National Institute of Mental Health
Alliance for Research Progress
January 20, 2006 Bethesda, MD

Introduction

The National Institute of Mental Health (NIMH) held its Alliance for Research Progress (The Alliance) Winter Meeting Friday, January 20, 2006 at the Montgomery County Conference Center in Bethesda, Maryland. This fourth meeting of the Alliance was devoted to continuing an active dialogue with representatives of NIMH's patient and family constituency groups and to discussing a research agenda attuned to the needs of people with mental illnesses. Invitees embodied wide-ranging perspectives including those of consumers, providers of mental health services, family members, and others.

NIMH Director Thomas R. Insel, M.D., opened the meeting with a discussion of the "State of the NIMH." Presentations on the latest research on trauma and terror in the context of soldiers and their families, returning veterans, and natural disasters followed. Susan Essock, Ph.D., Chair of the National Advisory Mental Health Council's Workgroup on Services and Clinical Epidemiology, led a group discussion on NIMH research priorities during the lunch break. The afternoon presentations included the economics of treating depression in the workplace and a presentation on the new *Employer's Guide to Behavior Health Services* developed by the National Business Group on Health.

Speakers

Thomas R. Insel, M.D.
"Welcome and State of the NIMH"

Dr. Insel starts off the discussion.

Dr. Insel provided an update on NIMH stating that current challenges make setting priorities for the Institute more important than ever. "We must decide where we have the opportunities to make the biggest difference. NIMH faces an enormous challenge in fulfilling its mission to reduce the burden of mental and behavioral disorders through research on the mind, brain, and behavior," said Dr. Insel.

Dr. Insel outlined the key challenges for NIMH in Fiscal Year 2006: fewer new dollars,

increasing cost of individual grants, increasing number of grant applications, and reductions to commitments. For the first time since 1982 both the NIMH and the NIH received budget decreases. NIMH received a 0.6 percent decrease in the budget, even though, as he pointed out, the cost of doing research has steadily increased. Clinical research particularly has become more expensive because of new complex regulations and the cost of compliance. NIMH has had a big increase in the number of applications for grant support — close to 3,000 applications in 2006. "We have to do more with less," said Dr. Insel.

NIMH uses three principles to judge the priority of any given research proposal: (1) *relevance* — whether proposed activities pertain to the NIMH mission of reducing the burden of mental and behavioral disorders; (2) *traction* — which research areas are poised for rapid progress because of access to new research tools or recent scientific advances; and (3) *innovation* — emphasizing "discovery" science that may lack extensive pilot data, but which is extremely relevant and could provide an enormous pay-off.

Dr. Insel described how NIMH is addressing several critical issues including access to mental health care, coordination of care in the community, and community engagement through large scale practical clinical trials. NIMH has conducted large scale trials attempting to answer a simple yet fundamental unanswered question: what treatment works best for which person? Dr. Insel gave a brief update on these trials:

TADS: Treatment of adolescents with depression (439 enrolled, completed 2004)
(information available at www.nimh.nih.gov/healthinformation/tads.cfm)

CATIE: Effectiveness of antipsychotic drugs in schizophrenia and Alzheimer's disease patients (1460 enrolled, completed 2005)
(information available at www.nimh.nih.gov/healthinformation/catie.cfm)

STAR*D: Adults with treatment resistant depression (4041 enrolled, completed 2005)
(information available at www.nimh.nih.gov/healthinformation/stard.cfm)

STEP-BD: Treatment of adults with bipolar disorder (4328 enrolled, multiple treatment trials, ongoing)
(information available at www.nimh.nih.gov/healthinformation/stepbd.cfm)

DECADE OF DISCOVERY 2000-2010

Dr. Insel described the Decade of the Brain (1990-2000) as a time when mental disorders were defined as brain disorders. He pointed out that in the current Decade of Discovery (2000-2010) we recognize that there are hundreds, probably thousands of factors involved in mental illness. "For the last 50 years we have focused on serotonin, dopamine, and norepinephrine: a handful of neurotransmitters and their receptors, and those days are very, very much over," stated Dr. Insel.

CHANGE IN THE CULTURE OF SCIENCE

Dr. Insel spoke about current changes in the culture of science — from one of scientists working in "silos" — to an interdisciplinary culture where scientists work across animal species, across

levels of analysis, and across sites. Scientists from different universities and different environments are working together in what is now often called team science. This has changed the way one thinks about how science gets done, and it has also changed the nature of what is being studied. “Rather than scientists going after findings that get published in papers, increasingly what we are seeing is a push to develop databases or large-scale atlases or public resources that will lift all boats. We have whole new maps of the genome — to help us learn what areas are most important to explore,” said Dr. Insel.

There is also an increasing emphasis on public access and that results of NIMH funded science must be both understandable and accessible to the broad public so that these results can be applied as quickly as possible. Therefore, the key is to make sure that data — science supported through taxpayer dollars — are available to everyone.

“Evidence-based practices that actually get taken up, looking at processes for dissemination of discoveries, ensuring access, coordinating care in the community, getting the community engagement that you need for this whole process, these are all equally important and equally difficult and a priority for the NIMH,” concluded Dr. Insel.

Speakers: Dr. Robert Ursano, Dr. Susan Essock, Dr. Philip Wang, Dr. Elspeth Cameron Ritchie, Dr. Insel, and Dr. Friedman

Colonel Elspeth Cameron Ritchie, M.D., M.P.H.
“Soldiers and Their Families”

Colonel Ritchie, M.D., M.P.H., Psychiatry Consultant to the US Army Surgeon General, presented the current stresses on the US Army, including multiple deployments in Iraq, increases in head injuries and levels of post traumatic stress disorder, issues surrounding return to civilian life and reconnecting with family, and barriers to receiving proper mental health services. Colonel Ritchie said that adequately addressing the mental health needs of our soldiers and their families is critical to maintaining a resilient fighting force.

Colonel Ritchie told Alliance members that one theme that comes up repeatedly, especially for Guard and Reserve troops, is how to reconnect soldiers with their families, friends, employers, and colleagues after a year in Iraq or a year in Afghanistan. Often soldiers’ question why they should bother to make the effort to reconnect when they know they will be returning to fight again and soldiers often feel that others do not understand what they have been through.

Colonel Ritchie shared the basic principles of combat psychiatry in the military. The army does a lot of treatment for PTSD, and encourages people as much as possible to return to war. Most want to go back to the war to be with their colleagues. What has been added in the current Iraq war is sophisticated psychiatric treatment in theater; for example, if troops need SSRIs (selective serotonin reuptake inhibitors) and cognitive-behavioral therapy or psychotherapy if needed. By and large, they get excellent medical and mental health care in theater.

Colonel Ritchie shared some of the key findings on mental health problems in the U.S. Military. She described results from a seminal article written by Charles W. Hoge who found that approximately 17 percent of ground troops, infantry and Marines had symptoms of depression and anxiety. [New England Journal of Medicine, "Combat Duty in Iraq and Afghanistan, Mental Health Problems, and Barriers to Care," 7/1/2004 is available electronically at http://content.nejm.org/cgi/content/full/351/1/13]. Not surprisingly, the largest increase in mental health problems was for PTSD, which was comorbid with alcohol misuse. Only one-third of soldiers and Marines with significant, reported mental health problems received any professional help, including from chaplains. Most soldiers perceived that they would be stigmatized if they received care. Some of the other barriers to care are long wait times, difficulty getting into the clinic, and time off from work to get there.

Colonel Ritchie updated Alliance members on the military RESET Program. RESET is a rigorous long-range plan that requires intensive resourcing, repair and overhaul of equipment and aircraft, and prioritization and streamlining of facilities and personnel to support these efforts. Reducing barriers to mental health care is included in RESET and involves the following: (1) routine PTSD and depression screening into primary care, following existing practice guidelines, (2) integration of mental health services into primary care/troop medical clinics, (3) emphasis on the role of leaders at all levels in supporting and facilitating recognition of mental health problems and access to services, (4) education and training for leaders that PTSD symptoms are common and expected reactions after combat, and are associated with other adverse effects (e.g., alcohol abuse), and (5) assurance that there is accessible and visible behavioral health support at the unit level.

Colonel Ritchie said that the Army and the US public must work together to create a fundamental shift in the mindset towards mental health. She outlined key steps the military has taken to create this shift, including the creation of Military One Source, new partnerships between the US Army and the Veteran's Administration, and the creation of community based health care organizations. Military One Source (www.militaryonesource.com/) is a new free confidential counseling service accessed through the web and/or phone.

Colonel Ritchie also talked about a new program for wounded service members from the National Guard and Reserve called Community-Based Health Care Organizations. There are eight of these in the country. Their purpose is to refer service members to health clinics in their own communities and to provide assistance with medical appointments and benefits.

Colonel Ritchie also described liaison efforts between the US Army and the Veteran's Administration (VA). She is active in a newly created VA/Department of Defense mental health council. "We are working with you to put out the word. Many of our troops are going to be walking into your offices or the offices of your practitioners. We are trying to tell our colleagues

to ask if somebody is a veteran. Veterans today do not necessarily fit the stereotype of an older Vietnam veteran. Fifteen percent of our force is female. Veterans are ages 18 to 65. So ask if they are a veteran," said Colonel Ritchie.

Colonel Ritchie said that the Army is also encouraging practitioners to ask about head injuries. "The signature wound of this war is traumatic brain injury with the blasts, with the gunshot wounds, with hitting your head when the explosion goes off," explained Colonel Ritchie. If it is a severely wounded person, they will be screened for head trauma when they come to Walter Reed, but many of these soldiers get knocked out for a minute or two, brush themselves off, get up and go on. These soldiers return home with mild traumatic brain injury, and often become irritable and have difficulty concentrating. People close to them may think its just PTSD. It could be the effects of the head injury.

Often Soldiers, Sailors, Airman, and Marines are returning to the battlegrounds for the second or third time. A report on the effect of multiple deployments is coming out soon. "We are also educating leaders to see that just because somebody has PTSD does not mean they are broken. We can fix it. We can treat it. We can put them back to work," stated Colonel Ritchie. There are new treatment guidelines out for PTSD (www.oqp.med.va.gov/cpg/PTSD/PTSD_Base.htm), and practitioners are encouraged to use them.

In conclusion, Colonel Ritchie said that the leadership is committed to incorporating PTSD into primary care, integrating the mental health services and training leaders at all levels. Generals are asking what they can do to help take care of soldiers and their families. "There is a stereotype out there that the military does not care about mental health. They do, both to continue the war and to take care of their soldiers," explained Colonel Ritchie.

Matthew Friedman, M.D., Ph.D.
"Returning Veterans"

Matthew Friedman M.D., Ph.D., Executive Director of the VA National Center for PTSD (www.ncptsd.va.gov) and Professor of Psychiatry and Pharmacology at Dartmouth Medical School talked about the issues facing all returning veterans. He has worked with PTSD patients as a clinician and researcher for thirty years and has published extensively on stress and PTSD, biological psychiatry, psychopharmacology, and clinical outcome studies on depression, anxiety, schizophrenia, and chemical dependency. The VA functions as a bridge between the military health care, mental health care system and the civilian health care system, and the people that we are serving are our National Guard, Military Reserve or people who have recently retired from the military.

Dr. Friedman discussed the many ways that the current war in Iraq is different from past wars (such as Vietnam). In the current war, 45 percent of the soldiers felt they could be killed. The 2,000 fatality mark was passed in October of 2005. Guard and Reserve families do not live on military bases and this poses new challenges, but they are trying to build a grassroots network to deal with these challenges. In Iraq, the lives of more people are being saved; only 10 percent (in contrast to 25 percent in previous wars) die from their wounds. Wounded troops are at higher risk for PTSD.

Dr. Friedman outlined a three phase model for understanding the continuum of problems that all returning soldiers face. He emphasized that he was not referring to PTSD and depression, or diagnosable disorders. He was talking about the trajectory that any returnee from the intensity of combat in a war zone must traverse, which most people are going to navigate quite successfully. There may be some problems, but he suggested that the families and the health providers should recognize that it is a process, and it's only for a significant minority that diagnoses should be made and 'treatment,' should be prescribed. "Soldiers have been in this combat-ready situation for 12-18 months with 24/7 danger. All of a sudden they return home and cannot turn off the switch. Many people can turn off this switch with time, but others cannot and need help," asserted Dr. Friedman.

Stigma is a problem. People are afraid for their careers. Because of it, many returning soldiers are not going to a VA or a military hospital; instead they will go to a civilian practitioner because their records will be confidential. Therefore, community hospitals and civilian hospitals must be included in planning for transition from combat to and community life. "I think what was so significant about the Charles Hoge New England Journal article — was that we all knew that stigma was a problem," said Dr. Friedman. "We all knew that stigma was suppressing requests for mental health care, but we never really had numbers to put on it, and the numbers are shocking," declared Dr. Friedman. "Stigma is a major, major problem, and I know NIMH has been waging a campaign. I think it's something that is particularly pertinent to the people returning from Iraq and Afghanistan, because the longer the stigma keeps them away when we have effective treatments that work, the more the ripple effects of failed marriages, lost job opportunities, comorbid problems, distancing from family and children, alienation from community support."

Family breakdown must be prevented. Dr. Friedman shared with Alliance members that the biggest risk factor for returning soldiers is lack of support. "I cannot emphasize enough the importance of family involvement. Please look at the National Center for PTSD's website (www.ncptsd.va.gov/). We have an Iraq War Clinician Guide, which was produced in conjunction with Walter Reed Army Medical Center," said Dr. Friedman. It is being retrofitted for consumers, for families, for the troopers themselves.

Robert Ursano, M.D.
"Impact of Disaster: Distress, Illness, Risk Behaviors and Resiliency"

Robert Ursano, M.D.,Chairman of the Department of Psychiatry, Uniformed Services University of the Health Sciences, and Director for the Center for the Study of Traumatic Stress (www.usuhs.mil/CSTS) spoke to Alliance members about the impact of disasters. He and his team have completed studies on numerous disasters, disaster rescue workers, motor vehicle accident victims, family violence and Vietnam, and Desert Storm and Gulf War veterans. Dr. Ursano served as a national consultant for planning clinical care responses and research programs following September 11, and he is also a member of the Institute of Medicine Committee on Psychological Consequences of Terrorism.

The center has studied over 20,000 people spanning a wide range, and has been involved in nearly every national disaster for the past 20 years. These include earthquakes in San Francisco and Armenia, hurricane Katrina, embassy bombings in Africa, and airplane crashes in New York

City. Understanding the phases of disaster response is very important for leadership and the general population. There is an initial phase of working together where the feeling is that the hardships will be overcome, but following that, it is predictable that the next phase will be anger and disillusionment — who caused this, why wasn't it prevented, and where is the money to fix it?

Dr. Ursano believes that individuals with severe mental illness are probably the group with the highest rates of PTSD in our entire nation. "We ignore this reality in our treatment of severe mental illness. How many of your clients, your patients, have in fact been beaten, attacked, raped, robbed, or involved in serious accidents?" asked Dr. Ursano. "We very rarely in our present clinical care settings include the dual diagnosis of schizophrenia and PTSD, and yet it is probably present in somewhere between 50 and 80 percent of those with those disorders," said Dr. Ursano. Terrible tragedies frequently bring to our attention things that are hidden, things that we do not want to think about, parts of our nation and our health care system that we have forgotten, and this can be a good thing.

"PTSD is not uncommon at all. My bet is that most of you who were in a severe motor vehicle accident and after that for about a month or so you woke up at night had some nightmares, when the brakes went off behind you, you heard a screech and you jumped a bit. You decided you really did not want to watch the racing car movie that your son or daughter or friend was going to see, and you really didn't want to ride on the passenger side of the car, because that is where you were when the event happened. You'd rather drive the car. You had PTSD," reported Dr. Ursano. He described PTSD as the 'common cold' of psychiatry and psychiatry is rarely thought of as having common colds. "We also need to target common colds because it will reverberate through our entire mental health system as an opportunity to show that we have common colds, that people get these events, and they recover from them, and we need to treat mental illness like we do every other disease and illness, as a spectrum of diseases," asserted Dr. Ursano.

Dr. Ursano explained that PTSD is an 'event-related' disorder, meaning an event occurs and the brain changes. It may well be that all disorders are in fact event-related disorders at least in the early stages. So understanding the event -brain -change becomes a very important target for research strategies, clinical care strategies, and outreach to populations that will have echoes across all disorders — those that occur at the time of a disaster and those that are made worse at the time of a disaster.

Dr. Ursano also shared information resources available on his organization's Web site such as the Courage to Care Campaign (http://www.usuhs.mil/psy/courage.html), and educational fact sheets on trauma and disaster (http://www.centerforthestudyoftraumaticstress.org/factsheets.shtml#disaster). Dr. Ursano suggested that Alliance participants read Preparing for the Psychological Consequences of Terrorism: A Public Health Strategy — The National Academies Press, 2003 available at http://www.nap.edu/books/0309089530/html.

Discussion

Attendees ask questions

During the group discussion, attendees had the opportunity to ask questions of Dr. Insel, the presenters, and other participants. Colonel Ritchie talked about stigma and treatment-seeking behavior in the military. She stated that soldiers are concerned about jeopardizing their military career and security clearances if they seek mental health treatment. "The actual reality is that if they come and seek treatment, that is kept very discreet and should not impact their security clearance, but there is a perception that it will," said Ritchie. The current security clearance forms ask if you have had diabetes, cancer, or 'treatment for a mental illness.' Dr. Insel said that psychiatry is the only part of medicine — where there is actually greater stigma for receiving treatment for these illnesses than for having them.

Ms. Melissa Cockerham, Senior Research Associate from the Juvenile Bipolar Research Foundation described a challenge her organization and many others face. Many academic do not have access to a pool of potential research participants. Foundations and voluntary organizations, on the other hand, have access to large pools of potential research participants, but they do not have the money to do the actual research. Dr. Insel agreed that this dilemma demonstrates a "profound mismatch." He said that the Institute is very interested in helping to broker these match-ups. For example, in the area of autism, NIMH is working to address this challenge by bringing these different stakeholders together.

Dr. Eileen Resnick, the Scientific Program Manager for the Society for Women's Health Research asked if the military had programs that address women, specifically. Colonel Ritchie said that most services are combined except for sexual assault counseling services. She also said that women tend to leave the military at twice the rate that men leave, after their first tour. Colonel Ritchie suggested that it would be great for NIH to do a study looking at men vs. women after serving in the war to see if differences exist post-deployment.

Ms. Mary Guardino, Founder and Executive Director of Freedom from Fear, asked Dr. Friedman why more practitioners are not using cognitive-behavioral therapy (CBT) to treat trauma-related disorders even though it is an evidence-based treatment. Dr. Friedman agreed that a relatively low proportion of psychologists now use CBT or train in CBT. "There is a real mismatch between what is our evidence-based treatment and what is our pool of available, well-trained practitioners who can utilize that treatment. It is a major dissemination challenge, a knowledge management challenge. I am trying to address that within VA. Within VA, only 20 percent of the psychologists are trained in CBT. Only about 10 percent of them utilize it on a regular basis, and I think that is a microcosm of what is true in the world in general," concluded Dr. Friedman. Ms. Guardino suggested professionals utilize the Academy for Cognitive Therapy Website (www.academyofct.org/) to locate certified cognitive therapists in their geographic area.

Susan Essock, Ph.D.
Lunch and Discussion about NIMH Research Priorities

Dr. Insel introduced Susan Essock, Ph.D., the chair of the National Advisory Mental Health Council's Services and Clinical Epidemiology Workgroup, which is looking at setting priorities for services and interventions research. Dr. Essock said that the "decade of discovery includes discovering how to get our research findings into practice and how to get effective interventions implemented and sustained in routine practice settings." In order to have effective treatments for everyone, more information is needed. She asked the audience to give recommendations to the NIMH in response to a series of questions: What areas of research need to be developed? How can we reduce the burden of mental illness? Where is there traction to make a difference through research, including places where there are collaborative opportunities with other communities and agencies? How do we involve the workforce? How do we partner with the payers of mental health services? How do we address issues of access and disparities? Some barriers may be socioeconomic while others are related to how individuals respond differently. How can we organize resources in more effective ways?

Ms. Valerie Porr, M.A., President of TARA the National Association for Personality Disorders told Alliance members, "We need NIMH to put out 'standards of care' for mental health treatment." Dr. Insel said that standards of care are not NIMH's mission. "Part of our strength, I think, is that we stay out of the marketplace and that we remain an unbiased taxpayer-funded source of high quality information that people can rely on." Part of this decade of discovery is trying to figure out better ways to get information to the public.

Ms. Cynthia Folcarelli of the National Mental Health Association expressed gratitude for and excitement about the Institute's investment in practical clinical trials, such as STAR*D and the CATIE trials. She said that the results should have enormous potential to improve public mental health systems, but that misinterpretations of the data — including by the media — threaten that potential. Ms. Folcarelli emphasized that widespread misinformation about NIMH study findings is a very serious problem. "We have got to come up with a solution," she said. "We are completely committed, totally committed to working with NIMH to solve this." Dr. Insel welcomed her feedback and clarified some of the information about the trials for the group. "I think one of the places we're at now with both of these trials, both the CATIE and the lead in for the STAR*D, is it raises the question of whether you want to look at these treatments as the glass half full or the glass half empty. Clearly, both of these studies are showing that these treatments are not enough," Insel said. Dr. Insel said that he would be glad to discuss this further.

Dr. Essock said, "I am also very sympathetic to what you're saying about having answers ready for stakeholders. How do we interpret these studies? How do we know what your questions are? How do we know what the big payers' questions are so that as investigators we can be presenting these data in ways that get answers to both the front page of USA Today and to the consuming troops? I've been working with some of our council representatives. Renata Henry is there from the National Association of State Mental Health Program Directors and she said how much she would welcome a set of frequently asked questions as part of conveying research findings to clinicians and administrators. This is one of the things the workgroup is grappling with, and I welcome you bringing this up as such a timely example of how we get information out and interpreted where it belongs."

Andrew Sperling of NAMI thanked Dr. Insel for the Institute's clarifying web statement about the CATIE trial and urged him to continue giving input to the Centers for Medicare and Medicaid Services' Dr. McClellan and his staff to engage them as much as possible about the interpretation of the results prior to decisions about renewing guidance on the use of the drugs.

Ms. Marcela Gaitan of the National Alliance for Hispanic Health asked if there were any particular efforts to recruit minorities to be part of these clinical studies, and also to look at the dosage response among this group. Dr. Essock replied that there were indeed such efforts to recruit diverse participation, and this is one of the reasons these are both national studies with a wide variety of sites, but that the first phase of the findings have not yet been analyzed to address these issues.

Ms. Valerie Porr asked NIMH leadership were she could find definitive mental health information for her constituents. "NIMH should be able to provide you information that is scientifically rigorous and of practical importance," Dr. Insel replied. Ms. Porr asked how a person who has no experience with NIMH finds out about NIMH, because it is not the responsibility of volunteer organizations to disseminate to the whole United States. She asked why information could not be provided in user-friendly terminology on the Internet for the public, instead of to the public through advocacy groups. Dr. Insel responded by saying that NIMH has a wide range of communication efforts for the public including approximately 60 different publications describing the range of mental illnesses.

"What is so interesting to me is that in spite of that big investment and the whole army of people we have working on this and the outstanding writers and the outstanding people who do this kind of public interpretation, it obviously — I mean, I do not need to do anything more than look around the table to realize it isn't enough. So we do need to think about how to do this better, and it's extraordinary that in an era where there is electronic information available, where we have invested so much in a website that can change every few minutes and provide the latest and best information, that provides plenty of guidance in terms of recommendations not only of what is available but what not to do, all those kinds of things, it obviously is not enough," Dr. Insel said. Dr. Essock agreed that how NIMH packages results from research studies is extremely important.

Philip S. Wang, M.D., Dr. PH
"Can Enhanced Depression Care Save Money?"
Rationale and Interim Results of the NIMH WORCS Trial

Dr. Philip Wang is an assistant professor of psychiatry and health care policy at Harvard Medical School. His current research focuses on three large areas: (1) psychopharmacoepidemiology, (2) psychopharmacoeconomics, and (3) mental health services research. Dr. Wang is the principal investigator of the NIMH-sponsored "Work Outcomes Research and Cost Effectiveness Study", also called the WORCS trial, and an author of over 100 scientific publications. Dr. Wang is also a member of the FDA's Psychopharmacologic Drugs Advisory Committee and NIMH's Services and Clinical Epidemiology Study Section. He has worked with the American Psychiatric Association to develop evidence-based treatment guidelines.

The motivation for the WORCS study is that the economic costs of depression are staggering according to Dr. Wang. Depression costs the U.S. tens of billions of dollars annually, with lost productivity comprising the lion's share of this total. This occurs because depression is common, it negatively impacts work performance, and even people who seek treatment often receive inadequate services. Although NIMH-sponsored trials during the past decade have identified several effective interventions, there is widespread reluctance to implement such enhanced depression treatment programs. One reason is that there is competition with other specialty interest for scarce treatment dollars. In addition, the metrics currently available on the value of treatments are not adequate and do not inform purchasers what their return-on-investment would be for investing in treatment programs.

Dr. Wang reviewed earlier research that has been conducted in this area. He and his co-investigators found that depression is associated with not only absenteeism but also "presenteeism" — showing up for work but not necessarily functioning effectively. They also found that depression disrupts other aspects, such as the quantity and quality of one's work as well as one's interpersonal relationships with coworkers. Fortunately, several lines of evidence suggest that effectively treating depression would address these impairments. For example, the original National Comorbidity Survey funded by NIMH showed that respondents who have remitted depressions no longer have associated absence and work cutback losses. Both "synchrony of change" time series as well as meta-analysis of treatment trials performed by Mintz and colleagues, all show that effective treatment of depression leads to less impairment. There is also a dose/response effect—that is the longer someone is treated, the less impairment they experience; however, there is also a lag in that the improvement in peoples' work performance tends to take longer than their improvement in depressive symptoms.

In spite of this evidence that clinical trial treatments would improve the work impairments from depression, real-world treatments are much less effective, reported Dr. Wang. Data from earlier epidemiologic studies have repeatedly shown that many people with depression fail to receive any treatment as well as adequate treatment, and there are long delays even among people who seek treatment. Those who do receive treatment may get it outside the health care system, such as unproven complementary and alternative (CAM) therapies. In fact, due to the frequency with which CAM treatments are used, they account for about a third of all mental health service use in the U.S, Dr. Wang said.

He also said that some critics have argued that if the people with serious mental illnesses get treated adequately, then maybe the under-treatment that has been observed among cases in the general population is not such a big public health problem. Unfortunately, data from the original National Comorbidity Survey show that among people who qualified for the federal definition of serious mental illness, (i.e., impaired in multiple areas of life, such as not working, lacking relationships, making suicide attempts, etc.) few are getting any treatments and, of the people who get some treatment, very few were getting effective treatment. Some have also wondered if under-treatment and poor quality care may have improved recently. After all, a lot of new treatments for depression have been introduced in the past decade and there has been a lot of direct-to-consumer advertising promoting these treatments. Unfortunately, data from the NIMH-sponsored National Comorbidity Survey Replication published in 2005 show that still only about 50 percent of the people who had a major depressive disorder actually sought treatment of any

kind. Then of those, only a fifth get treatment that looks like it's intensive enough that it could help them.

Dr. Wang reviewed the results from several NIMH-funded primary care effectiveness trials of interventions to enhance the care of depression. These have consistently shown positive impacts for the interventions when it comes to clinical outcomes. The people given these enhanced-care interventions do get more effective care and their depression severity improves relative to usual care. Some data are also emerging that these interventions can improve productivity and reduce employee turnover—an important result because it can cost a company a year of wages to replace a worker. While there would clearly be benefits to enhancing depression care, there would also be higher costs if people get effective treatment. Dr. Wang reviewed economic analyses that have balanced the two to determine the cost effectiveness. It appears the more one spends to intervene, the more depression-free days one gets. However, regardless of the intervention, it is a bargain -- between $10 to $35 per day.

Dr. Wang concluded by saying that the potential benefits of enhanced depression care on work outcomes are not accounted for in these earlier cost-effectiveness analyses. For this reason, it remains possible that employers could actually save more than they spend on enhanced depression treatment, because of the increased productivity and not having to replace skilled workers that they might experience. For this reason, Dr. Wang and his co-investigators have launched a formal study of this issue in the form of the WORCS trial. To date, 150,000 workers in over 20 national companies have been invited to participate in the WORCS trial Dr. Wang reported. This trial is designed specifically to look at the return-on-investment to employers for enhanced depression care in workers. When the trial is complete, the results may help serve as a policy lever to increase the uptake of enhanced depression care programs by convincing purchasers that they make good business sense.

Ron Finch, Ed.D.
"Employer's Guide to Behavioral Health Services"

Dr. Finch

Ron Finch, Ed.D, Director of the Center for Prevention and Health Services at the National Business Group on Health, talked to Alliance members about the Employer's Guide to Behavioral Health Services. Dr. Finch said that for this report behavioral health was defined as encompassing both mental health and substance abuse. Dr. Finch said that behavioral health disorders are serious, common and expensive and his organization recommends evidence based care to treat these disorders.

The Employer's Guide to Behavioral Health Services is a blueprint of action strategies and recommendations for employers to create and implement a system of affordable, effective behavioral health services. It is available on the

National Business Group on Health's Web site at
www.businessgrouphealth.org/prevention/et_behavioralhealthreport.cfm.

The National Business Group on Health is not a lobbying organization, but an association with 245 members from the Fortune 500 companies and 62 of the Fortune 100 companies as members. Taken together, the member companies cover over 50 million beneficiaries including workers, retirees, and family members. He said what must be done for the workforce of the future will challenge every rule and regulation in place, from retirement rules to healthcare benefits rules and regulations. One challenge is to integrate employee benefits from health plan benefits, employee assistance programs, disability management, and prevention and health promotion. Dr. Insel said that it was the first time he'd ever heard that the companies themselves are recognizing that this makes economic sense for them to do this. Dr. Finch said, "Our president ..when asked are we really recommending truly equal benefits, she said yes, and the reporter asked her why. She said because it makes economic sense. Those companies that don't do it, they can waste money if they choose to. I thought that was a pretty insightful answer and a pretty bold answer."

Dr. Finch said, "We're recommending that employers eliminate unequal benefits and make the benefits for behavioral health the same as they are for medical/surgical benefits. One of the problems there is with the comorbid conditions, what we call the red flag conditions. If there's comorbid depression and an employee on disability or anybody else hits the limits of the behavioral health benefit that undoes the effectiveness of the disease management program. So limits are not appropriate."

Dr. Finch stated that screening for behavioral health problems in primary care is critically important. American business needs a best practice guideline for psychotropic medications and improved partnerships between employers and the public mental health system. Currently there is a lack of knowledge and understanding about behavioral health programs among benefits managers. He suggested the need to stop the adversarial relationship between payers and behavioral health providers/services so that information about each other's needs and issues can be exchanged. Employee Assistance Programs can be used as a management tool for productivity and absenteeism, coordination of services, counseling, organizational assessment, and health promotion. He also talked about the National Committee on Evidence-Based Benefits (http://www.wbgh.com/evidencedbased/index.cfm) which consists of 25 nationally-recognized people working with their members.

Dr. Essock pointed to the synergy of this effort and the charge of the Council Workgroup, because one of the cross cutting themes is the need for tools to know what's being delivered." Mr. Finch said, "How many of them would like evidence-based benefits? Probably 100 percent of them. Do they know about how to purchase them, or how to identify them? Probably not, and that's why we have the National Committee For Evidence-Based Benefit Design. If NIMH could inform this, this would be great."

Final Question and Answer Period and Wrap-UP

During the final discussion period, Alliance participants had the opportunity to direct comments and questions to the NIMH Director, and to engage all of the presenters in discussion on pressing

needs in the mental health field. Ms. Teresa Twomey from Postpartum Support International asked Dr. Insel to describe NIMH research on non-medical interventions and/or social support for mental disorders. Dr. Insel responded that the Institute has been most focused on trying to define the evidence base for either cognitive-behavior therapy, interpersonal therapy for depression, or some forms of psychosocial intervention. The Institute is also studying preventive interventions particularly for at-risk children.

Ms. Marcela Gaitan, Senior Policy Advisor for the National Alliance for Hispanic Health, asked about NIMH work in community participatory research using community-based organizations. Dr. Essock responded that an NIMH grantee, Mary McKay, studies engagement and community participation. As a member of the National Advisory Mental Health Council, Dr. Essock indicated that she is aware that NIMH realizes this is an area where we need to do more. With regard to intervention research center applications, previous requests for applications made a community core optional. Now a center application will no longer be fundable unless there is a community core that has a convincing argument for how community partners are engaged. It is one thing to develop interventions, but unless they can be brought out in the communities, it will not matter to most people, and researchers will not be welcomed in those communities.

Dr. Insel said, "The other place where this has become a large issue and one that we've tried to move the goal line a bit is in epidemiology and these large scale studies of prevalence, where it's become extremely important now to bring in a community perspective and to make sure that we're really getting data that are accurate for a diverse community."

Dr. Insel also said that there is no conflict between psychosocial interventions and medication interventions, partly because of the growing evidence that psychosocial interventions change the brain in a fundamental way and in a way that often overlaps with what medications are doing. So they have begun to be seen as synergistic, and some people respond better to one than to others. Some require both. What is still not known is how to identify who should get which treatment, and that is where NIMH and its researchers will be helpful. The reason is to have research in the future that will go from what has been done for three decades — comparing group data — to being able to look at individual data to find out why a particular person got better. Another interest is in trying not only to prove that something works, but to find out why it doesn't. Sometimes an evidence base means that it can be clearly demonstrated that a treatment or intervention that is in wide public health use is useless, and that's a very important contribution that NIMH data can make.

Barbara Wolff, R.N. from the Board of Directors of Depression and Related Affective Disorders asked NIMH leadership if they were interested in funding research on support groups for people with mental illnesses. Wayne Fenton, M.D., Director of the Division of Adult Translational Research and Treatment Development at NIMH responded by saying that NIMH is supporting a study of the NAMI Family to Family program for schizophrenia. Lisa Dixon is the investigator on the study that compares it to professionally-led family programs.

Ms. Cynthia Folcarelli, Executive Vice President of the National Mental Health Association, thanked NIMH for its focus on trauma and for its renewed commitment to children's mental health.

Dr. Insel closed the meeting by repeating some key messages from the day. He was enthusiastic about the attendees' interest in the latest research in trauma and terror, and economic aspects of depression in the workplace. He said that he had heard their message that NIMH needs to do a better job communicating with its stakeholders. He wanted attendees to know that NIMH is committed to community engagement and to increasing diverse participation in clinical trials. Dr. Insel said that the interest they expressed on research on peer support groups was useful information for him. Also, he clearly heard from attendees the importance they attach to making sure that what NIMH does has a practical impact — and urged continued emphasis particularly in child research.

Finally, Dr. Insel highlighted how helpful it was to have Dr. Susan Essock at the meeting. The Institute is involved in a very intensive and fairly rapid effort to analyze its services portfolio, and looking at what has been invested, what has been achieved, what NIMH needs to do better, and discovering where the gaps and opportunities are so that as plans are made for the next five years, these ideas can be incorporated.

Asking Questions and Networking

Dr. Witten, National Schizophrenia Foundation, and Dr. Hughes, CHADD

Mr. Grossman, ASA, and Dr. Nakamura, NIMH

Dr. Brounstein, SAMHSA

Ms. Cynthia Folcarelli, NMHA

Ms. Sheila Rabaut, NARSAD, and Ms. Melissa Cockerham, Juvenile Bipolar Foundation

Mr. Andrew Sperling, NAMI, and Mr. Steve Doochin, NARSAD