HAPS Health and Productivity Sciences, Inc.

White Paper
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Employee Mental Health and Well-being Strategy

It is hard to find an executive, manager, or employee who has not encountered someone at work or home with a mental health problem. Most often, the person has anxiety, or both.

Depression and anxiety are common mental disorders that can last for months or years. In the workplace, depression and anxiety are associated with presenteeism, absenteeism, work disengagement, job turnover, job loss, and career stagnation, which threaten the economic security and quality of life of employees and their families. Employers also pay a steep price (Hasin, 2018). In 2019 alone, productivity loss due to depression cost an estimated $198.6 billion of its total cost of $382 billion (Greenberg, 2023). Depression also added an estimated $127.3 billion in incremental medical care costs (Greenberg, 2023).

Frequently, employees with common mental disorders also develop functional limitations in carrying out work tasks and work-related activities (e.g., commuting). A portion will also develop a work disability. We developed the Work Limitations Questionnaire (WLQ©) as a tool to understand how health problems were impacting employee job performance and productivity (Lerner, 2001; Lerner, 2003). The average employee with clinically-diagnosed depression experiences functional limitations affecting their work 20 to almost 50% of the time in a two-week period (Table 1); (Lerner, 2021). These are limitations in time management, performing physical, cognitive, and interpersonal job tasks, and maintaining work output (e.g., quantity, quality, and timeliness). The average depressed employee misses the equivalent of one to two workdays in two weeks.

Table 1. Presenteeism and Absenteeism Among Employees with Clinical Depression from Workplace Studies: Means (Standard Deviations)

EMPLOYERS	Global Security Firm (US only)	Health Plan Group Customers and Individual Employers	VA Medical Center Employed Patients	State Government Employer #1	State Government Employer #2	Academic Medical Center Employer
PRESENTEEISM WLQ Scores						
% At-work Productivity Loss Past 2 Weeks	9.7 (4.3)	10.3 (4.4)	12.3 (4.7)	10.2 (4.1)	9.3 (4.5)	10.8 (4.1)
% of Time with At-work Limitations, WLQ Scale Scores						
Time Management	45.3 (23.3)	42.7 (22.0)	52.0 (23.5)	44.9 (19.7)	41.0 (22.6)	48.7 (20.2)
Physical Job Tasks	15.4 (17.4)	22.3 (20.2)	41.3 (24.7)	21.5 (21.5)	26.0 (24.1)	21.1 (17.0)
Mental-Interpersonal Job Tasks	35.3 (16.3)	38.1 (17.3)	46.8 (21.4)	37.7 (15.3)	32.4 (17.8)	39.0 (15.4)
Output Tasks	39.1 (22.2)	42.3 (23.5)	46.1 (24.3)	40.1 (22.9)	36.2 (23.2)	39.5 (24.2)
ABSENTEEISM WLQ Time Loss Module						
Absence Days Past 2 Weeks	2.7 (1.2)	1.6 (2.2)	1.8 (2.4)	1.5 (1.6)	2.0 (2.1)	1.12 (1.9)
% Productivity Loss Due to Absence	25.9 (12.8)	14.6 (18.8)	18.6 (22.4)	15.0 (14.6)	21.3 (22.5)	–

This human and economic toll on employees and employers is unnecessary and can be reduced with a workplace mental health strategy that gives greater priority to helping people with common mental disorders make the transition from being a patient to being a capable and engaged employee. Currently, our health care system chiefly offers a clinical care model that fails to adequately address work limitations or focus on achieving this transition.

In this white paper, we discuss mental health and the nation's labor supply, the reasons why (despite efforts to improve care access, quality, and affordability), the prevailing employer mental health and well-being strategy is not having a sufficient impact on employee and business outcomes, and what employers can do to change course without creating an entirely new service system.

Common Mental Disorders and their Care

Many employers and policymakers first began to take notice of the widespread impact of common mental disorders during the pandemic when self-reported depression and anxiety symptoms in the United States (US) rose from 36% to almost 40% of adults. Some population subgroups experienced rates that were notably higher (Czeisler, 2020; Goodwin, 2022). Of grave concern to many employers were reports from several employee surveys, which found similarly high rates of self-reported depression, anxiety, stress, and burnout (Gallup, 2023; Lyra, 2024).

Though pandemic-era rates of common mental disorders have receded as the global health crisis has waned, common mental disorders continue to represent an unrelenting health threat. Historically, major depression and anxiety disorders have been among the most prevalent of all adult health problems, occurring in approximately 9% and 19% of Americans each year, respectively (Substance Abuse and Mental Health Services Administration, 2023; Harvard Medical School, 2007). Depression and anxiety were common among employees long before 2020 (Kessler, 2022; Penninx, 2022), and their extensive and expensive workplace consequences were already known (Lerner, 2017; Chokka, 2023). Importantly, according to a series of studies, depression and anxiety rates were on an uphill trajectory years before the pandemic began (Goodwin, 2022).

While we do not know why the relatively high rates of depression and anxiety persist and appear to be climbing, studies focusing on the pandemic years offer provocative examples of the influence of psychosocial stressors. Studies have found that most of the people with mental health problems during the pandemic did not have COVID-19, which suggests that the virus itself was not a root cause (Czeisler, 2021). Though research on long COVID suggests that the virus is associated with certain mood and cognitive difficulties, a sizeable portion of the growth in pandemic-era mental health problems is thought to be related to exposure to psychosocial stressors.

Rates of self-reported depression and anxiety symptoms rose to almost 40%

By now, many of these stressors-social isolation and loneliness, unexpected or rapid changes in family routines (especially around schooling and childcare), and the illness, hospitalization, and/or death of loved ones-are well known. In the work domain, common stressors included the loss of work hours and income, leading to economic instability and insecurity, threatened or actual business closures, new work routines such as working from home, work-family conflicts, and occupationally-related job demands and safety concerns (especially among front-line workers).

To some employers, the workplace mental health implications of stressors may seem like old news and now that the pandemic has ended their importance may fade into the background of mental health priorities. However, work stressors remain a significant threat to employee mental health and well-being and to the employers' ability to attract and retain workers.

Studies find that pressures on workers are growing; a scenario that will pose greater risks to the physical and mental health of the labor supply and result in more significant economic pressures on companies (US Surgeon General, 2022). Research also indicates that work stressors have become a mainstream concern for working people. This concern is reflected in their attitudes towards work, in the value they place on work relative to other parts of their lives, and in making important work and career decisions. A large survey of human resources professionals reported that mental health and well- being have emerged as top concerns for workers when making job and career decisions (SHRM, 2023). Large employee surveys report that worker disengagement and employee concerns about work stress are at an all-time high (Gallup, 2023; Lyra, 2024).

Transitioning from Patients to Employees

Care that directly addresses employee work limitations and work challenges related to common mental disorders is a missing piece of mental health and well-being strategy. A key reason is that a clinical model of assessment and intervention, which does not prioritize work performance, is standard in the health care system.

Clinical care is essential for diagnosing and treating depression and anxiety. Still, its primary goal is to reduce symptoms such as negative mood and loss of interest in usual activities, and to prevent illness recurrences. Treatment usually involves medication, psychotherapy, and/or other counseling techniques. Improvements in job performance, productivity, and engagement are considered important but secondary goals. Work performance is rarely given much attention except in severe or highly complex cases, where care providers may encourage the employed patient to formally request a work accommodation or sick leave. For most employed patients, there will be little discussion of work, let alone intervention (Chokka, 2023).

Many work challenges do not fit neatly into the symptom framework (Sidebar 1). From the clinical perspective, work challenges are assumed to be resolved by effectively delivering clinical care. It is common clinical practice to give medication a chance to work before delving into "non-medical" issues such as those involving employment or family relationships. However, it makes little sense to wait until symptoms are under control. Even in the unlikely scenario where employees quickly obtain high-quality care and have excellent medication adherence, the clinical treatment process does not necessarily provide quick symptom relief. Anti-depressants take an average of six weeks to begin to produce symptom relief. Six months after treatment initiation, between 40 and 50% of patients have a response (i.e., a 50% decrease in symptoms), 30% attain full remission, and 30% do not respond to treatment and require additional intervention. Thus, after six months of treatment, as many as 40% of patients are left with incomplete or no relief.

Sidebar 1

Frequently Reported Work Challenges

- Easily distracted from work tasks
- Difficulty thinking deeply or maintaining concentration
- Diminished ability to problem-solve
- Unable to organize work, especially high-volume work
- Lacking energy to get through the workday
- Feeling isolated and disconnected from coworkers
- Feeling unfairly treated by managers
- Unable to support the organization's mission, goals, and/or leadership
- Feeling voiceless or unimportant
- Feeling contributions are devalued
- Perceiving effort and work as meaningless

Many employers have been struggling for years to improve mental health care, including problems related to its access, quality, and affordability; problems further aggravated by the pandemic. Fortunately, during the pandemic and since then, employers have continued and, in some cases, increased their investments in mental health care and well-being services (Sidebar 2). These investments have had an impact on the structure of care including, mainly, the introduction of technology and insurance coverage to facilitate remote access to primary and specialty mental health care. However, there has been little substantive change in the actual content of care.

Employee-centered Care

In our extensive research conducted with approximately 35 US companies, we have found that employees with common mental disorders frequently demonstrate patterns of thinking, feeling, and behaving in work roles that interfere with work efficiency, effectiveness, and satisfaction. Employees may lose the insight necessary to evaluate routine work situations, and will benefit from learning new coping skills and tapping into resources, when available, such as job control and social supports. Evidence suggests that a comprehensive workplace intervention is one that supports both clinical care and employee-centered care.

Employee-centered care has three features.

1. It assesses the nature of and extent to which employees are having difficulty with work functioning.
2. It identifies potential sources of this difficulty including the employee's health and medical treatment, coping skills and resources, and characteristics of the person's job and workplace.
3. It applies fit-for-purpose solutions for the employee and the work organization.

Employee-centered care is different from job coaching. The new model incorporates a systematic, tailored approach to assessing work challenges related to common mental disorders, the job, and the workplace, and applies a multi-dimensional protocol-driven approach to improving functional performance and the person-environment fit. Coaching usually emphasizes intra-personal approaches to problem-solving such as meditation and mindfulness to deal with work stress (Table 2).

Evidence suggests that a comprehensive workplace intervention is one that supports both clinical and employee-centered care

Sidebar 2

Employee Health Benefits Trends During and Soon After the Pandemic

- Employee health benefits and employee contributions overall generally were maintained at pre-pandemic levels or were increased (Claxton, 2021)
- Telehealth coverage for mental health care was expanded (Fischer, 2021)
- Spending on digital mental health care increased (Business Group on Health, 2023)
- Large and mid-sized companies offered new programming such as stress management, sleep hygiene, financial counselling, and/or resiliency programs, and to a lesser degree expanded leave options and benefits (Business Group on Health, 2021)
- The number of companies initiating or expanding contracts with Employee Assistance Programs (EAPs) increased mainly among smaller employers and remained high in the saturated mid-sized and large employer sectors (Attridge, 2022)
- More companies adopted care navigation platforms to identify and provide additional services to high-cost patients (Claxton, 2023)

Table 2. Comparison of Care Models

	CLINICAL CARE	EMPLOYEE-CENTERED CARE
Care Client	■ Patient	■ Employee
Targeted Problems	■ Symptoms (e.g., mood, fatigue, nervousness, agitation)	■ Diminished ability to perform job tasks, missed work time, low productivity, disengagement with work
Problem Assessments	■ Symptoms and symptom severity	■ Functional performance, time loss, work productivity, disengagement with work
Interventions	■ Psychoeducation ■ Prescribed medications ■ Psychotherapy ■ Work accommodations in severe, complex cases ■ Coordination of primary and speciality care	■ Counseling to change counter-productive thoughts, feelings, and behaviors ■ Identification of stressors at work and at home ■ Tailored strategies to modify coping with stressors and barriers to functioning, identify ineffective work behaviors and substitute others ■ Motivational activation to access workplace supports and resources ■ Coordination with the clinical care treatment process
Duration of Treatment	■ Highly variable: depending on modality between 6-12 months	■ 16 weeks (bi-weekly contacts)
Time to Results	■ 16-26 weeks	■ 16 weeks
Key Outcomes	■ Reduced symptom severity, remission, or relapse	■ Recovered work functioning, reduced work time lost, and work re-engagement

The Evidence

We have found that employees recover their ability to function effectively at work more quickly and completely with employee-centered care (Lerner, 2021). With funding from federal research agencies and private and public sector employers, approximately 30,000 employees have completed a brief, confidential online mental health and functional performance screening tool, and more than 1,000 employees have enrolled in randomized trials or observational studies comparing usual care to our new care model, Be Well@Work Employee-centered Care©. A documented evidence base supports the program's ability to achieve both statistically significant and clinically meaningful impacts on employee mental health, presenteeism, absenteeism, and work productivity. In six studies, documented in fourteen peer-reviewed journals, employee-centered care, with or without usual care, outperformed usual care.

- Depression symptom severity declined by 30-50% (4-11 points) from a baseline depression score of 12-17 (PHQ-9 scale 0-27)
- Work productivity loss from presenteeism improved by 2-6 points (WLQ Productivity Loss score range 0-33), from a baseline productivity loss of 9-12%
- A 6-point improvement in the percentage of productivity lost is a one-year productivity gain of $6,000 for an employee earning $100,000 annually
- Averaged across a company of 10,000 employees with 10% depression prevalence, this would be equivalent to a gain of $6 million in one year

Employee-centered care delivered a realistic 5:1 return-on-investment

By focusing directly on improving work functioning, employee-centered care delivered a realistic 5:1 return-on-investment. (Lerner, 2021). This care model does not require a new vendor or system, so the lead-time to implementation is relatively brief. Existing providers in primary care, outpatient health care clinics, behavioral health programs, wellness programs, and EAPs can be trained in a matter of weeks to deliver the care and supervise other care providers. Also, because it is delivered by telehealth technology, it is reimbursable under current arrangements or can be adapted for existing contracts.

Conclusion

The future of work depends on having a mentally-healthy workforce. Achieving this goal will depend on adopting a new vision of care and its purpose. Current workplace mental health strategy is leaving millions of employees with common and debilitating mental health problems without the help they need and want, and preventing employers from obtaining adequate value from their mental health and workforce investments. Making employee-centered care an integral part of workplace mental health and well-being strategy offers a timely and practical solution to what has been seen as a seemingly intractable problem.

Case Example

I got depressed about two years ago. I had just turned 45, had become the Director of Marketing for a medium-sized company after working hard for most of my career, and I think the stress just overwhelmed me.

I would find myself at my desk, with a To Do List a million items long, and I just couldn't make myself start even the most straightforward thing. One day I totally spaced on a meeting with our CEO, and I knew I had to do something. I have a good relationship with my primary care doctor, so I went to see her and she diagnosed me with depression and started me on an antidepressant medication. She said the medications wouldn't work right away but, not to worry, they could be increased, which they were at my follow-up meeting a few weeks later.

Meanwhile, it was still awful at work. I really did believe in the company I was working for, but I just could not concentrate; everything took longer than usual. My mind kept wandering when I was talking to people on the phone, my inbox felt like a mountain to climb every day, and really, I was unable to do my job. I started taking days off from work and sometimes coming in late, which is so not me. For a while, it felt like I was just waiting for the meds to kick in, but during that time I was really disengaged at work, which just made me feel worse.

Six months later, I was back to square one. There was a lot going on at work. We were in the middle of a management reorganization and of course that was the moment when my teenager started having problems with friends, and I started to get depressed again. I'm actually really good at helping my kid, but I just could not keep up with the changes at work and rather than responding the way I usually would, by trying to help support the new systems, I felt so disconnected. It was bad.

My company offered me the Be Well@Work program, so I enrolled in that and began working with my telehealth counselor. It worked with my schedule and I knew my company must think highly of it, since they offered it. What a difference it made for me, compared to the last time I had gotten depressed! In the past, no one ever thought to ask about how my depression impacted my job, where I spend almost 50 hours a week and which is such a huge part of my life. At each Be Well@Work session, we focused on a specific problem I was having at work. We worked through a manual I was given, that gave me tips and assignments in between sessions, which were so helpful. It didn't feel like the therapy that I've had in the past; it was so clearly designed to help me get back on track.

About Health and Productivity Sciences, Inc.

- C Corp startup established in 2014
- Founded by Debra Lerner, David Adler and Paul Summergrad, Senior Scientists and Clinicians from Tufts Medical Center and Tufts University School of Medicine
- Exclusive, global licensee of IP from Tufts Medical Center, Boston MA
- Business-to-business model offering ready for market and pipeline products including the Be Well@ Work Employee-centered Care implementation system

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