The Unbearable Lightness of Mental Health

Alberto Colombi, MD, MPH

Is wellness just a physical matter? Is the burden of disease just a matter of costs? These are obviously rhetorical questions. No one would challenge the notion that health is more than the absence of disease and is at the very least a state of mental and physical well-being. But how often do we try to understand “mental wellness”? How often do we look into screening, diagnosis, intervention, and referral of mental issues in a fragmented mental healthcare system?

Similarly, no one would deny that the total burden of disease on work and on society is more than just its direct healthcare cost. Most of us recognize that indirect healthcare costs should be factored in, and these include absenteeism and presenteeism. Nevertheless, how often do we truly try to quantify health-related loss of function, hindered performance, and, ultimately, productivity loss? Compounding mental health and productivity loss, how well do we do in weighing in the intangible loss of function associated with mental stress and disease?

From prevention to treatment, there is an unintended but actual difference in how matters of physical and mental wellness are being addressed—one with empathy, the other with stigma. For instance, should an injury occur, a legion of good healthcare and safety colleagues will investigate, intervene, and discuss corrective actions. Should a heart attack happen—a personal matter, mind you—emergency response would be activated, people trained in CPR would come forward, defibrillators would be made available, and wellness teams would address risk prevention—from blood pressure to cholesterol level—and, in the back end, coronary artery disease claims utilization and costs would be analyzed.

But what about stress or depression, let alone a fatal case, as in suicide? A hallway murmur would follow perhaps, but no one will ask:

- Could it have been prevented?
- Are our health programs adequate?
- Did our wellness team raise awareness?
- Do we facilitate access to treatment and to prevention of mental discomfort and disease?
- Are our employee assistance programs proactive?

It is “personal,” we have no right “to interfere,” and we do not mean to. But would you let a personal heart attack take place without questioning if the ambulance arrives on time? Without activating the emergency response system, without even trying CPR, and without questioning if appropriate cardiovascular health-promotion programs are in place? Two personal matters that are nevertheless being treated very differently.

One argument for such disparity is that mental health is light, evanescent, elusive. Even excluding the personal suffering, if we look at economic figures only, that alone should be a compelling reason to better understand the whole “weight” of the issue.

Let us look at some preliminary figures. In our company, during a period of 7 years or so, some 28,000 employees filled out a self-reported Health Risk Assessment (HRA) Questionnaire online. Of these, about 19,000 were US employees, of whom about 1800 voluntarily filled out the validated depression screening instrument Patient Health Questionnaire (PHQ)-9 and responded to the Work Limitations Questionnaire (WLQ), which assesses limitations in performing normal job functions that result from physical or emotional matters. The WLQ calculates a Productivity Loss Index and a Time Loss Index. The approximately 1800 employees also completed a Stress Satisfaction Offset Score, which explores demand, control, effort, and reward of their job situation.

Thus unassumingly, imperfectly, and while attending to the usual center-stage physical wellness characters—cardiovascular disease, diabetes, and metabolic syndrome prevention—we found ourselves looking at a respectable sample of our own employees who were sending us a message about mental wellness. Such a message cannot be ignored—our own people telling us that stress is the most important risk factor for them (69%), but the one which they are least ready to change (11%), either because they are not interested in

Dr Colombi is Corporate Medical Director, PPG Industries, Inc, Pittsburgh, PA.

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change, or possibly because they do not believe that change is possible.

We are trained to interpret self-reported chronic conditions, predisease predictors, and lifestyle risk factor stratification, but we are unprepared to read through a message about stress, let alone depression. We wonder what this all means: Is there an unrecognized issue of adapting organizations to human psychology—“organonics”—as much as there is a recognized need of adapting tools to human physiology, as in traditional ergonomics? While we wonder about organizational stressors and the possibility of prevention, we also ask ourselves what will be the treatment experience for those who might have screened positive for clinically relevant depression.

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Although their triage ends with the recommendation to consult with their personal physician—who is really taking care of them, and how? What will be their rehabilitation and early and safe return to work experience in a fragmented healthcare system, where stigma for mental disease does not facilitate early identification, screening, referral, and return to function?

Can we at least make the business case that mental wellness deserves as much attention as physical wellness does? Let us take another look at the productivity loss associated with these preliminary data.

Our company’s preliminary self-reported HRA data show that besides the expected impact of allergies and bronchitis, stress and depression are of utmost importance for preventing productivity loss. Stress is one of the most relevant factors for loss of productivity on a population basis. According to our data, about $2 million are estimated lost per 1000 employees each year due to sub-par performance resulting from what is defined as “stress.” These data give equal importance to stress at work and at home, stress about parental care as much as about care for an elderly relative. Similarly, our data indicate that depression is another critical area for loss of engagement and productivity.

In addition, our data show that not only the few severe, untreated depression cases result in very high individual productivity loss, but that the moderate and mild depression cases, which are more common, add up to the overall population burden of disease when prevalence is considered. In fact, moderate and mild unaddressed depression may account for two thirds of the burden of depression on overall productivity loss. This, in our data, is estimated to translate to about $1 million per 1000 employees annually. Accordingly, we would estimate that each year, for every 1000 employees, possibly $3 million is lost in absenteeism or presenteeism because of stress and depression combined. Even if these estimates need further critical refinement, this entire issue carries substantial weight on financial grounds alone.

Let me conclude with the obvious: Economics is not the only consideration. In the initial days of occupational safety many decades ago, the seeds of good safety programs were rooted in the moral unwillingness to accept the “normalcy” of preventable disease, disability, and loss of life. Similarly, I am confident that mental well-being has to start with our nonacceptance of stigma and avoidable, crippling disability—let alone loss of life—from mental illness.

Although mental distress requires the respect that is due to personal matters, it also deserves supportive environments, relationships that respect employees’ dignity, and practical ways of balancing work and life. Keeping employees healthy, productive, and engaged is arguably a good business proposition. And although mental health seems “soft,” its unbearable lightness does measure up in the ability of health to generate wealth.

References