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# @work

Official Publication of Disability Management Employer Coalition

## Workplace Mental Health

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# @work

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### Contact DMEC

800.789.3632

[info@dmec.org](mailto:info@dmec.org)

5173 Waring Road, Suite 134, San Diego, CA 92120-2705

### Editor

Peter Mead, CPDM

[editor@dmec.org](mailto:editor@dmec.org)

For all editorial questions

### Layout & Production

Mark Jaquette

### Editorial Review Panel

Linda J. Croushore, MEd, CRC

Steven M. Genduso, MA, CPDM

Thomas P. LeRoy, PT, MSERG

Terri Morris, CEBS, CPDM

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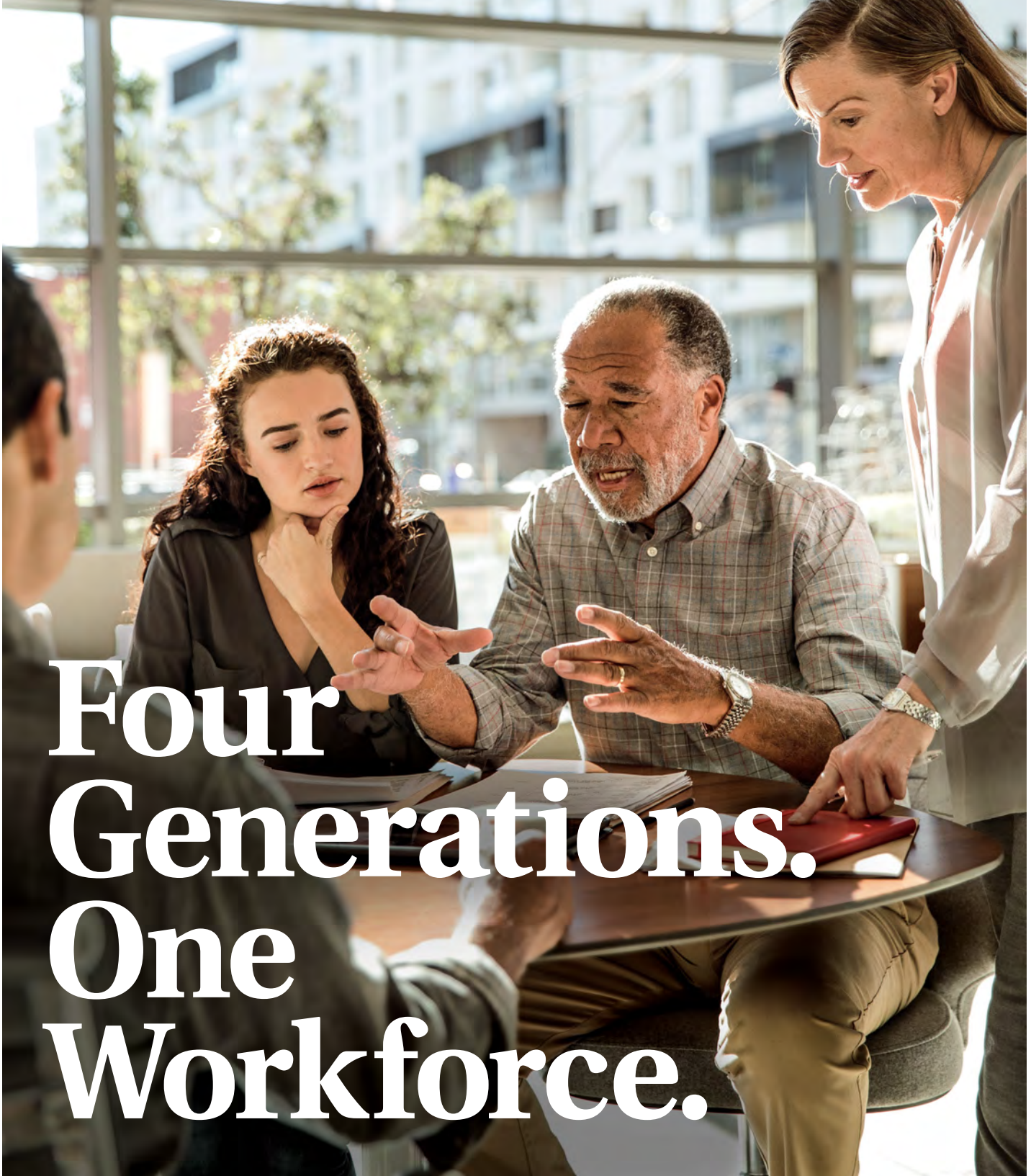
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## Mental Health Employer Resources & Tools

It is essential for employers to build and sustain cultures of health and well-being in their organizations. DMEC's mental health resource page provides a variety of free resources and tools to help you address mental health in your organizations and bridge the gap by combating the stigma around mental illness. [Learn more.](#)

# Free Resources



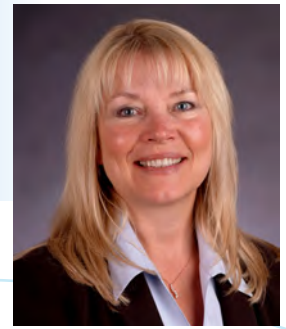
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**Terri L. Rhodes**

CCMP, CLMS, CPDM, MBA  
President and CEO, DMEC

## Let's Stamp Out Stigma

The national conversation about U.S. health-care reform has touched on many important topics: more coverage and better insurance, new ways of providing care, cost containment, and prevention.

However, in the last several years, our attention has turned to mental health in a more critical way. Healthcare professionals, policymakers, and employers are trying to move beyond old stereotypes and are taking overdue steps to address this pervasive and debilitating illness. Yet, we still have a long way to go.

May is Mental Health Awareness Month. Let's use this opportunity to stamp out stigma!

At the top of the list, we need to reduce the stigma attached to mental illness. Mental illness is often treated the way cancer was 50 years ago — in whispers and

rumors. Or it's demonized as the cause of crime and violence. DMEC surveys indicate the level of workplace mental health stigma is resistant to change. This is not the progress we need.

Mental illness is like any other illness. While laws affecting health insurance require parity for mental health benefits, more than 50% of individuals with mental illness still avoid needed treatment. Untreated mental illness can result in other illnesses and behaviors, such as chronic pain and substance abuse which leads to even higher costs to employers.

Motivating employers and health plans to treat mental illness like any other illness is only part of our challenge. DMEC surveys make clear that younger employees tend to attach less stigma to depression, anxiety, and other mental illness. So how do we move from looking at

mental illness through a microscope wondering if the person is stable and walking on egg shells, to openly discussing the illness like any other.

The entire organization benefits when stigma is reduced. Here are four steps to help reduce stigma:

1. Know the facts. Educate yourself about mental health. Learn the facts instead of believing the myths. Our website is a good place to start for free resources. See page 3 of this issue for mental health employer resources and tools that DMEC members can access at no cost.

2. Educate others. Find opportunities to pass on facts about mental health. If your co-workers perpetuate myths and stereotypes, let them know that an illness is an illness, and everyone benefits when we talk about mental health openly.

3. Know your own attitudes. We all grow up with stereotypes, but these can be changed. People are unique individuals and not defined by any illness, mental or otherwise. Check your attitude from time to time.

4. Speak with care. Our speech influences the thought and speech of others. When discussing mental health, use neutral and descriptive language. Mental health is an illness of another organ, the brain.

Taking these steps to reduce mental health stigma creates a more fair and productive workplace. And in the process, we can potentially lower many types of legal and reputational risks associated with unfair treatment.

Terri L. Rhodes  
DMEC CEO

*"May is Mental Health Awareness Month. Let's use this opportunity to stamp out stigma!"*

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## CM #9

### Long Legal Contest to Cap Leave as Accommodation

On April 2, the U.S. Supreme Court refused to review a ruling by the 7th Circuit U.S. Court of Appeals rejecting “multi-month” (more than two months) leave as an accommodation under the Americans with Disabilities Act (ADA). For now, *Severson v. Heartland Woodcraft* applies only in the 7th Circuit’s states of Illinois, Indiana, and Wisconsin. Last August, a month before the *Severson* ruling, United Parcel Service (UPS) paid \$2 million to settle a 10-year legal battle with the Equal Employment Opportunity Commission (EEOC) over

UPS’ rigid 12-month leave cap. Yet two months later, after *Severson*, EEOC Acting Chair Victoria Lipnic said leave can be an ADA accommodation, but “the idea that it can go on and on forever is problematic.” Lipnic made these comments last October at the Association of Corporate Counsel annual meeting. According to the petition to review *Severson*, extended leave as an accommodation is accepted by the 1st, 6th, 9th, and 10th Circuits. Other circuits may be more favorable venues for litigation to put a cap on leave as an accommodation under the ADA.

## CM #10

### Compliance Questions Over Massachusetts Equal Pay Act

Laws requiring equal pay for comparable work can be a compliance challenge. According to Massachusetts, the first state to pass an equal pay law in 1945, women working full time earn only 84.3% of what men earn in that state. The state passed the Massachusetts Equal Pay Act (MEPA) in 2016, which takes effect on July 1, 2018. MEPA provides an affirmative defense for any employer that has conducted a good faith, reasonable self-evaluation of its pay practices and taken steps to correct any impermissible disparities within three years of MEPA passage and before any legal action has been filed. To assist employers with this self-evaluation, the state office of

the attorney general (OAG) provides a “Pay Calculation Tool.” Reviewing the tool, employment law firm Jackson Lewis commented, “The Tool can help organize relevant data and be used to conduct basic self-evaluations. As the OAG Guidance makes clear, however, the Tool is not appropriate for larger pay groups or sophisticated pay systems. Therefore, most employers should not rely on the Tool alone to meet their obligations under MEPA.” For more details about MEPA compliance, visit <https://www.jacksonlewis.com/publication/massachusetts-equal-pay-act-calculation-tool-what-employers-need-know>.

## CM #11

### Low Cost Impact from New York City Paid Sick Leave Law

Employers experienced nominal impact, negative or positive, from the New York City Earned Sick Time Act, according to a study of the Act’s first two years, conducted by the Center for Economic and Policy Research of The City University of New York. Concerning employee retention, the study found that “virtually no employers reported any change in turnover.” On productivity, more than 94% of employers reported that “the paid sick days law had no effect on business’ productivity,” with 2% reporting that productivity increased, and 4% reporting that productivity

decreased. On reducing the number of sick employees reporting to work, the study found that 92% of employers reported no change in the spread of illness in the workplace, while nearly 7% reported that the spread of illness decreased. Fully 90% of employer respondents reported no change in the number of employees coming to work sick, with increases and decreases reported equally at 5% each. To learn more about the study and the impact of the city’s paid sick leave law, visit <http://cepr.net/images/stories/reports/nyc-paid-sick-days-2016-09.pdf>.

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By  
**Liz R. Scott, PhD**  
Principal/CEO  
Organizational Solutions

# Science and Innovation *in Workplace Disability Management Programs*

Emerging innovations in medicine and psychology are driving the evolution of disability management.

Two of the most inspiring and exciting recent innovations, that are showing real results and practical application in return to work (RTW): pharmacogenetics and cognitive behavioral therapy with an RTW focus. Increasingly, measured research results are showing that each has a real and lasting impact on reducing costs and an employee's time away from work.<sup>1</sup>

More effective interven-

inter-individual variability in drug response, rank between the fourth and sixth leading causes of death in the United States.<sup>3</sup> At the level of the individual workplace, this means that an employee who has an adverse drug reaction may be absent, resulting in the need to replace that employee or increase the workload on other employees, affecting productivity and morale.

An employee with a mental health condition such as depression may end up on short-term disability (STD). If the condition has the potential for successful pharmacological treatment, then the doctor or psychiatrist has to find the



*"For mental health conditions, the symptoms are often experienced subjectively... testing medications for the condition can often take months or even years."*

tions are badly needed by American employers and employees. The Gallup-Healthways Well-Being Index surveyed 94,000 U.S. workers across 14 major occupations, finding that 77% of workers fit the survey's definition of having a chronic health condition (asthma, cancer, depression, diabetes, heart attack, high blood pressure, high cholesterol, or obesity). The total annual costs related to lost productivity reach \$84 billion.<sup>2</sup>

Adverse drug reactions, due at least in part to

drug that will have the intended effect on the person. For mental health conditions, the symptoms are often experienced subjectively, including good and bad periods, which means that testing medications for the condition can often take months or even years.

Help is being found in the growing field of genetics. In recent years, disability management professionals have been introducing employers to the benefits of pharmacogenetic testing to better manage medical conditions and reduce time away from work. Wendy Jackson, manager of Canadian

benefit programs at Magna International, is an employer championing the value of pharmacogenetic testing within the workplace. “In our U.S. divisions, we do pay for the testing on some of the drugs that qualify. This is cost-effective for us in the long term,” she says.<sup>4</sup>

The pharmacogenetic testing process is simple. It is based on the concept of individualized drug treatment, in which the choice of drug is influenced by a patient's own genes.<sup>5</sup> It begins with a person taking a simple cheek swab to capture saliva and sending the sample to a laboratory. A report is sent back to the person, and often to their doctor, outlining a large number of medications and how the person is likely to react to each of them.

### Reducing Experimentation

When an employee takes a new drug for the first time there will either be no reaction, a toxic reaction, or the drug will have the intended effect. A pharmacogenetic test shows which drug will have which effect, both now and in the future, because a person's genes do not change.

Pharmacogenetics can greatly reduce the time needed for experimentation with drugs and dosages, since lab tests show the doctor and the patient which medications would have the intended effect. The doctor and the patient are the only two people with access to the information, ensuring compliance with the Genetic Information Nondiscrimination Act.

Cost and insurance coverage of pharmacogenetic testing may vary. Health plans may cover some tests if requested by physicians. Cost of the tests may vary from \$100 to \$2,000 per test, and response time may be up to several months. Even so, the process is still faster than trial-and-error on psychotropic medications, with the

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employee off work until the right medication in the right dosage begins to alleviate symptoms and the employee begins to enjoy restored function.

In our experience working with Canadian testing firms, the cost for the mental health-related tests we most often use is in the range of \$400 to \$450. Costs are more than twice that in the United States, with an average response time of about four weeks, due in part to regulatory overhead of the Genetic Information Non-discrimination Act.

Managing the condition faster means less time away from work and often a more timely return to work, producing a positive experience for

complement medication. To that end, cognitive behavioral therapy (CBT) with an RTW focus is often combined with pharmacogenetic testing.

CBT has emerged over the past several decades as a particularly powerful tool in treating depression, anxiety, and post-traumatic stress disorders. The treating psychologist uses a range of proven talk-therapy tools including reframing, mindfulness, and resilience building to address problems the employee faces in daily life. This approach can include homework with progressive treatment, usually over six to eight weeks. CBT has shown superior efficacy in treating social phobias

*“Pharmacogenetics can greatly reduce the time needed for experimentation with drugs and dosages”*

both employee and employer. Pharmacogenetic studies are rapidly shining light on the inherited nature of medical differences in each person; the enhanced drug discovery of pharmacogenetics provides a stronger scientific basis for better drug therapy on the basis of each patient's genetic make-up.<sup>6</sup> Ensuring a drug does not have a toxic effect means healthier employees, fewer complications during time away, and more timely return to work.

But some mental health conditions require a second line of treatment to

as well, conditions that can produce significant durations in disability claims. Adding CBT to disability management strategies is proving to be particularly effective, as it can greatly increase the effectiveness of resilience building in RTW and transitional RTW. A series of coping skills are progressively introduced by the psychologist to build this resilience.

The disability management process works concurrently with a CBT program, introducing the employee back into work as early as possible in the

process. A study in Canada tested the effect of combined CBT and disability management in a manufacturing workplace. Over two years, the program produced a 56% reduction in the incidence of serious mental health claims, and a 52% reduction in duration.<sup>7</sup>

Disability management professionals should be consistently examining the tremendous strides being made in the medical and behavioral sciences. Professionals should mine best practices that can be successfully applied in disability management programs and workplaces.

Pharmacogenetics and CBT are only two examples of techniques that are producing very encouraging results. Many more emerging best practices are waiting to be explored and implemented. Video conferencing can bring doctors and medical professionals closer to patients in isolated or rural communities, and as this technology develops, it may be possible to incorporate virtual reality to dramatically enhance that experience in the near future. An employee may be able to receive CBT treatment from a psychologist, in that psychologist's office, without making a journey to a remote location. A psychologist on the East Coast could treat a patient on the West Coast as easily as if they were located in their own town. This is already being leveraged by technology companies such as "Doctor On Demand" and others.<sup>8</sup>

### Choosing New Directions

Disability management professionals can incorporate the leading edge of technology and research to increase their impact on employee care, engagement, and return-to-work outcomes. As pharmacogenetics and CBT show, when new and emerging research is successfully used in disability management programs, the results are healthier employees, more productive workplaces, and reduced economic impact on employers.

It also shows why the discipline of disability management continues to be enormously beneficial for both employers and for society as a whole. This is most apparent in the experience of the employee. When the unfortunate happens, disability management helps employees restore meaning to their lives. It benefits workplaces. It makes society healthier and more productive. It changes lives.<sup>9</sup>

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# An Effective Tool in Court

## *Refuting Psychological “Junk Science”*

The federal and state workers' compensation (WC) systems contain a great deal of imprecision that makes psychological claims difficult and unpredictable. Employers can eliminate some of these challenges by applying current psychological standards of care for treatment and when claims are litigated.

WC systems have many pitfalls to avoid. First, each has its unique rules, regulations, and laws pertaining to workplace injuries. This creates considerable variation in what is an allowable workplace psychological injury; not all states allow WC psychological injury claims (more on this below).

Second, WC systems don't require accurate and current psychological diagnoses relating to a workplace psychological

injury. For example, states that allow WC psychological claims frequently refer to “depression,” a nonmedical term that lacks specific diagnostic criteria. Instead, “major depressive disorder” is a recognized diagnosis with specific criteria that can be applied to a person.

Third, WC systems do not require the sub-

mission of supporting documentation that meets the current psychological and psychiatric standards of care. Thus, WC systems frequently are at odds with these professional standards.

Due to this imprecision, each WC system is ill-designed to make accurate WC psychological injury determinations. This issue becomes especially important since WC claims that are denied and have exhausted all WC appeals can transfer to the tort system, where the Daubert standard applies, supporting a focus on accurate, current psychological diagnoses.

Three types of WC claims relate to psychological conditions:

- **Mental-physical:** A psychological condition aggravates an individual's physical condition, such as migraines.
- **Physical-mental:** A physical workplace

*"The Daubert standard is used in court proceedings to evaluate whether an expert's testimony is based on valid scientific methods and is appropriately applied to the facts of a litigated case."*

injury results in the development of a psychological condition.

- **Mental-mental:** An individual is subjected to repeated workplace situations, such as workplace stress, that are the catalysts for the development of a psychological condition.

The following states do not allow any WC mental-mental claims: Alabama, Arkansas, Connecticut, Florida, Georgia, Idaho, Kentucky,





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In several states and under the Federal Employees Compensation Act (which covers many federal employees) it is possible to file psychological injury claims only when circumstances occur beyond those normally encountered by

Frye<sup>2</sup> standards. Tort proceedings in the majority of states and federal courts utilize the Daubert standard, establishing more precise psychological findings based on current standards of care. When a WC claim has exhausted all appeals within the WC system, the claim can proceed in the tort system.

*"When current professional psychological and psychiatric standards of care are applied, imprecision is removed from the WC system."*

others in the same work environment or the catalyst is sudden versus gradual exposure. The states that allow these claims are: Arizona, Colorado (for firefighters only), Illinois, Iowa, Louisiana, Maine, Maryland, Mississippi, Missouri, New Jersey, New York, North Carolina, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, and Virginia. Massachusetts and the District of Columbia allow mental-mental claims only in very limited cases.

The only states allowing mental-mental claims are Alaska, California, and Hawaii.

The tort system is very specific about what types of information it allows to support claims of injury. Typically, tort systems require any professional documentation that is submitted to meet certain standards such as the Daubert<sup>1</sup> or

### **How Courts Apply Daubert**

The Daubert standard is used in court proceedings to evaluate whether an expert's testimony is based on valid scientific methods and is appropriately applied to the facts of a litigated case. Further, the Daubert standard requires that:

- 1) any methodology used by a professional can be and has been tested;
- 2) the employed method has been peer-reviewed and published;
- 3) the method has a known error rate;
- 4) standards apply to how the method is appropriately employed; and
- 5) there is extensive acceptance by the relevant scientific community.

Thus, the Daubert standard provides a starting point to address the disparities across all WC systems. In tort procedures in the U.S. court system, the Daubert standard weeds out junk science. Based

on my experience in more than 30 years of professional services (including WC work), I advocate to apply the Daubert standard in all WC systems. It is in the interest of all employers to advocate for the Daubert standard in the WC systems that have jurisdiction over their claims. Using such an approach provides a consistent framework, which bridges the differences in the state and federal WC systems. The Daubert standard is adopted in some state WC systems, including Florida's.

While each individual claim has its own set of facts driving litigation, it's still valuable to provide a brief overview of some of the key issues evaluated under the Daubert framework. Applying the Daubert standard in WC claims requires careful assessment of the reported psychological injury to assess whether the submitted professional documentation has successfully demonstrated:

- 1) the existence of a psychological condition that has diagnostic criteria;
- 2) whether the reported psychological injury meets a specific WC system's criteria for being an allowable injury; and
- 3) assessment of purported impairment in functioning.

This framework requires application of current psychological standards to review any medical treatment of the individual, as well as any documentation submitted by treating professionals. This fundamental approach can be applied in any WC system.

### **Challenges to WC Psychological Claims**

It's important to remember that while the WC system is focused on causation — did a workplace event cause a psychological injury? — that causation is focused on a "yes" or "no" answer from the professional. Any professional who opines that a workplace definitively caused a workplace injury must address empirical research that demon-



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states that there is a non-linear path for the development of psychological conditions. This is because:

- a) the majority of psychological conditions begin in adolescence;
- b) psychological conditions rarely occur immediately after a single event because there are life-long interactions between the biological, cognitive, perceptual, environmental, genetic, attitudinal, beliefs, and expectations factors for each individual; and
- c) most psychological conditions do not result in permanent impairment in functioning.

Although the WC system requires a “yes” or “no” answer that the workplace caused the injury, the above factors assure that a simple “yes” is not accurate in most cases.

When current professional psychological and psychiatric standards of care are applied, imprecision is removed

from the WC system. Moreover, purported psychological diagnoses without diagnostic criteria, unsupported professional documentation, and junk science are disallowed. Instead, a more objective evaluation of reported psychological injuries results, and potential functionality issues are evaluated in a consistent manner. Frequently, those litigated claims are settled outside of the WC arbitration system.

It is important for all treating professionals to provide treatments that meet the current professional standards of care to improve treatment outcomes. A 2012 study<sup>3</sup> demonstrated that when evidence-based treatment was provided to WC claimants in Colorado, treatment outcomes improved, treatment costs were substantially less than in other state WC systems, and claimants were more satisfied with the treatment — a winning situation for all parties involved.

### Case Study: Applying the Daubert Framework in Litigation

The Daubert framework can exert considerable impact on litigated claims. In a Texas WC claim, for example, an employee at one Texas university transferred to another Texas university. Her work position and associated work duties were identical in both positions.

Approximately two years after the employee transferred to her new job, she began to have attendance issues. Eventually, she filed a WC claim indicating that she could no longer complete her job duties. To support the claim, she submitted treatment records from her psychologist. The psychologist indicated her diagnoses were depression and attention-deficit hyperactivity disorder (ADHD), as well as “cognitive impairment.” The submitted documentation was screening tools, plus two psychological tests, the Minnesota Multiphasic Personality

Inventory (MMPI-2) and the Wechsler Adult Intelligence Scale (WAIS-IV).

The MMPI-2 is frequently used to confirm or rule out psychological conditions. The psychologist asserted that the claimant was “severely” depressed according to the results of the MMPI-2.

The WAIS-IV is utilized to assess a variety of cognitive functions, including general intelligence, verbal intelligence, performance intelligence, speed of response to test questions, and so forth.

The psychologist also administered two screening tools, the Beck Depression Inventory (BDI) and the Zung Anxiety Scale.

Based on the test results, the psychologist opined that the claimant wasn’t capable of doing her job and that she was permanently disabled.

First, “depression” is not a known condition; this is a layperson’s term. Instead, major depressive disorder is a condition that must be confirmed or ruled out with testing.

Second, ADHD is a life-long condition. The claimant worked successfully for 17 years with ADHD. However, after two years in her new position, she claimed she could no longer do the same job. This type of change is typically not observed with ADHD. While intermittent attentional issues may occur, typically these are not permanent and do not result in permanent disability. Typically, most individuals with ADHD are able to work.

Applying the Daubert framework to this claim produced several key findings.

First, screening tools can never be employed as diagnostic tools since they frequently do not have validity or reliability measures. Typically, they provide no means to assess the possibility of symptom exaggeration or malingering. Because of that, screening tools do not meet the current psychological testing standards and are inadmissible.

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Second, the claimant’s psychologist reported and interpreted invalid MMPI-2 results. All standardized tests include a set of validity measures that must be used to assess whether a test’s results can be interpreted. If a test’s results do not pass the required validity assessment, the test cannot be interpreted. Because the MMPI-2 results in this case were invalid, the test could not be interpreted and could not contribute to a diagnosis.

Consequently, the psychologist did not provide objective evidence of a major depressive disorder in the claimant. All professionals who administer psychological tests are required to follow the American Psychological Association (APA) testing standards regardless of APA membership; the claimant’s psychologist did not do this.

Third, the psychologist only reported percentile WAIS-IV scores for the claimant. Thus, when scores were reported, they looked very low and seemed to support the claims of impairment in cognitive functioning. For example, on an attention measure, the psychologist reported a percentile score of 35. However, WAIS test scores are typically

reported as IQ scores. When the same score that the psychologist reported was put into the appropriate IQ score form, her IQ score for that measure was 85, which was within the normal range. Applying a population bell curve during the deposition demonstrated that the psychologist reported the claimant’s WAIS-IV scores inappropriately and did not follow the psychological testing standards on how to report those scores. Thus, a re-examination of the scores demonstrated that the claimant had normal cognitive functioning. Consequently, there was no support of cognitive impairment in functioning.

A review of work records identified that the claimant had attendance issues and was about to be disciplined. She filed a WC claim indicating that the workplace duties were beyond her ability and that the repeated workplace stress contributed to her cognitive impairment and “depression.”

This WC claim was later dismissed due to use of the Daubert framework to review the submitted documentation for the WC claim.

*Tool in Court continued on p. 37*

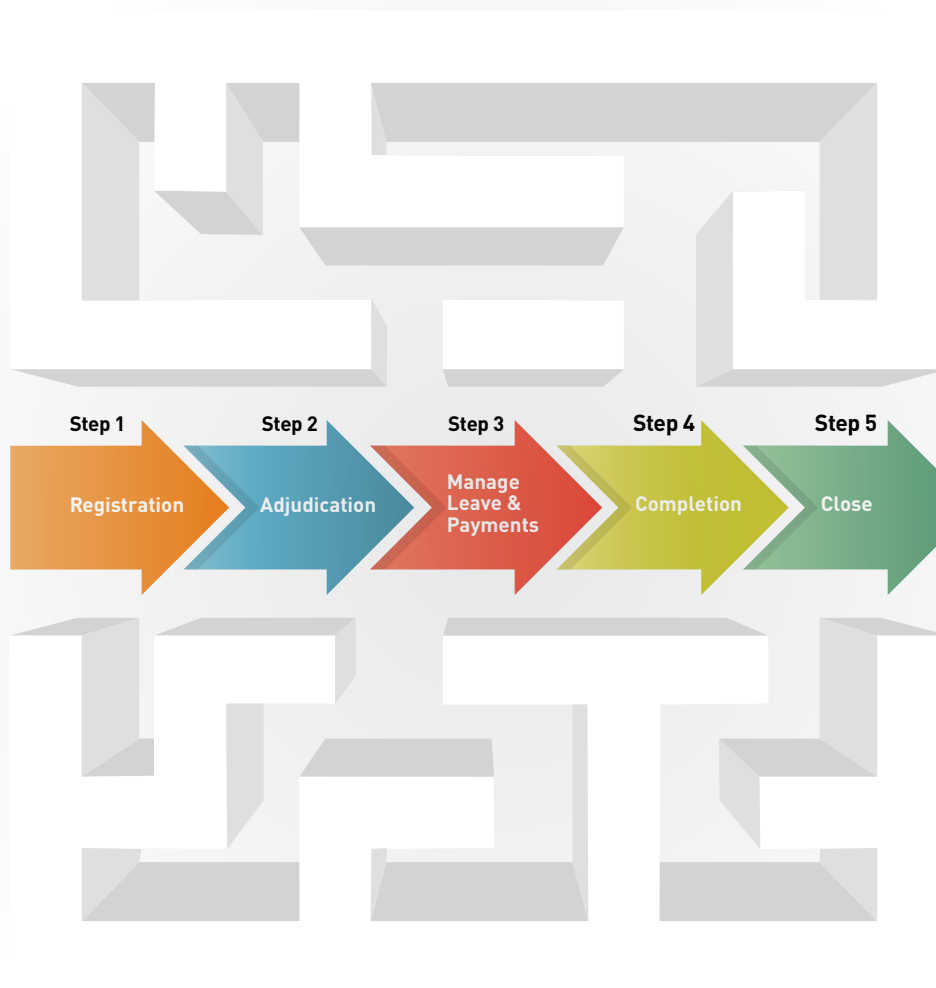


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# Enhancing Sleep: Strategic Tool for Improving Employee Mental Health

By

**Judy Gordon**

Wellness Director, The Hartford

**Jenna Carl, PhD,**

Medical Director, Big Health

Employee mental health is one of the most significant and difficult challenges faced by many employers today. According to the National Institutes of Mental Health, neuropsychiatric disorders, including mental health conditions, are the leading cause of disability in the United States.<sup>1</sup> For employers, the cost of depression and anxiety is double that of the next most costly health conditions. This is due to the substantial impact of mental health on healthcare expenditures, productivity, and absenteeism.<sup>2</sup>

The immense costs of mental health are due in part to the high prevalence of mental health conditions: one in five U.S. adults will suffer from a diagnosable mental health condition each year.<sup>3</sup> Prevalence is only half of the equation; the other is insufficient or ineffective treatment, the causes of which are complex and multifaceted.

Mental health has long been underserved by the U.S. healthcare system. Prior to passage and implementation of the Mental Health Parity and Addiction Equity Act (MHPAEA), employers could restrict mental health benefits more than medical/surgical benefits.<sup>4</sup> The MHPAEA was a much needed step in the right direction, but significant

challenges remain. An astonishing 70% of those suffering from a mental health condition in the United States do not receive treatment.<sup>5</sup>

One of the most significant barriers to treatment is the stigma surrounding mental health conditions. A national survey in 2017 found that 55% of people view depression to be a personal weakness or failing, which is, of course, erroneous.<sup>6</sup> With stigma such a significant barrier, employers have struggled to engage their employees in seeking treatment. Traditional workplace programs, such as Employee Assistance Programs (EAPs), are generally underutilized, with utilization ranges of 2% to 5% often cited. While EAPs provide necessary and helpful services for mental health and other personal, financial and work-related problems, EAPs cannot be the sole pillar to a comprehensive employee mental health strategy.

Approximately two-thirds of individuals with anxiety and/or depression also suffer from insomnia, a chronic difficulty falling or staying asleep.<sup>7</sup> Whereas the widely held view was that insomnia is just a symptom of anxiety and depression, recent research has revealed that insomnia is actually a significant risk factor for the development of anxiety and depression.<sup>8,9</sup> And further clinical research is showing that treating insomnia actually reduces the symptoms of anxiety and depression, meaning sleep

improvement is a strategic target for improving mental health.<sup>10,11</sup>

## Our Experience

Like most employers, mental health has an impact on our healthcare costs, productivity, and absenteeism. Our 2016 disability data showed that behavioral health was the second most common cause of disability-related leaves, behind maternity, with depression and anxiety being the most common causes of behavioral health related leaves. The average duration of behavioral health-related leaves was 28% longer than all other claims. During the same period, 5.5% of medical spending was attributed to behavioral health claims with depression and anxiety accounting for 30% of those claims.

Similarly, poor sleep was common among our employees and that, too, had an impact on healthcare costs. Based on our 2014 health risk assessment, 40% of employees were, on average, getting less than the recommended seven hours of sleep a night, slightly more than the U.S. average of 35%.<sup>12</sup>

Reviewing medical and prescription drug claims data of employees with a prior diagnosis of insomnia or with past prescriptions for sleeping pills, revealed that about one in 10 employees had an insomnia-related claim. This is consistent with trends in the U.S. population overall. On average, these employees

had healthcare expenditures 2.5 times greater than those without an insomnia claim.

Understanding that sleep is fundamental and closely linked to good mental health, we chose to implement a sleep improvement program. The goal was to proactively address mental health among employees, engaging a greater number than were being reached by the EAP. Because sleep does not carry with it the same stigma often associated with mental health conditions, we believed a sleep program offered in the workplace would attract more employees than traditional mental health programs and engage employees who might otherwise not seek help.

After reviewing the workplace sleep improvement programs available in the marketplace, we decided to partner with Big Health, a company cofounded by a leading sleep expert from Oxford University and a former insomnia sufferer. Big Health had created Sleepio, a digital sleep improvement program based on cognitive behavioral therapy (CBT) for insomnia that was validated by clinical evidence. Sleepio is now supported by 24 peer-reviewed papers in the scientific literature, including six randomized controlled trials, demonstrating its effectiveness in improving not only insomnia but also anxiety, depression and overall psychological well-being.<sup>13</sup>

In 2015, we offered Sleepio to our employees, with roughly 30% of the population engaging in the program by completing Sleepio's online sleep test and receiving personalized sleep help. Sixty percent of sleep test completers indicated they were troubled by their sleep, one in five seriously so. Nearly 12% of the population has participated in the full CBT program for insomnia — more than double the level of engagement in EAP during the same period.


## Conclusion

Sleepio has helped participants meaningfully improve their sleep. Participants are falling asleep faster, spending less time awake at night, and, on average, have gained seven hours of sleep a week, leading to significant reductions in the use of over-the-counter and prescription sleeping pills. Improved sleep has also led to a greater than 65% reduction in the number of employees reporting missed work and lost productivity due to poor sleep.

Most exciting is the impact the program has had on participants' mental health. Overall, program participants reported a 74% drop in stress levels, a 56% drop in anxiety symptoms and a 54% decrease in depression based on clinically validated measures.


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# Mental Health and the Disability Mindset: How Employers Can Help Prevent the Spiral

By

**Daniel Jolivet, PhD**

Behavioral Health Director  
The Standard

If you looked online on Oct. 10, 2017, you would have seen a flood of tweets, blog posts, and news articles about World Mental Health Day. These candid posts, written by individuals who have experienced and often overcome a behavioral health condition, showcased how people with a mental illness see themselves.

A common theme among the posts was that people with behavioral health conditions — including depression, anxiety, post-traumatic stress disorder, or substance abuse issues — frequently struggle with feelings of inadequacy and worthlessness. What's more, these individuals noted how they often suffer through their conditions in silence because they fear how others will label them.

While our culture has made great strides in recent years to become more accepting of people with behavioral health conditions, these individuals often face a huge challenge: rejoining or remaining in the workforce.

## The Disability Mindset

One of the biggest issues for these individuals is how employers approach or support an employee experiencing a mental illness, especially someone using

a disability leave for their condition.

Many employers unconsciously assume that an employee with a behavioral health diagnosis won't improve, that a depressed or anxious employee will always be depressed or anxious, for example. The assumption may be "unconscious" but employees can identify it; according to a survey by The Standard, 60% of employees were concerned about losing their job when coming forward about the need for accommodations or disability support. That unconscious assumption is harmful to employees and their success in the workplace, and it puts employers at risk of litigation.

An employee's feelings of shame and inadequacy can spiral into a mindset that's hard to overcome. This "disability mindset" occurs when someone on a disability leave thinks about their abilities in a self-limiting way, which clouds how they envision their future. This mindset can make employees feel that they won't be able to get better and resume their normal predisability life.

This perception has wide-ranging implications. If someone thinks that they'll never be able to rejoin or stay in the workforce because of their condition and that their employer has written them off as permanently disabled, it's easy for them to feel hopeless and stop trying.

Employees with behavioral health issues can and do get better. But it often takes the help of an alert, informed employer. The opportunity for employers lies in supporting an employee with a behavioral health condition and understanding that these employees can contribute to the workplace — just like employees who have a physical health condition.

## Providing Accommodations under the ADAAA

Accommodations are key in creating an environment that helps employees overcome a disability mindset and encouraging stay at work (SAW) or return to work (RTW).

It would be surprising for an employee with cancer to be denied the time to attend their chemotherapy and radiation appointments. But employees with behavioral health diagnoses are often denied the time to attend to their care during work hours (e.g., attend psychiatric appointments or substance abuse recovery meetings) or provided with accommodations (e.g., modified work schedules or a temporary job reassignment). Employers are often less sympathetic toward behavioral health diagnoses because of the cultural perception that an employee just needs to "pull it together" and work through the condition.

However, the Americans with

Disabilities Act Amendments Act (ADAAA) requires employers to provide reasonable accommodations for employees with health issues, including behavioral health conditions. Employers need to be aware that failing to accommodate an employee may not just result in the loss of a qualified employee; it also could result in legal action.

Accommodations can be incredibly helpful in mitigating an employee's behavioral health condition and aiding in SAW or RTW. However, it's important that these accommodations be targeted to an employee's exact situation. Doing this is necessary medically and fits with the ADAAA requirement to engage employees in an interactive process that identifies and implements a reasonable accommodation.

Successful accommodations for an employee with a behavioral health condition are often straightforward in nature. Here are a few examples:

- Flexibility with appointments allows employees to attend treatment through an employee assistance program (EAP), see their doctor, or participate in a substance abuse recovery program.
- Many behavioral health conditions disrupt an employee's natural sleep/wake cycles. A flexible schedule can allow for increased productivity and help reduce errors or accidents.
- Employees with depression or anxiety often struggle with focus and attention to detail. Here, an employer can break down tasks into smaller actions, provide coaching or reviews of work, or move the employee's workstation to a quiet place that allows them to better focus.

In addition, it's important for employers to ensure their policies don't limit or impede an employee's ability to keep working or RTW. For instance, policies that require employees to be



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100% recovered before RTW create the perception that an employer doesn't support an employee's recovery and that an employee with a mental health condition is damaged.

#### Creating a Culture of Acceptance and Support

While being mindful of privacy concerns, there are additional ways to foster a supportive workplace that accepts employees with behavioral health issues:

- Make the most of disability-focused vendor services. A disability carrier or third-party administrator may be able to assist in SAW and RTW support, particularly in terms of setting up a formal RTW program with transitional duty positions. Some vendors have comprehensive disability programs to help identify at-risk employees *before* a disability claim is filed and to help an employer implement accommodations proactively.
- Give employees early reminders of available benefits. For some employees, early assistance can successfully address their condition before it

requires a disability leave. Even before a claim, perhaps while employees are experiencing productivity problems, remind them about benefits available, including an EAP, wellness program, or health concierge services.

- Reach out to employees on a disability leave. We often hear employers say that they don't want to intrude or don't know what to say to an employee who is out on leave. However, regular communication can prevent an employee from becoming isolated and thinking that their employer has written them off entirely. This also maintains an open line of communication for an employer to understand where an employee may be in the recovery process.

#### Integrating Mental Health Accommodation Principles at a Program Level

A state public administration group implemented a SAW/RTW program providing better benefits coordination and communication of available employee resources, accommodations for employees with behavioral health conditions, transitional work support,

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manager training, and efforts to shift the group culture to be more inclusive of people with mental health issues. After four years, the group realized a disability duration of 57 days for behavioral health claims, which was 25 days less than the industry average. We believe this was due in part to the organization integrating this above approach into its workforce.

### Conclusion

Based on our experience, we believe that understanding mental health issues in the workplace and providing accommodation can pay off, especially in terms of an employee's dedication to a company. When employees are helped through difficult times, they usually are more loyal and committed to their company. In addition, this approach demonstrates a company's commitment to its workforce; other employees will notice, too. In the current tight market for key talent, this approach can help retain valued employees and reduce the time and cost associated with recruiting and training new employees.

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# Navigating the Roadblocks of Invisible Disabilities – Teresa’s Story

By  
**Virginia Shutt, MS, CRC, CEAS**  
Vocational Rehabilitation Specialist  
The Guardian Life Insurance Co. of America

According to the National Institute of Mental Health, one in six U.S. adults lives with a mental illness (44.7 million in 2016).

Employers are significantly affected when mental health issues strike an employee, whether that impact is felt first through a health plan or a disability case. While the medical system focuses on diagnosis and treatment, employers often focus on symptoms and how to reduce or eliminate their impact on the employee’s functional abilities. This mental health return-to-work (RTW) process is very similar to the RTW process for other conditions such as musculoskeletal problems, cancer, or digestive disorders.

Recently, Guardian Life worked with an employee who was off work on a long-term disability (LTD) claim due to a mental health condition; we will call her “Teresa Jones” to protect her privacy. I was her vocational counselor and primary service contact. Teresa never expected life to take this turn, but with our help, she navigated the winding road around her symptoms and back to work. She later told us that returning to work was a core part of her progress in wellness.

She had been working over 25 years

at her church’s preschool, serving the past nine years as the preschool director, and she had been dedicated to her job and the needs of the students and their families 24 hours a day, seven days a week. She found immense joy and satisfaction in working with her students, their families, and the church community. She felt quite confident that the work she was doing was good and important. She had grown into her role as director by working at virtually every position in the program, and much of her self-worth was tied into the preschool and her work in it.

In June 2016, she experienced a traumatic event that left her with anxiety and post-traumatic stress disorder (PTSD). While attending a family picnic, she was the sole witness to her brother-in-law’s drowning. She had been powerless to save him, whether by direct action or reaching others to help.

In the days and months following, she experienced flashbacks and feelings of hopelessness, being overwhelmed, and being responsible for the family’s tragedy. For her, these symptoms were debilitating. She was unable to perform activities of daily living such as getting out of bed and preparing for a work day. She ceased working at the job that she loved.

The experience she had with PTSD has played out similarly in the lives of many. It is projected that 7% to 8% of

the American population will develop PTSD at some point in their lives, making this condition one of the most common of the serious mental illnesses.

About 8 million U.S. adults have PTSD during a given year, a small portion of those who have gone through a trauma. Nearly 10% of women develop PTSD sometime in their lives compared with about 4% of men. Among military veterans, PTSD is more common due to the daily exposure to potentially traumatic events. Recent data suggest that 11% to 20% of service members who return home from deployment in Afghanistan and Iraq have PTSD symptoms. PTSD occurs in about 15% of Vietnam veterans and 12% of Gulf War veterans.<sup>1</sup>

For some employers or in some cases, PTSD can be a frustrating diagnosis. But remember that a diagnosis is not a disability. Experiences that generate profound dysfunction and loss of work capacity in one person may have a lighter impact on someone else. When a disability is invisible, with no obvious physical manifestations, many people tend to question if it is there at all. Some employers may assume that when an employee has had performance problems and trust has eroded in the work relationship, the employee is “malingering” or is a “symptom magnifier.”

Teresa Jones' employer did not believe these things about her. She had earned her employer's trust and become the go-to leader of the preschool program. Perhaps that helps explain why this disability scenario continued for months, long enough to generate an LTD claim: her employer was convinced that she was truly debilitated.

She was diagnosed with PTSD earlier in her disability. As we began working with her and she accepted a collaborative relationship focused on helping her return to work, she shared her concerns and fears around this transition. Over time, she was able to verbalize her lack of confidence and worries about her ability to succeed.

Jones expressed difficulties making decisions on her own and starting and finishing tasks. She shared how she was having difficulties in relationships, anxious/fearful thoughts, trouble falling asleep and staying asleep, diminished pleasure, and excessive worry. When the RTW effort began, she could not imagine returning to functionality.

To address her barriers, I provided vocational counseling regarding strategies to address her symptoms and mitigate their impact on her. This vocational counseling was coordinated with her psychological therapist to assist in reinforcing the coping skills that she was learning through therapy. She was also concerned she would not be able to return to work in the same industry or job. Vocational rehabilitation counseling was supplemented by mental health therapy provided by her psychiatrist.

I educated Jones on ways to address her functional limitations in interpersonal skills and work tolerance through consistent and predictable phone appointments and the provision of aptitude and interest testing that highlighted her strengths and gave her opportunities to explore additional

options she had for returning to the workforce. I also provided tips and suggestions for addressing deconditioning and decreased stamina, as well as guidance to assist her in reducing her fears about being unsuccessful in handling stress while attempting to return to work.

In partnership, we set short-term goals for Teresa Jones to complete at the start of her RTW planning. As she completed each short-term goal, we

reviewed her progress to gradually increase her confidence. She could begin to see that each small increment of progress was actually bringing her closer to returning to work.

Teresa Jones learned ways to reduce mental exertion and workplace stress.

Rather than trying to imagine leaping back into her former 24/7 leadership role, she considered RTW increments that seemed more feasible: part-time to full-time ramp-up schedules, changing her role to a less stressful position, looking for jobs that are more predictable, and ways to practice coping skills with phone apps.

I created a strengths-based functional resume and assisted in mock interviewing and job searching. She

was beginning to imagine a work life that might be feasible. I further helped her learn the "do's and don'ts" of disability disclosure: how much of her symptoms to explain to people in asking for support and how much to manage internally using the strategies and

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*"Jones used the tools she learned: her strong aptitudes, setting short-term goals, reminding herself of her successes, using coping skills, and knowing how to address her RTW barriers."*



coping tools she had learned.

Ultimately, through negotiations with her employer, Jones returned to work in a different role (child care attendant) than she had held in March 2017. These negotiations helped her participate in a successful return to work. I continued to stay in contact with her through her transition to employment, providing consistent contact to ensure that her needs were being met.

While participating in RTW services, Jones incorporated the tools she learned — her strong aptitudes, setting short-term goals, reminding herself of her successes, using coping skills, and knowing how to address her RTW barriers — which made her return to work a success.

### Insurance Considerations

In a case like this, the employer plays an understated but crucially important role.

The employer's decision to accommodate this employee — even after well over six months of disability — made this success story possible. In our experience, smaller employers may be more willing to approve extra efforts to retain the skills of key employees. Larger employers are more often driven by corporate policy; some do not accommodate after six months. Typically the employee is terminated, with the potential of returning to work elsewhere before the end of the remaining LTD

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benefit, or transitioning to a Social Security Disability Insurance claim.

In every case, assessing the employee's financial impact and options is an important part of performing a comprehensive assessment and finding an appropriate RTW solution. In some cases, financial disincentives make disability preferable for the person who would experience a lower income from working than from disability.

This was not the case for Teresa Jones. The pay in her new position was only slightly less than the pay in her former position, which virtually eliminated any financial disincentives. This new position came open in time for the accommodation, and as an experienced employee who was now achieving stabil-

ity, she was the natural choice. She didn't regard the new position as a "step down;" it was a positive development to re-affiliate with work and an organization that she valued.

### Conclusion

I called Teresa to follow up with her about a month after her successful return to work. Were things continuing to go well? Did she need any further services? She expressed gratitude and happiness, and spoke of herself as "recovered." Recovery from a significant, temporary disabling mental health episode is possible. Employers can play a key role, through provision of insurance and supporting return-to-work efforts.

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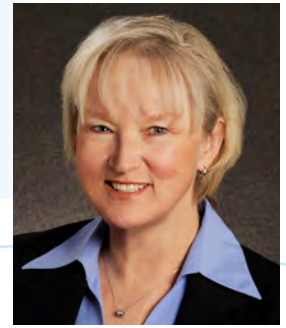
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**Marti Cardi, JD**  
VP Product Compliance  
Matrix Absence Management

# The ADA's Little-Known "Association" Provision

The Americans with Disabilities Act (ADA) provides job protections for employees associated with an individual with a disability — a little-known ADA provision with great potential to cause problems for employers.

The ADA "association" provision protects applicants and employees from discrimination based on their relationship or association with an individual with a known disability. The purpose is to prevent employers from taking adverse actions based on unfounded stereotypes and assumptions about individuals who associate with people who have disabilities.

A family relationship is not required. The association provision extends protection to employees associated with any person with a disability. This could include an employee with a disabled roommate, friend, teammate, client, and so on, plus a disabled family member of any degree — a sibling, parent, spouse, child, grandparent, third cousin twice removed, etc.

### Association Discrimination in Action

Here is how one employer went wrong. New Mexico Orthopaedics Associates (NMOA) terminated a temporary employee and refused to hire her to a full-time position because her 3-year-old daughter had disabilities. The manager texted to the employee immediately prior to a scheduled shift:

- "Look Melissa you have a child whom is medically disabled you do not belong in the workplace or in my clinic at NMO! Go home stay with your daughter that's where you belong not here"

- "Sorry Melissa but life isn't fair sometimes we have no room here for a disability and I will not accommodate to one nor will NMO have a good day"

The Equal Employment Opportunity Commission sued and NMOA accepted the terms of a consent decree: pay the employee \$165,000, conduct ADA training, and meet other settlement terms.

### More Examples of Illegal Association Discrimination

- A business owner refuses to hire an applicant because of fear that the applicant's need to care for his disabled child will cause excess absences.

- A restaurant owner terminates a chef upon learning that the chef's boyfriend is HIV-positive because the owner fears that the chef will transmit the disease to customers and coworkers through food.

- A store owner refuses to promote a part-time salesperson to full time because of his fear she will get breast cancer like her mother and sister have and will be unable to work full time.

- An employer refuses to hire an applicant because he determines that her spouse's disability will increase the

company's health insurance costs.

- An employer hires an applicant whose husband has a disability only on the condition that the employer won't provide health insurance to the applicant.

- A manager treats employees differently by refusing to let an employee take a week of unpaid leave to care for her disabled mother who is in town for medical treatments, but allowing another employee to take a week to attend a father/son camp.

Under the ADA, there is no duty to accommodate an employee who is associated with a disabled person.<sup>1</sup> But in California, such a duty may exist. The definition of "disability" under the state's Fair Employment and Housing Act (FEHA) includes someone who is associated with a person who has a physical or mental disability. At least one California court has held that disability discrimination under FEHA includes failure to accommodate a person associated with a person who has a "disability."

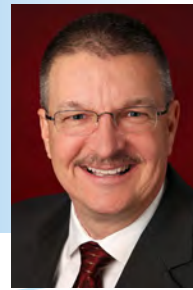
Employers must judge employees on their ability to perform a job and not on stereotypes about "association" with a disabled individual.

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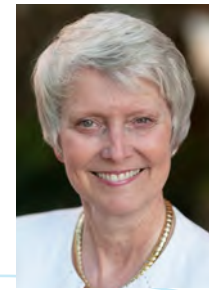
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**Glenn Pransky, MD**  
Scientific Advisor  
Lincoln Financial Group



**David Berube, MD**  
Chief Medical Officer  
Lincoln Financial Group



**Jana Martin, PhD**  
CEO  
The American Insur. Trust

# Workplace Mental Health: Research on Preventing Lost Productivity & Work Disability

Significant mental health illness (MHI) affects almost 20% of employees and costs employers over \$80 billion annually, mostly for lost productivity and absenteeism.<sup>1</sup> Anxiety, depression, and substance abuse are the most common mental diagnoses; together, they account for over 8% of all long-term disability claims.<sup>2</sup> Although treatment may improve mood, behavior, productivity, and absenteeism,<sup>3</sup> and can be cost-effective for employers,<sup>4</sup> studies have shown that many people with MHI don't get proper treatment.<sup>5</sup>

Why does this problem persist? Several factors may be involved. Employees and their family members may not be aware that they have a significant problem or that it's treatable; screening for MHI may not be adequately addressed in primary care.<sup>6</sup> Some workers may be concerned about stigmatization and discrimination at work or in their community. Co-pays for healthcare visits and pharmaceuticals can be daunting, and insurance coverage for therapy may be limited.<sup>7</sup>

Patients often wait a month or more for an appointment with a psychiatrist.<sup>8</sup> Primary care physicians, who have limited training and specialization in MHI, may have to fill in for mental health professionals. Quality of care has been a problem; in one study, only 14% of insured MHI patients received care that met best practice guidelines.<sup>9</sup> Employers are often unsure

about how to help someone with MHI stay at work or return to work, citing concerns about confidentiality, stigma, managing the employee, and accommodations.<sup>10</sup> They may not recognize or address psychosocial and organizational job characteristics that affect work outcomes.<sup>11</sup>

For all these barriers to effective treatment, effective solutions are available. Scientific investigations and consensus recommendations provide evidence that can help employers achieve better results. Studies show that with good health insurance coverage for MHI, workers are much more likely to pursue treatment.<sup>9</sup> Online and in-person resources can educate employees about early recognition and treatment, how mental health professionals can help people cope with life's challenges, and expected results in terms of better function at work and at home.<sup>12</sup> Confidential screening for MHI, in person or by phone, can identify MHI and engage people to initiate treatment early on if linked to the right interventions.<sup>13</sup>

New healthcare delivery options may help as well. Providing psychological services using telecommunication technologies (telepsychology) can be as effective as in-person therapy and may help address the shortage of professionals available for in-person treatment.<sup>14,15</sup> However, positive results will depend on engaging trained, licensed mental health professionals who are adept at using telepsychology.<sup>16</sup>

Regardless of how care is delivered, scientific evidence supports specific treatments that are most effective. Health insurers can have a significant role in ensuring quality and compliance — especially through MHI disease management.<sup>17</sup>

Accommodations for employees with MHI can be challenging, but the basic principles are similar to those for other medical conditions. Having clear policies as well as strong, consistent leadership support for treatment and return to work (RTW) is an important starting point. Employers have generally had success when they offer encouragement, respect confidentiality, inquire about what types of accommodations would be helpful, and engage case managers and RTW coordinators to facilitate communication and the RTW process in a supportive environment.<sup>18</sup> RTW strategies may include modified training and supervision, and gradually increasing hours and work demands.<sup>19</sup>

Effectively addressing MHI is challenging, but material evidence now exists for what works and how to achieve better results. Early recognition, appropriate treatment, and productive accommodations are good for your bottom line and, more importantly, good for your employees.<sup>1</sup>

## References:

All references can be retrieved at this link: <https://drive.google.com/file/d/15ILcylGYCK9oID-NU2HqgSqBtzuxdy6u/view?usp=sharing>

**Bryon Bass**SVP, Disability and Absence Practice & Compliance  
Sedgwick

# Increasing Awareness of the Impact of PTSD in the Workplace

One of the most heartwarming commercials on air today features a veteran at an animal shelter surveying dogs available for adoption. While most of the dogs are playfully vying for attention, he notices one dog with soulful eyes, quietly resting in the corner. He learns the dog had a rough time before arriving at the shelter. The veteran and animal immediately connect, and the scene closes with the two kindred spirits driving down the highway in search of new beginnings.

The commercial spot does an excellent job portraying the impact of post-traumatic stress disorder (PTSD). Veterans returning from combat have frequently confronted the harsh realities and casualties of war. Although identified especially among veterans, PTSD is now a diagnosis in virtually all population groups.

PTSD is most commonly described as a mental disorder that can develop following a person witnessing or experiencing a traumatic event. The condition can lead to feelings of isolation and withdrawal from everyday activities. It can affect a person's memory and negatively impact relationships with others. Normal sights and sounds can trigger an intense emotional response and mentally transport the person back to darker times. As more attention has turned toward the importance and value of

holistic health, PTSD is becoming the focus of more workplace conversations.

Historically, first responders and medical personnel have been monitored and treated for PTSD symptoms. Police officers, firefighters, paramedics, and other first responders routinely come across scenes involving violence, wreckage along interstates and highways, or the horrific devastation of natural disasters or bombings. Medical professionals are also frequently confronted with life-or-death situations in rendering emergency care.

Beyond these high-risk groups, individuals in any profession may have been the victim of an assault, rape, or auto collision and may experience flashbacks or anxiety in the workplace. Recent headlines of school shootings, convenience store robberies, and construction company fatalities underscore the need to address PTSD at the workplace on a much broader basis.

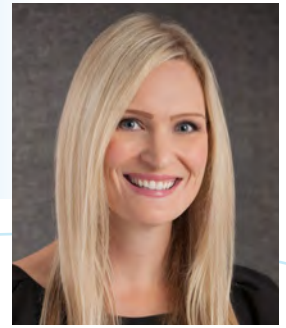
How can employers assist employees suffering PTSD, whether from occupational or nonoccupational sources, and how can they minimize and mitigate its impact on the workplace? First, employers should make mental health resources available as part of their benefits package and employee assistance program. This can include access to mental health professionals and behavioral specialists.

PTSD can be hard to diagnose and may affect individuals differently, severely impacting a person's productivity and posing added risk to the person, coworkers, and customers. It is important to offer assistance and provide help as soon as the need is recognized.

Second, employers can help increase awareness and understanding of PTSD in the workforce. Managers, supervisors, and employees need to know how PTSD might impact them and how to spot potential symptoms among coworkers. They need to know how to access resources and assistance in these instances.

Third, companies can educate workers about self-care techniques and ways to mitigate PTSD. These might include running and exercise, meditation and yoga, or use of therapy animals. Just as the condition manifests differently in individuals, the ways to relieve symptoms also vary.

PTSD warrants increasing awareness and attention. Elevate the conversation in your organization and offer assistance to those in need. Continue to promote the value of mental health resources in the workplace and eliminate stigma associated with mental health conditions. The good news is that effective PTSD treatments are available once the condition is identified.



**Rachel Shaw, JD**  
CEO and Principal  
Shaw HR Consulting

# Psychological Disabilities, the ADA, and the Stressed-Out Worker: Part 1

Work is stressful, but how do you know if mental illness is at the root of your employee's stressful feelings, and what you can do about it? Do your employees need a reasonable accommodation or simply support to learn coping mechanisms to manage their life and work stressors?

Mental disabilities are legitimate and very real. You will have employees with mental illness who need the support of reasonable accommodations to fully and safely do their jobs. Other employees may be managing common life and work stressors and could greatly benefit from a referral to your employee assistance program (EAP). And unfortunately, some employees may claim a mental disability to ease a performance issue.

All three scenarios can be managed using the same key: a process that treats all employees the same to identify the right solution that will mitigate the impact on the work and work environment. So, how do you sort this all out?

Because almost all mental disabilities are covered under the Americans with Disabilities Act (ADA), your organization must engage in an interactive process with the employee to determine if reasonable accommodations are available that, if implemented, would help the employee fully and safely perform their job.

An employer is alerted to start a timely, good-faith interactive process in three ways:

- 1) Request for accommodation
- 2) Perception that an employee has a disability impacting their successful or safe performance of the job
- 3) Knowledge of the disability as evidenced by a healthcare provider note

Once alerted, I employ a process I describe as a hallway. It's a metaphorical hallway with four doors or key process steps, leading to a justifiable decision and best possible outcome for an employee who may or may not need workplace accommodations. Each door serves as a step along the path of ADA compliance:

Door 1: Medical documentation

Door 2: Exploration of accommodation ideas

Door 3: Scheduling and holding a reasonable accommodations meeting

Door 4: Closing the process properly

The process is essentially the same whether a physical or psychological disability is involved, but some variations occur, especially due to the rise of stress-related disabilities.

Employers need to know some basics when engaging with employees who trigger the ADA. First, be quick to refer the employee to your EAP. Second, know that psychological disabilities that

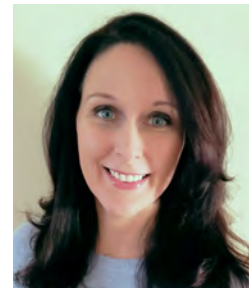
affect an employee's ability to work with a certain person or supervisor are typically not reasonable to accommodate (*Adams v. Alderson*, 723 F. Spp. 1531 [D.D.C. 1989]). Third, accept that these matters will always be complicated; patience will serve you well.

When alerted, get into the hallway and follow due process. You don't always know where the hallway will lead you, but a structured and consistently applied process will ensure you don't under-accommodate those in need or over-accommodate those who may be seeking to misuse ADA protections.

Start by talking with your employee. If the employee is asking for a workplace accommodation due to a disability, go to Door 1 and request more detailed information from a healthcare provider on the employee's psychological limitations at work. That data will then guide you down the hallway to consider accommodations (Door 2) and/or other appropriate next steps: an EAP referral, a leave of absence to support treatment, performance improvement support. When the steps are completed, or if they are not necessary, you may be ready to meet with the employee to develop and implement a reasonable accommodation (Doors 3 and 4).



**Michael Lacroix, PhD**  
Assoc. Medical Director, The  
Hartford Absence & Disability



**Jennifer Platz, LMHC**  
Director, The Hartford  
Absence & Disability

## Tell Me Again Your EAP Does What?

Employee assistance programs (EAPs) trace their origins to the alcohol abuse programs of the 1930s. They were expanded in the 1980s, when cutbacks to public mental health services led some defunded programs to team up with private industry. Employees did not immediately jump on the bandwagon, partly out of concerns with confidentiality as well as a lack of awareness of these programs.

But drug and alcohol abuse are not the only factors that negatively impact employee performance. As EAPs expanded, it became clear that broader behavioral health issues often impacted the workplace: depression, anxiety, and stress. The leading cause of disability worldwide is now depression.<sup>1</sup>

Employees accepted that the walls of confidentiality could hold firm and that the secrets told to EAP providers were not shared with employers. Employers appreciated the value of having employees' problems dealt with outside the human resources/performance management corridor. In many cases, the presenting "diagnoses" were not at clinical levels and could be resolved successfully in three to eight sessions, resulting in happier, more productive employees.

Today, it's not only substance abuse and psychological conditions impacting employee productivity, it's also child care, elder care, and finances. These are not clinical problems but life problems that most of us face; poor sleep is esti-

mated to cost the U.S. economy over \$400 billion per year.<sup>2</sup> Your elderly parent's dementia is not your diagnosis. But it can become a black hole impacting your productivity as you check in, schedule medical and hospice appointments, and take care of other needs; 31% of U.S. employees struggle to manage work and family responsibilities.<sup>3</sup>

You can be caught between your desperate need for a vacation or a new vehicle and the financial demands of two kids in college. And if you can't take that vacation, your stress may morph into distraction that could significantly impact your productivity: four out of five U.S. employees report that financial issues impact their job performance.<sup>4</sup>

Recognizing that many issues impacting employee productivity are simply life problems or work-life balance issues, many EAPs now provide such services as:

- Locating a nanny
- Arranging pet care or lawn care
- Free legal forms and documents
- Discounts on cell phone bills,

cruises, new car purchases, and so forth

EAPs have become resources for living, helping employees balance work, life, and everything in between. Many programs take the stance that whatever issue or needs an employee can verbalize, the EAP can assist. Our internal data show that in 82% of cases, the triggering issue can be resolved in one call, and employee satisfaction is at 94%.

EAP programs are also continually looking for new technologies to meet employee needs more conveniently. In addition to face-to-face and telephonic assistance, many EAPs now offer televideo, Skypeing, and other mobile apps.

In sum, EAPs benefit employees by assisting with work-life balance and help employers maintain a healthy and productive workforce. As the work environment continues to evolve and employee needs change, EAP vendors will evolve still further, meeting the challenges of flexible schedules, teleworkers, and more. Who knows, in the future your EAP program may become more like a personal assistant, managing many aspects of your life.

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**Roberta Etcheverry, CPDM**  
CEO  
Diversified Management Group

# Mental Health Stay-at-Work Strategies

Mental health conditions in the workplace present challenges for both employers and employees. For employees, the effects can be sudden and unpredictable, and the social prejudice and stigma surrounding mental health can leave employees reluctant to ask for assistance. For employers, these “hidden” disabilities are often misunderstood. Given that approximately one in five U.S. adults experiences mental health issues,<sup>1</sup> employers need to develop strategies for supporting ongoing employment.

When employees’ mental health impacts job performance, one challenge for employers and employees is having that first discussion regarding possible accommodations. Adrienne Paler, Sutter Health’s Director of Integrated Disability and Absence Management (IDAM), says that trust can be an issue for employees, who may fear what supervisors and peers will think if they ask for help. Paler’s organization has equipped agents in their human resources contact center with tools to streamline accommodation requests and reduce employee sensitivities or concerns about stigma.

As part of their Workplace Mental Health initiative to eliminate the social prejudice and stigma toward people who have mental health conditions, Sutter Health is developing a curriculum for managers and employees that will be deployed this year. The program

will build competencies around working with employees affected by mental health conditions, including peer-group awareness training, notes Stephanie Walsh, Sutter Health’s Director of Total Health & Productivity Management, Bay Area. Training managers will help dispel myths and misconceptions about mental health and provide guidance on strategies for navigating accommodation requests.

Because the process of accommodation is interactive, engagement with the employee to find collaborative solutions is key. The interaction helps identify the employee’s needs and keeps the employee informed about what the employer can and cannot do to support them, says Paler. Not all employees with mental health conditions are ready or able to return to the same job in the same capacity, so looking at a range of solutions or “pathways” can help support their ongoing employment. The interactive process requires this case-by-case analysis of exactly how an impairment impacts job performance and what specific accommodations may be effective.

An accommodation must ensure employees can work safely, without risk to themselves or others. As a healthcare organization, Sutter must also consider patient safety, adds Paler, which includes a wide range of variables. The accommodations analysis balances the goal of ongoing employment with the

operational needs of the organization. In the end, accommodations are only reasonable if employees can work safely and effectively.

Parallel to accommodations, Sutter also provides other resources to employees to support ongoing employment. Sutter’s IDAM team works closely with their employee assistance program (EAP) and can connect employees to assistance in real time. Distressed employees can obtain immediate psychological telephone support through the EAP.

Another program for employees on leave, WellCare, links IDAM/workers’ compensation with an assigned EAP clinician to help employees manage the stressors inherent in being off work. WellCare partners with employees throughout their leave and further supports their successful return to work.

When a mental health matter co-exists with an on-the-job injury, Sutter works with all care providers to ensure the employee gets needed treatment, says Walsh, and to connect employees with EAP and other support systems.

Paler says this “whole person” approach, which shows the employer’s care and concern for its employees, has produced positive outcomes in any organization where she has implemented it.

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**Matthew Bahl, JD**  
Dir. Health & Productivity Analytics  
Prudential Group Insurance



**Kristin Tugman, PhD**  
VP Health & Productivity Analytics  
Prudential Group Insurance

## The Middle Child Generation: Gen X and Engagement at Work

While a lot of attention is paid to Baby Boomers and Millennials, Generation X (Gen X) may be the most important generation currently in the workplace. In 2015, the first Gen Xers turned 50 and many have ascended or are ascending into key leadership roles at their organization.<sup>1</sup> This means that more organizations are being led by members of the most skeptical generation in the multigenerational workforce.

Gen X's skepticism has roots in the cultural, economic, and social angst of the late 1970s and early 1980s. Gen Xers watched their parents get downsized or laid off during the economic downturn in the 1980s.<sup>2</sup> Gen Xers' skepticism, however, is not just based on historical economic trends. Increasingly, Gen X is bearing the brunt of "sandwich generation" responsibilities. According to the Pew Research Center, almost 48% of Gen Xers are providing financial support to at least one child, with 27% providing full financial support.<sup>3</sup> Gen Xers are also caring for aging parents, balancing increased career obligations with increased family caregiving obligations.

Despite their skepticism (and being chronically overlooked), Gen Xers as a group are known for being savvy, self-reliant, and resilient.<sup>4</sup> As more Gen Xers step into important leadership roles, having a focused employee engagement

strategy for Gen X is paramount. Employee engagement is key to driving important organizational change as well as helping to promote a healthy and productive workforce.<sup>5</sup>

Developing targeted employee engagement strategies and programs for Gen X can help support larger health and productivity goals, and better engage key leaders at your organization. Such strategies might include:

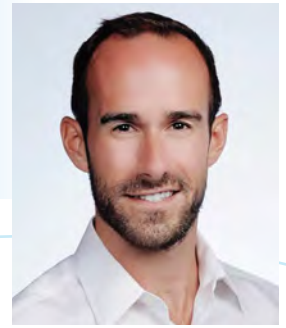
- **Listen To Gen X:** In employee engagement surveys, ask for the age of respondents so you can classify responses by generational group. Use these surveys to identify the specific concerns and opportunities of your Gen X population, and all employee groups, and then implement solutions based on the needs each group expresses.
- **Flexible Work Options to Support "Sandwich Generation" Obligations:** Like Millennials, paid parental leave garners a lot of attention. But for Gen X, flexible leave options to care for aging parents and older dependent children are also important. Developing robust and flexible leave options can help support Gen X and their sandwich generation obligations.
- **Financial Wellness:** 44% of Gen Xers say they are not confident about having enough money for retirement.<sup>4</sup> Financial stress, plus the stress of caring for adult children and aging parents, makes Gen X

particularly vulnerable to unexpected absence and disability related leaves. Incorporating financial wellness into your overall well-being strategy can help better engage this key population and reduce unplanned absences.

Gen X, our generational "middle child," plays a key role in most organizations. Developing and deploying targeted engagement and well-being programs is the key to helping this population stay healthy and productive at work.

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**Geoffrey Simpson**  
Director of Sales & Marketing  
Presagia

# Assessing Exposure to Mental Illness Risk

Mental illness, a common workplace concern, is the leading cause of disability in the United States.<sup>1</sup> Employees dealing with mental illness may find themselves unable to perform and often take leaves of absence to cope. One in five U.S. employees suffers from mental illness, leading to a loss of 217 million work days<sup>1</sup> and up to \$500 billion in productivity annually.<sup>2</sup>

Mental illness can be difficult for employers to identify. Stigma surrounding mental illness may prevent employees from self-identifying, due to fear of losing their job, being isolated by coworkers, or other perceived repercussions.<sup>1</sup> Although laws prevent employers from gathering sensitive health information from employees, data from your leave management effort can help you appropriately target interventions.

Begin by educating yourself on the various factors that drive workplace mental health problems. Stress is a risk factor in any workplace; physical and mental illnesses can develop from extended or excessive stressors.<sup>3</sup> Stress can lead to excessive absences. In the 2017 Mental Health America's Workplace Health Survey, 33% of respondents attributed workplace absences to stress. Key contributors to employee stress include workload, expectations, management, and team relationships.

Another key factor is difficult or frequent interactions with the public; an

analysis of a medical claims database showed higher rates of depression among high-contact workers.<sup>4</sup> Employers can investigate to identify stress, depression, and other risk factors within their organization so they can intervene before these manifest as mental health problems.

Next, establish goals for your investigation. For starters:

1. Identify specific employees who could benefit from targeted interventions, such as a referral to an employee assistance program or health and wellness program.
2. Identify high-risk jobs and business units needing focused interventions, or look for broader management issues that could be driving problems such as stress.
3. Ensure consistent and continuous measurement of your absence data during interventions. Look for improvements and continue to adapt your strategy.

You'll next want to take a look at your data on absences. While you're limited in the specific mental health information you can collect about employees — when certifying a family and medical leave, the employer may only ask the minimum information required to determine that the leave is medically necessary — you can look for patterns of absence, which may allow you to associate certain trends with mental health and then focus interventions. For example:

- Absence days by week or month: Certain times of years such as holidays lead to more stress.
- Absence days by location and job type: Do specific locations or jobs have more absences? Is this due to the nature of the work or other factors, including undue stress or management issues?
- Intermittent leave cases for employees' own serious health conditions (check continuous, too): Which areas of the business units have higher usage volumes?
- Intermittent usage by employee (check continuous, too): Which employees are potentially at risk?

Readily available reports such as these can help connect absence rates and mental health risks. Information is crucial to building an effective mental health strategy that can help your employees stay healthy and reach their full potential.

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**Gary Anderberg, PhD**  
SVP Claim Analytics  
Gallagher Bassett

## The Role of Mental Health and the EAP in Resolving WC Claims

Attitudes are changing about engaging with mental health issues that impact workers' compensation (WC) claims.

Historically, WC adjusters were warned they were “buying a mental claim” if they acknowledged that depression or related issues were delaying a claimant's return to work (RTW). Three new medical codes for psychiatric healthcare, introduced in 2018,<sup>1</sup> are changing that. It is now possible to provide a short course of cognitive behavioral therapy (CBT) or to refer the claimant into the employer's employee assistance program (EAP) counseling service without creating an additional claim exposure for the WC program. You can use this opening to improve RTW and reduce disability durations.

The first step is recognizing when the injured worker is struggling with issues beyond the physical and clinical aspects of the disabling injury. In many cases, claims involving mental/nervous complications are flagged and referred to case management, but not every system filter recognizes certain symptoms, such as missing provider appointments or “attitude” issues. Some carriers and third-party administrators (TPAs) now employ systems to help detect these outlier claims earlier in the claims process. The classic presentation is a general delay in normal clinical progress cou-

pled with the injured worker's non-responsiveness in dealing with the adjuster and/or providers.

What to do? The first question is whether your organization offers an effective EAP and whether the injured worker is eligible for this benefit. Quality EAPs are designed to help employees through various life crises; being off work, often in pain, and confused by WC complexities can certainly qualify as a crisis situation.

Unfortunately, many employers look at their EAP as a purely nonoccupational benefit and never tell the WC adjuster how to refer the injured worker to the EAP when a short course of behavioral therapy may be of the greatest benefit. Note also that in most cases, the EAP services are already paid for through HR. Employers who have integrated EAP with their disability claim management function for both occupational and nonoccupational events have reported better outcomes and better employee satisfaction.<sup>2</sup>

In the absence of a suitable EAP, the WC adjuster now can select from established service vendors offering short courses (one to six visits) of CBT tailored to WC-specific needs and regulations. While a course of CBT does add to medical cost, when appropriately selected, it can help to bring a poten-

tially “runaway” claim back into compliance and a timely resolution.

Why is this important? Many employees who suffer on-the-job injuries were already financially fragile before their injury. According to a 2016 Federal Reserve report, 46% of adults could not produce \$400 cash for an emergency without borrowing or selling possessions.<sup>3</sup> A time-loss injury can push a family budget from “barely making it” to not making it. Meanwhile, the injured worker is in pain, undergoing medical treatments, and dealing with the bewildering world of WC claims. Is it any wonder that some folks don't cope well and slide into noncompliant, outlier status?

CBT, whether through an EAP or a qualified external provider, can make the difference in helping the claimant cope and deal with the stress of a WC claim. Take advantage of the new medical codes to talk with your WC carrier or TPA about using CBT.

### References

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## DMEC Provides Valuable New Tool for Leave Management Program Development

DMEC is proud to offer, for the first time, a rich new resource: the 2017 DMEC Employer Leave Management Survey raw data set.

This unique leave management benchmarking data can help you find opportunities for program improvement and identify potential compliance gaps. It gives you a deep dive into the experience of your professional peers with administration of the Family and Medical Leave Act (FMLA) and the Americans with Disabilities Act (ADA) programs.

The data and detailed comments of more than 1,200 survey participants is included for 74 questions. You can search the Excel worksheet by employer size category, industry, number of loca-

tions, and call center population to locate the experience of companies similar to yours. Or investigate what leave management issues might become important if a merger or a major project impacts your organization. Employer name and personal identity of survey participants are anonymous.

This rich data set includes valuable comments; some participants provide verbal snapshots of their company's response to important compliance or productivity issues. What challenges do your professional peers face, what compliance strategies do they have for:

- tracking bonding leave for continuous, reduced schedule, or intermittent leave;
- handling FMLA rule exceptions for key employees;

- determining qualified serious health conditions of employees;
- ensuring fitness for duty at the end of leave;
- interacting with the ADA and the ADAAA; and
- administering the married couple rule of the FMLA.

And as your peers respond to these challenges, we asked them what tools or resources help them facilitate compliance and program success in their organizations. Their answers can inform your search for the most appropriate leave management strategies and resources for your employee populations and your corporate configuration.

For more details, including pricing, visit <http://dmec.org/resources/surveys/leave-management-survey-raw-data/>.

### Reliance Standard / Matrix ADA Accommodation Data: 2017 Benchmark Analysis

Drawing from a sample size larger than the inaugural benchmark analysis, this statistical analysis is based on a review of more than 6,966 accommodation requests collected over a period of 12 months from employers representing a universe of 185,000 employees.

Contact your local Reliance Standard Sales or Account Management Professional for a copy!

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## DMEC Webinars Break New Ground for Regional Leave Management Updates

Keeping your professional knowledge up to date is an important component of DMEC's mission. This fall, we are excited to announce that the DMEC Tools & Tactics webinars will deliver important state-specific compliance updates.

### Regional Leave Law Webinars

Increasingly, new laws that employers must comply with are driven by legislation at the local level of states, counties, and municipalities. These could be expansions or additions to provisions of the federal Family and Medical Leave Act (FMLA), the Americans with Disabilities Act (ADA) protections, or state workers' compensation (WC) system reforms.

To address this complex patchwork of leave laws, we will host four regional sessions in October and November focusing on legislative updates, major circuit court rulings, and major changes to WC law in the four regions below.

- **Northeast:** ME, NH, VT, MA, RI, CT, NY, PA, NJ, DE
- **South:** VA, WV, NC, SC, GA, FL, MS, AL, TX, LA, MD, DC
- **Midwest:** WI, MI, IL, IN, OH, MO, AR, ND, SD, NE, MN, IA, KY, TN
- **West:** HI, AK, WA, OR, CA, ID, MT, WY, NV, UT, CO, AZ, NM, KS, OK

### *Tool in Court continued from p. 18*

#### Conclusion

A framework that meets current psychological standards of care can and must be used in treatment and litigation. It is important to stay abreast of these standards and to apply them consistently to assess each WC psychological claim based on its own specific set of facts and documentation.

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These regional webinars also will cover significant legal rulings by circuit courts that have a tremendous influence on particular states. One such striking example is the *Severson v. Heartland Woodcraft, Inc.* case. The 7th Circuit U.S. Court of Appeals held that a leave of absence of two months or more is not a reasonable accommodation under the ADA. Currently, *Severson* applies only in the Midwest states of the 7th Circuit: Illinois, Indiana, and Wisconsin. Yet on April 2, the U.S. Supreme Court declined to review the *Severson* case, opening the door to legal challenges to multi-month leave accommodations in other circuits as well.

All four webinars will qualify for continuing education credits (CEUs). Watch the webinar calendar at [www.dmec.org/calendar-of-events](http://www.dmec.org/calendar-of-events) for more information.



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