

Building the Mentally Healthy Workplace



A Strategic Plan for Improving Employer Mental Health Practices



Mental Health America of Wisconsin



September 2012

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**Wisconsin
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Academic Partner

Dr. Jerry Halverson

Our community partners

The Alliance, the Business Healthcare Group, Wisconsin United for Mental Health



Business Health Care Group

Driving Meaningful Change

THE ALLIANCE 
Employers moving health care forward

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for MENTAL HEALTH



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Section 1 Introduction

Employers understand the impact of mental disorders on their employees, family members of employees and their workplaces. And many want to do something about it. But even those employers who are highly motivated to address this issue are at a loss for what to do.

Until now.

Through an eighteen-month development grant awarded by the Wisconsin Partnership Program at the University of Wisconsin School of Medicine and Public Health, Mental Health America of Wisconsin and its partners have created a strategic plan that incorporates the recommendations of employers for building the mentally-healthy workplace.

The plan, which is outlined in detail in Section 3, is simple and based on refining and piloting two interventions for the workplace:

- Training for supervisors and managers on understanding mental disorders and responding to employees who may be experiencing these; and,
- Education for employees to reduce stigma, increase understanding of mental disorders and facilitate help-seeking.

The plan identifies additional resources to support employers and employees and ideas about outreach and engagement of additional partners. But at its core, it creates a feasible model for implementing these interventions and conducting a robust evaluation of their impact along a variety of dimensions.

The Business Case for Workplace Mental Health

Mental health issues have a significant impact on the workplace. The following data reported by the National Business Group on Health in their Employer Guide to Behavioral Health Services¹ (along with others sources, as noted) outlines the scope of the issue:

- In 2001, mental health and substance abuse treatment costs totaled \$104 billion and represented 7.6% of total healthcare spending in the United States. Depression alone cost employers an estimated \$44 billion in lost productivity.²

¹ Finch RA. Phillips K. Center for Prevention and Health Services. An Employer's Guide to Behavioral Health Services: A Roadmap and Recommendations for Evaluating, Designing, and Implementing Behavioral Health Services. Washington, DC: National Business Group on Health; 2005.

² Marlowe, J.B. (2002). Depression's surprising toll on employee productivity. Employee Benefits Journal. March, 16-20.

- Mental illness causes more days of work loss and work impairment than many other chronic conditions such as diabetes, asthma, and arthritis. Approximately 217 million days of work are lost annually due to productivity decline related to mental illness and substance abuse disorders, costing United States employers \$17 billion each year.
- Mental illness and substance abuse disorders, combined as a group, are the fifth leading cause of short-term disability and the third leading cause of long-term disability for employers in the United States. A Watson Wyatt survey found that fifty-three percent of employers reported that return to work is more difficult for employees following an absence for a psychiatric disability than after an absence for a general medical disability.³
- Research has shown that individuals with chronic medical conditions and untreated co-morbid mental illness or substance abuse disorders are the most complicated and costly cases. For example: healthcare use and healthcare costs are up to twice as high among diabetes and heart disease patients with co-morbid depression, compared to those without depression, even when accounting for other factors such as age, gender, and other illnesses.

A more detailed discussion of the business case can be found in these documents:

Business Case for Mental Health and Substance Use Disorder Treatment: A Literature Review

There is a compelling business case for effective treatment of mental health and substance use disorders. Access to quality mental health/addiction care - sometimes called behavioral health care - is essential because of the high prevalence of these conditions in the workplace and their impact on other health care costs and the corporate bottom line when left untreated.⁴

A Mentally Healthy Workforce - It's Good for Business

Most employers know that a mentally healthy workforce is linked to lower medical costs. What employers may not know is how to get from A to B: How does a company change a mentally unhealthy workplace into a healthy workplace? The Partnership provides some insight into that question with this publication.⁵

The Partners

Critical to creating this strategic plan was a partnership that bridged mental health advocates and professionals, the business community and the academic setting.

³ Watson Wyatt Worldwide. (1998). Staying at Work Survey, 1998. Alexandria, VA: Available from: www.watsonwyatt.com/publications

⁴ Partnership for Workplace Mental Health: <http://workplacementalhealth.org/Business-Case/Business-Case-for-Mental-Health-and-Substance-Use-Disorder-Treatment.aspx?FT=.pdf>

⁵ Partnership for Workplace Mental Health: <http://workplacementalhealth.org/Business-Case/The-Business-Case-Brochure.aspx?FT=.pdf>

Mental Health America of Wisconsin (MHA) is dedicated to promoting mental health, preventing mental illness and substance use disorders and achieving victory over mental illnesses and addictions through advocacy, education, information and service. It has provided information, education and advocacy around mental health issues since 1930. MHA has operated its own workplace outreach program—Healthy Mind Connection—since 2002. MHA is part of a national organization, Mental Health America, which also has a commitment to workplace mental health; they have created an educational presentation on workplace mental health called FundaMental Health. MHA is a founding member of Wisconsin United for Mental Health.

Wisconsin United for Mental Health (WUMH) is a public-private partnership that has been working since 2002 to respond to one of the objectives in Wisconsin's 2010 health plan: the reduction of stigma surrounding mental illnesses. With leadership from the Departments of Health Services and Workforce Development, involvement of other state agencies and partnerships with various mental health consumer, family, advocacy and provider agencies, WUMH has addressed stigma reduction through public education, creation of training and curricula, and dissemination of accurate information about mental illnesses through its website and to a wide variety of partners. The efforts that WUMH has been engaged in since 2003 around mental health in the workplace laid the foundation for the development grant application.

The Alliance is an employer-owned, not-for-profit cooperative moving health care forward by controlling costs, improving quality and engaging individuals in their health. Their 160 members are employers that self-fund their health benefits and control their health plan design. They are generally in the 100 to 1,000 employee range and most offer some form of a wellness program. These employer groups provide coverage to more than 83,000 individuals in southern Wisconsin and neighboring counties in Iowa and Illinois. Their primary service area spans 14 counties in Wisconsin: Adams, Columbia, Dane, Dodge, Grant, Green, Jefferson, Iowa, Juneau, Lafayette, Richland, Rock, Sauk and Walworth.

The Business Health Care Group (BHCG) is a membership organization of more than 1,100 employers and employer groups in an 11-county region of southeast Wisconsin. The BHCG was formed by a group of chief executive officers of area employers who had a common interest in reducing health care costs in southeast Wisconsin while continuing to offer quality care and reasonable health benefits for their employees. Both The Alliance and the BHCG have been actively engaged in educating their members about behavioral health issues over the past few years and understand the impact that mental health disorders have on businesses.

Dr. Jerry Halverson, is a psychiatrist with affiliation at the UW-Madison School of Medicine and Public Health and a staff member of Rogers Hospital in Oconomowoc. Dr. Halverson received his M.D. and his psychiatric specialty training at the University of Wisconsin, where he subsequently served in the Department of Psychiatry. Dr. Halverson clinical experience inform his understanding of how mental health issues can present themselves in the workplace and which employer practices are or are not helpful to persons with a mental illness. Dr. Halverson serves on various boards and committees through the Wisconsin Medical Society and the Wisconsin Hospital Association.

The project *Advisory Board* is identified in Attachment 1. Individually and collectively they contributed a great deal of knowledge and wisdom to the implementation of the grant and development of the plan.

MHA also contracted with Ady Voldedge consulting firm to assist with development of the survey, key informant interviews and focus groups and with the Wisconsin Women's Health Foundation for conducting the focus groups. Dr. William McGill, a subcontractor with Ady Voldedge, conducted the literature review of workplace mental health metrics and created the evaluation model.

Section 2

The Development Grant Findings

The goal of the development grant is described in the following excerpt from the grant application (see the Executive Summary of the grant application in Attachment 2):

Mental health disorders are a major cause of work loss through absenteeism and reduced productivity on the job, are a major driver of disability claims and can increase morbidity and health care costs for individuals with other chronic health conditions like diabetes and asthma. An employer survey conducted by the Wisconsin United for Mental Health (WUMH) found that most employers understood the significant impact of mental health disorders on their employees and in their workplaces, but there was a gap between this understanding and the implementation of best practices in workplace mental health. The goal of this project is to better understand why this gap exists and develop a strategic plan to address it.

Up to this point WUMH had been creating products and trainings that attracted employer interest but did not result in changes to employer behavior. By engaging more fully with employers we hoped to better understand their perspective, the challenges and barriers they faced in addressing these disorders, and what policies or practices that they viewed as potentially the most helpful to them and their employees.

The development grant had three primary interventions:

- A survey of employer members of The Alliance and the Business Health Care Group (BHCG) about their current mental health practices and attitudes about mental health in the workplace;
- Key informant interviews with selected employer representatives who had identified themselves as interested in participating when they responded to the survey; and
- Two focus groups of individuals who had identified themselves as interested in participating when they responded to the survey; one of employer members of The Alliance and one of employer members of the BHCG.

These three steps were designed to help us systematically hone in on the key elements for a strategic plan. Following each step findings were brought to the Advisory Board for review and comment, helping to shape the specific questions to be addressed in the next phase of the study.

The Survey

The employer survey was disseminated to members of The Alliance and the BHCG. 155 surveys were completed. The survey results and summary of key highlights can be found in Attachments 3a and 3b (note that in Attachment 3b the questions in parentheses were posed for comment by our Advisory Board when they reviewed the survey results). By design this survey incorporated a number of the

questions in the WUMH survey referenced in the executive summary for the grant referenced above. This allowed us to understand the generalizability of the findings from that earlier survey, which consisted of a convenience sample of those employers who took part in WUMH-sponsored symposia. Despite the fact that the employers surveyed for the development grant did not have the exposure to information provided during these symposia, the findings were quite similar. Importantly, the survey done for this grant also found a significant gap between the degree to which employers understood mental health disorders to impact their workplaces and the degree to which they were prepared to address these disorders.

Other key findings:

- Despite the fact that this survey occurred after implementation of required parity coverage for mental health and substance abuse disorders a significant percentage of employers indicated that these services were not offered at parity. Self-insured plans are not mandated to offer behavioral health benefits, but if they offer them they must be at parity.
- More than 50% of respondents indicated that they cover depression screening as part of a primary care visit.
- While most employers offer Employee Assistance Programs (EAPs) there is a sense that what is provided is fairly minimal and that even that is underutilized. This was viewed to be significant in that EAPs are positioned to provide some of the employee education and support that would address mental health disorders.

The Key Informant Interviews

Four key informant interviews were held. A summary of these interviews can be found in Attachment 4.

Key findings from these interviews included:

- For the most part employers don't measure or have a way of measuring the impact of mental disorders. They believe that absenteeism may be related to mental health disorders and some may look at these numbers.
- Key barriers to addressing mental health in the workplace were identified as stigma, employee distrust of management and privacy concerns related to information sharing.
- To the degree that manager training is made available it often does not cover mental health issues.

Focus Groups

The focus groups allowed us to explore in more depth some of the issues that emerged from the survey and key informant interviews. In particular the focus groups explored the following:

- Whether and how employers measure the impact of mental disorders.

- Whether employers have an understanding of the sorts of things they might be able to do in their workplace to address mental health issues.
- The sort of supervisor training offered around mental health issues.

Focus group members were also provided copies of the Wisconsin Worksite Wellness Resource Kit mental health pages (see Attachment 7), which represent a set of benchmarks for workplace mental health interventions. This was also utilized by focus group participants to identify interventions that they are or are not doing and ones they would be interested in implementing (see summary of scoring sheets in Attachment 5).

Finally, focus groups members had an opportunity to view selections from Mental Health @ Work: A Practical Guide for Supervisors, Managers and Leaders (see Attachment 6). This 45 minutes narrated Powerpoint presentation had been developed by WUMH to address the perceived need for supervisor and manager training.

Key findings from the focus groups included:

- Mental health issues do manifest themselves in the workplace and employers have a responsibility to respond to them.
- Stigma remains a significant issue in terms of how supervisors and other employees respond.
- Employers recognize their responsibility to identify and make available resources for individuals who may be experiencing mental disorders.
- Employers often feel constrained by the legal issues surrounding privacy, confidentiality and potential discrimination concerns related to the Health Insurance Portability and Accountability Act (HIPAA) and the Americans with Disabilities Act (ADA). Legal departments may dictate what a supervisor or manager can or cannot do.
- Larger employers may look at health claims, disability claims, EAP utilization or other data to try to understand the impact of mental health disorders, but they often do not have a clear sense of what to make of the data they have.
- Employers generally were not familiar with the Worksite Wellness Resource Kit or benchmarks for implementing mental health interventions.
- Most employers responded favorably to the supervisor/manager training but offered a variety of suggestions for improving it to make it more useful in their work settings. These included:
 - Creating shorter, stand-alone modules on the various topics covered in the training so they could fit more easily into typical training opportunities.
 - Incorporating video in order to show managers what to do, not just tell them.
 - Creating modules that reflect the different environment in a manufacturing worksite as opposed to a professional worksite.

Mental Health Metrics

Following the completion of the three planned phases of the development grant we recognized that a key factor that we needed to address moving forward was the question of measuring the impact of mental health conditions on the worksite. This would be critical in any type of evaluation of the impact

of mental health interventions. To this end we contracted with Dr. William McGill of Ady Voltedge to do a literature review of metrics that might be used as part of an evaluation. Based on this review Dr. McGill created a model for evaluating worksite mental health interventions. This model was reviewed with a group of employers who were among those who participated in the focus groups or key informant interviews. The evaluation component can be found in Attachment 9.

Implementation Plan

The beginning of a new WPP grant cycle in May 2012 provided an opportunity for the partnership to envision how to take what we had learned through the development grant to create an implementation plan. We were able to identify nine employers willing to work with us to refine and reformat the supervisor/manager training and create an employee education campaign and implement these in their worksites. The evaluation plan developed by Dr. McGill served as the basis for the evaluation of the project. The logic model for this project can be found in Attachment 9.

Section 3

The Strategic Plan: Building the Mentally Health Workplace

Objective 1: Implement a robust demonstration project of the interventions identified during the development grant.

A detailed plan was developed and submitted for a WPP implementation grant. If this is successful it will allow us to accomplish Objective 1; if not we will need to seek additional sources of funding.

The plan has two phases:

- Creation of products. Working with a group of approximately 10 employers of different sizes, different geographical areas and representing different sectors (professional, manufacturing, government, non-profit) refine and reformat the supervisor/manager training created by WUMH to respond to the recommendations made at our focus groups. This includes providing recommendations on how to facilitate healthy workplace communication and support return to work for people with mental illnesses while respecting the requirements of HIPPA and the ADA. Also, working with these same employers review existing employee education materials and either use these or create new products to form a year-long employee education campaign to address stigma, help-seeking and resource awareness. The campaign might consist of written materials, posters in break rooms, electronic information or videos, invitations for depression screening or lunch and learns.
- Implementation of products. All employers would incorporate the supervisor-manager training into their training process, ideally during the first six months of phase two. All employers would implement the employee education campaign over a one year period, with a booster session approximately six months after the completion of this initial campaign.

A robust evaluation will cover a variety of domains:

- Organization/employee engagement (overt support for program)
- Structural/organization measures (organizational infrastructure)
- Barriers/Facilitators (personal/social stigma, access to mental health services, self-efficacy)
- Process/Utilization measures (service/product offerings and participation)
- Short-term and intermediate outcome measures:
 - ✓ Leadership training effects on management awareness, education, behavior, employee interaction
 - ✓ Employee education effects on employee awareness, education, behavior
- Long-term outcome measures: absenteeism, presenteeism, workplace distress/engagement, employer health care and disability costs.

Objective 2: Refine and Update the Mental Health Section of the Worksite Wellness Resource Kit

The Wisconsin Worksite Wellness Resource Kit section on mental health consists of a set of benchmarks, nicely organized by the level of resources required for each, which provides guidance to employers on policies, practices and interventions that they can use in building a mentally healthy workplace. As such the Resource Kit is a valuable product for our efforts to inform employers on workplace mental health practices. The responses from our focus group affirmed this. However, the Resource Kit has some out-of-date references and does not include some newer information and resources that we have identified through our development grant.

By refining and updating the Resource Kit we will have an additional tool that we can disseminate to interested worksites right now to promote workplace mental health.

Objective 3: Develop an Outreach and Promotion Plan

The strategic plan document, the Resource Kit, the findings from a pilot project all have the potential to stimulate action around workplace mental health. Therefore it is critical that we formulate a plan for communicating these materials to key audiences and promoting implementation of practices. Key action steps include:

- A. Maintain and build upon the existing Advisory Board to guide the development and implementation of the outreach and communications plan.
- B. Continue to partner with The Alliance, the Business Health Care Group, and Wisconsin United for Mental Health to benefit from their networks with employers and employer groups.
- C. Cultivate relationships with other key groups such as the Chambers of Commerce, State Human Resource Managers, Wisconsin Manufacturers and Commerce, the Wisconsin Employment and Training Association, MRA, the American Society for Training and Development and others identified by the Advisory Board.
- D. Reapply to present findings from our study at the Wisconsin Worksite Wellness Conference and explore additional ways to utilize the Wellness Council of Wisconsin to promote our resources.
- E. Create attractive marketing materials summarizing our products and information. Create presentation templates we can modify for various audiences.
- F. Utilize web presence of MHA and partners to promote products and information.

- G. Reinstate MHA's "Healthy Mind Connections" newsletter to keep employers informed about new resources and training opportunities.
- H. Reach out to the Governor's Council on Fitness and Health to advocate for attention to mental health promotion when they are developing criteria for their Worksite Wellness Awards.
- I. Explore potential to develop and promote mentoring relationships between employers that have implemented workplace mental health programs and those interested in doing so.

Objective 4: Connect with Similar Efforts Elsewhere to Learn and Share

- A. Collaborate with the Partnership for Workplace Mental Health to connect to other projects they are working with, such as the Mid-State Collaborative in Kansas City.
- B. Collaborate with Mental Health America to share our findings at their annual wellness conference and with other affiliates conducting workplace outreach.
- C. Contact the Colorado Business Group on Health, which has workplace mental health projects in progress.
- D. Obtain new national standards being developed for businesses in Canada to determine value and applicability to our efforts.
- E. Explore potential to distill common elements of "what works" across sites to engage and maintain employer involvement and create change for employees.

Attachment 1: List of Advisory Board Members

Advisory Board

Employer members:

Jeff Kluever, Director of Benefits/Risk Manager, Journal Communications, Inc.;

Kim Schutte-meier, Manager of Employee Relations, WPS;

Tresa Martinez, EAP/CISM Coordinator, City of Madison;

Cindy Cerro, HR Manager, Culligan Water Softener Systems and board member of the Society for Human Resource Management (SHRM);

Mental Health Consumer Members

Alice Pauser; Access to Independence, Wisconsin Peer Specialist Program Coordinator.

Ava Martinez; NAMI- Dane County

Public sector members:

Michael Muelemans, Program Manager for WorkSource Wisconsin (a not-for-profit organization with the goal of providing Wisconsin employers with accessible and complete information regarding the employment of individuals with disabilities), Private Insurance Consultant and Writer;

Jonathon Morgan, Physical Fitness Coordinator, WI DHS, Division of Public Health, and member of the WI Governor's Council on Physical Fitness and Health which gives out the Governor's Worksite Wellness Awards;

Timothy Hallock, Quality Improvement Director with the WI Department of Health Services (DHS), Division of Long-Term Care, expert in Baldrige Criteria for Performance Excellence.

Health care members:

Dr. Gregg Schmidt, Professor of Psychiatry, UWSMPH, retired, consulting psychiatrist to Green County Human Services and Care Wisconsin;

Debra Lafler, MA, CWPD, Certified Wellness Program Director, Worksite Wellness Coordinator, Group Health Cooperative of South Central Wisconsin;

National/international partners:

Erica Ahmed, Mental Health America; Director of Public Education;

Claire Miller, Executive Director, Partnership on Workplace Mental Health;

Kathy Jurgens, Program Manager, Mental Health Works, Canadian, Mental Health Association, Toronto, Ontario.

Attachment 2: IMPROVING EMPLOYER MENTAL HEALTH PRACTICES:

Executive Summary

Mental health disorders are a major cause of work loss through absenteeism and reduced productivity on the job, are a major driver of disability claims and can increase morbidity and health care costs for individuals with other chronic health conditions like diabetes and asthma. An employer survey conducted by the Wisconsin United for Mental Health (WUMH) found that most employers understood the significant impact of mental health disorders on their employees and in their workplaces, but there was a gap between this understanding and the implementation of best practices in workplace mental health. The goal of this project is to better understand why this gap exists and develop a strategic plan to address it.

The project will build on and further develop and strengthen partnerships among mental health consumers and advocates, employer groups, academic partners, health and public health partners, and national and international groups with expertise in workplace mental health. The primary grant partners are Mental Health America of Wisconsin (the primary community partner), Dr. Jerry Halverson (the academic partner), The Alliance, the Business Health Care Group (BHCG), the Wisconsin Department of Health Services and WUMH. An Advisory Board is being created to obtain input from additional partners and promote dissemination of our findings. We will contract with the Wisconsin Women's Health Foundation and Janet Ady from Voltedge to assist in our key informant interviews, employer survey and focus groups.

The project will consist of the following activities: development of a database of evidence-based and best practices in workplace mental health; development of a database of interested individuals to be used for further partnership development and dissemination of grant results; preliminary assessment of current practices and policies of members of The Alliance and the BHCG; key informant interviews with leading employers in workplace mental health; an employer survey to identify potential barriers and facilitators of workplace mental health practices; focus groups to explore potential strategies; on-going review and analysis of results from interviews, survey and focus groups by partners and the Advisory Board; development of a strategic plan for promoting implementation of workplace mental health practices and dissemination of these results through hard copies, email, posting to various websites of partner groups and conference presentations. The outcome of the project will be a more robust partnership that is committed to implementation of the strategic plan.

MHA requests \$49,915 over a period of 18 months to complete this project.

In the long term the project will serve to achieve business support for the creation of mentally healthy workplaces resulting in decreased morbidity and enhanced wellness among employees, improved productivity and work quality, reduced health care costs, reduced absenteeism, improved employee morale, and improved organizational health. This project supports HW2020 pillar objective 3 by creating health-enhancing environments in the workplace and therefore supports the overarching focus area of social, economic and educational factors that influence health. People with chronic health conditions such as diabetes and heart disease, who also have a mental health disorder, experience increased morbidity and mortality from these conditions and their health care costs increase significantly when a mental illness co-occurs with these other conditions. By proactively addressing mental health concerns we lay the groundwork for reducing these health disparities in support of this overarching focus area in HW2020 and the WPP mission and also in addressing the health focus area of chronic disease prevention and management. The impact of all of these changes is in support of WPP's vision to make Wisconsin a healthier state.

The project is consistent with all of WPP's guiding principles: Promotion of health risk assessment, stress reduction and support for workers at risk of mental disorders all contribute to prevention and early intervention for mental disorders. This project promotes partnership development and

collaboration. The project supports enhancement by identifying barriers to effective mental health programs in the workplace and development of a strategic plan that will form the basis for implementation of innovative programs. Responsiveness is accomplished by reaching into a sector—the workplace—that has the potential to impact thousands of individuals who, due to stigma and access issues, might otherwise not seek out interventions that could significantly improve their health. The project supports efficacy by identifying evidence-based and best practices and how these might be best infused into the workplace. Finally, the project supports sustainability by addressing structural factors that currently limit implementation.

**Attachment 3a: Results of Employer Behavioral Health Practices Surveys:
The Alliance, the Business Health Care Group (BHCG) and
The Department of Health Services (DHS) 2009**

Notes:

- The following tables are numbered as the BHCG survey numbered its items. Two tables do not have numbers, because they represent items that were included in the Alliance survey but not in the BHCG survey. Also, shaded tables are not numbered; they include information from the 2009 DHS survey.
- Most values presented in the following tables represent **frequency counts** followed by the corresponding **percentage** of the total responses (i.e., count.....percent).
- In some cases, there were differences among the surveys being compared, in either the format or wording of questions. These differences are noted where appropriate.
- The survey was completed by 50 employers from the BHCG in May 2011 and 105 employers from The Alliance (49 in May 2011 and 56 in a follow-up in August 2011). 64 employers had responded to the original DHS survey in 2009.

1. How many full-time employees does your organization employ?							
Options – Alliance & BCHG	Alliance (q36) (May results)		BHCG		Options – DHS 2009	DHS 2009	
2 to 99	5	11%	33	66%	Fifty or fewer	20	32%
					51 to 100	10	16%
100-300	12	26%	5	10%	101 to 500	17	27%
301-500	10	22%	3	6%			
501-1,000	9	20%	1	2%	501 to 1,000	5	8%
<u>1,000+</u>	<u>10</u>	<u>22%</u>	<u>8</u>	<u>16%</u>	1,001 to 5,000	4	6%
Total	46	100%	50	100%	<u>5,000+</u>	<u>6</u>	<u>10%</u>
					Total	62	100%

2. Does your organization purchase health insurance or are they self-funded?				
	Alliance (q36)	BHCG		DHS 2009
Purchases health insurance		38	76%	
Self-funded	Not asked	12	24%	Not asked
Total		50	100%	

3. How much of an impact do you believe behavioral health issues have on your workplace? On a scale of 1=Very little to 7=A great deal...					
	Alliance (q36)		BHCG		DHS 2009
1 - Very little	1	1%	5	10%	A somewhat different question was used – see the shaded box below.
2	6	6%	4	8%	
3 - Somewhat	15	15%	9	18%	
4	17	17%	13	26%	
5 - Quite a lot	31	32%	8	16%	
6	13	3%	8	16%	
7 - A great deal	15	15%	3	6%	
Total	98	100%	50	100%	

The analogous question in the 2009 employer survey conducted by DHS was the following:

How prevalent are behavioral health issues in your workplace?	Count	Pct.
Not very prevalent	15	27%
Somewhat prevalent	28	50%
Very prevalent	13	23%
Total Respondents	56	100%

The Alliance and BHCG surveys approached the following questions differently:

- BHCG did not ask a separate question about offering behavioral health benefits, but included that as an option in the parity question (i.e. Yes, No, or We do not offer behavioral health benefits).
- The Alliance asked employers to respond Yes or No to the following: ‘We offer behavioral health benefits’ and did not include the option ‘We do not offer behavioral health benefits’ in the parity question.

No Number:

We offer behavioral health benefits.	Alliance (q37)		BHCG	DHS 2009
Yes	73	77%	Not asked	Not asked
No	22	23%		
Total	95	100%		

4. Does your organization offer behavioral health benefits at parity (e.g., the coverage amounts, co-pays and service limitations are no more restrictive than for other medical conditions?)					
	Alliance (q38)		BHCG (q4)		DHS 2009
Yes	63	72%	40	80%	Not asked directly; see the shaded box below
No	25	28%	8	16%	
We do not offer behavioral health benefits	(not an option)		2	4%	
Total	88	100%	50	100%	

From the 2009 DHS survey:

Does your worksite offer health insurance plans that cover or arrange treatment for:	Yes	No	Total
a. mental health disorders	49 (80%)	12 (20%)	61
b. substance abuse and addiction disorders	46 (77%)	14 (23%)	60

A cross-tabulation showed that 77% of respondents said that both mental health and substance abuse are covered, and 20% said that neither is covered.

Open-ended question— whether the employer’s health coverage for mental health or substance abuse disorders includes limitations/caps on coverage (39 responses).

- Responses indicating limitations/caps on coverage (24) —On number of visits (3); on amount (3); combination (2); unspecified or other limitations/caps (16)
- Responses indicating **no** limitations/caps on coverage (6)
- Don’t know/other responses (8)

5. Check which of the following best describes your pharmacy benefit:					
	Alliance (q39)		BHCG		DHS 2009
We do not offer a pharmacy benefit.	2	2%	5	10%	Not asked
We do not offer drugs used to treat psychiatric conditions as part of the pharmacy benefit.	2	2%	0	0%	
We offer drugs used to treat psychiatric conditions as part of the pharmacy benefit but their access is more restricted than for drugs for other conditions.	6	7%	1	2%	
We offer drugs used to treat psychiatric conditions as part of the pharmacy benefit in a manner which is nor more restrictive than for drugs for other conditions.	57	63%	25	50%	
We offer drugs used to treat psychiatric conditions apart of the pharmacy benefit with no restrictions.	23	26%	17	34%	
Other, please specify:	---		2	4%	
Total	90	100%	50	100%	

6. Our health plan covers screening for depression as part of a primary care visit:					
	Alliance (q40)		BHCG		DHS – 2009
Yes	52	59%	28	56%	Not asked
No	36	41%	22	44%	
Total	88	100%	50	100%	

Employee Assistance Program (EAP)

7. Does your organization provide an EAP?					
	Alliance (q41)		BHCG		DHS 2009 *
Yes	65	70%	27	54%	41 67%
No	28	30%	23	46%	19 31%
In Progress	(not an option)		(not an option)		1 2%
Total	93	100%	50	100%	61 100%

* A different format and wording was used.

8. What is the number of visits your EAP offers to employees?					
	Alliance (q42)		BHCG		DHS 2009
Range (lowest to highest)	0 to unlimited		3 to unlimited		Not asked
<u>Distribution</u>					
Less than 5 visits	36	63%	11	44%	
5 – 9 visits	17	30%	8	32%	
10 or more visits	1	2%	1	4%	
Unlimited visits	1	2%	5	20%	
<u>Other response</u>	2 4%		(none given)		
Total responses	57 responses		25 responses		
Average number of visits (for those giving a specific number)	3.29		4.4		

9. Does your EAP provide on-site programs?					
	Alliance (q43)		BHCG		DHS 2009 *
Yes	22	31%	13	42%	45 71%
No	50	69%	18	58%	18 29%
Total	72	100%	31	100%	63 100%

* The 2009 DHS survey had a question with a different format and wording. Seventy-one percent of respondents said that one or more listed programs (related to mental health, stress, etc.) were available in their workplace, and 29% said such programs were not available in their workplace; the programs listed were not specifically cited as EAP-run programs.

10. Does your EAP provide care coordination for your employees?					
	Alliance (q44)		BHCG		DHS 2009
Yes	42	61%	17	59%	Not asked
No	27	39%	12	41%	
Total	69	100%	29	100%	

No Number:

Management knows to consult with the EAP when an employee's behavioral health issues affect job performance.					
	Alliance (q45)		BHCG		DHS 2009
Yes	52	73%	Not asked	Not asked	Not asked
No	19	27%			
Total	71	100%			

11. What percentage of your employees utilizes your EAP?					
	Alliance (q46)		BHCG		DHS-2009
Range	0% to > 50%		0% to 21%		Not asked
<u>Distribution</u>					
Zero	8	13%	1	4%	
1-10%	42	69%	14	61%	
<u>More than 10%</u>	<u>11</u>	<u>18%</u>	<u>8</u>	<u>35%</u>	
Total	61 responses		23 responses		
Average percentage utilization	4.97 %		6.9%		

12. Please indicate whether or not your organization provides any of the following:

a. Stress management, stress reduction or other wellness activities or programs					
	Alliance (q47a)		BHCG		DHS-2009 *
Yes	41	45%	19	38%	Different format - - Stress: 51% W-L bal.: 54% Coping: 38%
No	35	38%	27	54%	
In progress	9	10%	2	4%	
Considering for 2012	7	8%	2	4%	

* In the DHS survey, respondents were asked to select which listed programs (related to mental health, stress, etc.) were available in their workplace. Fifty-one percent said programs related to stress/stress reduction were available, 54% said work-life balance programs were available, and 38% said programs related to coping and resiliency were available in their workplace.

b. Information/education about mental health, mental illness, substance abuse, etc.					
	Alliance (q47b)		BHCG		DHS-2009 *
Yes	42	47%	21	42%	Different format -
No	35	39%	26	52%	-
In progress	7	8%	1	2%	MH: 46%
Considering for 2012	6	7%	2	4%	SA: 49%

* In the DHS survey, respondents were asked to select which listed programs (related to mental health, stress, etc.) were available in their workplace. Forty-six percent said programs related to mental health/mental illness were available, and 49% said programs related to substance abuse/addiction were available in their workplace.

c. Flexible scheduling to allow employees to attend wellness activities offered at work.					
	Alliance (q47c)		BHCG		DHS-2009
Yes	48	52%	23	46%	66%
No	36	39%	24	48%	31%
In progress	4	4%	2	4%	3%
Considering for 2012	4	4%	1	2%	(not an option)

d. Accommodations to facilitate a return to work for an employee who has a behavioral health condition.					
	Alliance (q47d)		BHCG		DHS-2009
Yes	63	70%	27	54%	69%
No	25	28%	23	46%	26%
In progress	1	1%	0	0%	5%
Considering for 2012	1	1%	0	0%	(not an option)

e. Flexible scheduling to allow employees to attend medical appointments related to behavioral health conditions.					
	Alliance (q47e)		BHCG		DHS-2009
Yes	77	85%	44	88%	84%
No	13	14%	6	12%	16%
In progress	0	0%	0	0%	0
Considering for 2012	1	1%	0	0%	(not an option)

f. Referral or linkage to behavioral health services or treatment.					
	Alliance (q47f)		BHCG		DHS-2009
Yes	43	48%	24	48%	68%
No	40	44%	25	50%	28%
In progress	5	6%	1	2%	3%
Considering for 2012	2	2%	0	0%	(not an option)

g. Sensitivity training; training on stigma and discrimination.					
	Alliance (q47g)		BHCG		DHS-2009
Yes	26	29%	10	20%	43%
No	53	59%	36	72%	51%
In progress	8	9%	2	4%	7%
Considering for 2012	3	3%	2	4%	(not an option)

h. Depression self-screening tools provided with information on the EAP.					
	Alliance (q47h)		BHCG		DHS-2009
Yes	19	22%	8	16%	Not asked
No	57	65%	42	84%	
In progress	4	5%	0	0%	
Considering for 2012	8	9%	0	0%	

Upper Management: Understanding Behavioral Health

13. What consultation, training, or other assistance is available to help supervisors/managers manage behavioral health issues at work?

a. Information/education about mental health, mental illness, substance abuse, etc.					
	Alliance (q48a)		BHCG		DHS-2009
Yes	33	38%	12	24%	62%
No	43	49%	33	66%	34%
In progress	2	2%	3	6%	3%
Considering for 2012	10	11%	2	4%	(not an option)

b. Training on how to deal with employees who have behavioral health conditions that affect job performance					
	Alliance (q48b)		BHCG		DHS-2009
Yes	25	28%	10	20%	36%
No	51	57%	34	68%	53%
In progress	3	3%	2	4%	12%
Considering for 2012	11	12%	4	8%	(not an option)

c. Training on how to make accommodations for employees who have behavioral health conditions that affect job performance					
	Alliance (q48c)		BHCG		DHS-2009
Yes	25	28%	10	20%	41%
No	52	58%	34	68%	54%
In progress	4	4%	1	2%	5%
Considering for 2012	9	10%	3	6%	(not an option)

d. Information on legal issues related to behavioral health, accommodations, etc.					
	Alliance (q48d)		BHCG		DHS-2009
Yes	36	40%	12	24%	52%
No	41	46%	34	68%	45%
In progress	5	6%	1	2%	3%
Considering for 2012	7	8%	3	6%	(not an option)

14. Supervisors/managers understand the impacts of poor mental health in the workplace:					
	Alliance (q49)		BHCG		DHS-2009
Yes	59	65%	35	70%	Not asked
No	32	35%	15	30%	
Total	91	100%	50	100%	

15. How well-prepared are most of the supervisors/managers in your work site to effectively deal with employees who have behavioral health issues that affect their work performance?					
	Alliance (q50)		BHCG		DHS-2009
Not at all prepared	4	4%	6	12%	7 11%
Poorly prepared	28	31%	13	26%	16 25%
Somewhat prepared	56	62%	27	54%	31 49%
Well-prepared	3	3%	4	8%	9 14%
Total	91	100%	50	100%	63 100%

16. Is there action taken to work with or train a supervisor/manager who is creating an unhealthy work environment?					
	Alliance (q51)		BHCG		DHS-2009
Yes	70	77%	22	44%	Not asked
No	21	23%	14	28%	
Does not apply	--		14	28%	
Total	91	100%	50	100%	

**Attachment 3b: Highlights—Findings from the Employer Behavioral Health Practices Surveys
Conducted by the Alliance, BHCG and DHS**

Questions 1: While data is not exactly comparable, we believe that the DHS sample looks more like the Alliance than the BHCG in terms of a higher percentage of large employers. Employer size does seem to impact responses (e.g., larger employers more likely to have EAPs)

Question 3 (impact of behavioral health issues):

In all three surveys, one-quarter or fewer of the respondents think behavioral health issues are not very prevalent/have little or very little impact in their organizations. (The Alliance looks very different; why?)

Offering behavioral health benefits:

The Alliance asked directly if behavioral health benefits are offered; seventy-seven percent of respondents said yes and 23% said no. In Question 4, 4% of BHCG respondents indicated that behavioral health benefits are not offered.

Question 4 (parity):

The DHS survey was conducted shortly before the parity legislation was passed, and the survey did not ask directly about parity. However, 61% of those responding to an open-ended question reported caps or limitations on mental health/substance abuse coverage.

Alliance and BHCG employers have been surveyed since the implementation of the parity legislation. Twenty-eight percent of respondents in the Alliance surveys and 16% of BHCG respondents reported that behavioral health benefits are not offered at parity.

Question 5 (pharmacy benefit):

More than 80% of Alliance and BHCG respondents report that their pharmacy benefit is either no more restrictive for psychiatric conditions than for other conditions, or has no restrictions for psychiatric conditions.

Question 6 (depression screening part of primary care):

More than 50% of Alliance and BHCG employers cover depression screening as part of a primary care visit. (Do people find this surprising?)

Question 7 (EAP):

More than two-thirds of respondents to the Alliance and DHS surveys report having an Employee Assistance Program (EAP). Just over half of BHCG employers have one.

Question 8 (number of EAP visits offered):

The EAPs that these organizations have seem to offer a limited number of visits. Very few respondents report that their EAP offers more than 10 visits. How typical is this? What are implications for our efforts (e.g., is there value in promoting more visits for the best interests of the employee and employer, or will employees not use more even if offered?)

Question 9 (EAP provides on-site programs):

Less than half of Alliance and BHCG respondents say their firm's EAP offers on-site programs. Almost three-quarters of DHS respondents report on-site programs, but the question format/wording was not

the same and results may not be directly comparable. (How typical is this? As above, should we be promoting more availability of on-site programs?)

Question 10 (care coordination):

More than half of Alliance and BHCG respondents say the EAP offers care coordination.

No number:

Almost three-quarters of Alliance respondents say that managers know to consult with their EAP if an employee has a behavioral health issue that affects performance.

Question 11 (EAP utilization):

There is a good bit of variation reported in the utilization of the EAP, for example Alliance respondents reported that anywhere from zero to more than 50% of employees use their EAP. Overall, however, most respondents reported that ten percent or less of their employees make use of the EAP. (Is this surprising/typical?)

Questions 12a–12h (workplace programs):

There are some differences among the surveys in terms of workplace programs offered. Alliance and BHCG respondents most often report offering flexible scheduling to allow employees to attend medical appointments (12e) and accommodations to facilitate a return to work (12d). They least often offer sensitivity training/training on stigma and discrimination (12g) or depression self-screening tools (12h).

Questions 13a–13d (training/supports for managers/supervisors):

In general, roughly 20–50% of respondents report that various trainings or other supports are provided to supervisors/managers to help them deal with behavioral health issues. Respondents to the DHS survey were generally somewhat more likely to report providing such support to supervisors. (Is this surprising/typical? Is this an area of potential value/opportunity?)

Question 14 (supervisor/manager understanding):

More than two-thirds of Alliance and BHCG respondents report that supervisors/managers understand the impacts of poor mental health in the workplace.

Question 15 (supervisor/manager preparedness):

In all three surveys, at least one-third of respondents say supervisors/managers are not at all prepared or poorly prepared to deal effectively with employees who have behavioral health issues that affect their work performance. (This data from a DHS survey was a prime factor in development of this grant. This data is confirmatory. What does this suggest about potential opportunity? Is there receptivity from employers to training of this sort? How do we find out?)

Question 16:

Seventy-six percent of Alliance respondents say that action is taken to deal with a supervisor/manager who is creating an unhealthy workplace environment. Less than half of BHCG respondents say that this happens.

**Attachment 4: Improving Employer Mental Health Practices
Summary of Key Informant Interviews**

	Employer A	Employer B	Employer C	Employer D
<u>Background</u>	<ul style="list-style-type: none"> Professional 2600 employees 	<ul style="list-style-type: none"> Manufacturing 450 employees 	<ul style="list-style-type: none"> Manufacturing company- 150 employees 	<ul style="list-style-type: none"> Provide local government services 755 F/T employees who are eligible for benefits
<u>Health Plan</u>	<ul style="list-style-type: none"> Self-funded Deductibles- \$1,200, \$2,400, or \$4,950. All preventive care is covered at 100%. 	<ul style="list-style-type: none"> Self-funded MH covered as any other illness 	<ul style="list-style-type: none"> Self-insured MH coverage is covered as any other illness 	<ul style="list-style-type: none"> Self-funded, offer the “Cadillac plan” w/ little-to-no cost to employee Minimal co-pay and prescription cost As of 1/1/2012 employees will be paying premiums for the first time and increased co-pays MH is covered in the benefits description of coverage
<u>EAP</u>	<ul style="list-style-type: none"> Yes 	<ul style="list-style-type: none"> Yes, but piecemeal 	<ul style="list-style-type: none"> No- due to underutilization 	<ul style="list-style-type: none"> Yes
<u>Mental Health Awareness and Perceptions</u>	<ul style="list-style-type: none"> Mental health includes drug and alcohol abuse, anything involving an employee or their family, includes stress, anxiety, and depression. They were not sure, but suspected that “behavioral health” was having effects on employee absenteeism and 	<ul style="list-style-type: none"> State of well-being. This includes conditions not necessarily diagnosed with some physical condition. Leadership has personal experience w/ MI Come to realize that mental health is not easily curable, but it’s real. 	<ul style="list-style-type: none"> Defines MI as a disorder or condition that impacts life at work and/or home Does not use MH terminology unless the employee does 	<ul style="list-style-type: none"> MH is not clearly defined by the organization; but may refer to it as MH or BH. Depression and Anxiety are the most prevalent issues and prescription use

	other symptoms.			
How does “mental health” pertain to the workplace	<ul style="list-style-type: none"> The organization understands identifying and managing behavioral health in the workplace and at the primary care level is more cost effective and can increase presenteeism and decrease absenteeism. 	<ul style="list-style-type: none"> hypertension is a big factor there are challenges with high turn-over and attendance they think absenteeism probably is related to mental health 	<ul style="list-style-type: none"> Inc. absenteeism Loss of production Lack of efficiency Understand it’s an illness and want employee to be well, recognizing if employee is not well it impacts their work 	<ul style="list-style-type: none"> There is pressure due to pay freezes and changes w/ collective bargaining rights These issues are having a huge impact on morale and productivity
Measurement	<ul style="list-style-type: none"> They can look at leaves of absence, via Unum Work with provider to identify providers and the authorization process, so they could manage the condition, not just the benefits meet with the TPAs weekly EAP serves as clearinghouse, they get five visits through here with no deductible 	<ul style="list-style-type: none"> They don’t have any data on “mental health” per se. 	<ul style="list-style-type: none"> Do not have a tool for measuring and tracking (do not track attendance) Think it would be nice to be able to track and have data to compare or use to determine what kind of trainings might be needed 	<ul style="list-style-type: none"> Do not have a tool for measuring and do not track anything that can be considered an indicator for impact of MH/MI
Barriers in the workplace	<ul style="list-style-type: none"> Have worked hard to eliminate barriers. One was by eliminating co-pay for behavioral health. Another example is lumping behavioral health in with chronic diabetes and 	<ul style="list-style-type: none"> Lack of knowledge among supervisors – what the symptoms are, etc. Employee privacy/information – how much can a supervisor get 	<ul style="list-style-type: none"> Stigma (embarrassment, even by the ones receiving treatment) Do not use screening tool- not sure if employees would find it helpful; but willing 	<ul style="list-style-type: none"> Poor communication Most significant barrier- distrust of administration and their motives. The organization does not communicate with employees well, thus does not come across as

	heart disease.	involved. <ul style="list-style-type: none"> • Stigma – thinks insurance benefit has a “carve out” – now it’s mental health parity. Would have to check what his own policy is. 	to explore ways to incorporate screening into their bi-yearly health fair <ul style="list-style-type: none"> • Do not think primary physicians are doing an adequate job in assessing people who might be at-risk • Not having EAP support/ Lack of community resources to help employees find appropriate and effective mental health referrals 	employer friendly.
Supervisor Training	<ul style="list-style-type: none"> • Yes, does ongoing training. • Offers training on-demand via webinars. • Finds that managers don’t have time for training until they have a situation, then they need it immediately. 	<ul style="list-style-type: none"> • Managers don’t recognize it well, don’t know how to step in and help 	<ul style="list-style-type: none"> • Company provides Supervisor Training on Performance Management for all employees regardless of the situation. • MH has not been addressed; but supervisors have been trained to assess performance not behavior and offer support to all employees whether they need help at work or home. 	<ul style="list-style-type: none"> • Provides annual training; but nothing around MH • Would like to see: • Scenario-based training is very popular • Reintegration for employees who were on leave for MI diagnosis and how to decrease anxieties that made them take leave in the first place • Education about being understanding MI • Education on reasonable accommodations

Attachment 5: Improving Employer Mental Health Practices Summary of Focus Groups

Initial work on the Wisconsin Partnership Program grant involved key informant interviews and employer surveys with members of The Alliance and the Business Healthcare Group. The third phase of the project was to conduct focus groups to explore more deeply key issues identified in the surveys and key informant interviews. Two focus groups, one in Madison and one in Milwaukee, took place in early 2012. The focus group guide was prepared by Ady-Voltege with input from the WPP Leadership Team. The moderator of the focus groups was Julie Whitehorse of the Wisconsin Women's Health Foundation.

The moderator asked participants to answer as employers rather than as individual employees; the sessions were recorded for later transcription. In brief, the focus groups addressed: participants' understanding and awareness of mental health in the workplace and their organization's coverage of mental health; any metrics that were used to measure the cost or success of mental health programs; any benchmarks used or how likely organizations would be to use such resources; and mental health training for managers/supervisors.

This document paraphrases and summarizes the remarks of focus group participants.

Focus Group #1
January 26, 2012

Background on Mental Health

Mental health touches everything about an employee—attitude, behavior, well-being, whether they show up every day, and how they behave at work. Someone with good mental health in the workplace is stable, does their job, can be counted on, and doesn't have to be monitored much.

People with mental health issues act 'atypically'. Other signs—moodiness; arguments with others; attendance issues; productivity issues; disciplinary issues; stress.

Participants agreed that substance abuse is a part of mental health in the workplace; it can be a cause or a symptom.

Sometimes people aren't even aware that they're having a mental health problem; they think it's normal to feel the way they do. Other people can see it, though. A point that came up more than once is that sometimes mental health issues are due to things outside of work that 'spill over' into the workplace. Regardless of whether the problem arises at work or outside of work, employers need ways to help an employee get the help needed.

An employer has some responsibility to help employees find a balance between work and home life, and should consider whether the work environment promotes that balance.

Even before the moderator introduced the topic, a couple of people mentioned that employers should find resources and tools to help employees dealing with mental health problems, and

maybe train supervisors/managers to recognize early signs of problems so the problems don't become more serious and/or so the employee can continue to be productive.

There was discussion of FMLA situations, and the perception that some employees abuse this type of leave; also the difficulty of dealing with other employees' reactions to someone's mental health-related leave or accommodation, and the supervisor's inability to address others' reactions directly due to privacy concerns. Employers struggle with these situations.

In general, participants seemed to have limited knowledge of the specific details of their own health plans' coverage for mental health conditions, but most reported that their coverage changed when parity was passed.

Measurement

This group reported very limited tracking of mental health-related data. Some participants said they don't measure anything. A couple of people thought that most people who take disability leave have a physical rather than mental health condition, so they haven't felt the need to track mental health data. Two people said they look at pharmacy claims, e.g. whether antidepressant use is increasing, but they don't do much with the information.

Cited as barriers to measuring or analyzing mental health-related data:

- The time needed to do this
- The relationship of mental health to other (physical) health conditions makes it hard to separate out the impact of mental health
- Doubts about how important it is to do this— one person suggested that it (mental illness?) may be expensive when it occurs, but isn't very common (then he/she conceded maybe it's more common than realized, just not identified or measured)
- Not being sure how to use the data

Benchmarks

Only one person had previously seen or knew of the resource list from the Worksite Wellness Resource Kit. One person mentioned that most of these activities would be handled through their EAP. All but two individuals said their organization has an EAP; one of those two said they used to have an EAP, but eliminated it because of cost and because few people used it.

Having a list of mental health-related resources would be helpful, but primarily for use by HR or the EAP rather than managers.

Several people thought it would be a good idea to make resources available on the internal work web so that employees can access them on their own, because some employees may not want to go through HR or the EAP.

There was a little skepticism that there would be much benefit from implementing mental health-related resources or programs, or that they could know if there was much benefit.

Supervisor Training

Employees often go to their manager or HR when they have an issue of some kind. Things that are mental health-related also get referred to the EAP or the health care provider, if professional help is needed.

Managers are uncomfortable talking to employees about mental health issues; they're not trained for this, and so on. Several people indicated that training for managers/supervisors would be a good resource for organizations to implement.

A couple of people said their organization uses supervisor training, others said it was limited. All said that when such training occurred, it was paid for by the organization. Most of the training described was not directly related to mental health/mental illness, but dealt with things like substance abuse or workplace violence.

Supervisor training was offered in various ways:

- Online training videos
- Face-to-face training provided by consultants, professional trainers, insurance companies
- In-house (internally developed) programs
- Send employees to programs in the community

Participants really liked the video—they had concerns about the overall length, but really like the fact that it consisted of short segments that could be used individually.

Other

The issue of stigma came up a few times; participants acknowledged that stigma makes it harder for employees to discuss mental health issues.

Focus Group #2
February 23, 2012

NOTE: More than the first focus group, the organizations represented in Focus Group 2 varied a lot in size, from about 15 employees to several thousands. The different realities for small and large organizations factored into the discussion several times.

Background on Mental Health

If a mental health condition (or other health condition) affects a persons' work, it's an issue for the employer. Mental health issues may not involve an employee specifically, but a family member instead, or be due to things outside of work. Wellness is part of mental health. Substance abuse is definitely related to mental health, and is no less important to address.

There's still a stigma related to mental health issues, so people don't tell their employers because they don't want to be labeled.

There are legal issues for employers. Maintaining privacy can be a difficult aspect of mental health issues, especially in small firms.

Employer size makes a difference—a bigger company will be able to deal with a situation differently than a small company. Later in the discussion, one speaker noted that other participants' organizations seemed to have a much greater awareness of mental health issues than his/her organization, probably due to organization size.

The employer may want to provide resources to help employees; this is just an extension of providing other healthcare and employee assistance services.

It's important to consider mental health from a security or safety perspective; one speaker in particular seemed focused on the potential for violence, but also seemed to think that employers can take precautions, and that with help, employees could work through problems and get back to being productive.

Your Health Plan's Coverage

Only a couple of people knew for sure if they had mental health coverage; again, knowledge of details was limited. In some cases participants seemed to be conflating or confusing aspects of their health plans with features of their EAP.

A couple of people made the point that a high-deductible health plan serves as a barrier to care for mental health as well as other medical conditions, so even if a health plan covers mental health, employees won't have easy access to services if they can't afford the deductible. A high-deductible plan may be all that small firms can afford.

There was considerable discussion about the details of participants' EAP, for example, how many visits are covered, who is eligible, what issues the EAP deals with, and so on. Some of the large firms had fairly generous EAPs.

Measurement

Some of the organizations represented in Focus Group 2 do more in terms of measurement than in the first group. However, even employers that look at these data don't always know how to interpret or use the results.

Some things looked at:

- Claims (mental health and medical) and utilization
- Spending on prescription drugs; which drugs are used most
- Employee surveys related to productivity (barriers to productivity? Not quite sure what this is)
- Health risk assessments (may include mental health questions)
- EAP utilization
- Disability claims

One speaker described a study of their firm's spending on mental health. They looked at integration among their healthcare vendors and EAP, and tried to get at whether employees taking behavioral health medications (antidepressants, etc.) were getting best practice

treatment, i.e. how many were seeing a mental health specialist versus being prescribed these drugs by a primary care provider. Another speaker said they do something similar, and require vendors to refer people to the best appropriate treatment program. These speakers were both from large organizations.

A speaker from a small company was curious about the potential for abuse of mental health benefits. One person reported relying on their drug vendor to help spot abusive or unnecessary use of medications. Also, others suggested that the effects of undiagnosed and untreated conditions are harder to quantify and track than the costs of mental health treatment and medications. One person said that the cost of prescription medication is small compared to the benefit of having someone at work every day doing their job.

Several participants expressed surprise to see how often behavioral health drugs are used by their employees and/or health risk assessment data regarding employee stress levels. Participants from small firms suggested that the stress level can be even greater in small firms, because everyone has to wear so many different hats.

Benchmarks

Participants said they frequently provide information to their employees about all sorts of things, but finding new and fresh ways to do it is always a challenge. They agreed that having a list of mental health resources to share with employees would be helpful.

Supervisor Training

All but one of the participants said they do supervisor training, but some of it is not specific to mental health. As with the first focus group, various formats were used, including online training; having a trained counselor come in to do a presentation; group training; specialized day-long training for HR and managers.

This focus group also liked the video, and the fact that the segments could be used separately. There was interest in having a manual or user guide to go along with the DVD, and some participants pointed out the need to integrate the use of the video with the organization's own policies and procedures.

The speaker who was most focused on the potential for violence in mental health situations said his organization has a forensic psychologist on retainer to do risk assessments and assess threat levels if they have concerns about an employee.

Other

There was some discussion about whether the issue of mental health in the workplace is just the latest fad and that some people may be using a mental health problem as an excuse. It was suggested that there need to be ways to ensure that this isn't happening.

Several participants seemed to think that younger workers would have less concern about stigma than older workers.

Additional Focus Group Materials

Focus group participants were asked to react to two specific products to provide feedback on their potential value.

Benchmarks

Responding to some comments from key informants we wanted to provide employers with a set of benchmarks; policies and practices that employers should consider having in place as part of creating a mentally-healthy workplace. After reviewing a few sets of materials identified by our Advisory Board we decided to use the resources identified in the Wisconsin Worksite Wellness Resource Kit. This set of policies and practices was well organized by level of resource investment and comprehensive of the types of activities identified for workplace mental health practices. During the focus group each member was provided with a copy of the form on the following pages and asked to indicate which of the practices they already had in place and which they would like to have in place. In the second focus group they were also asked to rate which they thought were of the most value to them.

For focus group one we bolded those items that showed the biggest gap between what employers offered and what they would like to offer. In focus group two we bolded those that were most often identified as of most value. As can be seen there is a high degree of correspondence between these. As can be seen, in focus group two more employers offered more of the policies or practices. We believe this represents the presence of more very large employers who would have the resources to do so.

Supervisor/Manager Training DVD

The identification that supervisors and managers were not well prepared to address mental health issues was a clear finding in the employer surveys as well as the key informant interviews. Because a new training DVD had been completed by Wisconsin United for Mental Health we showed portions of the DVD to the focus group members. A summary of their survey responses following viewing the DVD is provided.

List of Resources Companies Can Use to Benchmark Themselves Focus Group #1	Currently Have in Place	Would like to have in place	Top Rated
Low Resources			
1. Provide materials and messages about mental health, mental illnesses, suicide prevention, substance use, trauma, and health promotion through various means: brochures, fact sheets, paycheck stuffers, intranet, etc.	5	3	n/a
2. Provide resources for confidential screenings for depression, anxiety, posttraumatic stress disorder, etc. (personal, on-line, print)	3	4	n/a
3. Encourage the use of telephone help lines - 800 numbers	5	2	n/a
4. Provide a variety of mental health presentations and trainings with an emphasis on prevention, treatment, and recovery messages for all staff including supervisors/managers, and executive leadership.	1	4	n/a
5. Offer stress reduction presentations on varied topics: conflict resolution, managing multiple priorities, project planning, personal finance planning, parenting, etc.	3	5	n/a
6. Provide flexible scheduling during work for lunch and learn and other trainings such (yoga, meditation, physical activity, self-help groups, etc.)	5	3	n/a
7. Provide a quiet room or stress reduction room at the worksite.	1	3	n/a
Medium Resources			
1. Create and sustain a mental health-friendly workplace that provides support and accommodations for employees who are returning to work after receiving or are in mental health/alcohol treatment and recovery. Provide family/employee flexibility allowing schedule accommodations for medical/treatments, sessions, and appointments, as needed.	5	2	n/a
2. Provide trainings specific to educating managers/supervisors in recognizing mental health as a factor in performance issues and offer interactive training components and information for supervisors/managers on how to engage EAP,HR and other resources. Provide targeted mental health support for supervisors/managers and executive leadership addressing mental health issues specific to their needs and stressors.	1	5	n/a
3. Create policies and practices that provide guidance to supervisors/managers on how to address performance issues, which include offering consultation, accommodation, and information through EAP or include the HR staff.	1	5	n/a
4. Review policies and practices concerning employee privacy and confidentiality, return to work and HIPAA, accommodation and ADA guidelines.	4	1	n/a
5. Evaluate or reevaluate the workplace environment, the organization, and its culture with a focus on reducing workplace stress, workload issues, performance reviews, address employee engagement and concerns.	5	3	n/a
High Resources			
1. Provide onsite or off-site Employee Assistance Program (EAP).	5	2	n/a
2. Provide confidential Employee Assistance Coordinators (EACs) to help staff obtain information about supportive resources in their community.	0	5	n/a
3. Provide and maintain comprehensive health insurance coverage, which includes mental health as part of employee benefits packages. Include screening, brief intervention and referral (SBIRT) as a covered evidence-based benefit.	6	1	n/a
4. Provide and maintain comprehensive health insurance coverage with referral mechanisms to connect employees easily to mental health treatment services.	7	0	n/a
5. Become a workplace that is able to provide assistance to serious mental illnesses and major traumatic events.	2	6	n/a

List of Resources Companies Can Use to Benchmark Themselves Focus Group #2	Currently Have in Place	Would like to have in place	Top Rated
Low Resources			
1. Provide materials and messages about mental health, mental illnesses, suicide prevention, substance use, trauma, and health promotion through various means: brochures, fact sheets, paycheck stuffers, intranet, etc.	6	1	
2. Provide resources for confidential screenings for depression, anxiety, posttraumatic stress disorder, etc. (personal, on-line, print)	4	2	
3. Encourage the use of telephone help lines - 800 numbers	6	2	
4. Provide a variety of mental health presentations and trainings with an emphasis on prevention, treatment, and recovery messages for all staff including supervisors/managers, and executive leadership.	5	1	x
5. Offer stress reduction presentations on varied topics: conflict resolution, managing multiple priorities, project planning, personal finance planning, parenting, etc.	5	1	
6. Provide flexible scheduling during work for lunch and learn and other trainings such (yoga, meditation, physical activity, self-help groups, etc.)	3	1	
7. Provide a quiet room or stress reduction room at the worksite.	2	1	
Medium Resources			
1. Create and sustain a mental health-friendly workplace that provides support and accommodations for employees who are returning to work after receiving or are in mental health/alcohol treatment and recovery. Provide family/employee flexibility allowing schedule accommodations for medical/treatments, sessions, and appointments, as needed.	5	0	
2. Provide trainings specific to educating managers/supervisors in recognizing mental health as a factor in performance issues and offer interactive training components and information for supervisors/managers on how to engage EAP, HR and other resources. Provide targeted mental health support for supervisors/managers and executive leadership addressing mental health issues specific to their needs and stressors.	3	3	x
3. Create policies and practices that provide guidance to supervisors/managers on how to address performance issues, which include offering consultation, accommodation, and information through EAP or include the HR staff.	6	1	x
4. Review policies and practices concerning employee privacy and confidentiality, return to work and HIPAA, accommodation and ADA guidelines.	7	0	
5. Evaluate or reevaluate the workplace environment, the organization, and its culture with a focus on reducing workplace stress, workload issues, performance reviews, address employee engagement and concerns.	5	1	
High Resources			
1. Provide onsite or off-site Employee Assistance Program (EAP).	6	1	x
2. Provide confidential Employee Assistance Coordinators (EACs) to help staff obtain information about supportive resources in their community.	4	1	
3. Provide and maintain comprehensive health insurance coverage, which includes mental health as part of employee benefits packages. Include screening, brief intervention and referral (SBIRT) as a covered evidence-based benefit.	6	2	
4. Provide and maintain comprehensive health insurance coverage with referral mechanisms to connect employees easily to mental health treatment services.	7	1	
5. Become a workplace that is able to provide assistance to serious mental illnesses and major traumatic events.	5	1	

Responses **AFTER** viewing Supervisor/Manager Training DVD
Focus Group #1

Length: The response ratings ranged from good to very good

Comments:

- “Longer than many of our videos”
- “30 minutes would be preferred. But good to be able to move to each section”
- “After viewing I feel length is okay”

Format: The response ratings were generally very good.

Comments:

- “I think the format is precise and easy to understand”

Usefulness of Content: The response ratings were mostly good to very good; one poor

Comments:

- “Practical”
- “This is something I would not want sups/mgrs. handling; HR would do this”

Likelihood of using this video: Mostly moderate to high; one low

Comments:

- “Availability for mgrs. for training is tight”
- “We already have similar video but might be good to have another option”
- “Possibly—would need to consider current online resources”
- “Not sure our organization would use it”
- “Easy to understand; has broad application”
- “It gives specifics which our supervisors are always looking for”

Overall Interest: The response ratings averaged from moderate to high interest; one low

Comments:

- “We need to determine the best way to share the info.”
- “Could maybe use specific slides in conjunction with in person training”
- “My HR interest is high; not sure of org. interest”
- “Don’t have a tool like this”
- “Good way to train our supervisors”

Responses **AFTER** viewing Supervisor/Manager Training DVD
Focus Group #2

Length: The response ratings ranged from good to very good

Comments:

- “47 minutes is a good time for a manager training”

Format: The response ratings ranged from good to very good

Comments:

- “This isn’t bad...it goes through if you have an EAP or not”
- “you can switch around”

Usefulness of Content: The response ratings ranged from good to very good

Comments:

- “This would have been beneficial ”
- “I think it would be extremely valuable... in a big company”
- “Yeah, I’ll definitely watch it.”
- “I liked that you’re able to click on a particular section that you want”

Likelihood of using this video: The response ratings averaged moderate likelihood of use

Comments:

- “I would not present to a supervisor group as a general audience...I’d lose them in 15-20 minutes. I’d have to integrate it with tangible, real-life work scenarios”
- “It’s nice to have a tool that’s not the same training that we had over and over...addressing depression with our EAP speaking.

Overall Interest: The response ratings averaged from moderate to moderately high interest (only one participant indicated a very low interest rating)

Comments:

- “This training would complement other types of trainings we’ve had”.

Attachment 6: Information about Mental Health @ Work Trainings

Mental Health and the Workplace

Mental Health @ Work - *a competitive advantage* -- Wisconsin United for Mental Health's two-part multimedia educational series on why mental health matters in the workplace. A listing of state, national, and international mental health resources and websites is included.



The first section, Mental Health @ Work Matters, has been designed to help Management, HR, EAP and other professional staff to learn about:

- The various types of mental illnesses.
- How having mentally healthy employees lowers costs.
- Reasons why employers should care about their employees' mental health.
- Ways employers can create mentally healthy workplaces.

View Mental Health @ Work Matters, Part 1

Section two of the training series, Mental Health @ Work: A Practical Guide for Managers, Supervisors, and Leaders, has been designed to equip you with ways to support the mental health of your employees by:

- Promoting mental health in the workplace.
- Recognizing when there may be a mental health issue with an employee.
- Addressing employees who are showing performance and emotional or mental health issues.
- Locating resources, finding assistance, and offering "suggested" reasonable accommodations for employees.
- Assisting an employee to create a plan for success at work

View Mental Health @ Work: A Practical Guide for Managers, Supervisors, and Leaders, Part 2

To request a hard copy of the Mental Health @ Work DVD, please email Cara Hansen at cara@mhawisconsin.org.

MENTAL HEALTH

WHAT:

Mental health is a state of well-being in which a person realizes their own abilities, can cope with the normal stresses of life, can work productively, and is able to contribute to his or her own community. Mental health is the foundation for well-being and effective functioning for an individual and community (Healthiest WI 2020). Addressing mental health and physical health as interlinked, is key to overall health and wellness. Mental health issues such as stress, anxiety, depression and other conditions are routinely listed as top concerns in employee health surveys.

WHY:

Mental health conditions are the second leading cause of worksite absenteeism. Estimated costs for untreated and mistreated mental illness total approximately \$150 billion in lost productivity each year in the U.S. and businesses pay up to \$44 billion of this bill. Additionally there are indirect costs to employers such as absenteeism, work impairment, and disability benefits. However, the total health care costs for workers who receive treatment for depression are two-thirds less than the medical costs of untreated individuals (JOEM, 2005). Effective treatment potentially can save direct and indirect costs for employers and can improve quality of life for all employees.

More than 90 percent of employees agree that their mental and personal problems spill over into their professional lives, and have a direct impact on their job

performance. Even moderate levels of depressive or anxiety symptoms can affect work performance and productivity. It is in the employer's best interest to address mental health as part of a worksite wellness program.

A positive work environment decreases stress, improves overall health, and boosts productivity (NMHA 2006). Most mental illnesses are highly treatable at 70-90 percent; however, untreated mental illness can increase the risk for possible suicide.

Employers can do more to promote integrated mental and physical health care by creating supportive workplaces that destigmatize mental illness, encourage self-screening, and connect employees to resources. These successful businesses will not only generate cost savings seen in improved employee engagement and well-being, results will be shown in higher product quality, better cost control, greater employee loyalty, and healthier workplaces.

HOW

TABLE KEY 
I = Individual level
E/O = Environmental / Organizational level
P = Policy level

LOW RESOURCES	I	E/ O	P
1. Provide materials and messages about mental health, mental illnesses, suicide prevention, substance use, trauma, and health promotion through various means: brochures, fact sheets, paycheck stuffers, intranet, etc.	★	★	
2. Provide resources for confidential screenings for depression, anxiety, post-traumatic stress disorder, etc. (personal, on-line, print)	★	★	
3. Encourage the use of telephone help lines - 800 numbers	★	★	
4. Provide a variety of mental health presentations and trainings with an emphasis on prevention, treatment, and recovery messages for all staff including supervisors/managers, and executive leadership.	★		
5. Offer stress reduction presentations on varied topics: conflict resolution, managing multiple priorities, project planning, personal finance planning, parenting, etc.	★	★	
6. Provide flexible scheduling during work for lunch and learn and other trainings such (yoga, meditation, physical activity, self-help groups, etc.)		★	★
7. Provide a quiet room or stress reduction room at the worksite.	★	★	
MEDIUM RESOURCES			
1. Create and sustain a mental health-friendly workplace that provides support and accommodations for employees who are returning to work after receiving or are in mental health/alcohol treatment and recovery. Provide family/employee flexibility allowing schedule accommodations for medical/treatments, sessions, and appointments, as needed.		★	★
2. Provide trainings specific to educating managers/supervisors in recognizing mental health as a factor in performance issues and offer interactive training components and information for supervisors/managers on how to engage EAP, HR and other resources. Provide targeted mental health support for supervisors/managers and executive leadership addressing mental health issues specific to their needs and stressors.	★	★	★
3. Create policies and practices that provide guidance to supervisors/managers on how to address performance issues, which include offering consultation, accommodation, and information through EAP or include the HR staff.		★	
4. Review policies and practices concerning employee privacy and confidentiality, return to work and HIPAA, accommodation and ADA guidelines.			★
5. Evaluate or reevaluate the workplace environment, the organization, and its culture with a focus on reducing workplace stress, workload issues, performance reviews, address employee engagement and concerns.		★	★
HIGH RESOURCES			
1. Provide onsite or off-site Employee Assistance Program (EAP).	★	★	
2. Provide confidential Employee Assistance Coordinators (EACs) to help staff obtain information about supportive resources in their community.	★	★	
3. Provide and maintain comprehensive health insurance coverage, which includes mental health as part of employee benefits packages. Include screening, brief intervention and referral (SBIRT) as a covered evidence-based benefit.	★	★	★
4. Provide and maintain comprehensive health insurance coverage with referral mechanisms to connect employees easily to mental health treatment services.	★	★	★
5. Become a workplace that is able to provide assistance to serious mental illnesses and major traumatic events.		★	★

BEST GENERAL RESOURCES:

Calculators:

Log on to these free calculators to find out how depression and alcoholism are affecting your organization's bottom line:

www.depressioncalculator.org

<http://www.depressioncalculator.com/Welcome.asp>

www.Alcoholcostcalculator.org

http://www.wellsteps.com/roi/resources_tools_roi_cal_health.php

<http://hc-sc.gc.ca/ewh-semt/occup-travail/work-travail/cost-cout/index-eng.php> (*Self-Assessment Tool for Measuring the Costs of Work Stress*)

- ❖ Partnership for Workplace Mental Health. A program of the American Psychiatric Foundation, which advances effective employer, approaches to mental health by combining the knowledge and experience of the American Psychiatric Association and employer partners. The quarterly journal is: Mental Health Works. www.workplacementalhealth.org
- ❖ Mental Health America of Wisconsin (affiliated with National Mental Health America): <http://www.mhawisconsin.org/Content/> Offers a Milwaukee MH Provider Guide and provides mental health resources, fact sheets, MH and AODA online screenings. MHA created a collaborative effort between MHA and the business community. The "Healthy Mind Connection" addresses mental health in the workplace-includes links, and mental health friendly workplace resources.
- ❖ The Employer's Guide on Disability and Employment: Work Source Wisconsin www.WorkSourceWi.com Phone: 1-866-460-9602

LOW RESOURCES

1. Provide mental health and mental illness materials through various means - brochures, fact sheets, paycheck stuffers, intranet, health fairs, etc.
 - ❖ Mental Health America: <http://www.nmha.org>
This link will take employers directly to a comprehensive site offering fact sheets on mental illnesses and other mental health information and stress. Site offers Mental Health in the Workplace toolkit and other helpful information provided by Mental Health America to businesses/employers.
 - ❖ American Psychiatric Association: www.healthyminds.org
Resources and information on mental illness/mental disorders across the life span.
 - ❖ National Institute on Mental Health: www.nimh.nih.gov
 - ❖ Current health information, articles, and research. www.webmd.com
 - ❖ Medline Plus: Provides mental health resources in English and Spanish;
<http://www.nlm.nih.gov/medlineplus/mentalhealth.html>
 - ❖ National Mental Health Information Center, SAMHSA:
<http://www.healthfinder.gov/orgs/HR2480.htm>
Provides a wide array of information on mental health to people, the public, policymakers, providers and the media.
2. Offer confidential screenings: depression, bipolar disorder, generalized anxiety, post-traumatic stress disorder, eating disorder, alcohol abuse (on-line / print)
 - ❖ Screening for Mental Health (SMH): <http://www.mentalhealthscreening.org/>
Offers six mental health screening tools (assessment) with telephone and online interactive screening. SMH is the largest provider of evidence-based health screening tools.
 - ❖ Wisconsin United for Mental Health: Provides a direct link to screening tools
www.wimentalhealth.org
 - ❖ Mental Health and Alcohol Use Screening Tool (Mental Health America of Wisconsin):
<http://www.mhawisconsin.org/screening.aspx>

3. Encourage the use of telephone help lines - 800 numbers
 - ❖ Wisconsin has a partial system of 2-1-1 information and referral lines. 2-1-1 in some communities, United Way in other communities.
 - ❖ National Suicide Prevention Lifeline: 1-800-273-TALK www.suicidepreventionlifeline.org
 - ❖ Maternal and Child Health Hotline (MCH): 1-800-722-2295 www.mch-hotlines.org
Referrals to services and county specific resources
 - ❖ Wisconsin Mental Health or Substance Abuse Services: 267-7792 or 267-2717
Local mental health departments/crisis numbers: http://dhfs.wisconsin.gov/MH_BCMH/index.htm
4. Provide a variety of mental health presentations and trainings with an emphasis on prevention, treatment, and recovery messages for all staff including supervisors and management.
 - ❖ Check with local health insurance providers to see if they offer classes and resources.
5. Offer stress reduction presentations on varied topics: conflict resolution, managing multiple priorities, project planning, personal finance planning, etc.
 - ❖ Check with local health insurance providers to see if they offer classes and resources.
 - ❖ A local listing of stress management programs can be found at:
www.yellowbook.com/category/stress_management_programs/Wisconsin
 - ❖ Mindfulness-based Stress Reduction www.sharpbrains.com
 - ❖ Stress at Work Toolkit: The US DHHS <http://www.cdc.gov/noish/docs/99-101>
6. Provide flexible scheduling for access to classes during work or childcare after work for yoga, meditation, physical activity, etc. *Need supervisory buy-in and encouragement.*
7. Provide a quiet room or stress reduction room at the worksite. *Set aside a room in a quiet place to provide short stress breaks for employees.*
8. Offer self-care resources for employees dealing with depression or other mental health problems in the workplace.
 - ❖ Anti-Depressant Skills at Work: Dealing with Mood Problems in the Workplace
<http://www.comh.ca/antidepressant-skills/work/>
 - ❖ WRAP for Work: Recovery at Work: <http://www.mentalhealthrecovery.com/>

MEDIUM RESOURCES

1. Create and support a mental health friendly work environment that provides family/employee friendly accommodations for medical appointments when needed.
 - ❖ Workplaces That Thrive: A Resource for Creating Mental Health-Friendly Work Environments
http://www.promoteacceptance.samhsa.gov/publications/business_resource.aspx
 - ❖ Mental Health Association of Minnesota (MHAM) offers a toolkit and mental health resources/links for employers for mentally healthy workplaces. <http://www.mentalhealthmn.org>
 - ❖ The Healthy Mind Connection, a collaborative effort between Mental Health America of Wisconsin and the business community, provides education, tools and resources to address mental health in the workplace. This site offers fact sheets, links, and mental health friendly workplace resources for employers nationally and in Wisconsin.
Mental Health America of Wisconsin: <http://www.mhawisconsin.org/Content/>
 - ❖ The Resource Center to Address Discrimination and Stigma (ADS Center), sponsored by SAMHSA, helps people design, implement and operate programs that reduce discrimination and stigma associated with mental health problems.
URL: <http://www.stopstigma.samhsa.gov/>
2. Provide mental health friendly presentations and mental health trainings for supervisors, business leadership team or management. *Check with EAP, local health providers for speakers or trainers.*
3. Create policies that provide guidance to supervisors on mental health consultation and information, and improve their skills to intervene or supervise an employee with mental health issues.
 - ❖ Mental Health Works. Complex issues. Clear solutions. Offers an Interactive course for supervisors/managers with resources CD-ROM. <http://www.mentalhealthworks.ca>
 - ❖ Employers and educators need practical information about reasonable accommodations for people who have psychiatric disabilities. <http://www.bu.edu/cpr/reasaccom/index.html>
4. Review policies and practices concerning employee privacy and confidentiality, return to work and HIPAA, accommodation and ADA guidelines.

- ❖ www.mhawisconsin.org
 - ❖ www.NAMI.org
 - ❖ www.wimentalhealth.org
 - ❖ Department of Labor, Office of Disability Employment Policy. A robust site with comprehensive information for employers on accommodation and workplace information. www.dol.gov/odep
5. Evaluate or reevaluate the workplace environment, the organization, and its culture with a focus on reducing workplace stress, workload issues, performance reviews, address employee engagement and concerns.

HIGH RESOURCES

1. Provide onsite or off-site Employee Assistance Program (EAP)
Employee Assistance Professionals Association www.eapassn.org
2. Provide Employee Assistance Coordinators (EACs) to help staff obtain information about treatment and recovery resources in their community. <http://www.eac.org>
3. Provide and maintain comprehensive health insurance coverage, which includes mental health and substance abuse as part of the employee benefits package
 - ❖ Information about federal health care requirements and resources: <http://www.healthcare.gov>
 - ❖ Health Insurance-Provision of Mental Health and Substance Abuse Frequently asked questions at: <http://www.mentalhealth.samhsa.gov>
 - ❖ Mental Health Insurance Pays: <http://www.webmd.com/news/20060329/mental-health-insurance-pays>
4. Offer health insurance coverage with referral mechanisms to connect employees easily to mental health services. Include Screening and Brief Intervention and Referral to Treatment (SBIRT) for substance abuse as a covered benefit service for your employees. WI Initiative for Promoting Healthy Lifestyles <http://www.WIPHL.org>
5. Become a workplace that is able to provide assistance to serious mental illnesses and major traumatic events.
Trauma can have a significant impact on a person's well-being, mental health, and use of substances. The website for the National Center for Trauma-Informed Care includes information about the effects of trauma and how workplaces can create trauma sensitive and informed environments: <http://mmentalhealth.samhsa.gov/nctic>
 - ❖ Handling Traumatic Events: A Manager's Handbook, a U.S. Government publication with guidance on anticipating and reacting to traumatic events such as suicides, assaults, and natural disasters. <http://www.opm.gov/ehs/htm/toc.asp>
 - ❖ Supported Employment: Workplace Accommodations and Supports. Provides information to employers on how to help persons with mental illnesses in the workplace who require a more structured strategy for assistance for persons who have more serious mental illnesses to obtain and maintain employment through the provision of ongoing support.
 - ❖ http://www.disability.gov/employment/.../supported_employment
<http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/employment>

Attachment 8: MHA Project: Evaluation Component

I. OVERVIEW

OBJECTIVE

Primary objective is to improve the productivity and reduce employer costs associated with absenteeism, disability claims and health care costs due to unrecognized and untreated mental disorders. This will be accomplished by enhancing the overall mental well-being of management and employees via the development and dissemination of appropriate management training tools and employee education tools.

EMPLOYER PARTICIPANTS

We have a goal of retaining at least 10 employers for the project. Organizations are expected to vary across demographics such as industry, size, revenue, employee mix (blue-collar, white-collar, age, etc).

ASSUMPTIONS

- Feedback will be a vital determinant of program success. Implications are for timely entry of data and for continuous feedback.
- The program evaluator will be responsible for developing and hosting all surveys, forms and reporting tools.
- To support timely data entry online forms will be created to enter aggregate data such as number of EAP referrals in a given month; number of EAP website hits, etc.
- Dashboards will be created and updated regularly for leadership review and to promote buy-in.
- All measures collected during the project will necessarily be collected at baseline, where feasible.
- Multiple outcome measures will be collected at each collection point.
- Data will be reported in aggregate only.
- Data collected on an individual basis (survey data) will be collected confidentially, stripped of identifiers, and reported in aggregate only.
- We will rely on existing tools where feasible (where psychometric data are available) with a preference for public domain instruments. For example, a number of public domain short surveys exist for assessing self-efficacy, presenteeism, workplace distress and other measures of intermediate and long-term outcomes. We will adapt and incorporate a number of these into a master survey instrument. For purposes of comparison and to preserve psychometric properties, full scales (sets of items within a given survey that target specific content domains) will be retained where suitable. Proprietary tools will be used only with authors' permissions.
- The master survey for employees will be translated to non-English versions as necessary and feasible to accommodate other primary language needs (contingent upon the needs of the participating organizations)
- We assume that employers will be 'new' to evaluation and will need significant support and materials aimed at ensuring high levels of organizational engagement.
- We assume that employers will allow employees to complete online tools while on the job. For those without computer access at work, paper versions will be made available and keyed by MHA staff
- Study consent will be obtained for all those participating in the project
- We expect to obtain IRB approval for the project
- We expect to conduct the evaluation project in a manner suitable for publication in a peer-review journal.

EVALUATION DOMAINS (see section II for potential measures in each domain)

- Organization/employee engagement (overt support for program)
- Structural/organization measures (organizational infrastructure)

- Barriers/Facilitators (personal/social stigma, access to mental health services, self-efficacy)
- Process/Utilization measures (service/product offerings and participation)
- Short-term and intermediate outcome measures:
 - ✓ Leadership training effects on management awareness, education, behavior, employee interaction
 - ✓ Employee education effects on employee awareness, education, behavior
- Long-term outcome measures: absenteeism, presenteeism, workplace distress/engagement, employer health care and disability costs.

ANALYSIS

Short-term and Intermediate outcomes are understood mostly to be proxies for long-term outcomes. When conducting analyses of long-term outcomes, these same short-term and intermediate outcomes will be used as descriptor/predictor variables to understand changes in long-term outcomes.

Early proxies for long-term outcome measures such as process measures will be used to develop a final analytic model. The analytic model will be developed from other key metrics that one-by-one prove to be helpful (based on univariate statistical analyses). The final analytic model will tell us which of all the key metrics contribute together to effect long-term outcomes

Outcomes analysis will look at change in long-term outcomes such as absenteeism, medical claims data for depression and other mental health indices via a regression equation. Key drivers will include engagement measures, structural measures, process measures, utilization measures. In effect, we will be able to attribute changes in key employee mental health outcome measures to the degree of organization engagement, organization wherewithal to support salutary MH activities, the extent of offerings and the extent of participation in those offerings, and the relative influence of facilitators and barriers.

TIMELINE

Project will consist of three primary phases:

- Phase 1 refers to baseline data collection and development of supervisor training and employee education materials, and program launch. Estimated time to complete 12 months.
- Phase 2 refers to the implementation component of the program and begins with the program launch (completion of Phase 1). Estimated time to complete 20 months. Supervisor/manager training is envisioned to take place primarily during the first six months of year two, however implementation will vary by employer based on their training schedule, number of supervisors/managers to be trained and number of locations. The employee education campaign is envisioned to roll out in a consistent manner across all employers (e.g., specific interventions identified for each month of year two). The basic campaign is expected to cover year two of the grant. In order to help assess the long-term effects of the educational and training messages, a booster session will occur in the middle of grant year three. It is expected that with time, knowledge and skill levels will atrophy. A booster session is expected to help restore knowledge and skill levels.
- Phase 3 refers to analysis and reporting. Estimated time to complete 4 months although dashboard and other reports are expected to be produced throughout the evaluation period.

Phase 1

Baseline data (below) are important for comparison with long-term outcomes.

- Absenteeism; # of days, day of the week (from HR)
- Presenteeism (scale from Workplace Outcome Suite)
- Life satisfaction (scale from Workplace Outcome Suite)
- Workplace distress (scale from Workplace Outcome Suite)
- Number of MH claims; cost of MH claims
- Culture assessment
- Depression calculator
- Number of referrals to EAP, mental health provider, other

- Mental health mix survey (determination of employee mix of mental health issues from claims data or other sources)
- Master surveys (a combination of public domain mental health items/scales and items/scales developed specifically for this project)
- Organizational readiness to change assessment

Pre-project data collected prior to any interaction with employers (immediately prior to initiation of development phase). Confirmatory baseline data collected as needed (immediately prior to program dissemination). These same measures will be captured as long-term outcomes (both 16 and 20 months post-launch).

Phase 2/Phase 3

See table at end of document.

EVALUATION REFINEMENT

The evaluation plan was reviewed with potential employers during the development of the grant application. Employers indicated their ability to provide the types of data identified. Once a grant is awarded we will have further discussions with employers to more specifically identify the data sets, data collection plan and survey items and administration. We assume that during this process we will identify the need to refine or revise certain aspects of the evaluation. The goal is to always include measures for all the evaluation domains identified above, although the specific measures, number of measures and collection schedule may be modified to meet employer constraints. Finalization of the master surveys will occur with employer input as to desired/feasible length and item set.

II. POTENTIAL MEASURES

ORGANIZATION/EMPLOYEE ENGAGEMENT

- Number and types of communication modalities used to introduce initiative
- Number and types of communication modalities used during each temporal interval
- Frequency (number of times any given communication occurs)
- CEO/President formally encouraged participation? (y/n) If yes, how?
- Upper management formally encouraged participation? (y/n) If yes, how?
- Middle management formally encouraged participation? (y/n) If yes, how?
- Supervisors formally encouraged participation? (y/n) If yes, how?
- Employee leadership formally encouraged participation (y/n) If yes, how?
- Readiness for organizational change survey questions
- An employee advisory group will be formed or identified (if already extant) to help create grassroots support for program
- A key HR person or similar will be identified and serve as the primary contact for both employees and for the evaluator
- A backup individual is identified or plan is created to ensure project continuity if there is a change in the key HR person.

STRUCTURAL/ORGANIZATION MEASURES

This information, provided by the employer, will measure the wherewithal to provide MH employee support or help to differentiate employers on key demographics:

- We offer behavioral health benefits (y/n)
- Mental health coverage (plan description)
- Behavioral health benefits are offered at parity with other medical conditions (y/n)
- Which of the following describes your pharmacy benefit...
- EAP (y/n)
- Number of EAP staff
- HR w/no EAP (y/n)
- Number of HR staff
- Number of HR staff serving employees with MH issues
- Industry
- Annual Revenue
- Org website with MH portal (y/n)
- Organizational mental health culture
- Employee demographics: number of employees including demographic breakout by gender, age, etc.
- Mental health mix characterizing the relative prevalence of key mental health issue (from claims data, etc)

BARRIERS AND FACILITATORS

- Stigma (included as a scale in Master survey)
- Self-efficacy (included as a scale in Master survey)

PROCESS/UTILIZATION

- Number and types of training/educational materials used
- Frequency and timing of use for each
- Modality used for dissemination (online, hard copy, meeting)
- Participation rates per activity/event
- Satisfaction rates per activity/event

SHORT-TERM AND INTERMEDIATE OUTCOMES

- By self-report (survey), employer partners have better understanding & knowledge of ...

- Workplace mental health
- HIPAA/ADA issues
- Supervisory skills for handling MH issues
- By self-report (survey) employees demonstrate
 - Increased understanding of MH issues
 - Reduced stigma through attitudinal change and willingness to address MH issues
 - Awareness, beliefs, attitudes
- By self-report (survey) management assessed for...
 - Felt comfort and confidence dealing with MH issues (including stigma & self-efficacy)
 - Felt comfort and confidence dealing with HIPAA/ADA aspects of MH issues (including stigma & self-efficacy)
 - Satisfaction with the training they have received
 - Reported openness on part of employees
 - Felt support from upper management
 - Number of different employees spoken with concerning MH issues/concerns
- By self-report (survey) employees assessed for...
 - Felt comfort and confidence dealing with MH issues
 - Felt comfort and confidence dealing with HIPAA/ADA aspects of MH issues
 - Satisfaction with the training they have received
 - Indicate reduced levels of stigma
 - Report more openness on part of employees
 - Number of different employees spoken with concerning MH issues/concerns
- Number of EAP referrals
- Number of EAP or other org MH website hits
- Number of other services utilized
- Number of new counseling cases

LONG-TERM OUTCOMES

- Absenteeism; # of days, day of the week per person (from HR)
- Presenteeism (scale from Workplace Outcome Suite)
- Reduced overtime to cover absent employees
- Health care costs
- Number of MH claims
- Life satisfaction (scale from Workplace Outcome Suite)
- Workplace distress (scale from Workplace Outcome Suite)
- Number of MH claims; cost of MH claims
- Empathia culture assessment
- Depression calculator
- Number of referrals
- Mental health mix survey

III. MASTER SURVEY

Two master survey instruments will be developed: Management and Employee. The Master surveys will include items that can inform the evaluation of barriers/facilitators, short-term and intermediate outcomes and long-term outcomes. The Management Master survey will reflect in part the content of management training materials. The Employee Master survey will reflect in part the content of the employee educational materials. Where appropriate, same/similar questions will be asked for both versions for purposes of comparison; i.e., a similar change in ratings among supervisors and employees on questions related to MH stigma would help show whether a system/culture shift has occurred. Survey topics will include, but not necessarily be limited to, the following:

- Awareness of MH prevalence in society and the workplace
- Knowledge/beliefs about mental health issues
- Attitudes toward mental health issues and those with them (including stigma)
- Evaluation of barriers/facilitators related to access to care, stigma, sense of self-efficacy
- Self-reported MH issues, workplace distress
- Self-reported workplace engagement, presenteeism
- Self-reported use of medications/herbals for MH issues

The following are possible sources of questions/scales for the Master Survey or other tools. We expect that the Master surveys will contain 25-50 questions. We will NOT be using all the tools below with all questions (would be hundreds of questions), but will likely be taking select items or scales from the surveys below (with authors' permission for proprietary tools).

Current grant survey (26 items for employers)

- Perceived impact of behavioral health issues on workplace
- Do you have an EAP
- Percent of employees using EAP

Workplace Outcomes Suite (25 items; 8 item short form)

Sample Items below (Strongly agree to Strongly disagree)

- >I feel stimulated by my work
- >I feel passionate about my job
- >My life is nearly perfect

Stanford Presenteeism Questionnaire (13 items for employees)

Sample Items below

- >In the past month, have you experienced depression, stress or anxiety? y/n/dk
- >At work, I was able to focus on achieving my goals despite my depression, stress or anxiety. Strongly agree to Strongly disagree
- >Despite my depression, stress or anxiety, I felt energetic enough to complete all my work

HRA-University of Michigan (60 items for employees with most not needed)

Sample Items below

- In general, how satisfied are you with your life (include personal and professional aspects). Completely satisfied to Not satisfied
- In general, how strong are your social ties with your family and/or friends?
Very strong to Weaker than average
- How often do you feel tense, anxious or depressed? Often to Never

Quick Inventory of Depression Symptoms Self-report (16 items for employees)

Sample Items below (for past 7 days)

- I never take long than 30 minutes to fall asleep; I take at least 30 minutes to fall asleep, less than half the time; I take at least 30 minutes to fall asleep, more than half the time; I take more than 60 minutes to fall asleep, more than half the time
- There is no change in my usual appetite; I eat somewhat less often or lesser amounts of food than usual; I eat much less than usual and only with personal effort; I rarely eat within a 24-hour period and only with extreme personal effort or when others persuade me to eat.

World Health Organization Health and Work Performance Questionnaire (HPQ; 11 items)

Sample Items below

- How often was your performance lower than most workers on your job?
- How often did you not concentrate enough on your work?
- How often was the quality of your work lower than it should have been?

Centers for Disease Control Workplace Health Site Visit Interview Questions (49 items)

- Which of the following avenues are used within your organization to communicate information to employees?
--intranet/website, --e-mail, --newsletter, --bulletin board, --payroll stuffers, --mailings to employees' home, --other
- Does your organization have annual objectives for wellness (committee, departmental, individual)?
- Why are you interested in health promotion activities

Empathia culture assessment

Proprietary (28 items; +/- 5 points; 10 point scale total)

Organizational readiness to change

Sample Items below (5-7 items, y/n)

- We have a mental health initiative in place now
- We have considered adding a mental health initiative over the past 6 months
- We have no plans to add a mental health initiative over the next 6 months

Below is the timeline for Phase 2 Evaluation and Phase 3 Analysis-Reporting

Tool/Domain	Baseline April 2013- Mar 2014	Short-term outcomes April 2014- July 2012	Intermediate outcomes August 2014	Intermediate & Long-term outcomes April 2015	Pre-booster Intermediate and long- term outcomes* Sep 2015	Post-booster Intermediate and long-term outcomes* Oct 2015	Analysis and Reporting Due by Mar 31 2016
DASHBOARD FEEDBACK	Yes	Yes	Yes	Yes		Yes	
MANAGEMENT							
STRUCTURAL MEASURES	Yes						
MENTAL HEALTH MIX	Yes			Yes			
MANAGEMENT ENGAGEMENT	Yes	Yes	Yes	Yes			
PROCESS MEASURES		Yes	Yes	Yes	Yes	Yes	
EMPLOYEE UTILIZATION/PARTICIPATION MEASURES		Yes	Yes	Yes	Yes	Yes	
TRAINING MATERIALS/PROGRAM SATISFACTION		Yes					
<u>MASTER SURVEY: MGMT</u> INCLUDING AWARENESS, KNOWLEDGE, BELIEFS, STIGMA, SELF-EFFICACY	Yes	Yes	Yes	Yes	Yes	Yes	
INTERMEDIATE OUTCOMES	Yes	Yes	Yes	Yes			
LONG-TERM OUTCOMES	Yes	Yes	Yes	Yes	Yes	Yes	
EMPLOYEES							
EDUCATION MATERIALS/PROGRAM SATISFACTION		Yes					
<u>MASTER SURVEY: EMPLOYEE</u> INCLUDING AWARENESS, KNOWLEDGE, BELIEFS, STIGMA, SELF-EFFICACY	Yes	Yes	Yes	Yes	Yes	Yes	

*Booster Session: We propose to end the employee (including management) education by Apr 2015. Six-months later (Oct 2015), a booster education/training session will occur in which select measures will be repeated one month before and after

Attachment 9: Logic Model for WPP Implementation Grant Proposal /Mental Health America of Wisconsin

Inputs	Activities	Outputs	Short-Term Outcomes (Attitudes, Learning)	Intermediate Outcomes (Action)	Long-term Outcome (Condition)s
<p>Community partners:</p> <ul style="list-style-type: none"> ▪ MHA-Wisconsin ▪ WUMH ▪ The Alliance ▪ BHCG ▪ DHS <p>Employer partners/ pilot sites</p> <p>Academic partner: Jerry Halvorson, M.D. Evaluator: Bill McGill</p> <p>WPP Grant Advisory Board</p> <p>Resources developed under WPP development grant:</p> <ul style="list-style-type: none"> ▪ Strategic plan ▪ Compilation of workplace MH resources ▪ Findings from focus groups and interviews with employers <p>MH @ Work Sup/Mgr. training</p> <p>Worksite Wellness Toolkit</p> <p>WPP funding</p> <p>In-kind contributions from partners</p>	<p>Ongoing development and strengthening of project partnership through addition of employer partners, regular teleconferences, meetings and exchange of information.</p> <p>Periodic meetings of Grant Advisory Board.</p> <p>Develop overall project work plan and evaluation plan</p> <p>Refine and reformat supervisor/manager training to better meet employer needs.</p> <p>Explore and identify effective ways to help employers address HIPAA/ADA issues related to employee MH</p> <p>Identify or develop and then pilot MH-related presentations and trainings to employees</p> <p>Enhance and refine the Workplace Wellness Resource Kit</p> <p>Evaluate overall project</p>	<p style="text-align: center;">Process Outputs</p> <p>Effective partnerships among community partners, employer partners, academic partner and evaluator</p> <p>Development of Advisory Board</p> <p>Finalized project work plan and evaluation plan</p> <p style="text-align: center;">Final Outputs</p> <p>Supervisor/manager training is developed, refined, and field-tested at pilot employer sites</p> <p>Guidance and resources related to HIPAA/ADA requirements are developed and field-tested at employer sites.</p> <p>MH-related presentations and trainings for employees are developed, refined, and field-tested at pilot employer sites.</p> <p>Workplace Wellness Resource Kit is enhanced and disseminated.</p> <p>Results from all grant activities are analyzed, summarized, shared with partners, and reported to WPP</p> <p>Presentation materials developed reflective of grant findings</p>	<p>Grant partners and Advisory Board members are satisfied with:</p> <ul style="list-style-type: none"> • the operation of the partnership (e.g. communication, collaboration) • the project outputs and the potential for improving workplace mental health. <p>Employer partners have better understanding and knowledge of:</p> <ul style="list-style-type: none"> • workplace mental health, • HIPAA/ADA issues • MH-related resources for employees. • Supervisory skills for handling mental health issues in the workplace <p>Employees demonstrate:</p> <ul style="list-style-type: none"> • increased understanding of mental health issues • Reduced stigma through attitudinal change and willingness to address mental health issues 	<p>Supervisors/managers demonstrate:</p> <ul style="list-style-type: none"> • Greater comfort and confidence in dealing with employee MH issues • Greater comfort and confidence in addressing HIPAA/ADA aspects of employee MH situations <p>Employees are more willing to seek out help, when needed, for mental health concerns.</p> <p>Employer partners are more willing to actively address issues and implement policies and solutions to recognize, support and address mental health concerns.</p>	<p>Employees demonstrate:</p> <ul style="list-style-type: none"> ▪ Improved productivity ▪ Reduced absenteeism / presenteeism ▪ More effective use of health services (less use of general medical care, greater use of specialized mental health care); reduced health care costs ▪ Reduced use of disability benefits; reduced disability costs. ▪ Reduced stress and / or stress coping <p>Workplaces indicate benefits from improved employee MH:</p> <ul style="list-style-type: none"> • Healthier • More productive • Supportiveness