

Employee Assistance Programs (EAPs): An Allied Profession for Work/Life

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Basic Concepts & Definitions

This entry examines the major theories, policies, and best practices related to designing and administering an Employee Assistance Program (EAP). An emphasis is placed on the dual roles of EAP to support both individual employees and also the employer work organizations. To accomplish these goals, EAPs often partner with other strategic work organizations including work-life, human resources, management, occupational health, and medical departments.

A majority of employees today find themselves under significant pressure to perform at a high level with maximum productivity by employers who expect their organizations to “do more with less.” This tension between the limited organizational resources given to employees and the increasing productivity demands of employers contributes to a variety of problems experienced by employees. These problems are further affected by efforts to balance work with also trying to have a healthy and fulfilling personal and family life. EAPs can play an important role in helping employees, as well as their family members, to balance the demands of work and personal life, while also supporting the employer’s goals for improved and sustained levels of high workplace productivity.

When first established during the 1940s, EAPs focused on providing outreach to, identification of problems, and early intervention for employees struggling with alcohol-related problems. Over the past few decades, the employee assistance (EA) field has grown significantly and is addressing more complex employee health and behavioral health, as well as work-life employee challenges. Today, most EAPs are considered “broad-brush” programs, designed to support multiple kinds of employee, family, and workforce performance issues. Employers

provide EAPs for a variety of reasons ranging from wanting to support employees and their family members, accepting the evidence that healthy employees make for a more productive workplace, and protecting themselves from liability and legal issues, in addition to simply believing that offering employee assistance is “just the right thing to do.”

EAPs have clearly made their mark with U.S. business. The majority of large U.S. employers now provide EA benefits to employees and their family members (Mercer, 2008). More than 75% of employees in state and local government have access to EA services, and 40% of employees working in the private sector have access to an EAP (U.S. Department of Labor, Bureau of Labor Statistics, 2008). The 40% rate is lower than what might be expected; however, more than 90% of all businesses in the United States are small employers with fewer than 50 employees, and smaller companies are less likely to provide EA services. According to a national benefits survey conducted in 2008, 52% of small employers (1 to 99 staff) offered an EAP to their organization, compared to 76% for medium employers (100 to 499 staff) and 89% of large employers (more than 500 staff) (SHRM, 2009a).

As a starting place to understand this multidisciplinary and multidimensional field, it is important to first review how EA is defined. Although the field has yet to agree upon a standardized definition, the Employee Assistance Professional Association (EAPA), the largest, international, professional organization for EAPs, provides a comprehensive definition of EA that is acceptable to most professionals in the field. EAPA defines EA as the “work organization’s resource that utilizes specific core technologies to enhance employee and workplace effectiveness through prevention, identification and resolution of personal and productivity issues” (EAPA, 2010c). EAPA further defines an EAP as “a worksite-based program designed to assist (a) work organizations in addressing productivity issues, and (b)

‘employee clients’ in identifying and resolving personal concerns, including, but not limited to, health, marital, family, financial, alcohol, drug, legal, emotional, stress or other personal issues that may affect job performance” (EAPA, 2010c, p. 6).

A second professional organization for EAPs is Employee Assistance Society of North America (EASNA), whose focus is on advancing knowledge, research, and best practices to achieve healthy and productive workplaces. EASNA defines EA as:

an employer-sponsored service designed for personal or family problems, including mental health, substance abuse, various addictions, marital problems, parenting problems, emotional problems, and financial or legal concerns. This is typically a service provided by an employer to the employees, designed to assist employees in getting help for these problems so that they may remain on the job and effective. EAP originated with a primary drug and alcohol focus with an emphasis on rehabilitating valued employees rather than terminating them for their substance problems. It is sometimes implemented with a disciplinary program that requires or strongly encourages that the impaired employee participate in EAP. Over the years, EAP has expanded to also incorporate not only mental health and substance abuse issues but also health and wellness and work/life types of concerns. Although one facet of EAP services is focused on the individual employee and their family members, another component is the services offered to the organization. This may include prevention, training, consultation, organizational development, and crisis response services (EASNA, 2010, p. 1).

EASNA has partnered with the Council on Accreditation (COA) to develop the accreditation standards for programs that offer EA services. Although not a direct provider of

accreditation, EASNA offers guidance and mentoring to programs that are seeking accreditation. According to the COA EAP accreditation standards, EAPs are defined according to the EAP Core Technology. The EAP Core Technology represents themes from an early research study conducted by Roman and Blum (1985; 1988) to identify the unique characteristics of EAPs that are common to all programs and that define the practices of the field. Their research, based on observations made during onsite visits to more than 425 EAPs, resulted in the identification of six EA core functions, still regarded by many in the field to be the basic framework for defining and understanding the distinguishing properties of an EAP. Content areas identified by Roman and Blum (1988) included supervisory and/or management functions such as “identification of employees’ behavioral problems based on job performance issues” (p. 19), “provision of expert consultation to supervisors, managers and union stewards on how to take the appropriate steps in utilizing employee assistance policy and procedures” (p. 19), and “availability and appropriate use of constructive confrontation” (p. 20).

The second set of unique EA functions included programs and interventions related to benefits management. These included “micro-linkages with counseling, treatment and other community resources” (p. 20) and “the creation and maintenance of macro-linkages between the work organization and counseling, treatment and other community resources” (Roman & Blum, 1988, p. 21). The final set of functions emphasized substance abuse in the workplace and contended that a “focus on employees’ alcohol and other substance abuse problems offers the most significant promise of producing recovery and genuine cost savings for the organization in terms of future performance and reduced benefit usage” (Roman & Blum, 1988, p. 21).

In subsequent years, EAPA expanded and revised the Core Technology to include eight distinct initiatives and/or activities that all EAPs provide to work organizations:

1. Consultation with, training of, and assistance to work organization leadership (managers, supervisors and union officials) seeking to manage troubled employees, enhance the work environment and improve employee job performance.
2. Active promotion of the availability of EA services to employees, their family members and the work organization.
3. confidential and timely problem identification/assessment services for employee clients with personal concerns that affect job performance.
4. Use of constructive confrontation, motivation and short-term intervention with employee clients to address problems that affect job performance.
5. Referral of employee clients for diagnosis, treatment and assistance, as well as case monitoring and follow-up services.
6. Assisting work organizations in establishing and maintaining effective relations with treatment and other service providers, and in managing provider contracts.
7. Consultation to work organizations to encourage availability of an employee access to health benefits covering medical and behavioral problems including, but not limited to, alcoholism, drug abuse and mental and emotional disorders.
8. Evaluation of the effects of EA services on work organizations and individual job performance (EAPA, 2010b, p. 6).

Even though the original research to identify key EA functions was conducted more than 20 years ago, the EAP Core Technology continue to have value as a guiding framework for the

establishment and evaluation of the field. In fact, a recent survey of 200 members of EAPA found that the vast majority of professionals active in the EA field today (85%) were familiar with the EAP Core Technology (Bennett & Attridge, 2008).

Given their close working relationship with Human Resources (HR), which is also often the work organization or department that oversees and manages the EAP contract, it is important to review the definition of EAP from a HR or benefits perspective. The International Foundation of Employee Benefit Plans (IFEBC) defines an EAP as:

an employment-based health service program designed to assist in the identification and resolution of a broad range of employee personal concerns that may affect job performance. These programs deal with situations such as substance abuse, marital problems, family troubles, stress and domestic violence, as well as health education and disease prevention. The assistance may be provided within the organization or by referral to outside resources (2005, Glossary).

The Society for Human Resource Management (SHRM) provides the following definition for an EAP:

work-based intervention program designed to identify and assist employees in resolving personal problems (e.g., marital, financial or emotional problems; family issues; substance/alcohol abuse) that may be adversely affecting the employee's performance. EAPs that offer medical benefits such as direct counseling and treatment, rather than just referrals for counseling and treatment, are regulated under ERISA and subject to COBRA. EAP plans are usually 100% paid by the employer and can include a wide array of other services, such as nurse

lines, basic legal assistance and referrals, adoption assistance or assistance finding elder care services. EAP services can be made available to not only the employee but also to immediate family members or anyone living in their home (SHRM, 2009b, para. 1).

Recently, the National Business Group on Health (NBGH) established a work group to study EAPs and address the group's concern regarding an observed lack of "coordination and integration between employer-sponsored health plans and EAPs" as reported in a 2004-2005 report by the National Committee on Employer-Sponsored Behavioral Health Services (Rothermel et al., 2008, p. 7). In 2008, this group expanded the definition of EAP to include the provision of:

strategic analysis, recommendations and consultation throughout an organization to enhance its performance, culture and business success. These enhancements are accomplished by professionally trained behavioral and/or psychological experts who apply the principles of human behavior with management, employees and their families, as well as workplace situations to optimize the organization's human capital (Rothermel et al., p. 15).

Although the definitions of EA and EAP vary, all EAPs would likely agree that they provide individual- and organizational-based services through a "world of work" lens, meaning that EA services must be provided objectively and in an impartial manner as the EAP represents and supports the views and goals of both the individual employee and his or her employer, and in some work settings, the EAP serves the public good.

Importance of Topic to Work and Family Studies

The EAP and work-life fields often share similar goals of supporting employees and working families, while also supporting the needs of the employer and the broader workplace. Both fields strongly value the importance of work and embrace the notion that one's work life and personal life influence each other. Both fields also typically report to HR or another department within the work organization, with services being managed internally but have most of their client-contact services provided by a network of other contractors, staff from vendors, and other business partners. In many companies, EAPs and work-life services are provided by the same program or sold under the same contract; however, they may actually be business arrangements in which one program partners with another program to meet the needs of an organization (Attridge, Herlihy, & Maiden, 2005).

Just as Kanter (1977) suggested that work and life could not be viewed as separate spheres, EAPs recognized that their initial focus on occupational alcohol problems could not be addressed within a vacuum. In fact, as EAPs worked more and more with alcohol-abusing and recovering employees they found that in order to truly support sustained recovery they had to expand their services to address a variety of work-life concerns that affected individual employees and their families just as much as problem-drinking. For example, consider the employee referred to the EAP after being identified by the workplace as having a drug problem after failing a random drug test. It turns out that the employee is a single mother who has been hiding a substance abuse problem for several years and is open to the idea of attending treatment. The EAP would then work with her to identify an appropriate rehabilitation program but may also be faced with the question of who would care for her young child. Thus, the EA professional

finds himself or herself needing to resolve issues related to child care, workplace leave policy, and other family-related concerns, similar to the work-life professional.

As noted earlier, many workplaces now have integrated their EAP and work-life programs within the same department, or if they are outsourced, these programs are often provided by a single contractor or vendor. This notion of “one-stop shopping” is perceived as a benefit, not only for the employer as it simplifies the contracting process but also for the employee as having one service provider offer a single point of contact for employees and family members wishing to access services (Swihart & Thompson, 2002; Willaman, 2001). With the overlap from mental health and substance abuse into work-life issues, it makes sense that EAPs and work-life programs function collaboratively as both address various issues critical for helping employees reclaim and sustain a sense of work-life balance.

For example, a manager might realize that one of his employees has not been coming to work on time regularly and when at work appears sluggish and less productive. The manager could bring these performance problems to the employee’s attention, who could then seek help through the EAP and work-life program. A common underlying cause of sudden changes in work performance is due to the spillover effect from stress at home into the workplace. The EA professional might uncover that this employee has been sluggish at work recently because she is not getting enough sleep at night due to increased stress related to marital problems and increased pressure to provide physical and emotional care for her elderly mother who recently fell and broke her hip. EA and work-life services in collaboration could assist this employee in accessing supportive resources within the community and returning attention to self-care and improved work performance.

Additionally, EAPs and work-life programs rely on similar methods for service delivery including telephonic assessment and referral, brief intervention, problem resolution, and follow-up. Both kinds of programs also usually offer outreach; education and training programs; information provided through newsletters, tip-sheets, and web-pages; consultation to managers and supervisors; and program evaluation (Herlihy, Attridge, & Turner, 2002).

In addition to work-life programs, EAPs partner with Occupational Health and Medicine programs to promote physical and mental health and well-being (Goetzel & Ozminkowski, 2006). Newly emerging workplace initiatives focused on health promotion and employee wellness are often provided by Occupational Medical programs and/or broader work-life programs. One contribution the EAP has been able to make in this area is to support employees' behavioral change, particularly with employees struggling to change behaviors related to nutrition and smoking, and identifying and treating chronic behavioral health conditions such as depression and anxiety that negatively affect productivity and quality of work-life. Health promotion and workplace wellness programs reach employees and their family members through many different channels, including traditional office visits, telephone calls, Internet resources, and onsite workplace events, such as employee health and wellness fairs and screening.

Collaboration with other benefits programs has been a growth area for EAPs within the United States as employers seek new and creative ways to support employee productivity and reduce costs associated with health care, disability, and other negative outcomes. The number of EAPs with "integration activity" increased from about 1 in 4 in 1994, to over 1 in 3 in 2002 and is now expected to be the majority (Herlihy & Attridge, 2005). Part of the reason for this growth in integrated programming is a natural business development response to the rise in the

popularity of work-life programs and the benefits to the organization of collaboration between EAP and Work-Life (Attridge, Herlihy, & Maiden, 2005; Csiernik, 2005).

EAPs help to form the foundation to support an employer's most valuable asset-its employees. Helping to balance the challenges from work and personal life, as well as supporting working families, is no easy task. EAPs and work-life programs are designed to help employers reduce risk while increasing productivity in a healthy and effective manner.

State of the Body of Knowledge

EAPs were first developed in the United States during the 1940s in response to growing concerns among employers about employee problem-drinking and its impact on workplace accidents and injuries and decreased worker productivity. Offered as an alternative to terminating alcohol-dependent employees, EAPs were designed to help the workplace address alcohol use and abuse among working adults during an era when skilled labor was in short supply due to World War II. Alcoholics Anonymous (AA) was introduced to union leaders and corporate medical directors as a path to recovery and rehabilitation of alcohol-impaired employees (Steel, 1989; Trice & Schonbrunn, 1981). This led to the creation of Occupational Alcoholism Programs (OAPs) that were designed to provide cost-effective support to employers to identify and encourage recovery of alcohol-dependent employees. Studies published by the Yale Center of Alcohol Studies and the National Committee on Education and Alcoholism further supported a structured plan for business to implement OAPs that included employee and supervisory education along with additional consultation to supervisors regarding referring troubled employees to OAPs, collaboration with occupational medical departments, policy development regarding treatment and discipline, referrals to rehabilitation services, and plans to evaluate outcomes (Henderson & Bacon, 1953).

During the 1950s and 1960s, OAPs grew in number and acceptance, largely through support from the U.S. Federal Government and legislation such as the Federal Comprehensive Alcohol Abuse and Alcoholism Treatment and Rehabilitation Act (called the Hughes Act) of 1970. The Hughes Act required the Federal Civil Service Commission-later renamed the U.S. Office of Personnel Management (OPM)-to develop alcohol intervention programs and make them available to all federal employees. In 1972, this legislation was amended to include drug abuse in addition to alcoholism. The Hughes Act also established the National Institute on Alcohol Abuse and Alcoholism (NIAAA) with part of its mission to promote the growth and diffusion of EAPs nationwide. NIAAA funded two Occupational Program Consultants (OPCs) in each state whose primary role was to promote and establish OAPs in private industry. OPCs organized with labor representatives and formed the Association of Labor Management Administrators and Consultants on Alcoholism (ALMACA), which was the precursor for the Employee Assistance Professionals Association (EAPA).

The Rehabilitation Act of 1973 also served as a promoter of OAPs and later EAPs as it forbid workplaces with federal contracts and grants of more than \$2,500 to discriminate against employees with physical or emotional problems or disorders. This resulted in higher utilization of EAPs for employees seeking support services for alcohol and drug abuse, in addition to mental health problems. During the 1980s, OAPs expanded to cover a wide array of personal and work-related problems and OAPs were renamed Employee Assistance Programs (EAPs). The passage of The Drug-Free Workplace Act of 1988 and its subsequent amendments spurred further growth of EAPs as they offered expertise and guidance for the management of employees with substance abuse problems.

As EAPs continued to grow in popularity within the United States, so did the advent of managed care for behavioral health problems. Beginning in the early 1990s, managed behavioral care (MBC) companies partnered with EAPs to provide care that is more continuous. EAPs took on an initial assessment and advocacy role to help employees determine the appropriate level of care and treatment plan, as well as to advocate for care and reduce barriers for employees to access mental health benefits. As EAPs became more accepted within public and private workplaces, they continued to expand their services to meet the changing needs of employees and employers. Services broadened to cover issues such as work-life balance, elder care, workplace violence, and supporting companywide changes, such as mergers and downsizing.

Assessment and Brief Counseling. One of the most defining services EAPs offer is direct, confidential, short-term problem resolution or counseling to individual employees and often their family members. A critical skill of the EA professional is his or her ability to assess underlying problems that are not always presented as the cause for work-related, personal-related, or other mental health complaints. Because EAPs work with diverse populations on a daily basis, EA professionals must be savvy enough with regard to objective assessment and procedures to uncover hidden problems that are often the underlying cause of presenting symptoms and complaints. It is typical for employees to present to the EAP with the problem being related to their family or work. After a proper and comprehensive clinical assessment, it may be revealed that other, sometimes more troubling issues are also involved, such as a drinking problem, a gambling addiction, or an undiagnosed depressive disorder.

Work Performance Focus. How an individual's personal problems may be affecting his or her ability to function at work is another key component of the EAP assessment. With every client, EA professionals assess not only the individual's health, mental health, and overall

personal well-being but also how individual and personal problems affect productivity and work performance. The most common initial reason employees seek help from an EAP is for personal relationship/marital problems.

More Than Mental Health. More recently, employees have been coming to EAPs for problems related to or exacerbated by financial and legal problems, for which EAPs usually provide consultative and educational services (Wilburn, 2007). Additional problems commonly addressed by EAPs include work and other personal relationships, mental health (depression and anxiety), stress, substance abuse and other addiction problems, child/parenting concerns, and other emotional issues. Selvik, Stephenson, Plaza, and Sugden (2004) reported that 60% of EAP clients were assessed as having depression, anxiety, or other mental health problems.

Management Services. While perhaps better known for their provision of direct services to employees, EAPs also provide support services to managers and supervisors. Services such as management consultation and organizational programs are often considered more important to both employers and the EAP, as they tend to be the types of services that reach the most troubled employees and, when handled appropriately, provide the best return-on-investment (ROI). For managers and supervisors, as well as the broader work organization, EAPs provide a wide array of organizational solutions and services ranging from education and training to health fairs and screenings, to crisis intervention and consultation to managers and supervisors regarding dealing with troubled employees, new policies related to behavioral health, and much more.

One of the original core technology functions that all EAPs are expected to provide is consultation to managers and supervisors. This is often provided through education about constructive confrontation and other ways to interact with troubled employees often resulting in a referral to the EAP. Although the majority of contacts made by employees to the EAP are

through “self-referral,” EAPs and businesses place a high priority on their ability to support managers in making supervisory referrals to the EAP for employees who have been observed as having work performance and/or productivity issues. EAPs use supervisory orientation and training to educate newly hired and seasoned managers about EA services (Csiernik, 2003; Donahoe, Johnson, & Taquino, 1998; Hreceniuk, 2008; Weiss, 2003; Willbanks, 1999). EA services supporting managers and supervisors, specific to constructive confrontation and referral of a troubled employee to the EAP, are critical elements of any successful EAP. These same problems are often quite challenging for supervisors lacking the guidance of an EAP (Harrison, 1982). When these difficult employee/manager situations are handled appropriately, results for both the troubled employee and the workplace have been positive and cost-effective (Besenhofer & Gerstein, 1991; Boone, 1995; Hargrave, Hiatt, Dannenbaum, & Shaffer, 2007; Hiatt, Hargrave, & Palmertree, 1999; Keaton & Yamatani, 1993).

Organizational Services. EAP services are also provided at the organizational level, either to the entire company or to smaller business units within the work organization. Some of these services include advance planning and immediate response services for crisis events (e.g., accidents, violence, and natural disasters) and leading group interventions and support groups, companywide educational programs, and supporting other internal areas with planning and implementing policy and programmatic changes. Other organizational roles for EAPs involve interacting with union leaders and members and benefit coordinators, such as work-life, health and wellness, drug-free workplace training and mandatory referrals, and outplacement. EAPs also work with managers and supervisors around organizational issues that may result from pending or actual change in the workplace or related workforce development issues. Specific services around these issues include providing guidance regarding how to appropriately support

employees during times of organizational change, supporting return-to-work and work accommodation efforts, offering performance management guidance for managers, training and education, and other consulting and coaching services, disability management, and risk management services.

Crisis Services. Because of their use of systems theory and ability to view the workplace at multiple levels-the micro level with individuals and the macro level with the organization-EAPs are well-suited to work with employees and employers at all stages of crisis. EAPs received increased recognition by workplace leaders after they provided support to thousands of individuals and groups following the World Trade Center terrorist attacks on September 11, 2001. Following these events and subsequent incidents of violence and terrorism, EAPs saw a surge of utilization among employees seeking crisis support and short-term assistance but not necessarily in need of formal and long-term mental health services (Ellin, 2001). Using a continuum model to assess and respond to the workplace's changing needs, EAPs can work with an organization before, during, and after a crisis (Everly & Mitchell, 2008; Jacobson, Paul, & Blum, 2005). A multi-component, multi-phased response to workplace critical incidents guides EAP interventions according to the principles of Critical Incident Response (CIR) to address the psychological aftermath of an incident of mass violence and/or disaster. Workplace CIR models include preventative training and risk assessment, immediate response for victims including psychological first aid (Brymer et al., 2006), critical incident stress management (Everly & Mitchell, 2008), individual assessment and support, group intervention, management consultation, and post-incident response such as ongoing support, assessment, and evaluation.

Additional consultation to the workplace regarding preparedness, crisis communication, and strategic response has been viewed by management as a primary benefit offered by EAPs

(Ottenstein & Jacobson, 2006; VandePol, Gist, Braverman, and Labardee, 2006). Research on the cost-effectiveness of crisis preparation and workplace services by EAPs has been largely positive, particularly regarding outcomes of avoiding trauma-related costs in employee disability leave and shorter duration periods before return to work after a critical incident (Attridge & VandePol, 2010).

EAP Delivery Models. Employees and managers often have the choice as to whether they access EA services in-person, via phone, or-less often but increasing-via web-based technologies. Usually this choice depends on the type of EAP offered or the EAP model. Currently, several kinds of operating models exist from which companies can purchase EA services. The model of EA services is important as it directly impacts the type of service provided and often the relationship the EAP has with the broader work organization. The more traditional EAP model is referred to as an “internal” EAP. Internal EA professionals are employed by the company or work organization offering the EAP.

As outsourcing benefits and other workplace programs such as EAPs became popular in the 1990s and continues today, EAPs integrated with larger managed behavioral health companies, functioning as contractors to the workplace to provide EAP services. This is referred to as an “external” model of EA service delivery and is currently the most popular model within the United States today (Merrick et al., 2003; Rothermel et al., 2008). Two additional models of EA service delivery include the “combination” or “hybrid” EAP that typically began as an internal EAP and expanded services to be offered to other workplaces, as well as the “consortium” model, which describes a situation when several smaller companies share the cost of purchasing the EAP.

Researchers have attempted to compare outcomes from the various models of EAPs and, while empirical research is limited, some key differences have been noted. Rather than employ full-time clinical staff, external EAPs typically rely on affiliates or subcontracted counselors to provide the majority of the mental health and counseling services. These professionals are part of a network arrangement and work in the same geographic areas where the employee population for the workplace is located. In most contexts, these counselors or affiliates are not full-time employees of the EAP and they are often licensed clinical social workers, counselors, psychologists, or marriage and family therapists. Affiliates perform EAP work on behalf of EAP vendors in a variety of settings offsite from the workplace, such as in private practices, health care agencies, and hospital-based mental health clinics. Depending on how the EAP is contracted, the degree of onsite presence with the external EAP model is variable-but often lower than with internal EAP models. Perceived benefits of the external EAP model include increased perception of confidentiality, increased ability to address problems across the country and globally, and increased attention to quality assurance and cost-effectiveness (Masi et al., 2002). Additional studies suggest that internal EAP models provide increased numbers of face-to-face counseling sessions for employees; however, external programs see increased numbers of family members (Jacobson, 2009).

Service Delivery Channels. Due to the physical distance between the external EAP and the workplace, the use of telephone-based EAP counseling service is often emphasized and 24-hour access is almost always offered. Additionally, EAP websites often include information and services that can be used by employees and their family members from any computer. A consequence of this primarily offsite approach is that the use of the EAP for management consultations and other workplace or organizational services tends to be lower when compared to

internal or onsite EAPs and oftentimes the number of management referred clients and serious substance abuse cases are lower (Amaral, 2008).

Research. For most of their existence, EAPs have relied on anecdotal evidence with limited empirical data to support outcomes from clinical and organizational interventions. Improvement resulting from to EAP counseling interventions were traditionally measured through self-report surveys of client satisfaction (Csiernik, 2003; Csiernik, Hannah, & Pender, 2007; Dersch, Shumway, Harris, & Arredonondo, 2002; Harris, Adams, Hill, Morgan, & Soliz, 2002; Philips, 2004) and sometimes basic indicators of mental health and well-being, such as the Global Assessment of Functioning (GAF) (American Psychiatric Association, 2000; Jacobson & Jones, 2010) or other more general level of functioning scales (Back-Tamburo, 2005; Greenwood, DeWeese, & Inscoc, 2005; Hargrave & Hiatt, 2004; Harris et al., 2002; Masi & Jacobson, 2003; Selvik et al., 2004). Although several key research-based books and texts on EAPs exist (Attridge et al., 2005; Oher, 1999; Richard, Emener, & Hutchinson, 2009), the empirical research base for the EA field is limited. Additional 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).

Service Utilization Issues. One area of research suggests that EAP service utilization and impact rate is relatively limited with face-to-face utilization for counseling services averaging 3% to 5% each year (Amaral, 2008; EASNA, 2009). This raises questions about whether or not employees in the most need are actually accessing and using services. Some EAPs report that individuals who self-refer to the EAP often do so for mild to moderate problems that cause acute stress (e.g., family/marital issues, legal problems, financial concerns), rather than for serious mental health disorders and substance abuse. One of the major limiting factors to EAP use is that

stigma and discrimination for mental health and addiction problems is widespread. This may result in many employees who could benefit from professional help do not seek help because of fears of discrimination or shame at work. One of the successes of the onsite EAPs is that when mental health professionals are on staff at the worksite and interacting with management and employees on a regular basis, it can lead to greater acceptance of these complex issues, and the negative impact of mental health and substance abuse stigma is minimized.

Clinical Best-Practices. Given the recent push to develop best practice and evidence-based practice, the EAP field has expanded its breadth of research as it tries to better understand which specific interventions are most appropriate and effective for various employee problems. For example, EAPs have been studying the application of psychological first aid following workplace critical incidents and disasters (Ruzek, 2007; VandePol, Labardee, & Gist, 2006) and cognitive-behavioral therapy for employees with mild depression and/or stress-related illnesses (Wang, Simon, & Kessler, 2008). With regard to alcohol abuse, one emerging evidence-based medical practice being applied and evaluated within the EAP field is the application of Screening, Brief Intervention, and Referral to Treatment (SBIRT), being used by EAPs to “identify and manage risky and hazardous alcohol use and dependence” within the workplace (McPherson et al., 2009, p. 287).

Disability and Return-to-Work. Another promising trend for EAP research is to examine the effects of EAP collaboration with Disability Management and Return-to-Work (RTW) programs for employees with primary or co-morbid mental health conditions (Attridge & Wallace, 2010). Implementing a RTW program can meet the employer’s duty to accommodate and facilitate the return of disabled employees to the workplace. These programs are based on the philosophy that people can safely perform progressively more demanding levels of work

while also participating in the process of recovery and getting medical and/or mental health care for their problem. Workplace accommodations can be done in many areas for when the employee is back at work, either part time or full time. It is common for such accommodations to be modified or even discontinued as the employee recovers. EAPs can serve a valuable role in coordinating such care and supporting the employee and their family through this transitional period. It is particularly important for the EAP to be involved in supporting the employee's RTW due to the high overlap of behavioral health conditions and stress-induced illness issues with other chronic medical problems.

Productivity Measurement. The impact the EAP has on the larger work organization can be challenging to objectively measure. A recently developed standardized measure to assess work performance outcomes related to the EAP and the field of Health and Productivity Management (Kramer & Rickert, 2006) is the use of the Health and Productivity Questionnaire (HPQ; Kessler et al., 2003; 2004). The HPQ measures the impact of chronic illness on productivity using measures of presenteeism and absenteeism—two important outcomes for EAPs (Jacobson, 2009; Jacobson & Parry, 2009; Rothermel et al., 2008). With norms from more than 200,000 employees worldwide, the HPQ is considered a reliable and valid measure for use in the workplace (Kessler et al., 2003; 2004). A shorter, more workplace-friendly version of the HPQ, the HPQ-Select, administered by the Integrated Benefits Institute (IBI), is leading the way in corporate benchmarking in health and productivity. The HPQ-Select is currently being adopted by many EAPs that are working to combine their operational experiences in a large international reporting database (Amaral, 2008; Jacobson & Parry, 2009).

Workplace Outcomes. Studies show that, when appropriately administered to emphasize the EAP core technology components (Roman & Blum, 1988), EAP services produce positive

clinical change, as well as contribute to better work-related outcomes such as reduced absenteeism and turnover, increased productivity, and cost savings in medical, disability, or workers' compensation claims (Attridge & Amaral, 2002; Harlow, 2006; Hargrave, Hiatt, Alexander, & Shaffer, 2008; McLeod, 2001; McLeod & Henderson, 2003; Yandrick, 1992). Research consistently shows improvement of presenteeism-related problems, both from EAPs with traditional onsite models to those using external models with increased reliance on phone contact between the employee and the EA professional. For example, a study of almost 60,000 EAP cases found that employee absenteeism was reduced from an average of 2.37 days of unscheduled absences or tardy days in the prior 30-day period before using the EAP to only 0.91 days after completing use of EA services (Selvik et al., 2004).

Referral and Case Management. Some studies suggest that EAPs are particularly effective at helping employees with behavioral health and substance abuse issues navigate successfully through the many treatment options available. EAPs are also well-suited to provide longer-term follow-up support and case-management assistance after treatment to reduce the likelihood of relapse and improve the overall RTW process (Cook & Schlenger, 2002). A survey of more than 800 EA professionals, experienced in the delivery of EAP services for employees struggling with alcohol problems, reported that almost 90% of EAP clients referred out of the EAP and into community treatment for alcohol and drug treatment were successful in completing their recommended specialized treatment (Attridge, 2003).

Cost-Benefit. Several studies have objectively demonstrated the cost-benefit of EAPs (Attridge & Amaral, 2002; Blaze-Temple & Howat, 1997; Christie & Harlow, 2007; Jorgensen, 2007; McDaid, 2008). Researchers have reported typical ROI estimates being \$3 or more (up to \$10) return for every \$1 dollar invested in the EAP (Dainas & Marks, 2000; Hargrave & Hiatt,

2004; Hargrave et al., 2008; Jorgensen, 2007; Philips, 2004). According to the National Business Group on Health, “a well-run EAP will provide a positive return on investment” (Rothermel et al., 2008, p. 8).

Implications for Research and Future Practice

EAP as a Profession. EAP is a multidisciplinary field with a large percentage of EA professionals holding advanced or graduate degrees in social work or psychology (Jacobson, 2006). Application of EAP services using a strengths perspective or application of ecological theory has been suggested as a method for continuing to provide vital services to the workplace in the future (Christensen, Todahl, & Barrett, 1999; Maiden, 2001; Van Den Bergh, 2000). Despite their popularity and continued growth among businesses, the EAP field is suffering from a shortage of trained EA professionals, as there is currently only one graduate school with a master’s program dedicated to preparing social work graduates for the EAP field (Jacobson & Hosford-Lamb, 2008; Masi, 2002). This lack of professional education and knowledge foundation presents a real challenge to developing leaders and researchers who will advance the EAP field (Masi; Pompe & Sharar, 2008).

Certification of Individuals. Lacking a formal discipline, EAPA created an independent certification procedure for EA professionals. The Certified Employee Assistance Professional (CEAP) is a voluntary credential that identifies individuals as EA professionals who have met established standards for EA practice, adhering to the EAPA Code of Ethics (2009) and Standards of Practice (EAPA, 2010b). More than 5,000 individuals have earned the CEAP designation through EAPA (EAPA, 2006). The CEAP credential is not without its criticism, as the EA field struggled to come to consensus regarding the level of professionalism required to provide direct EA services (Sharar, White, & Funk, 2002).

Accreditation of Programs. In addition to individual certification, the EA field has a voluntary accreditation process to ensure an EAP demonstrates its ability to meet specific minimum standards for quality practice and to ensure that EA professionals have the required qualifications and levels of experience to provide quality services (Haaz, Maynard, Petrica, & Williams, 2003). EAP accreditation standards were created in 2001 by the Employee Assistance Society of North America (EASNA), in partnership with the Council on Accreditation (COA) (Stockert, 2004). While no longer administered by EASNA, the accreditation process provided by the COA includes a comprehensive self-study followed by an onsite review conducted by trained and experienced EAP peer reviewers. These COA accreditation standards are now in their eighth edition and include 12 primary components with more than 50 sub-areas. To date, 57 EAP programs have been accredited by COA: 13 organizations that provide primarily EA services and 44 multiservice organizations that offer EAP services as well as other kinds of services.

Globalization. The EA concept, initiated and popularized within the United States, continues to be a model program that is duplicated in countries around the world. The specifics of how EA is defined and used vary based on the country's legal system, culture, health care system, resources for mental health and substance abuse, and views toward addiction and recovery as well as behavioral health and work-life balance (Masi, 2005; Masi & Tisone, 2010). For example, EAPA member chapters are located in Australia, Canada, Greece, Ireland, Japan, South Africa, and the United Kingdom in addition to more recent development activity in Chile and China. The EASNA organization hosts its annual institute on an alternating basis between cities in Canada and the United States. With all this global interest in EAP, the profession has a

strong future and many opportunities for positive change and evolution (Burke, 2008; Masi & Tisone, 2010).

Technology. There is an increasing reliance on employee outreach through innovative practice modalities (Richard, 2009). Phone- and web-based services have allowed many employees to become more familiar with the purpose of EAPs. EAP websites are becoming more elaborate and now typically offer access to provider lists, tip sheets, educational webinars, and self-assessment tools. The stigma associated with addressing addictions and delivering prevention programs through the Internet, where it can be accessed at any time, with relative anonymity, might reduce mental health issues (Masi, Freedman, Jacobson, & Back-Tamburo, 2002). Although only a small percentage of EAP clients receive clinical services through the Internet, the use of online or web-based counseling between EAP clinicians and employees is rapidly advancing as a new practice model (Parnass et al, 2008).

Like other businesses, EAPs have not been spared the negative stress and strain caused by the recent economic recession. As businesses struggle to do more with less, they have placed increased pressure on benefits providers, including EAPs, to offer more cost-effective services. While EAP utilization is higher than ever, employers are looking for ways to cut costs. One way to provide services at a potentially lower cost is through phone and online counseling. Although cost-savings are potentially of value, these practices are now a wide-open field in much need of standardization and training for a host of ethical and legal issues (Centore, 2007; Jones & Stokes, 2009).

Continued Integration with Work-Life, Wellness, and Health Promotion Programs. As mentioned earlier in this article, EAPs that partner and collaborate with work-life programs, occupational health and medical programs, and other organizational departments significantly

increase their scope of services. Historically, EAPs have been in the forefront of wellness and prevention since their inception. This historical focus provides a foundation for the EAP's strong role in the current prevention, health promotion, and worksite wellness focuses that are a part of the far-reaching health care reform initiative and Affordable Care Act.

Additionally, the overall workplace impact is enhanced through various strategies for assisting troubled employees through consultation regarding disability benefits, EAP participation in disease management cases with co-morbid behavioral health problems, training for staff who provide health risk appraisals, and collaboration with management to identify and support employees who may be struggling with personal problems that affect their work performance and/or productivity. Strong evidence exists supporting 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 (Parks & Steelman, 2008). Also important are the findings from a recent survey that found that the majority of EA professionals consider prevention to be a core component of their professional identity and that about one-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%).

Conclusion

This chapter provided an overview to the multifaceted and fast-changing field of EA. What the future will look like will depend on the emerging needs of employers, employees, family members, and broader communities. What we do know is that EAPs are a respected workplace benefit for both employees and employers and they are likely to continue to grow and

adapt as businesses are pressured to increase productivity, while at the same time supporting a healthy and safe workforce. Individual employees will continue to struggle to balance competing work-life demands and EA professionals will be there to support them in evaluating problems and potential solutions, identifying and accessing resources, and advocating as a change agent within the workplace. It is clear that EAP and other work-life programs benefit from partnering with each other to move forward as a vital resource to today's workplace. These two fields are also ripe with potential for research in the development and testing of evidence-based practice.

References

Amaral, T. M. (2008, April). *Global benchmarking: Implications of research data for EAP best practices*. Paper presented at the Annual Institute of the Employee Assistance Society of North America, Vancouver, BC, Canada.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders*, (4th ed.). Washington, DC: Author.

Attridge, M. (2003, November). *EAPs and the delivery of alcohol and drug services: Results of the EAPA/Join Together 2003 survey of EAPA members*. Paper presented at the Annual Conference of the Employee Assistance Professionals Association, New Orleans, LA.

Attridge, M., & Amaral, T. M. (2002, October). *Making the business case for EAPs with the core technology*. Paper presented at the Annual Conference of the Employee Assistance Professionals Association, Boston.

Attridge, M., Herlihy, P., & Maiden, P. (Eds.). (2005). *The integration of employee assistance, work/life, and wellness services*. Binghamton, NY: Haworth Press.

Attridge, M., & VandePol, B. (2010). The business case for workplace critical incident response: A literature review and some employer examples. *Journal of Workplace Behavioral Health*, 25(2), 132-145.

Attridge, M., & Wallace, S. (2010). *Able-minded: Return to work and accommodations for workers on disability leave for mental disorders*. Vancouver, BC, Canada: Human Solutions. Retrieved from http://www.humansolutions.ca/www/docs/HSreport_10.pdf on May 1, 2010.

Back-Tamburo, M. (2005). *An examination of clinical outcomes from employee assistance program and work/life product integration*. (Doctoral dissertation). University of Maryland, School of Social Work, Baltimore.

Bennett, J. B., & Attridge, M. (2008). Adding prevention to the EAP core technology. *Journal of Employee Assistance*, 38(4), 3-6.

Besenhofer, R. K., & Gerstein, L. H. (1991). Referrals to employee assistance programs (EAPs): Characteristics of hypothetical supervisors, EAPs, and substance abusing workers. *Employee Assistance Quarterly*, 7(2), 41-62.

Blaze-Temple, D., & Howat, P. (1997). Cost benefit of an Australian EAP. *Employee Assistance Quarterly*, 12(3), 1-24.

Boone, C. M. (1995). The effectiveness of EAP supervisory training. *Employee Assistance Quarterly*, 11(1), 17-27.

Brymer, M., Jacobs, A., Layne, C., Pynoos, R., Ruzek, J., Steinberg, A., Vernberg, E., & Watson, P. (2006). *Psychological first aid: Field operations guide*. Washington, DC: U.S. Department of Health and Human Services. Retrieved from http://www.ptsd.va.gov/professional/manuals/manual-pdf/pfa/PFA_2ndEditionwithappendices.pdf on May 1, 2010.

Burke, J. (2008, April). *The current global view of EAPs and the opportunity for tomorrow*. Paper presented at the Annual Institute of the Employee Assistance Society of North America, Vancouver, BC, Canada.

Centore, A. J. (2007). *The therapist's clinical guide to online counseling and telephone counseling: The definitive training guide for clinical practice*. Cambridge, MA: Author.

Christensen, D. N., Todahl, J., & Barrett, W. (1999). *Solution-based casework: An introduction to clinical and case management skills in casework practice*. New York: Aldine DeGruyter Press.

Christie, J., & Harlow, K. (2007). Presenting the business case. *Journal of Employee Assistance*, 37(3), 21-23.

Cook, R. F., & Schlenger, W. (2002). Prevention of substance abuse in the workplace: Review of research on the delivery of services. *Journal of Primary Prevention*, 23, 115-142.

Csiernik, R. (2003). Employee assistance program utilization: Developing a comprehensive scorecard. *Employee Assistance Quarterly*, 18(3), 45-59.

Csiernik, R. (2005). What we are doing in the Employee Assistance Program: Meeting the challenge of an integrated model of practice. *Journal of Workplace Behavioral Health*, 21(1), 11-22.

Csiernik, R., Hannah, D., & Pender, J. (2007). Change, evolution, and adaptation of a university EAP: Process and outcome at the University of Saskatchewan. *Journal of Workplace Behavioral Health*, 22(2/3), 43-56.

Dainas, C., & Marks, D. (2000). Abbott Laboratories' EAP demonstrates cost-effectiveness through two studies and builds the business case for program expansion. *Behavioral Health Management*, 20(4), 34-41.

Dersch, C. A., Shumway, S. T., Harris, S. M., & Arredonondo, R. (2002). A new comprehensive measure of EAP satisfaction: A factor analysis. *Employee Assistance Quarterly*, 17(3), 55-60.

Donahoe, T. L., Johnson, J. T., & Taquinoa, M. A. (1998). Self-disclosure as a predictor of EAP supervisory utilization. *Employee Assistance Quarterly*, 14(2), 1-9.

Ellin, A. (2001, September 30). Personal business; traumatized workers look for healing on the job. *New York Times*. Retrieved from

<http://www.nytimes.com/2001/09/30/business/personal-business-traumatized-workers-look-for-healing-on-the-job.html?pagewanted=1> on December 1, 2001.

Employee Assistance Professionals Association (EAPA). (2006). *EAPA standards and professional guidelines for employee assistance programs - Addendum: Toward the standardization of employee assistance measures*. Arlington, VA: Author. Retrieved from: <http://www.eapassn.org/files/public/utilization06.pdf> on January 1, 2009.

Employee Assistance Professional Association (EAPA). (2009). *EAPA Code of Ethics*. Retrieved from <http://www.eapassn.org/files/public/EAPAcodofethics0809.pdf> on September 1, 2010.

Employee Assistance Professionals Association (EAPA). (2010a). The core technology of EAP. Arlington, VA: Author. Retrieved from <http://www.eapassn.org/i4a/pages/index.cfm?pageid=521> on May 1, 2010.

Employee Assistance Professionals Association (EAPA). (2010b). *EAPA standards and professional guidelines for employee assistance programs*. Arlington, VA: Author. Retrieved from <http://www.eapassn.org/i4a/pages/index.cfm?pageid=804> on May 1, 2010.

Employee Assistance Professionals Association (EAPA). (2010c). *What is an employee assistance program (EAP)?* Arlington, VA: Author. Retrieved from <http://www.eapassn.org/i4a/pages/index.cfm?pageid=869> on May 1, 2010.

Employee Assistance Society of North America (EASNA). (2009). *Selecting and strengthening Employee Assistance Programs: A purchaser's guide*. Arlington, VA: Author. Retrieved from www.easna.org/publications on May 1, 2010.

Employee Assistance Society of North America (EASNA). (2010). *EASNA website*. Retrieved from <http://www.easna.org> on May 1, 2010.

Everly, G. S., & Mitchell, J. T. (2008). *Integrative crisis intervention and disaster mental health*. Ellicott City, MD: Chevron Publishing Corporation.

Goetzel, R., & Ozminkowski, R. (2006). Integrating to improve productivity. *Journal of Employee Assistance*, 36(4), 25-28.

Greenwood, K. L., DeWeese, P., & Inscoc, P. S. (2005). Demonstrating the value of EAP services: A focus on clinical outcomes. *Journal of Workplace Behavioral Health*, 21(1), 1-10.

Haaz, E., Maynard, J., Petrica, S., & Williams C. (2003). Employee assistance program accreditation: History and outlook. In R. P. Maiden (Ed.), *Accreditation of employee assistance programs* (pp. 1-26). New York: Haworth Press.

Hargrave, G. E., & Hiatt, D. (2004). The EAP treatment of depressed employees: Implications for return on investment. *Employee Assistance Quarterly*, 19(4), 39-49.

Hargrave, G. E., Hiatt, D., Alexander, R., & Shaffer, I. A. (2008). EAP treatment impact on presenteeism and absenteeism: Implications for return on investment. *Journal of Workplace Behavioral Health*, 23(3), 283-293.

Hargrave, G. E., Hiatt, D., Dannenbaum, S. E., & Shaffer, I. A. (2007). Effectiveness of a telephone-based EAP anger management program for referred employees. *Journal of Workplace Behavioral Health*, 22(4), 17-27.

Harlow, K. C. (2006). The effectiveness of a problem resolution and brief counseling EAP intervention. *Journal of Workplace Behavioral Health*, 22(1), 1-12.

Harris, S. M., Adams, M., Hill, L., Morgan, M., & Soliz, C. (2002). Beyond customer satisfaction: A randomized EAP outcome study. *Employee Assistance Quarterly*, 17(4), 53-61.

Harrison, E. L. (1982). Training supervisors to discipline effectively. *Training and Development Journal*, 36(11), 111-113.

Henderson, R. M., & Bacon, S. D. (1953). Problem drinking: The Yale plan for business and industry. *Journal of Studies on Alcohol, 14*(2), 247-262.

Herlihy, P., & Attridge, M. (2005). Research on the integration of employee assistance, work/life and wellness services: Past, present and future. *Journal of Workplace Behavioral Health, 20*(1-2), 67-93.

Herlihy, P., Attridge, M., & Turner, S. P. (2002). The integration of employee assistance and work/life programs. *EAPA Exchange, January/February*, 10-12.

Hiatt, D., Hargrave, G., & Palmertree, M. (1999). Effectiveness of job performance referrals. *Employee Assistance Quarterly, 14*(4), 33-43.

Hreceniuk, T. (2008, April 21). The business case for tackling mental health. *Canadian HR Reporter, 21*(8), 26.

International Foundation of Employee Benefit Plans. (2005, August). Benefits and compensation glossary, 11th Edition. Brookfield, WI: Author.

Jacobson, J. M. (2006). Compassion fatigue, compassion satisfaction, and burnout: Reactions among employee assistance professionals providing workplace crisis intervention and disaster management services. *Journal of Workplace Behavioral Health, 21*(6), 133-152.

Jacobson, J. M. (2009, August). *Moving away from silos: Integrating health, safety, and productivity at the U.S. Department of Energy*. Presentation at the 2009 Department of Energy/National Nuclear Safety Administration (DOE/NNHS) Integrated Safety and Management Conference, Knoxville, TN.

Jacobson, J. M., & Hosford-Lamb, J. (2008). Working it out: Social workers in employee assistance. *Social Work Today, 8*(2), 18-23.

Jacobson, J. M., & Parry, T. (2009, April). *Health and productivity management: Recommendations to the U.S. Department of Energy*. Presentation for the U.S. Department of Energy Occupational Medicine EFCOG Group, Chicago.

Jacobson, J. M., Paul, J., & Blum, D. (2005). The EAP workplace critical incident continuum. *The Journal of Employee Assistance*, 32(2), 28-30.

Jacobson, J. M., & Jones, A. (2010). Standards for the EAP profession: Isn't it time we all start speaking the same language? *Journal of Workplace Behavioral Health*, 25(1), 1-18.

Jones, G., & Stokes, A. (2009). *Online counseling: A handbook for practitioners*. New York: Palgrave MacMillan.

Jorgensen, D. G. (2007). Demonstrating EAP value. *Journal of Employee Assistance*, 37(3), 24-26.

Kanter, R. (1977). *Work and family in the United States: A critical review and agenda for research and policy*. New York: Sage Publications.

Keaton, B., & Yamatani, H. (1993). Benefits of mandatory EAP participation: A study of employees with last chance contracts. *Employee Assistance Quarterly*, 9(11), 67-77.

Kessler, R. C., Ames, M., Hymel, P. A., Loeppke, R., McKenas, D. K., Richling, D., et al. (2004). Using the World Health Organization Health and Work Performance Questionnaire (HPQ) to evaluate the indirect workplace costs of illness. *Journal of Occupational and Environmental Medicine*, 46(6), 523-537.

Kessler, R. C., Barber, C., Beck, A., Berglund, P., Cleary, P. D., McKenas, D., et al. (2003). The World Health Organization Health and Work Performance Questionnaire (HPQ). *Journal of Occupational and Environmental Medicine*, 45(2), 156-174.

Kramer, R. M., & Rickert, S. (2006). Health and Productivity Management: Market opportunities for EAPs. *Journal of Employee Assistance*, 36(1), 23-33.

Maiden, R. P. (2001). The evolution and practice of occupational social work in the United States. *Employee Assistance Quarterly*, 17(1/2), 119-161.

Masi, D. A. (2002). Professional education: The key to developing conceptual thinking. *EAP Exchange*, 32(3), 23-25.

Masi, D. A. (Ed.). (2005). *The international employee assistance compendium, 3rd Edition*. Boston: MASI Research Consultants, Inc.

Masi, D. A., Altman, L., Benayon, C., Healy, H., Jorgensen, D. G., Kennish, R., et al. (2002). Employee assistance programs in the year 2002. In R. W. Manderscheid & M. J. Henderson (Eds.), *Mental Health, United States, 2002*. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2004. DHHS Publication Number: SMA 3938. Retrieved from <http://mentalhealth.samhsa.gov/publications/allpubs/SMA04-3938/default.asp> on May 1, 2010.

Masi, D. A., Freedman, M., Jacobson, J. M., & Back-Tamburo, M. (2002). *Utilization factors and outcomes for EAP and Work-Life programs: Comparing face-to-face, telephone, and online service experiences*. Baltimore: The University of Maryland.

Masi, D., & Jacobson, J. M. (2003). Outcome measurement of an integrated employee assistance and work-life program. *Research on Social Work Practice*, 13(4), 451-467.

Masi, D., & Tisone, C. (2010). *Fourth international employee assistance compendium*. Boston: Masi Research Consultants.

McDaid, D. (2008). *Mental health in workplace settings*. Consensus paper. Luxembourg: European Communities. Retrieved from http://ec.europa.eu/health/ph_determinants/life_style/mental/docs/consensus_workplace_en.pdf on May 1, 2010.

McLeod, J. (2001). *Counselling in the workplace: The facts. A systematic study of the research evidence*. Rugby: British Association for Counselling and Psychotherapy.

McLeod, J., & Henderson, M. (2003). Does workplace counselling work? *British Journal of Psychiatry*, 182, 103-104.

McPherson, T. L., Goplerud, E., Olufokunbi-Sam, D., Jacobus-Kantor, L., Lusby-Treber, K. A., & Walsh, T. (2009). Workplace alcohol screening, brief intervention and referral to treatment (SBIRT): A survey of employer and vendor practices. *Journal of Workplace Behavioral Health*, 24(3), 285-306.

Mercer. (2008). *Mercer 2007 national survey of employer-sponsored health plans*. New York: Author. Retrieved from <http://www.mercer.com/home.htm> on January 1, 2009.

Merrick, E., Horgan, C., Garnick, D., Hodgkin, D., Keck, K., & Cenczyk, R. (2003). The EAP/Behavioral health carve-out connection. *Employee Assistance Quarterly*, 18(3), 1-13.

Oher, J. M. (Ed.). (1999). *The employee assistance handbook*. New York: Wiley.

Ottenstein, R., & Jacobson, J. M. (2006). A seat at the table: The EAP role in corporate disaster planning and response. *Journal of Employee Assistance*, 36(2), 13-15.

Parks, K. M., & Steelman, L. A. (2008). Organizational wellness programs: A meta-analysis. *Journal of Occupational Health Psychology*, 13(1), 58-68.

Parnass, P., Mitchell, D., Seagram, S., Wittes, P., Speyer, C., & Fournier, R. (2008, April). *Delivering employee eCounseling programs: Issues and experiences*. Paper presented at

the Annual Institute of the Employee Assistance Society of North America, Vancouver, BC, Canada.

Philips, S. (2004). Client satisfaction with university employee assistance programs. *Employee Assistance Quarterly*, 19(4), 59-70.

Pompe, J. C., & Sharar, D. (2008). Preparing for the challenges of research. *Journal of Employee Assistance*, 38(2), 7-9.

Richard, M. A. (2009). Cyberspace: The new frontier for employee assistance programs. In M. A. Richard, W. G. Emener, & W. S. Hutchison, Jr. (Eds.), *Employee assistance programs: Wellness/enhancement programming, 4th Edition*. (pp. 288-292). Springfield, IL: Charles C Thomas.

Richard, M. A., Emener, W. G., & Hutchison, W. S., Jr. (Eds.), (2009). *Employee assistance programs: Wellness/enhancement programming, 4th Edition*. Springfield, IL: Charles C Thomas.

Roman, P. M. (2007, May). *Underdeveloped workplace opportunities for Employee Assistance Programs*. Paper presented at the Annual Institute of the Employee Assistance Society of North America, Atlanta, GA.

Roman, P. M., & Blum, T. C. (1985). The core technology of employee assistance programs. *The ALMACAN*, 15(3), 8-9, 16-19.

Roman, P. M., & Blum, T. C. (1988). Reaffirmation of the core technology of employee assistance programs. *The ALMACAN*, 19(8), 17-22.

Rothermel, S., Slavit, W., Finch, R. A., et al. (2008). *An employer's guide to employee assistance programs: Recommendations for strategically defining, integrating, and measuring employee assistance programs*. Washington, DC: National Business Group on Health, Center for

Prevention and Health Services. Retrieved from <http://www.easna.org/documents/PS2-NBGRRecommendationsforDefiningandMeasuringEAPs.pdf> on May 1, 2010.

Ruzek, J. I. (2007). Psychological first aid. *Journal of Mental Health Counseling, 29*(1), 17-33.

Selvik, R., Stephenson, D., Plaza, C., & Sugden, B. (2004). EAP impact on work, relationship, and health outcomes. *Journal of Employee Assistance, 34*(2), 18-22.

Sharar, D. A., Amaral, T. M., & Chalk, M. B. (2007, May). *The need for employer-driven EAP performance outcomes*. Paper presented at the Annual Institute of the Employee Assistance Society of North America, Atlanta, GA.

Sharar, D., White, W., & Funk, R. (2002). Business ethics and employee assistance: A national survey of issues and challenges. *Employee Assistance Quarterly, 18*, 2.

Society for Human Resources Management (SHRM). (2009a). *2008 employee benefits*. Washington, DC: Author. Retrieved from <http://www.shrm.org>

Society for Human Resource Management (SHRM). (2009b). SHRM Website. Retrieved from www.shrm.org/Research/Articles/Articles/Pages/CMS_004450.aspx on January 1, 2010.

Steel, P. (1989). A history of job-based alcoholism programs: 1955-1972. *Journal of Drug Issues, 19*, 511-532.

Stockert, T. J. (2004). The Council on Accreditation employee assistance program accreditation process. *Employee Assistance Quarterly, 19*(1), 35-44.

Swihart, D. L., & Thompson, D. A. (2002). Successful program integration. *EAPA Exchange, September/October*, 10-12.

Trice, H., & Schonbrunn, W. (1981). A history of job-based alcoholism programs: 1900-1955. *Journal of Drug Issues, 11*, 171-198.

U.S. Department of Labor, Bureau of Labor Statistics. (2008). *National compensation survey: Employee benefits in the United States*. Washington, DC: U.S. Government Printing Office. Retrieved from <http://www.bls.gov/ncs/> on May 1, 2010.

Van Den Bergh, N. (2000). Where have we been?... Where are we going?: Employee assistance practice in the 21st century. *Employee Assistance Quarterly*, 16(1/2), 1-13.

VandePol, B., Gist, R., Braverman, M., & Labardee, L. (2006). Strategic specialty partnerships: Enabling the EAP for evidence informed best practices in workplace crisis response. *Journal of Workplace Behavioral Health*, 21(3/4), 119-131.

VandePol, B., Labardee, L., & Gist, R. (2006). The evolution of psychological first aid. *Journal of Employee Assistance*, 36(2), 18-20.

Wang, P. S., Simon, G. E., & Kessler, R. C. (2008). Making the business case for enhanced depression care: The national institute of mental health-Harvard work outcomes research and cost-effectiveness study. *Journal of Occupational & Environmental Medicine*, 50(4), 468-475.

Weiss, R. M. (2003). Effects of program characteristics on EAP utilization. *Employee Assistance Quarterly*, 18(3), 61.

Willbanks, K. D. (1999). The role of supervisory referral in employee assistance programs. *Employee Assistance Quarterly*, 15(20), 13-28.

Wilburn, C. (2007). Helping employees with financial problems. *Journal of Employee Assistance*, 37(2), 12-13.

Willaman, M. (2001). What work-life/EAP meld means to plan sponsors. *Health Plans*, 17-19.

Yandrick, R. M. (1992). Taking inventory: Process and outcome studies. *EAPA Exchange*, July, 22-35.