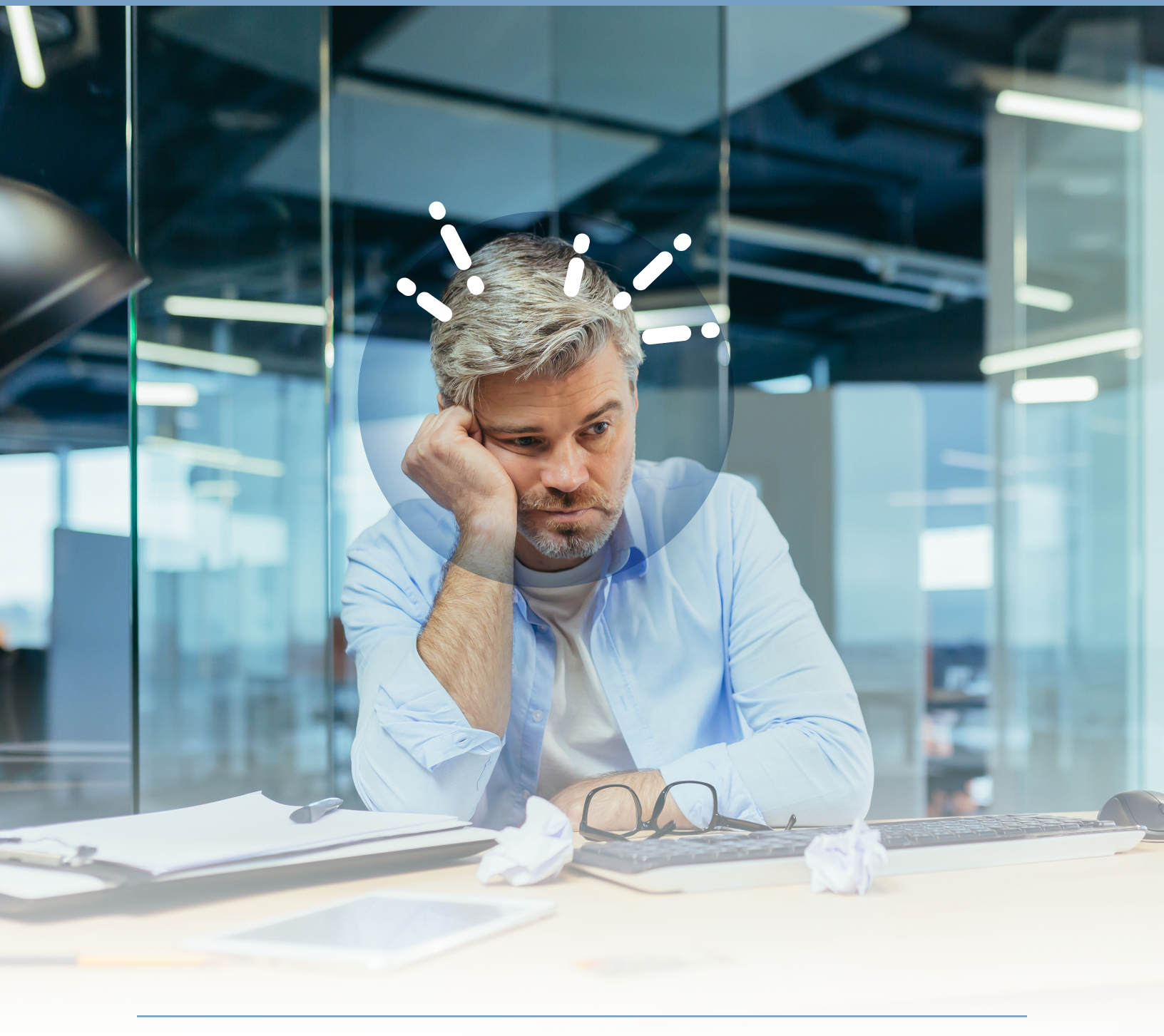


A DEEPER UNDERSTANDING OF COMPLEX CHRONIC MENTAL HEALTH CONDITIONS

An Overview of the Burden of Major Depressive Disorder and Bipolar I Disorder and Its Impact on the Workforce

abbvie

MDD and Bipolar I Disorder Are Debilitating and Complex Conditions

More than 1 in 5 adults in the United States experience a mental health disorder[1]

Major depressive disorder (MDD) is a serious mental health condition that affects an individual's ability to feel, think, and go about their everyday tasks. It can impact sleep habits, appetite, and ability to enjoy life.[2]

Bipolar disorder is a serious mental health condition that causes unusual shifts in mood, ranging from extreme highs—defined as mania or manic episodes—to extreme lows or depressive episodes.[3]

- Bipolar I disorder is specifically defined by:[4]
  - **manic episodes** that last for **at least 7 days** (nearly every day for most of the day) or that are so severe that the person needs **immediate medical care**.
  - **depressive episodes** that typically last **at least 2 weeks**.

Major depressive disorder and bipolar I disorder involve a blend of some shared and some specific mechanisms, courses, and outcomes of illness.

Primary risk factors of MDD and bipolar I disorder[5,6]

- Having a family member who lives with a mood disorder or other mental health condition.[5]

- Having specific genetics or brain structure, including 1 of 44 known risk variant genes for MDD and decreased brain activity in certain areas of the brain.[5,7]

- Experiencing trauma or stressful life events.[5]

- Excessive use of drugs or alcohol.[5]

In addition to the above overlapping risk factors, bipolar I disorder also includes **adverse childhood experiences (ACE)** such as poverty or abuse as a key risk factor.[6]

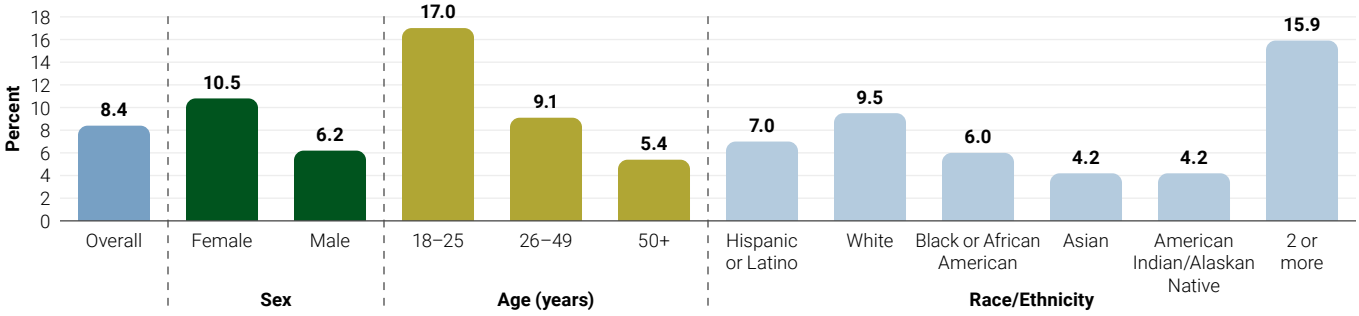
Bipolar disorder is highly prevalent in samples of depressed patients and can easily be missed, which can have negative consequences such as underdiagnosis and delay in care.[8] Careful clinical assessment, including screening for bipolar disorder by investigating whether there is a history of manic or hypomanic episodes (by using a scale such as the Mood Disorder Questionnaire), can help substantially with correctly identifying individuals with bipolar disorder.[8]

Individuals May Experience Depressive and Bipolar Episodes Throughout Their Most Productive Years[9]

An estimated **8.4%** of adults in the United States had **at least one major depressive episode** in 2020. Depression is a leading cause of disability in the US.[9,10]

- In a 2018 national survey, **65% of adults with major depressive episodes had severe impairment**.[11]
- According to the National Institute of Mental Health, the prevalence of a major depressive episode is **higher among adult females** (10.5%) compared to males (6.2%), and the prevalence within adults is **highest among individuals aged 18–25 years** (17.0%).[9]

Latest Prevalence Data from NIH of Major Depressive Episode Among U.S. Adults in 2020[9]*



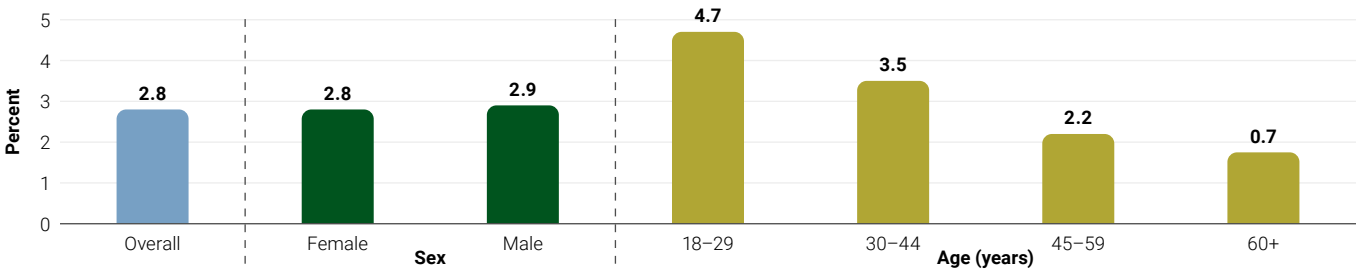
Women in their early adulthood face the highest odds of depressive symptoms, directly impacting workplace performance.[9]

Individuals with MDD are also at an increased risk for suicide. About two-thirds of individuals with MDD contemplate suicide, and about 10%–15% commit suicide.[12]

An estimated **2.8%** of adults in the United States are affected by a **bipolar disorder**. Bipolar I disorder has a **long and complex journey** in which those affected experience episodes of depressive states, placing them at a higher risk for disablement and recurrence.[13]

- Bipolar disorder is considered a **top 10 cause of disability in young adults** worldwide.[14]
- Based on diagnostic interview data from National Comorbidity Survey Replication (NCS-R), the 1-year prevalence of bipolar disorder among adults was **similar for males (2.9%) and females (2.8%)**.[13]
- Individuals with bipolar disorders are most vulnerable between the ages of 18 and 44 years.[13]

Latest Prevalence Data From NIH of Bipolar Disorder Among U.S. Adults[13†]



More than 50% of patients with bipolar disorder report severe functional impairment in the year following a bipolar disorder episode.[15]

Individuals with bipolar disorders face several treatment challenges, with ~70% reporting being misdiagnosed at least once.[16]

- Misdiagnoses include MDD, schizophrenia, borderline personality disorder, and generalized anxiety disorder.

NIH=National Institutes of Health.

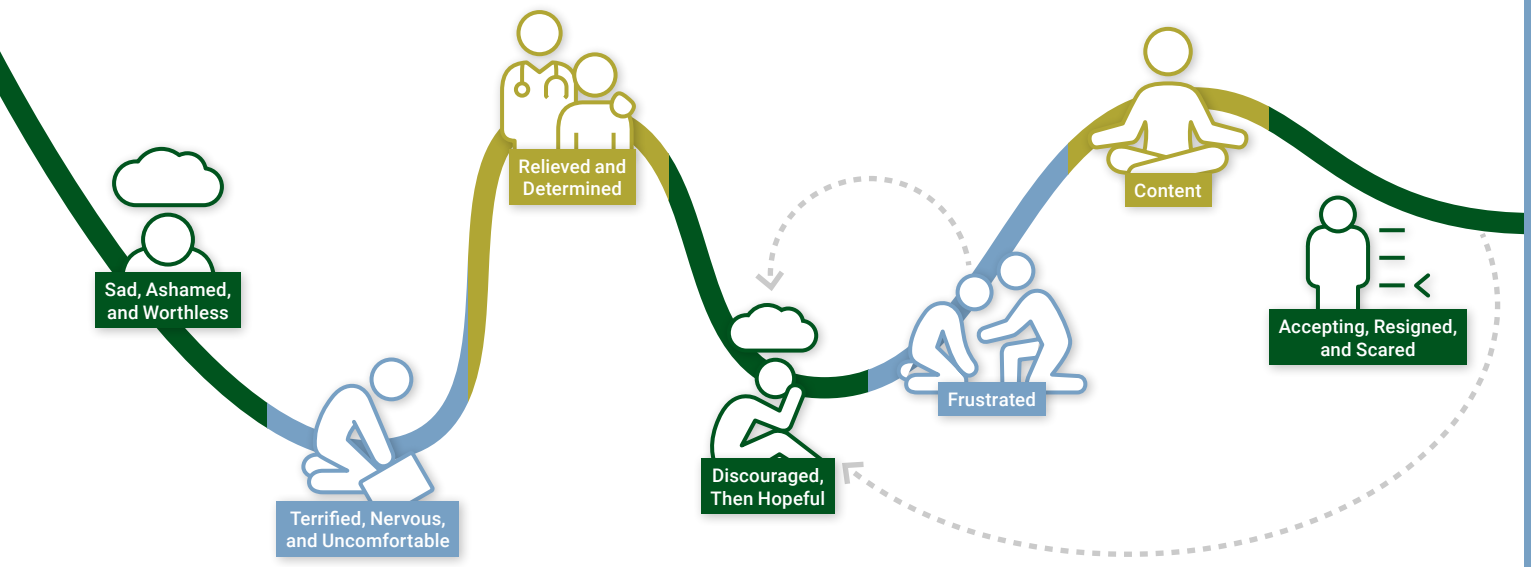
*Data courtesy of Substance Abuse and Mental Health Services Administration.
†Data from NCS-R.

The Burden of MDD and Bipolar I Disorder Can be Magnified by the Complex Patient Journey

MDD patient journey*

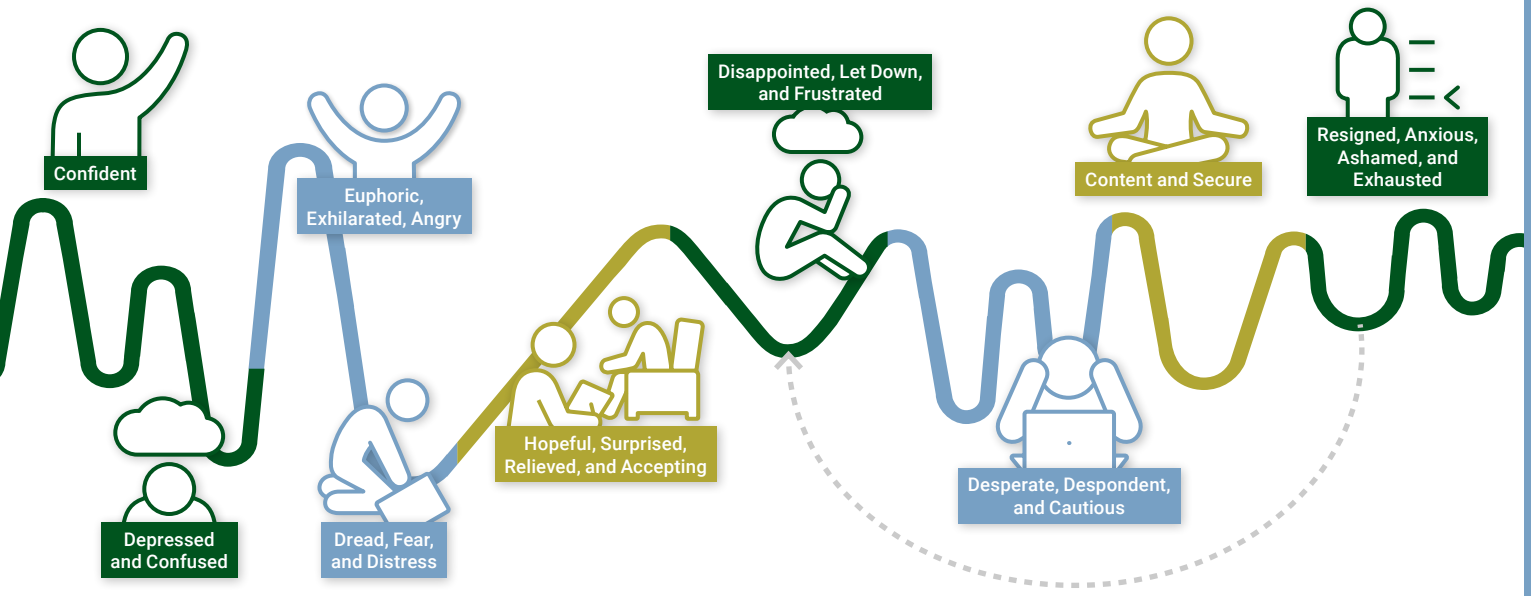
Weeks to Years — Several Weeks — Months to Years — Months to Years

PHASE 1	PHASE 2	PHASE 3	PHASE 4	PHASE 5	PHASE 6	PHASE 7
"Is This Normal?" Symptom Development	**"Breaking Point"** HCP Presentation	**"A Way Forward"** Diagnosis and Treatment Plan	**"Back to Square One"** Response/ Tolerability Issues	**"Taking a Chance"** Subsequent Treatment Changes	**"A Sense of Normalcy"** Adequate Response to Therapy	**"Ups and Downs"** Living With MDD



Bipolar I disorder patient journey

Months to Years	Days to Weeks	Single Consultation	Weeks to Months	Months to Years	Months to Years	Rest of Life
PHASE 1	PHASE 2	PHASE 3	PHASE 4	PHASE 5	PHASE 6	PHASE 7
"A Bumpy Ride" Symptom Onset	**"The Crash"** HCP Presentation	**"This Makes Sense"** Diagnosis and Treatment Initiation	**"The First Setback"** Inadequate Response and/or Tolerability Issues With 1L Treatment	**"The Search"** Subsequent Treatment and/or HCP Changes	**"Achieving Balance"** Adequate Response to Therapy	**"Bipolar Roulette"** Living With Bipolar I Disorder

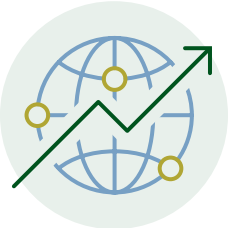


1L=first line; HCP=healthcare provider.

*This hypothetical patient journey is based on a qualitative market research from 2021 (N=74). It is a proposed journey that may not be experienced by all MDD patients.

COVID-19 Further Increased the Burden of Mental Health Conditions[17]

The pandemic brought unprecedented loneliness, fear, suffering, grief, and financial worries—all stressors known to increase depression



In the first year of the pandemic, the global prevalence of **depression surged by 25%**.

The pandemic disproportionately affected the mental health of young adults aged 18–29 years, women, racial and ethnic minorities, and those with lower levels of education.

Since the pandemic, an enormous increase in mental health impairment and the related **economic burden** has resulted in potential costs to the US healthcare system of approximately **$1.6 trillion**.[18]*

Studies report that individuals with bipolar I disorder may wait as long as 5–10 years from the onset of symptoms before a confirmed diagnosis.[19]

On average, patients with bipolar I disorder experience 2 episodes per year: depressive episodes lasting about 24 weeks and mania lasting about 30 weeks.[20]

As part of mental health education programs, include prevalence statistics and general education on MDD and bipolar I disorder to raise awareness of these common chronic conditions.

*The proportion of US adults who report symptoms of depression or anxiety has averaged approximately 40% since April 2020; the comparable figure in early 2019 was 11.0%. These data translate to an estimated 80 million additional individuals with these mental health conditions related to COVID-19. If, in line with prevailing estimates, the cost of these conditions is valued at about $20,000 per person per year and the mental health symptoms last for only 1 year, the valuation of these losses could reach approximately $1.6 trillion.

MDD and Bipolar I Disorder Can Cause an Array of Symptoms Beyond Negative Feelings of Sadness[2]

Symptom burden can lead to impaired quality of life in individuals with MDD and bipolar I disorder[9]

MDD[2]

- Continued feelings of sadness, hopelessness, pessimism, emptiness, guilt, or worthlessness ⇔
- Thoughts of death or suicide or suicide attempts ⇔
- Fatigue, lack of energy ⇔
- Insomnia or other sleep issues such as waking up very early or sleeping too much ⇔
- Anxiety, irritability, restlessness
- Lack of interest or joy in hobbies and activities ⇔
- Changes in appetite, leading to weight loss or weight gain ⇔
- Moving, talking, or thinking more slowly
- Forgetfulness ⇔
- Trouble concentrating, thinking clearly, or making decisions ⇔

Bipolar I Disorder[3]

Depressive episode symptoms

- Feeling down, sad, worried, worthless, anxious, guilty, empty, or hopeless ⇔
- Lack of interest, or no interest, in activities ⇔
- Feeling tired, low energy ⇔
- Forgetfulness ⇔
- Indecisiveness
- Difficulty concentrating ⇔
- Changes in sleep, either sleeping too much or too little ⇔
- Changes in appetite, either eating too much or too little ⇔
- Thoughts of death and/or suicide ⇔

Manic episode symptoms

- Intense feelings of euphoria, excitement, or happiness
- Appearing abnormally jumpy or wired
- Having excessive energy
- Insomnia or restlessness (a decreased need for sleep) ⇔
- Speaking fast or being unusually talkative
- Having racing or jumbled thoughts
- Distractibility
- Inflated self-esteem
- Doing impulsive, uncharacteristic, or risky things like having unsafe sex or spending a lot of money
- Increased agitation and irritability ⇔

⇔ Depressive symptoms can be shared between MDD and bipolar I disorder.

Impaired quality of life due to MDD and bipolar I disorder can reduce productivity and negatively affect an individual's ability to perform daily activities.[2]

Screening tools such as the Beck Depression Inventory (BDI) and Bipolar Depression Rating Scale (BDRS) can be used to determine an individual's condition.[21,22]

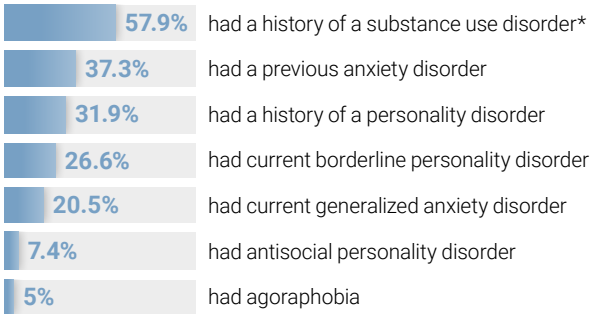
MDD and Bipolar I Disorder Are Associated With an Increased Risk of Conditions That May Exacerbate Poor Health Outcomes

Comorbidities in MDD[23,24]

Psychiatric comorbidities

In a national survey of 36,309 U.S. adults, the **lifetime prevalence** rate of MDD was **20.6%**, with most individuals experiencing moderate or severe disease.

- Lifetime prevalence of other psychiatric disorders among those with DSM-V MDD:



*Alcohol use disorder (40.8%) and nicotine use disorder (38.9%) were the most common.

Medical comorbidities

A literature review of 199 articles assessing the association between MDD and **medical comorbidities** showed:

- Increased incidence and worsening of **cardiovascular disease/events**
- Worsening of **metabolic syndrome**
- Increased incidence of **diabetes** and worsening of existing diabetes
- Increased incidence of **obesity**

Comorbidities in bipolar I disorder[25]

Psychiatric comorbidities

The most common **mental health disorders that co-occur with bipolar disorder** in community studies include **anxiety, substance use, conduct disorders, eating disorders, attention-deficit/hyperactivity disorder, and impulse control**, as well as **autism spectrum disorders and Tourette syndrome**.

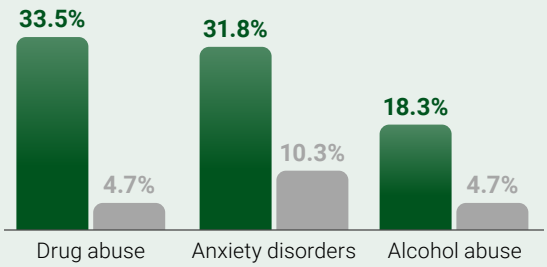
Medical comorbidities

General **medical comorbidities** of bipolar I disorder include:

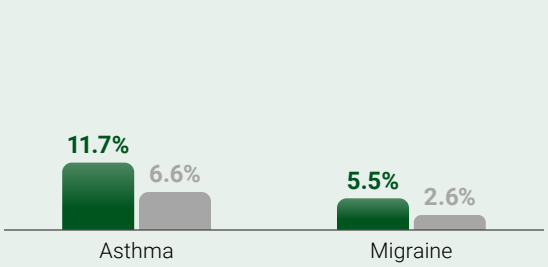
- Migraine
- Thyroid illness
- Obesity
- Type 2 diabetes
- Cardiovascular disease

A cross-sectional analysis investigated the differences in the prevalence and association of **psychiatric and medical comorbidities** in bipolar disorder patients vs the general inpatient population.[26]

- Most prevalent **psychiatric comorbidities** included:

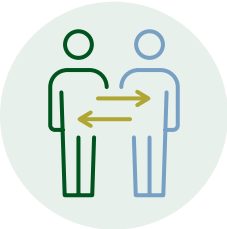


- Most prevalent **medical comorbidities** included:



Patients with bipolar disorder
General inpatient population

Individuals in Marginalized Communities Face Racial Disparities That Limit Appropriate and Timely Care of MDD and Bipolar I Disorder



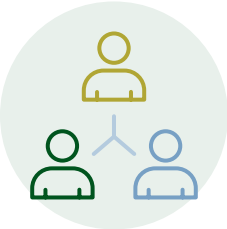
Racial disparities in management of MDD[27-29]

Black American adults are **20% more likely to experience** serious mental health problems, such as **MDD** or **generalized anxiety disorder**.

Although rates of depression are lower in Blacks (24.6%) and Hispanics (19.6%) than in Whites (34.7%), depression in **Blacks and Hispanics** is likely to be **more disabling and persistent**.

In 2018, **Asian Americans were 60%** less likely and **Hispanic Americans 50%** less likely to have **received mental health treatment** than non-Hispanic Whites.

When faced with the notion that ethnic minorities are less likely to seek mental health care than their White counterparts, it is also important to consider various social constructs such as stereotyping and lack of access to medical care, which may limit treatment modalities and approaches when addressing mental illness in minorities.[30]



Racial disparities in management of bipolar disorder[28,31,32]

While marginalized racial and ethnic communities, such as **Black and Hispanic-Latinx individuals**, are **no less likely** to experience bipolar disorder than White individuals, these communities are not adequately diagnosed and treated for it as compared with White individuals.

According to a literature review in 2018, **Black individuals** with bipolar disorder are **more likely to receive an incorrect diagnosis** than people of European ancestry with the condition.

A 2017 study assessing disparities in treatment and service utilization found that **Hispanic individuals** with bipolar disorder are **less likely to get the treatment** they need than **White individuals** with bipolar I disorder.

According to research from the Satcher Health Leadership Institute at Morehouse School of Medicine, racial mental health disparities cost the United States around $278 billion between 2016 and 2020 as a result of premature deaths linked back to mental health, substance use disorder, and suicide.[33]

Encourage open communication regarding mental health conditions to help move from stigmatizing related issues to providing support and actionable solutions.

Create resources in languages most commonly used by members within the organization in order to increase access to care and improve support of mental health.

Healthcare Utilization Rates and Costs Continue to Increase for MDD and Bipolar I Disorder

Economic burden of MDD[34]

A study evaluating the incremental economic burden of adults with MDD in the United States between 2010 and 2018 illustrated a consistent increase in direct and indirect costs:

- The **economic burden of MDD** among U.S. adults was an estimated **$326 billion** in 2018.*
- **Indirect and comorbidity** costs accounted for **~85% of total costs** for MDD.

Study Design: This study used a framework for evaluating the incremental economic burden of adults with MDD in the US that combined original and literature-based estimates, comparing MDD-related costs between 2010 and 2018.

Inclusion Criteria:

- US adults (≥18 years) with MDD
- Patients in each study year were required to have continuous healthcare eligibility

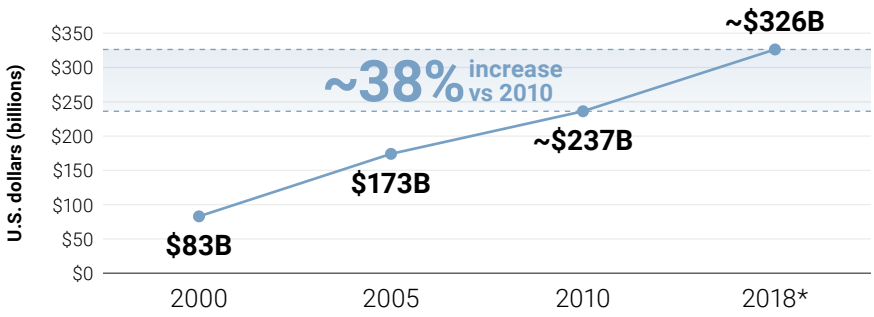
Exclusion Criteria:

- Adults with unknown MDD status
- Patients with MDD who had health maintenance organization, capitated, or Medicare coverage were excluded from the analysis

Limitations:

- The analysis relied on a combination of original and literature-based estimates
- The relationship between presenteeism and absenteeism was based on costs in 2002, which might have evolved over time
- The National Survey on Drug Use and Health (NSDUH) data do not contain the exact age for all respondents
- The claims data did not allow for direct estimation of costs for individuals aged ≥65 years
- The data did not allow for analysis of beneficiaries covered under certain types of managed care plans
- Potentially important cost categories were not incorporated into the methodology, thereby resulting in understated estimates
- The use of claims data in the study relied on 2015 results for a 2018 burden-of-illness estimate

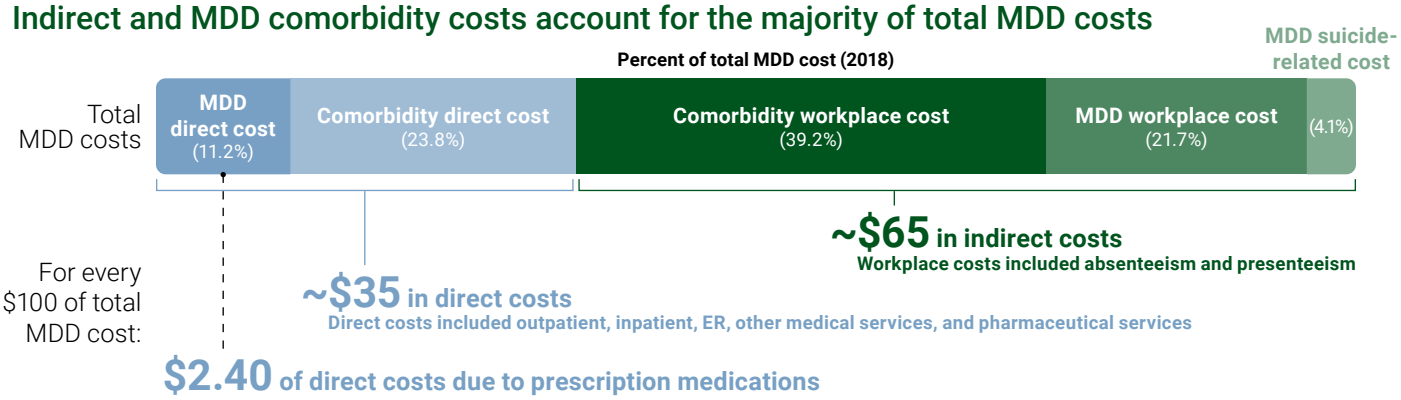
Total Annual Costs Attributed to Adults With MDD[34†]



Key direct cost burden changes between 2010 and 2018:[34]

- **15.1%** increase in outpatient ($42,940 vs $49,428)
- **19.2%** increase in inpatient ($23,150 vs $27,605)
- **104.7%** increase in emergency room (ER) ($5,545 vs $11,349)

Indirect and MDD comorbidity costs account for the majority of total MDD costs



With an increasing number of working adults experiencing MDD, identifying ways to reduce costs could translate into significant reductions in the economic burden. Effectively treating MDD could reduce direct and indirect costs by reducing presenteeism and absenteeism.[34]

*2018 costs adjusted to 2020 values.
†Inclusive of both direct and indirect costs associated with MDD.

Economic burden of bipolar I disorder[35]

A U.S. study estimated the national economic burden of bipolar I disorder in 2015 as **$202 billion**, of which **23%** was associated with **direct healthcare costs**.

Two cohorts were defined as the bipolar I disorder cohort and the nonbipolar I cohort. The bipolar I disorder cohort comprised all adult patients from the Truven Health Analytics MarketScan databases with at least one diagnosis of bipolar I disorder. The nonbipolar cohort had no documented diagnosis of any type of bipolar disorder.

Direct healthcare costs were assessed using 3 large US claims databases. They were estimated using a retrospective matched cohort design. They included medical and pharmacy costs and were assessed separately for insured (commercial, Medicare, and Medicaid coverage) and uninsured individuals.

Select direct healthcare costs included:[35]*

~$16.5 billion in outpatient

~$13.3 billion in inpatient

~$11.5 billion in pharmacy

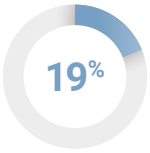
Direct total healthcare costs were estimated based on 107,943 commercially insured, 9,436 Medicare-insured, and 84,640 Medicaid-insured patients with bipolar I disorder who, on average, incurred $17,468, $30,757, and $20,764 in direct healthcare costs, respectively.

Key Study Limitation: Data presented is based on patients with a recorded diagnosis of bipolar I disorder; therefore, patients with bipolar I disorder and not yet diagnosed were not included with the cohort study sample, which could impact results.

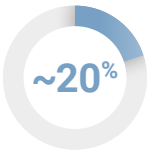
A 2020 systematic review provided an updated report of the economic burden of bipolar in the US, including cost and HCRU estimates compared with previous reviews, to highlight the following key drivers of direct costs for those with bipolar I disorder:[36]

- Frequent **psychiatric interventions**
- **Nonadherence** to bipolar disorder–related medication
- The presence of **comorbid medical or psychiatric conditions**
- **Sub-optimal clinical management** due to a misdiagnosis of unipolar depression following a BD diagnosis

The key drivers of cost in bipolar I disorder were tightly associated with barriers to optimal care management. Providing comprehensive care and improved access to care can help mitigate costs that occur due to unnecessary treatment steps and contracting restrictions.[36]



Additionally, based on a 2013 retrospective analysis of psychiatric hospital claims of 2,351 bipolar patients, of those who were hospitalized for a bipolar disorder episode, **19% were readmitted to the hospital within 90 days** of the previous admission.[37]



A retrospective cohort analysis of the Truven MarketScan database from 2012 to 2016 in adult patients (N=51,480) with new episodes of bipolar I disorder demonstrated that **~20% required psychiatric hospitalization** (95% CI, 19.3–20.0).[38]

Review your utilization data for mental health conditions, including MDD and bipolar I disorder, to gain a better understanding your burden among your members. Talk to your healthcare plan advisors about how to help improve mental health care and treatment coverage.

*Costs were calculated using a prevalence-based approach and the 2015 Census Bureau estimate of the US adult population. Direct healthcare costs were estimated using a retrospective matched cohort design.[35]

~60% of Cases Are Misdiagnosed Between MDD and Bipolar I Disorder, Causing Significantly More Hospitalizations, ER Visits, and Outpatient Visits[16,39]

Study Design: A retrospective study based on IBM® MarketScan® Commercial Database between January 2014 and June 2019 evaluated and compared healthcare resource utilization (HCRU) and costs of patients initially misdiagnosed with MDD who received a subsequent bipolar I disorder diagnosis (N=14,729) versus patients diagnosed with bipolar I disorder without any prior MDD diagnosis (N=16,072).

Cohorts were weighted using the inverse probability of treatment weighting approach based on propensity score. Patient characteristics were evaluated during the baseline period and compared cohorts using standardized differences. Rates of HCRU were compared between cohorts using rate ratios obtained from Poisson regression models. Nonparametric bootstrap procedures were used to estimate 95% CI and *P* values.

Study Limitations: Retrospective databases are subject to coding errors or data omissions. Results are for commercially insured patients and may not be applicable to other patient populations.

Patients Diagnosed With MDD Who Received a Misdiagnosis Followed by a Subsequent Bipolar I Disorder Diagnosis vs Patients Who Received an Initial Bipolar I Disorder Diagnosis

	All-cause HCRU*	Mental health–related HCRU*
Rate of hospitalizations	**94% greater**† (0.45 vs 0.23)	**116% greater**† (0.41 vs 0.19)
Rate of ER visits	**33% greater**† (1.37 vs 1.03)	**77% greater**† (0.52 vs 0.30)
Rate of outpatient visits	**38% greater**† (24.64 vs 17.84)	**77% greater**† (15.26 vs 8.63)

Patients in the misdiagnosed bipolar I disorder cohort used significantly more resources during the follow-up period compared with patients in the bipolar I disorder–only cohort, with higher per patient-year rates of hospitalizations, ER visits, and outpatient visits.

In addition to misdiagnosis adversely affecting health outcomes as a consequence of delayed, ineffective, or inappropriate treatments, misdiagnosis of bipolar I disorder as MDD was also associated with significantly higher HCRU and costs.[39]

Review your provider network and prior authorization process to ensure your members have access to psychologists, psychiatrists, and primary care providers knowledgeable and experienced with treating mental health conditions. Further, make sure that MDD and bipolar I disorder treatments are covered and available with limited restriction.

*Rate per person-year costs were calculated over the 12-month follow-up period post-index and compared between patients diagnosed with bipolar I disorder vs misdiagnosed patients (weighted analysis). Misdiagnosed patients: patients who were initially diagnosed with MDD and later diagnosed with bipolar I disorder. Percent values represent rate ratios.
†*P*<0.001, statistically significant.

Magnitude of Work Impairment and Productivity Loss in MDD and Bipolar I Disorder

A 2011 study investigated the relationship between a continuum of depression symptom severity and the magnitude of productivity loss in a large, heterogeneous, and representative sample of outpatients initiating treatment for depression. According to the study, the relationship between depression symptom severity and productivity loss among 771 patients who initiated treatment for depression showed a significant linear relationship.[40]

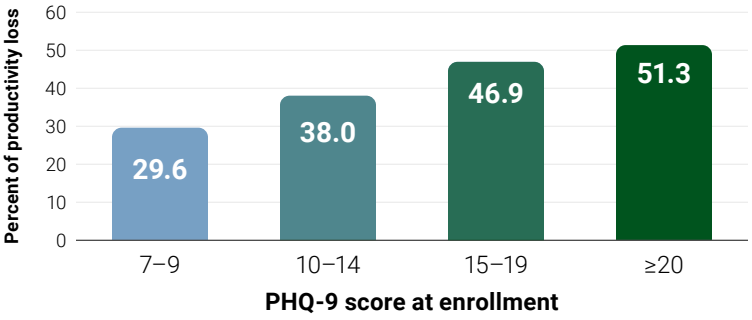
Data were obtained from patients participating in the DIAMOND (Depression Improvement Across Minnesota: Offering a New Direction) initiative, a statewide quality improvement collaborative to provide enhanced depression care.

- The study utilized the **PHQ-9 Questionnaire for Depression Scoring and Interpretation Guide**, which tracks patients' overall depression severity as well as improvement of specific symptoms with treatment on a daily basis.[40]

Interpreting PHQ-9 Score[41]

Diagnosis	Total score	For score	Action
Minimal depression	0–4	≤4	The score suggests the patient may not need depression treatment
Mild depression Moderate depression	5–9 10–14	5–14	Physician uses clinical judgment about treatment, based on patient's duration of symptoms and functional impairment
Moderately severe depression Severe depression	15–19 20–27	>14	Warrants treatment for depression, using antidepressant, psychotherapy, and/or a combination of treatment

Productivity Loss (Absenteeism and Presenteeism Combined) by PHQ-9* Score at Enrollment: Percent of Work Time Missed or Impairment at Work in Past 7 Days[40]



With every 1-point increase in PHQ-9 score, patients experienced an additional mean productivity loss of 1.65% (P<0.001), illustrating the strong linear relationship between depression symptom severity and the combination of work loss and productivity impairment.

Minor levels of depression can still be associated with a significant loss of productivity.

Key Study Limitation: This study lacked detailed data on other health conditions that might be associated with work loss and productivity reported.

According to a 2010 cross-sectional survey of patients diagnosed with bipolar I disorder* and subjects without a history of bipolar I disorder, respondents with bipolar I disorder reported lower levels of work productivity and were more likely to miss work and have worked reduced hours.[42]

- Bipolar I disorder respondents vs those without bipolar I disorder who reported missing work during the previous week were significantly more likely to report that they missed work because they were too upset, depressed, or nervous (30.6 vs 1.7% respectively; P<0.001).
- Respondents with bipolar I disorder reported higher scores (i.e., greater negative effect on workplace productivity) on the Endicott Workplace Productivity Scale.

Key Study Limitations: Subjects included in the bipolar I disorder group were being treated by psychiatrists and employed; therefore, results are not representative of the total population of bipolar I disorder subjects. Recall bias is a limitation inherent in questionnaire-based studies.

MDD and bipolar I disorder were both associated with lower work functioning, including more absences and more impaired work productivity.

Create access to on-site work clinics to drive evaluation of individuals who are experiencing mental health conditions to assess how their disease is impacting their quality of life and level of work productivity.

PHQ-9=Patient Health Questionnaire-9.

*With at least two episodes of mania in their lifetime and at least one episode of mania within the previous two years.

Treatment Strategies to Help Reduce the Economic Burden of MDD and Bipolar I Disorder

Employers can provide support by taking action to reduce mental health burden among employees which may reduce productivity losses[43]

- Educate your leaders about mental health awareness and best practices for promoting employee health and well-being.
- Provide employees with a wide variety of options for where, when, and how they work to enhance their performance.
- Evaluate your health plan coverage to include comprehensive mental health treatment and care coverage. Drive improved access by minimizing step-through requirements and authorization barriers.
- Use member feedback to evolve your existing employer-led mental health programs by proactively expanding related services and treatments.

MDD and bipolar I disorder treatment regimens can be complex and require individualized treatment planning for optimal results[3,12]

Agents that are hypothesized to impact activity of serotonin, norepinephrine, dopamine, and other neurotransmitters may help manage depression and bipolar I disorder symptoms.

If monotherapy is not sufficient for acute and/or maintenance therapy, most patients are given combination therapies to effectively treat long-term symptoms and prevent recurrences.[3,17]

According to an analysis performed on the Sequenced Treatment Alternatives to Relieve Depression (STAR*D) trial, 70% of patients with MDD did not achieve "within-normal" quality of life after 1L monotherapy treatment and required adjunctive therapy.[44]

Agents used for MDD[12]

- Selective serotonin reuptake inhibitors (SSRIs)
- Serotonin and norepinephrine reuptake inhibitors (SNRIs)
- Atypical antidepressants
- Tricyclic antidepressants
- Monoamine oxidase inhibitors (MAOIs)
- Other medications including mood stabilizers and antipsychotics as add-on therapy to antidepressants

Agents used for bipolar I disorder[3]

- Mood stabilizers
- Antipsychotics
- Antidepressants in certain circumstances

Work with your pharmacy benefit advisors to evaluate your current formulary coverage to ensure members have access to mental health treatments.

Because not all patients respond to the same treatment protocols, ensure your benefit plan offers access to a comprehensive formulary for members to have adequate and individualized treatment plans.

Ensure You Are Creating a Mental Health–Friendly Workplace for Your Employees

A 2022 workplace report on mental health in America found that:

- **86%** of human resources (HR) professionals indicate that offering mental health resources can **increase employee retention**.[45]
- HR professionals in the **healthcare sector** (61%) are most likely to indicate that their staff **experience more mental health struggles** than other industries, in large part due to pandemic-induced stress at work.[45]
  - Industries such as the nonprofit sector (47%), government/public administration/military (41%), and education (39%) claim that their employees are more likely to experience mental health issues than other industries.
- Nearly **9 in 10** HR professionals (88%) believe offering **mental health resources can increase productivity**, while **78%** say offering such resources can **boost organizational return on investment**.[45]

The International Labour Organization and the U.S. Department of Labor Recommend the 4 A's of a Mental Health–Friendly Workplace[46]

1	2	3	4
Awareness	**Accommodations**	**Assistance**	**Access**
Build awareness and a supportive culture by conducting mental health training and antistigma campaigns and informing all employees of available resources.	Make it simple for employees to request and use reasonable accommodations and other workplace supports, such as adjustments or modifications that enable people with disabilities to perform the essential functions of a job efficiently and productively.	Advertise the services available to assist employees, such as an employee assistance program (EAP), stress management training, or other supports. In addition to increased employee productivity, the benefits of EAPs include reduced medical costs, turnover, and absences.	Ensure access to mental health services by assessing the specific mental health benefits covered by your health insurance programs, including access to treatment and support.

Develop a mental health education program that shares management techniques, and consider opportunities to adjust the work environment to minimize stigmas and triggers.

Voice of the Purchaser Survey on Behavioral Health Support[47]

National Alliance, in partnership with HR Policy Association and in conjunction with the Path Forward, conducted the **Voice of the Purchaser Survey on Behavioral Health Support** to understand the perceived importance and performance of services received from behavioral health service providers, including health plans from **221 public and private employers**.

Network access

- While **99%** agreed that effective and timely access to in-network behavioral health providers was important, only **31%** were satisfied; **31%** expressed dissatisfaction with efforts to systematically identify and address gaps in network access; and **33%** expressed dissatisfaction with efforts to help facilitate access for members having problems accessing timely behavioral health services.
- Tele-behavioral health services were important to **95%** of employers, and **65%** were satisfied with these services.
- Only **34%** of employers agreed that their behavioral health directories accurately reflected the providers available to plan participants, and **26%** indicated dissatisfaction that their plan provided a directory that accurately reflected in-network behavioral health providers.
- **84%** of employers agreed that behavioral health access and quality were as important as the financial management of behavioral health costs.

Quality of care

- While **54%** were satisfied with the promotion of standardized measurement for behavioral health services, only **33%** were satisfied with engagement and reporting of behavioral health outcomes.
- Monitoring appropriate prescribing of behavioral health medications relative to patient outcomes was important to **94%** of employers, and **41%** indicated being satisfied with performance in this regard.
- **43%** of employers were satisfied that their service providers administered denials that were clinically justified and sensitive to patient needs.

Integration of behavioral health into primary care

- **84%** agreed that it was important that plans support, promote, and incentivize integration of behavioral health into primary care, but only **28%** were satisfied.
- **64%** agreed that early identification through broad use of behavioral health screenings can help mitigate the severity of mental health issues.

Workplace mental health support

- Achieving high engagement in workplace behavioral health programs was important to **92%**, but only **39%** were satisfied.
- Providing behavioral health awareness and stigma reduction programs was important to **89%**, and **40%** were satisfied that their vendors were meeting these needs.

Health equity and whole-person health

- Only **27%** of employers were satisfied that their service providers evaluated and tailored behavioral health services to diverse communities (e.g., LGBTQ+, People of Color).
- Only **14%** of employers were satisfied with service provider support of whole-person program integration through data and process coordination.

Systematically assess and address gaps in access in your institution as network access, quality, and equity of care can be important to the management of mental health.

Raising Awareness and Improving the Chronic Care for Members With MDD and Bipolar I Disorder

STEP 1

Raise Awareness of the Prevalence of MDD and Bipolar I Disorder and the Burden of Disease

- Create an awareness campaign that provides information on MDD and bipolar I disorder prevalence, management, and general education.
- Include mental health screening and quality-of-life questionnaires on your organization's employee resource site to encourage assessment of risk factors and possibly improve timely connection to care and treatment.

STEP 2

Establish an MDD and Bipolar I Disorder Care Pathway to Support Timely Access to Comprehensive Care

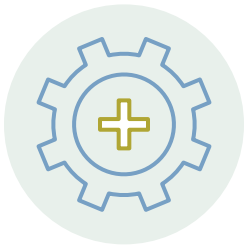
- Optimize network adequacy ratios (e.g., members per mental health–treating provider) to minimize time to treatment.
- Eliminate barriers to appropriate MDD and bipolar I disorder care by minimizing "step-through" and authorization requirements.
- Promote use of telehealth providers to improve access to a mental health–treating provider and accommodate urgent visits.
- Review your formulary coverage for MDD and bipolar I disorder treatments and, if necessary, redesign to include additional treatment options to allow for individualized treatment approaches.

STEP 3

Utilize Employee Education and Care Management Programs for Continued Support

- Establish an MDD and bipolar I disorder education program to increase awareness of treatment and management strategies.
- Stay up to date on the current treatment options for MDD and bipolar I disorder and make sure your employees have unrestricted access.

AbbVie's Employer Strategies Focus on Improving Workforce Health and Productivity by Addressing:



Disease State Awareness

Raising awareness of the burden and impact of disease

Access to Treatment

Establishing and expanding access to treatment

Engagement and Educational Support

Developing connections to promote engagement and educational support

For additional information and support, contact your AbbVie Account Executive.

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US-PSYB-230008 June 2023

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