CHAPTER 17

Employee Assistance Programs: A Research-Based Primer

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17.1 INTRODUCTION

Employee Assistance Programs (EAPs) are an important part of many organizations. This chapter features a review of the literature to provide a research-based overview of EAPs and their role in supporting the mental health and work performance of employees. Many aspects of EAPs are presented in this chapter, including what defines an EAP, the history of the field, the scope of EAP services, what makes EAPs unique, the market prevalence of EAPs, utilization, outcomes, the return on investment (ROI) for EAPs, and future trends. But first the business need for EAPs is examined to understand why these programs were initially developed and why they continue to flourish.

17.2 WORKPLACE MENTAL HEALTH AND ADDICTIONS

17.2.1 Why are EAPs Needed?

Comprehensive reviews of the research literature on workplace mental health abound, including reports by researchers (Brun et al., 2003; Kahn & Langlieb, 2003), business groups and consultants (American Psychiatric Association, 2006; National Business Group on Health/Finch & Phillips, 2005; Watson Wyatt Worldwide, 2007), the Canadian government (Larson et al., 2007), the
United States government (DHSS, 1999; Masi et al., 2004), the European Union (McDaid, 2008), and the World Health Organization (WHO; Hyman et al., 2006). There are a number of conclusions from these reviews that support the need for more employer attention to workplace mental health and addiction issues and thus also to the need for EAP services:

- Mental health disorders and addictions are widely experienced among working-age populations. An estimated one in four adults have a diagnosable mental disorder, one in five adults have an alcohol use problem, and one in eight adults have a drug or other kind of addiction.
- Many people with mental health disorders and addictions suffer from chronic medical conditions (such as heart disease, asthma, diabetes and hypertension).
- Over a third of people with alcohol and drug addictions have a high rate of also having another kind of addiction or mental disorder.
- Untreated mental health disorders and addictions can damage the individual in many ways, such as an increased risk of illness, personal problems, incidents at work or school and even family breakdown.
- Employees with untreated mental health and substance abuse disorders can lead to problems for their employers, such as poor customer relations, absenteeism, diminished work quality and performance, on-the-job accidents and disability claims, work-group morale issues and turnover.
- Society also bears the burden of consequences related to mental health, alcohol and drugs, all of which add up to hundreds of billions of dollars in economic costs in terms of lost work productivity, health care services use, law enforcement and other areas.
- Many kinds of treatments have been proven to be both clinically effective and cost-effective, but sadly most people with mental health or addiction disorders never see a professional care provider for treatment.

The majority of adults with mental health disorders and addictions in the United States and Canada are under-diagnosed, under-treated or get no treatment at all (Green-Hennessy, 2002; Statistics Canada, 2003).

The implications of this alarming evidence are not lost on some employers. Savvy business leaders recognize the critical role that mental health factors play in the overall success of their company. This understanding has guided the development of a new approach to the design of employee health benefits called Health and Productivity Management (Kramer & Rickert, 2006; Loepke et al., 2007). For example, a recent survey of senior human resources (HR) executives found that mental health is now considered the number one driver of indirect business costs, such as lost productivity and
absence (Employee Benefit News, 2007). This is important because these indirect kinds of costs are typically far greater than the direct costs that most employers are naively so concerned about, like health care costs and insurance claims (Goetzel, 2007; Kessler et al., 2003, 2004).

17.3 PROFILE OF EMPLOYEE ASSISTANCE PROGRAMS

Many employers have responded to mental health and addictions in the workplace by implementing Employee Assistance Programs. Let us now examine the nature of EAPs.

17.3.1 Definition: What are EAPs?

EAPs are employer-sponsored programs designed to alleviate and assist in eliminating a variety of workplace problems. Employee Assistance Programs typically provide screening, assessments, brief interventions and outpatient counselling for mental health and addictions problems as part of their basic services offered to client organizations. The source of these employee problems can be either personal (legal, financial, marital or family-related, mental health problems and illnesses, including addiction) or work-related (conflict on the job, harassment, violence, stress, etc.). EAPs are a field of practice composed of multidisciplinary professionals including social workers, psychologists, professional counsellors, substance abuse counsellors and nurses.

An EAP is a worksite-based program designed to assist organizations in addressing productivity issues and employee clients in identifying and resolving personal concerns, including health, marital, family, financial, alcohol, drug, legal, emotional, stress, or other personal issues that may affect job performance (Employee Assistance Professionals Association, 2003).

17.3.2 History: Where Did EAPs Come From?

EAPs were originally established in the 1940s to address alcohol abuse and its impact on the workplace. These early EAPs, or Occupational Alcohol Programs (OAPs) as they were originally called, helped companies to identify troubled employees and support them through the process of recovery and return to work (Trice & Schonbrunn, 2003). The US federal government promoted OAPs through legislation such as the Hughes Act of 1970, which required all federal agencies and military installations to have an OAP and its
amendment in 1972 to include drug abuse (Jacobson & Kominooth, 2009). In the 1970s, OAPs realized their services had to address more than just alcohol and drug abuse. During this period many OAP professionals belonged to the Association of Labor/Management Administrators and Consultants on Alcoholism (ALMACA).

During the 1980s, EAPs became more popular in the United States and Canada. At this point the mix of services offered expanded to build on the focus of OAPs to feature more comprehensive elements. The field also grew through the activity of two major professional organizations: the Employee Assistance Professionals Association (EAPA; which evolved from ALMACA) and the Employee Assistance Society of North America (EASNA; which has a strong Canadian influence). When the drug-free workplace legislation was passed in 1988 in the United States, EAPs continued to grow in importance as they became vital to businesses by providing expertise and guidance to employers regarding the management of employees with addictions.

In the 1990s, EAPs became a standard component of employee benefits at the majority of large companies. EAPs responded to this growth in market penetration and the greater demands of new clients by broadening their menu of services to address issues such as work/life balance, elder care, workplace violence, drug testing and supporting company-wide changes such as mergers and downsizing. In the 2000s, EAPs continue to evolve with the rapidly changing American workplace (see final section of this chapter on trends for EAPs). Today, the number of members in the two major professional associations exceeds 5000 and is growing worldwide.

17.3.3 Scope of Services: What do EAPs do?

The primary job of an EAP professional is to meet privately with employees or their family members to identify and resolve workplace, mental health, physical health, marital, family, personal addictions or alcohol, or emotional issues that affect a worker’s job performance. These kinds of cases typically comprise about two-thirds of all cases at an EAP. The most common initial reason for seeking help from an EAP is for personal relationships/marital issues. Most EAPs also offer consultative and educational services around legal and financial issues that affect employees (Wilburn, 2007). Other aspects of an EAP include services that support individual supervisors with their management and work team problems – these are called ‘management consultations’ – as well as more strategic consulting around organizational change and workforce development issues (Hyde, 2008). EAPs offer preventative and immediate response services for crisis and workplace critical incidents (Everly & Mitchell, 2008).
**Program type**

In the beginning, almost all EAPs were ‘internal programs’, in which EAP professionals worked for the same company that they supported. These kinds of EAPs are still common within large companies, universities and the public sector. However, the more prevalent type of EAP today is the ‘external program’, which has a staff of EAP professionals who are employed by an independent company and supply contracted EAP services to other companies. External EAPs hire counsellor affiliates (part-time or full-time licensed mental health professionals within the community) to provide the majority of telephonic or face-to-face clinical services. External types of EAPs are cost-effective for companies with employees at worksites in different geographical areas. There is a third type, called Blended EAPs, in which the company has a few key EAP managerial staff and this group works with an external EAP vendor to provide the counsellors and other services (Turner, Weiner & Keegan, 2005).

**17.3.4 The Core Technology: What makes EAPs Unique?**

There are several aspects of EAPs that contribute to their unique role in employee benefits and the larger health care system. Such attributes include how the EAP is accessed, the focus of the EAP on restoring employee work performance, specialization in alcohol and drug addiction problems and being responsive to difficult issues or incidents that affect the workplace.

**Confidential, free, and immediate access**

Arguably, the most essential function of a successful EAP is its ability to provide confidential services, free of charge, when needed to employees and, oftentimes, their family members. Additionally, EAP services are voluntary, and most employees who use EAP services do so through self-referrals. Virtually all EAPs feature some form of 24-hour assistance every day of the year. This is accomplished through advanced telephone and web-based technologies. Knowing that this help is always available can be reassuring to employees and supervisors.

**Core technology**

The EAP core technology, developed by Paul Roman and Terry Blum over 20 years ago, represents the essential components of employee assistance
Table 17.1  EAP core technology components

<table>
<thead>
<tr>
<th>Core technology component</th>
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<tr>
<td>1 The identification of employees’ behavioural problems includes assessment of job performance issues (tardiness, absence, productivity, work relationships, safety, etc.)</td>
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<tr>
<td>2 The evaluation of employees’ success with use of EAP service is judged primarily on the basis of improvement in job performance issues</td>
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<td>3 Provision of expert consultation to supervisors, managers and union stewards on how to use EAP policy and procedures for both employee problems and for management issues</td>
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<tr>
<td>4 Availability and appropriate use of constructive confrontation techniques by EAP for employees with alcohol or substance abuse problems</td>
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<tr>
<td>5 The creation and maintenance of micro-linkages with counselling, treatment and other community resources (for successful referral of individual EAP cases)</td>
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<tr>
<td>6 The creation and maintenance of macro-linkages between the work organization and counselling, treatment and other community resources (for appropriate role and use of EAP)</td>
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<tr>
<td>7 A focus on employees’ alcohol and other substance abuse problems</td>
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</table>

(Roman & Blum, 1985, 1988; Roman, 1990). There are seven components (See Table 17.1). The key is for the EAP counsellor to assess how an employee’s concern – or presenting problem – is affecting the workplace and his or her ability to function at work. The EAP counsellor is trained to help the employee to identify the stressors that impact work and determine how the person can better cope with the situation. This ‘work-function’ perspective, while central for EAPs, may or may not be shared by other mental health providers in the community or outpatient network who may elect not to focus on work issues when treating a client. Another core component is to have the EAP staff work closely with the company in order to train managers and supervisors on how to successfully engage the EAP and to understand the larger issues of importance to the organization. It is critical for the EAP staff to know the range of resources available to assist employees from within the company and from the surrounding local community. Even though it was first introduced more than 20 years ago, a recent survey conducted this year found that the vast majority of professionals active in the EA field today (85%) were familiar with the EAP core technology (Bennett & Attridge, 2008).

**Alcohol and drug issues**

In 1990, the seventh component of the EAP core technology was added (Roman, 1990). This component harkens back to the days of OAPs and
places a strong emphasis on screening and assessments for alcohol and drug issues. The workplace offers a useful context for the identification and referral for individuals with drinking and drug abuse problems (Roman & Blum, 2002). The EAP can provide confidential services to management and staff workers with substance use disorders and associated mental health disorders. This typically means being directly involved in providing screening, referring employees for treatment and offering follow-up care and support during recovery. In such cases, sometimes the political leverage that comes from the EAP counsellor being affiliated with the employer can help employees with substance troubles to get into treatment in order to keep their job. This process can also use what has been called ‘constructive confrontation’, in which the EAP professional leads others at the company in a coordinated intervention with the person in trouble from alcohol or drug abuse. Thus, by offering access to an EAP, an employer can be more successful in reducing harm from the misuse of alcohol and other drugs by having a dedicated and experienced resource available and ready to support the company’s alcohol and drug policy.

**Crisis**

EAPs can also deliver unique value in their ability to increase awareness of, and preparedness for, traumatic incidents and the kinds of serious workplace problems to which managers are not comfortable in responding on their own, such as natural disasters, workplace bullying and violence, domestic abuse, fatal on-the-job accidents and suicide (Paul & Thompson, 2006). Avoiding a lawsuit from a critical incident or effectively dealing with sensitive human resources issues can be a value trump card for an EAP.

**17.3.5 Market Penetration: How Many Companies have an EAP?**

Due in part to this unique mission and their relatively low cost, EAPs are now widely adopted across North America. EAPs have become the primary channel for many workers to get their first access to mental health care and addiction treatment services, particularly in unionized environments and medium to larger size organizations (Csiernik, 2002). For example, in the regional province of Ontario, Canada during the period of 1989 to 2003, the number of employer organizations with an EAP doubled – going from 28% to 67% (Macdonald *et al.*, 2007). A more recent 2006 national survey of Canadians found that half of workers (50%) had access to an EAP where they worked (Desjardins Financial Security, 2006).
The figures on EAP market penetration are similar in the United States. In 1985, about 31% of companies in the United States had an EAP and this had risen to 33% in 1995 (Hartwell et al., 1996). In the next seven years, this figure had almost doubled. A 2002–3 national survey in the United States revealed that 60% of full-time workers were employed in settings with an EAP (Roman & Blum, 2004). In 2007, about three-quarters of all businesses in the United States had an EAP (Employee Benefit News, 2007). Similar findings come from the most recent Society for Human Resources Management Survey of Employer Benefits [SHRM] (2008). It found that in 2008 three-quarters of businesses in the United States (75%) offered EAP services to their employees. This figure is up slightly from five years earlier, when it was 70% in the 2004 SHRM survey. However, in 2008 as in past years, having an EAP varied substantially based on company size, ranging from 52% for small employers (1–99 staff), 76% for medium employers (100–499 staff), and 89% for large employers (500+ staff)(SHRM, 2008). Today, well over 100 million American workers have access to an EAP (Masi et al., 2004).

17.3.6 Utilization: How often are EAPs used?

Utilization rates for an EAP are commonly measured by a metric that compares the total number of people who use the EAP for a clinical issue (which is primarily employees but also includes some spouses and dependants) to the total number of employees active at the company the EAP supports. For many years the typical EAP clinical case utilization rate has been between 5% and 10% of the number of total employees at the company (Amaral, 2005). The amount of contact with the EAP service is actually much higher that the clinical case utilization rate would suggest, as each individual case can have multiple sessions (or calls) with an EAP counsellor. The average number of counselling sessions used by an employee with access to a six-session maximum model is about four sessions (Jacobson & Hosford-Lamb, 2008). EAPs with a telephonic-based external program model tend to have an average number of contacts per case that is even lower.

Although 5% use among all employees may not seem that significant, keep in the mind that the relevant group for clinical use of an EAP is really not the entire employee population, but rather it is more appropriately the 10 to 20% or so with mental health disorders, addictions or personal life events in a given 12-month period that merit clinical assistance and direction into community services or professional treatment. Indeed, one would hope that the vast majority of employees at a given company should be healthy and functioning well enough not to need the EAP. Depending on the rate of turnover at a company, the cumulative use rate for an EAP over a number
of years is even higher, as an employee may use it one year and not need to
so again for several years. For example, a 2006 survey found that about
one in 10 workers (11%) with access to an EAP had used ever it (Desjardins

In addition, about 10 to 20% of the total caseload of all EAP users is of a
much different nature than those who need assistance for their own personal
or family issues. These other kinds of EAP users are supervisors who need
help to better manage a worksite issue or other staff needing support after a
workplace critical incident. Some EAPs also can have a large slice of their
total mix of EAP services devoted to supporting organizational development
and more strategic issues at the company (Hyde, 2008). Still others use the
EAP in a more preventative mode and seek information and educational
materials from the EAP office or website or onsite training workshops. This
kind of non-clinical contact can double or triple the total contact use rate for
an EAP over just the clinical case rate.

17.4 EAP OUTCOMES AND BUSINESS VALUE

17.4.1 Effectiveness and Outcomes: Do EAPs Help?

All EAPs measure the level of client satisfaction with program services
and most find it to be very high (Dersch et al., 2002; Phillips, 2004). For
example, one study used an independent survey firm and random sampling
techniques to conduct follow-up interviews with over 1,300 cases nationally
from an external model EAP. The results revealed that 95% of users reported
being satisfied with the EAP service (Attridge, 2003c). But having high
levels of client satisfaction is not enough to show the full value of an EAP.
Also needed is evidence of clinical symptom relief and work performance
improvement among EAP clients (Csiernik, 2004; Roman, 2007). These
outcome areas produce immediate returns to the company as well as create
additional long-term cost savings in related areas later on (reduced health
care claims, disability insurance claims, less turnover, etc.).

EAP outcomes

Studies show that, when appropriately administered to emphasize the core
technology components, EAP services produce positive clinical change, im-
provements in employee absenteeism, productivity and turnover, and savings
in medical, disability or workers’ compensation claims (Attridge & Amaral,
Table 17.2  EAP impact on employee work performance: results from six studies

<table>
<thead>
<tr>
<th>Improved work performance</th>
<th>Sample size</th>
<th>EAP model</th>
<th>Source</th>
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<tbody>
<tr>
<td>61% of all cases had improved work performance</td>
<td>1,190 cases</td>
<td>Internal programs at many universities with mostly in-person model</td>
<td>Phillips (2004)</td>
</tr>
<tr>
<td>50% of all cases had improved absence and productivity at work</td>
<td>882 cases</td>
<td>Internal program with in-person model</td>
<td>Kirk (2006)</td>
</tr>
<tr>
<td>64% of cases with work issues as primary problem had improvement after EAP use; Average of 46% improved productivity rating on 1–10 scale for EAP cases</td>
<td>Not specified – 10,000+</td>
<td>National data warehouse with dozens of EAPs; mostly internal programs with in-person model</td>
<td>Amaral (2008a)</td>
</tr>
<tr>
<td>Reduction from 15% to 5% of all clients who ‘could not’ do their daily work or who experienced ‘quite a bit’ of difficulty doing their daily work in past four weeks</td>
<td>59,685 cases</td>
<td>Blended program with mostly in-person model</td>
<td>Selvik et al. (2004)</td>
</tr>
<tr>
<td>57% of cases had improvement in ability to work productivity, with average gain in productivity of 43% on 1–10 scale</td>
<td>11,909 cases</td>
<td>National EAP provider – external program with mostly telephonic model</td>
<td>Attridge (2003a)</td>
</tr>
<tr>
<td>Number of work cut-back in past 30 days was reduced from 8.0 days to 3.4 days (58% gain in productivity)</td>
<td>3353 cases</td>
<td>National EAP provider – external program with mostly telephonic model</td>
<td>Baker (2007)</td>
</tr>
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</table>

Examples of results from six major contemporary studies illustrate the kinds of improvements obtained after EAP use in the primary outcome area of work productivity for individual employees. These findings consistently show improvement of presenteeism problems, both from EAPs with a traditional in-person model or from those with an external model with telephonic contact between employee and counsellor (see Table 17.2).

**EAP referrals**

A necessary part of the EAP service is to appropriately refer some of the clinical cases – particularly those cases requiring more extensive psychotherapy,
pharmacological treatment or alcohol/drug treatment – to providers of mental health care outside of the EAP. Such referrals are usually to outpatient clinical settings staffed by licensed psychologists, psychiatrists, social workers or other professionals. At this point the referral client must pay for these services however the benefit is arranged. In these cases, the effectiveness of the EAP thus ultimately rests with these other providers.

Fortunately, the success rates for the treatment for some of the most common mental health disorders are quite high. According to a landmark study that examined over 300 meta-analysis papers (each paper itself a review of many other original studies), outpatient mental health treatment is largely effective at improving patient functioning (Lipsey & Wilson, 1993). A recent randomized control experimental design study demonstrated the effectiveness of mental health treatments on reducing clinical symptoms for depression and improving work absence and presenteeism outcomes (Wang et al., 2007). Consumer opinion research has also found generally positive results from the perspective of clients who used mental health services (Seligman, 1995). Thus, the evidence strongly indicates that once people with mental health disorders can get to a treatment provider – perhaps after referral from the EAP – the treatments are generally effective at restoring better mental health and work functioning.

Some studies indicate that EAPs are particularly effective at helping employees with substance abuse issues to navigate successfully through the many treatment options available and with providing follow-up support and case-management assistance after treatment to reduce relapse issues and improve the return-to-work process (Blum & Roman, 1995; Cook & Schlenger, 2002). A survey of over 800 EA professionals experienced in this area found that almost nine in 10 referral cases from the EAP were believed to be successful in completing their recommended specialized treatment for alcohol or drug issues (Attridge, 2003b). As with mental health, literature reviews of the hundreds of outcome studies on alcohol and drug abuse treatment have agreed upon the general effectiveness that professional treatment can provide to those suffering from alcohol and drug abuse problems (Canadian Centre on Substance Abuse, 2005; Miller et al., 2003; NIDA, 1999). In particular, the combination of cognitive behavioural therapy, pharmacological therapy and self-help peer support groups has been the most helpful in getting addicts to reduce and better manage their alcohol or drug use for long periods of time.

17.4.2 EAP and ROI: Dollars and (Business) Sense

Employers purchase EAPs to provide services to the individual employees, members of their family, and the organization as a whole. A fundamental management question then becomes whether or not their EAP is providing
enough value to cover the cost of sponsoring the service. In other words, is the financial return on investment (ROI) a positive ratio? For perspective, fees for EAPs in the last decade have been in the range of $15 to $25 dollars per employee per year (Hartwell et al., 1996; Sharar & Hertenstein, 2006). The average annual cost to employers for single coverage in the United States in 2007 was $4,479 (Kaiser, 2007). Thus, this level of cost for an EAP represents about one-half of 1% of total health care costs at most companies. Thus, EAPs are one of the least costly of all benefits services for most companies.

To help answer the ROI question, the ‘EAP Business Value Model’ was created to better conceptualize the components of total business value that mental health workplace services can offer employers (Attridge & Amaral, 2002; Attridge, Amaral & Hyde, 2003; Amaral & Attridge 2004, 2005; Attridge, 2005). This model organizes the business value that results from positive employee mental health into three classes of outcomes that are important to employers: health care outcomes; human capital outcomes; and organizational outcomes.

- The health care value component includes the impact of the program on medical, mental health, disability and workers’ compensation claims. These are the direct costs paid by most employers that can be routinely measured and tracked.
- The human capital value component comprises indirect costs. It represents the savings that an employer can expect when effective prevention and intervention services result in avoided employee absenteeism, reduced presenteeism and turnover and enhanced employee engagement, retention and recruitment.
- The organizational value component includes costs associated with workplace safety risk management, legal liability risk prevention, organizational culture change, improved worker morale, and secondary impacts on health costs and human capital costs. Ultimately, these costs affect the bottom line of company net profitability.

This triadic model is a useful heuristic for understanding what an EAP can do for a company. Most researchers and industry experts now believe that there is enough solid evidence in each of these value component areas to ‘make the business case’ for providing greater access to mental health services in general and to workplace-based services in particular (American Psychiatric Association, 2006; Attridge, 2005, 2008a; Finch & Phillips, 2005; Goetzel et al., 2002; Kessler & Stang, 2006a; Langlieb & Kahn, 2005). This conclusion is supported by many case studies of EAP outcome value at companies such as Abbott Laboratories, America On Line (AOL), Campbell Soup, Chevron, Crestar Bank, Detroit Edison, DuPont, Los Angeles
City Department of Water & Power, Marsh & McLennan, McDonnell Douglas, NCR Corp, New York Telephone, Orange County (Florida), Southern California Edison, the U.S. Postal Service, and the U.S. Federal Government (Blum & Roman, 1995; Yandrick, 1992).

The typical analysis produces an ROI between $5 and $10 in return for every $1 invested in the EA program (Attridge, 2007; Hargrave et al., 2008; Jorgensen, 2007). In fact, as in most other cost-benefit studies of health care services, the financial benefits from the area of improved employee productivity (presenteeism) comprises the largest and most immediate part of the overall cost savings to the employer from employees’ use of EAP services (Goetzel, 2007; Hargrave et al., 2008). Several ROI calculator tools are available that offer rough estimates of illness burden costs and potential savings from prevention and intervention programs for mental health and alcohol problems in the workplace (Attridge, 2008b; see the following websites: www.alcoholcostcalculator.org, www.bipolarsolutions.com, www.depressioncalculator.com, and www.intelliprev.com).

17.5 FUTURE TRENDS IN EAP

Before closing this chapter, a number of advances in the field must be acknowledged. These trends include integration of EAP with other areas of employee benefits, Internet-based EAP, measurement and interventions for employee engagement and presenteeism, research on EAP and expansion of EAP around the world.

17.5.1 EAP Trend 1: Integration with Other Employee Benefits

In the last decade, EA professionals have begun to collaborate with other business groups in the areas of work/life, health and wellness, and disability management to address the mental and physical needs of employees and develop prevention and early intervention programs that try to improve overall health and well-being. The number of EAPs with integration activity has increased from about one in four in 1994 to over one in three in 2002 and is now expected to be the majority of EAPs (Herlihy & Attridge, 2005). Part of the reason for this growth is a natural business development response to the rise in the popularity of work/life (W/L) programs and the benefits of collaboration between EAP and W/L. Another reason is that EAPs are well suited to offer prevention services that target employee behavioural risks and workplace culture issues (Caggianelli & Carruthers, 2007; Goetzel & Ozminkowski, 2006). There are many examples of how EAPs are increasingly delivering
their services in greater integration and collaboration with work/life and wellness kinds of services (Attridge, Herlihy & Maiden, 2005; Csiernik, 2005).

There is also a conceptual and empirical rational for greater collaboration among health and workplace service providers towards delivery of comprehensive organizational wellness (Bennett, Cook & Pelletier, 2003; Grawitch, Gottschalk & Munz, 2006). In addition, there is now a strong scientific evidence base for the effectiveness of potential EAP partners in the areas of worksite wellness and stress management intervention programs that have been shown to improve employee health and work performance (see meta-analysis by Parks & Steelman, 2008).

Also important are the findings from a new survey that the majority of EAP professionals consider prevention to be a core component of their professional identity and that about a third of EAPs already deliver prevention-oriented services to employees and organizations (Bennett & Attridge, 2008). The prevention services provided most often by EAPs to their client organizations (on at least a quarterly basis) were alcohol or other drug screening/training (40%), team building (32%) and depression screening (25%). Given the increasing prevalence of delivering prevention services and the positive attitudes towards them among providers, some have even argued that preventive services should be added to the core technology of EAP (Bennett & Attridge, 2008).

17.5.2  EAP Trend 2: Internet Services and e-Counselling

Related to the greater integration of EAP with other health and wellness services is an increasing use of the Internet in the promotion and delivery of EAP (Richard, 2003, 2009). Web-based services have allowed many employees to become more familiar with the purpose of EAPs. Websites for EAPs are becoming more elaborate, offering access to provider lists, tip sheets, Webinars and self-assessment tools. Many of these sites are even embedded within the larger company intranet or human resources website. One advantage of this common portal approach is a lessening of the reluctance some people have to seek out counselling. At Ernst & Young, when they combined the EAP, work-life and HR/benefits website functions, the result was a big increase in the use of the EAP and of the work-life services – from 8% and 12%, respectively to a combined 25% annually (Turner, Weiner & Keegan, 2005). There is less stigma associated with addressing addictions and delivering prevention programs through the Internet, where it can be accessed at anytime, with relative anonymity. Although still a small fraction of all client contact, the use of online or web-based counselling between EAP clinicians and employees is advancing as a new practice model (Parnass et al., 2008).
17.5.3  EAP Trend 3: Measuring Employee Work Performance

Given that one of the unique features of employee assistance is a focus on the work productivity of employee clients, it has been surprisingly difficult for EAPs to accurately measure productivity in order to assess clinical symptom severity and to gauge improvement. This scenario has dramatically changed in the last decade due to recent advances in the validity and reliability of self-report tools for measuring employee productivity, absence and health factors (Attridge et al., 2009). There are now several brief assessment tools that can reliably and validly measure employee productivity/presenteeism and absence. One of most widely tested tools is the Health and Work Performance Questionnaire (HPQ), developed by the World Health Organization and Harvard University (Kessler et al., 2003, 2004). The HPQ has subscales of a seven-item Presenteeism Scale and a four-item Absenteeism Scale and norms from more than 200,000 workers worldwide. A short form of the HPQ is being adopted by leading employers in the United States for use as an annual all-company benchmarking practice (see website for the Integrated Benefits Institute). This HPQ measure has also been incorporated into standard use among dozens of EAP providers who combine their operational experiences in a large international reporting database (Amaral, 2008b).

The opportunities that better measurement of worker performance provides for EAPs (and other health service providers) is enormous as it allows the comparison of EAP cases over time before and after use of the EAP and the comparison of the EAP cases to the rest of the employees on work absence and productivity metrics (Attridge, 2004). Even more significant is the trend among leading companies to switch their focus from reducing ‘negative’ outcomes (such as absence and presenteeism) to encouraging the development and maintenance of ‘positive’ outcomes such as employee engagement. Indeed, major studies by the Gallup organization, Watson Wyatt and others on employee engagement have linked it to overall company profitability and customer loyalty (Grawitch et al., 2006; Harter et al., 2003; Watson Wyatt Worldwide, 2002).

17.5.4  EAP Trend 4: Revitalizing Research

Although there are several key research-based books and texts on EAP (Oher, 1999; Attridge, Herlihy & Maiden, 2005; Richard, Emener & Hutchinson, 2009), the empirical research on EAPs is a relatively small literature. For example, one review found almost 200 reports on the business value of EAPs, but few works were from peer-reviewed research journals and almost all of these EAP studies use non-experimental research methods (Attridge &
Fletcher, 2000). Instead, most of the reports in this review were conference presentations, trade journal articles or industry white papers. However, these weaknesses in research rigour are largely due to the applied nature of the service delivery context and are not unique to EAPs as they are common to much of the research conducted on workplace health issues (Attridge, 2001; Kasl & Jones, 2003; Kessler & Stang, 2006b). Nonetheless, much has already been learned from this past research and operational practices have been established well enough to allow for EAP industry accreditation of provider companies and certification of individual professionals. Yet, more basic research is needed on the factors that determine just which kinds of operational practices drive service quality, user satisfaction and important outcomes (Roman, 2007; Sharar, Amaral & Chalk, 2007). Higher quality research on the effectiveness and value of EAPs can also be used to argue for general fee increases, which have tended to stagnate or even go down in the past decade due to pressures of ‘commoditization’ of the industry (Sharar & Hertenstein, 2006).

The good news is that there is robust political support for research and opportunities for disseminating it through the two major industry organizations. Each association has research committees and work groups, conferences and publication outlets for research work (the peer-reviewed *Journal of Workplace Behavioral Health: EAP Practice and Research*, published by Haworth Press and affiliated with EASNA; and the *Journal of Employee Assistance*, published by EAPA).

A practical limitation to more and better research on EAPs is that there are so few people trained in how to do quality research who specialize in the area of EAP and only a handful of university-level programs that focus on EAP exist to produce new scholars (Pompe & Sharar, 2008). In addition, compared to the heyday era of abundant government funding for alcohol-related services, hardly any financial support exists today for EAP research from the industry or from government (Roman, 2007). Most of the research that is done is paid for by larger EAP providers, conducted by external consultants, or contributed by university students and professors. A promising new development, however, is the creation of a foundation dedicated exclusively to funding basic and applied research in the employee assistance field (Tisone, 2008).

### 17.5.5 EAP Trend 5: Going Global

The employee assistance concept began in the United States and remains very popular with over 75 local chapters of EAPA. However, there has also been significant expansion and adaptation of employee assistance services
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more recently in other countries. For example, there are EAPA member chapters located in Australia, Canada, Greece, Ireland, Japan, South Africa and the United Kingdom as well as some start-up activity in Chile and China. The EASNA organization hosts its annual institute on an alternating basis between cities in Canada and the United States. There also has been some qualitative research on the progress of EAP development in Australia (Kirk & Brown, 2005; Smith, 2006), Europe (Hoskinson & Beer, 2005; Nowlan, 2006; Malhomme, 2008), Germany (Barth, 2006; Gehlenborg, 2001), India (Siddiqui & Sukhramani, 2001), Ireland (Powell, 2001; Quinlan, 2005), Israel (Katan, 2001) and South Africa (Maiden, 1992, 2001). With all of this global interest in EAP, the profession has a strong future and many opportunities for positive change and evolution (Burke, 2008).

17.6 CONCLUSION

Employee Assistance Programs have a long history of supporting employees and organizations in a variety of ways. They bring a unique focus on how to maintain or restore employee work performance through troubles with mental health, addiction and workplace events. The role of employee assistance in supporting worker mental health and job performance is already a key component to the overall success of thousands of organizations. This chapter has used a research literature review to provide an overview of why companies need an EAP, what defines EAP, what are its roots, what services are commonly provided, what makes EAPs unique, how many employers have an EAP, how often employees use the EAP, outcomes from EAP use, and their business value to employers. Also examined were five trends in the EAP field, focusing on service integration, the Internet, measurement, research and globalization.

REFERENCES


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