Photo-illustration by Joe Griffin (NCCOSC)

Mental Health Works

Third Quarter 2013

Resilience and Mental Health: U.S. Marine Corps and U.S. Navy Combat & Operational Stress Control

PAGE 6

Partnership for Workplace Mental Health™

Published by the Partnership for Workplace Mental Health, a program of the American Psychiatric Foundation

Dear Reader:

Providing employers with tools to foster a mentally healthy workplace has always been a primary goal in publishing *Mental Health Works*. Education about a problem can only go so far without the tools to bring about change. This issue of *Mental Health Works* proudly features three tools for employers to use in their workplaces.

The first was brought about through a collaboration between the Partnership for Workplace Mental Health and Employers Health, a national employer coalition. Together, we developed ***Right Direction,*** which gives employers turn-key tools and resources to conduct worksite education about depression. The initiative encourages companies to invest in their workforce to gain healthier, more productive employees, as well as to achieve decreased disability costs, less turnover, and better retention of valued employees.

You have likely heard many reports about the mental health needs facing our military personnel during combat and when they return home. These needs are not new, and there are numerous approaches currently operating to support veterans. The second tool we feature is called Combat & Operational Stress Control. This comprehensive approach and doctrine, while developed for use with a military audience, has practical applications in the civilian workforce as well.

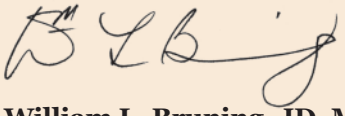
Lastly, the **National Action Alliance for Suicide Prevention** and the Suicide Prevention Resource Center have created new tools to help prevent suicide. Two new information sheets and a manager guide are now available to help managers and coworkers address this issue in the workplace. By making these resources available, we hope that employers will feel better equipped to help prevent suicides and care for those dealing with suicide loss.

Mental Health Works' goal is to serve your needs as an employer addressing behavioral issues in your workplace. Please contact us to share your ideas, questions, and concerns — we want to hear from you! Please contact us at **mhw@psych.org** or 703-907-8561.

Sincerely,

Alan A. Axelson, MD

Co-Chair, Partnership for Workplace
Mental Health Advisory Council



William L. Bruning, JD, MBA

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Mental Health Works

Partnership for Workplace Mental Health™

Mental Health Works is published quarterly by the Partnership for Workplace Mental Health, a program of the American Psychiatric Foundation, the philanthropic and educational arm of the American Psychiatric Association. The Partnership collaborates with employers to advance effective employer approaches to mental health. Learn more at www.WorkplaceMentalHealth.org or by calling 703-907-8561.

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Right Direction Initiative Helps Employers Take on Depression

BY CLARE MILLER AND MARCAS MILES, MA

The Partnership for Workplace Mental Health is pleased to introduce an initiative to help employers raise awareness about depression in the workplace. The Partnership collaborated with Employers Health, a national employer coalition based in Ohio, in the development of *Right Direction,* which gives employers turn-key tools and resources to conduct worksite education. Employers Health decided to focus on depression in part because of the strong link between employee satisfaction and well-being and business success.

The new initiative encourages companies to invest in their workforce to gain healthier, more productive employees, as well as achieve decreased disability costs, less turnover, and better retention of valued employees. *Right Direction* is unique in that it goes beyond telling employers what they should do to actually providing a step-by-step tool to destigmatize depression in the workplace and help employees function better both at work and outside of work.

Depression in the Workplace

Depression matters to employers, in part because it is so prevalent: one in 10 people struggle with depression. Despite advances in treatments, only one-third of people with diagnosable mental health conditions seek care. As such, employers are in a unique position to increase awareness about the condition and encourage employees to seek help when they need it.

Depression can impact an individual's ability to perform in all areas of life, including work. Here are some signs of depression at the workplace:

- Difficulty making decisions
- Lack of interest in activities and work
- Lower quality and/or quantity of work
- Tardiness and missing deadlines
- Distraction or lack of focus
- Frequent sick days

These effects on the workplace can be very expensive to employers, particularly in the area of absenteeism and lost productivity. Mental illnesses such as depression cause more work loss and impairment than other chronic health conditions, including arthritis,

Our Partner

The Partnership collaborated with **Employers Health** to develop *Right Direction.* Employers Health is a national employer coalition of employers working together to improve the cost, quality, and accessibility of high-value healthcare services through value-based group purchasing, data analysis and benefits-design consultation, educational programming, community quality initiatives, and legislative monitoring and advocacy.

Based in Ohio, Employers Health represents more than 300 member organizations and three million lives.

EMPLOYERS HEALTH®

asthma, back pain, diabetes, hypertension, and heart disease. Depression costs employers $44 billion in lost productivity. Depression can affect healthcare costs too — people with depression typically consume two to four times more healthcare resources than those without. And depression can be a chronic condition — one-half of those who've had depression will have a recurrent episode.

The good news is that with treatment, people are able to successfully manage depression and live happy and successful lives. And when individuals get the help and support they need, their employer can benefit, too, in improved performance and productivity.

The Right Direction Initiative

Right Direction is not your standard mental health campaign with images of people holding their head in their hands. It was developed in partnership with employers and is designed to be eye-catching and to stand out amid myriad messages coming at employees at a workplace. It features a wilderness theme, suggesting that having depression can make one feel lost in the woods. A brown bear is positioned in various workplace scenes such as an elevator, an office, a construction site, and a hospital. The central message is to take a step in the right direction to learn more and seek help if you need it.

Right Direction is an effort from the Partnership for Workplace Mental Health, a program of the American Psychiatric Foundation, and Employers Health Coalition, Inc., and is supported by Takeda Pharmaceuticals U.S.A., Inc. (TPUSA) and Lundbeck U.S.

In developing *Right Direction,* the Partnership and Employers Health engaged an employer workgroup comprising representatives from corporate, government, and nonprofit organizations to ensure the resources developed meet the varying business needs of employers. The end result is the *Right Direction* "Field Guide," a toolkit that includes a step-by-step implementation plan, an approach to sharing the business case with the C-suite, and educational presentations, as well as corresponding promotional resources, such as posters, intranet copy, and template materials that can be developed into TV slides.

The toolkit and resources are available free of charge to all employers in the United States through **www.RightDirectionforMe.com/ForEmployers.** The website also serves as the employee portal, offering educational information on common symptoms of depression in the workplace, a depression screening tool, resources for how to discuss depression with family members and how to talk with employers about job accommodations, and additional resources outside the workplace to access for help.

We invite all readers to explore the site and hope you will consider bringing *Right Direction* to your workplace!

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Support for this educational initiative is provided jointly by Takeda Pharmaceuticals U.S.A., Inc., and Lundbeck U.S.

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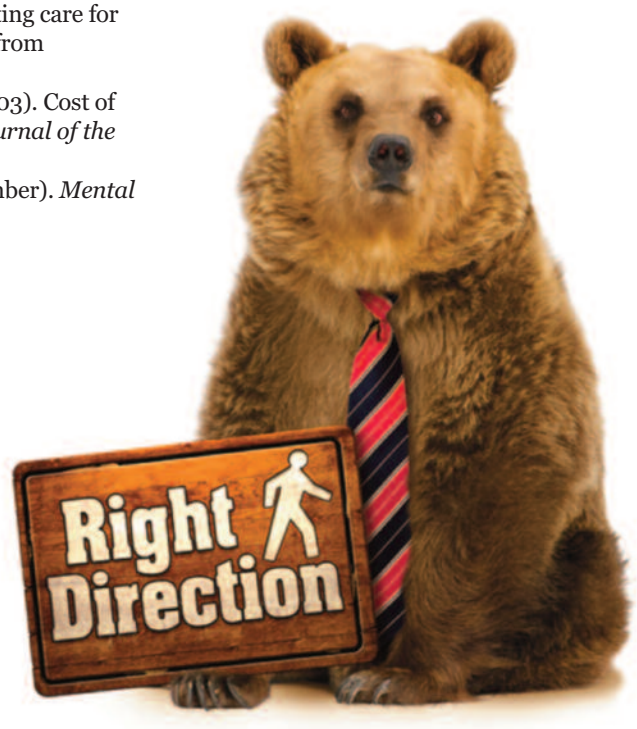


Resilience and Mental Health: U.S. Marine Corps and U.S. Navy Combat & Operational Stress Control

BY KATE A. BURKE, MA

Photo-illustration by Joe Griffin (NCCOSC)

The Naval Center for Combat & Operational Stress Control (NCCOSC) is dedicated to the mental health and well-being of Navy and Marine Corps service members and their families.

The major focus of the center is to promote resilience and to investigate the best practices in the diagnosis and treatment of posttraumatic stress disorder (PTSD) and traumatic brain injury (TBI). The center is a program of the U.S. Navy Bureau of Medicine and Surgery.

www.nccosc.navy.mil

You have likely heard many reports about the mental health needs facing our military personnel, both during combat and when they return home. Some veterans continue to face challenges years after active duty. These needs are not new, and there are numerous approaches currently operating to support veterans. One such program, called **Combat & Operational Stress Control** (COSC), provides a comprehensive approach and doctrine focused on fostering the resilience of members of the U.S. Marine Corps and U.S. Navy and their families. The program has been implemented over the last few years to encourage healthier responses to the stress of military life and reintegration.

The tools of the COSC create a roadmap to help service members and their families access the appropriate level of support they require to maintain mental health and recover from various levels of distress, mental injuries, and mental illness. These tools are available to active Navy and Marine Corps personnel, their families, and retired personnel. While there are clearly many unique features of working in the armed forces, many parallels can be drawn and practices can be adopted in the civilian workforce. As the COSC doctrine is in the public domain, with proper attribution the strategies can be adapted for any workplace. It is imperative for workplace leaders to be in full support of all the components of the approach for the strategies to be successful. If the strategies are

adopted fully, leaders will be equipped to recognize when their employees are in distress and to react appropriately. The following is a short summary of the COSC doctrine's origin with a high-level review of its three primary components, which are designed to work together as a comprehensive framework for supporting resilience. The three primary components are the stress continuum model, the five core functions of a leader, and stress first aid.

Background on COSC

Captain Paul S. Hammer, MD, an early champion of COSC and director of the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury, explains that the foundation of the COSC model builds upon the military culture of strong communal support generated from being part of a unit. Communal support occurs when an organized group provides its members with resources to meet their needs as well as avoid isolation. This type of community support is a known protective factor in mental health and helps prevent or reduce an individual's vulnerability for developing a disorder (Jennings, Bryan, Bradley, & Jobes, 2011). In fact, according to Dr. Hammer, U.S. Marine Corps unit leaders were instrumental in creating the COSC model to address challenges faced by their unit members, and for this reason, the information is oriented to their perspective.

Unit leaders are regularly called upon to keep their team healthy and "ready," or exhibiting optimal functioning and adaptive coping. They recognized additional needs in 2005, when the third year of the Iraq War saw an increase in intense fighting (Nash, 2010). The realities of combat and long deployments, in addition to other life stressors that also occur in civilian life, were cumulatively resulting in increased acute mental health needs among their units, Dr. Hammer said. At the time, the practice was to refer those in need of help to medical personnel *only,* removing the unit leaders from the process and isolating the unit members from their teams. Unit leaders recognized that many team members would benefit from additional support outside of a purely medical response. They were motivated by what they observed in their teams day to day and instinctively sought to increase the role of unit cohesion and support. Leaders also recognized that unit cohesiveness, while primarily protective of mental health, can also discourage reaching out for assistance outside the group, particularly when team members are faced with the stigma that surrounds mental health issues (Jennings, Bryan, Bradley, & Jobes, 2011).

In response to these unit leaders' concerns, a more formal review was conducted in 2007 to examine the impact of mental health and distress on military personnel and to clarify who ought to be involved in the maintenance of health. Retired Navy Psychiatrist William P. Nash, MD, the primary author of the COSC doctrine, and many colleagues gathered and synthesized a tremendous amount of information on how to actively foster resilience, prevent and respond to stress problems, and eliminate the stigma associated with getting needed help. As this model has been implemented, contextual examples based on various roles as well as family status inform the identification of where a person falls on a stress continuum and how to best intervene. The resulting **COSC Doctrine** recognizes that maintenance of health or any required recovery of personnel includes roles for unit

Stress Injury as a Bridging Concept

Combat and operational stress is now seen as a literal wound to the mind, body, and spirit.

Just like physical injuries, stress injuries are important indicators of risk—both for being unable to perform normally in some situations and for developing a mental disorder, such as PTSD, if these injuries don't heal completely.

There are other parallels between stress injuries and physical injuries—both normally heal over time, both heal faster and more completely with appropriate acknowledgement and care, and neither are the sole fault of the individual. Although physical and stress injuries normally heal, both can leave their mark, signifying lasting change in the area of the injury. Sometimes the scars caused by physical or stress injuries become places of enhanced strength, but sometimes the opposite occurs.

— COSC Doctrine

leaders, the individual, and family members, as well as medical experts as required (Nash, 2010). COSC is implemented throughout the U.S. Marine Corps and Navy through various officer trainings and is included in boot camp for enlisted members. COSC's three components — the stress continuum model, five core functions of a leader, and stress first aid — were developed to emphasize inclusion of the following key factors taken directly from the doctrine:

- Unit leader oriented
- Multidisciplinary
- Integrated throughout the organization
- Without stigma
- Consistent with the warrior ethos
- Focused on wellness, prevention, and resilience

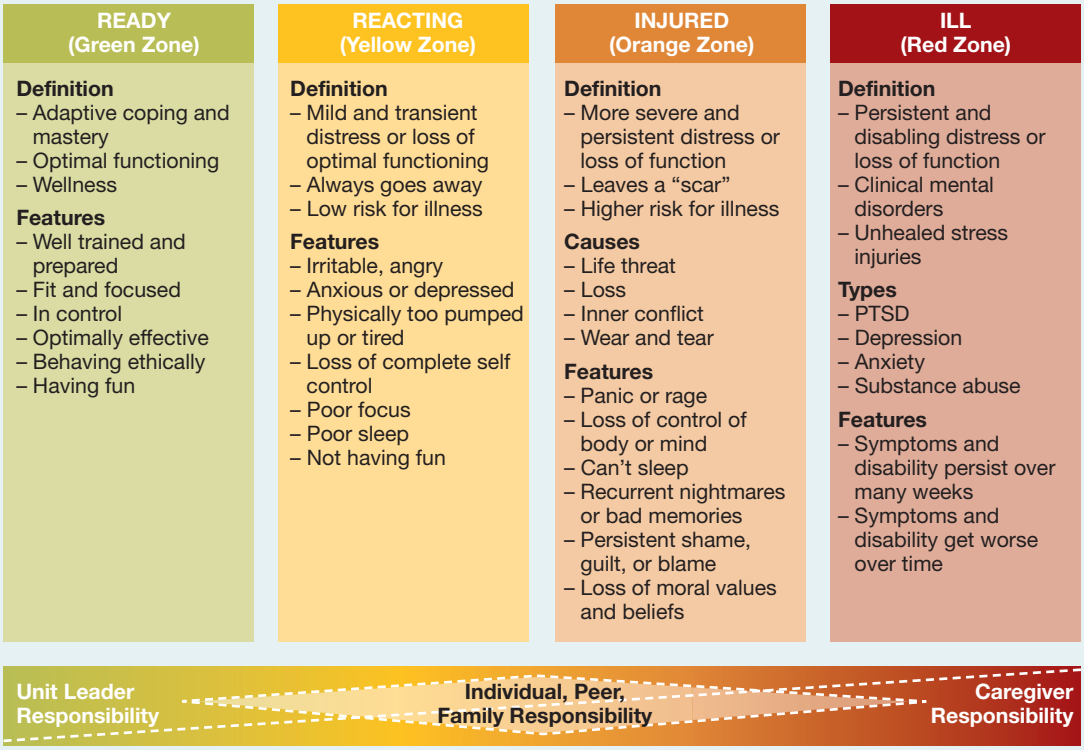
These key factors reflect the impetus for COSC as well as the aim to be comprehensive in who was involved with its creation as well as its implementation. In order for COSC to be effective, there was recognition that the COSC components must fit with the culture of the military, and that focusing on strength and recovery would facilitate the reduction of stigma and remove barriers for service members seeking help.

Stress Continuum Model and Using Accessible Language

The first component of COSC is the stress continuum model. Keeping with the unit leader orientation and multidisciplinary approach, military commanders, unit leaders, and health and religious ministry advisors together created the foundational stress continuum model shown in Figure 1. The model illustrates how unit leaders can view team member needs based on levels of stress as indicated by the four colors zones titled Ready or *Green,* Reacting or *Yellow,* Injured or *Orange,* and Ill or *Red*. The level of a team member's mental distress guides the unit leader's response and referral to medical professionals, if needed, which will be described in the following sections of this article in relation to the other two components of COSC.

Fundamental to the design of the stress continuum is the bottom portion of the figure, which shows a diagonal line going from the unit leader's responsibility, through individual, peer, and family responsibility, to the caregiver's responsibility. The caregiver responsibility is filled by medical and religious ministry personnel, both during combat and noncombat operations. This diagonal line reflects the unit leader's desire to continue their involvement in the response to and recovery from the team member's distress. While the distressed individual may rely more on the unit leader or on medical personnel, dependent on the level of distress, the unit, peers, and family members all participate in the recovery and stay connected to facilitate the return to the Ready state. This demonstrates the approach's commitment to unit cohesiveness and support of

Figure 1: Stress Continuum Model



Nash, 2010

struggling comrades working toward recovery while remaining part of the team, even if they require additional levels of intervention outside the unit.

The upper portion of Figure 1 defines the four zones and the features or behaviors that can be observed at each level of stress. The titles Ready or *Green,* Reacting or *Yellow,* Injured or *Orange,* and Ill or *Red* are designed both to create accessible terms and to make a bridging concept between mental and physical health. The *Green* zone is the desired state, where individuals exhibit optimal functioning and adaptive coping. The COSC doctrine refers to psychological wounds as "stress injuries," which range from typical stress reactions in the *Yellow* zone to *Red* zone stress illnesses that need intervention to prevent long-term disability.

As Figure 1 shows, the description of the *Orange* zone level of distress includes causes. These conditions constitute a significant tipping point, when it is likely referrals for medical intervention outside the unit as well as more time for recovery might be required. The model defines these causes as follows:

- Life-threat. Due to exposure to lethal force or its aftermath in ways that exceed the individual's capacity to cope normally at that moment, life-threatening situations provoke feelings of terror, horror, or helplessness.

- Loss. Loss can be felt due to the death of close comrades, leaders, or other cared-for individuals or the loss of relationships, aspects of oneself, or one's possessions by any means.
- Inner conflict. Stress arises due to moral damage from carrying out or bearing witness to acts or failures to act that violate deeply held belief systems.
- Wear and tear. This stress comes from the accumulated effects of smaller stressors over time, such as those from nonoperational sources or lack of sleep, rest, and restoration.

By applying parallel language from physical injuries or illness to mental injuries and illness, there is an implied parallel to recovery and return to wellness and readiness. For example, when someone breaks a leg, there is typically no stigma attached. When the individual returns to work after sufficient healing time, the person may perform more slowly on the job while rebuilding strength. In the same way, people can recover from mental injuries and mental illnesses.

As the stress continuum model illustrates, the level and source of intervention shifts according to the level or severity of mental injury or illness, with recognition that common difficulties and the time typically needed to work through them also vary. An individual in distress can seek help directly, be referred by peers or family members, or be required to access help through the chain of command, all with the intention of having distressed individuals recover and move left through the stress continuum from the *Red, Orange,* or *Yellow* zones back to the *Green* Ready state.

Five Core Functions of a Leader

The second of the three COSC components is the five core functions of a leader. COSC emphasizes that leaders build resilience in their teams by helping them prepare for, recover from, and adjust to life in the face of stress, adversity, trauma, or tragedy. The overall COSC approach with all its components is being implemented across all levels of the U.S. Marine Corp and the U.S. Navy. Officers and enlisted service members get training about these tools and have access to this model, which shows the leadership's dedication to having the model work effectively. Medical leaders provide train-the-trainer sessions to ensure the integrity of the message. COSC training is adapted to stressors that exist for specific roles such as medics or Special Forces personnel, among others. The widespread familiarity with COSC allows those who may be distressed to seek help more readily when they need it, as there is a common understanding of the terms used to describe various levels of distress.

Through the five core functions, unit leaders employ the stress continuum to recognize and react to what they observe in their teams, for example to be aware when a member moves from the *Yellow* zone to the *Orange* zone and professional care may be appropriate. The five core functions that equip leaders to accomplish this are described below:

Figure 2: Five Core Functions of a Leader

Photo-illustration by Joe Griffin (NCCOSC)

Strengthen
- Leadership that is Firm, Fair, a Source of Courage, Communicates Plans and Listens
- Expose to Tough, Realistic Training
- Foster Unit Cohesion

Mitigate
- Remove Unnecessary Stressors
- Ensure Adequate Sleep and Rest
- Conduct After-Action Review (AAR) in Small Groups

Identify
- Know Crew Stress Load
- Recognize Reactions, Injuries and Illness

Treat
- Rest and Restoration (24-72 Hours)
- Chaplain
- Medical

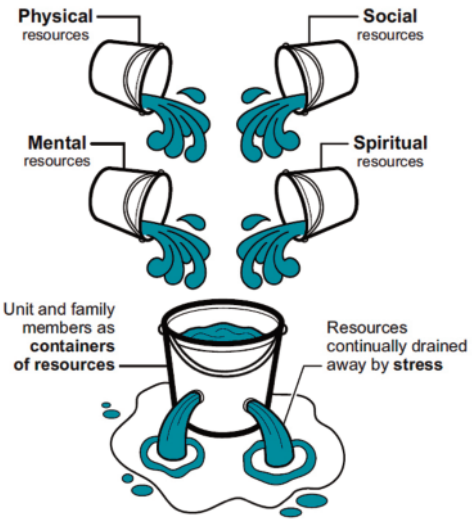
Reintegrate
- Keep with Unit if at all Possible
- Expect Return to Full Duty
- Don't Allow Retribution or Harassment
- Communicate with Treating Professionals (Both Ways)

Strengthen: For leaders to strengthen their units, they must focus on three things — training, social cohesion, and leadership. These areas have been part of military training for many years. The inclusion of the stress continuum informs the existing training as well as adds new insights. Training itself involves some level of stress, and this is required in order to build the resilience needed in combat. The unit leader should always see strengthening in light of the whole cycle represented in Figure 2. Social cohesion includes building a trusting and supportive group, which results in unit cohesion and increases protective factors. Leadership in this model is described as inspiring a focus on the mission, instilling confidence, and providing a model of ethical and moral behavior that safeguards unit members from possible discrimination or barriers to seeking help when needed.

Mitigate: As stress is a given in life, in particular for those in military service, another key role of leaders is to continually monitor the stress levels of their teams and to mitigate the impact of stressors by encouraging team members to replenish their energy levels and readiness through sleep, rest, recreation, and spiritual renewal. This allows team members to experience *Yellow* level stresses but return to the *Green* Ready state quickly.

COSC uses a metaphor of a leaky bucket for the impact and mitigation of stress. As depicted in Figure 3, everyone has a bucket of resources that is continually depleted through various stressors. Each person is required to replenish these resources. Just as the body requires food to fuel the muscles, the mind and spirit require various resources to operate in a healthy manner. This mitigation needs to happen both during combat and during noncombat operations.

Figure 3: Leaky Bucket Metaphor for Stress



Nash, 2010

Identify: The ability to identify stress levels assumes monitoring by leaders who know their team and will be able to recognize changes in behavior that indicate a team member is moving from Yellow into *Orange* or *Red* levels of mental or stress injury or illness. The COSC doctrine includes decision flowcharts that provide guidance on determining the level of stress in a marine, sailor, or family member and suggests actions to take in response. The material from these decision flowcharts has been incorporated into training presentations.

Treat: Corresponding to the levels within the stress continuum, the level of treatment should reflect and match the severity of distress. For example, a team leader witnessing rage in a team member might ask, "Are you moving into the *Orange* zone?" The leader might describe the behaviors that are being observed and discuss next steps with the individual. Tools available for treating various levels of stress include self-aid or buddy aid, which is nonprofessional peer support in the *Yellow* to *Orange* zones; moving to support from unit leaders, chaplains, or others in the chain of command; then finally to definitive medical or psychological treatment as the individual moves from the *Orange* to the *Red* zone. Again, maintaining connection to peers and the unit facilitates healing at all stages of intervention.

Visit the Naval Center at **nccosc.navy.mil** for training presentations geared to specific functions. These materials note that leaders, too, need to be Ready and in the Green zone to best lead and function in their role, reinforcing the need for social cohesion and using shared language to best look out for one another.

Reintegrate: This part of the cycle is crucial to rebuilding trust and mentoring the injured service member to return to the *Green* Ready state. It requires continuous monitoring and removal of stigma to return the confidence of the stress-injured service member and their peers. Reintegration can take months, depending on the severity of the injury or illness and the length of time a person requires for recovery. In each case, reintegration is based on measuring and weighing the capabilities and psychological readiness of the individual to perform his or her duties — again in parallel to what would be measured with a physical injury or illness. There will be cases where individuals will not recover sufficiently to return to duty. In these cases, continued support in transitioning to other work is also within the leaders' role. With mental and stress injuries or illnesses, it is all the more significant to communicate with a consistent attitude of respect and trust. Sufficient time is required to allow the injured individual a fair opportunity to demonstrate competence and self-confidence and to regain the respect and trust of their peers. This process leans heavily on the leaders' skills in strengthening the unit.

Stress First Aid

The third component of COSC is stress first aid. As depicted in Figure 4, this mechanism is used by unit leaders or team members to triage, or prioritize, the seriousness of a person's stress level as defined in the colors and levels of the stress continuum. Stress first aid is used in combat and operational situations and has three simple aims: preserve life, prevent further harm, and promote recovery. Built using the base of psychological first aid tools created for first responders in the civilian context, COSC stress first aid was designed specifically for use in Navy and Marine Corps units and families and can be applied during military training, on the battlefield, and in offices and homes. Dependent on the triage assessment, unit leaders engage any of their five core functions of

Figure 4: Stress First Aid

Seven Cs of Stress First Aid:

1. **Check**
   Assess: observe and listen
2. **Coordinate**
   Get help, refer as needed
3. **Cover**
   Get to safety ASAP
4. **Calm**
   Relax, slow down, refocus
5. **Connect**
   Get support from others
6. **Competence**
   Restore effectiveness
7. **Confidence**
   Restore self-esteem and hope

Photo-illustration by Joe Griffin (NCCOSC)

leadership, apply them within the seven levels of stress first aid, and intervene in a way that is consistent with the level of distress that exists with the team member or family member.

As shown in Figure 4, the stress first aid cycle represents the aim of returning to wellness and readiness and includes continuous monitoring, just as all the COSC components are intended to be applied. Continuous Aid, including *check* and *coordinate,* is the ongoing assessment of stress levels. Primary Aid, including cover and calm, is a brief process that can be used by all parties and allows time to better assess what level of intervention, if any, is required. Secondary Aid, including *connect, competence,* and *confidence,* addresses more severe levels of stress in the *Orange* and *Red* zones of injury and illness and includes reaching out to others, such as military leaders, religious ministry, or medical support personnel. Secondary Aid also indicates a longer time needed for recovery, which overlaps with information from the stress continuum.

Applying COSC to Civilian Workplaces

All workers, civilian or enlisted, face varied levels of life and occupational stressors, which likewise can lead to mental stress injury or illness. Following are a few ways to adapt and provide training on the stress continuum and other components of COSC in your workplace.

Ongoing leadership and peer support. Implementing this type of program creates a supportive environment and demonstrates that fostering mental health and resilience across an organization is a shared responsibility. A socially cohesive environment for your staff includes support from leaders across all levels of your organization to build trust and respect. While the Navy and Marine Corps have implemented the COSC model in concert with the military's integrated system of healthcare, civilian workplaces can

adapt the model through coordination among leadership, managers, human resources, employee assistance programs, occupational health, and company-sponsored medical providers, with the aim of keeping the workforce healthy and productive.

Photo-illustration by Joe Griffin (NCCOSC)

- Employers could build a "Workplace Operational Stress Control" training component into existing training vehicles. Training adapted from the COSC model could be housed with other required manager trainings such as compliance and/or sexual harassment to equip managers to observe whether negative behavior changes are arising and to react with appropriate levels of response. A separate component could be included in training for new hires so people are knowledgeable and use shared language when seeking help or when helping peers.
- Wide use of the strategies within an organization will facilitate familiarity and adoption of the tools. Leaders and peers can reinforce use of the language from the stress continuum in recurring staff meetings or in one-on-one supervisor check-ins with staff.
- Consider using these tools among cross-functional teams (i.e., human resources, employee assistance programs, health promotion, and integrated disability management) for a more integrated response and a common language across all benefit areas. Ongoing reinforcement of the tools' messages during annual health fairs or health insurance enrollment periods will also build a supportive culture.

Stress mitigation. Recognize that the positive outcomes we seek in resilient workforces and mentally healthy workplaces include mitigation of stress. Coordinate efforts with wellness or employee assistance program efforts to provide specific suggestions on how staff might replenish their resource buckets.

Removing barriers. The stress continuum and the use of color terms when discussing mental stress levels can remove stigma barriers for staff to access help when they need it and help them return to the *Green* zone of full productivity and engagement. Early intervention can prevent an increase in the burden of some stress injuries or illnesses.

Stay connected. When situations require that a person goes on leave, remember the role of communal support. Research suggests that keeping managers engaged with employees in seeking their return to work and reintegration can improve outcomes (Christian, 2013). Staying connected with your staff will allow for smoother reintegration upon their return.

For more information, contact Amy Rohlfs, Strategic Communications Dept. Head, Public Affairs Officer, Naval Center for Combat & Operational Stress Control, amy.rohlfs@med.navy.mil

Support our veterans. By adopting the COSC approach, you not only help your own workforce, you also equip your teams to be supportive environments for veterans who are reintegrating into civilian jobs after active duty.

The comprehensive nature of the COSC approach is supported in research that addresses the various levels of support needed in the range of human experience — prevention, early intervention, and disease and disability management. We hope that this brief summary of the approach has piqued your interest and motivates you to continue or adopt supporting practices.

Thank you to all those in our armed forces for serving to protect us and in this case for making available best practices that can be adopted in the civilian workforce.

*Kate A. Burke, MA is associate director of the Partnership for Workplace Mental Health and can be reached at **kburke@psych.org** or 703-907-8586.*

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Suicide Prevention and Response: New Tools Help Employers Take Action

BY KATE A. BURKE, MA

Suicide is a topic that must be brought out of the darkness in order to save lives. There are many organizations working to dispel myths and bring hope and light to the subject so that those in crisis feel comfortable seeking help to recover and reengage fully in life. Employers can play a powerful role in preventing suicide and responding appropriately when tragedies occur.

Suicide is more common than you might think. A report published in the *American Journal of Public Health* in the fall of 2012 found that more Americans die by suicide than in car crashes, by homicide, or in other injury-related deaths (Rockett, 2012). For every suicide death, an estimated minimum of six people are affected, resulting in approximately six million American "survivors of suicide" in the last 25 years (Crisis Care Network, 2013). As employers, your workforce can be impacted directly through the suicide of employees or more indirectly through employees who lose family members or friends, or through the loss of clients or vendors to suicide.

While the burden of suicide is carried by the working-age population, age 24-64, most workplaces are relatively unprepared to help employees who are struggling with suicidal thoughts or to assist colleagues following the death of a co-worker by suicide (CDC, 2010).

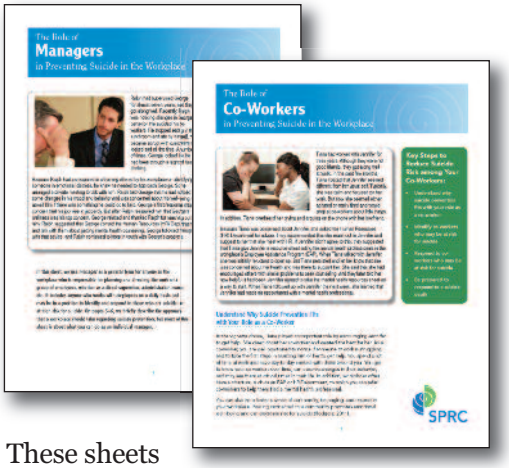
Employees are affected when family members, clients, vendors, and others who surround the work team attempt suicide or die by suicide. Because of the stigma associated with suicide, many people are unsure how to respond to a co-worker who had a death in the family due to suicide. Apart from the human cost, suicide deaths often lead to a decrease in productivity and workplace morale when left unaddressed or handled poorly by workplace leaders. Moreover, suicidal behavior and untreated mental illness can often lead to escalating healthcare costs. When a suicide death of an employee does affect the workplace, the surviving co-workers are often left feeling a mixture of grief, trauma, and guilt that can linger for a long time.

New Tools to Help Employers Respond

Many organizations are coming together to work collaboratively to maximize their collective impact and respond to the reality of suicide. Coordinated suicide prevention in the United States began in the late 1950s. Over the following 50 years, many more organizations were developed to respond to the loss of life through suicide. A revised **National Strategy for Suicide Prevention,** which was released by the U.S. Department of Health and Human Services (HHS), Office of the Surgeon General, and National Action Alliance for Suicide Prevention (2012), is representative of the new research and resources available to prevent suicide. The Partnership for Workplace Mental Health is pleased to serve on the **Workplace Task Force** of the **National**

Action Alliance for Suicide Prevention (Action Alliance). Co-chaired by The Honorable John M. McHugh, Secretary of the Army, and The Honorable Gordon H. Smith, President and CEO, National Association of Broadcasters, the Action Alliance is the public-private partnership that is advancing the national strategy. The Workplace Task Force is pleased to share resources that have been created to specifically address the impact of suicide and suicide attempts in the workplace.

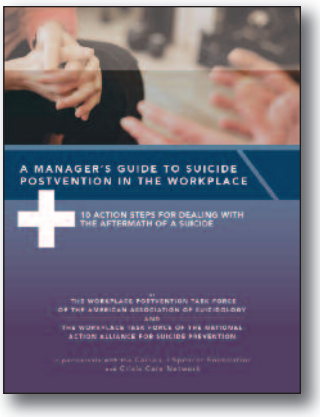
Informational Sheets on the Role of Managers and Co-Workers in Preventing Suicide



In March, the Suicide Prevention Resource Center (SPRC), the nation's only federally supported resource center devoted to advancing the national strategy, posted two new information sheets online for the workplace: **The Role of Managers in Preventing Suicide in the Workplace** and **The Role of Co-Workers in Preventing Suicide in the Workplace.** These sheets provide basic information to help managers and employees (co-workers) recognize and respond to people who may be suicidal or at high risk. They also contain a list of relevant resource materials and organizations. These sheets are part of SPRC's series of customized information sheets for professionals who work in settings that bring them in contact with individuals at potential risk of suicide.

Having tools that are tailored to both of these perspectives is important, as an individual who is experiencing a crisis may not reach out to his or her manager or supervisor. It is helpful to have tools for co-workers who may have more interactions with the individual or more opportunity to notice behavior changes in their colleagues. Informed managers allow teams to work together to support those in crisis and to find resources.

Manager's Guide to Suicide Postvention in the Workplace



In May, the Action Alliance's Workplace Task Force released the **Manager's Guide to Suicide Postvention in the Workplace: 10 Action Steps for Dealing with the Aftermath of Suicide.** The primary developers of this resource were the American Association of Suicidology and the Action Alliance in partnership with Crisis Care Network and the Carson J Spencer Foundation.

Postvention may be a new term to many readers. Postvention is psychological first aid, crisis intervention, and other support offered after a suicide to affected individuals or the workplace as a whole to alleviate possible effects of a suicide death. The manager's guide describes postvention in more detail and provides a checklist for applying 10 action steps in dealing with the aftermath of a Suicide — framed in three phases of immediate, short-term, and longer-term responses. It is important to remember in supporting staff that individuals respond differently to suicide loss over time and in comparison to one another.

"When employers are dealing with the aftermath of a suicide crisis, they often have the 'deer in the headlights' experience because they never thought it would happen to them.

Knowing the Warning Signs and Intervention Steps

Content included in **The Role of Co-Workers in Preventing Suicide in the Workplace** (Suicide Prevention Resource Center, 2013) describes the most effective way to prevent suicide is to increase awareness of the warning signs and to intervene by reaching out to the person in distress. Employers can take an active role by educating managers and employees about the warning signs and appropriate action. The figure here, from a wallet card from **National Suicide Prevention Lifeline,** lists the warning signs that require intervention and the steps suggested in the co-worker information sheet.

The first three signs require immediate action, which could include calling 9-1-1 or the crisis line, 1-800-273-TALK. In these cases, it is essential to stay with the person in crisis or to make sure the person is in a private, secure place with another caring person. If someone appears to be experiencing other warning signs, it is important to reach out to the person directly. Here are some tips on how to intervene:

- Ask how he or she is doing.
- Listen without judging.
- Mention changes you have noticed in the person's behavior and say that you are concerned about his or her emotional well-being.
- Suggest that he or she talk with someone in the employee assistance program (EAP), the human resources department, or another mental health professional. Offer to help arrange an appointment and go with the person.
- Continue to stay in contact with the person and pay attention to how he or she is doing.

When signs are unclear or when employees are unsure how to respond, employees should be instructed to talk with their EAP or human resources department, or call the crisis line.

Instead of a knee jerk reaction, which can often cause more harm than good, managers can respond thoughtfully to alleviate the impact of suicide or suicidal behavior and support their workforce through this difficult time," said Sally Spencer-Thomas, PsyD, CEO and co-founder of Working Minds: Suicide Prevention in the Workplace, a program of the Carson J Spencer Foundation.

The manager's guide also includes tools such as sample communications that can be used in the case of a suicide, as well as a decision-making flowchart that walks managers through various response scenarios appropriate for a near-fatal attempt at suicide, an employee death by suicide, or an employee bereaved by the suicide death of someone

they know. The decision-making flowchart is also informative as it speaks to both prevention and postvention. In the case of a near-fatal suicide attempt, the response would include prevention, and the reaction in the workplace would still require a great deal of sensitivity and leadership from the employer.

"Most business leaders have never been taught about suicide prevention nor how to respond to suicide in the workplace." Bob VandePol, President of Crisis Care Network, explained, "These tools can build on the leadership skills many employers already exhibit in supporting their employees — in life and death situations where expertise is desperately needed." Leaders and managers are often thrust into the role of responding to suicide and suicide attempts. Postvention materials become crucial, as many people are not informed about resources that are available or have never had to face the issue of suicide. The manager's guide and information sheets will help in such crises but will also provide information that leaders can share and can use to help turn postvention into prevention.

Suicide prevention is the ultimate goal of all these tools. We hope that the use of these tools will better equip you to help prevent suicides and to better care for those dealing with suicide loss.

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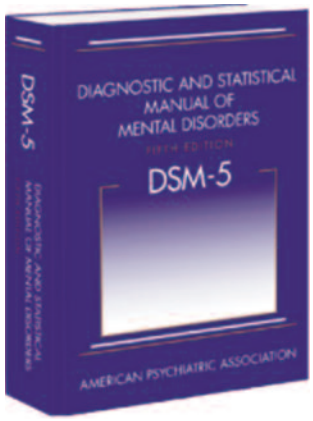
DSM-5 Published — What Employers Need to Know

BY EMILY KUHL, PhD

In May 2013, the American Psychiatric Association (APA) published the Fifth Edition of *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) (American Psychiatric Association, 2013).

DSM is the guidebook used by clinicians and researchers to diagnose and classify mental disorders in this country as well as around the world. The publication of DSM-5 marks an important milestone—revising the classification of mental disorders, as well as the criteria and descriptions used to diagnose them, for the first time since 1994. This revision reflects nearly two decades of scientific advances and clinical experience.



The primary workplace impact of DSM-5 will fall on health plans. Employers may wish to consult with their plans to learn more about changes to benefits and practices.

What DSM-5 Means to Employers

The most substantial impact of DSM-5 for employers is that it contains the best available science for diagnosing mental disorders and conditions prevalent in working populations, including depressive disorders, anxiety disorders, sleep-wake disorders, and substance use disorders.

"Good care starts with an accurate diagnosis, but DSM-5 goes beyond just integrating the latest scientific findings to produce more appropriate diagnostic criteria," said Darrel Regier, MD, MPH, vice-chair of the DSM-5 Task Force. "DSM-5 also includes a more evidence-based chapter organization of the entire classification as well as new tools to make more precise diagnoses, such as scientifically tested questionnaires, available for free to clinicians, to help screen for the presence of disorders and, when present, to help assess their severity. This positions clinicians to provide better care for employees and their family members."

Implementation of DSM-5 will generally be under the purview of an employer's health plans or the entity responsible for administrative claims processes related to the reimbursement for healthcare services.

Implementation of DSM-5 will generally be under the purview of an employer's health plans or the entity responsible for administrative claims processes related to the reimbursement for healthcare services. DSM-5 will continue to use the statistical codes contained in the U.S. clinical modifications of the World Health Organization's *International Classification of Diseases* (ICD). The ICD-9-CM and forthcoming ICD-10-CM contain the internationally approved statistical codes for all medical diseases or disorders but do not contain detailed descriptions of how to diagnose these conditions.

Claims payment systems will be updated to reflect the new DSM-5. It is expected that full transition to DSM-5 by the insurance industry can be achieved by December 31, 2013. The APA is actively working with insurers and the Centers for Medicare & Medicaid Services to assist with DSM-5 implementation.

Employers may wish to consult with their health plans to inquire how the transition is going. As healthcare organizations, practices, and insurers update their medical systems to reflect DSM-5, complications in its implementation may result in payment delays or administrative problems that could negatively affect the experience of employees and their dependents who are accessing care. If such problems occur, employers may help by encouraging plans to work quickly to correct implementation issues to ensure reimbursements to providers and patients are not delayed.

This may also be a good time to review diagnostic exclusions that may exist in the mental health benefit plan design. It is especially important for employers to ensure that diagnostic exclusions do not run afoul of the Mental Health Parity and Addiction Equity Act. The law does not require that specific diagnoses be covered, but if a plan provides benefits coverage for a mental health/substance use disorder in one classification, it must also provide coverage in other classifications if a corresponding medical/surgical benefit exists in that classification. For example, if medical or surgical benefits are covered for outpatient and inpatient services and for both in-network and out-of-network services, mental health/substance use disorder services must be covered for all of the same settings. For more information on the parity law's requirements, see the **Employer Guide for Compliance with the Mental Health Parity and Addiction Equity Act** developed by Milliman, Inc., the APA, and the Partnership for Workplace Mental Health (2012).

Diagnostic and Statistical Manual of Mental Disorders focuses on providing the tools necessary for determining a diagnosis and does not include recommendations for treatment. Guidelines for the treatment of mental disorders are developed by the APA through its **Clinical Practice Guidelines**.

Changes from Previous Versions

DSM-5 is different from its predecessors in fundamental ways. The manual's chapters are organized on the basis of how disorders may relate to each other based on neuroscience research, including genetic vulnerabilities, risk factors, prognosis, comorbidities (disorders that tend to occur simultaneously), and neuroimaging findings. It also distinguishes some disorders due to a greater understanding of their basic causes and characteristics since the last edition was published. For example, in DSM-IV, a single chapter on anxiety disorders included obsessive-compulsive disorder and posttraumatic stress disorder, but in DSM-5, there are three sequential chapters covering these disorders (i.e., Anxiety Disorders, Obsessive-Compulsive and Related Disorders, and Trauma- and Stressor-Related Disorders). This move emphasizes both their distinctiveness and interconnectedness.

"The changes to the manual will help clinicians more precisely identify mental disorders and improve diagnosis while maintaining the continuity of care," said David J. Kupfer, MD, chair of the DSM-5 Task Force. "We expect these changes will help clinicians better serve patients and deepen our understanding of these disorders based on new research."

Additional Information on DSM-5

There are a variety of informational resources available for employers and insurers wishing to learn more about DSM-5 and its implementation.

- **Highlights of Changes from DSM-IV-TR to DSM-5**
- **Insurance Implications of DSM-5**
- **Online Assessment Measures,** including disability measures.

Learn more at **www.dsm5.org**

Throughout the manual, disorders are framed in the context of age, gender, and cultural expectations. In fact, disorders now are loosely organized along a developmental lifespan across the manual as a whole as well as within each chapter. And although DSM-5 includes several new diagnoses—such as binge eating disorder, disruptive mood dysregulation disorder, and hoarding disorder—the new manual has fewer distinct disorders than DSM-IV.

More Precise Diagnoses

Many of the changes in DSM-5 were adjustments made to better characterize disorder symptoms in terms of appearance, duration, or severity. Certain conditions were combined because of the recognized overlap between some disorders or, in the case of autism spectrum disorder, some disorders clearly exist along a continuum rather than as separate conditions. In Section III, several conditions are introduced that warrant more research before they might be considered as formal disorders for the main book.

The Development Process

The product of the most comprehensive and transparent development process in APA history, the new manual represents the strongest science and the contributions of more than 1,500 U.S. and international experts from a diversity of mental health and medical fields. Draft diagnostic criteria were made available online as part of three open-comment periods that drew more than 13,000 responses from consumers, advocates, and mental health and medical professionals and organizations. Every response was reviewed and considered by the DSM-5 Task Force and Work Groups.

APA is working to make future revision processes more responsive to breakthroughs in research, with incremental updates until a new edition is required. Since the research base of mental disorders is evolving at different rates for different disorders, diagnostic guidelines will not be tied to a static publication date but rather to scientific advances.

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Save the Dates

Disability Management Employer Coalition Annual Meeting

August 18 – 21, OMNI at CNN Center, Atlanta, GA

As a critical component of their business strategy, employers must find better ways to control the escalating costs associated with workforce absence and disability, while remaining compliant with state and federal leave laws. Join your peers from across the country in learning how to better manage the frequency and duration of workforce absence, bring your programs into compliance with complex leave laws, safely return employees to work, and come away with practical, real-life solutions to your most pressing challenges. Partnership director Clare Miller will be moderating a panel on early intervention in mental health disability management. The conference will also feature a special keynote address from Former First Lady Rosalynn Carter. **Register Now.**

HERO Forum for Employee Health Management Solutions

September 24 – 26, Hilton, at Walt Disney World, Lake Buena Vista, FL

Experience small format workshops where you can drill down deep into the details of design and implementation of exemplary programs. Hear from award winning employee health management programs mangers and the industries top innovators. HERO (Health Enhancement Research Organization) brings you unbiased, evidence-based, employer-focused view on managing employee health. **Register Now.**

2013 USBLN 16th Annual Conference & Expo

September 30 – October 3, Los Angeles Airport Marriott, Los Angeles, CA

Be sure to join us for the US Business Leadership Network's (USBLN) 16th Annual Conference in Los Angeles, California at the Los Angeles Airport Marriott. The 2013 USBLN® Annual Conference & Expo is the preeminent national business to business event that focuses on disability inclusion in the workplace, marketplace, and supply chain. This conference brings corporate, government, disability-owned businesses and BLN affiliates together to create workplaces, marketplaces, and supply chains where people with disabilities are fully included as professionals, customers and entrepreneurs. **Register Now.**

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Depression in the Workplace: Why it Matters and What You Can Do About It

Live Webinar, Thursday, October 16, 1:00 – 2:00 P.M. E.T.

Only one-third of employees and dependents needing mental health treatment seek it. Join Partnership director, Clare Miller in participating on a webinar sponsored by the National Association of Worksite Health Centers (NAWHC). This webinar will provide employers and those working with onsite health and wellness programs information on a new initiative, called *Right Direction,* focused specifically on depression in the workplace. Developed by the Partnership for Workplace Mental Health, a program of the American Psychiatric Foundation, and Employers Health, a national employer coalition based in Ohio, *Right Direction* is available free to employers looking to address depression in their workplace. **Register Now.** Use the discount code "PWMH" for 50% off the registration cost. Note that the discount won't be applied until the form is completed.

EAPA's 2013 World EAP Conference

October 16 – 19, Arizona Biltmore, Phoenix, AZ

The Employee Assistance Professionals Association (EAPA) is the world's largest, oldest, and most respected membership organization for employee assistance professionals. With members in over 40 countries around the globe, EAPA is the world's most relied upon source of information and support for and about the employee assistance profession. The 2013 World EAP Conference is the most intensive and comprehensive learning/networking opportunity dedicated to the growth of the employee assistance profession. **Register Now.**

Don't Bear the Unnecessary Costs Related to Depression.

One in 10 people struggle with depression. And it impacts your business more than you may realize in the form of call-offs, low productivity and poor quality. Depression costs employers $44 billion a year in lost productivity.

The majority of affected employees will improve with appropriate diagnosis and treatment.

Let Right Direction show you how, by investing in a mentally healthy workforce, you'll gain:

- Healthier, more productive employees
- Decreased disability costs
- Less turnover
- Retention of valued employees

To find out more about this free initiative, visit **RightDirectionForMe.com/Employers**

Right Direction is an effort from the Partnership for Workplace Mental Health, a program of the American Psychiatric Foundation and Employers Health Coalition, Inc., and is supported by Takeda Pharmaceuticals U.S.A., Inc. (TPUSA) and Lundbeck U.S.

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Helping businesses solve the productivity puzzle.

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Untreated mental illness saps productivity. It increases absenteeism and health care and disability costs.

The Partnership for Workplace Mental Health collaborates with employers to advance effective approaches to mental health.

- Business case for action
- Employer case studies
- Research Works issue briefs
- *Mental Health Works* newsletter

Good mental health is good for the bottom line.

Learn more at **www.WorkplaceMentalHealth.org**

Partnership for Workplace Mental Health™

For more information on Mental Health Works and the Partnership for Workplace Mental Health, visit **www.WorkplaceMentalHealth.org**

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