Beyond Bootstraps: A Rural, Midwestern Health Care Organization's Response to Employee Depression

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Depression is one of the most prevalent and costly employee health issues in American business and industry. Despite the high costs—both human and economic—associated with depression and the availability of prompt and efficacious treatment options, most employers remain unresponsive due to either a lack of concern or awareness regarding the significant impact of depression on the workplace.

Keywords: Depression; health care; women; workplace; wellness

The Beyond Bootstraps initiative provides an affordable, practical, and effective solution for medium-sized employers interested in addressing depression among their workers. Beyond Bootstraps integrates concepts from holistic health promotion and employee assistance programs (EAP) to successfully address workplace depression on two levels: education/awareness and intervention. Outcomes indicate (a) a measurable increase in awareness of depression, (b) a reduction of depressive symptomatology, and (c) a significant cost savings to the organization.

Major depression is one of the most prevalent and costly employee health issues in American business and industry (Conti & Burton, 1994; Druss, Rosenheck, & Sledge, 2000; Druss, Schlesinger, & Allen, 2001; Goetzel et al., 1998; Kessler et al., 1999; Simon et al., 2001; Williams & Strasser, 1999). At any given time, 2% to 3% of men and 5% to 9% of women are experiencing depression (Kessler et al., 1999), and more than 70% of those affected are actively employed (Regier et al., 1988).

Greenberg, Stiglin, Finkelstein, and Berndt (1993) estimated the annual cost associated with lowered productivity and absenteeism due to depression in the workplace at $44 billion, or $3,000 per employee. In 1998, the Health Enhancement Research Organization (HERO) surveyed more than 46,000 employees across the United States and found depression to be

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the most costly modifiable risk factor in the workplace with regard to annual health care claims. HERO researchers estimated annual health care expenditures for employees who self-reported depression at $3,189.01 compared with $1,679.31 per year for nondepressed employees (Goetzel et al., 1998).

The success rate for treating depression with medication, psychotherapy, or a combination of both is more than 80%, and most people who seek treatment get relief within weeks (Elkin et al., 1989). Still, nearly two out of three people with depression never reach out for help (Vaccaro, 1991). Lack of awareness, stigma, and underdiagnosis in primary care settings prevent many people with depression from getting appropriate care (Vaccaro, 1991). Regier et al. (1988) found that people suffering from depression frequently avoid treatment because they fear the negative impact it may have on their work situation.

The National Institute of Mental Health's Depression Awareness, Recognition, and Treatment (D/ART) Worksite Program (1995) has been educating U.S. employers about the impact of depression on business and industry for several years. But despite the high prevalence and cost—both human and economic—associated with employee depression and the availability of prompt and efficacious treatment options, employers appear to remain largely unresponsive (Conti & Burton, 1994). The National Worksite Health Promotion Survey (Association for Worksite Health Promotion, 1999) found that only 12% of companies offered programs to address depression (n = 1,544) at the work site.

As a national leader in promoting workplace depression initiatives, the D/ART Worksite Program has published several case studies describing potential models for addressing employee depression (D/ART Worksite Program, 1995; Vaccaro, 1991). These models tend to involve large corporations in urban areas such as the Ford Motor Company, Westinghouse, First National Bank of Chicago, and McDonnell Douglas (Vaccaro, 1991). By contrast, the purpose of this article is to describe how a relatively small, rural midwestern health care organization is effectively responding to employee depression.

BACKGROUND

Mercy Medical Center–North Iowa employs 2,800 employees, 87% of whom are women. Mercy's multiple-site network includes affiliated hospitals, primary care clinics, hospice, and long-term care facilities throughout 16 counties in north Iowa. The main campus is a 350-bed facility where the majority of Mercy employees are located.

Kailo, an Indo-European word meaning "whole" or "of good omen" (*American Heritage Dictionary of the English Language*, 2000) is the name of Mercy's employee wellness initiative. Reflecting Robison and Carrier's (1999) model for holistic health promotion, Kailo focuses less on the traditional wellness goals of reducing biomedical risk factors for *illness* and more on bolstering physical, psychosocial, and spiritual factors for *wholeness*. In keeping with the principles of Robison and Carrier's approach, purpose and meaning in life and social connectedness are viewed as the most important determinants of health and well-being.

Some of the program's benefits include paid time to attend and a complimentary lunch during monthly educational sessions called Kailo Breaks, free workout facilities, an extensive employee wellness library, and various no- to low-cost health screenings. In addition, Kailo members and their immediate family members have access to a nontraditional employee assistance program (EAP) called Kailo for One.

The purpose of offering Mercy employees an alternative EAP was to increase utilization by reducing the stigma and barriers attached to accessing the service in its current format. The first year of implementation, Mercy's EAP utilization increased 171%—from 319 to 865 sessions—545 of which were provided through Kailo for One.

Kailo for One differs from most traditional EAPs in the following ways:

- Kailo for One is marketed to employees as a "customized wellness service." The phrase *employee assistance program* is never used.
- Employees who access Kailo for One are referred to as "participants" rather than as "clients" or "patients," and counseling sessions are called "meetings."
- The Kailo for One provider, a licensed independent social worker, routinely participates in wellness program functions to maximize face-to-face interaction with employees.
- The Kailo for One provider's office is located on-site in the highly visible Kailo wellness office rather than a behavioral health unit or an off-site counseling center.
- No mandatory supervisor referrals are accepted. Kailo for One is strictly voluntary.
- No limits are imposed as to the number of sessions per employee.
- Sessions are available on all three shifts.
- Open-access scheduling is practiced. Employees are offered an appointment the same day they request a session.
- The service is marketed to employees using a respectful sense of humor to reduce the stigma attached to addressing psychosocial distress.

The integration of the overall Kailo program and the Kailo for One service provided the foundation for the depression initiative titled "Beyond Bootstraps." "Beyond Bootstraps" refers to the phrase "just pull yourself up by your bootstraps" and was chosen as a means of communicating that depression is a complex and serious mind-body illness and cannot be treated with "feel-good" phrases and "get-a-grip" attitude (D/ART Worksite Program, 1995). Thus, employees were encouraged to move "beyond bootstraps" and learn how to *really* help when someone they know is depressed.

INITIATIVE DESIGN

For ease of discussion, the initiative is divided into two levels—an education/awareness level (Level I) and an intervention level (Level II). Level I goals are to (a) define depression as a complex mind-body illness and not a personal weakness, (b) increase knowledge of signs and symptoms of depression, (c) increase awareness of depression-related resources in the work environment as well as in the community, and (d) reduce the stigma attached to discussing depression in the workplace.

Level II goals are to (a) use the Beck Depression Inventory–II (BDI-II) (Beck, Steer, & Brown, 1996) to measure the prevalence of depression among Mercy employees, (b) reach out in a nonthreatening manner to employees who score positive for depression according to the BDI-II, (c) measure pre- and post-BDI-II scores of employees who access Kailo for One, and (d) use benchmarking data to estimate the by-proxy cost savings in reduced health care claims and productivity associated with reducing depression (Chapman, 2001; Goetzel et al., 1998; Kessler et al., 1999).

MARKETING

A Beyond Bootstraps marketing campaign was rolled out in an attempt to create a safer environment for discussing mental health issues in the workplace and to encourage attendance at the training sessions. Electronic mail messages, a newsletter article, bulletin board displays, educational brochures, and a poster series featured a basset hound sitting next to a pair of worn boots with the slogan "Let's Move Beyond Bootstraps." The marketing message debunked myths about depression, stressed the high success rate for treatment, and intentionally used an "other" focus to encourage employees to learn how to help a friend, family member, or coworker who might be depressed.

IMPLEMENTATION—LEVEL I

The Kailo for One provider presented manager-specific trainings as part of Mercy's quarterly leadership development series. The 50-minute sessions emphasized how supervisors could be more compassionate and understanding, as well as more effective in identifying and managing potentially depressed supervisees. In addition, supervisors were provided with a brochure designed to function as a "just-in-time" training tool for future use. *Just-in-time* refers to training that is available—in this case, by self-study—either just before or during the time the information or skill is needed. Finally, supervisors were encouraged to contact Kailo for One or EAP for assistance if needed.

The focus of the employee-specific training sessions was to educate as many employees as possible about the signs and symptoms of depression and how to access resources for help. This was achieved through a combination of Kailo Breaks and delivering in-services at departmental staff meetings at all of Mercy's locations throughout north Iowa. Training attendees were also provided with a just-in-time educational brochure in case they or someone they knew might become depressed.

IMPLEMENTATION—LEVEL II

Following approval by Mercy's institutional review board (IRB), the BDI-II was distributed to all Mercy employees in January 2000 as part of a data packet to be voluntarily completed for biannual membership renewal in the Kailo wellness program. The BDI-II is a 21-item self-report assessment tool used to measure the presence and severity of depressive symptoms in adults and adolescents older than 13 years of age (Beck et al., 1996). Although the BDI-II is not recommended for specifying a clinical diagnosis of depression, it is a reliable and valid indicator of depressive symptomatology consistent with the fourth edition of the American Psychiatric Association's (1994) *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-IV*).

An informed consent form was attached to the BDI-II explaining the purpose of the survey and that the results would be (a) seen only by the Kailo for One provider, (b) kept in the Kailo office, and (c) reported back to the organization in aggregate only. Respondents were informed they would receive an outreach letter from the Kailo for One provider if they scored 17 or higher out of a possible 84 points. Beck et al. (1996) suggest a cut score of 17 for minimizing false positives in diagnosing clinical depression.

The outreach letter provided respondents with their scores, suggested they *may* be experiencing depression, and encouraged them to seek help in whatever form they were most comfortable—whether it be counseling, medication, or some alternative resource, such as a self-help guide, a trusted friend, or a spiritual adviser. Contact information for internal and external resources was also provided. In addition, respondents were informed that if their survey indicated suicidality, the Kailo for One provider would contact them immediately by telephone and offer services.

RESULTS

Consistent with workplace health promotion practice (Wellness Councils of America [WELCOA], 2000) and the FOCUS-PDCA model for process improvement (Hospital Corporation of America, 1993), the Beyond Bootstraps depression initiative was evaluated on three levels: (a) objective or participation, (b) process or satisfaction, and (c) impact. Once again, to facilitate our discussion, we have divided the results into an education/awareness level and an intervention level.

Level I: Education/Awareness

Participation

Nearly 65% of Mercy employees attended a Beyond Bootstraps training session. In-service roster signatures indicate that 90% of Mercy's 400 leaders (n = 360) participated in a supervisor-specific training, and 49% of Mercy's 2,800 employees (n = 1,385) participated in an employee-specific training.

Satisfaction

Of the 307 participants in the supervisor-specific training sessions who returned program evaluations, 93% either agreed or strongly agreed with the statement, "Overall, this course was very beneficial." A sampling of 192 participants in the employee-specific trainings indicated that 99% agreed or strongly agreed the session was enjoyable.

Impact

Of the 307 participants in the supervisor-specific trainings who returned a program evaluation, 94% agreed or strongly agreed they had a greater understanding of depression following the Beyond Bootstraps session, and 95% of respondents agreed or strongly agreed that the information they received was practical and useful.

Randomly distributed program evaluations from the employee-specific trainings indicated that 98% agreed or strongly agreed they had increased their level of knowledge of the signs and symptoms of depression (n = 190), 98% agreed or strongly agreed they had additional ideas about how to address depression (n = 190), 99% agreed or strongly agreed they had additional ideas about how they could be more supportive to someone else with depression (n = 190), and 96% agreed or strongly agreed that the Beyond Bootstraps depression initiative was evidence that their employer was responding to employees' needs (n = 188).

Level II: Intervention

Participation

Of the 1,274 employees who completed Kailo membership survey packets, 74.5% opted to complete the BDI-II survey ($n = 950$). Using a cut score of 14 and higher, results of the survey indicated a 12% prevalence of depressive symptomatology among Mercy employees. As mentioned, to reduce false positives, a more conservative cut score of 17 and higher was used to determine who would be contacted by the Kailo for One provider. Of the survey respondents, 78 (8.2%) met this criterion and received either an outreach letter or a telephone call.

The Kailo for One provider, in conjunction with Mercy's IRB, used clinical and legal expertise to decide which employees' survey responses warranted the more invasive response of an immediate telephone call for assessment and referral due to potential risk for suicide. Four employees were identified as "high risk." Three of these employees received telephone responses. Two of the employees were already under the care of a counselor, psychiatrist, primary care provider, or a combination of the three and were on medication for depression. The third employee agreed to make a Kailo for One appointment and talk with her primary care provider, and the fourth employee was already participating in Kailo for One.

Thirty-five of the 78 letter recipients (45%) accessed Kailo for One for counseling. As a matter of procedure, all employees who access Kailo for One are asked to voluntarily complete a pre- and post-BDI-II, regardless of presenting circumstances. This is in addition to the organization-wide BDI-II baseline survey conducted in January 2000. To date, 157 employees have completed at least the pre-BDI-II.

Satisfaction

In addition to a BDI-II, all employees who access Kailo for One are asked to complete an evaluation of Kailo for One services upon termination of its services. So far, 96% ($n = 160$) of respondents have indicated that they are either satisfied or very satisfied with the service they received from Kailo for One.

Impact

The statistical analysis was completed using four one-samples *t* tests to compare the pre- and post-BDI-II scores on 45 persons who completed a BDI-II before and after participation in Kailo for One sessions (see Table 1). The BDI-II scores improved 58.2% (pre-BDI-II mean = 19.26; post-BDI-II mean = 8.04; confidence interval [CI] = 4.55-11.53), which was statistically significant ($p = .000$) using a 99% confidence interval. Using Jacobson and Truax's (1991) statistical approach to evaluate the significance of clinical change, our analysis of participants' progress with this program indicates that 75.6% demonstrated optimal progress, 15.6% demonstrated very favorable progress, 4.4% had favorable progress, and 4.4% had insufficient progress (see Table 2). The average number of Kailo for One sessions per participant was 5.8.

According to Simon et al. (2001), it is not necessary to completely eliminate depressive symptomatology to reduce work impairment and organizational costs. The degree to which productivity increases as depressive symptoms decrease, however, is not clearly defined.

TABLE 1. One-Sample *t* Test for Pre– and Post–Kailo for One Beck Depression Inventory–II

Kailo for One	Premean	Postmean	*t* Test	*df*	*p* Value
All cases (*N* = 45)	19.26	8.04	–8.66	44	.000

TABLE 2. One-Sample *t* Test for Each Preseverity Level to Determine Meaningful Change Postservices

Preseverity[a]	BDI-II	Post Mean	Post CI[b]	*t* Test	*df*	*p* Value
4 = Severe	29-63	1.462	0.877-2.046	–9.461	12	.000
3 = Moderate	20-28	1.5	0.925-2.075	–6.708	5	.001
2 = Mild	14-19	1.286	0.933-1.639	–4.372	13	.001
1 = Minimal	0-13	1.33	0.769-1.897	1.301	11	.220
All preseverity cases		1.377	1.144-1.611	–9.203	44	.000

Note. BDI-II = Beck Depression Inventory–II.
a. Severity levels as defined by Jacobsen and Truax (1991) using a statistical approach to define meaningful change.
b. Confidence interval (CI) set at 99%.

When there is complete symptom remission from depression, the cost savings are easier to estimate (Goetzel et al., 1998; Kessler et al., 1999).

As mentioned, the HERO study (Goetzel et al., 1998) estimated that the annual costs of health care claims for depressed employees is $1,508.90 more than for nondepressed employees, and Kessler et al. (1999) estimated that the monthly salary-equivalent loss in productivity due to depression was $182 to $395. Using these figures, cost savings were calculated for every participant whose depressive symptomatology was reduced to a score of 13 or below—the suggested cut score for "minimal" symptomatology (Beck et al., 1996).

Currently, 24 employees have gone from depressed to nondepressed according to their pre- and post-BDI-II scores. Multiplying 24 employees by an average of $288 per month in regained productivity and $1,508.90 reduction in annual health care claims, Mercy's total estimated cost savings associated with the elimination of depressive symptomatology in these employees is $119,158.

With total program costs estimated at $45,000, the Beyond Bootstraps depression initiative has a demonstrated cost-benefit ratio of 2.65.

DISCUSSION

The Beyond Bootstraps depression initiative was designed to function as a practical approach to addressing employee depression. It was accomplished in a nonthreatening, holistic, and relational manner with sensitivity to the privacy, confidentiality, and trust of Kailo program participants as the overriding priorities. From a research perspective, the limitations inherent in such an intervention include (a) the absence of a control group and experimental design, (b) the inability to eliminate the impact of other interventions (i.e., medica-

tion, alternative therapies) that might have been used in conjunction with the Kailo for One counseling sessions, (c) the inability to access individual health care claims data by name (this is prohibited by human resource policies and procedures to protect confidentiality and minimize legal liability), and (d) the inability to capture the actual number of employees and their friends, family members, and coworkers who perhaps benefited from information they received during the Beyond Bootstraps depression initiative by seeking treatment outside the Kailo for One service.

We suggest, however, that the results of our experience have value for employers who are interested in addressing the issue of depression in the workplace as a means for improving employee and organizational well-being. To that end, and in no particular order, we offer the following synopsis of what we believe to be our critical success factors.

Holistic approach. Robison and Carrier's (1999) holistic approach to health promotion provided the foundation for the successful implementation of the Beyond Bootstraps initiative (see Table 3). From a holistic perspective, depression is defined as a complex, whole-body illness affecting physical, psychosocial, and spiritual well-being. Attention to purpose and meaning in life and relationships are considered vital to the reduction of depressive symptomatology in this approach; thus, participants are encouraged to explore these areas of their lives in addition to accessing the traditional treatment options of medication and/or talk therapy.

In addition, the Kailo staff interacted with participants from a position of ally rather than expert. Their primary function was to reconnect participants with their own internal wisdom about their health and well-being, thus involving them in their own healing process.

Relational work. Building trust and relationships with employees is important to the success of any workplace health initiative, but it is absolutely imperative when addressing mental health issues. Miller's (1985) relational theory suggests that women experience their lives and their health through their relational connections and that growth-fostering relationships are paramount to women's mental and psychological well-being. The phrase *invisible work* was coined to describe the skill and time necessary to build healthy relationships that go virtually unnoticed and unappreciated in most work environments (Miller, 1985).

Countless hours of face-to-face contact with employees in both formal and informal interactions were perhaps the biggest key to the success of the Beyond Bootstraps initiative and, indeed, the overall Kailo wellness initiative. This is not to suggest that the outcomes are the result of a placebo effect. In relational theory, the practice of "naming" the work of building and maintaining relationships through interaction and connection becomes as much a part of the treatment protocol as therapy and/or pharmaceutical intervention. Mercy employees feel comfortable talking to Kailo staff and calling the Kailo for One provider when they are struggling.

We believe positive and trusting relationships led to the high response rate on the January 2000 BDI-II survey and the successful recruitment of a high percentage of identified employees into Kailo for One. In addition, the unique therapeutic combination of relational theory, cognitive-behavioral, and solution-oriented approaches used in the Kailo for One sessions continues to be an important factor in the program's positive outcomes.

Collaborative spirit. The integration of Mercy's employee health promotion and employee assistance program is unique. In most organizations, health promotion practitioners and EAP providers function separately. Many times, the result is that wellness programs

TABLE 3. Robison and Carrier's (1999) Principles of Holistic Approach to Health Promotion

Focus	Health: Main objective is to address the interconnected web of genetic, social, emotional, spiritual, and physical factors that contribute to health.
Emphasis	Meaning and support: Meaning in life, relationships and work, and supportive human systems are considered the primary determinants of health.
Motivation	Happiness: Reason for change is primarily to enhance a sense of purpose and enjoyment in life.
Primary assumption	People are good: People have a natural desire and ability to seek out and create health.
Professional role	Ally: Primary job is to facilitate people's reconnection with their own internal wisdom about their body and their life.
Change process	Creating consciousness: People are assisted in understanding and healing life issues that underlie illness and behavioral struggles.

are perceived as "fluffy" and lacking substance, and EAP programs are perceived as crisis oriented and stigmatized. What is more, both programs struggle with participation and credibility. Our experience has been that through collaboration, many of these barriers were removed. Participation increased dramatically, and credibility and legitimacy within the organization vastly improved.

Customer service. Intentionally relocating the Kailo for One provider on-site, offering counseling sessions on all shifts; scheduling same-day appointments; communicating openly and honestly about confidentiality and privacy concerns; and eliminating session limits were all key elements of the customer service focus of the service.

Highly visible location. Counterintuitive to the idea that employees would prefer a remote and more private location for seeking counseling services in the workplace, our experience has been that locating the Kailo for One service adjacent to the Kailo wellness office has increased access and reduced stigma associated with traditional EAP programs. Anecdotal evidence suggests that employees feel less inhibited about being "seen" in the Kailo office—a place they could be for a number of reasons—versus being seen going into a counseling or EAP office. In addition, many employees express that having the Kailo for One office located in a wellness office just "feels less clinical" than the prior location in Mercy's mental health unit.

Marketing. Nonthreatening, nonshaming messages and a respectful sense of humor were used to reduce stigma, build trust, and create a safe environment for discussing mental health issues in the workplace.

Adequate resources. The financial resources needed to successfully implement a workplace depression initiative will vary according to the size of the organization and the level to which depression is addressed. The time and materials estimate for the first year of this initiative, including part-time salary and benefits expenses for the Kailo for One provider, is

$45,000, less than half of the estimated by-proxy cost savings. Subsequent annual costs are projected to be $25,000 per year.

CONCLUSION

The literature makes a strong case for addressing depression in the workplace—it is prevalent, costly, and treatable. Still, most U.S. employers remain unresponsive. One possible explanation for employers' disinterest in depression could be a lack of awareness of the significant impact depression is having on the vitality and viability of their organizations. If this is the case, the first challenge is one of educating employers as to why addressing depression in the workplace is so imperative.

The next challenge will be to provide employers with working models so they will know how to overcome the significant barriers associated with addressing mental health issues in the workplace such as fear, stigma, legal concerns, and issues of confidentiality. The Beyond Bootstraps depression initiative provides a template for how one medium-sized employer worked through these barriers to create a safe, nonthreatening work environment where depressed employees feel supported in getting the help they need when they are struggling.

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