Employee Views of Organizational Wellness and the EAP:

Influence on Substance Use, Drinking Climates, and Policy Attitudes

Joel B. Bennett
Wayne E.K. Lehman

Texas Christian University

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Joel B. Bennett, Ph.D., is an associate research scientist with the Institute of Behavioral Research at Texas Christian University. Dr. Bennett has taught psychology, consulted in organizational wellness, and is currently developing a training program to address the effects of workplace culture and corporate downsizing on employee substance use.

Wayne E. K. Lehman, Ph.D., is a research scientist with the Institute of Behavioral Research at Texas Christian University and director of the Drugs and the Workplace project. His research interests are in the measurement, etiology, and impact of employee drug use. Address:

Institute of Behavioral Research
Texas Christian University
Box 298740, Fort Worth, Texas, 76129
(817) 921-7226 - FAX: (817) 921-7290
JBENNETT@GAMMA.IS.TCU.EDU

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Abstract

This study examined the influence on substance use of organizational wellness and of attitudes toward the EAP. We developed the Organizational Wellness Scale (OWS) to assess perceptions of healthy (e.g., respectful) and addictive (e.g., workaholic) work climates. Employees from a municipal organization (N = 780) who scored high on the OWS reported less personal and co-worker substance use and enabling behaviors, and more favorable attitudes towards substance use policies. Results suggest that, beyond the influence of the EAP, work site health may effect both individual and work group substance use. Using the OWS, health service providers could benefit from monitoring the impact of organizational wellness on individual and work group health.

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The idea that organizations vary in healthy versus addictive or dysfunctional climates has been discussed by several authors (Kets de Vries, 1991; McMillan & Northern, 1995; Rosen, 1991; Schaef & Fassel, 1988). However, there has been little empirical investigation of these climates, particularly of their influence upon employee substance abuse and co-worker enabling of colleagues who use alcohol or drugs. Traditionally, Employee Assistance Programs (EAPs) have been seen as helping companies curb substance use. While EAPs have worked with substance use prevention in individuals (as their counselors, educators, and referral sources), they also assess and counsel with regard to the overall social health of work-groups and departments.

The work of EAPs can either be facilitated by a climate of health or constrained by a climate of addiction. For this reason, employee views of the EAP and their perception of work place healthiness may overlap or coincide. Consequently, it can be difficult to distinguish the unique influence of the EAP or of corporate wellness on personal and work group substance use. To address this difficulty, the following research assesses the unique influences on substance use of both the EAP and of organizational wellness. In addition, to help the EAP in an assessment of climate, we introduce the "Organizational Wellness Scale" which has three components -- Healthy and Balanced Work Perspective, Co-worker Respect and Openness, and Organizational Supports.

We predict that employees who have either a positive view of their workplace as healthy or a positive image of the EAP will be less likely to report substance abuse. Moreover, if wellness occurs at an organizational level, these employees are also likely to report less drinking or drug use climates, and more supportive attitudes toward workplace substance use policies. This article addresses two questions: (1) What influence does organizational wellness have on substance use

(at individual, social, and policy levels), beyond the influence of EAP?, and (2) What influence does the EAP have on substance use, beyond the influence of organizational wellness?

Organizational Wellness and the EAP

Csiernik (1995) commented that while the majority of EAP programs have focused on individualizing problems of wellness, recent advances have considered a more holistic and ecological approach. This approach considers the impact of social systems at work, environmental factors, as well as work practices and policies. Csiernik argues:

> If the future of Employee Assistance Programming includes greater involvement in wellness initiatives two courses of action will be required. Initially, a more holistic and complete definition of wellness will need to be adopted. Secondly, EAPs will need to expand their comfort zone and work towards not only assisting in enhancing workers' wellness but also in creating well workplaces (1995: 11).

In fact, the expansion of the EAP role as advocate of corporate wellness may be stimulated by the recent and unbridled growth of managed care programs (Hyatt, 1994; North, 1992; Robbins, Gerson, & Moore, 1992). Through orientation efforts and awareness programs, employees become familiar with individual EAP professionals who may be seen as providing more available and accessible counseling services than a list of HMO providers. In fact, EAP providers may offer more strategic referrals to meet the specific needs of employee clients (Conlin, Amaral & Harlow, 1996). EAP involvement in the continuum of care has also been associated with more positive outcomes than those found in typical treatment programs (Blum & Roman, 1995).

Whether competing or cooperating with managed care, the EAP can serve as a proximal or immediate "gatekeeper" for a number of health service functions: prevention advocacy, risk management, quality assurance, cost effectiveness, and behavioral risk reduction ("How Managed Care," 1992; Springer, 1996). As these roles expand and the EAP communicates and networks throughout an organization, EAPs may be in a special position to assess the "bigger picture" of wellness at the level of corporate culture. They may also have a need and obligation to do so.

Still, while there is a good deal of discussion about corporate health, "organizational wellness" remains a somewhat fuzzy, unmeasured, and subjective concept. Thus, any clarification (and measurement) in this area could benefit program development and evaluation. Fortunately, writers and researchers have previously offered analyses of either organizational health or organizational dysfunction/addiction. The following review of this literature focuses on organizational features that might have the most relevance for the EAP role in substance use prevention and intervention.

Organizational Health. Health Promotion Programs (HPPs) at work have traditionally sought to change employees' unhealthy living habits, which include substance use (Sonnenstuhl, 1988). Shain, Suurvali, and Boutilier (1986) suggest EAPs and HPPs work together to develop education programs for changing unhealthy life-styles in several areas: smoking cessation, weight control, nutrition, exercise and fitness, stress management, drug and alcohol counseling, and mental health counseling. However, such programs are often episodic and ignore occupational factors (Sauter, Murphy, & Hurrell, 1990); participation in them may only be a "Band-Aid" for employees who return to unhealthy or socially adverse working conditions. For example, Trice and Sonnenstuhl (1990) identify four unhealthy working conditions that promote alcohol use: work place culture (beliefs that condone drinking), social control (inefficient surveillance of use), work alienation, and work stress. Prevention efforts are likely to fail in the absence of programs that address these ongoing conditions.

In order to influence such broad aspects of work culture, health promotion efforts might need stronger integration into organizational structure and philosophy. Administrators, practitioners, and researchers of health promotion endorse such HPP integration. Harris (1994), in a survey of ninety-five members of the editorial board of the *American Journal of Health Promotion,* concluded that HPPs have not been successfully integrated into organizational goals and objectives. For such integration to occur, respondents felt that employers should show more

respect to employees, that HPPs focus more on social support (Gottlieb & McLeroy, 1994) and healthy work cultures (Allen & Bellingham, 1994), and that managers should allow time for health promotion activities (e.g., child care, flexible hours).

While HPPs and EAPs are two proponents of a healthy company, the campaign for organizational wellness extends beyond the reduction of health risk behaviors. In his survey and interview research of healthy companies, Rosen (1991) identifies key managerial strategies that develop not only healthy people, but healthy profits as well. These strategies include: showing trust, appreciation and respect for employees, leadership through increased participation at more organizational levels, continuous learning through new training and re-training programs, and establishing closer partnerships between work and family.

The above researchers make a good argument for the administrative promotion of healthy companies, but there is little research on employee perceptions or values of organizational health. Various symposia at a recent conference on occupational stress and health have begun to address this lack (American Psychological Association, 1995). The symposia presented an employee attitude survey and organizational audit from the Saint Paul Fire and Marine Insurance Company (Moran, 1995), an opinion survey used by the Ford Motor Company (Slade, 1995), and a Healthy Company survey derived from Rosen's work (Moyer, 1995). Across different studies, the importance of supportive co-worker relationships, open communication, and reduced 'workaholism' were some key factors related to employee well-being.

Organizational Addiction. In comparison to organizational health, a number of authors have viewed organizational cultures as unhealthy ("neurotic," "addictive," or "co-dependent") (Kets de Vries, 1991; Schaef & Fassel, 1988). Addictive organizations are characterized by: a norm of workaholism, hierarchical structures that perpetuate feelings of powerlessness, fixation on the "bottom line" to the point of ignoring values and health, avoidance of feelings and

conflicts, and sometimes the presence of a central or administrative employee who has a substance addiction (Schaef & Fassel, 1988).

Like the addicted individual and his or her family, addictive organizations function like a "closed" system. They fail to consider feedback from the environment because they: (a) deny or minimize the problem, (b) prefer confusion to taking responsibility, or (c) are self-absorbed or focused on one thing (e.g., the bottom line) (Eisenberg & Goodall, 1993; McMillan & Northern, 1995). Social relationships that ignore, avoid, minimize, or enable co-worker drinking problems have also been labeled co-dependent (Allcorn, 1992; McMillan & Northern, 1995). In fact, research has shown that employees do minimize or enable substance use by "looking the other way" or avoiding problem situations (Ames & Delaney, 1992; Roman, Blum & Martin, 1992). Thus, one measurable correlate of an unhealthy culture may be informal social supports for co-worker substance use (Walsh, Rudd, Biener, & Mangione, 1993).

Of the various aspects of an unhealthy culture, addiction may best correlate with employee abuse of alcohol or drugs. A quantitative assessment of a culture's addictive qualities may be difficult since such "closed" systems are characterized by indirect communication, and the capacity to "impression manage" outsiders into thinking everything is fine (McMillan & Northern, 1995). However, once assured of anonymity and confidentiality, employees might report on some aspects of an addictive climate.

Integrating Health and Addiction: A Measure of Organizational Wellness. Based upon the research outlined in the above review, we generated a list of sixteen items to assess employee perceptions of organizational health and addiction. On the basis of psychometric and factor analyses a final set of ten items were combined into a measure of organizational wellness (see Table 1). This 'Organizational Wellness Scale' thus combines elements of health and addictive or dysfunctional climates into a single index. We used this measure to explore the main predictions set out earlier; that perceptions of organizational wellness will correlate with less substance use.

Insert Table 1 about here

Method

Sample

The sample city was located in the southwest and included approximately 4,000 employees (excluding uniformed police and fire) who were divided into different work groups that ranged in size from 6 to 80. We randomly selected work groups in the seven largest departments, resulting in a final sample of 909 employees representing all job classifications. Since the current study investigated perceptions of work climate, we assumed that only employees with some tenure could provide meaningful assessments of their work site. Thus, only those who had worked for the city for at least one year were used for the current analysis, resulting in a total sample of 799. These employees were 69% male, and 68% were older than thirty with a full 40% in the age group of 41 to 50. Over 60% had completed course work beyond high school and 70% had worked for the city for more than 6 years. Employees were 54% White, 24% African American, and 18% Mexican American or Hispanic. Eight percent indicated having used the EAP services at some point, and about 1% reported visiting the EAP for drug or alcohol purposes.

Measures

All employees completed a paper-and-pencil questionnaire titled “Employee Health and Performance in the Workplace.” Questionnaires were administered by research staff to small employee groups during working hours on city property. All questionnaires were anonymous and confidential. No names were collected, and no original data were given to city officials. Participation was completely voluntary and employees could choose to withdraw their participation at any time. We used measures in three areas: Organizational Wellness, Employee Orientation or Attitudes Towards EAP, and Substance Use and Related Measures.

Organizational Wellness Scale. Employees rated how much they agreed with a list of ten statements. Responses options were 'Strongly Disagree' (1), 'Disagree' (2), 'In Between' (3), 'Agree' (4) and 'Strongly Agree' (5). Each of these items are listed in Table 1, along with the percent of those who agreed (scored '4' or '5') or disagreed (scored '1' or '2'), and the average response to each item. A principal components factor analysis with varimax rotation suggested that three different areas were covered by these items. As shown in the Table these were labeled (1) 'Healthy and Balanced Work Perspective' which represents a priority on health and the absence of workaholism among co-workers; (2) 'Co-worker Respect & Openness' which represents appreciation of diversity and non-avoidance of conflict; and (3) 'Organizational Supports' suggesting that employees see the city offering classes and policies that allow time for health promotion. The internal consistency of these items was relatively high, *alpha* = .75.

EAP Orientation. Two items asked how likely was it that the employee would recommend or go to the EAP for help. These items are listed in Table 2. Response options were 'Very Unlikely' (1), 'Unlikely' (2), 'In Between' (3), 'Likely' (4) to 'Very Likely' (5). As the table shows, employees were almost three times more likely to recommend than not recommend the EAP. The internal consistency of these items was relatively high, *alpha* = .73. It should be noted that only 65% of employees in the selected sample indicated that they were aware of the various services provided by the EAP. As might be expected, these employees had more positive attitudes toward EAP ($\underline{M} = 3.59$) than those who were not aware of EAP services ($\underline{M} = 2.96$), $\underline{F}(1, 714) = 44.67$, $\underline{p} < .001$. This finding suggests that awareness of EAP services is likely a pre-requisite for a positive orientation toward EAP.

Insert Table 2 about here

Substance Use and Related Measures. Table 3 provides descriptions and average responses to fifteen measures pertaining to substance use in three areas: (1) Personal Substance Use: alcohol, legal drug, illicit drug, use at work, problem drinking, and problem behaviors

associated with drinking, (2) Work Climate Related to Substance Use: past experience ignoring or enabling co-workers, estimates that co-workers would enable, likelihood that supervisors enable, perception of co-worker alcohol use that effects work, and perception of co-worker drug use; and (3) Attitudes Towards Substance Use Policy: favorable attitudes toward policy in general, support for drug-testing programs which were in place within the city, opinions about severity of discipline applied to substance users employed by the city, and support for educational programs.

Insert Table 3 about here

Analysis Plan

We began with two questions: (1) What influence does organizational wellness have on substance use (at individual, social, and policy levels), beyond the influence of EAP?, and (2) What influence does the EAP have on substance use, beyond the influence of organizational wellness? To answer these questions we first classified employees into two groups based upon their responses to the organizational wellness scale. Those who scored below or equal to the median of that scale (Mdn = 3.34) were considered to perceive “Low” wellness, those scoring above were viewed as perceiving “High” wellness. Employees were also classified as either “Low” or “High” in EAP orientation on the basis of their responding above or below the median of the EAP scale (Mdn = 3.0). Next, two sets of univariate Analyses of Covariance (ANCOVAs) examined the relationship between these measures to each of the fifteen substance use measures listed in Table 3. One analysis examined Organizational Wellness (Low, High) while covarying EAP orientation, treated as a continuous measure. The other analysis examined EAP Orientation (Low, High) while covarying Organizational Wellness, also treated as a continuous measure. These ANCOVAs assess the separate and independent effects of either wellness or EAP orientation while controlling for the other as a covariate.

Results

The correlation between EAP Orientation and the Organizational Wellness Scale (OWS) was .23 ($p < .001$), indicating that those who had a positive image of the EAP also saw their work place as healthy. However, this association was moderate suggesting that not all employees who regard the EAP as a source of help also view their work site as healthy. In fact, only 31% of employees were high on both EAP orientation and OWS, and many were either high on OWS but low on EAP orientation (24%) or low on OWS and high on the EAP measure (19%).

Table 4 presents the results of the two separate ANCOVA analyses. The first three columns of numbers show differences between those scoring low and high on the OWS and the statistical test of those differences. The next three columns show differences between those scoring low and high on EAP orientation and the statistical test of those differences. An informal comparison of the two sets of results suggest that perceptions of organizational health may be more closely related to substance use than were perceptions of EAP. However, EAP orientation may be more closely aligned with the particular aspects of organizational health that deal with personal enabling, and with education or referral related to substance use.

Insert Table 4 about here

Personal Substance Use. For each of the six substance use measures, those who scored high on the OWS reported significantly less substance use than those scoring low on the OWS. For example, the most reliable finding in this group of substance use measures shows that employees drank more frequently when they worked in a climate of lower ($M = 2.23$) rather than higher ($M = 2.02$) wellness, $F (1, 721) = 10.59$, $p < .002$. Similarly, those who scored high on EAP orientation also reported significantly less alcohol use ($M = 2.02$) than those with low EAP orientation ($M = 2.23$), $F (1, 726) = 9.47$, $p < .003$. No other comparisons for the EAP measures were statistically significant. These findings suggest that, compared to organizational wellness, EAP orientation may be more limited in it's relationship to substance use. Still, results suggest

either that employees who use less alcohol have also found the EAP helpful or that those who have a positive EAP orientation tend to be non-drinkers.

Work Climate. Those who were classified as high on the OWS had significantly lower scores on each of the five climate measures than employees who were classified as low on the OWS. Thus, employees who reported more organizational wellness also reported less enabling at the personal, co-worker, and supervisory levels and, also reported less co-worker alcohol and drug use. The most reliable finding in this group occurred for co-worker enabling. Employees who were classified as high on the OWS estimated significantly less likelihood of co-worker enabling ($M = 2.03$) than those who scored low on the OWS ($M = 2.30$), $F(1, 703) = 46.86$, $p < .001$. EAP orientation was also associated with all climate measures except for co-worker drug use. In particular, personal and co-worker enabling was significantly less for those with a higher EAP orientation.

Policy Attitudes. Employees scoring high on either the OWS or EAP orientation also held more favorable views of the substance use policy, drug testing, and education/referral programs. For example, employees who viewed the EAP as approachable and helpful were more likely to support drug testing in the workplace. Of all comparisons in Table 4, the most reliable finding for both the OWS and EAP measures pertained to general favor of substance use policy.

Discussion

The findings of the current survey study suggest that we developed a reliable index of organizational wellness, which demonstrates that employees may have coherent perceptions of their workplace (department and work group) as possessing qualities of ecological and social health. The relationship between these perceptions and substance use were explored and compared with views of the EAP as positive and helpful. Results indicated that employee views of organizational wellness correlated significantly and in a consistently negative direction with each of the following: self-reports of substance use, perceptions of personal and co-worker

enabling of substance use, and perceptions of co-worker alcohol and drug use. Moreover, organizational wellness was associated with more favorable attitudes toward substance use policy. Clearly, employees who perceived their work place as healthy (versus unhealthy) also reported less substance use by themselves and their co-workers.

Comparable relationships between employee attitudes towards EAP and substance use were generally not as reliable or as consistent. However, those who said they would use or recommend the EAP reported less alcohol use, less personal enabling, less co-worker enabling and less co-worker drinking. One explanation may be that those who don't drink or enable others are more open to using the EAP. Interestingly, the association between EAP orientation and estimates of co-worker enabling was more reliable than the associations between EAP orientation and either personal drinking or personal enabling. It seems that employees who are willing to recommend the EAP also believe that their colleagues would rather do something proactive about co-worker drinking/drug problems than ignore them.

Perhaps the clearest finding showed that positive views of either organizational wellness or the EAP were associated with favorable attitudes toward substance use policy. Policy attitudes included areas dealing with referral, supervisory training, EAP, and educational classes. There was, however, no relationship between either EAP or wellness with attitudes towards the disciplining of substance abusing employees. This suggests that employee tolerance of co-worker problems may not be influenced by working conditions related to health and wellness. Employees may also not see the EAP role as reflective of disciplinary components of policy. At the same time, employees did feel that drug-testing was a positive approach, especially if they also felt positive about organizational wellness and the EAP. Seen in a negative light, these findings suggest that employees who perceive unhealthy environments show little support for substance use policy. Because our measures of drinking or drug use climate correlated with organizational

wellness, it is quite likely that the presence or enabling of substance use contributes to an unhealthy work environment.

Implications and Suggestions

Wellness is not only an individual issue, and our results imply that corporate health may effect substance use at both the individual and work group level. We believe that these findings are relevant to any area of the workplace involved in health promotion: HPPs, EAPs, managed care, as well as HMOs. Because it covers issues of concern to them all, the scale developed here could be adapted by service professionals in each of these areas. To the degree that these service elements are not integrated, the idea of organizational wellness as a centralizing or synthesizing concept may prove quite useful for wellness policy implementation. We suggest that health promoters and EAPs use the Organizational Wellness Scale for several purposes: (1) to stimulate discussion among health professionals, (2) to assess how individuals perceive the organization, (3) to promote the idea of a "healthy company" to management and administration, (4) as part of an intervention in addressing substance use that may be occurring at a work group level, and (5) as part of a workshop or psycho-educational module on wellness.

While these findings are encouraging and have potential usefulness, they are based on survey data and thus subject to the limitations imposed by such methods. In the absence of longitudinal or objective data (e.g., health claims, absences, drug-tests), it is difficult to assess whether organizational wellness causes substance use, whether those who use substances have negative attitudes that influence their perceptions of the workplace, or whether some other unmeasured construct accounts for the observed relationships. It should also be pointed out that this is the first time the Organizational Wellness Scale (OWS) has been used. It has not been cross-validated on other samples different from the municipal organization of the current study and it's accuracy and test-retest reliability have yet to be assessed.

Despite these limitations, we believe the current results point to the need for both

corporate policy makers and EAPs to expand their views of health and wellness beyond the level of individual problems. The current measure includes assessment of a balanced work perspective (lack of a workaholic pace), perceptions of social health (e.g., openness, non-avoidance of conflict), as well as the perceived presence of policies that support individual health promotion. We hope that future research explores the relative importance of each of these climate factors as they effect areas other than substance use. If organizational wellness curbs substance use problems it may also help with other areas traditionally targeted by health promotion (e.g., stress, mental health, fitness, and nutrition). The prevention of work-related health and psychological disorders may be greatly facilitated by efforts to improve the overall health of work climates.

Table 1. Items of the Organizational Wellness Scale (Percent Agree/Disagree; Means and Standard Deviations

Item	% Agree	% Disagree†	Mean	SD
Healthy and Balanced Perspective				
1. People in my work group have a lot of vitality and a healthy outlook on life.	41	26	3.16	1.05
2. Health and safety is a top priority in my department.	61	17	3.63	1.13
3. Most projects are planned so that we rarely rush or are pressured to meet deadlines.	29	47	2.73	1.21
4. It is easy for my co-workers and I to forget about job pressures once the work day is over.	50	25	3.30	1.08
5. On most jobs and tasks, my co-workers work at a fairly even pace.	60	18	3.43	.97
Co-worker Respect & Openness				
6. In my department, differences in lifestyle and culture are appreciated (including minorities, those with disabilities, and elderly employees).	45	21	3.23	1.06
7. In my work group, it is better to keep your ideas to yourself than to cause conflict with supervisors or co-workers. (Reverse Scored)	45	31	3.12	1.15
8. Even when they differ, people at work are truthful about their personal viewpoints or feelings.	40	30	3.08	1.04
Organizational Supports				
9. The city offers wellness classes that we can attend (such as smoking cessation clinics, exercise programs, or stress reduction workshops).	42	30	3.08	1.11
10. Policies are flexible enough to meet the personal and family needs of different employees (such as maternity leave, sick days, flex time, flexible	63	18	3.52	1.09

Note. Higher values indicate agreement with the statement (1 = "Strongly Disagree" to 5 = "Strongly Agree"). N = 780 (Employees with City for one year). Scale Statistics: Mean = 3.32; SD = .69; *alpha* = .75.
† Employees responding "In between" are not reported in Table.

Table 2. Items of the EAP Orientation Scale (Percent Agree/Disagree; Means and Standard Deviations

	Item	% Unlikely	% Likely †	Mean	SD
1.	If you had an alcohol or drug problem, how likely would you go to the EAP for help?	32	48	3.20	1.41
2.	How likely would you be to recommend the EAP to a co-worker who you thought needed help?	24	60	3.52	1.38

Note. Responses were on a 5 point scale (1 = "Very Unlikely" to 5 = "Very Likely").

N = 780 (Employees with City for one year). Scale Statistics: Mean = 3.36; SD = 1.24; *alpha* = .73.

† Employees responding "In between" are not reported in Table.

Table 3. Measures of Personal Substance Use, Work Climate, and Attitudes Towards Policy

Scale	Description	Range	Mean	SD
Personal Substance Use				
Alcohol	Frequency of drinking, getting drunk, and problems associated with use. (1) no use, (2) monthly, (3) weekly, (4) problems as a result of drinking (morning drinking, shakes, DWI, hospitalization, arrests). (Ordinal Composite based on 12 items).	1 - 4	2.12	1.05
Legal Drug	Use of the medicines for illness and with a doctor's prescription: pain killers, cough medicine, tranquilizers, sleeping pills, stimulants. (Summary of 5 items; No = 1, Yes = 2)	1 - 4	1.76	.90
Illicit Drugs	Employees classified as drug users if they reported marijuana/other illicit drug use in the last year, or consequences from drug use: fights, accidents, arrests, missing work, selling drugs. (Dichotomous response to 8 items; 1 = non-user, 2 = user)	1 - 2	1.08	.28
Use at Work	Frequency of drinking and drug use associated with work in the last year. (1) no use (2) alcohol rarely (3) alcohol monthly (4) illicit drug use (5) dealing drugs or working intoxicated. (Ordinal composite scale of 6 items).	1 - 5	1.24	.89
Problem Drinking	Presence of symptoms in the past year: drinking upon waking, shakes and tremors, drinking more than intended, staying drunk for a day or longer, black outs. (Dichotomous based on 5 items)	1 - 2	1.15	.36
Problem Behaviors	Presence of any ten problems due to alcohol use. DWI, hospitalization or illness, missing work, accidents, fights, arrests, entering treatment, supervisor warning, or going to the EAP. (Dichotomous based on 10 items)	1 - 2	1.04	.20
Work Climate Related to Substance Use				
Personal Enabling	Items asking employees actual response to perceived co-worker use (e.g., ignored situation, talked with co-worker). (Average of 5 items; *alpha* = .69)	1 - 2	1.60	.30

Table 2 continues

Table 2 continued

Scale	Description	Range	Mean	SD
Co-worker Enabling	Perceptions of what co-workers would likely do with an employee who had a drinking/drug problem (e.g., ignore the problem, cover for or "pick up the slack" for the co-worker). (Average of 4 items; *alpha* = .69)	1 - 4	1.60	.30
Supervisor Sanctions	How likely supervisors could do anything to stop drinking on the job, and how likely it is to get caught drinking on the job. (Average of 2 items)	1 - 4	2.03	.80
Co-worker Drinking	Perception of co-worker drinking (to socialize), talk about drinking, getting drunk, parties with alcohol. (Average of 5 items; *alpha* = .79).	1 - 5	1.99	.80
Co-worker Drug Use	Perception of any co-worker use of marijuana or other illicit drug, under the influence at work, or knowledge of drug dealing by employees. (Summary score based on 4 items).	1 - 3	1.50	1.15
Attitudes Towards Policy				
General Favor	Support for substance use policy, perceptions that it is fair, confidential, and effective. (Average of 4 items; *alpha* = .75)	1 - 5	3.48	77
Drug Testing	Support for drug-testing of three types: new job applicants, for cause, and random. (Average of 3 dichotomous – yes, no -- items)	1 - 2	1.90	.22
Discipline	Opinion of what city should do to employees suspected of having an alcohol or drug problem: (1) give a written or oral warning, (2) place on probation, (3) suspend from work for several days, and (4) fire them. (Composite with higher scores indicating more severe discipline).	1 - 4	1.67	1.02
Educational Programs	Support for: referring employees for treatment, education programs for supervisors and employees, EAP for assessment and referral, training supervisors to recognize and deal with problems, and improving working conditions. (Average of 5 dichotomous items).	1 - 2	1.93	.18

Table 4. Personal Substance Use, Alcohol/Drug Climate, and Policy Attitudes as a function of Organizational Wellness and EAP Orientation

Scale	Organizational Wellness		F	EAP Orientation		F
	Low	High		Low	High	
Personal Use						
Alcohol	2.23	2.02	10.59**	2.23	2.02	9.47**
Legal Drugs	1.88	1.68	9.47**	1.74	1.78	ns
Illicit Drugs	1.11	1.06	4.44*	1.08	1.08	ns
Use at Work	1.34	1.17	6.88**	1.26	1.22	ns
Problem Drinking	1.19	1.11	9.78**	1.17	1.14	ns
Problem Behaviors	1.07	1.02	9.18**	1.04	1.04	ns
Work Climate						
Personal Enabling	1.63	1.57	8.88**	1.65	1.55	18.73***
Co-worker Enabling	2.30	2.03	46.86***	2.24	2.07	26.90***
Supervisor Sanctions	2.13	1.94	14.76***	2.08	1.98	5.75*
Co-worker Drinking	2.16	1.87	27.94***	2.03	1.96	4.85*
Co-worker Drug Use	1.63	1.41	8.44**	1.55	1.46	ns
Policy Attitudes						
General Favor	3.23	3.68	95.76***	3.32	3.63	58.89***
Drug Testing	1.89	1.91	4.18*	1.88	1.92	6.91***
Discipline	1.61	1.71	ns	1.66	1.68	ns
Education/Referral	1.92	1.94	8.59**	1.91	1.96	16.91***
N	364	435		405	394	

Note. Means are adjusted for covariates. Organizational Wellness ANCOVA comparisons (Low vs. High) use EAP orientation as a covariate and vice versa. Ns vary due to missing cases.

$p < .05$ ** $p < .01$ *** $p < .001$

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