The Relevance of an Employee Assistance Program to the Treatment of Workplace Depression

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ABSTRACT. Employees presenting to an Employee Assistance Program (EAP) who were identified as depressed were compared to employees not identified as depressed on a number of variables collected as part of the clinical record-keeping procedures of an EAP. Results indicated that employees identified as depressed were significantly more impaired in terms of work productivity, work absence and global functioning than employees not identified as depressed. Further, the results showed that there was significant improvement for both groups on these variables after the EAP intervention. However, employees identified as depressed continued to be more impaired at closing on all indicators than employees not identified as depressed. More intensive psychosocial treatment may be required to optimize work functioning among depressed employees. [Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <docdelivery@haworthpress.com> Website: <http://www.HaworthPress.com> © 2005 by The Haworth Press, Inc. All rights reserved.]
KEYWORDS. Treatment, depression, assessment, impairment

INTRODUCTION

A major depressive episode is defined by the presence of five or more of the following symptoms occurring together for most of nearly every day within a two-week period: (1) the individual reports depressed mood or appears depressed to others, (2) interest or pleasure in all activities is markedly decreased, (3) there is a marked loss or increase in weight or marked decrease or increase in appetite, (4) the individual sleeps either too much or not enough, (5) the individual’s activity level is either slowed or increased, (6) there is fatigue and a loss of energy, (7) the individual feels worthless or guilty (to an extreme degree), (8) the individual has difficulty thinking or concentrating, (9) the individual has repeated thoughts about death or suicide. Either (1) or (2) must be present for the diagnosis, and these symptoms must be a change from previous functioning. Also essential to the diagnosis is the caveat that these symptoms must cause significant distress and result in impairment of work, social, or personal functioning (DSM-IV, 1994).

At any one time, at least 4% of individuals are struggling with a major depressive episode, and another 6% are experiencing depressive symptomology at a level severe enough to impair their productivity in the workplace (Waraich et al., 2004). Employees who are depressed are likely to have both social and work disabilities that negatively impact productivity and absenteeism (Wells et al., 1989), thus creating an economic burden for employers. Indeed, the cost of depression to employers in terms of total lost workdays has been shown to be greater than the cost of many other common medical illnesses (Druss et al., 2001).

There are both medical and psychosocial treatments for depression that have substantial empirical support. Antidepressant medications have demonstrated effectiveness and will also prevent recurrence if continued after remission (American Psychiatric Association [APA], 2000). Of the psychotherapies, cognitive behavioral therapy (CBT) and interpersonal therapy (IPT) have the strongest empirical support (APA, 2000). However, as psychosocial treatments are more difficult to access, the majority of those depressed individuals who do seek treatment are initially offered antidepressants and followed by their family physician.

Employee Assistance Programs (EAPs) have developed in their present form out of recognition of the benefits of confidential services for
employee problems that may affect work performance. Although these programs were originally designed primarily to help employees with drug and alcohol problems, their role has expanded substantially over the years (Wrich, 1980). EAPs now offer assistance for a wide variety of common concerns that may affect an employee’s ability to perform optimally at work, including marriage and family problems, alcohol and drug dependence, financial and legal problems, and anxiety and depression. An important goal of these programs is early intervention, so that employee problems may be resolved before they have a major impact on functioning. One of the services offered by EAPs is short-term, solution-focused counseling for all employees who request it. Presumably, some of these employees are likely to be experiencing symptoms of depression. However, the extent to which EAP interventions can return these individuals to optimal functioning has not previously been studied.

We examined data collected from an EAP as part of their regular clinical procedures in order to compare characteristics of those employees seeking counseling services who are identified as depressed, with those of employees not identified as depressed. We also considered how depressive symptoms may affect EAP outcomes. We addressed the following questions: (1) What proportion of employees presenting to an EAP are identified as having depression? (2) What background characteristics are more often seen in these individuals? (3) Are there reliable differences at intake between those employees identified as depressed and those presenting with other concerns in the areas of work impairment, work absence, and global functioning? (4) Are there differences in outcomes between those identified as depressed and those presenting with other problems?

**METHODOLOGY**

**Sample**

Interlock is an Employee Assistance Program offering services to over 350 companies across Canada. As part of a Quality Improvement initiative, Interlock reviewed information from a database containing clinical information on 1,411 employees seeking assistance from their program. The information was anonymous and the analysis reported was approved by the Clinical Research Ethics Board of the University of British Columbia. Clients were seen between April 2003 and April 2004 by experienced clinicians, all had a Master’s degree with ten years
of clinical experience. Services were offered all across British Columbia and in other centers in Canada.

The sample consisted of 463 males and 948 females. The mean age of the sample was 42, with no difference between men and women. No data on specific occupational groups was gathered. However, as Interlock maintains contracts with a variety of employers from different sectors, the sample likely represents a fairly diverse group of individuals. Information on clients is gathered in a systematic way and entered into a computerized database. As part of this record-keeping, a list of clinical issues is documented for each client. Depression could be documented on the client record as a clinical problem at the initial telephone intake, during the initial assessment by the clinician, or at any time during the intervention. Identifying individuals as depressed in this manner allowed for the formation of two groups for the purposes of comparison: 385 employees were identified as depressed and considered members of the depressed group, and 1026 employees were not identified as depressed, and thus considered members of the non-depressed group.

Work impairment, work absence, and a rating of global functioning were made by the clinician at intake and again at closing. Work impairment due to the presenting problem was rated as None, Mild, Moderate, or Severe. Mild work impairment was defined as impairment evident to the worker, but unnoticed by the supervisor. Moderate work impairment was defined as impairment that had been noticed by the supervisor. Severe work impairment was defined as an inability to function on the job.

Work absence due to the presenting problem was also rated as either None, Mild, Moderate or Severe. For this variable, Mild work absence was defined as absence of a few hours, Moderate work absence was defined as an absence of from one to five days, and Severe absence was defined as currently being on medical leave. The Global Assessment of Functioning Scale (GAF; DSM-IV, 1994) was used to assess the client’s current level of global functioning. Ratings were made by the clinician both at intake and at closing.

Statistical analyses employed included chi-square to test differences in categorical data, and t-tests to compare interval and ratio data. In addition, for the analyses of outcome data, ordinal scores were transformed into interval data (None = 1, Mild = 2, Moderate = 3, Severe = 4) so that a repeated measures ANOVA could be used to consider differences in outcomes between depressed and non-depressed workers, con-
trolling for ratings at intake. Because of the exploratory nature of the study, no statistical correction for multiple analyses was employed.

RESULTS

First, the proportion of employees presenting to an EAP with mental health concerns was estimated. We found that 27% of the individuals in our sample were identified as depressed. In addition, 25% reported symptoms of anxiety. There was some overlap, in that 8.8% of the sample reported symptoms of both depression and anxiety. Problems with alcohol and drug dependence were reported by 4% and 2%, respectively.

Second, characteristics of employees in the depressed group were compared to employees in the non-depressed group in terms of gender, age, family history of mental health issues, family history of addiction, and current antidepressant medication. There was no difference between the groups for either gender or age. However, employees in the depressed group were significantly more likely to report a family history of mental health issues, $\chi^2 (1, N = 1411) = 8.91, p = .004$, and also significantly more likely to report a family history of addiction, $\chi^2 (1, N = 1411) = 5.88, p = .015$, than employees in the non-depressed group. Nonetheless, we must note that the actual numbers were small, with only 4% of employees in the depressed group reporting a family history of mental health issues, and only 5% reporting a family history of addiction. Further, employees in the depressed group were significantly more likely to be taking antidepressant medications than employees in the non-depressed group, $\chi^2 (1, N = 1411) = 132.54, p < .001$. However, only 22% of all employees in the depressed group were taking antidepressant medications at the time they initiated contact with the EAP.

Third, the percentage of employees reporting work absence at intake as either None, Mild, Moderate, or Severe in each group was compared using a Pearson chi-square which revealed a significant difference between the groups, $\chi^2 (4, N = 1391) = 75.28, p < .001$. The results are presented in Table 1, and suggest that a greater percentage of employees in the depressed group reported work absence in each category except for the None category, as compared to employees in the non-depressed group. Particularly significant is the fact that of those employees identified as depressed, approximately 20% were on leave from work at intake, compared to 7% of non-depressed employees.
When the two groups were compared on ratings of work impairment, again there was a significant difference between the groups, $\chi^2 (4, N = 1391) = 100.03, p < .001$. Comparing the percentages for the two groups, it is evident that employees in the depressed group reported greater work impairment than employees in the non-depressed group, with 33.9% of those in the depressed group reporting work impairment of a degree that had been noticed by supervisors, compared to 16.5% of non-depressed employees.

Lastly, the mean GAF ratings were compared, revealing that employees in the depressed group were functioning at a significantly lower level at intake than employees in the non-depressed group ($M = 63.47$ and $M = 68.12$, respectively, $t (1361) = -10.68, p < .001$).

**Outcomes of EAP Interventions**

To examine whether EAP interventions were equally helpful for those individuals identified as depressed as for those presenting with

<table>
<thead>
<tr>
<th>Intake</th>
<th>Closing</th>
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<tbody>
<tr>
<td></td>
<td>Depressed</td>
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<tr>
<td>Work Absence</td>
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<tr>
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<tr>
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<tr>
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</tr>
<tr>
<td>Moderate</td>
<td>23.0%</td>
</tr>
<tr>
<td>Severe</td>
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</tr>
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N = 1,411
other concerns, we used repeated measures ANOVAs to investigate three outcomes: work impairment, work absence, and global functioning. The ordinal scores for Work Impairment and Work Absence were treated as interval scores for these analyses.

The results of the analyses of work impairment outcomes revealed a significant main effect for time $F(1, 1379) = 543.05, p < .001$, as well as a significant interaction between time and group membership, $F(1, 1365) = 24.15, p < .001$. These results are portrayed graphically in Figure 1, and indicate that the intervention was helpful in reducing work impairment for both groups. The significant interaction indicates that employees in the depressed group benefited more than the non-depressed employees in terms of improvement in work impairment. However, employees in the depressed group remained significantly more impaired than employees in the non-depressed group at closing, $t(445.26) = 2.02, p = .04$ (equal variances not assumed).

The results of the analyses for work absence indicated a main effect for time, $F(1, 1369) = 206.12, p < .001$, and a significant interaction between time and group membership, $F(1,1369) = 23.16, p < .001$. These results are portrayed graphically in Figure 2, and indicate that the intervention was helpful in reducing work absence for both groups. Again, the interaction suggests that employees in the depressed group had a

**FIGURE 1.** Changes in work impairment from intake to closing for employees in the depressed and non-depressed groups.
greater degree of improvement than those in the non-depressed group. Again, employees in the depressed group continued to report significantly higher work absence than employees in the non-depressed group at closing, \( t(439.66) = 2.01, p = .045 \) (equal variances not assumed).

The analyses of changes in GAF scores revealed a significant main effect of time, \( F(1,1350) = 91.51, p < .001 \). However, there was no interaction between time and group membership, suggesting that both groups improved at the same rate on this measure. The results are portrayed graphically in Figure 3. In a pattern consistent with the other outcome measures, GAF scores for employees in the depressed group remained significantly lower at closing than GAF scores for employees in the non-depressed group, \( t(1353) = 3.23, p = .001 \).

**DISCUSSION**

The results of this study indicate that there are clear differences between those employees identified as depressed and other employees presenting to an EAP, and these differences are evident both at intake and after the intervention. As almost a third of those individuals presenting to an EAP were identified as depressed, the consistently higher
level of impairment seen in these individuals is a critical issue for employers and EAP providers alike.

In our examination of outcomes, it was found that both groups of employees benefited from the EAP intervention, reporting decreased work impairment and work absence. Further, clinicians’ ratings of global functioning were higher for both groups post-intervention. These findings clearly support the value of psychosocial interventions for distressed employees. Further, the EAP intervention appeared to be particularly helpful in reducing work impairment and work absence in those employees identified as depressed. Despite this finding, however, the depressed employees continued to have higher scores on work impairment and work absence at the completion of the intervention.

EAPs need to demonstrate their effectiveness to their customers in responding to the problem of workplace depression. These initial analyses revealed the value of psychosocial treatments in an EAP context. However, they raise the question of whether longer and/or more intensive psychosocial treatments would return these depressed employees to optimal functioning, a question that needs to be addressed in future studies. Further research is also needed to examine the sustainability of workplace gains post counseling. If employers are committed to workplace effectiveness, and recognize the need to address the problem of
workplace depression, they need to be prepared to partner with their EAP to establish and support more intensive programs and dedicated solutions.

LIMITATIONS

This study has several limitations. First, because clinicians who work for EAPs do not use diagnostic criteria to identify depression, we have no information as to whether employees met psychiatric definitions of depressive disorder. We therefore cannot differentiate between individuals with minor or major depression, dysthymia, or bipolar disorder. Second, we have no measures of severity of the depression. Third, the results reported here cannot be generalized to all employees, as this is a self-selected sample of individuals presenting to an EAP. There may be important unmeasured differences between those individuals who choose to go to an EAP and individuals who seek help elsewhere (or do not seek help at all). Nonetheless, we believe these results represent a useful first look at the issue of depression as it applies to EAPs. In future studies, we hope to include measures to provide more information on symptom severity and diagnostic criteria. Such information would allow us to identify those individuals who may require immediate referral to more specialized treatment, and those individuals more likely to return to full functioning following a short-term, solution-focused, EAP administered intervention.

REFERENCES


