Center for Prevention and Health Services

National Business Group on Health

AN EMPLOYER'S GUIDE TO BEHAVIORAL HEALTH SERVICES

A roadmap and recommendations for evaluating, designing, and implementing behavioral health services

- **Major Trends in the Epidemiology, Treatment, and Cost of Behavioral Healthcare in the United States**
- **The State of Employer-Sponsored Behavioral Health Services in the United States**
- **Recommendations to Improve the Design, Delivery, and Purchase of Employer-Sponsored Behavioral Healthcare Services**

- **Overview of the President's New Freedom Commission on Mental Health**
- **Measuring Quality in Behavioral Healthcare**

What is Behavioral Healthcare?

Behavioral healthcare is an umbrella term and refers to a continuum of services for individuals at risk of, or suffering from, mental, behavioral, or addictive disorders. Behavioral health, as a discipline, refers to mental health, psychiatric, marriage and family counseling, and addictions treatment, and includes services provided by social workers, counselors, psychiatrists, psychologists, neurologists, and physicians. In this publication, the term "employer-sponsored behavioral healthcare services" refers to all employer-sponsored services that address mental health or substance abuse problems including services offered through the health plan, disability management programs, EAP, and health promotion or wellness programs.

What is a Mental Illness?

Mental illness/behavioral health disorder (also known as mental disorder): is a health condition that is characterized by alterations in thinking, mood, or behavior (or some combination thereof), that is mediated by the brain and associated with distress and/or impaired functioning. Mental disorders cause a host of problems that may include personal distress, impaired functioning and disability, pain, or death.

Serious emotional disturbance (SED): A diagnosable mental disorder found in persons from birth to 18 years of age that is so severe and long lasting that it seriously interferes with functioning in family, school, community, or other major life activities.

Serious mental illness (SMI): A SMI is defined as a diagnosable mental, behavioral or emotional disorder that meets the criteria specified in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) and causes functional impairment that limits one or more major life activities. Examples of individuals who meet these criteria include those adults with: mood disorders (major depression, dysthymia, mania); anxiety disorders (panic disorder, generalized anxiety disorder, phobia, post-traumatic stress disorder); antisocial personality disorder, schizophrenia, and other non-affective psychoses.

Serious and persistent mental illness (SPMI): Individuals with the most severe types of Serious Mental Illness and who have the most severe functional limitations can be said to have serious and persistent mental illness (SPMI).

What is a Substance Abuse Disorder?

In this publication, a substance abuse disorder refers to either substance abuse or substance dependence. Substance abuse is the problematic use of alcohol or drugs occurring when an individual's use of alcohol or drugs interferes with basic work, family, or personal obligations. Substance dependence is a clinical diagnosis that is made when an individual using alcohol or illicit drugs meets at least three of the six criteria set forth in the DSM-IV for either alcohol or drug dependence including a strong desire to use the substance, a higher priority given to use than to other activities and obligations, impaired control over its use, persistent use despite harmful consequences, increased tolerance, and a physical withdrawal reaction when use is discontinued. Substance abuse and dependence can occur with the use of alcohol, illicit drugs, and prescription medications.

Sources: Department of Health and Human Services. Healthy People 2010. Chapter 18 – Conference Ed. Mental Health and Mental Disorders. Referenced on the SAMHSA Website. Terminology of Mental Disorders. http://www.mentalhealth.samhsa.gov/features/hp2010/terminology.asp. Accessed 8-24-05; World Health Organization. Lexicon of alcohol and drug terms. Available at: http://www.who.int/substance_abuse/terminology/ who_lexicon/en/index.html. Accessed 10-3-05.

Executive Summary

Introduction

The delivery of behavioral healthcare is relatively complex when compared to the delivery of general medical care. The industry annually generates more than $104 billion in direct care expenses and continues to experience rapid reorganization and realignment of services in response to purchaser demands. Employer, federal, state, and local government purchasing strategies continue to change in response to price and demand for behavioral healthcare services.

The complexity of the behavioral healthcare provider market has resulted from a combination of events and issues, including benefit design, payer and individual provider expectations, and new provider entrants into the marketplace. Major trends, such as consumer-driven healthcare, have and will continue to affect the delivery of behavioral healthcare. Both payers and providers need to carefully analyze the influence these trends have, and will continue to have, in shaping the delivery of care.

Recently, there has been an increased focus on the effective delivery of behavioral health services. The federal government as well as a number of other agencies and organizations have released landmark reports that chronicle the promise of timely, high-quality, and evidence-based behavioral health services for recovery, including the:

- *Surgeon General's Report on Mental Health (U.S. Department of Health and Human Services; 1999)*. The first ever Surgeon General's report on behavioral health presented the evidence to support a wide range of effective treatment modalities.
- *President's New Freedom Commission Report on Mental Health: Achieving the Promise — Transforming Mental Health Care in America (U.S. Department of Health and Human Services; July 2003)*. The taskforce, established by the President, examined the failings and successes of the public mental healthcare system and established six goals for improving behavioral healthcare in America.
- *Improving the Quality of Healthcare for Mental and Substance Abuse Conditions (The Institute of Medicine; November 2005, Quality Chasm Series)*. This report describes a multifaceted and comprehensive strategy for ensuring access, improving quality, and expanding mental health and substance abuse treatment services.

Employers understand that behavioral health benefits are essential components of healthcare benefits. Over the past few decades, employers have tried to improve the delivery of behavioral healthcare services in a number of ways. Despite important progress, employers' current approaches to managing cost and quality are insufficient. Standardized and integrated programs addressing the delivery of behavioral healthcare services remain rare. And unfortunately, it is not customary for employers to integrate behavioral healthcare benefits offered through the health plan with behavioral health benefits offered through disability management, employee assistance, or health promotion programs. The result is that employer-sponsored behavioral benefits are fragmented, uncoordinated, duplicative, and uneven in terms of access and quality.

Employers have been at the forefront of quality improvement in healthcare and have established quality measures, review processes, evaluation tools, and other means of promoting the quality of the healthcare services they sponsor. Most employers have focused their quality promotion efforts on general healthcare services. Now, employers need to focus on promoting the quality of the behavioral healthcare services they sponsor.

The National Business Group on Health (Business Group) has a strong history of addressing employer-sponsored behavioral healthcare services. Yet, until now, the Business Group has never released a comprehensive *Guide* on evaluating, designing, and implementing behavioral health benefit design.

Purpose of the Guide: A Blueprint for Action

This *Guide* is a blueprint of actionable strategies and recommendations that will allow employers to create and implement a system of affordable, effective, and high-quality behavioral health services. The recommendations featured in this *Guide* are based on the best-available administrative and clinical practices; these practices have years of evidence to support their immediate and widespread implementation.

The findings and recommendations presented in this *Guide* provide a process for employers to examine their current behavioral health benefits and services and to develop contracting requirements to guide their selection of future health plans, Managed Healthcare Organizations (MCOs), Managed Behavioral Healthcare Organizations (MBHOs), disability managers, Pharmacy Benefit Mangers (PBMs), and Employee Assistance Vendors (EAPs).

Specifically, this *Guide* provides information for employers to:

- Improve coordination among health management programs and vendors.
- Standardize the delivery of behavioral health services and programs, whether developed in the general medical setting or the specialty behavioral health system.
- Include evidence-based treatment modalities in behavioral health benefit structures.
- Develop enhanced programs and measures of continuous quality improvement.
- Promote quality and accuracy in the practice of prescribing psychotropic drugs.
- Improve the efficacy of disease management programs for chronic medical conditions by including behavioral health screening and treatment.

The goal of the *Guide* is to help employers:

- Increase employee health status
- Manage employee productivity
- Control the cost of healthcare and disability

Approach

The National Business Group on Health, funded by the Department of Health and Human Services' (DHHS) Center for Mental Health Services (CMHS), convened the *National Committee on Employer-Sponsored Behavioral Health Services (NCESBHS)* in January 2004. The Committee was established to review the current state of employer-sponsored behavioral health services and to develop recommendations to improve the design, quality,

structure, and integration of programs and services. The *Committee* was also charged with reviewing the recommendations of the President's New Freedom Commission on Mental Health and determining how they might apply to employer-sponsored behavioral health benefits and programs. (For more information on the President's New Freedom Commission Report on Mental Health, please see *Appendix A: The President's New Freedom Commission Report on Mental Health*).

The *Committee* consisted of 25 benefits and healthcare experts including academic researchers, disability management professionals, Employee Assistance Program (EAP) professionals, healthcare benefits specialists, representatives from managed care and managed behavioral health organizations, pharmacology experts, and medical directors and benefits managers from Business Group member companies. Several members of the NCESBHS have served on national boards, expert panels, and federal commissions dedicated to the improvement of behavioral healthcare, including the Institute of Medicine Board, the President's New Freedom Commission on Mental Health, and the Surgeon General's Report on Mental Health. (See *Appendix C: Acknowledgements* for a list of *Committee* members and their affiliation)

Summary of Key Findings

The *Committee's* review resulted in twelve key findings. They are summarized as follows:

1. **Mental illness and substance abuse disorders are serious, common, and expensive health problems.**
   In 2001, mental health and substance abuse treatment costs totaled $104 billion and represented 7.6% of total healthcare spending in the United States ($1.4 trillion).[1] Unlike other medical conditions such as heart disease or diabetes, the indirect costs associated with mental illness and substance abuse disorders commonly meet or exceed the direct treatment costs.

2. **Research has conclusively shown that depression and other mental illness and substance abuse disorders are a major cause of lost productivity and absenteeism**.[2,3,4]
   Mental illness causes more days of work loss and work impairment than many other chronic conditions such as diabetes, asthma, and arthritis.[3] 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.[4] In total, estimates of the indirect costs associated with mental illness and substance abuse disorders range from a low of $79 billion per year to a high of $105 billion per year (both figures based on 1990 dollars).[5,6]

3. **Disability costs related to psychiatric disorders are high and continue to rise.**
   Mental illness and substance abuse disorders represent the top 5 causes of disability among people age 15-44 in the United States and Canada (not including disability caused by communicable diseases) [Note: includes employed and unemployed populations].[7] Further, 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.[8]

4. **The efficacy of treatment for mental illness and substance abuse disorders is well documented and has improved dramatically over the past 50 years.**[9]
   For most mental illnesses there is a range of well-tolerated and effective treatments. Current research suggests that the most effective method of treatment is multimodal and combines pharmacological management with psychosocial interventions such as psychotherapy.[9]

5. **A significant proportion of individuals with behavioral health problems are treated exclusively in the general medical setting, which has become the "de-facto mental healthcare system."**[10]
   Among patients diagnosed with a mental illness, 42% of those with clinical depression and 47% of those with generalized anxiety disorder (GAD) were first diagnosed by a primary care physician.[11] Approximately 22.8% of individuals treated for a mental illness or substance abuse disorder[12], and half (51.6%) of patients treated for depression, are treated by a general medical provider such as a primary care physician.[13] Further, it is estimated that 11%-36% of patients presenting at primary care have a mental illness.[11] Numerous studies over the past two decades have found that the adequacy and quality of mental healthcare delivered in the general medical setting is sub-optimal.[12] In fact, the *National Co-morbidity Survey Replication* (NCS-R) found that only 12.7% of individuals treated in the general medical sector received minimally adequate care compared to 43.87% of patients treated in the specialty mental health sector.[12]

6. **Primary care physicians (PCPs) and other general medical providers are — and will continue to be — an integral part of behavioral healthcare in the United States.**
   However, significant quality problems have been found with general medical providers' screening, treatment, and monitoring practices. Many of the recommendations presented in this *Guide* suggest programs, benefits, and practices that will support general medical providers in the provision of high-quality behavioral healthcare services.

7. **Psychotropic drugs have become the major treatment modality in behavioral healthcare whether prescribed by general medical physicians (e.g., primary care physicians) or by behavioral health specialists (i.e. psychiatrists).**
   The availability of prescription medications as a method of treatment has improved the lives of many individuals with mental illness and substance abuse disorders. However, a number of quality problems have been identified with current psychotropic medication prescribing practices (e.g., pharmacological management is frequently the sole treatment modality). Further, the escalating cost of psychotropic drugs is of concern to employers. In 1987, psychotropic medications were responsible for 7.7% of all mental healthcare spending in the United States (including expenditures from private insurance, Medicare, Medicaid, etc); by 2001, psychotropic drug spending was responsible for 21.0% of total mental health spending.[14] In 2001, private employers spent approximately 17% of their total behavioral health expenditures on prescription medications.[1]

8. **While employers have focused their attention on the management of high cost chronic medical conditions (e.g., heart disease and type 2 diabetes), such management efforts have not fully addressed the significant additional burden of co-morbid mental illness. Access to specialty behavioral healthcare services is**

critical to delivering effective disease management services for chronic medical problems. Therefore, limitations on behavioral healthcare benefits may limit the efficacy of disease management programs for individuals with co-morbid medical and behavioral health conditions. Disease management programs will not realize their full potential without fostering better coordination between the general medical healthcare system and the specialty behavioral healthcare system.
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.[15,16]
- Patients with mental illness and substance abuse disorders are often less responsive to treatment. For example, depressed patients are three times as likely as non-depressed patients to be non-compliant with their medical treatment regimen.[17]
- The presence of type 2 diabetes nearly doubles an individual's risk of depression and an estimated 28.5% of diabetic patients in the United States meet criteria for clinical depression.[16]
- Approximately one in six patients treated for a heart attack experiences major depression soon after their heart attack and at least one in three patients have significant symptoms of depression.[17]

9. **Access to specialty mental healthcare services is constrained due to benefit design with higher co-pays, visit limits, and management of utilization. These additional financial limitations are not applied to psychotropic drug benefits or to many behavioral health interventions delivered in the general healthcare setting.**
This has created a perverse incentive for patients to a.) access mental healthcare from general healthcare providers (where there are no visit limitations and co-pays are significantly lower) and to b.) rely on psychotropic medication as an exclusive method of treatment.

10. **Limiting behavioral healthcare services can increase employers' non-behavioral direct and indirect healthcare costs.**
One study found that limiting employer-sponsored specialty behavioral health services increased the direct medical costs of beneficiaries who used behavioral healthcare services by as much as 37%.[18] Further, the specialty behavioral health service limitation substantially increased the number of sick days taken by employees with behavioral health problems. The study concluded that savings attributed to limiting behavioral health benefits were fully offset by increased use of other medical services and lost workdays.[18]

11. **Employers have tightly managed behavioral health benefits delivered by the specialty mental healthcare system, but have not as yet implemented comprehensive and integrated management programs to address quality and costs for psychotropic drugs and behavioral health services delivered by general medical providers.**
Specialty mental health services have been managed tightly by managed care systems over

the past two decades. Utilization review techniques and other methods have reduced the percent of total healthcare dollars employers spend on mental healthcare benefits. In fact, private employers experienced a 50% decline in their mental healthcare premiums (not including the cost of psychotropic drugs) during the 1990s: the average cost of private employers' behavioral healthcare premiums dropped from 6.1% of total claims costs in 1988 to 3.2% in 1998.[19] Yet, employers have not adequately managed the cost or quality of behavioral healthcare services delivered in the general medical setting despite the high proportion of patients treated for behavioral disorders in the general medical setting. Further, employers are not receiving good value for their investment in psychotropic drugs.

12. **The lack of coordination and integration among managed care vendors of employers (MCOs, MHBOs, EAPs, PBMs, and others) has created significant quality and accountability problems.**
    Employers can address these problems by improving the design of their health insurance benefit structures, and by requiring their behavioral health vendors and managers to coordinate with one another. Figure 1.0 lists and explains the progr
ams vendors and employers currently use to manage their health, behavioral health, disability, and employee assistance benefits.

FIGURE 1.0 EMPLOYER-SPONSORED HEALTH AND BEHAVIORAL HEALTH

Benefit or Program	Services Offered	Manager or Vendor
Employee Assistance	Prevent intake, referral, and treatment related to mental illness and substance abuse	Human resources department, medical department or other internal manager, EAP vendor
Disability Management	Short-term and long-term disability management services	Internal or external (contracted) disability managers
Health Plan	Primary care, other non-psychiatrist physician care, general inpatient and outpatient care relating to all physical and mental illnesses and substance abuse disorders	Managed care organization (MCO)
Mental Health Plan	Specialty mental health services (in-patient psychiatric hospitalization, psychiatrist visits, psychotherapy, etc) specific to mental illness and substance abuse disorders	Managed behavioral health organization (MBHO) may be "carved-out" (hired directly by an employer) or "carved-in" (hired by an employer via their MCO)
Pharmacy Benefit	Prescription medications (drugs for all medical conditions, psychotropic drugs, etc)	Pharmacy benefit manager (PBM) may be "carved-out" (hired directly by an employer) or "carved-in" (hired by an employer via their MCO)
Wellness Program	Prevention activities relating to mental illness and substance abuse disorders	Medical department or external vendor

BENEFITS AND MANAGERS

I. Recommendations Directed at Health Plan Benefits and Services

The key findings described above guided the development of the *Committee's* recommendations for the delivery of standardized and integrated behavioral health services.

The recommendations featured in this *Guide* are meant to guide employers as they develop their medical and behavioral health benefit plans. Employers are encouraged to add these recommendations to contract language with Managed Care Organizations (MCOs), Managed Behavioral Health Organizations (MBHOs), Pharmacy Benefit Managers (PBMs), and/or Disability carriers as appropriate. Adoption of the recommendations will require employers to change their vendor contract language and to make changes to their benefit structures. Adoption of recommendations regarding best-practice implementation and quality improvement measures will necessitate that employers instruct their MCOs, MBHOs, and PBMs to track patient and provider data. Wherever possible, the management vendors should incorporate the recommended standards as a part of their normal provider performance review. Employers should require these vendors to present their findings of these reviews annually.

1. ***Recommendations to Improve the Delivery of Covered Behavioral Healthcare Services in the General Medical Setting***
   - ***a. Documentation and Monitoring*** — Document diagnosis upon initiation of treatment.
   - ***b. Addressing the High-Risk of Co-Morbidity*** — Screen for depression and other common behavioral health conditions among individuals with chronic medical illnesses.
   - ***c. The Importance of Tracking Patient Progress*** — Monitor patient progress with standardized evidence-based instruments. Reimburse patient monitoring as a lab test.
   - ***d. Collaborative Care*** — Use the collaborative care model to address the needs of patients with mental illness and/or substance abuse disorders who are receiving treatment in primary care.

2. ***Recommendations to Improve Collaboration Between Providers in the General Healthcare System and the Specialty Behavioral Healthcare System***
   - ***a. Referrals to the Specialty Behavioral Healthcare System*** — Coordination of care upon referral from primary care to specialty behavioral healthcare.
   - ***b. Improving the Collaboration Between Disease Management Programs, General Medical Care, and Specialty Behavioral Healthcare*** — Employers should require their disease management vendors, as part of their regular practice, to periodically screen all patients enrolled in their respective programs for common behavioral health conditions, and coordinate care with other providers as indicated.

3. ***Recommendations to Improve Benefit Design for Behavioral Health Screening and Treatment Services***
   a. ***Equalizing Benefits Structures*** — Equalize medical and behavioral health benefit structures
   b. ***Reimbursement for Non-Psychiatrist Physicians*** — Reimburse primary care and other non-psychiatrist physicians for screening, assessing, and diagnosing mental illness and substance abuse disorders. [Rules and policies regarding the payment of non-psychiatrist physicians (e.g., primary care physicians) for the treatment of mental illness and substance abuse disorders should be well publicized to primary care physicians, other non-mental health providers, and their clinical/business administrators.]

4. ***Recommendations to Improve the Accuracy and Quality of Prescribing Psychotropic Medications in the General Medical and Specialty Behavioral Healthcare System***
   a. ***Adoption of a national best-practice guideline for the prescribing and monitoring of psychiatric drug interventions*** — Require MCOs, MBHOs, and PBMs to adopt a national best-practice guideline for the prescribing and monitoring of psychiatric drug interventions.
   b. ***Annual assessment of provider performance in relation to the nationally accepted standard best-practice guideline chosen*** — Require MCOs, MBHOs, and PBMs to annually assess their provider's performance in relation to the nationally accepted standard best-practice guideline they have chosen (4a). [Employers should also require that their healthcare managers (i.e. MCOs, MBHOs, and PBMs) to provide them with a summary of the data collected, problems that were identified, and the performance plan improvement to address these problems, annually.]
   c. ***Periodic Review of Formulary*** — Periodically review the formulary and make adjustments as necessary based on information garnered from the assessment suggested in 4b.

5. ***Recommendations to Improve Behavioral Healthcare Services for Individuals with Serious Mental Illness***
   a. ***Evidence-Based Treatment Modalities for the Seriously Mentally Ill (SMI)*** — Provide coverage for evidence-based treatment modalities for seriously mentally ill children and adults. Such evidence-based modalities include:
      - Targeted clinical case management services;
      - Assertive community treatment (ACT) programs;
      - Therapeutic nursery services; and
      - Therapeutic group home services.

b. ***Providers of Evidence-Based Treatment Modalities for the Seriously Mentally Ill (SMI)*** — Direct MCOs and MBHOs to add providers that can deliver the evidence-based treatment modalities described in 5a to their networks.

c. ***Annual Review of Behavioral Health Treatment Modalities*** — Direct MCOs and/or MBHOs to annually review behavioral health treatment modalities and make recommendations about whether new treatment modalities should be added to employers' benefit structures.

II. Recommendations Directed at Disability Management Vendors and Services

6. ***Recommendations to Improve Employer Management of Behavioral Health Disorders that Qualify for Short- and/or Long-Term Disability Benefits***

a. Review short-term and long-term disability management programs and instruct vendors to actively manage all behavioral health disability claims.
- Involve a behavioral health specialist in certification of psychiatric disability and treatment planning.
- Involve a behavioral health specialist in the review of the treatment plan.
- Refer employees on disability for a psychiatric condition to EAP for return-to-work assistance.

III. Recommendations to Improve Employee Assistance Program Services

7. ***Recommendations to Improve the Structure of Employee Assistance Programs (EAPs)***

a. Reduce redundancies between EAPs and health plans by re-structuring EAPs. EAPs should not duplicate services offered through the health plan (MCOs and MBHOs), but should be re-structured, if necessary, to provide the following functions:
- Support management in addressing issues of productivity and absenteeism that may be caused by psychosocial problems.
- Assist in the design and development of a structured program to deliver health promotion and healthcare education tools that significantly affect employee and beneficiary health and productivity and lead the effort to deliver behavioral healthcare education programs.
- Functionally coordinate with other health services including health plan, disability management, and health promotion.

b. Based on an analysis of current EAP services, the NCESBHS found that an important function that EAPs provide is assessment and short-term counseling for individuals at risk of mental illness and substance abuse disorders and those with problems of daily living (e.g., divorce counseling, grief processes). In the restructuring of EAPs, as recommended in 7a, it is essential that these services be retained and provided by an EAP or other entity.

c. Conduct periodic organizational assessments to evaluate the effects of work organization on employee health status, productivity, and job satisfaction.

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About the Center for Prevention and Health Services (CPHS)

The Center houses the Business Group's projects and resources that relate to the delivery of preventive and other health services through employer-sponsored health plans and worksite programs. Through the Center, employers can find practical toolkits to address preventive health and health promotion issues at the worksite. Employers will find current information and recommendations from federal agencies and professional associations, model programs from other employers, and the latest clinical and health services research results. In addition, the Center provides opportunities for employer participation in teleconferences and in-person solutions workshops. Currently, the Center has initiatives in racial and ethnic disparities in health and health care, terrorism and public health emergency preparedness, maternal and child health, preventive services, health services research and quality, health and work performance, benefit design, and wellness programs.

For more information, visit http://www.businessgrouphealth.org/prevention/index.cfm or contact Kathryn Phillips at phillips@businessgrouphealth.org.

About the National Business Group on Health

The National Business Group on Health, formerly the Washington Business Group on Health, is the national voice of large employers dedicated to finding innovative and forward-thinking solutions to the nation's most important health care issues. The Business Group represents over 200 members, primarily Fortune 500 companies and large public sector employers, who provide health coverage for approximately 50 million U.S. workers, retirees, and their families. The Business Group fosters the development of a quality health care delivery system and treatments based on scientific evidence of effectiveness. The Business Group works with other organizations to promote patient safety and expand the use of technology assessment to ensure access to superior new technology and the elimination of ineffective technology.

National Business Group on Health

50 F Street NW, Suite 600 • Washington DC 20001

Phone (202) 628-9320 • Fax (202) 628-9244

www.businessgrouphealth.org

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