Thank you.

So, since I have no discussants, I’m hiring all of you. [Chuckling]

So I want you to feel free to engage whenever – if you have a question or you want to make a comment as I go along. I think that would be good, especially at this point in the afternoon when you’ve all been sitting for awhile. And I’d love to hear your feedback.

This is a great opportunity to be here, because I often end up presenting this kind of information, often to employers and employer groups, also to pharmaceutical companies, and also to academics who are mostly in clinical medicine or health policy. So it’s nice to have this different mix of disciplines and experiences here, and I would just love to hear what you make of all this, and how it might be relevant to some of the work that you do.
The Clinical and Occupational Correlates of Work Productivity Loss Among Employees with Depression

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Adler D, Chang H, Berndt E, Irish J, Lapitsky L, Hood MY, Reed J and Rogers WH

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Unlike what most people think about academics, everything I do is team-based work. And this is one of the teams. I’ll also mention that Ben and I worked together for ‘about a hundred years’ and, probably, some of his work is in here, too.
The Burden of Depression

- **Common**
  - Lifetime Prevalence 16.2%
  - Annual Prevalence 6.6%
- **Underdiagnosed and Undertreated**
  - 50% Undiagnosed
  - 75% Have comorbid psychiatric diagnosis
  - < 50% Diagnosed have adequate treatment
- **Expensive**
  - $44-51.5 Billion (2003 dollars) in lost work productivity
  - $26.1 Billion in direct costs
- **Chronic**
  - Mean Episode Duration 16 weeks
  - Recurrence Rate 50% of first episodes followed by a recurrence
    - 75% with recurrence have second episode
    - 95% of those have a third episode
- **Disabling**
  - Severely Limits Social Role Performance in 60%

Let me just back up a little bit. How many people in the room know someone who has had depression? Right, very, very common. Right, we all know this, and we also know how difficult it is to deal with. It’s not only difficult because it’s often people we really care about and they start to behave in ways that are so difficult for other people to take, but also because they often don’t get the help that they need.

So, it’s not news, here, that depression has an impact on the workplace. Let me start by saying that there have been studies that have looked at this and tried to quantify just how big an impact it is, and there have been years of studies showing that people with chronic depression have trouble entering the labor market at all. We know that people with severe and chronic mental illnesses have trouble getting into the labor market, trouble hanging on to jobs, and so on. But there’s a lot more left to learn.
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Just to give you kind of the broad background on what we know about the burden of depression is that the lifetime prevalence is about 16 percent in the U.S. population; annually, it’s about 6 or 7 percent. Even to this day, with all of the tremendous advancements in the care of people with mental illnesses – and particularly depression – 50 percent of people with major depression are still undiagnosed. So we still have major problems. And these are not just people who don’t have a primary care doctor; these are people who are in the system. When you see some of our data, you’ll see what that looks like.

Seventy-five percent of people with a major depressive disorder also have a comorbid psychiatric diagnosis. About 50 percent of people who do get diagnosed with major depression have adequate treatment, and the other 50 percent do not get adequate treatment. And now there are specific guidelines around treatment, and a lot of efforts nationally to try to improve the quality and access to depression treatment.
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So this is a very important and big issue. Part of the reason it’s important, in addition to the human suffering – I mean, we don’t really need to argue that point, “Is there human suffering involved?” – is the tremendous economic impact of depression.

There have been some very good studies that have tried to quantify sort of the ‘big picture’ costs for us. We know that, roughly speaking, it’s about $44 to $52 billion dollars in lost productivity, and some of that is due to premature death due to suicide and some of that is due to absenteeism, presenteeism, disability – and I’ll come back to those terms a little bit later – and about another quarter of a billion – $26 billion, excuse me – in direct costs of medical care.
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So, what is it like to have a major depressive episode? Well, the average duration is about 16 weeks. You’re quite sick during that period of time, usually. Fifty percent of people who have a first episode of major depressive disorder have some kind of recurrence; it doesn’t go away, it comes back before the symptoms remit. Seventy-five percent of the people who have a recurrence have a second full-blown episode of major depressive disorder, and 95 percent of those have a third episode.

So, probably one of the misunderstood aspects of depression is that it is a chronic disease. Many of the people who have depression – they thing MOST people who have depression as adults probably had it as adolescents. Okay? And I think some of you will probably know many people in that situation. Unfortunately, for many of us in our age group, these kinds of things weren’t diagnosed and weren’t treated back then.
I always say to my parents, “Why didn’t you tell me we had mental illness running up and down both sides of our family?” And they say, “Well, we didn’t know!” And so, I let them off the hook. But it’s quite clear to me now – now that I do this kind of research – exactly what’s been going on all these years in our household. (Chuckling) All kinds of things! All kinds of personality disorder! So, anyway…

And also, we know from other studies like the Medical Outcomes Study on social and role performance that this is a severely disabling condition, both in the workplace and at home and all kinds of community participation.

So, we know all that already. So why is it important to continue to look at depression in the workplace? Well, it’s kind of interesting, when you look at the data on depression, that a lot of the data that comes out of treatment studies – so, you know, they’re people who are being tested, they’re getting good diagnosis, sometimes they’re getting good treatment – there’s not a lot of good design elements in these studies for really studying work.
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And to add on to some of Ben’s earlier points, there are often not control groups of people who are not depressed. Usually work issues are secondary end-points, so they’re not very well measured. Some of these people in the studies were never working to begin with. Some people have only a very marginal connection to paid work; they may work very few hours a week. And they may only look at one criteria at the end, like the employment rate. So there hasn’t really – you know, this is all changing right now, but we really don’t understand, sort of, what happens when a person gets depressed who is employed?
And that was the question that we really started with in this study – why is it that some people who have depression – because we know a lot of people have depression while they’re working – why is it that some people seem to hang in there and do reasonably okay? At least we seem to think so. We hear all these CEO’s who come forward and admit they had depression, and here they are still running a Fortune 100 company. Something happened! I hope they’re running it well. You get a lot of that kind of testimonial stuff, you know – but, it’s true though – there are a lot of people we know that seem to do okay, and other people who don’t do okay. And the question is, you know – can we get a deeper understanding of what it’s like to become depressed when you’re working and, sort of, what happens, what are the whole dynamics here?
One of the things that people never study with depression – I can almost say that pretty safely – is what’s the contribution of the workplace to the outcome of depression? Okay? And so this is exactly the right kind of audience. I don’t have to tell you anything here. I usually have to justify this terribly. And this is an NIMH-sponsored study – National Institute of Mental Health – and I had to spend lots and lots of pages justifying why it’s important to look at work. And they still didn’t get it, but they funded it anyway. So, maybe they thought they’d embarrass me in the end – but – ha ha!

And finally, where our real goal is – as I say, you know, I do a lot of work with employers. I mean, employers are saying, “Okay, we get it. We’re vulnerable. We have problems. What do we do about this? What’s the next step?” And so that has really challenged me and my partners back at the Health Institute to figure out – what would we do if somebody said, “Come in here and fix the problem for us.” And so we’re very interested in particular in multi-modal models that look at workplace issues, as well as medical care issues, because both of them need attention, we believe.
Since that’s sort of the philosophy, if you will, behind what we call the Health and Work Study. The Health and Work Study was funded by the National Institute of Mental Health. They were not particularly interested, in the old days, in workplace kinds of studies. They’ve gotten more interested. So it’s a very interesting experience as a researcher to try to bring this kind of topic to them and to engage them in it.

This study involved a very large screening effort. We went into primary care offices in practices – physician offices around Massachusetts, where I’m from. What we needed to do was first determine, could we identify people who were employed, who had no plans to leave the labor market?

The Health and Work Study

- NIMH-Sponsored 2000-2004
- Screened 14,000 in MA physician offices
- Enrolled 574 eligible employed ≥ 15 hours/week with no plans to stop working, no major comorbidities
- Depression Group = 229 (Dysthymia = 59, MDD = 85, Double Depression = 85)
- Healthy Controls = 173
- Rheumatoid Arthritis Group = 87
- Surveyed at BL, M6, M12, and M18
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So, these were people who were actively working at least 15 hours a week, who said that they were going to be there. They didn’t have any active disability claim. They weren’t planning on filing for disability or Worker’s Comp for any reason. And then we had to determine whether or not they in fact had depression, so we went through many steps of screening to determine, in fact, these people were clinically depressed.

So we screened 14,000 people in Massachusetts, and out of that we found about 570 that were eligible. We also excluded people from the study who had any other major disabling comorbid conditions – medical comorbidities and bi-polar illness.
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In the end, we had 229 people with depression. There are three different groups in here, for those of you who may not be so familiar with depression. Group 1 is the Dysthymia group. Dysthymia is chronic low-level depression lasting two years or longer, and that’s actually quite prevalent, too. We have another group, the Major Depressive Disorder group – which is the one you’re probably more familiar with – which is an acute episodic form of depression. And Double Depression, which is both – both of those conditions running concurrently.

And healthy controls – so we had a healthy control group here, these are all people who are employed at least 15 hours a week. They met the same criteria, except they’re not depressed. No major disabling conditions. But they were all at the doctor the day we recruited them, so they came into the study with aches and pains – you know, whatever brought them there.
And then we also included a rheumatoid arthritis group, also meeting the same criteria. So why did we do that? Well, when we started this study, we hypothesized that people with depression would have worse outcomes in the workplace than healthy controls. You probably don’t need rocket science for that one.

But the question was, if you take a group of people – so the controls are sort of the best-case scenario, you know, the high functioning benchmark, if you will. That’s kind of where they are. They’re a high functioning benchmark.

But then we wanted another benchmark that would take a group that said, you know, this is a group that typically experiences problems, it’s a progressive condition, also episodic, where people can be very symptomatic and have lots of trouble functioning. There’s lots of literature on it. And so we also recruited the rheumatoid arthritis group as a way of giving us that group that was at high risk of having functional problems in the workplace over a period of time.
So we have our lower and our higher group, and we want to know where is depression? And nobody has ever really done this before, and it was very interesting to us to try to figure it out.

And actually, I went into the study hypothesizing that people with depression are probably not all that bad off, actually. They’re worse than controls, but they’re probably not any worse than some of these other disabling conditions. This is our bias and the stigma associated with mental illness – and I was dead wrong, I’ll tell you that right now. So that’s something we’ve learned.

And we surveyed people – this is all self – aside from the initial clinical assessment data that we had, the rest of the data is all based on self-report, and people are surveyed every six months.
Impact Measures

- Unemployment vs Employment
- Job Retention vs Turnover
- Absenteeism
- Presenteeism

Our major impact measure – so, everyone’s employed at the baseline. They’re actively employed, not planning on leaving. We find them, and then we follow them up six months later. So what you’re going to be looking at today is actually data from two different studies that we’ve done – sub-analyses of the data. We’ll be looking at what happens to people six months later. And I actually do know what happens to people 12 months later, too, but it’s not here yet.

We asked a number of things. One, we asked how many of those people who are employed at the baseline are now unemployed six months later. And actually, the NIMH study sections came back to us and said, “Oh, this is really stupid, you shouldn’t study this because the unemployment rate is going to be so low, you’re not going to be powered enough to find it.” So we said, “Okay, it’s only one of our criteria, but we’ll go for it anyway.”
The second thing that we looked at is, among those people who were still employed at six months – you know, they’re in a job, it’s six months later – what kind of flip-flopping around occurred? Because turnover is obviously a big issue, both for employees and employers. Now, there are some situations where turnover could be a very good thing for an employee. They can get out of a rotten job and go somewhere else. But we tried to look at that pretty closely, because it is a big issue for employers as well.

The other criterion among those people who were still employed – how much work time is being missed due to their depression? And finally, the presenteeism – and some of you may know Sean Sullivan from the Institute of Health and Productivity Management, and he’s probably the one who’s responsible for coining that term. It gets used everywhere now. It’s sort of what happens at work. It’s the at-work impaired job performance and productivity loss.
Impact Measures

- Unemployment vs Employment
- Job Retention vs Turnover
- Absenteeism
- Presenteeism

There are many kinds of conditions that people continue to come to work even though they’re not feeling well or they are suffering from significant impairment. And as you know, that’s very much the case with people with chronic illnesses. Not everybody with a chronic illness can elect to stay home, or wants to stay home.
These are very important criteria, I think, for sort of filling out the multi-dimensionality of the picture. You know, we’re looking at all these things simultaneously. So for those of you who are that familiar with it – you know, I thought for years – you know, how to explain these concepts of absenteeism and presenteeism, and after many years, I decided the only difference is, you know, where your head falls down. And so, when you’re absent, you’re usually in bed on a pillow. When you have presenteeism, your head might be on your desk – (chuckling) – but basically, the same thing – but they require very different kinds of measurement.

Absenteeism, we have a measure; it’s a self-report measure of time missed from work, and then we look at productivity loss. Just a simple ratio dividing the time absent by the time that’s usually worked. And you can get into all kinds of fancy economic models of substitution costs, and ‘blah-blah-blah’ – you know, for bringing in new workers, and team effects – but we do this in a very, very simple way.
Presenteeism we measure with the Work Limitations Questionnaire, which is a 25-question questionnaire that gives you four measures of impaired functioning. The four measures are the percent of time you had difficulty, because of your health, functioning in your ability to handle the time demands of your work, the physical demands, the mental-interpersonal demands, and the output demands, which is primarily work quantity and quality.
So you get those four scales, and you also get a productivity loss estimate. So, the kinds of data that you get – just to summarize that is – in this particular questionnaire, it’s a little bit different. There are other productivity loss questionnaires out there. There are functional questionnaires, which many of you are familiar with; for example, the SF-36, which is not work specific, which measures role disability. And they were work productivity loss questionnaires that will give you kind of an overall sense of what the lost productivity is, but they don’t really tell you where the problem is.

And so in designing the WLQ, the questions are all about things that happen at work and the extent to which health interferes with them. What that does, is it generates three type of data, and we hope that these data are helpful for developing strategy in the workplace. This is what it’s all about for us. It’s not just putting a dollar figure on this, but for you to be able to go back and say, “Gee, if I could change something, what should I focus on?”
At the task level, you can get data on the percent of time a person was impaired performing a specific task. I use this example a lot, but it’s such a great example. A project was done by the Federal Reserve Bank of Dallas, and when they got their results back – you know, their the bank of the banks, I guess, in the U.S., and they count out the money and send it out – and they didn’t care what the scores were on the scales and some of the other things when they noticed that people in one of their departments were having a problem where health was interfering with their ability to concentrate. That’s all they needed to know – that this was a problem – because these are people that are counting money all day. And so, for an employer like that, it’s a big issue! The rest of the stuff – the amount of money they’re losing didn’t make a difference at that point.
So this stuff can be very, very useful for people who are very knowledgeable about their own workplace and need to find a way to get in there and do something. You have four job level scales, which are the scales I just described to you. And as you know, with scales and surveys, the more questions you ask, the more accuracy you get. So you get a more accurate reading of where the problem is if you use the scale level.

And finally, these four scale scores can be rolled up and weighted to give you an estimate of the productivity loss, approximately – and it’s a very conservative estimate of productivity loss. It was built to be very conservative. And because, typically, these productivity loss estimates suffer from poor generalizability, we don’t really know what the relationship is in all work contexts, so we built this to be extremely conservative in giving the productivity loss estimate.
That’s a little background on that measure; now to go back to the model.

So here we were looking at all these various kinds of work outcomes, right – job loss, turnover, absenteeism, and presenteeism – and we wanted to see the degree to which we could find some of the variables that seemed to explain the differences in outcomes. First we want to characterize the outcomes, and then we want to look at some of the explanatory variables. What we looked at were depression symptoms. We have a severity measure that runs basically from zero to 27. We use the PHQ-9 put out by Kurt Kroenke, which is a great instrument, it’s easy to do, it gives you nice data. It’s becoming the standard on self-report.

We also measured medical comorbidities and, again, most of the people in the study so not have medical comorbidities. We ruled them out. We went through their records and found them and took them out – talked to their doctors. And finally, we used physical health status measured by the SF-12 PCS, for those of you who are interested.
Then we went into out work measures. We actually have ‘bazillions’ of work measures, but I’m just going to focus on three of them here – the three important ones. One is that we coded everybody’s occupation. We had the standard open-ended questions on occupation. We used the 1990 6-digit occupational code. For those of you who have done occupational coding, you know that’s quite a cumbersome thing.

Then we have two measurements of job requirements. One is the subjective measures, which are based on the (Robert) Karasek’s model, which I’ll come back to. We actually don’t do a lot of analysis with them any more because we’re worried that they’re biased by the depression, and they’re highly correlated with our outcomes all the time. And every time we try to look at whether they’re biased by depression, we can’t get a firm answer on it, so we just basically – you know, to be conservative, again – put them aside. It’s an interesting thing – you can’t quite nail that one, even with longitudinal data. We’ve tried.
Key Explanatory Variables

- Depression Symptoms
- Medical Comorbidities
- Physical Health Status
- Occupation
- Objective/Subjective Job Content
- Work History

The objective measure of job content comes from the ONET – anyone use the ONET Job Classification yet? Isn’t that a nightmare! (Chuckles) That one’s a tough one! People who have used the Dictionary of Occupational Titles all these years, or the Position Analysis Questionnaire, or other ways of characterizing job content – the federal government, in all its wisdom, decided to have one system that everybody was going to use. Except, nobody knows how to use it – you know – so this is the real problem.

And so we actually paid people to figure out how to use it and we classified every job in our study according to their ONET codes. It’s actually an extremely powerful system for research. So it’s imputed data based on the 6-digit occupational code – has all kinds of dimensions that are really great to look at. Lots of fun stuff – but you know, you could sort of drown in it.

And finally, we looked at some work history variables, because this is a real issue with a chronic disease. To what extent are people carrying baggage in – from all the years of being depressed – into their current work situation? That’s another hard one to nail.
I apologize for this – this is very busy – just baseline demographic data. It’s actually not that important to know all the demographics. The main thing here is that the average age – we have very significant differences on a number of baseline variables, because these are sort of apples to oranges comparisons when you’re dealing with different condition groups. So it’s very difficult to make these comparisons.

We know that the rheumatoid arthritis group typically is older, that’s why there’s a significant difference there.

There’s a much higher prevalence of depression in women, so you’re going to get a difference there than with the controls.

We have much less education – you see this in almost every publication – on people with depression. Again, they’re carrying that baggage of having many, many years of probably being depressed.
We don’t see much in the way of occupational differences, although I think our data – as we add more data – is starting to show some differences there. But again, we’re in Massachusetts, and Massachusetts has lots of people that are considered professional technical, and so some of that’s a geographic thing going on there.

And finally, they have lower earnings to start with in the depression group.

This is all very typical impact of depression work. Not a lot else going on. The only other thing that’s kind of interesting is that – in terms of the number of jobs that they’ve had over their lifetime since 18 or since graduating school (I forget what it is) – they do have more jobs. There’s much more flip-flopping around in terms of job tenure.

So those all give you the picture of sort of what people come to a study with, and they already come with a very significant work history.
This is just some data, too, that will tell you again at baseline you also have some very significant differences. Even though we ruled out people with medical comorbidities, you do have people reporting all kinds of somatic symptoms. And, generally speaking, what you find with the rheumatoid arthritis group on their physical health – if you have a low scale on the SF-12’s, that poorer health. On the WLQ, higher scales is worse. Okay? So, did I say that right? Yes. A score of 100 or – the highest score on the SF-12 is 70 and that means the best health.

So basically what you see here is the rheumatoid arthritis group has the worst health, but it’s not that different from the depression groups, interestingly enough – they look very, very similar on physical health. On mental health, the depression groups are clearly much worse, and on depression severity.
<table>
<thead>
<tr>
<th>Baseline Health Status</th>
<th>Dysthymia</th>
<th>Major Depression</th>
<th>Double Depression</th>
<th>Rheumatoid Arthritis</th>
<th>Control</th>
</tr>
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<tbody>
<tr>
<td>n = 489</td>
<td>59</td>
<td>85</td>
<td>85</td>
<td>87</td>
<td>173</td>
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<tr>
<td>Mean No. Medical Diagnoses</td>
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<td>.2</td>
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<td>Mean SF-12 Physical Health Status</td>
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<td>44</td>
<td>52**</td>
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<tr>
<td>Mean SF-12 Mental Health</td>
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<td>34</td>
<td>50</td>
<td>52**</td>
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<tr>
<td>Mean PHQ-9 Severity</td>
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<td>14</td>
<td>4</td>
<td>3**</td>
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<tr>
<td>% On Anti-Dep</td>
<td>45</td>
<td>34</td>
<td>49</td>
<td>23</td>
<td>10**</td>
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<tr>
<td>% Had Recent Mental Health Visit</td>
<td>75</td>
<td>85</td>
<td>71</td>
<td>41</td>
<td>34**</td>
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</tbody>
</table>


Let me just draw your attention down to the bottom two rows, there. If you look at the first three columns, that’s that depression group that is on antidepressants. These are all people who just left the doctor’s office. They just walked out. Okay. We went back in and told their doctors that they were depressed. We went back in and told them, but that doesn’t mean anything necessarily happened.

And that’s not all medical care. Some of that is – you know, people are coming in for all kinds of reasons. They don’t tell the doctor they’re suffering. It’s a very complicated problem, obviously, that others have been working on for years. But this is Massachusetts. These are plans that are all in the know. They know about evidence-based medicine, and this is what we see.
## Baseline Health Status

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<td>50</td>
<td>52**</td>
</tr>
<tr>
<td>Mean PHQ-9 Severity</td>
<td>10</td>
<td>14</td>
<td>14</td>
<td>4</td>
<td>3**</td>
</tr>
<tr>
<td>% On Anti-Dep</td>
<td>45</td>
<td>34</td>
<td>49</td>
<td>23</td>
<td>10**</td>
</tr>
<tr>
<td>% Had Recent Mental Health Visit</td>
<td>75</td>
<td>85</td>
<td>71</td>
<td>41</td>
<td>34**</td>
</tr>
</tbody>
</table>

* p ≤ .01  ** p ≤ .001


So, very, very discouraging kind of data. It just is mind-boggling to see this – the very high rate of people who say in the last three months they saw some kind of health person – broadly defined – for an emotional problem. That could be a support group, family counseling – it could be anything. That could be a support group, family counseling, that could be anything. I said to the psychiatrist I work with, “What accounts for these really high rates? And he goes, “Well, this is Massachusetts. Everybody goes for help!”

We see this in the control group, too. We see all kinds of interesting use of healthcare services – again, not necessarily for depression.
So what happened? The ‘tah-dah’ – so – this is the first thing, and I will try to walk you through this as best I can.

Six months later, we go back, we ask them the same questions; we go look at their data. Look at that percent that’s now unemployed six months later. Okay? It’s between 12 and 15 percent that lost their jobs, are not working, currently have no job in the depression groups – compared to 2 and 3 percent in the comparison groups. This is really startling data.

When you think about the national – now, we started this study right when the economy tanked, which is really interesting because Massachusetts, probably like many other states, had full employment. I’d love to get some of your thoughts on why this might happen. So full employment. And the unemployment rate was roughly, what, 5 or 6 percent, they were reporting, at its worst around the country. And so those are really high, high rates of unemployment, of job loss, in a very short period of time – very, very discouraging for people with depression.
Employment Outcomes at M6

<table>
<thead>
<tr>
<th></th>
<th>Dysthymia</th>
<th>Major Depression</th>
<th>Double Depression</th>
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</tr>
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<tbody>
<tr>
<td>N = 489</td>
<td>59</td>
<td>85</td>
<td>85</td>
<td>87</td>
<td>173</td>
</tr>
<tr>
<td>% Now Unemployed</td>
<td>14</td>
<td>12</td>
<td>15</td>
<td>3</td>
<td>2**</td>
</tr>
<tr>
<td>% Employed and Retained Job</td>
<td>87</td>
<td>80</td>
<td>87</td>
<td>91</td>
<td>95*</td>
</tr>
<tr>
<td>% Employed and Job Turnover</td>
<td>13</td>
<td>20</td>
<td>13</td>
<td>9</td>
<td>5</td>
</tr>
<tr>
<td>Of Employed Group</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean Change in Work Hours</td>
<td>-2.1</td>
<td>-2.3</td>
<td>0.8</td>
<td>0.5</td>
<td>0.8</td>
</tr>
<tr>
<td>% Income Increase</td>
<td>40</td>
<td>41</td>
<td>47</td>
<td>49</td>
<td>50</td>
</tr>
<tr>
<td>% Income Same</td>
<td>28</td>
<td>15</td>
<td>17</td>
<td>30</td>
<td>20*</td>
</tr>
<tr>
<td>% Income Decrease</td>
<td>32</td>
<td>45</td>
<td>37</td>
<td>21</td>
<td>31</td>
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* p < .01  ** p < .001


Then we looked at the group that was still working. So they may have lost – there may have been lots going on in the past six months, but we said of those of you who are still working, was that – you know, we asked, did you change your line of work, did you change your employer, did you do this, do that? We looked at a whole bunch of things. Then if they said “yes” to any of those things – typically, they said “yes” to lots of those things. “Were you fired or laid off?” And people said, “Yes, I was fired AND laid off.” You know, you couldn’t really figure out what happened. We then looked at their job codes to see if, in fact, they looked like they were in a different job.

And so out of the group that was still employed – which ordinarily we would regard as a very, very good outcome, right? We’d look at the employment rate and say fine, everybody’s working. Well, look at the turnover rate. The percentage of people that retain their job, for example, in the dysthymia group was 87 percent – 13 percent turned over, in six months.
There’s a lot of – you know, I can tell you qualitatively – because I’ve interviewed a lot of the patients in the depression group – there’s a lot of walking off the job. You know? Had enough, walk off the job, without another job to go to – which is a problem, especially in the current economy. It was fine right in the beginning of the study, but it’s not fine now.

You see tremendous differences, again, in terms of the outcomes of people even though they’re employed. So this was the stuff that NIMH told us not to look at because it’s not important. We already know that there’s very little unemployment. So, anybody have a theory of why we see this now? Any economists in the room? I have a sort of a theory about why we see it…. 
One of the issues may be that when you have full employment, there are lots of people in the labor market that ordinarily might not be there. And they’re not necessarily in the best jobs for them. And you know, when the going gets rough, they’re the low-hanging fruit. They’re right out the door. Some of it elective, and some of it sent, you know, sent out the door with the door slammed behind them. In any case, we don’t really know why that happens, and our study wasn’t designed to look at the effects of economic change. But it’s certainly very interesting and very provocative.

The other thing is – we looked at other kinds of changes, and we see a little bit of change in income, that their incomes look like they’re not rising as much in the depression period; so, we’re still looking at this data pretty closely.

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One of the things that you don’t see here that we are very sure of is, among the turnover group – which is very, very small, we’re talking about very few people, and I wouldn’t even show you the statistical results on that – but in the depression groups, there’s a larger proportion of people who said they left their job and took a lower-paying job because of their health than you see in the comparison groups. And it is significant that the numbers are very small. So, they’re not necessarily going to better jobs, but they are turning over.
So here are our scores on presenteeism. Again, this is a lot, and I’ll summarize this for you because – I should have done bar graphs, but we’re right in the middle of analyzing these data, so I have it all as numbers that are impossible to read. I really apologize.

But, basically, what you find is that, at the baseline – when people are sick, when they’re in the doctor’s office, you get the depression groups roughly reporting – let’s look at the time, mental-interpersonal, and output scales, because those are the ones that are most relevant for people with depression – you get people saying that they are limited in their ability to perform those particular types of job tasks anywhere from 20 percent of the time to up to 40 percent of the time in the prior two weeks. These are very sick people, by and large, right? So you would kind of expect that. But they’re all working. They’re still going to work. They’re missing a little bit of work.
So that’s the presenteeism piece at the beginning of the study, and that correlates to roughly between 6 and 9 percent productivity loss, according to our data. Actually, if you look at other data on productivity loss due to depression, it’s much higher. Sometimes it’s twice that. It’s the measurement. We feel pretty comfortable with a conservative measurement.

And those are very significant differences all the way across the board. On every scale, you see the depression groups look worse – with the exception of the physical scale, in which case the rheumatoid arthritis group – and there you go – you know, the rheumatoid arthritis group should look a little worse. They were also at the doctor, they all had diagnosed rheumatoid arthritis.

So what happens by follow-up? Well, what happens is – if you look at the change data longitudinally – and we control for baseline differences and characteristics, by the way, on all of this – you don’t see this here, but everything is controlled, adjusted for gender differences, age differences, and so on, medical differences.
What you find, basically, is that there’s a highly significant improvement in the depression groups over a six-month period. In fact, they’re functioning at work does get a heck of a lot better. But the “ah-ha” is that it never catches up to the control group. I can tell you that that’s true at 12 months, too. Never catches up. They have a big decline, they get better, their symptoms go down – the primary driver is the reduction in symptoms. The symptoms go down, the functioning gets better, but it never catches up. So it’s kind of, again, a fairly distressing finding.
In terms of absences, you find more absences at baseline, again due to depression. And you find more absences, again, at follow-up. Sometimes they improve, and sometimes they don’t improve. It’s not a real consistent picture. So there are all these levels of problems. Surprisingly to us in this study, that’s what we found, that actually the picture was much worse than we had anticipated.

<table>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>N = 451</strong></td>
<td>51</td>
<td>75</td>
<td>72</td>
<td>84</td>
<td>169</td>
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<td><strong>Absences Baseline</strong></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Days Missed</td>
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<td>1.9</td>
<td>1.7</td>
<td>0.7</td>
<td>0.7**</td>
</tr>
<tr>
<td>% Prod. Lost</td>
<td>8.1</td>
<td>19.6</td>
<td>19.3</td>
<td>7.4</td>
<td>6.6**</td>
</tr>
<tr>
<td><strong>Follow-Up</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Days Missed</td>
<td>1.2</td>
<td>1.6</td>
<td>1.2</td>
<td>0.8</td>
<td>0.5**</td>
</tr>
<tr>
<td>% Prod. Lost</td>
<td>11.5</td>
<td>20.7</td>
<td>13.7</td>
<td>8.3</td>
<td>5.2*</td>
</tr>
</tbody>
</table>

* p< .01 ** p< .001

Effect of Having the Worst Score on Explanatory Variables vs. the Best Score

WLQ Output Scale

Job Content
- Requirement for Use of Judgement and Communication Skills
  
- Required to Work with External Customers
  
Depression Symptoms
- Difficulty Concentrating/Fidgety, Distracted
  
- Sleep Problems/Fatigue
  
Physical Health
- SF-12 Physical Component Scale

Impact on WLQ Outputs:
- Requirement for Use of Judgement and Communication Skills: p<.01
- Required to Work with External Customers: p=.34
- Difficulty Concentrating/Fidgety, Distracted: p<.001
- Sleep Problems/Fatigue: p<.001
- SF-12 Physical Component Scale: p<.01


Now I want to get to the title, here, in my remaining few minutes, which has to do with the correlates.

Okay, so we got the bad news. We know what this looks like. It’s pretty much a picture of what we call substantial job upheaval; just substantial repercussions of the depression in almost any aspect of work that you look at. And these are the people who we consider to be good and functional. They’re still employed, or they were employed, they wanted to hang in there.

Now we look at – this is using our baseline data only, but I’m pretty sure that these will strengthen as we go on. Again, what we tried to do was to figure out what are some of the variables that might be driving the results, and here we’re looking at the presenteeism indicators.

I’m going to start from the middle, because – just to confuse you all – and see if anybody’s listening.
One of the things that we wanted to know about depression was that – we know it’s the sheer load of symptoms that’s the driver of a lot of these things. You know, the people who have – there’s a big linear relationship there. Worst symptoms, worst outcomes, any way you look at it.

But one of the interesting things when it comes to the workplace is that we say, “Well, are there certain symptoms that just make it miserable for people to carry on a job?”

This is where we think we can really have an impact on medical care – not only on the employer’s side, but on medical care and patient information. Because imagine being able to say to a patient – you know, the patient comes and says, ‘Ah! I can’t concentrate, I can’t do this, my boss is screaming at me.” And you say, “You know what, you can’t concentrate. That’s your depression. If you take your meds, that might get better. Let’s look at your concentration level.” That’s not how medical care is done, at all, right now, if it’s done for depression at all.
So what did we find? We looked at specific depression symptoms and which ones seemed to be important to predicting a worse outcome. Well, low and behold, difficulty concentrating – level of distraction – is just really rough on people. It’s a highly significant predictor of trouble at work. So is the extreme fatigue that goes with depression. Those two things are really important.

What that picture tells you is that the very highest levels of concentration difficulties, compared to the lowest – you basically average 40 percent increase in limitations handling the output demands of your job. So that’s the extremes that you’re seeing there, a 40-point impact on that scale, just from that one thing alone, at the very, very highest levels. And obviously, people don’t all have those highest levels. But it’s a way to show you the impact.

Again, also, sleep problems at work are very important.

We found those two consistently were very impairing symptoms for people who were working, irrespective of some of the jobs that they were in and other factors.
Another factor was their physical health, measured by the SF-12. Again, these were supposed to be relatively physically healthy people here, but they’re carrying around all kinds of somatic symptoms, and that’s another driver. So getting physicians to pay attention to the fact that those are important for functioning. You know, sometimes they write them off and they say, “Ah, they’re complaining because it’s their depression they’re complaining about, and I don’t have to pay attention to the fact that their stomach hurts and their head aches and they have low back pain.” But these symptoms – these physical health problems – are impairing people on the job. Okay? So, again, another important way to communicate with patients.

And finally, going back to the ONET systems, the imputed data. In this particular model we find that if you’re in a job that requires you – or an occupation, actually – it’s occupational level data – if you’re in an occupation that requires you to use a high level of judgment and high-level communication skills, depression is not a very good thing to have. Okay? Which is not surprising.
Effect of Having the Worst Score on Explanatory Variables vs. the Best Score

WLQ Time Scale

- **Job Content**
  - Requirement for Use of Judgement and Communication Skills: p<.001
  - Required to Work with External Customers: NS

- **Depression Symptoms**
  - Difficulty Concentrating/Fidgety, Distracted: p<.001
  - Sleep Problems/Fatigue: p<.002

- **Physical Health**
  - SF-12 Physical Component Scale: p<.001

n=329  
R²=.35  
p<.0001  
Model adjusts for age, gender and education.


This is the time management scale. This is things like working the required number of hours, doing your work without taking breaks or rests – the kind of thing we all have to do, sort of day in and day out.

And here we find the same thing. Judgment and communication skills are extremely impaired by the depression, and people in those jobs don’t do very well.

We looked at some of the occupational codes. You can imagine what are the occupational codes that high levels of those two elements, and it’s just lots and lots and lots of jobs. Right? And so you see the same kind of result there.
Finally, you see a slightly different result when you look at the two other scales. This is difficulty performing the cognitive and interpersonal demands of your job like concentrating, interacting with other people, and so on. And here is where you find that if you’re in a job that requires you to work with external customers – and this one’s a good for industry – how many jobs are they concerned about customer service?

We can also see this when we use service industry indicators, too, on people’s work. But this particular variable is highly significant for people with depression with regard to their making it worse in their ability to perform their mental and interpersonal tasks. We see the same thing on the physical demands scales; the same effect.

What we learn there, then, is that the job does make a difference. ‘Big news!’ It does make a difference. It may make a difference in ways that we can influence medical care to pay more attention to what it is that the person has to do for a living. It also may help medical care to be more aware of the symptoms and how those symptoms might be affecting people on the job.
But what it says to us is that, even if you had excellent medical care going to everybody with depression – which, obviously, is a dream – you would still have problems with day-to-day functioning; because depression is the kind of condition, like other chronic conditions, that just keeps coming back. It keeps coming and going. The medications are not always effective. People don’t always stick with them. There are all kinds of problems. So we need other kinds of initiatives that are going to allow people with depression not only to retain their jobs when they want to, but to sustain their productivity over time.

And that’s my presentation.
Deb, thank you so much for a terrific presentation! Before we open up to the audience, there was a question or two I had for you, actually.

I’m kind of curious – because I’m not that familiar with the medical best practices for depression, so – you made the comment towards the end of your presentation that if a patient goes into the physician’s office and says, “I’m having trouble concentrating, I’m having trouble doing my job” – what would be the appropriate response? And to investigate various pharmaceutical interventions for the patient at that point? And you’re suggesting that’s what’s not happening. Is that correct?

QUESTION 1: (Pat McGovern, PhD, Associate Professor, University of MN and panel moderator)

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Question & Answer

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LERNER:

There are several things that are not happening – and I’m not an expert on this – but what’s not happening is, they’re not screening, for example. There is a recommendation that patients should be screened routinely. The question is, how often do you screen them? Once a year, or do you screen them every two years? You know, what’s a reasonable amount of screening? So that’s a very tough question, particularly for a condition like this. So the screening is an important piece.

Then the second piece is to – and one of the things about screening is that it does begin to tell you whether or not this is a depression that might be due to, let’s say, a serious life event, and this is probably going to pass on its own, and they should come back, and you don’t start them on a medication. Or, it’s something that would make sense to begin to try either a mediation and/or counseling. And so you know that – counseling models – there’s less and less counseling available to people, so this has become a problem as well, because the research suggests that both things are useful.
**Question & Answer**

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The other thing that a physician probably needs to do – at least, in some of the practices we looked at – is that they had the behavioral health carve-outs. So if the primary care doc can’t handle it, what we see happening is, they say to the patient, “Turn over your card, there’s a phone number there, call that number.” Well, how many people leave the office and call that number? Not very many; and even if they do once, they don’t do it twice. So there are a lot of problems in communication.
**Question & Answer**

**Question:** You noted on one of your last slides that you adjusted for age, gender, and education. I’m wondering, particularly over time, if there is opportunity to also look at physical activity, obesity, some of the lifestyle factors that are related to depression, and whether or not they have an impact?

**Response:** Whether they have an impact on work outcomes?

**Question:** Yes, particularly over time. So either you can control for it in your analyses, or have a look at it.

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**QUESTION 2: (Nico Pronk, PhD, Vice President, Center for Health Promotion, HealthPartners)**

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**LERNER:**

Right. Well, I know that obesity is related to functioning on these scales, because I have looked at that independent of this study; and so that is something that you’ll see in your data too, I’m sure, when you pull the health risk data together. And Dee Ettington and others have done a good job on this. You know, they look at some of the health risk factors. If you look at whether it’s depression plus obesity in what’s driving the work outcomes in a work population, you would need a study specifically designed for that, because that’s a tough question, actually, to answer. You do need longitudinal data going forward on it. It’s a good hypothesis, though.
Question & Answer

**Question:** Hi, I’m Nancy Baker. I was interested – you looked at several different types of depression – did you find any significant difference in the outcomes between the depression types, compared to the RA control group?

**QUESTION 3:**

Hi, I’m Nancy Baker. I was interested – you looked at several different types of depression – did you find any significant difference in the outcomes between the depression types, compared to the RA control group?

**LERNER:**

Sometimes we do. I’m just trying to think if we saw it at this time period. I think that we have seen – maybe on one of the WLQ scales – I don’t have the data in front of me, and it may not be in these databases – but once in awhile, we do see a difference. But typically, it doesn’t hold for very long.
Question & Answer

**Question:** Hi, I’m Nancy Baker. I was interested – you looked at several different types of depression – did you find any significant difference in the outcomes between the depression types, compared to the RA control group?

But there are differences on some of the outcomes that you do see in the groups. And also, I suspect that over time we’ll see a difference because the dysthymic group was basically at that steady state – for many of them, they’re at a steady state of just having those low level symptoms. But I wonder, for example, with the major depression group, if they have another episode, it kind of throws everything off balance again and they get back into the cycle of having to start all over again with their treatment and recovery.

So I think that probably over time we might see something, in terms of the ability to close the gap with the control group.
Question & Answer

Question: I have another question for you, Deb. Trying to think about, what can the employer do, and what are reasonable expectations? I’m intrigued by the fact that it’s the jobs that involve these interpersonal skills and the judgment and decision-making. And then, earlier, you had said that the issue is people improve with time but they never catch up. And so, what would be the approach for the employer if the job has those characteristics as essential functions? Is it the employer’s role to try and counsel the employee to look at a job without those same functions in it? Or what would you recommend?

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Question & Answer

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LERNER:
That’s a very good question, and we have several grant proposals out right now looking at interventions for depression in the workplace. And so we have some ideas about how you might approach this. One of the things that I always say is that there’s a real big gap between doing nothing, which is kind of the situation right now for people with depression in the workplace – not everybody, but there are many workplaces where that happens – and redesigning their job totally, or placing them in another job. That’s kind of the last resort. Then there’s the no resort.

We all think, at our group, that there’s probably lots of things that can be done in between, little tweaks that could be done to the job that don’t really change fundamentally what the person is doing, but might help them function throughout the day. At the same time, that can’t be done in isolation of getting people into treatment and keeping them on treatment, because it just won’t work. Treatment is clearly going to be important.
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There have been several studies, for example, that have shown in groups that – you know, you give great treatment – high quality treatment – that the symptoms go down, and eventually the employment picture does improve. Unfortunately, they haven’t looked just at people who have been employed and had control groups like this study; but it does give you the sense that it is worth it to treat people.

There is a study going on right now that’s looking at return-on-investment issues, and so on. We don’t really look at that. The question is, are there things that could be done in the workplace, given the existing infrastructure, that can help people function better? And I suspect that there are lots of things that could be done before you get into the accommodation area.