in an employee specific training. More than 90% of supervisors who attended the depression trainings agreed the information was "very beneficial," and 99% of employees considered the depression trainings "enjoyable." Nearly all leaders ($n = 307$) and employees ($n = 190$) who completed post-session evaluations agreed the trainings had increased their understanding and knowledge of what depression was, the signs and symptoms of depression, and how to access resources for help.

Level II: Intervention

The first step in the intervention process was to more rigorously measure the prevalence of depression among Mercy employees. Following approval from the hospital's Institutional Review Board and legal consultation, the Beck Depression Inventory-II (BDI-II) (Beck, 1996) was distributed as part of a bi-annual wellness assessment packet to 1,274 Kailo members. Recipients were asked to voluntarily complete the BDI-II and sign an informed consent form explaining the purpose of the study, how the results would be used, and what follow up they could expect if they scored positive for depression.

Nearly 75% of Kailo members opted to complete the BDI-II ($n = 950$). Using a cut score of 14 and greater, survey results indicated 12% of Mercy employees were experiencing depressive symptoms. To reduce false positives, follow up responses were limited to employees who scored a more conservative 17 and greater. Seventy four (7.7%) of the survey respondents scored positive for depression and received a letter offering services. An additional four employees who scored positive for depression were also identified as being at high risk for suicide and received immediate follow up by telephone.

To encourage more employees to access help for depression and other psychosocial issues, Mercy's current internal EAP underwent a major overhaul. Although the traditional EAP remains available, an alternative EAP-like service was created and re-marketed to employees through the wellness program. The new service, called "Kailo for One," differs from Mercy's traditional EAP in that it:

- Is never used for formal or mandatory supervisor referrals or substance abuse issues.
- Has no session limits.
- Is available on all shifts.
- Is never reported to insurance providers.
- Offers same day appointments on most days.
- Is located onsite in the highly visible wellness office as opposed to the hospital's behavioral services department.

The Kailo for One service increased overall EAP use by 171% in its first year, and an additional 67% in its second year. Approximately 68% of employees voluntarily accessing Kailo for One also scored positive for depression according to the BDI-II.

A statistical analysis of pre- and post-BDI-II scores for 45 employees participating in Kailo for One indicated a mean improvement in BDI-II scores of 58.2%, which was statistically significant ($p = .000$) using a 99% confidence interval. Of the 45 cases, 75.6% had optimal progress, 15.6% had very favorable progress, 4.4% had favorable progress, and 4.4% had insufficient progress. The average number of sessions was 5.8 (Putnam, 2003).

Although the literature is clear that any reduction in depression is likely to decrease costs and increase produc-

IN SUMMARY

Managing Workplace Depression

An Untapped Opportunity for Occupational Health Professionals

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1. Despite well established research demonstrating the serious effect of depression on the workplace in terms of human and economic costs, most organizations remain either un- or under-responsive to the need for company based depression initiatives.

2. Organizational barriers to addressing depression in the workplace can include information gaps, lack of data to justify increased investment in employee mental health programs, and employers' ambiguous role in managing employee depression.

3. Although many occupational health practitioners may feel ill prepared or uncomfortable addressing mental health issues, the devastating effect of depression on an organization's productivity as a result of absenteeism and presenteeism emphasizes the need for occupational health nurses to take a leadership role in moving companies toward more aggressive responses to workplace depression.

4. Kailo, a non-traditional wellness initiative developed at Mercy Medical Center-North Iowa, combined the expertise of staff from the hospital's occupational health, health promotion, benefits, and employee assistance program departments to overcome the significant organizational and individual barriers associated with addressing worksite depression and successfully identifying and treating depressed employees.

tivity, this can be difficult to measure. However, when depressive symptoms are eliminated, cost savings can be more easily assessed using benchmarking data comparing costs of employees with depression versus employees without depression.

The HERO data indicated employees with depression generate approximately $1,508.90 more in expenses than employees without depression (Goetzel, 1998), and Kessler (1999) estimated the monthly salary equivalent associated with lost productivity caused by depression was $182 to $395. In the 45 cases mentioned previously, 24 employees went from depressed to non-depressed. By multiplying 24 by $1,508.90 in reduced health care costs and an average of $288 per month in regained productivity, Mercy conservatively calculated an annual cost-savings of $119,159 during the first year of the Beyond Bootstraps depression initiative. With program costs totaling $45,000, the cost–benefit ratio of Mercy's comprehensive approach to addressing depression was 2.65.

Summary

Depression is one of the most prevalent and costly health issues affecting the American work force. Despite well established research demonstrating the association between employee depression and reduced on-the-job productivity, increased absenteeism, and higher health care use, most employers remain largely unresponsive to the need for company based depression initiatives.

Organizational and individual barriers can prevent companies from effectively managing employee depression. Organizational barriers include information gaps, lack of data to justify increased investment in employee mental health programs, and employers' ambiguous roles in addressing depression. Individual barriers such as an inability to recognize signs and symptoms; stigma; confidentiality and privacy concerns; and unavailability of easily accessible, quality resources can keep employees who are depressed from seeking treatment.

Many occupational health professionals may feel ill prepared or uncomfortable taking the lead in creating more aggressive worksite responses to depression, but they are, perhaps, in the best of all possible positions within an organization to succeed. Occupational health professionals have the credentials, credibility, training, and experience necessary to build a strong case for business leaders for why investing in workplace depression programs is so important. Occupational health professionals are the most qualified to design and deliver destigmatized, customer friendly programs and services for employees to access for help with depression, and to integrate their services with other departments such as benefits, health promotion, EAP, and human resources, to create an effective, organization-wide depression initiative.

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