WHITE PAPER

Screening for Depression in the Workplace: Current Research & Applications

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I. INTRODUCTION

In today's complex and highly competitive workplace, a number of factors can disrupt the ability of workers to perform at their full potential. Among adults of working age, certain mental health conditions are highly prevalent (Smit et al., 2006). In particular, ailments such as depression and other mood disorders among employees can substantially and negatively impact an employer's bottom line (EASNA Research Notes, 2009). Depression is of particular interest to employers given its frequent appearance in early to mid-adulthood and potential for reoccurring episodes that disproportionally affect adults of working age (Bender & Kennedy, 2004).

Prevalence of Depression

The most common type of mental illness among adults aged 18 to 60 is depression, which under the generic category 'depression' includes major depressive disorder, bipolar disorder, persistent depressive disorder (formerly called dysthymia), and seasonal affective disorder (Kessler et al., 2005). Worldwide, estimates range as high as 350 million people affected[1] to approximately 5% of the general population experiencing a depressive episode in the past 12 months (Bender & Farvolden, 2008).

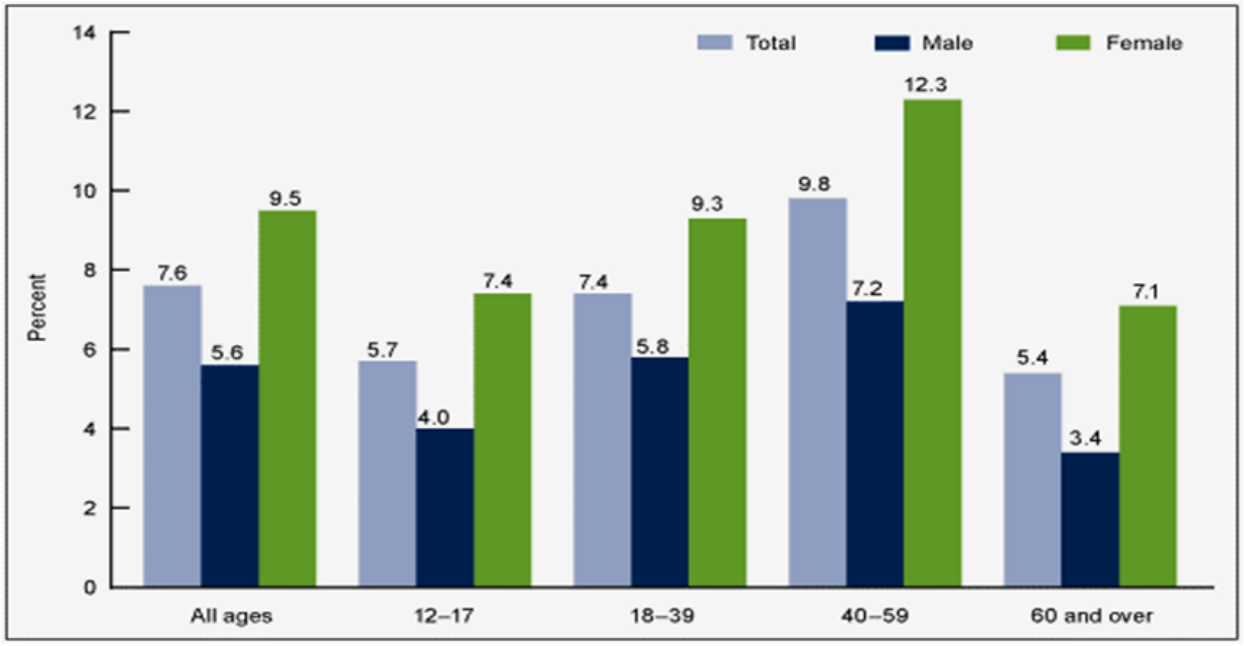

Figure 1. Percentage of persons aged 12 and over with depression, by age and sex: US, 2009–2012[2].

[1] World Health Organization. Depression. Fact Sheet No.369 October 2012. www.who.int/mediacentre/factsheets/fs369/en/

[2] NCHS Data Brief #172 Depression in the US Household Population 2009–2012. www.cdc.gov/nchs/data/databriefs/db172.htm

Characteristics of Depression

As defined by the World Health Organization, depression is an enduring condition with mood, cognitive and physical symptoms marked by sadness, loss of interest or pleasure, sleep or appetite disturbances, feelings of hopelessness, fatigue and poor concentration. Common depression-related cognitive symptoms: indecisiveness, attention and memory deficits, can be as debilitating as most other serious medical conditions. These difficulties, reported by over half of depressed individuals, are much more frequent than previously thought and may significantly impair an individual's ability to function at work or cope with daily life; ultimately leading to substantial work impairment, performance dysfunction, and loss of employment (Wang & Gorenstein, 2014). Beyond just a brief case of "the blues" or a few days of sadness, the deeper, more enduring condition defined as clinical depression with its high global prevalence has earned a characterization as the "common cold" of mental health disorders. At its most severe, depression can lead to suicide. Depression can also occur in association with many other psychiatric and physical illnesses. In some individuals, physical illness such as stroke and cardiovascular disease may increase the risk of developing depressive symptoms as much as three times (Goodwin, 2006). Additionally, other mental health conditions may coexist with depression, including anxiety disorder, obsessive compulsive disorder, and panic disorder.

Gender and Age Differences in Depression

In 2014, the Centers for Disease Control and Prevention released a report entitled Depression in the US Household Population 2009–2012, which indicates 7.6% of Americans over 12 suffered from moderate or severe depressive symptoms in the past 2 weeks (see Fig. 1). Clear patterns of depression by age group were reported: adults aged 40–59 and 18-39 had markedly higher rates than those of younger or older age groups (Pratt & Brody, 2014). In 2013, the Substance Abuse and Mental Health Services Administration released the results of its National Survey on Drug Use and Health which reported that 6.9% of adults 18 or older had experienced a major depressive episode in the past year (SAMSHA, 2013). A 2013 poll of 100,000 Americans, the Gallup-Healthways Wellbeing Index found similar rates. This survey also reported that young adults (18-21) are least likely to be depressed, with the rate of depression then generally rising and peaking in late middle age, until age 65, when it drops dramatically. In all three of these surveys, females were identified as suffering higher rates of depression than males[3].

Historical approaches to reaching men with mental health and suicide prevention messages have often been unsuccessful, and newer innovative approaches need to be explored.

However, depression in males often goes undiagnosed. Men are more likely to report fatigue, irritability, loss of interest in work, than feelings of sadness or worthlessness. Males account for only one in ten diagnosed depression cases in the US (Mental Health America, 2007). For many men, challenges exist in acknowledging mental health concerns or suicidal thoughts due to deeply engrained social conditioning, and research suggests that 50-65% of depression in males are unaddressed. This resistance to asking for help coupled with not accessing available services contributes to excessive productivity losses and the higher suicide rate among men (Möller-Leimkühler, 2002).

[3] www.gallup.com/poll/164090/employment-linked-depression-free.aspx

Treatment for Depression

Depression and other mental health disorders have a sizeable impact on the health, quality of life and productivity of millions of individuals worldwide, most often in their prime years of productivity (Burton, et al., 2008; Chima, 2005). However, with many significant scientific advances over the last half century, the diagnostic features, clinical course, and patterns of morbidity for depression and other mental health conditions are now well understood and a range of reliable treatments exists for virtually every such disorder. The good news is that, properly identified and addressed, depression is highly treatable (Gilbody, Whitty, Grimshaw, & Thomas, 2003). The use of patient-administered screening tools has become firmly established as a quick and reliable option in the first step of depression assessment.

To ensure proper treatment, an initial positive screening for depression must be followed by a clinical interview to determine if a diagnosis of depression is indicated. Efficacy rates of treatments have improved dramatically and are now comparable to or exceeding those for other well-understood medical conditions (Russell, Patterson, & Baker, 1998). Clinical studies have repeatedly demonstrated there are effective treatments for depression, often a combination of medication and therapy (Pampallona, et al, 2004). Recommended options for mild depression are typically psychosocial treatments and should be the first line treatment. For moderate and severe depression approaches often consist of basic psychosocial support combined with antidepressant medication and psychotherapy, such as cognitive behavioral therapy, interpersonal psychotherapy or problem-solving treatment[4]. Additionally, reducing symptom severity in individuals with major depression can significantly improve occupational functioning (Trivedi, et al., 2013).

II. PREVALENCE OF DEPRESSION IN THE WORKFORCE

Depressive disorders are relatively common in most workforces compared to other mental health conditions (Burton, et al., 2008), and most people with depression (an estimated 68%) are employed (Charbonneau et al., 2005). Researchers have reported that historically, mental health conditions affecting working adults in the US have been under-identified and under-treated (Bender & Kennedy, 2004) which hinders precise prevalence figures. Data points which illustrate the current understanding of the prevalence of workforce depression at roughly 10-20% include:

- In a given year, 18.8 million American adults (9.5% of the adult population) will suffer from a diagnosable depressive illness[5].
- In 2014, Employers Health, an employer coalition conducted a survey of working adults aged 16 to 64 to evaluate the societal and economic burden of depression in the workplace. Entitled *The Impact of Depression at Work Audit*, its findings include that 23% of respondents reported they have been diagnosed with depression in their lifetime (Medscape Medical News, 2014).

[4] World Health Organization. Depression. Fact Sheet No.369 October 2012. www.who.int/mediacentre/factsheets/fs369/en/

[5] Centers for Disease Control & Prevention Workplace Health Promotion: www.cdc.gov/workplacehealthpromotion/index.html

- In 2013, the Gallup-Healthways Well-Being Index reported an average of 12% of US full & part-time workers saying they have been diagnosed with depression at some point in their lifetime, with about half of those (representing 6.1% of all US workers) currently being treated for depression (Gallup.com, 2013).
- In another study, almost one in five employee participants reported having ever been labeled by a doctor or medical professional as suffering from depression. However, most of these depressed employees (73.5%) remained working (Wang & Gorenstein, 2014).

III. IMPACT AND COST OF DEPRESSION AT WORK

Numerous researchers have investigated the impact and costs of mental health conditions at work to both employees and employers, which are frequently estimated at over $100 billion annually (CDC, 2009). Employees suffer negative health consequences, lose wages and related benefits, and occasionally employment. Employers experience excessive rates of absenteeism, presenteeism (the loss of workplace productivity resulting from health problems and/or personal issues), and unnecessary medical expenses. Mental disorders are significantly associated with decreased work productivity and about one-third of the annual $51 billion cost of these conditions is related to productivity losses (Dewa, Thompson & Jacobs, 2011). Other studies indicate the productivity costs of mental disorders such as depression and anxiety are significantly greater (on average 2.3 to 1) than the health-related medical and pharmacy costs alone (Loeppke et al, 2009).

Studies focusing on depressive disorders provide compelling evidence of the magnitude of its societal consequences due to its relatively high occurrence during the years of 18-65 of the health and work productivity losses now attributable to this condition (Lerner & Henke, 2008). Projected to the US workforce, annual depression-related productivity losses had human capital costs of nearly $24 billion (Birnbaum et al., 2010). Over the past two decades, short- and long-term disability costs for employers have continued to rise with depressive disorders accounting for an increasing proportion of claims over time (Rost, Fortney, & Coyne, 2005). Mental health claims generally are highly resource-intensive and comprise the majority of financial costs to insurance companies or self-insured work organizations in comparison to other disorders, up to 30% or more of the typical employer's corporate disability experience (Marlowe, 2002; Rost, Smith, & Dickinson, 2004).

Depression-related Absenteeism and Presenteeism are Often Interrelated

Most of the studies on mental health conditions and workplace productivity which show associations between such ailments and absenteeism, particularly with short-term disability absences, although depression and anxiety specifically are more consistently associated with presenteeism than absenteeism (Sanderson & Andrews, 2006). Research on the financial impact of depression on employers is extensive and reveals that roughly two-thirds of the cost is not found in benefit plan expenses, but rather, in productivity areas of absenteeism and presenteeism. When presenteeism is measured by a validated questionnaire, results show that multiple dimensions of job performance are significantly impaired by depression (Adler et al., 2006). Figures reported for the extent of presenteeism due to depression fluctuated across

studies, with a range of 25-80% in lost time, some which likely represents a reflection of different measurement approaches. Detailing the exact workplace costs of depression in all its configurations is a difficult task. But an increasing number of data points clearly illustrate compelling evidence of the importance of workplace depression screening, outreach and enhanced treatment, both in the interest of workers' health and employers' bottom line.

- Compared to employees without depression, those employee EAP clients assessed with depressive symptoms reported 2.5 more days absence per month, were more likely to take long-term disability leave, and reported higher frequency of presenteeism symptoms - greater difficulty concentrating (55%), difficulty multitasking (36%) and making mistakes (19%) (Lam et al., 2012).

- In one large manufacturing corporation, depression accounted for at least as much medical and disability costs as hypertension, diabetes, back problems, and heart disease. When disability and incidental absences as well as health care expenses were combined into a measure of total health and disability costs, employees with depression cost an additional $5415 annually (Druss, Rosenheck & Sledge, 2000).

- One workplace study, which measured absenteeism costs as the total of disability and incidental absence expenses, reported that female employees with depression cost employers an average of $4602 annually, while male employees with depression cost employers $3541 per year (Birnbaum, Leong, & Greenberg, 2003).

- Full-time workers who have been diagnosed with depression average 8.7 missed work days each year due to poor health. Workers who have never been diagnosed with depression miss an average of 4.6 work days per year. In total, workers who have been diagnosed with depression miss an estimated 68 million additional days of work each year than their counterparts who have not been depressed, resulting in an estimated cost of over $23 billion in lost productivity annually to U.S. employers (Gallup.com, 2013).

- The *Impact of Depression at Work Audit* reports that among workers with diagnosed depression, 40% reported absenteeism rates averaging an average of 10 days a year, with 64% of survey participants reporting cognitive challenges: difficulty concentrating, indecisiveness, forgetfulness having the most impact on their productivity (Medscape Medical News, 2014).

- In another study, 60% of employee participants who reported being labeled by a medical professional as suffering from depression and who continued to work reported performance-related impairments with such cognitive symptoms as concentration difficulties, indecisiveness, and forgetfulness; with 40% taking more time to complete jobs, and 37% making more mistakes. One in three workers had taken off work for depression, with these periods being lengthier for men than women (Wang & Gorenstein, 2014).

- Another study found that employees with depression typically take an average of nine days leave annually due to effects from the illness (Ipsos Healthcare, 2012)

IV. EVIDENCE-BASED WORKPLACE INTERVENTIONS FOR DEPRESSION

The existing evidence for effective, scientifically-valid screening interventions for depression in medical settings is strong, and while lesser in number, systematic reviews of similar workplace-based interventions are increasing indicating that treatment and other program expenditures for employees with depression are typically offset by reductions in absenteeism, disability and improvements in on-the-job productivity (Burton et al., 2008; Murray et al., 2013). A few examples of case studies and published data detailing results of worksite prevention education, screening, and brief interventions listed below are illustrative.

- One cost-benefit modeling study suggests every one dollar invested by employers in enhanced depression care yields approximately three dollars for the company in the form of productivity gains by employees (LoSasso et al., 2006).
- One study of workers with depression who utilize mental health treatment were more likely to be highly productive than workers with depression who did not have mental health treatment (Dewa & Hoch, 2015).
- Another study of outpatients from 77 clinics demonstrated a significant relationship between improvement in depression symptoms and improvements in productivity following routine depression treatment, underscoring the benefit of depression care to improve work outcomes and to yield a potential return on healthcare investment to employers (Beck et al., 2014).
- The US Preventative Services Task Force recommendations from 2009 found good evidence that evidence-based screening methods improve the accurate identification of individuals suffering from depression[6].
- A study of 604 employees in a managed healthcare plan, all identified with depression were randomly assigned to an intervention that included telephone support and choice of telephone psychotherapy, in-person psychotherapy or antidepressant medication. The other half of the participants were assigned to usual care, which included feedback about their screening results, and advice to seek care from their usual provider. After 12 months, those in the intervention group were 40% more likely to have recovered from their depression, 70% more likely to stay employed, and worked an average of 2 more hours per week compared to those in usual care group. The value of more hours worked among the intervention group was estimated at $1,800 per employee per year, far exceeding the $100-$400 per person outreach and intervention program costs (Wang et al., 2007).

Barriers to Treatment of Employees with Depression

Despite the severity of the burden of depression, there is also evidence that a significant proportion of workers with this conditions do not pursue assistance, with estimates from one-third to one-half of US workers (Birnbaum et al., 2010; Pratt & Brody, 2014). Similar findings (40-57%) are reported for Canadian workers (Dewa & Hoch, 2015) and Australian (42%) workers

[6] US Preventative Services Taskforce. Recommendations for Depression Screening in Adults www.uspreventiveservicestaskforce.org/Page/Document/final-evidence-summary20/depression-in-adults-screening

(Reavley & Jorm, 2014). Overall rates of treatment for depression remain low, and for many, the treatment received is often inadequate (Wang et al., 2005; Finch & Phillips, 2005).

Results of the National Comorbidity Survey and other studies have ascertained that the most significant barriers to treatment for mental disorders were attitudinal, for example: the lack of recognition that help is needed, that treatment was not effective, the stigma of accessing treatment, and not regarding the cost, availability nor convenience of using treatment services (Mojtabai et al., 2011). One of these major barriers to seeking assistance for depression in the workplace environment is stigma. Results from the *Impact of Depression at Work Audit*[7] illustrate that few employees are comfortable discussing depression and other mental health problems with their colleagues. Respondents' self reports in the *Audit* show that of the 23% having been diagnosed with depression in their lifetime and nearly 58% of these individuals reporting they had not told their employer about their diagnosis, with 49% believing that doing so would put their job at risk. Other findings include the observation that utilization of EAPs (which are designed to help employees deal with personal concerns and psychological distress) by those with depression is low. Thus, while many employees are suffering with mental health issues, large percentages are failing to take advantage of resources at their disposal. Some reasons cited include: employees don't know, or want to admit that they are depressed; they fear seeking assistance will adversely affect their employment status; they are embarrassed; or don't know where to seek help.

Ineffectively treated, depression remains an issue that leads to employees failing to get needed care, widespread loss of productivity, and increased short-term disability claims for employers. Contrary to concerns expressed prior about recent health care reform, study findings indicate that for continuously enrolled populations, providing insurance coverage parity for behavioral treatment improved insurance protection, but had little impact on benefits utilization, costs of insurance plans, or quality of care. There is solid evidence to support that employers realize overall cost savings benefits from medical and disability cost reduction and increased productivity when mental health prevention, education and treatment are provided and employees are encouraged to avail themselves of such services (Goetzel et al., 2007) These market pressures and incentives from health reform are prompting more employers to start or expand employee wellness efforts, including depression screening programs.

V. THE CASE FOR WORKPLACE-BASED DEPRESSION SCREENING

Given the significant impact of depression on the workplace, the remedial effects of treatment, and considering the relatively large proportion of workers with depression and other mental disorders who do not use services, more available and cost effective efforts in the workplace to address this gap are clearly indicated. Unfortunately, many employers remain unaware of the true nature and cumulative extent of the direct and indirect costs of depression among their workforce and covered lives. In one survey, 36% of managers reported no formal support or specific resources to handle an employee with depression (Ipsos Healthcare, 2012). Managers

[7] Society for Human Resource Management. Survey: 23% of Workers Diagnosed with Depression www.shrm.org/hrdisciplines/safetysecurity/articles/pages/employees-missed-work-depression.aspx

underestimated the number of employee days out-of-role attributable to depression (Wang & Gorenstein, 2014). Often, they have mistaken assumptions about the availability of effective treatment, and they are unaware of how often depression contributes to worker disability. In the past, employers have been disinclined to take proactive measures to improve efforts in education about, intervention for and treatment of depression in part because their return on investment has historically been unclear. (Goldberg & Steury, 2001). Today, there is solid evidence to support that work organizations benefit from overall cost savings from depression treatment due to medical and disability cost reductions as well as increased productivity (Partnership for Workplace Mental Health, 2009).

Employer initiated policies and programs designed to lessen the impact of commonly occurring health disorders on workers will contribute to a reduction in absenteeism and presenteeism. Given the indirect costs of mental disorders are much higher than their medical costs, prevention, early detection and adequate treatment of these conditions may be particularly cost-effective (de Graaf, et al., 2012). These systematic efforts to identify and treat depression in the workplace such as organized screening and enhanced depression treatment can significantly improve employee health and productivity, leading to lower overall costs for employers (Wang et al., 2007). Screening and brief intervention approaches have been successfully implemented in medical and other settings, yet remain an underutilized way to help control these costs among employees in the workplace setting.

By increasing prevention information, providing opportunities for depression screening, and facilitating treatment for depressive disorders, employers can diminish the negative impact of depression their workforce, while reducing their associated costs.

Workplaces can be an appropriate and effective setting for these efforts for the following reasons: 1) social and organizational supports are available when employees are attempting to change unhealthy behaviors; 2) policies, procedures and practices can be introduced into the workplace and organizational norms can be established to promote certain behaviors and discourage others; and 3) financial or other incentives can be offered for participation. Since most employers tend to have long-term relationships with their workers; the likelihood that employees and their family members will attain health benefits through such efforts is high, as is the potential for employers to achieve a positive return on investment (Goetzel, Roemer, Liss-Levinson & Samoly, 2008).

Research indicates that employers which support the needs of employees living with depression can enjoy a positive return on investment, as one cost-benefit modeling study indicated that every $1 invested by employers in enhanced depression care yielded approximately $3 in the form of employee productivity gains (LoSasso, Rost, & Beck, 2006). Workplace based initiatives can have a positive effect in improving screening, detection and treatment for depression. Many individuals with current depressive disorders actively participate in the workforce, in particular, the tendency of individuals with depression to come to work while unwell makes the workplace an ideal setting for increasing access to appropriate treatment and supports targeting workplaces with enhanced screening as a treatment approach to reduce the economic cost of such disorders (Goetzel, et al., 2002; Sanderson & Andrews, 2006).

Unfortunately, hesitation to enact supportive policies and programs can often stem from the stigma and negative perception of mental health issues; however, the prevalence and cost of depression, including comorbidity with chronic medical disorders, makes it a condition that can no employer or union with an interest in reducing health care costs and increasing productivity can ignore (Jones & Paul, 2012). Most employers know that a mentally healthy workforce is linked to lower medical costs, as well as less absenteeism and presenteeism. And most employers know that a mentally unhealthy workforce is associated with increased loss of productivity. What employers may not know, however, is how does a company change a mentally unhealthy workplace (or a marginally healthy one) to a healthy workplace? Where does it start?

VI. INCORPORATING DEPRESSION SCREENING IN WORKPLACE WELLNESS PROGRAMS

Worksite wellness prevention and promotion programs have great potential to improve employee physical and emotional health. They strive to promote a healthy lifestyle for employees, maintain or improve health and wellbeing, and prevent or delay the onset of disease by assessing participants' health risks and delivering tailored preventive, educational and lifestyle interventions. (National Institute for Healthcare Management, 2011). Additionally, well-designed, evidence-based employee health promotion and wellness programs can reduce employee medical costs, achieve productivity improvements in worksite populations, and show a positive return on investment for employers. The most effective of these programs offers individualized health screenings and risk-reduction counseling to employees within a workplace environment where broader health awareness initiatives were already underway (Centers for Disease Control & Prevention, 2008).

At their core, these initiatives provide preventive educational services, assess participants' health risks, and deliver lifestyle management interventions designed to lower health risks and improve outcomes. Such programs typically offer decision support aids, workplace safety and injury prevention initiatives, facilitate proper use of and/or reduce spending for health care services, and increasingly are incorporating disease management programs for chronic conditions, such as depression. Through the use of coaching or other incentives to encourage program participation, features may include web-based education and screening platforms, Employee Assistance Programs, and other efforts to manage employee illness and disability. Contemporaneously, the new wellness and prevention provisions included in the Affordable Care Act have heightened the attention to and expectations for healthier workforce initiatives among employers.

In a 2011 literature review and best evidence synthesis, health risk screenings at the workplace were among the top four highest factors leading to positive effects of a workplace wellness program. Depression and other mental health screenings were among the five interventions that could provide short term gains in productivity (Cancelliere et al., 2011). Improved individual health-related outcomes and favorable organizational economic results have been associated with employer-sponsored wellness programs which have several characteristics in common, including: 1) a workplace culture that encouraged wellness to improve employees' lives, not only to reduce costs; 2) both employees and leadership were motivated by an organizational

environment and policies which supported the wellness programs and their health in general; 3) workplace and community health organizations provided education, screening, and treatment access; and 4) Successful wellness programs utilized web-based technology to facilitate health risk assessments and wellness education. (Kaspin, Gorman, & Miller, 2013).

VII. CONCLUSIONS

When the aim is to reduce symptoms of depression and anxiety in employee populations, a broad range of health promotion interventions appear to be effective (Martin, Sanderson, & Crocker, 2009) and employers and employees should consider a depression education, screening and intervention programs as a healthy, win-win investment (Wang, et al., 2014). The Centers for Disease Control and Prevention recommends a number of strategies employers can pursue to support employees' mental health such as promoting greater awareness placing confidential self-rating sheets in workplace locations; facilitating depression recognition screenings through online platforms, onsite medical services and EAPs; training supervisors in depression recognition; and ensuring workers' easy access to needed psychiatric services through health insurance benefits and benefit structures[8] .

A WORKFORCE WHICH IS MENTALLY HEALTHY IS GOOD FOR BUSINESS

Investing in a mentally healthy workforce is good business. It can increase productivity, lower both medical and disability costs, while decreasing both absenteeism and presenteeism.

Perhaps the most valuable contribution of depression education, prevention and screening programs in the workplace can be a greater awareness of the health and productivity effects of mental health issues and the opportunity to obtain assistance through an employer's EAP, healthcare coverage, or via community resources. For leaders of organizations, proven strategies for improving the mental health of employees generally involve the allocation of sufficient resources for early identification and treatment, employee assistance programs, efforts to culturally destigmatize depression and its treatment, and management education about depression and proactive approaches to addressing its impact in the workforce.

[8] CDC Depression. www.cdc.gov/workplacehealthpromotion/implementation/topics/depression.html

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ABOUT SCREENING FOR MENTAL HEALTH, INC.

We envision a world where mental health is viewed and treated with the same gravity as physical health.

Screening for Mental Health, Inc. (SMH), a pioneer of large-scale mental health screening for the public, provides innovative mental health and substance abuse resources, linking those in need with quality treatment options. SMH programs, offered online and in-person, educate, raise awareness, and screen individuals for common mental health disorders and suicide. Thousands of organizations worldwide including hospitals, military installations, colleges, secondary schools, and work organizations utilize our educational and screening programs which have reached millions ranging from teenagers to adults.

In 1991, I had the idea to begin screening for depression much like my colleagues in the medical field were screening for physical diseases like cancer and diabetes. It's important that we screen for mental illness because it allows us to identify these illnesses early on—making treatment more effective.

From that initial National Depression Screening Day in 1991, our programming and reach has expanded dramatically. In addition to National Depression Screening Day in October, we now also have National Alcohol Screening Day in April and the National Eating Disorders Program which is promoted annually during the National Eating Disorders Awareness Week—the last week of February.

In addition to these annual screening events, we have several educational screening programs targeted toward various demographics including teenagers, college students, the general adult population and seniors. Since our founding, thousands of organizations worldwide including hospitals, mental health centers, social service agencies, government agencies, military installations, older adult facilities, primary care clinics, colleges, secondary schools, corporations, and HMO's have utilized our educational and screening programs.

I encourage you to explore our website, learn more about the programs we offer, take a look at our educational resources and blog, and even take a mental health screening yourself. Educate yourself on the signs and symptoms of mental illness and join us as we strive to have mental health viewed and treated with the same gravity as physical health.

Douglas Jacobs, M.D.

Founder & Medical Director