**List of Research Studies**

Deitz, D., Cook, R., & Hersch, R. (2005). Workplace Health Promotion and Utilization of Health Services: Follow-up Data Findings. The Journal of Behavioral Health Services & Research, 32(3), 306–319. Retrieved October 21, 2018 from <https://doi-org.proxy-um.researchport.umd.edu/10.1007/BF02291830>

This is a study assessing the impact of a worksite wellness program/employee assistance program, which includes information on substance abuse, on utilization of services, costs, and employee behaviors (pp. 306-307). The program being studied consists of many different types of interventions (e.g., seminars, mailings, supervisory training) (p. 306). The study design is that a workplace wellness program that incorporates substance abuse information was presented at one site, and a workplace wellness program that did not was presented at another; the study occurred over 2 years (p. 307).

Findings from this study relevant to our work include:

* There were 254 employees who made a claim (on the employers Managed Care Organization plan). Of those over 60 percent had general healthcare costs above the median of all employees. The results indicate that having a claim related to substance abuse or mental health is associated with higher overall healthcare costs (statistically significant) (p. 309).
* The study found that gender, being 30 or older, and having a salary below the median had a statistically significant relationship with having a substance abuse/mental health claim (p. 309).
* The study found that that average number of medical visits for employees who utilized the employee assistance program after the intervention was almost twice the amount of those who had not (the difference was statistically significant) (p. 310). The study also found that employees accessing the employee assistance after the intervention program were also more likely to have outpatient visits for a substance abuse or mental health problem (p. 311).
* The study found that employees from the site that included substance abuse information were more likely to utilize substance abuse and mental health services that the site that did not (with the largest difference in the youngest age group in the study [under 30 years old]) (p. 313).
* The study found that employees from the site that included substance abuse information were also less likely to report binge drinking, compared to the other site where there was an increase (p. 316).

Lindrooth, R. C., Lo Sasso, A. T., & Lurie, I. Z. (2005). The Effect of Expanded Mental Health Benefits on Treatment Initiation and Specialist Utilization. *Health Services Research*, *40*(4), 1092–1107. Retrieved October 21, 2018 from <https://doi-org.proxy-um.researchport.umd.edu/10.1111/j.1475-6773.2005.00406.x>

This is an article about the same study as listed below (Lo Sasso, 2006). It seeks to measure the impact of a change in mental health benefits on whether employees initiate treatment for psychiatric disorders (p. 1092). The changes involved reduced copayments, reduced co-payments for in-network providers, and an effort to reduce the stigma around mental illness (p. 1092). This study samples employees who were enrolled in the company’s health plan between 1995 and 1998 (p. 1092). Findings in the study indicate that the impact of destigmatization of mental illness and having lower co-payments for in-network specialty providers resulted in an 18 percent increase in the probability of starting mental health treatment by employees in the organization (compared to before the change was implemented) (pp. 1092, 1102). In addition, the study finds that there was an increase in diagnoses of major depression after the changes to benefits offered by the employer were done (p. 1101). The study also indicates that men, those under 30, those who have single coverage, and those who are not white tend to be less likely to start mental health treatment in the study (pp. 1103-1104). The study also finds that those who started treatment during this period (1995-98) were more likely to start treatment with nonphysician mental health specialists than nonspecialist physicians or psychiatrists (people were more likely to start treatment with a nonspecialist physician compared to a psychiatrist) (p. 1104).[[1]](#footnote-1) Finally, the study found that treatment initiation continued to rise through the period covered in the study (p. 1105).

Lo Sasso, A. T., Lindrooth, R. C., Lurie, I. Z., & Lyons, J. S. (2006). Expanded Mental Health Benefits and Outpatient Depression Treatment Intensity. *Medical Care*, 44(4), 366–372. Retrieved October 21, 2018 from <https://doi-org.proxy-um.researchport.umd.edu/10.1097/01.mlr.0000204083.55544.f8>

This was a study of the effects of a change in mental health benefits for employees of a large corporation in the United States; the changes involved reduced copayments, promotion of a network of specialty health providers, and an effort to reduce the stigma around mental illness (p. 366). The study looked at claims data to see how the change impacted outpatient treatment of depression among those who were continuously enrolled for one year and compared them with a control group (generated from MarketScan data compiled from companies similar to the one being studied) (pp. 366-67). The study found that there was a 26 percent increase in the probability of starting depression treatment, and those who did initiate treatment received 1.2 additional mental health treatment visits (compared to the control group) (pp. 366, 370). The study also found that those in the control group were not more or less likely to initiate treatment (p. 369).

One interesting thing mentioned in this study is that the modal number of visits among those who seek out mental health treatment is one (e.g., most have one visit and do not go back), which indicated they do not get enough treatment to have an impact (pp. 366-67). The study indicates it is unclear as to why, but the structure of health insurance may be a reason (e.g., requiring preauthorization may prevent people from getting mental health care but other studies do not find this relationship) (p. 367).

Lo Sasso, A. T., Rost, K., & Beck, A. (2006). Modeling the Impact of Enhanced Depression Treatment on Workplace Functioning and Costs: A Cost-Benefit Approach. Medical Care, 44(4), 352–358. Retrieved October 21, 2018 from <https://doi-org.proxy-um.researchport.umd.edu/10.1097/01.mlr.0000204049.30620.1e>

This is a cost-benefit analysis of depression treatment, using data from a randomized controlled trial of primary care patients in a variety of positions, who were employed (p. 352). The study happened in 12 primary care practices (who did not employee mental health professionals to treat depression). The practices were divided into six blocks by treatment patterns for depression (and one was randomly assigned to provide enhanced care for depression) (p. 353). For 2 years, managers monitored response to treatment with those in the enhanced care group providing more follow-up with patients (p. 353). The research team interviewed patients at different stages of the study and included those who were consistently employed in the study (p. 353). Based on the data, they did a cost-benefit analysis under three types of employment conditions based off the cost to replace the employee (or the ease of replacement), the degree to which team production is used, and the degree of penalties for shortfalls in production (p. 354).

The study found that benefits of treatment included increases in productivity and a decline in absenteeism, with enhanced depression treatment resulting in a net benefit to the employer of $30 for each participating worker in Year 1, and $257 per participating worker in Year 2 (p. 352). The study found that return on investment was higher in companies that use team production, have substitute labor, or have penalties for output shortfalls (p. 352). However, it was lower in firms with high turnover rates and a lot of employees with dependent coverage (p. 352).

Milne, S. H., Blum, T. C., & Roman, P. M. (1994). Factors Influencing Employees’ Propensity to Use an Employee Assistance Program. Personnel Psychology, 47(1), 123–145. Retrieved October 24, 2018 from <http://search.ebscohost.com.proxy-um.researchport.umd.edu/login.aspx?direct=true&db=bth&AN=9411113184&site=ehost-live>

This is a study of approximately 2,000 employees in a large firm and seeks to learn about the relationship between perceptions of an Employee Assistance Program (EAP) and willingness to use it (p. 123). The study finds that awareness of the program as well as the feeling that it is accessible and supported by management impacts employee confidence in the EAP and if they are willing to use it (p. 123). Interestingly for our purposes, the study indicates that the level of confidence by employees in the EAP was based on if they felt it was confidential, credible, and neutral in organizational politics (e.g., labor disputes) (p. 141). The study covered several regions, and it found that regional EAPs were not equally accepted by employees although perceptions of management support for the EAP did not vary significantly (p. 141). The study also found that opinions about the EAP in this organization did not vary significantly by gender, amount of time at the organization, and level in the organization (p. 140).

Reynolds, G. S., & Lehman, W. E. K. (2003). Levels of substance use and willingness to use the Employee Assistance Program. The Journal Of Behavioral Health Services & Research, 30(2), 238–248. Retrieved October 23, 2018 from <http://search.ebscohost.com.proxy-um.researchport.umd.edu/login.aspx?direct=true&db=cmedm&AN=12710376&site=ehost-live>

This is a study of randomly selected municipal employees, who were surveyed about their willingness to use the EAP (p. 238). The study found that those who were considered problem drinkers and drug users (e.g., got drunk once a week or more, had problems because of drinking, those who used unlawful drugs recently, and if they had problems from drug use) were less likely to utilize the EAP to help deal with a drug/alcohol problem or recommend it to another person than nonproblematic users and nonusers (pp. 241-243). The study found that problem drinkers and drug users who were unaware of the EAP were less likely to use it/recommend it as were drinkers who did not support substance abuse policy/enforcement at work (p. 245). However, there was not a significant difference in willingness to use/recommend EAP between problem drinkers, nonproblem drinkers, and nondrinkers who were aware of the EAP; and the relationship between drug use and attitudes to substance abuse policy/enforcement at work was not significant (p. 245). Employees in general who were aware of the EAP, supportive of the substance abuse policy/enforcement at work, had lower tolerance of coworker substance abuse, and reported more cohesion among their work group were more likely to use the EAP to help deal with a drug/alcohol problem or recommend it to another person (pp. 241, 243-244). The study found that willingness to use the EAP did not significantly vary according to gender or race (p. 246).

Trudeau, J. V., Deitz, D. K., & Cook, R. F. (2002). Utilization and cost of behavioral health services: Employee characteristics and workplace health promotion. The Journal of Behavioral Health Services & Research, 29(1), 61–74. Retrieved October 21, 2018 from <https://doi-org.proxy-um.researchport.umd.edu/10.1007/BF02287832>

This is a study about the impact of a health promotion/substance abuse education program at an insurance company in the United States (the study compared program participants [who volunteered for the program], a matched sample of nonparticipants, and the whole group of nonparticipants) (pp. 61, 69, 73). The study also seeks to measure influences on behavioral health use and costs as well as the outcomes associated with behavioral health utilization (p. 61). The study uses health claims data from the managed care organization offered by the insurance company (p. 63). Findings from the study include:

* Women were over twice as likely as men to have a behavioral health claim as men (p. 66).
* Employees older than 30 were about 1.5 times more likely than those under 30 to have a behavioral health claim (p. 66).
* Employees who made less than the median salary for the company were about 1.4 times more likely to have a behavioral health claim than those with salaries above the median (p. 66).
* Employees with general health care costs above the median for the company were about 1.5 times more likely to have a behavioral health claim than those who do not (p. 66).
* However, despite this these four predictors only accounts for a small amount of the likelihood of having a behavioral health claim (explaining only 5% of the variance in the model) (p. 66).
* Employees with behavioral health claims were less likely to receive high performance ratings than employees without behavioral health claims (31% vs 38%, statistically significant difference) (p. 68). There was a negative correlation between the average monthly cost of behavioral health claims and work performance ratings, among those who had at least one behavioral health claim (p. 68).
* However, a model with race, occupation group, exempt status, age, and whether there was a behavioral health claim had limited ability to predict performance ratings, the R2 of the model was only .07, indicating that performance ratings are influenced by many other factors (p. 69).
* Those who participated in the intervention were not more likely than those who did not participate in the intervention to have a behavioral health claim (p. 69). This is true overall and for those who did not have a behavioral health claim before the intervention (pp. 69-70). However, those who participated in the study and did have a behavioral health claim before the study were more likely to have a claim after than the study than non-participants (p. 69).
* There was not a significant difference between participation in the intervention and performance ratings (p. 71).

1. This study is not specific about what a nonphysician specialist is, but I suspect it is a psychologist/counselor or someone else similarly trained in mental health. [↑](#footnote-ref-1)