Royal Canadian Mounted Police External Review Committee

Employee Assistance Programs -

Philosophy, theory and practice

DISCUSSION PAPER 5

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Royal Canadian Mounted Police
External Review Committee

The Committee publishes a series of discussion papers to elicit public comment to assist the Committee in the formulation of recommendations pursuant to the *Royal Canadian Mounted Police Act* (1986). The views expressed in this paper are not necessarily the views of the Committee.

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Royal Canadian Mounted Police
External Review Committee

Discussion Paper Series

Number 5: Employee Assistance Programs

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FOREWORD

This research paper is the fifth in a series produced by the Research Directorate of the RCMP External Review Committee for discussion purposes. This document is an abridged version of a more comprehensive paper prepared for the Committee by Shimon Dolan and Jacob Wolpin (Dolan & Wolpin, 1990).

The complete report, copies of which are available by writing to the Committee's Director of Research, consists of more than 200 pages of discussion, analysis, tables, and an extensive bibliography. As in this abridgement, the complete report discusses Employee Assistance Programs in general while making specific reference to both Canadian and police experience.

This document is a simplified report written for the decision makers. Its goal is to enable the reader to understand the complexity involved in choosing, implementing, evaluating and managing an EAP, particularly in the context of policing.

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Chapter I: The Increased Popularity of EAPS

Over the past 25 years, Employee Assistance Programs (EAPS) have grown dramatically in quantity, focus, scope and importance to all work organizations.[1] This new form of intervention has been implemented not only in the United States[2] but to varying degrees and in different packages in countries such as: Canada,[3] West Germany,[4] England,[5] New Zealand,[6] and Australia,[7] to name a few.

In varying forms EAPs have also been adopted by unions and by medical, legal and other professional societies as well as by most civilian federal workers in the United States (Roman et al., 1987). More than two decades ago, the Washington Business Group on Health suggested that EAPs would become the most effective and practical system/method for delivering mental health services to employees in the future (Goldbeck, 1978).

1.1 EAPS in Canada

According to numerous sources, there has been a robust growth of EAPs in Canada over the last two decades.[8] According to surveys conducted in British Columbia (Lynch, 1983) and Ontario (MacDonald & Dooley, 1989b), establishment of EAPs on worksites vary anywhere from 6 to 53 per cent, depending on the size of the organization. Interest continues to grow. In Canada, various branches of government, as well as health and education services, were found to be more likely to have EAPS, whereas the construction and retail trade sectors were found to be under-represented.

The growing need for EAPs has been repeatedly suggested by scholars and practitioners. For example, Sheppel (1989) argues that, in 1983 alone, Canadians lost 83 million days of work due to emotional and behavioral problems. Of the employees surveyed, 61 per cent reported emotional problems as the primary reason for absence from work. In addition, 65 to 80 per cent of employee terminations were due to personal rather than technical factors.

1.2 Purpose/Benefits of EAPs

After businesses and industries realized that human beings bring their health problems to work (Miller, 1984; 1985), and following a considerable rise in the incidence of mental and emotional difficulties (e.g., divorce, substance abuse, single parenthood, stress, depression) among the workforce,[9] corporations extended a helping hand to their work force through the creation of EAPs in order to serve the interests of both management and employees.[10]

The United States Bureau of National Affairs, in a special report (BNA, 1987), considered the following events to be major reasons for the growth of EAPs in the United States: federal seed money grants, broadening of workers' compensation/handicap coverage, expansion of benefits and a changing corporate culture. To this list, Roman and Blum (1988) added the perceived escalation of health care costs borne by employers and increased sensitivity to personal health and fitness, consistent with the goals of health promotion.[11]

It is important to note that EAPs developed with different purposes in mind will have different goals and definitions of success. These can be categorized as "benefit to the employee" (e.g., to reduce health risks, promote "welliness", improve quality of life) or "benefit to the employer' (e.g., to improve productivity and profits, resolve management problems, limit employer liability). However the literature suggests that the focus is shifting towards a more comprehensive "employer benefit".[12] These changes have "profound implications for the way EAPs are organized, staffed, and designed to function" (McClellan & Miller, 1988, p. 26).

1.3 EAPS in the Private and Public Sector

Job-based programs can be found in both private and public sectors, functioning "under various auspices: union, management, joint labour-management, or a consortium of several industrial organizations, or unions" (Straussner, 1988, p. 53).

In the private sector, EAPs are justified on an economic basis as well as on their assumed contribution to the company's human resources (Schmitz, 1983). Basically, EAPs in industry have two main goals: to prevent or detect all problems that affect work performance and to maintain or restore healthy (mental and physical) human resources. Major emotional and personal problems are addressed, including off-the-job problems when it is assumed that productivity might be affected, through counselling and supportive services. For this reason, financial, legal, marital and family problems, as well as substance abuse, are a real concern for organizations in the private sector. Consultation and education services are also offered. Training sessions regarding problems known to cause stress and impair performance (Gam et al., 1983a) can be held for all employees or for a selected group. Executive assistance and counselling programs may represent a new phenomenon which can be included as part of EAPS.

The four basic models of EAP may be characterized as follows:

1 **Alcohol/substance abuse** - Programs are located in corporate medical departments or self reference is made to an external contractual service centre. Many occupational alcoholism programs rely on staff comprised of recovered alcoholics (Schmitz, 1983). The current tendency, however, is to shift to expanding the program to address all substance abuse and to professionalizing these programs through the addition of licensed mental health staff.

2 **Information and referral** - The non-professionally based programs address a variety of employees' concerns such as legal, consumer, financial, child-care, housing and education matters. Along with personal-problems services, employees can also be referred to appropriate outside or internal helping resources or agencies. Professionally based programs, on the other hand, exclude direct counselling and psychotherapy, while providing diagnostic intake and referral to an appropriate treatment resource for employees.

3 **Executive counselling** - These programs address executive concerns through diagnostic intake, counselling, information and referral services. They cover all personal problem areas including, but not limited to, marital and family relations, interpersonal relations, emotional

difficulties and career concerns. Services are provided on-site or off-site, through medical or personnel department sponsorship, and by in-house staff or external consultants (Schmitz, 1983, p. 77).

4 **Comprehensive employee health and counselling** - The comprehensive model, according to Schmitz (1983), provides broadly based, integrated professional services that emphasize prevention and rehabilitation rather than treatment, and "wellness" rather than illness. The staff is trained to recognize multiple problems and is normally equipped to diagnose and deal with them through internal intervention or through referrals.

In the United States, the public sector seems to be lagging well behind the private sector in implementing EAPs (Talagrand, 1982). However, their number has increased in state and local governments (Kemp, 1985) and, since early to mid 1980s, there is a growing interest on the part of cities and towns in setting up EAPS.

Federal agencies in the United States operate a variety of EAP models. Some government agencies have their own EAPS, with services performed by in-house staff or qualified individuals brought in under contract; others use another federal agency's in-house program or contract, with yet another agency assuming contract leadership (Fisher, 1983). The selection of the model is mostly guided by the profile and geographical dispersion of the work population.

1.4 Character of EAP Users

Following a survey conducted in Canada and the United States by Braun and Novak (1986), the following attitudes, beliefs and feelings were identified by EAP directors as being held by users of program services: (a) confidence in the services provided by the EAP (20%), (b) openness to change (10%), (c) desire to seek services because of peer referral (10%), (d) perception of the EAP as free and convenient (7%), (e) belief that supervisors support EAP use (6%), (f) belief that EAP use is an alternative to job loss (5%), and (g) perception of a need for help (5%).

Chapter II: EAPs: History and Definition

As shown in Chapter I, even if the available data is not conclusive, there exists an important trend towards major growth in volume and importance for EAPs in the workplace.

2.1 Going Back 60 Years (the United States)

The historical background of the Employee Assistance Programs (EAPS) movement is blurred (Roman, 1988). It may have evolved partly out of Occupational/industrial Alcohol Programs,[13] or it may be traced to more general, job-based programs, e.g., social betterment, personnel counselling and occupational mental health.[14]

In the 1930s, the development of Alcoholics Anonymous (AA) and the beginning of scientific research into alcohol problems were a definite incentive towards the implementation of format workplace alcoholism programs.[15] Moreover, World War II gave a strong impetus to the federal funding of hundreds of mental and social service programs (Sonnenstuhl & Trice, 1986) so that inexperienced workers would be able to join the workplace environment. From then on, and especially in the 1950s and the 1960s, a large number of alcoholism programs which were either management-based or supported by labour unions emerged (McClellan, 1984). Job-based programs gathered momentum in the 1950s as private industry came to realize that providing "troubled employees" with assistance benefitted the company (Stennett-Brewer, 1987). As they became aware that issues such as drug abuse, domestic violence, depression and divorce played a major negative role in job performance, companies with alcohol abuse programs began to offer help to their troubled employees in other areas of mental and emotional health (BNA, 1987).

The 1970s brought significant changes to the workplace-programs movement, the main one being a shift in the focus from alcoholism *per se* to identifying employees' impaired behaviour and productivity (Masi, 1984). The introduction of new legislation, as well as incentives to include problems other than drinking (Wrich, 1974; Roman, 1988), encouraged state and local governments, businesses, labour organizations and others to establish EAPs to address all problems that interfere with an employee's job performance (Masi, 1984).

2.2 A Brief History of EAPs in Canada

The historical background of the EAP movement in Canada is less dear. EAPs here have not been available as long nor are they as widespread, but the field is rapidly growing. Roman (1988) considers Canadian EAPs unique: socialized medical care helps generalize treatment, organized labour is more strongly involved and there is greater focus on alcoholism.

It is believed that the concept of EAPs in Canada evolved out of alcohol and drug abuse (especially heroin) programs, as was the case in the United States[16] Development was slow and management interest limited. It is important to note that legislation similar to that in the United States does not exist in Canada. However, in 1977 the Treasury Board of Canada stimulated the implementation of EAPs across all federal departments (McGurrin, 1985; Epp, 1988) and the largest single employee assistance service in Canada is now part of the Department of National Health and Welfare.

At the provincial level, several alcoholism agencies in Newfoundland, British Columbia, New Brunswick and Ontario, for instance, have functioned as catalysts for alcoholism programs in the work setting. In Quebec, there have been many programs implemented in the para-public sectors, particularly the school boards and the hospitals in the metropolitan Montreal area.

Many Canadian organizations are renewing interest in and taking an active part in reviving the EAP movement (MacMaster, 1988), yet "... there is a long way to go in this field in catalysing the development of EAPs and related programs in Canadian workplaces" (Epp, 1988, p. 2).

2.3 What is an EAP?

2.3.1 Basic Definition

EAPs are complex systems which represent and influence a large number of people, ranging from employees to management and including, among others, families, health care networks and even the general public (Ford & Ford, 1986). They cover a wide range of organizations and associations, where management, labour, or both, may be involved. Programs possess a wide variety of organizational structures. Yet, regardless of their titles and organizational constitution, all are concerned with preventing, identifying and treating personal problems that adversely affect job performance (Sonnenstuhl & Trice, 1986).

The title "Employee Assistance Programs" was coined by the National Institute of Alcohol Abuse and Alcoholism (NIAAA); according to Masi (1984), if achieves two major purposes: "(1) It conveys that the program focuses on assisting employees, regardless of the type of problem from which they may suffer. (2) It avoids the stigma that may be attached to a more narrow program, specifically identified as for alcohol or drug problems" (p. 5).

Based on a large number of definitions which began to appear in the 1980s, three major assumptions distinguish EAPs from other parallel human resource strategies:

1. Employees' problems are private unless they cause job performance to decline.

2. The productivity problem resides with the employees and their personal lives.

3. It is the role of supervisors to identify deteriorating job performance (without having to determine the essence of the problem).

Thus, EAPs place the "problem" not within organizational dynamics or relationships, but rather within the individual. It is expected that through diagnostic, referral and treatment services provided by EAPS, the "Troubled employee" will return to reasonably productive performance after alleviating or eradicating the basis of impairment.

In conclusion, one may retain the most comprehensive definition of an EAP offered by the Addiction Research Foundation (ARF, 1984b):

- a framework of specific policy and guidelines that provide **fair and consistent** treatment for all workers who need help...

- it allows employees to seek help **confidentially**...

- it links them with the **best help** available in the community...

- it strives to **get them back to productive well-being** and to avoid the need for disciplinary action and ultimate job loss...

- over the long term, it encourages workers to seek assistance with stressful personal situations **before** a problem develops...

- it **"belongs" to everyone: workers and management in partnership**...

- it **costs a lot less than doing nothing**.

2.3.2 Main Characteristics

If we try to combine the characteristics spelled out by Hollman (1981) with the dimensions specified by Roman and his associates[17] as well as by Trice and his colleagues,[18] we can sum up the unique features of EAPs that distinguish them from other workplace interventions:

1. The problems encountered by employees must be dealt with through appropriate professional treatment.

2. EAPs favour a "broad brush" approach.

3. EAPs have a number of distinguishing policy qualities, updated on a regular basis and formally communicated to all levels within the organization.

4. EAPs will try to solve problems which affect the employee's job performance only, following constructive confrontation.

5. The responsibilities for EAPs rest upon:

    a) the personnel or medical department for managing it;
    b) the immediate supervisor for identifying and encouraging the troubled employee; and
    c) the employee for using the system.

6. EAP activities are now moving towards a preventive strategy.

7. The focus of EAPs my be extended, especially towards substance abuse problems.

8. All EAPs need professional assistance and expert advice and guidance especially on emergent behavioral health Issues.

9. The time frame for contemporary EAPs tends to be short, running from an average of 3 months up to a year.

Moreover, based on a number of writings, we can identity the following components as being imperative to an effective EAP:[19]

1. A company has to establish a clear policy, which describes the responsibilities of both the organization and its workers, with regard to health and personal problems that affect job performance. It should include a policy statement, a procedure for ensuring confidentiality and specific procedures for referral or voluntary use.

2. Administrative functions should include the organizational location of EAP, the recordkeeping system, staffing, the relationship of the EAP to medical and disability benefit plans and malpractice/liability insurance.

3. There should be proper education and training to realize an effective EAP.

4. Referral network resources must be adequate and professional.

5. It is essential to measure program effectiveness and overall improvement.

2.3.3 Services Offered

The "traditional" EAP package is believed to contain the following components: assessment, referral, aftercare/follow-up, management consultation, supervisory training, employee education, motivational counselling and policy development. However, based on a survey done among a sample of professionals and practitioners in the EAP field "only 16.8% of the respondents provided all of these services. Interestingly enough, about 3% of the respondents did not provide any one of these services" (McClellan & Miller, 1988, p. 31).

A number of classifications of EAPs have been attempted, based on the source of problems (personal, family, work, etc.), the direction of services (developmental or remedial) or more general operational concerns (administration, counselling, education, etc.). While EAPs come in a wide variety of forms, most of them contain some or all of the following components: referral, training of managers, employee education, individual counselling, a hot line and group

counselling.[20]

Chapter III: Models for EAP

Any company considering the development of an EAP has to pay great attention to its own unique characteristics. It is believed that factors such as size of the organization, geographic location and diversity, employee population, values and goals, as well as other features, must be considered and appraised when examining the various models.

There are many different ways of administering EAPs and therefore many different models. Good (1984), for example, believes that "there are almost as many choices to be made in setting up such a program as there are companies" (p. 80). In this section we will attempt to summarize six different models of EAPS. They include: in-house services, external services, internal/external programs, the consortium model, union-based programs and finally EAP models for small organizations. These descriptions are derived from a number of sources which have already attempted numerous classifications.[21]

3.1 The Various Dimensions of EAP Models

It is important to note that EAPs can be classified along several dimensions. Spicer et al. (1983) identify three of them:

1. The **focus of the program** or what services are offered:

    a. Alcohol-only programs--dealing with problems related to alcohol and drug use.

    b. Broadbrush programs--dealing with all problems, e.g., emotional/psychological problems, marital and family problems, job stress, alcohol and drug problems, legal problems, financial problems.

    c. "Wellness" programs--dealing with health promotion in general, and advocating anticipation and prevention of all problems as well as the treatment of them.

2. The **location of the program**: EAP models differ greatly in where employees go to get their services. This source of variability affects both the operation and the evaluation of the EAP.

3. The **level of formality** which is determined by the following aspects:

    a. How was the organization's EAP established?

    b. How are troubled employees identified?

c. How are the employees made aware of the organization's EAP?

d. What kinds of records are kept on employees who use the EAP?

There is no single EAP model; each model is most appropriate for a particular type of client and specific circumstances. It is also important to recognize that "often the theoretical EAP model that an organization chooses may differ considerably from how the EAP actually operates" (Spicer et al. 1983, p. 9).

3.2 Internal Services, or In-House Programs

Large organizations tend to have in-house programs or corporate EAPS. These are administered under the company's auspices by a co-ordinator with a counselling staff, all of whom are employed by the company. They may be an integral part of either the personnel/human resources or medical departments or else constitute an independent service directly responsible to senior management.

In-house programs offer services to all employees and often to family members as well (Lanier et al, 1987). These may range from simple diagnosis and referral, to extensive psychotherapeutic treatment of employees. Normally, they are staffed by mental health professionals (e.g., social workers, psychologists, certified alcoholism counsellors) with strong clinical backgrounds (Sonnenstuhl & Trice, 1986).

The advantages of internal programs are diverse. Expertise is ensured by hiring professionals to develop the program; employers believe it is a most effective manner to express humanitarian concerns (Sonnenstuhl & Trice, 1986); EAP professionals present at the work site can easily recognize the needs of the company (BNA, 1987); and, finally, it is believed to be cost-effective over time.

However shortcomings have been pointed out; the main criticisms concern the confidentiality issue as well as that of conflicts of interest faced by therapists (Sonnenstuhl & Trice, 1986). Lanier et al. (1987) describe a special type of internal "informal" program where services are offered on a part-time basis by special categories of employees (occupational physicians, occupational health nurses, recovering alcoholics, personnel or industrial relations specialists). The main problem with this type of service is that the "counsellor" (e.g., a personnel officer) will in some cases obtain confidential information about an employee.

3.3 External Services, or the "Contracted" Approach

Nowadays, many businesses, especially medium-sized companies comprised of fewer than 2,000 employees, contract with profit and non-profit organizations (e.g., a private consultant, a social service agency, a hospital or a university) to provide mental health services for their troubled employees.[22] These agencies provide a variety of services such as treatment,

supervisor training, diagnosis of employees' problems and referrals to other treatment agencies, which can be delivered either on-site or off-site.

Companies choose this route for various reasons. It is a quick and efficient way to implement a program where a manager will simply be delegated responsibility for co-ordination. Moreover, this model may deal more effectively with the sensitive issue of confidentiality.

The major drawback to contracted services is believed to be a lack of experience with the workplace. Dispatching employees to professional treatment becomes the principal focus and primary organizational prevention may be forgotten. Moreover it is more difficult to hold accountable and to evaluate those who provide external services.

3.4 Internal/External Programs

A combination of internal and external services is needed for large corporations situated in various locations. These organizations usually have a corporation-wide EAP with one or more internal co-ordinators based in one or more locations. In the other sites, local contractors are often used. Both the co-ordinator and the contractor provide direct services to employees. The advantage of this mixed approach is that there is combined knowledge about the internal organizational structure as well as information about local resources and how to use them.

The **community resource network** is a particular example of combined services. "This strategy recognizes that agencies outside the company already provide a wide range of counselling services that are available to employees and that the program co-ordinator's function is to direct employees to those resources" (Sonnenstuhl & Trice, 1986, p. 20).

In summary, contractual programs tend to be newer, seem to originate from the broadbrush program, report to senior executives within the organization, cost more per employee and availability of services is extended beyond regular working hours. On the other hand, in-house services, having originated as extensions to alcohol-based programs, are somewhat older and more prevalent. They are structured in a more traditional manner, cost less and are generally supported by unions. Moreover they tend to concentrate on medical referrals and on alcohol-related problems, although various training programs may be linked to them. This comparison between the two models basically suggests that each tends to serve a different category of workers and thus, the benefits and limitations of each must be carefully considered in planning a good and effective EAP (Straussner, 1988a).

3.5 Consortium Model

An EAP consortium "is a cooperative agreement among companies and agencies that do not have enough employees to warrant their own EAP. Instead, they pool their resources and develop a collaborative program to maximize the individual resources of each company" (Masi, 1984, p. 61). This type of model best fits organizations with fewer than 2,000 employees. The advantages of the consortium model include:

1. The consortium decreases costs for small or medium-size organizations.

2. Confidentiality is easier to maintain.

3. Often there is better identification of and communication with community resources.

4. The range of employees served is increased.

5. Usually the ECS (Employee Counselling Services) staff has greater diversity and better credentials.

The disadvantages include:

1. Some supervisory and management staff are reluctant to deal with outsiders.

2. The service provider usually knows little about the participating organizations.

3. Consortiums are more complex because they include several companies.

4. There is some communication difficulty regarding role definition.

5. Participating agencies may disagree about the services needed and the apportionment of costs.

6. Some counsellors find it difficult to become a part of the formal and informal work-site networks.

3.6 Union-Based Programs

Over the past five years, unions have been more active in promoting programs for dealing with occupational alcoholism and other EAP services.[23] Labour unions can use different plans to implement and administer EAPs either directly or through co-operation with management. Several models have been described:

1. Programs operated under union auspices: they require special skills and unique techniques enabling union representatives to solve issues related to conflict of interests.

2. The consortium model: labour and management create a separate non-profit organization outside the context of collective bargaining agreements. Both sides are the perceived owners and beneficiaries of the program.

3. The union-counsellor model: volunteer labour union members, specially trained, work independently from management and help convince employees to get the treatment they need.

4. The collective bargaining model.

5. Occupational programs initiated in local unions: they usually become joint labour-management programs through collective bargaining or institutionalization.

3.7 EAP Models for Small Organizations

The various EAP models that have been devised to meet the needs of small organizations are: central diagnostic and referral (CDR) services, consortiums, independent contracts and clinical liaison personnel (Gray & Lanier, 1985/86).

A **central diagnostic and referral (CDR) service** is an association that provides assessment and referral services to a number of work places in the same community.

The **consortium model** is made up of multiple firms that collaborate in sharing an outside EAP. It covers a wide variety of services ranging from assessment to referral and follow-up.

Independent contracts represent a straight-forward outside service by a contractor who covers ail or most areas commonly used by EAP users.

Clinical liaison is a contractual service that provides assessment and referral, as well as treatment and aftercare and is located in a community.

In sum, all models have some elements in common. What constitutes an advantage for one model could be regarded as a disadvantage in another model. The delineating factors are the purpose, the clients, the cost and the efficacy of the program. The next chapter will examine the criteria for choosing, implementing and maintaining EAPS.

Chapter IV: Implementing, Maintaining and Evaluating an EAP

This chapter will offer some guidelines for implementing and maintaining an effective EAP. These are based on experience and advice published by practitioners and scholars about existing programs. However, the measures suggested here may well vary from one organization to another based on their specific situation (e.g., size and location, population).

4.1 How to Get Started

Before setting up a program, top-level support from senior executives must be ensured.[24] Shepell (1989) recommends the creation of a steering committee comprised of representatives from both labour (i.e., employees and unions where present) and management. This group of individuals should examine the need for an EAP, propose a practical structure and analyze plans to implement the program. These plans should identify the assumptions and objectives, in addition to the strategies and remedies, for attaining the goals. Finally, a survey should be conducted among employees to ensure that the newly-designed EAP responds to their needs. Pre-program analysis and assessment is highly recommended, and has proven to be profitable, so that programs can be better designed and monitored, thereby making it possible to identify problems, solution/options, impediments and resources more accurately (Sholette, 1983).

4.2 Designing/Developing an EAP

The beginning of an EAP deserves special recognition, yet it is difficult to outline the beginning process because each work situation is unique. However, both union and management should recognize that this new method of resolving personal problems is fundamentally different and that the program will and should evolve over time.

Broadly speaking, some key issues should be recognized prior to commencement of any EAP program:[25]

1. Commitment: both union and management need to feel prepared to deal with unexpected problems and they must be able to handle the often stressful changes that may occur during the initial period, so that the program will be strongly supported throughout. "**Mutual trust and relative power are central b to this step**." (Corneil, 1982, p. 24)

2. Communication: a study of existing programs and close review of existing policies and procedures will illuminate the issues to be served by the EAP. **The best EAPs fit smoothly into existing policies and procedures**.

3. Structure:

    a. Select a cross-section of employees to serve on your committee. This group of employees will represent a wide variety of views and needs, and therefore will play a major role in formulating the program and its operation. **The best EAPs are "owned" by the employees**.

b. Develop your EAP policy. This written statement will define, among other things, the logic behind the program, its objectives and authority, the roles and responsibilities of the various personnel in the organization (e.g., department heads, supervisors, employee representatives) and the commitment to confidentiality. **The best EAPs are a benefit that everyone can use confidentially**.

4. Training: this is a two-step procedure. First, a selected staff needs to be trained; second, the employees need to be educated and awareness about the program must be created. **The best EAPs are rooted in training and education**.

5. Evaluation: evaluate your program. Re-examining the program regularly will give some indication as to what aspects need to be tuned up or changed. **The best EAPs become one of the ways an organization emulates itself**.

4.3 Choosing a Consultant/Counsellor

Many organizations prefer to confront issues linked with developing an EAP by selecting and delegating this task to a consultant (either internal or external). It is evident that choosing the right person to fill this role is critical for the success of the program.[26] Sonnenstuhl & O'Donnell (1980) as well as Shepell (1989) recommend consideration of a number of issues:[27]

- availability;
- confidentiality;
- consultant's orientation towards services, education, training and assessment;
- environment and available resources.

4.4 EAP Implementation

The introductory steps in setting up an EAP are extremely important. Everything done during the initial phase of a program plays a significant role in its survivability. The strategies for implementing an EAP, offered by Maynard and Farmer (1985), can be appropriate for many organizations. These authors believe that it is essential to study the organization (e.g., players, structure) and find out its motives and goals for the EAP. Also, the personal involvement of the "right people" (e.g., the C.E.O. or C.O.O., union representatives, V.P. of Human Resources, Medical Director) has to be sought. At all times, the EAP should function as consistently as possible with other company practices and goals. It has to be incorporated into other company systems and become an integral part of the company's operations.

In order to implement an effective EAP, the following activities need to be initiated by the EAP coordinator (Maynard & Farmer, 1985):

- meet with company contact person or supervisor;
- meet with C.E.O./C.O.O./union leaders;

- brief managers, supervisors and union representatives;
- meet individually with other key personnel;
- conduct employee orientation meetings;
- assess needs of employees;
- distribute materials;
- orient and train supervisors and managers;
- put out fires.

Based on these activities, it can be argued that the EAP co-ordinator's goals are: "communicating the benefits of the EAP to various company groups (e.g., executives, supervisors, union representatives, employees, personnel staff) in terms relevant to each group, developing an understanding of the needs and concerns of each group, identifying influence networks and potential program supporters or resisters, and becoming personally visible and known" (Maynard & Farmer, 1985, p. 35).

It is recommended that the various activities be carried out concurrently with both management and the union throughout the entire process, in order to avoid labour-management conflicts. It is also suggested that the various activities be executed in roughly the order in which they are presented in this section, even though some may be conducted simultaneously. The logic behind the sequence offered by Maynard and Farmer (1985) is that it starts with individual meetings (where design and planning take place), then introduces the services to employees (first personally, then with written materials), and concludes with the orientation and training of management.

However, if must be remembered that it takes time for the word to spread that counselling is a real help to employees who are having problems, and for managers to see the increase in productivity, better morale and improved interpersonal relations. Sheppel (1989) suggests that it takes at least two years for a company to see a significant increase in cost savings and that the organization that sticks to its original commitment will retain its EAP and reap long-lasting benefits.[28]

4.5 EAP Maintenance

Maintenance of EAPs is believed to be an autonomous and self-sufficient function, somewhat abandoned, sandwiched somewhere between implementation and evaluation (Gumz, 1985). In order to keep an EAP "alive" a system of maintenance activities is needed that will provide for and encourage a level of meaningful activity and will permit adjustments on a regular basis (Erfurt & Foote, 1977).

As a result of her work, Gumz (1985) of the Bureau of Personnel and Employment Relations for the State of Wisconsin's Department of Health and Social Services, came up with suggestions for maintaining a program in the following areas: publicity efforts, personnel meetings and briefings, program monitoring and community resources. These guidelines are supposed to:

1. Spread the Word, or Promote the Program through a variety of methods

2. Keep in Touch, or Train Personnel. All resource co-ordinators, supervisors, union stewards, and in some cases employees, should be kept aware of the presence of the EAP.

3. Track Down the Paperwork, or Pre-Evaluate. In order to evaluate and then adjust an EAP, information regarding recent performance of the program is necessary.

4. Screen the Community Treatment Resources. Here the focal point is the treatment agencies that perform a service for the parent organization. Communications between the EAP and the community treatment agencies have to be examined regularly.

A "health" EAP is a program where all its components are being cared for and kept in excellent shape. Since developing or purchasing an EAP involves a major investment, maintaining if is of utmost importance. The guidelines offered here are only some suggestions that can be used as maintenance activities.

4.5.1 Key Ingredients of a Successful EAP

A number of attributes are deemed to be critically important to ensure an effective, smoothly operating, comprehensive program: top management support; labour backing; strict confidentiality; a written policy; clear procedures; organization-wide education and communication; easy access; supervisor training; insurance involvement; professional leadership; an information assessment and referral service; a community referral network; follow-up and evaluation.[29] Finally, it is worth noting the assertion made by the Addiction Research Foundation, which claims that a good EAP needs teamwork. This teamwork should include: representation from management; representation from the union(s) or other employee associations, or a cross-section of employees; health service personnel (physician, psychologist, occupational health nurse, etc.); and referral agents, who know what services in the community will be required in each individual case.

4.6 Evaluating EAPs

In order to have a reasonable chance to succeed, an EAP should be designed to include specific evaluation plans (Masi & Teems, 1983a), in other words a process should be established by which the progress of the program will be monitored constantly. It has been argued that a program needs to be assessed for its cost-effectiveness and efficiency, and the results of this exercise should be made known to all members of the organization. Here, the confidentiality issue may become problematic and the evaluation must then be conducted by a third party (Masi and Friedland, 1988). The main reasons to evaluate a program include: the justification of its existence to some external authority (usually the source of funds and/or support); the verification that its objectives are being met; and the improvement of its performance (Foote and Erfurt,

1981a).

4.6.1 Problems and Challenges in Evaluating EAPs

When appraising EAPS, some unique aspects of the program need to be taken into account and at least four areas are regarded as problematic:

1. Staffing. Most program administrators are not trained in conducting a proper evaluation procedure.

2. Preparation. Very few programs include an evaluation phase as part of the initial planning process and many lack measurable goals and objectives.

3. Standardization. The great variation in models complicates the development of standardized, reliable and valid measures and definitions.

4. Data Collection. For most organizations available data is less than adequate for conducting a meaningful evaluation. Employee confidentiality may limit access to data. The presence of a control group is important.

4.6.2 The Various Evaluation Methods

Evaluating a program can be achieved through a wide variety of ways and different methods have been proposed. **Needs assessment surveys** are used to estimate the number of potential clients and the services required by them. **Process evaluation** is used to compare the actual operation of a program with its intended function. Hence, it alerts staff to operational weaknesses of the program. **Outcome evaluation** is used to determine the program impact upon the areas of client satisfaction, problem resolution and improved quality of life. **Impact evaluation** is used to measure the expected changes brought about in those employees and organization units taking part in the program (Jones, 1983). **Cost-effectiveness analysis** uses economic indicators to measure the efficiency of the program.[30] In summary, the following evaluation priorities have been cited by EAP counsellors and administrators: assessing the quality of referral sources, client outcome and satisfaction, employee awareness, program utilization, job performance changes, supervisory attitudes, cost-benefit and training effectiveness.[31]

4.6.3 Cost-Analysis Methods

"In today's competitive business and health care climate, questions of economic benefit often arise. While statistical significance and clinical significance are of critical importance for the EAP researcher, decision makers within a company may be most interested in financial significance" (Owen, 1987, p. 87). Information about this key issue may be obtained through the following methods:

1. **Cost-Containment Activities**. Strategies used to reduce expenditures or control rising costs. (Examples: prepaid services, case management.)

2. **Cost-Offset or Cost-Impact Analysis**. Strategies used to determine the areas where cost savings occur as a result of providing a service. (Examples: percentage reduction in absenteeism following legal problems, productivity.)

3. **Cost-Effectiveness Analysis.** Strategies used to calculate the cost of obtaining some desired outcome. (Example: comparing in-patient and out-patient programs by dividing the real costs of each by the number of improved clients.)

4. **Cost-Benefit Analysis.** Strategies used to compare the benefits (tangible and intangible) of a program with its costs (directly and indirectly). (Example: a comparison of an employee hypertension screening program with an alcoholism treatment program.)[32]

Different measures of work performance have been used by researchers and administrators to assess program impact. They include absenteeism (lost time in duration and frequency), number of disciplinary actions received, number of grievances filed, number of on-the-job accidents, number of visits made to the company medical unit, amount of workers' compensation paid, amount of sickness and accident benefits paid, health insurance claims and turnover rate.[33]

A final cautionary note should be sounded on the problems in conducting a cost-benefit analysis within EAPS. EAP managers are currently experiencing a major difficulty in attempting to demonstrate the economic feasibility of their programs. In fact, a number of reports claim that EAPs are not effective in achieving established goals, whether economic or non-economic. The main reasons are: all costs are not easily identified, benefits may be difficult to translate into monetary value and, finally, the methodological quality of the research being conducted is quite low.[34] More and better research is needed if the EAP concept is to survive; the lack of good research or program evaluation data is one of the major ethical issues facing EAPS.

Chapter V: Job Based Programs in the Police Force

Policing is an intricate activity in a complicated world and the stresses and strains facing police officers seem to be on the rise.[35] Whether officers are worried about financial affairs, uncertain about their children's health, the risk of the job, the lack of appreciation of the work they are doing, distraught about an impending divorce/separation, or generally unhappy about life or about working conditions such as shift work (to list but a few), the feelings are real and need to be addressed. Considering that officers' personal problems can have a negative effect on those around them, or those encountered while on patrol, the personal health and well being of police force members should be a concern for all members of the police organization, as well as for the public at large.

To address these issues many forces across Canada[36] and the United States[37] started to develop officer assistance programs. "The ultimate objectives of these programs are to re-establish officers as effective members of the police community" (Hodson & Fallon, 1989b, p. 18).

Besner (1985), a psychologist in the private sector who has been involved in counselling police officers and their families for many years, argues that an employee assistance program can benefit a police department in many ways. For instance:

1. It can be used to assist the alcoholic or troubled employee, serving as a preventive and intervention mechanism.

2. The EAP counsellor can develop a screening instrument and train supervisory personnel to identity problem employees. Absenteeism rates, decreased work performance, sloppy appearance, tardiness and increased letters of complaints are a few of the areas that could be explored.

3. The counsellor can assist the officer who has been involved with excessive-use-of-force incidents, automobile accidents, shooting incidents or fatalities. A few counselling sessions can greatly benefit the officer's emotional well being.

4. The counsellor can implement a stress management program. Studies have indicated an increased incidence of stress-related health problems, such as ulcers and heart disease, among police officers. The suicide rate is also considered relatively high.

5. The counsellor can provide a training forum for work and non-work related issues.

6. The counsellor can help boost department and employee morale by showing staff that the department cares about their well being and is looking out for their needs.

7. The counsellor can also develop a spouse program with emphasis on family-related issues and how work can affect the officer's home life.

8. Finally, this program promotes mental health. By providing the employee with easier access to help, if reduces the time between the initial appearance of a problem and treatment. The earlier the intervention occurs, the greater the return to the department in terms of cost, productivity and community safety.

Unfortunately, programs are sometimes difficult to implement in this sector for a variety of reasons. Police departments are set up in a quasi-military fashion and often constitute a 'closed society' (BNA, 1987, p. 93). Accordingly, the belief held by most police officers that admitting to problems and seeking help is a weakness--the "John Wayne Syndrome"--survives. Moreover, confidentiality within the system is viewed with skepticism by many police officers (Brennan et al., 1987). Similar conclusions were drawn by Dolan (1989a) when recommendations were made based on the impact on changes in patrol systems (e.g., oneman vs. two-man) for the Montreal Urban Community police force.

5.1 Sources of Stress Faced by Law Enforce Officers

Usually, "people don't request police assistance when their lives are orderly and proper. The police become involved when life's activities are in serious disarray and lives are in jeopardy" (Bratz, 1986, p. 2).

Many researchers suggest that psychological stressors often become more chronic and disruptive to officers' professional and personal lives than physical stress.[38] Based on a recent summary of the literature by Brennan et al. (1987), the following description can characterize police officers' confrontation with psychological stress factors: facing the responsibility for other peoples' lives (Duncan et al., 1979); the frustration that accompanies working with the court system and police administration (Kahn and French, 1970); ambiguity in the role of the police officer in today's complex society and having to adapt to a work environment which includes sub-cultures, ethnic groups, or lifestyles different from one's own; conflict in separating on-duty activities from personal life and maintaining a balance in allocating time to both (Capps, 1984); and the strain of having to deal with the ambiguous nature of many laws (Wilson, 1968).

Police officers are often required to perform tasks that are inconsistent with their own values, and they often face a negative public image (Brown, 1984). They must also adapt to the inconsistency of having long hours of inactivity and yet being expected to respond to sudden, unpredictable crises (Margolis et al., 1974). In addition, training for some job duties is often not sufficient to allow officers to feel comfortable in performing them, and officers are often placed in situations for which there are no performance criteria (Bard, 1976).

Having to cope with poor equipment, lack of administrative support and departmental disciplinary action adds to the numerous stresses mentioned above, without forgetting exposure to death, near-death experiences and accidents (Daviss, 1982), as well as family disruption caused by an officer's changes in shifts, internalized feelings and displaced anger.

Finally Tipps (1984) identified specific job-induced problems, rooted in the earliest stage

of a police officer's career at the police academy, namely: work schedules, emotional exhaustion, negative public image, overprotecting the spouse and family, hardening of emotions, identity problems and problems with children.

In sum, one of the main incentives for police forces to implement an EAP is stress reduction and stress management. While some stressors, especially the long-term ones, could be handled through organizational changes and interventions (see Dolan, 1989), the role of counselling services for individual police officers is crucial in alleviating stress and remedying its consequences. This role would encompass the provision of stress management training, career and more general counselling services (Dolan, 1989).

5.2 A Police Department EAP Model

The stresses and strains in police work are often compounded by problems that arise from daily functioning "off the job", and the emotional turmoil can be excessive, resulting in a variety of "escapist behaviour" which could be manifested in abusing alcohol and/or drugs.

Establishing an EAP to deal with alcohol abuse and other problems is considered to be a sensible and effective solution; it has been adopted by various forces, one of which is the Lincoln (Nebraska) Police Department. The Lincoln EAP[39] is a free-standing, non-profit service centre and, as such, is not a formal part of the organizations it serves (i.e., all city departments). A broadbrush program, it provides a variety of counselling services to employees and their families. The professional staff offers help for marital, family, substance abuse, emotional, legal, financial and vocational problems. The Lincoln EAP also provides management consultation and training to help managers and supervisors encourage employees to use the counselling program when work performance has declined because of personal reasons. Employees who come to the Lincoln EAP receive assessment, short-term motivational counselling, referral to the appropriate agency or practitioner, and follow-up.

Although the EAP had proved successful for Lincoln's other city departments, it became apparent that the police department was under-utilizing ft. Consequently, remedial action was undertaken. The main thrust of the remedy included the assignment of internal resource officers (IRDs) composed of four police department members: a sergeant, a detective, a police officer and a representative from the police department's personnel office. These "insiders" benefitted from a higher level of trust and bridged the gap between the police department and the EAP. The four IRDs received special training, especially on how to facilitate referrals to the EAP. Their function was to provide support for officers who were apprehensive about seeking outside help, to act as trouble shooters and, generally, to provide information to fellow officers about the EAP process.

5.3 Peer Counselling Program

The first department in North America to develop and implement an integrated and fully department supported peer counselling program using regularly employed officers and civilians on a large scale was the Los Angeles Police Department (Capps, 1984).

A peer counselling program can play an important frontline role in providing timely and effective assistance to police personnel whose personal lives and effectiveness on the job are being adversely affected (Schaer, 1986). Such help, while not designed as a substitute for professional services, has nevertheless been found to be a particularly effective means of providing assistance, as demonstrated by the rapid growth of self-help groups.

Peer counsellors in the police force are normally volunteer policemen, from a cross-section of the work force, who are trained to assist their fellow employees. These individuals possess some skills and sensitivity to the personal and emotional problems encountered by their colleagues. They are sometimes drawn from committees which oversee health and safety or educational issues. One of the most important responsibilities of a peer counsellor is the promotion of trust, anonymity and confidentiality for policemen who seek the assistance.

In Canada, many peer counselling groups exist among police forces. Although data on the success of these programs is scanty, proponents seem reasonably content. In Quebec, for example, a major proponent of this model is M. Olieny, a former policeman turned psychologist, who is at present working at the police academy. He believes in early education and sensitivity to stress related problems during the initial training of policemen. Because of his background as a policemen, he enjoys more credibility and trust when he consults his peers.

In Ontario, the Metropolitan Toronto Police Force has a peer counselling program headed by its EAP co-ordinator. The program is composed of 18 peer counsellors serving more than 7000 uniformed and civilian employees (Schaer, 1986). They are specially trained to develop specific interviewing, communication and counselling skills; to identify the causes of personal problems or job-related difficulties; to understand psychological stress and how it can affect the work and life of police personnel; and to make client referrals to available community resources.

Another success story regarding the use and application of a peer counselling program has been recently reported by MacKillop (1990). Sgt. MacKillop discussed with much enthusiasm the continued success of a stress management program involving peers in the Waterloo Regional Police Force. According to his testimony, this is the only kind of program regarded as being credible and confidential by members of the police force.[40]

5.4 What Can a Police Department Do?

In August 1984, the National Police Research Unit of South Australia held a seminar on occupational stress, which was attended by police psychologists and welfare officers. The following recommendations were made by the seminar leaders (Olekanus, 1985, p. 115):

1. A centralized welfare agency, comprised of psychologists, medical officers and chaplains, with close liaison between the various specialists. Staffing levels between 1:2000 to 1:1000 were recommended for each of the services.

2. In cases of acute stress, such as shooting incidents or disasters, that there be:
   a) a mandatory interview/debriefing with a psychologist, with the possibility for further follow-up interviews;
   b) referral to a peer counsellor;
   c) some level of counselling be provided to spouses.

3. A general occupational health scheme, which should include regular medical checks, a means for improving health and fitness and monitoring for stress symptoms.

4. Increased and maintained training at all levels on stress awareness and management.

Bratz (1986) offers several constructive options to stress management. He believes that these approaches may be utilized separately or in various combinations to combat stress in law enforcement:

1. Establish a special unit with the primary responsibility for counselling and conferring with members in need.

2. Acquire the services of a local psychologist or psychiatrist.

3. Establish a routine psychological testing process at predetermined Intervals.

4. Design a stress training program for all departmental officers.

5. Encourage personnel to get involved in physical exercise.

A unique approach was adopted by the Metro-Dade Police Department, Dade County, Florida. The department's basic training staff, working at the Southeast Florida Institute of Criminal Justice, established the Spouse Awareness Program. It is offered to the spouses of trainees to provide them with information regarding the true nature of police work. Spouses participate in activities normally reserved for trainees; this allows them to appreciate, to a limited extent, the degree of stress that trainees experience (Tipps, 1984).

Two other programs worth looking into are: the Home Visit Program (Petrone & Reiser, 1985) and the Critical Incident Program (Wagner, 1983). The goal of the first program is to determine whether an outreach approach by in-house mental health specialists for distressed officers will positively affect morale and productivity and significantly reduce sick time, medical costs and civil liability. The results led to a recommendation to expand the Home Visit Program in order to enable all officers who are on long-term sick or IOD leave for more than 30 days to have the benefit of support and remedies. The program appears to establish rapport, provide vital support to the department and facilitate more positive communications with distressed officers (Petrone & Reiser, 1985, p. 37).

The second program deals with trauma counselling. Due to the nature of police work, such incidents as accidents, shootings and hostage takings are frequent, and might have a grave impact in early intervention is not provided. Individuals who experience a trauma can benefit from a psychological support service. Although the symptoms of distress in response to a trauma vary from officer to officer, and often personal vulnerability due to "off work" problems might significantly enhance the after-shock, an effective emotional assistance can prove to be most valuable for the officer. Some specialists share the belief that experiencing emotions at a high intensity with proper professional assistance might prove to be a beneficial learning experience as if provides an optimal opportunity for officers to learn about the way they respond to stressful situations (Wagner, 1983). The learning takes place, in a supportive atmosphere, during a focused counselling interview. The reassurance and support officers receive serve to debrief the experience. The opportunity to look at the situation will enable the officers to put the pieces of the experience together, an essential psychological task following a trauma. They will feel better and calmer. The initial "stress signs", which are anxiety symptoms, will lessen or go away. More important, the debriefing and the subsequent integration will prevent the development of delayed symptoms or lessen those that do occur.[41]

To summarize, here are some practical suggestions which a police department could implement in order to help its troubled officers:

1. Put more emphasis on how an officer can deal with the personal stresses and strains of being human in the police force. This issue must be confronted at a very early stage of police training.

2. Use an internal program. Many police officers are distrustful of "outsiders"--those who are not part of the police system. They also believe that outsiders simply cannot understand or help them (Brennan et al., 1987).

3. Use officer-counselling. While the officers assigned to a "stress unit" need not be certified psychologists or psychiatrists, they must be aware of counselling procedures and techniques and have sufficient knowledge to recognize potentially serious problems (Bratz, 1986).

4. Build a program to be utilized by families of law officers. Police officers' families

often feel isolated and in need of a support system. At the same time, the officers require the love and listening ear of their families (Tipps, 1984; BNA, 1987; Hodson & Fallon, 1989a).

5. Adopt a more pro-active role, namely, focus on prevention.

In sum, the implementation of an EAP in police forces requires some special considerations. Policemen seem to be more sensitive to issues of confidentiality and trust in the system; reports also suggest that they trust peers/colleagues more than other, professional, service providers. Consequently, before implementing an EAP within a police force, careful consideration of the credibility and confidentiality of the system is needed. In relative terms, a mixed approach of using resources from within the force (peers or buddy system), along with professional expertise, seems to be the more effective approach for this sector.

Chapter VI: Final Reflections and Conclusions

Because EAP is a relative newcomer in the work world, there are still many questions and issues that remain controversial. With the increase in concern about health care costs, the first significant question that many ask is: who should bear the responsibility for employees' care: the employees themselves, the employer, or perhaps the various levels of government through their extensive health delivery system? In retrospect, the emergence of EAPs suggests indirectly that neither the individual worker nor the government should bear the entire responsibility for caring for the emotional and behavioural problems of employees. Because it affects performance (directly or indirectly), many companies should assume some responsibility by providing EAPS.

Data regarding EAP coverage in Canadian organizations suggests that although the programs are well promoted, most businesses are ill-informed or uninterested in their creation. Those that become involved are generally large, private sector corporations (1000 or more employees) or public and para-public sector employers of similar, and sometimes, smaller size.

In Canada, EAPs seem to be needed more than in other countries, given the alarming statistics on the consumption and impact of alcohol on Canadians. It has been estimated that 3.5 to 7 per cent of the active work force, amounting to between 350 000 and 700 000 of Canada's 10 000 000 employed individuals, experience severe alcohol-related problems. These contribute to lower productivity, absenteeism, lowered worker morale and accidents at work, and have been estimated to cost Canadian industry about $21 million per day. Alcohol intake is believed to exacerbate child abuse, marital disruption, social aggression and violent crimes (cited in Dolan & Schuler, 1987, p. 279).

Adding to this phenomenon is the impression that more and more Canadians are suffering from stress-related physical and mental problems. A national committee of the Canadian Mental Health Association estimated that 15 to 30 per cent of the work force is believed to be seriously handicapped by emotional problems at any time (cited in Dolan & Schuler, 1987, p. 280).

With regard to a police force, stress seems also to be on the increase (Arsenault et at., 1987). It has been estimated that among all factors contributing to health and safety problems, stress and burnout are among the top-ranked, leading to a sharp rise in suicides. Although suicide statistics for police officers are not readily available (they are often disguised as work accidents), interviews conducted by the authors in several police forces indicate otherwise. Consequently, some sort of program intervention and stress management is called for before the situation becomes a "real epidemic".

6.1 Contemporary Problems with EAPs

Despite a consensus regarding their value, EAPs are facing some major problems and obstacles on conceptual as well as on practical grounds. While EAP advocates regard these obstacles as quite natural, given the evolution of the field, opponents suggest that the problems are serious enough to suggest that EAPs represent just another fad in organizational life.

There is no single way to classify the many issues and obstacles to EAPS. Nevertheless, an attempt was made by Hollmann (1981) to classify current deficiencies in EAPS:

1. Most EAPs tend to be treatment-oriented (i.e., they deal with symptoms of the problem) rather than the cause of the problem (e.g., boring job, unfair supervisor, overburden of responsibility).

2. Most EAPs tend to be reactive rather than pro-active. In other words, "EAP occurs after the fact, namely, attention is directed to the past instead of the future" (p. 38).

3. Most EAPs tend to be fragmented. Hollmann (1981) concludes that the majority of the programs fail to:

   a) recognize the possible interdependence between multiple problem areas (e.g., family problems, lack of support);

   b) consider the possible interdependence between the problem and internal organizational conditions (e.g., insensitive superior); and

   c) integrate with other human-resource management activities (e.g., staffing, promotion, performance appraisal, training).

Another way to tackle the current challenges to EAPs is to recognize some of the limitations of most programs. It is important to note that an EAP should not be regarded as a panacea to solve all performance problems in an organization, nor should it be regarded as an exact science designed to solve all human misery. In fact, if any program is perceived as such, it is bound to fail. in addition, some objective limitations characterize, to some degree, many EAPs and thus contribute to their "non-success". For example, an absence of the following might all contribute to a failure of the program and should guide any potential client organization in attempting to purchase or implement a program:

- precise definition and clear mission for the EAP (Diesenhaus, 1985/86);
- benchmark data (Jones, 1983; Santa Barbara, 1984b; Albert et al., 1985);
- precise implementing procedures (Diesenhaus, 1985/86), or lack of established policy and procedural methods (Madonia, 1985);
- standards and ethical principles (BNA, 1987; Penzer, 1987; Roman & Blum, 1987);
- sufficient dissemination of information (Steele & Hubbard, 1985);
- evaluative systems (Penzer, 1987; Gerstein & Bayer, 1988);
- training for supervisory personnel and counsellors (Googins & Kurtz, 1980; Masi, 1982);
- top-level support (Witte & Cannon, 1979; Maynard & Farmer, 1985);
- competent staff (Nahrwold, 1983);

- preventive dimension (Hollman, 1981; Beale, 1984; Delaney, 1987).

Finally, a major vacuum in the field of EAPs is the lack of systematic information about what works and what does not work. Too often, according to Epp (1988), organizations are "in the dark" in making decisions regarding an EAP's implementation or modification. Since scholarly research on EAPs is largely unavailable to consumers, it is most important for potential buyers of the service to be involved in self-education, in information gathering and in internal discussions prior to making a decision.

6.2 Enhancing EAP Success

Although EAPs have some limits and unresolved issues, this should not deter organizations from using them. One of the assets of EAPs "lies in the fact that each EAP may be tailored to meet the specific need of employees at a specific company, industry, institution, or government unit" (Appelbaum & Shapiro, 1989, p. 42). That is to say that the available data on models and approaches and on scope and limitations is useful in the sense that it provides a menu of available services, their pros and cons and permits the more sophisticated user to make an intelligent decision regarding the segment(s) it wishes to adopt and implement. It also provide the user with a realistic assessment concerning chances for success.
In order to increase the chance for success in implementing an EAP program, Hollmann (1981) pinpoints a number of issues that need to be addressed:

1. **The Integrative and Preventive Dimensions** - The following should be included:

   a) Integration of the problem area to include the possibility that a troubled employee might have multiple problems that should be treated in a co-ordinated manner.

   b) Integration of the EAP activity with other human resource activities; for most companies, various activities conducted by the personnel/human resource office is done independently of the EAP, health or medical department; more coordination between these units is called for.

2. **Quality Assurance Procedures** - in order to protect EAP consumers and to provide guidelines for EAP practice, it is essential to use definitions and practice standards that are carefully and precisely drawn. The EAP movement can learn in this regard from the mistakes and errors committed earlier by other professionals such as physicians and psychologists. An interesting example of quality assurance procedures is offered by McClellan (1985/86).

3. **The confidentiality issue** - This issue has to be treated with extra care in accordance with strict professional ethics.

4. **The location issue** - Most EAP experts warn against placing the program in the personnel/human resource department.

5. **Continuous training of supervisory personnel and counsellors** - initial training should be followed up. Continuing education of counsellors is also essential.

6. **Staffing** - Foote, Erfurt and Austin (1980) argue, based on their experience at General Motors, that at least one full-time staffer is needed. Further, research indicates that even external services are not used to the full extent if a permanent liaison person in the organization is not at hand (Blum and Roman, 1987; BNA, 1987).

7. **Promotion/Education** - Braun and Novak (1986) conclude that EAPs must be engaged in promoting their service. Pamphlets, training sessions and other media should be used for such promotion.

8. **Evaluation** - The more data available for evaluation purposes, the easier if is to demonstrate the tangibility of the service.

6.3 Future Directions and Trends

EAPs have traditionally proven their effectiveness in "secondary prevention", which involves early detection of a problem and prompt intervention or treatment. What is generally missing in EAPs is a "primary prevention" which would decrease the incidence of problems that might otherwise become severe.

In the future, primary prevention will become effective as EAP professionals recognize the active role they need to assume. One EAP expert (interviewed for this project) stated: "My real test of effectiveness will be materialized at the point where I will run myself out of business". Two approaches are commonly used in primary prevention: (a) educational approaches and (b) improvements in instruments/tools permitting early (or very early) diagnosis.

Educational approaches, according to Lewis and Lewis (1986), will be used more and more in the future for preventing the incidence of problems most frequently seen among the employees of a given organization. A variety of methods, including role simulations, workshops, seminars and film presentations, should be used to educate employees about potential problems and teach them how to self-diagnose the early signs and symptoms of a problem. Some examples of popular workshops sponsored by many EAPs include: stress management; preventing burnout at work; effective parenting; improving communication skills; assertiveness training; marriage enrichment; increasing social support systems.

Another developing area is the **improvement of tools/instruments** available for the organization and the EAP specialist. The new family of diagnostic tools utilize state-of-the-art technology such as computer-assisted diagnosis and computerized files enabling systematic

follow-up and assessment of intervention success. These tools are perceived by most users as being more credible. As stated by one physician-turned-EAP-specialist: "Because we live in a technological society it seems that gadgets and computerized equipment improve the credibility of the service, as it boosts the image of the field being more precise and more scientific".[42]

One of the sophisticated programs currently available is called **SDI (Stress Diagnostic Inventory)**. The software package was developed by researchers at the University of Montreal for use on a personal computer and it can be tailored for any given client.

SDI was developed following 10 years of research on stress and burnout and their consequences on individual and organizational health.[43] It is intended to assist diagnosis at both the individual and the organizational or unit levels. The user simply replies to a series of questions on a computer screen, and diagnosis (in either English or French) is displayed or printed immediately following the completion of the battery of tests. Because the computer is programmed with norms for different occupations, the diagnosis includes a reference for establishing the severity of the problem. The computer is capable of assembling any paper and pencil inventory/test currently used by EAP experts for the purposes of assessment.

The beauty of the program is that, in addition to individual analysis, it performs aggregate analyses, thereby identifying epidemiological trends and consequently providing an early warning for a given problem that seems to be apparent in a specific location or in some categories of employees. The potential uses for instruments of this kind are enormous as they permit the simultaneous analysis of individual and group data. This permits a more balanced and holistic approach to organizational intervention (i.e. for both treatment and prevention), as well as individual treatment.

6.4 Concluding Remarks

Most employers and employees who have experienced EAPs view them quite positively. Decision-makers in the corporate world must become convinced that investing in EAPs leads to a double-winning position: furthering organizational effectiveness and enhancing employees' well being. Nonetheless, an EAP is not a panacea. While it will provide assistance for personal problems it will not eliminate all tardiness, absenteeism, accidents or morale problems. Also, it will not solve union-management or other organizational malaise.

A comprehensive EAP has a two-fold function: correction and prevention. While the area of correction has received ample attention and various models of service delivery are used in many organizations, the area of prevention is still in its infancy. Because of the fact that most organizations operate with limited resources, EAPs need to demonstrate tangible results, as well as indications of cost-effectiveness in the long run, in order to prosper in organizations. While if is widely recognized that not all results of EAP intervention can be measured precisely, if is generally agreed that the benefits outweigh the costs, assuming that the program is properly implemented and managed.

The major drawback of many EAPs is that they are geared towards microscopic intervention, after the fact. Their preventive role should be the trend for the future where the traditional, individual assessment will be coupled with educational efforts and will be expanded to include organizational diagnosis, thereby permitting a new array of organizational, microscopic interventions. The notion that some organizations, or some units within an organization, might be breeding grounds for generating and fostering employees' problems is beginning to be recognized. It is for these reasons that a number of recent cases of employee burnout have been recognized by workers compensation boards in Ontario and in Quebec, as well as in several arbitral awards. Thus, if individual treatment is performed in isolation from the unit/department, it might be nothing more (in some cases) than an exercise in futility. This calls for increased collaboration between the traditional EAP professional and the human resources expert and between the physician and the supervisor. The new EAP will represent this eclectic and multi-disciplinary approach. One final conclusion seems to be evident: regardless of the approach chosen, regardless of the scope and technology used, EAPs are here to stay.

Notes

1 Googins, 1975; Hollmann, 1981; Masi, 1982; Jones, 1983; Trice & Beyer, 1984; Roman & Blum, 1987a; Straussner, 1988; Appelbaum & Shapiro, 1989.

2 Levine, 1985; Steele, 1982; Masi & Teems, 1983a.

3 Roy-Brisbois, 1983; Santa-Barbara, 1983a; Canadian Mental Health Association, 1984.

4 Bilik, 1987.

5 Whitbread's, 1989.

6 Johnson & Black, 1985.

7 Carmody-Sheehan, 1983; Roman, 1983a; Terry, 1987.

8 Alcohol and Drug Addiction Foundation, 1978; Albert et al., 1985; Klarreich et al. 1985; MacMaster, 1988; MacDonald & Dooley, 1989a.

9 Sonnenstuhl & O'Donnell, 1980; Dickman & Emener, 1982b; Ray, 1982; Gerstein & Bayer, 1988.

10 Johnson, 1985; Levine, 1985; Appelbaum & Shapiro, 1989.

11 McClellan, 1983; Delaney, 1987.

12 McClellan & Miller, 1988a; Spicer, 1987; Kim, 1988.

13 Presnall, 1981; Trice & Schonbrunn, 1981; Trice & Beyer, 1984; Masi, 1986; Brock, 1987; Masi & Goff, 1987.

14 Roman, 1983; Sonnenstuhl, 1986; Sonnenstuhl & Trice, 1986; Roman & Blum, 1987a.

15 Trice & Schonbrunn, 1981; Roman, 1988.

16 Shain & Groeneveld, 1980; Shain, Suurvali & Boutilier, 1986.

17 Roman & Blum, 1985; Roman et al., 1987.

18 Sonnenstuhl & Trice, 1986; Trice & Sonnenstuhl, 1988.

19 More specific information and details can be obtained from the full length report mentioned at the beginning of this paper.

20 Jones, 1983; Kemp, 1985; Levine, 1985; Lanier et al., 1987.

21 Gray & Lanier, 1985-86; Lanier et al., 1987; Masi & Friedland, 1988 and Appelbaum & Shapiro, 1989.

22 Addiction Research Foundation, 1984a; Lanier et al, 1987.

23 More information and examples about union-based models and/or labour involvement can be found in: Pedis (1980); Putnam & Stout (1982); Trice & Beyer (1982); Hudson (1983); Lynch (1983); Cohen-Rosenthal (1985); MacDonald & Albert (1985); Riediger (1985); Tramm, (1985); Stennett-Brewer (1986); BNA (1987) and Wilcott (1987).

24 Erfurt & Foote, 1977; Barrie et al., 1980; Masi and Teems (1983a).

25 Corneil, 1982; Addiction Research Foundation, 1984b.

26 Hellan & Campbell, 1981; Corneil, 1982; BNA, 1987.

27 More detailed information about these is elaborated in the original report (Dolan and Wolpin, 1990).

28 Other more detailed Information on implementation and the specific functions performed by EAP practitioners and supervisors can be obtained from the detailed report by Dolan and Wolpin (1990).

29 Dickman & Emener, 1982a; Masi, 1984; Appelbaum and Shapiro, 1989.

30 Kim, 1988; Masi and Friedland, 1988. More detailed information on different evaluation methods and on the specific type of questions to be asked when evaluating a program can be found in the detailed report by Dolan and Wolpin (1990).

31 Jones, 1987; Balgopal & Patchner, 1988.

32 A number of cost-benefit analysis models have been described in Shain et al. (1986) and several practical examples in both the public and private sectors in Canada and the U.S. are described in Dolan and Wolpin (1990).

33 Foote et al, 1978; Gam et al., 1983b; Nadolski and Sandonato, 1987.

34 Jerrell & Rightmyer, 1982; Myers, 1984; Starr and Byram, 1985.

35 Dolan et al., 1988; Dolan, 1989.

36 Metro Toronto Police Force - Schaer, 1986; Ottawa Police Force -Welsh & Westwick, 1984.

37 Los Angeles Police Force - Petrone & Reiser, 1985; Metro-Dade Police Department, Dade County, FL. - Tipps, 1984; Chicago Police Department - Wagner, 1983; Cleveland, OH, Police Department Bratz, 1986.

38 Singleton and Teahan, 1978; Dolan, 1989.

39 As cited in Brennan et al., 1987.

40 Additional information on peer counselling can be found in Capps (1984) and Hodson & Fallon (1989a)

41 For more information about post trauma counselling see: Roy-Brisebois, 1983; Welsh & Westwick, 1984; Gwaltney, 1987.

42 Source: interview conducted with the medical/EAP team of the Royal Victoria Hospital in Montreal.

43 Dolan & Arsenault, 1980; Arsenault & Dcgan 1983a, 1983b, Dolan & Arsenault, 1984; Dolan & Balkin, 1987; van Ameringen et al., 1988, Arsenault et al., 1989, Arsenault et al., 1990, and Dolan, 1990.

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