Csiernik, R. (2002). An overview of Employee and Family Assistance Programming in Canada. *Employee Assistance Quarterly*, 18 (1), 17-34.

1. INTRODUCTION

> "The EAP has been established to assist any employee, immediate family member or retiree in resolving a personal problem. The services provided will be professional, confidential, and available at the earliest sign of need. This program intends to make a positive contribution to the growth and development of each individual who utilizes its services as well as the company as a whole."
>
> Noranda Inc., Brunswick Smelter Division, Belledune, New Brunswick

As conspicuous as Employee Assistance Programs are on the Canadian landscape, the programs themselves remain surprisingly unexplored. While there has been extensive research conducted in the EAP field in Canada (Csiernik, 1997; 1998; 2000; Loo & Watts, 1993; Macdonald & Dooley, 1990; 1991; Macdonald, Lothian & Wells, 1997; Macdonald & Wells, 1994, MacDonald & Davidson, 2000; Massey & Csiernik, 1997; McKibbon, 1993a; 1993b; Newman, 1983; Rheaume, 1992; Rodriguez & Borgern, 1998) there has not been an extensive examination of the structure and functions of programs.

In response, a four page survey was developed in 2001 in conjunction with a national advisory committee of labour, management and service providers. Along with basic demographic information the instrument asked when programs began, who initiated the EAP, who provided services and what their qualifications were. Inquiry was made regarding referral routes, utilization, who was eligible to receive assistance, and for what length of time. Table 7.1 highlights the location of the respondents (7.1a) and their respective workforce sectors (7.1b). The greatest number of responses came from Ontario (40.3%) while Prince Edward Island had only one (0.7%) reply as did the Northwest Territories. As well, there were 14 (9.1%) national organizations that returned the survey. Government organizations constituted one quarter of the replies followed by manufacturing (15.6%), health care (13.0%) and education (13.0%). It was interesting to note that 100 (64.9%) of the 154 responses came from the public sector. Workforce size ranged from seven to 60,000, with a mean of 3,144 and a median of 1,350 employees.

Table 7.1: Organization Demographics (n=154)

Table 7.1a: Location of Organizations

Location	Frequency	%
British Colombia	5	3.2
Alberta	14	9.1
Saskatchewan	9	5.8
Manitoba	11	7.1
Ontario	62	40.3
Quebec	3	1.9
New Brunswick	12	7.8
Nova Scotia	9	5.8
Prince Edward Island	1	0.7
Newfoundland	11	7.1

Table 7.1b: Workforce Sector

Sector	Frequency	%
Government	40	26.0
Manufacturing	24	15.6
Education	20	13.0
Health Care	20	13.0
Forestry	8	5.2
Energy & Utilities	7	4.5
Law	7	4.5
Transportation	5	3.2
Mining	4	2.6
Sales and Service	4	2.6
Social Services	4	2.6

Yukon Territory		2	1.3		Communication	3	1.9
Northwest Territory		1	0.7		Construction	2	1.3
					Corrections	2	1.3
National		14	9.1		Finance	2	1.3
					Food Services	2	1.3

2. PROGRAM DEVELOPMENT

> "(the purpose of our EAP is) to provide a work environment that supports our employees' well-being" - law enforcement, Ontario

Despite an extensive history of occupational assistance in Canada (Csiernik, 1992) the EAP field remains relatively new as only 16 programs in the study were initiated prior to 1980. Nearly half, 65 (45.8%) were developed in the 1980s while another 56 (39.4%) were begun in the 1990s. There still also appears to be ongoing growth as 21 (13.6%) were created between 1997 and 2001 with five (3.5%) begun in the new century.

Table 7.2 examines who initiated the EAP. The majority of the workplaces in the sample (89.6%) were unionized and this is reflected in program initiation as more than half of the EAPs were created by a joint labour-management group. Management and/or human resources was responsible for beginning nearly one third of the programs (31.1%) followed by labour (6.4%) and occupational health (5.8%). While occupational health services were extensively involved in Occupational Alcoholism Programs (Csiernik, 1992; 1997) this latter finding suggests a decreasing importance of health services in EAP program development. Also, smaller organizations were more likely to have had their EAP initiated by management while larger organizations were most likely to have

a joint labour-management group as the driving force behind program development.

Table 7.2: EFAP Initiator (n=154)

Initiataor	Frequency	%
Joint Labour-Management Group	82	53.2
Management	48	31.2
Labour	10	6.5
Occupational Health	9	5.8
Individual	3	1.9
Not Reported	2	1.3

3. SERVICE DELIVERY

"(the purpose of the EAP) is the promotion of human wellness and the creation of healthier employees, families and communities."

Suncor Energy – Oil Sands Fort McMurray, Alberta

Table 7.3 presents the three primary sources of providing assistance through an EAP and the extent to which each option was used by the survey respondents. What was most surprising was not that the majority of programs (86.4%) used at least one professional counsellor outside of the workplace but how many now used a hybrid model. Nearly one third of the organizations, 47, use a combination of internal volunteers, either referral agents, union counsellors or members of a 12-step fellowship, in conjunction with an internal coordinator or counsellor and at least one external professional counsellor. Another 30 (19.5%) organizations use an internal professional supported by a third party, external counsellor. Only six (3.9%) organizations in the study used internal volunteers

alone to provide assistance. It was also interesting to note that while 133 companies do use external counsellors or counselling agencies just over one quarter, use external counselling as their sole mechanism for providing EAP services. As well, the larger an organization is, the greater the likelihood that an internal professional would be involved in providing services to the workforce.

Labour initiated programs were the most likely to use internal volunteers to provide assistance (70.0%) followed by joint committee initiated EAPS (56.1%) and by management initiated programs (31.2%). The number of internal volunteers used ranged from 1 (n=4) to 300 (n=1) with a mean of 40 and a median of 15. The amount of education and training provided to internal volunteers varied widely. One organization only provided its internal volunteers with one half day of training after which they were allowed to become part of the EAP while another required three weeks. One (n=10) and two (n=6) weeks of training were not atypical though nearly 40% of organizations using peer supports reported providing three days or less. Thirty-four organizations reported that their internal volunteers also received annual follow-up education and training lasting from one half day (n=1) to two weeks (n=3) with a mean of four days.

Table 7.3: Delivery of EFAP Services (n=154)

	Frequency		%
	sub-total	total	
1. Internal Volunteers		72	46.7
Referral Agents	64		41.6
12-step members	15		9.7
Union Counsellors	13		8.4
2. Internal Professionals		91	59.1
Social Workers	46		29.9
Occupational Health	46		29.9
Human Resources	35		22.7

3. External Professionals				133	86.4			
Multidisciplinary Agency			86		55.8			
Private Practitionners			56		36.4			
Assessment Referral Service			13		8.4			
Consortium			7		4.5			

Those providing EAP services are a well educated group in Canada (Table 7.4a). Nearly 80% of organizations use at least one counsellor with a Master's degree while slightly more than 40% have at least one counsellor with a doctoral degree. As well, nearly 40% of EAP counsellors had a specialized diploma in addiction studies while one third have EAP studies certificates. Of the 154 respondents, 119 (77.3%) had counsellors who were members of a professional association with practice guidelines and ethical codes of conduct (Table 7.4b). Nearly two-thirds (n=76) of organizations use registered social workers to provide assistance through their EAP followed by certified psychologists (n=56), certified alcohol and drug counsellors (n=46), certified trauma specialists (n=41), certified Employee Assistance Professionals (n=33) and certified occupational health nurses (n=22).

	Table 7.4: Service Provider Qualifications							
	Table 7.4a: Degree/Diploma (n=139)							
			Frequency	%				
Community College			27	19.4				
Undergraduate			33	23.7				
Masters			111	79.9				
Doctoral			56	40.3				
Addiction Certificate			55	39.6				
EAP Studies Certificate			47	33.8				
	Table 7.4b: Certification (n=119)							
				Frequency	%			

Registered Social Worker (R.S.W.)		76	63.9			
Registered Psychologist (C. Psych)		56	47.1			
Certified Alcohol and Drug Counsellor		46	38.7			
Certified Trauma Specialist (CTS)		41	34.5			
Certified Employee Assistance Professional		33	27.7			
Certified Occupational Health Nurse		22	18.9			
Certified Marital and Family Therapist (AAMFT)		9	7.8			
Clinical Counselling Certificate		8	6.7			

4. PROGRAM ACCESS

When workplace based assistance evolved from Occupational Alcoholism Programs to Employee Assistance Programs the emphasis remained on the employee. However, in the intervening years there has been acknowledgment that immediate family members should also be counselled through the auspices of these initiatives. This has contributed to many programs changing their name from Employee Assistance to Employee and Family Assistance. In this survey, 144 of 154 (93.5%) organizations allowed family members to use the company program. There were several groups, however, that were not readily allowed access to the EAP by the organization including part-time employees (27.9%), probationers (42.9%), seasonal workers (44.8%), retirees (54.6%) and employees who had been laid off (63.0%).

Each of the 154 programs in the study allowed those entitled to use the EAP to do so voluntarily. Nearly three-quarters had an informal referral system in place with 74 (48.1%) encouraging peers to refer their colleagues to the program. Sixty-two organizations had a formal referral pathway to EAP as an option while 49 (31.8%) also had a mandatory program usage component. However, there were only eight companies that had drug testing as a method through which EAP was

accessed, and all eight were private sector organizations that used third party providers for their service delivery.

The capping of service has always been a contentious issue in EAP. Four organizations did not respond to the question of if their program had a maximum number of counselling sessions. Seventy-two (48.0%) did cap EAP use while 78 (52.0%) did not (Table 7.5). Three (2.0%) organizations had a monetary cap rather than a limit on the actual number of sessions allowed. One organization allowed only two sessions, while two allowed for three and four for four. In reality these are not EAPs or EFAPs but rather assessment and referral services and it is somewhat a misnomer to include them in the research. In each of these cases the average number of sessions was the cap. For organizations with a capped service from five to twelve sessions the average number of counselling sessions was 5.1 while for the 78 non-capped organizations the average was 5.0. Simply stated, there was no difference in the average number of sessions between the two groups. Capping did not provide any real savings and in fact where services were capped at eight, ten or twelve, average use by employees and family members was greater than in instances where no formal cap was in place. This finding was not influenced by whether the organization was public or private sector nor who initiated the program. EAPs that used internal volunteers were the type of program most likely not to have a capped number of counselling sessions (50%). Just under one third of programs using internal professional service providers did not have a cap in place while 80.8% of programs with an external service provider did have a formal cap on service provision.

Table 7.5: Service Capping (n=150)								
Number of Sessions Allowed		Average Number of Sessions		Frequency	%			
No Limit		5.0		78	52.0			
	2	2.0		1	0.7			
	3	3.0		2	1.3			
	4	4.0		4	2.7			
	5	3.4		11	7.3			
	6	4.8		23	15.3			
	8	5.3		11	7.3			
	10	6.4		11	7.3			
	12	8.0		6	4.0			
Financial Cap		3.3		3	2.0			

5. PROGRAM MAINTENANCE

The EAP committee was at one time the foundation of Employee Assistance Programming (Albert, Boyle & Ponee, 1984). In this survey 98 (63.6%) EAPs were administered by a formally structured and sanctioned committee. However, the significance of this finding is that over one third of EAPs are not administered through any type of joint labour/employee-management group. Seven (70.0%) of the ten EAPs initiated by labour had a committee while 85.4% of those developed by a joint committee continued to be administered by one. Just over one third (n=17) of the management initiated programs had an EAP committee while only two (22.2%) of nine of those developed by occupational health services had a committee in place to oversee and monitor the program and to nurture its development. The larger an organization was the greater the likelihood of having a committee with size ranging from three to twenty-five members.

Two aspects that are required for an EAP to continue to develop and be used are program promotion and supervisor training. However, one quarter of

respondents stated that their program did not do any type of regular promotion, with this slightly more the case for third party providers (27.1%) than programs using internal professionals (25.3%) or internal volunteers (20.8%). Twelve (7.8%) organizations stated that they conducted promotion campaigns as needed while four (2.6%) did them infrequently. Just under one quarter of the organizations (n=35) held an annual campaign while 19 (12.3%) ran quarterly campaigns and ten (6.5%) had semi-annual promotion activities. While utilization rate is not necessarily a comprehensive indicator of the health of an EAP, utilization rate was nearly two percentage points greater for organizations that conducted promotion campaigns (9.6%) than for those that did not (7.8%). Similarly, 38 (24.7%) organizations reported not providing any type of new employee orientation on the existence or function of the EAP. Those that provided an orientation for new employees had a program utilization rate of 9.8% compared to 7.2% for those organizations who did not, a difference of more than one third. Not surprisingly, the smaller the organization the less promotion that was conducted (Table 7.6).

Sixty-two (40.3%) organizations did not provide any type of supervisor education or training regarding EAP. Of these all 62 used as part of their service delivery or their exclusive provider of assistance, professionals external to the workplace. Only 36 (23.4%) of organizations had any type of regular training/education program in place with another 27 (17.5%) stating that they conducted these as the need arose.

	Table 7.6: Program Maintenance (n=154)					
Frequency		Program			Supervisor	

of Activity	Promotion			Training	
	frequency	%		frequency	%
monthly	5	3.2		0	0
bi-monthly	4	2.6		1	0.6
quarterly	19	12.3		6	3.9
semi-annually	10	6.5		4	2.6
annually	35	22.7		25	16.2
as needed	12	7.8		27	17.5
infrequently	4	2.6		4	2.6
never	43	27.9		62	40.3
not reported	22	14.3		25	16.2

6. PROGRAM COMPONENTS

"(we have) no policy or mission statement. EAP was added under (the) benefits plan with no formal program management of services."

- education sector, Alberta

When EAPs began to evolve a basic program consisted of a policy, an orientation to the new program and the provision of service. Since then many extra features have been added. One hundred and twenty-two (79.8%) EAPs had a formal policy in place that provided written documentation and the framework upon which the program was based while 50 (32.5%) had done some type of formal program evaluation. However, this meant that one in five EAPs in this survey had no policy statement and operated within the organization without a formalized mandate while two thirds were not able to or chose not to provide some form of rudimentary evaluative information regarding their program. Fifty-eight (37.7%) EAPs also had a distinct substance abuse policy in place in conjunction with or separate from the EAP policy, though only seven (4.5%) organizations had distinct drug testing programs. Nearly half (48.7%) of the respondents had a disability

management program in place while a greater number (61.0%) had established a wellness program.

The majority of organizations had a critical incident/trauma protocol in place (81.2%) with 41 (34.5%) having access to a certified trauma specialist as part of their service provision. The majority of organizations also provided counselling services throughout the day, seven days per week (70.8%). Interestingly, three-quarters (n=116) of the respondents also reported that their EAPs provided group training or counselling sessions on topics such as coping with organizational stress or change. Considering the origins of Occupational Alcoholism Programs and EAPs in the self-help movement it was surprising to find that only 17 (11.0%) organizations provided access to mutual aid/self-help groups on site. Of these, seven had Alcoholics Anonymous or related 12-step groups that met at the workplace, one featured peer led group debriefing sessions while there were four wellness-related groups on topics such as nutrition or weight loss.

7. UTILIZATION

Overall, the mean utilization rate across the 154 programs was 9.2% with a median of 8.4%, and a mode of 10.0% (n=13). Utilization ranged from 1.0% for an Alberta hospital and an Ontario forestry company to 30.0% at Dana Canada, an Ontario manufacturing company. There was slightly greater utilization among private sector companies than public sector organizations while utilization of EAP services was greater in unionized settings than in non-union environment. As well, utilization was also greater in organizations where representatives of labour

continued to be involved in the program's maintenance and development through involvement in a joint labor-management committee. Utilization rates were also greater when volunteers were involved, when a formal policy existed and there was at least one promotion campaign a year highlighting the existence of the EAP.

The most important discover, however, was that there is no uniform formula for determining utilization. Ten organizations did not calculate a utilization rate six reported that they did not know how the utilization rate they were reporting was calculated while fifteen relied exclusively on their external service provider. Of the 102 companies that did report a utilization rate there were 19 different calculations used (Table 7.7). The most commonly used formula was new files per year by the number of employees (n=39). This was followed by family members plus employees using the EAP divided by the total number of employees (n=21), and then total number of employees using the EAP divided by total number of employees in the workforce, even though family members had access to the counselling and assistance offered by the program (n=14). In this latter case, family members were not factored into either the numerator or the denominator. Only one organization that counted family members using the EAP also considered the number of family members in the denominator while another organization calculated utilization rate by dividing new cases into the total number of households represented by the workforce. As well, four companies included not only family members and employees but also retirees though they divided this total only by the actual number of employees, though again one company that counted retirees in the numerator also factored them into the denominator to obtain their utilization

calculation. Seven organizations determined utilization by dividing the number of referrals by the number of employees while three used counselling sessions as the numerator. Other utilization calculations reported in the survey were based on individual and group counselling sessions, families per year, hours of counselling provided, number of visits, and new cases.

Three organizations, recognizing the complications involved in determining an accurate utilization rate actually used two separate calculations. Of these three companies, two determined an employee only utilization rate along with a utilization rate that considered use by family members. The third company was interested not only in use but also in the rate of contact. However, perhaps the most telling response was “our utilization rate is actually a guess. I tend to focus more on costs”

Table 7.7: How Utilization Rate Is Calculated (n=154)			
19	no response		
15	defined by service provider		
10	not calculated		
6	do not know		
39	new files/employees (ongoing files not included)		
21	family + employees/total employees		
14	only employees using/employees (family can use)		
7	number of referrals/employees		
4	staff + families + retirees/employees		
3	employees only/employees (no family service offered)		
3	counselling sessions/employees		
1	number of calls/employees		
1	number of visits/employees		
1	new clients + carry overs + families/employees		
1	individual counselling + group sessions/employees		
1	new cases /household		
1	employee + families/employees + families		
1	families per year/employees		
1	employees + retirees/employees + retirees		
1	hours of service provided		

1	our utilization rate is actually a guess. I tend to focus more on costs								
	2 calculations								
2	employee use/employee population						as well as		
	employees + dependents/employee populaiton								
1	number of people / employees						as well as		
	number of contacts/employees								

Further complicating this is that there is also no common definition of how a case is defined as illustrated in Table 7.8. Twenty companies stated that it was their service provider who defined what a case was while six stated that it varied. The most frequent reply (n=32) to this open-ended question was that one new case was defined as either one new individual client or as one new family. For 31 organizations a phone intake was equivalent to a visit and would trigger the opening of a case while for 18 organizations a case necessitated an actual face-to-face counselling session. As well, one food sector organization in Alberta only considered a meeting as a case if some type of treatment plan was developed.

Different lengths of phone contact triggered a case for other organizations. For one company it had to be at least 45 minutes of phone contact before it was considered a case, while for a second four phone calls was equivalent to one visit while five companies responded that a minimum of fifteen minutes of contact constituted a new case. Seven different organizations from across Canada stated that they determined a case by the number of people that presented for counselling. For each of these companies two individuals from the same family would count as two cases, if five family members were seen it would constitute five

distinct cases. Contrarily, three companies simply viewed family members as extensions of employees and did not count them independently while one company stated that if a couple comes together it is one case but if they are also seen apart it became two cases in determining the utilization rate.

Five organizations stated that if they assisted the same client with two different problems in one year, that it would constitute two cases. It is hypothesized that this is one mechanism used to overcome the restrictions of service caps. Another organization reported that after every twelve hours of counselling they considered the situation a new case that again could be a creative way to circumvent capping of services for clients still in need of counselling. A third scenario that two organizations employed may too have arisen as a response to the capping of services. In these organizations if a client's case was closed but the client returned at some later time in the same year it was considered as a new case and the client became eligible for a new block of counselling sessions. This could also be one response by counsellors to employ who are no longer being paid by the counselling hour but by the head. Thus, if more heads are counted more counselling can be supplied to the client and the counsellor can claim remuneration from the third party provider who is coordinating the provision of clinical services.

Utilization rates are regularly used to compare organizations ability to assist employees, they are used in assessing what model of assistance should be used in certain situations, if additional program promotion or development is required and utilization is also used as a foundation evaluative tool. In quantitative research knowing how to count is a rudimentary necessity. However, in the multimillion

dollar, multidisciplinary, unregulated field of EAP, one that continues to both nationally and globally, this fundamental concept is lacking.

Table 7.8: How A Case Is Defined (n=154)	
20	defined by service provider
8	no response
6	varies
6	do not know
2	do not calculate
32	one new family or one indivdual = 1 case
31	phone call or visit
18	actual face-to-face counseling session
7	2 individuals = 2 cases, 5 family members = 5 cases
5	each new problem is a new case even if it is the same person
5	15 minute phone contact
3	family member counted with employee as one case
2	any contact that leads to referral
2	if client file closed and then client returns in the same year = new case
1	defined by area of service counseling versus group - 1 client can be 2 cases
1	every 12 hours of counselling is a new case
1	45 minute phone contact
1	4 phone contacts or one visit
1	only a case once treatment plan developed
1	only new clients, any repeat client is not a new case
1	couple together = 1, couple apart =2

8. CONCLUSION

"HLC is concerned with the personal well-being of all employees and their families. It is recognized that a wide range of personal problems may have an adverse effect on an employee's well-being and ability to perform his/her

duties. Personal problems can include illness (physical or mental), emotional problems, stress, financial, family, marital, legal, or other problems such as substance abuse. HLC's EFAP is designed to provide accessible, professional and confidential help to all employees and their family members who are experiencing personal problems through a process of assessment, short- term counselling, referral and follow-up."

-Health Labrador Corporation, Goose Bay, Labrador

Employee Assistance Programming remains a growing enterprise in Canada and while third party professionals are a prominent mechanism through which assistance is provided, peers and internal professionals remain important within many programs. Differences in EAPS arise depending upon who initiates the program, who provides the service, the size of the organization and if it is a unionized environment. There remains many areas that require continued program development including policies, promotion, orientation, supervisory and peer education and training and perhaps most importantly work on developing uniform definitions of critical terms such as what a case is and how utilization should be calculated.

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