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EFFECTIVENESS OF A UNIVERSITY EMPLOYEE ASSISTANCE PROGRAM USING THE WORKPLACE OUTCOME SUITE AND CLIENT SATISFACTION SURVEY

by

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A DISSERTATION

Submitted to the graduate faculty of The University of Alabama at Birmingham,
in partial fulfillment of the requirements for the degree of
Doctor of Philosophy

BIRMINGHAM, ALABAMA

2021

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EFFECTIVENESS OF A UNIVERSITY EMPLOYEE ASSISTANCE PROGRAM USING THE WORKPLACE OUTCOME SUITE AND CLIENT SATISFACTION SURVEY

JOSEPHINE JACKSON BANKS

COMMUNITY HEALTH AND HUMAN SERVICES

ABSTRACT

Background: Gallup (2013) reported that 30% of the U.S. workforce was not engaged in their work which means they were not reaching their full potential or productivity level. For organizations, lost productivity due to absenteeism or less than ideal performance at work impacts company performance and bottom line. Employee assistance programs are a resource to help increase employee health, productivity, and satisfaction through counseling interventions.

Methods: Data were collected by a large urban university EAP over a 20-month period. The analysis was limited to EAP clients over the age of 18. A total of 866 subjects participated in this study, who met the criteria. The total response rate was 14.9%. Paired t-tests, ANOVA F test, and a two-way ANOVA were used to compute the results.

Results: Clients reported an increase in presenteeism and work engagement after the intervention which was anticipated. Unexpectedly, analysis of the pre and post survey revealed an increase in hours absent due to a personal problem taking the employee away from work in the last 30 days and there was also an increase in workplace distress scores after the counseling intervention which was not expected. Examining life satisfaction before and after counseling intervention, there was no significant change. There was a significant difference in absenteeism based on gender and job types; further analysis

showed that absenteeism significantly improved by 14.7% in females but there was no improvement in males. For presenteeism, the analysis also showed significant mean difference across age groups and workplaces. For presenteeism, workplace distress and life satisfaction, there was significant mean difference between females and males stratified by primary issue.

Conclusion: The results of this study showed slight improvement in some work productivity outcomes, but not all. The outcomes that did not improve were surprising, but after further analysis of frequency data there was improvement segments of the study population. There were several limitations that likely contributed to the outcomes. Additional research is recommended with a larger sample size to determine the effects of EAP counseling on improved work effectiveness across employee demographics, job types, and work entities.

Keywords: employee assistance programs, mental health in the workplace, work outcomes, workplace outcome suite

DEDICATION

For my parents, Joe and Cristita Jackson. You raised me to be determined, resilient, and courageous -- I thank you for giving me the best parts of you. Mom, I am exceedingly grateful for your understanding, unwavering support, and unconditional love.

Rest in heaven Daddy.

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LIST OF ABBREVIATIONS

ACA	American Counseling Association
ALMACA	Association of Labor Management Administrators and Consultants on Alcoholism
ATR-BC	Art Therapy Registered-Board Certified
BLS	Bureau of Labor Statistics
CDC	Centers for Disease Prevention and Control
CGP	Chestnut Global Partners
CEAP	Certified Employee Assistance Professional
EA	employee assistance
EAP	employee assistance program
EAPA	International Employee Assistance Professionals Association
EAS	employee assistance services
EASNA	Employee Assistance Society of North America
EMDR	Eye Movement Desensitization and Reprocessing
HR	human resources
HRT	Human Relations Theory
LMFT	Licensed Marriage and Family Therapist
LPC	Licensed Professional Counselor
NCC	National Certified Counselor
OAP	Occupational Alcoholism Program

LIST OF ABBREVIATIONS (continued)

OD	organizational development
ODT	Organizational Development Theory
ROI	return on investment
US	United States
WOS	Workplace Outcome Suite
WOS-5	Workplace Outcome Suite 5-item Survey
WOS-9	Workplace Outcome Suite 9-item Survey
WOS-25	Workplace Outcome Suite 25-item Survey

CHAPTER 1

INTRODUCTION

Background

The U.S. labor force has grown from 62 million in 1950 to approximately 157 million in 2019 (Bureau of Labor Statistics [BLS], 2019). Workers have higher salaries, better benefits, and jobs have shifted from mostly farming and manufacturing work to service-providing industries. Overtime, changes in the U.S. population and populace of those actively employed or actively seeking employment gave rise to a more varied workforce to include older, female, and more ethnically diverse workers (Lee & Mather, 2008). With a diverse labor force comes different employee dynamics which can improve organizational outcomes but can also create challenges for the individual and work environment (Gomez & Bernet, 2019).

As the U.S. labor force and market has grown so have demands on the worker which ultimately affects the worker's physical and mental well-being. Consequently, maintaining a healthy workforce has become a top priority for both large and small companies. Research by Cadorette and Agnew (2017) supports that workplace stress is linked to higher job demands. Over the past few decades, studies have shown that workplace pressures are a major source of stress for adults in the United States. The Centers for Disease Control and Prevention [CDC] (2021) stated that:

> "Some employers assume that stressful working conditions are a necessary evil, that companies must turn up the pressure on workers and set aside health concerns to remain productive and profitable in today's economy. But research findings challenge this belief. Studies show that stressful working conditions are actually associated with increased absenteeism, tardiness, and intentions by workers to quit their jobs-all of which have a negative effect on the bottom line".

Because of this, business leaders seek ways to help their employees create work-life balance and promote favorable work environments with expectation that this balance will positively impact employee morale and workplace productivity as well as contain growing health care costs and the cost associated with time away from work and diminished productivity (Jacobs, et. al, 2017). Studies show that employers need to prevent stress and promote positive mental health to improve overall workplace mental health (Page, et. al, 2014) by providing wide-ranging wellness programs and encouraging employee participation which "can decrease employee burnout and turnover and increase job satisfaction, productivity, and mental wellbeing" (Passey, et. Al, 2018, p. 1789). In addition to improving work outcomes and being cost effective, wellness programs can also reduce morbidity and mortality (Fink, Zabawa, & Chopp, 2020).

One way that employers provide mental health and wellness assistance to their employees is through Employee Assistance Programs (EAPs). EAPs are employee-sponsored programs aimed at helping workers with job-related and/or personal problems that may affect their work performance and general well-being (Merick, et al, 2015). The

primary goal of an EAP is to help employees achieve work-life balance and enhance workplace productivity through improved mental and physical health.

Significance of the Study

Gallup-Healthways (2013) estimates that discontented workers in America are costing over $500 billion per year in lost productivity. Some of this dissatisfaction may stem from symptoms of mental health disorders. An estimated 20% of U.S. adults aged 18 or older live with a mental illness to include varying conditions from mild depression to severe impairment (U.S. Department of Health and Human Services [HHS], National Institute of Mental Health [NIMH], 2021). A typical worker spends 40 hours per week at the job; consequently, work can contribute to stress and in turn can trigger mental illness and other chronic diseases such as obesity, hypertension, heart disease which close to half of U.S. adults report having at least one of these preventable chronic diseases (Williams, et. al, 2020). Research indicates that employee health and disability due to physical and mental demands is a growing productivity concern (Williams-Whitt, et al, 2015). The financial problem of mental illness worldwide due to absenteeism, presenteeism, and lost productivity was estimated to be $2.5 trillion in 2010 and estimated to be $6.1 trillion by 2030 (de Oliveira, et. al, 2020). A study on workplace health promotion programs conducted by Cancellier, et. al (2011) indicated that high stress and poor work relationships contributed to diminished presenteeism. Depression alone accounts for 4.3% of the global mental health burden (Torquati, et. Al, 2019).

Employee well-being is important to both the worker and the employer. It is important to the employee because they are concerned about their individual health and

safety; it is important to the to the organization because it is perceived that healthier employees are more productive and will aid in better organizational performance (Beehr, 2019). EAPs were developed to lessen workplace issues and improve worker health and productivity with an ultimate goal for the employer of enhancing organizational performance.

The idea of occupational health began as early as the 17th century when Italian physician, Bernardino Ramazzini, illustrated the association of the work environment with health risks (The Lancelot, 2017). The concept of EA programs began in the 1940s (Masi, 2011) and today, approximately 80% of U.S. companies offer EA programs (SHRM, 2019).

EAPs provide a useful service to employers and studies have demonstrated positive EAP outcomes; however, many EAPs are in operation, but they are unaware of their true impact on work outcomes. Evaluating EAPs to determine client satisfaction, utilization and to some degree, rate of return (ROI) are not new concepts, but an effective way of measuring the impact of EAP services as it relates to work outcomes is a developing concept for EAPs and should be explored to further elevate the field (Merrick, et. al, 2015).

Purpose of the Study

Although EAPs have been increasingly utilized by employers for the past 70+ years, there is modest evidence demonstrating the success of mental health interventions on enhancing work-related outcomes (Wagner, 2016). In the last 10 or so years, the WOS

assessment tool was developed and is currently being promoted in the EA field as a best practice for evaluating program effectiveness of EAPs.

This study evaluated the effectiveness of an internal EAP at an urban university. The study explored the impact of the EAP's counseling services using the 5-item Workplace Outcome Suite (WOS-5). The WOS-5 measures five key work outcomes: absenteeism, presenteeism, work engagement, life satisfaction and workplace distress. The study also utilized the EAP's client satisfaction survey to evaluate the clients' contentment with EAP services. The aim of the study was to determine if EAP counseling services correlated with improved work effectiveness and if there were differences across employee demographics, the positions an employee holds, and where an employee works within the enterprise.

Research Questions

This study addressed the research questions provided below to expand the current body of knowledge on the effectiveness of employee assistance programs.

Hypothesis: EAP counseling interventions are associated with improvement in work absenteeism, presenteeism, work engagement, workplace distress, and life satisfaction.

Research Question One: Is there significant improvement over time in the five outcomes measured by the WOS?

Research Question Two: Is there significant improvement over time in the five outcomes measured by the WOS based on gender, age, ethnicity, job type, and workplace?

Research Question Three: Is there significant improvement over time in the five outcomes measured by the WOS based on primary presenting issue and gender, gender, age, ethnicity, job type, and workplace?

Computerized Search

A preliminary search of the literature was conducted through relevant library journal databases. The study author reviewed Employee Assistance Professionals Association (EAPA) and Employee Assistance Society of North America (EASNA) journals, interviewed local EAP subject matter experts and attended EAPA and American Counseling Association (ACA) annual conferences to engage scholars in the field regarding the WOS.

Upon examination of the literature, most relevant publications were found in the fields of EA, public health, education, and psychology. Scholars from several disciplines across the human services and public health have contributed to a body of work related to counseling, employee wellness, and employee assistance programs; however the majority of publications on the WOS were provided by Chestnut Global Partners (CGP), now Morneau Shepell, EAPA, EASNA, and articles found at the University of Maryland, Baltimore UMB Digital Archives.

The scholarly articles referenced in the literature review were obtained through various computer-based searches. Primary key words and descriptors used in these searches included, but were not limited to, combinations of these primary terms: employee assistance programs , employee assistance program evaluation, employee assistance program outcomes, employee assistance program utilization, employee

assistance program history, employee well-being, occupational wellbeing; performance; happy productive worker, labor force, workforce, health, labor force participation, labor force participation rate, workforce participation rate, productivity, effectiveness, evaluation, labor force health, labor force participation, workforce participation, work productivity, worker productivity, Organization Development Theory, Maslow's Theory, Human Relations Theory. Sample search pairings included "employee assistance program evaluation"; "employee assistance program outcomes"; "employee assistance program utilization"; "labor force health"; "workforce health"' "work productivity"; "health in the workforce".

Search results were narrowed to include only articles that met the following criteria: (a) were relevant journal articles and publications; (b) were available and accessible electronically; (c) were written in the English language, and (e) referenced the WOS, employee assistance programs, EAP and program evaluation, U.S. labor force, workforce, and health status of the workforce. After applying the above criteria, reference materials were reviewed and selected for inclusion in the literature review.

Definition of Terms

For the purpose of this study, the following terms are defined:

Employee Assistance Program: A programmatic intervention at the workplace, usually at the level of individual employee.

Client Satisfaction: Measurement to determine how satisfied a client is with EAP services.

Labor Force: Members of the population who are employed or willing to be employed.

Labor Market: The supply of (employees provide) and demand for (employers provide) labor.

Life Satisfaction: Being content with one's life.

Work Absenteeism: Missed time away from regularly scheduled work within the past 30 days, measured in hours.

Workplace Distress: An employee's feeling of dismay about the work setting/environment.

Work Presenteeism: When an employee is present on the job physically but is not mentally present or working at their typical level of job performance because of a health or personal issue (Lohaus & Habberman, 2019).

Work Engagement: An employee's dedication, focus, and investment in his or her job.

Work Effectiveness: Efficiency in and focus on accomplishing tasks and goals for the company. Work Effectiveness and Workplace Productivity are used interchangeably.

Worker: Members of the population who wish to offer his/her services for compensation.

Workforce: Members of the population who are actively working, employed labor force.

Workplace productivity: Efficiency in and focus on accomplishing tasks and goals for the company. Work Effectiveness and Workplace Productivity are used interchangeably.

U.S. Workforce: Workers employed in the United States of America.

CHAPTER 2

LITERATURE REVIEW

This chapter highlights literature relevant to the current workforce in the United States (U.S.) and the state of Alabama, health of the U.S. and Alabama workforce, history of employee assistance programs to include EAPs in Alabama and the university EAP used in this study, and the theoretical framework for this research study.

Workforce in the United States

Data obtained from the United States Department of Labor, Bureau of Labor Statistics (2019) indicated that the U.S. workforce (employed Americans) consisted of approximately 157 million individuals. The majority of the U.S. workforce, 107.8 million (roughly 7 out of 10) were employed in service-providing industries. Within the service sector several employment categories were evenly selected; 28 million workers were employed in the trade, transportation and utilities sector; 24 million workers were employed in the education and health services sector; and 21.5 million workers were employed in professional and business services. In addition, 16.7 million workers were engaged in leisure and hospitality services. The workforce also included 22.5 million workers employed by the government followed by 12.9 million workers composing the manufacturing sector (BLS, 2019). In comparison to the previous decade, service type

jobs increased while the share of jobs in manufacturing, trade and utilities decreased as noted in Figure 1 (Desilver, 2017).

Table 1

Sample of U.S. Jobs Shifting Toward Service Industry

INDUSTRY	%CHANGE
Educational Services	+23.6%
Healthcare and social assistance	+22.7%
Food Services	+18.5%
Transportation and other services	+17.5%
Professional and business services	+15.6
Arts and entertainment	+14.7%
Government	+1%
Mining, Construction, Manufacturing, Utilities, Information	-30.7%

Over the last three decades, the U.S. workforce participation rate has grown at a slower pace. Based on BLS (2021) data, the participation rate rose from the 1950s to the 1980s before peaking in the 1990s to early 2000s. Beginning in the mid-2000s a gradual decline occurred. From 2016 to 2019, the participation rate started to slightly rise, but declined in 2020 (Figure 1).

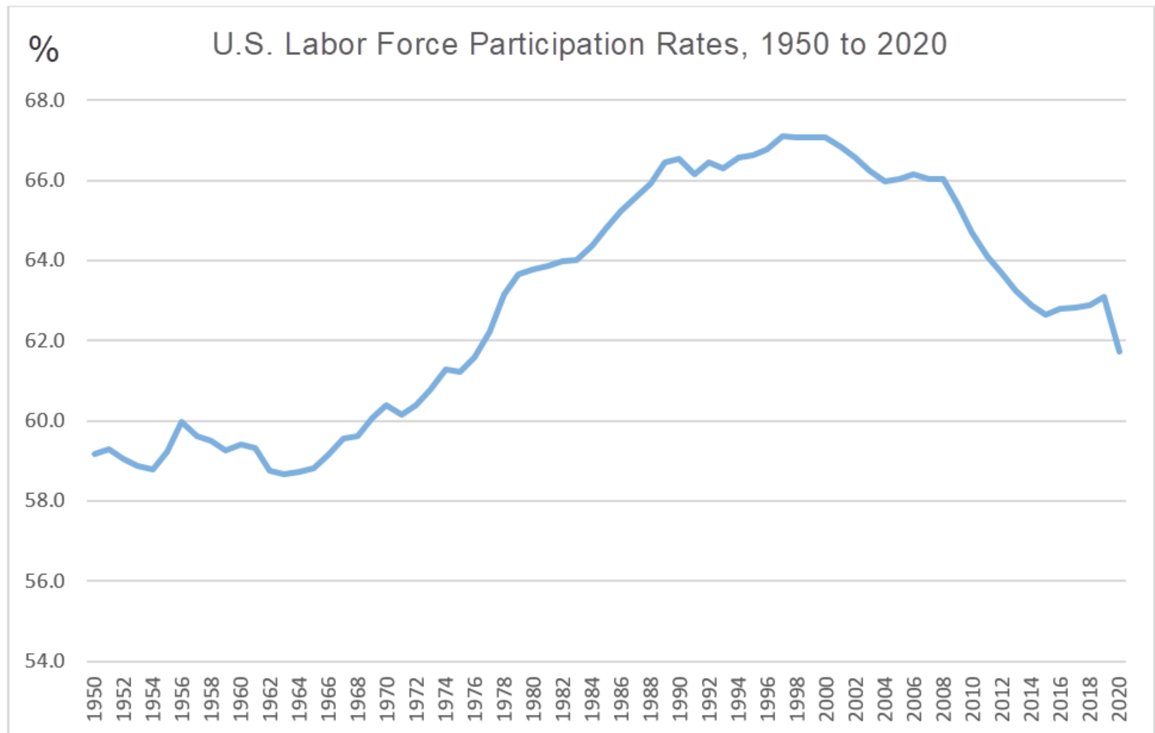

Figure 1. U.S Labor Force Participation Rates, 1950 to 2020. Data from BLS (2021).

The descending workforce participation rate was likely due to workforce composition such as age. According to the U.S. Bureau of Labor Statistics (2017), the downward trend of the overall participation rate was attributed to the baby-boom population aging out of the workforce. In addition, from 2000 to 2015, there was a significant decline in labor participation for teenagers and young adults. This decline occurred concurrently with an upsurge in college enrollment rates and young adults opting to stay in college longer (BLS, 2017). Although age contributed to the work force participation rate trending downward for the last two decades, the rate has increasingly become more diverse in relation to demographics such as age, gender, and racial and ethnic makeup (Buckley & Bachman, 2017).

Diversity in the workforce began to increase when the collective participation rate for men began to decline shortly after World War II. With pension and disability awards, the participation rate of women began to increase starting in the 1950s (Fullerton, 1999). Conversely, based on BLS data, the current workforce is still predominantly male at 53%, but this percentage is lower than in previous decades. American men averaged 70% of the U.S. labor force in 1950, compared to 53% in 2018 and women made up 30% of the U.S labor force in 1950 compared to 47% in 2018 (Grieger & Parker, 2018).

In the 1960s, the racial and ethnic workforce composition transformed with the change in immigration laws (Fullerton, 1999). Based on data from the 2019 BLS report, the current ethnic workforce composition is majority White (78%), followed by Blacks (13%), Asians (6%), persons of two or more races (2%), American Indians/Alaska Natives (1%), and Native Hawaiians/Pacific Islanders (<1%). People of Hispanic or Latino ethnicity, who may be of any race, made up seventeen percent (17%) of the labor force; Hispanics in the labor force were White (89%), Black (4%), and Asian (1%). According to the BLS (2018), the contributions of Hispanics have progressively increased over the past four decades and are expected to continue through the next five years due to high levels of immigration and overall population growth. In the 1980s, Hispanics made up 6% of the labor force compared to 17% today (Toossi, 2002).

Age demographics have also shifted over the years. The current workforce is largely represented of individuals aged 35 to 54 years of age (42%) due to these being the peak earning years (BLS, 2018).

Actively employed individuals aged 25 to 34 years of age represents 23% of the labor force, 55 years and greater at 22% and those 25 years of age and younger at 13%

(BLS, 2018). The percentage of older workers aged 55 years and greater is attributed to longer life expectancy than in previous generations, better education levels, and changes to social security benefits and retirement plans (Mislinski, 2020). It is anticipated that by 2028, Millennials (ages 23-39) and Generation X (ages 40-55) will make up 58 percent of the workforce. The median household income for all workers employed in the U.S. was $61,937 (U.S. Census Bureau, 2018).

The current workforce demographic changes in the U.S. are not much different from changes witnessed over the last 50 years. The workforce has always aged and will continue to do so; workforce diversity has increased with the entrance of women and minorities and this change will likely continue in the future; and workers in general having better access to education and the growth of technology will continue to drive a more educated workforce.

Workforce in the State of Alabama

Data obtained from the Alabama Department of Labor, Labor Market Information Division [AL LMI] (2020) indicated that the Alabama workforce (those employed in the state of Alabama) consisted of approximately 2.1 million individuals. Industries in the service-providing sector increased by 8,900 compared to 2019 and are represented as follows: 382,500 workers were employed in trade, transportation and utilities sector; 249,300 workers were employed in education and health services; 248,100 workers were employed in professional and business services; and 400,000 workers were employed by the government (AL LMI, 2020). In addition, 203,300 workers were engaged in leisure and hospitality services followed by 272,500 workers composing the manufacturing

sector (AL LMI, 2020). In comparison to the U.S. workforce, Alabama's labor force has more workers employed in the manufacturing and government sectors.

Compared to previous decades, Alabama workforce participation has declined. Based on BLS data (2021), the Alabama participation rate rose from the 1980s to 1990s before peaking in the early 2000s and then gradually descending; Alabama labor force participation began to increase in 2018 and has remained steady until the unexpected COVID-19 pandemic. The labor force participation rate highs and lows are comparable to those of the U.S. labor force, see Figure 2.

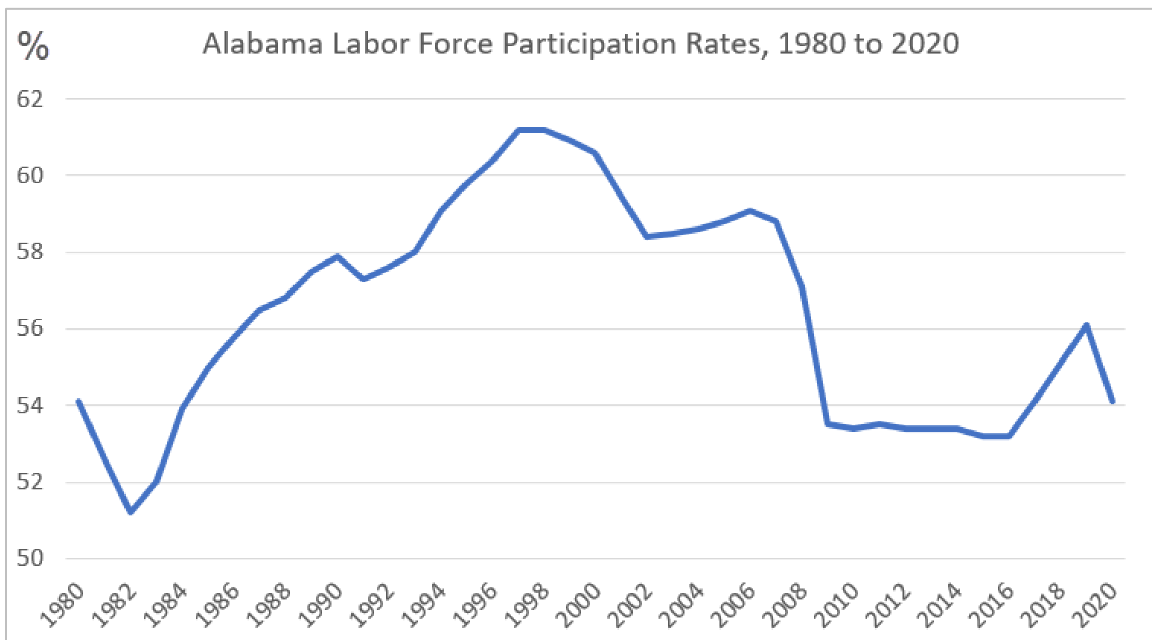

Figure 2. Alabama Labor Force Participation Rate, 1980 to 2020. Data from BLS (2021).

Similar to the U.S. workforce participation rate, the decline in the Alabama work force participation rate is likely due to workforce composition such as age. According to the BLS (2016), the downward trend of the overall participation rate was attributed to the baby-boom population aging out of the workforce; also from 2000 to 2015, teenagers and

young adults experienced the largest drop in participation, which coincided with a rise in school enrollment rates and young people staying in college longer. Although workforce participation trended downward for the last two decades, it has increasingly becoming more diverse (Buckley & Bachman, 2017).

According to the Alabama Department of Labor, the current Alabama workforce composition is majority White (71%), followed by Blacks (25%), Hispanics (4%). The Hispanic share of the labor force will continue to increase as the Hispanic population progressively grows. In the 1980s, Hispanics made up 6% of the labor force compared to 17% today (Toossi, 2002). In line with the U.S. workforce, the current Alabama workforce was largely represented of individuals aged 35 to 54 years of age (42%) due to these being the peak earning years (BLS, 2018). Actively employed were individuals aged 25 to 34 years of age at 22%, 55 years and greater at 22% and those 25 years of age and younger at 14% (BLS, 2018). The low percentage of actively employed workers aged 25 to 34 coincides with young people staying in college longer (Buckley & Bachman, 2017). The percentage of older workers aged 55 years and greater is attributed to longer life expectancy than previous generations, better education levels and changes to Social Security benefits and retirement plans (Mislinski, 2020). It is anticipated that by 2028, Millennials (ages 23-39) and Generation X (ages 40-55) will make up 58 percent of the workforce. At present the median household income for all workers employed in the Alabama was $48,486 (U.S. Census Bureau, 2018).

The workforce demographic changes in Alabama are not much different from changes witnessed over the last 50 years. The workforce has always aged and will continue to do so; workforce diversity has increased with the entrance of women and

minorities and this change will likely continue in the future; and workers in general having better access to education and the growth of technology will continue to drive a more educated workforce.

Health of the U.S. Workforce and Alabama Workforce

As the U.S. labor market has grown so have demands on the worker which ultimately affects the worker's physical and mental well-being; therefore, maintaining a healthy workforce has become a top priority for both large and small companies. Business leaders seek ways to help their employees create work-life balance anticipating that this balance will positively impact employee morale and workplace productivity as well as reduce healthcare costs, costs associated with time away from work, and diminished productivity.

The U.S. workforce consists of 157 million workers with 64% at age 35 and older. Many of these workers are personally restricted due to a personal chronic condition or due to caring for a family member who suffers from a chronic condition. Overall, U.S. workers without chronic health conditions average three lost workdays per year and those with chronic conditions such as arthritis/rheumatism, diabetes, heart disease, hypertension, lung disease, lost six to eleven workdays per year (Vuong, et al., 2015). According to findings from the National Health and Nutrition Examination Survey as reported by Pfizer (2007), 65% of the workforce was overweight or obese and 35% reported that they do not exercise; 21% of the workforce suffers from at least one mental or substance use condition annually; 36% of workers suffer from depression and 50% of employees who abuse alcohol did not attempt to seek help or manage their condition.

According to the Alabama Department of Public Health (2007), heart disease has been the leading cause of death in Alabama since 1926 and Alabamians aged 35 to 54 have the second highest heart disease death rate amid all 50 states. Alabama has the fifth highest diabetes death rate amid all 50 states with Alabamians aged 25-64 years having the second highest diabetes death rate amid all 50 states. Stroke has been the third leading cause of death in Alabama since 1966. Alabama has the fourth highest brain and blood vessel related disease death rate among all 50 states and Alabamians aged 25-64 years have the third highest stroke death rate among all 50 states.

Over the past few decades, studies have shown that workplace pressures are a major source of stress for adults in the United States. A significant amount of job-related stress stems from companies doing more with less – e.g., less resources and less human capital. As a result, the long-term effects of a lean workforce is stress and hence, reduced productivity (Hagel, 20132). Declining labor force participation rates can contribute to companies being pushed to do more with fewer resources. Having fewer workers can result in employees working longer hours and additional shifts which can heavily affect the workers physical and mental health (Lee et al. 2004).

The authors of Healthy People 2020 stated that individuals in the United States reported an average of 3.6 physically unhealthy days and 3.4 mentally unhealthy within a 30-day period. Because of these mental and physical challenges, most employers offer resources to their employees through Wellness and Employee Assistance Programs.

History of Employee Assistance Programs (EAPs)

EAPs are employee-sponsored programs aimed at helping workers with job-related and/or personal problems that may affect their work performance and general well-being. In order to participate in EAP services an employee can elect to volunteer for services (self-referral), a manager/supervisor can suggest an employee seek services, or a physician, friend/family member, or co-worker may recommend that the employee engage in counseling. The International Employee Assistance Professionals Association (eapassn.org) defines EAPs as programs that:

> "serve organizations and their employees in multiple ways, ranging from consultation at the strategic level about issues with organization-wide implications to individual assistance to employees and family members experiencing personal difficulties. As workplace programs, the structure and operation of each EAP varies with the structure, functioning, and needs of the organization(s) it serves. In general, an EAP is a set of professional services specifically designed to improve and/or maintain the productivity and healthy functioning of the workplace and to address a work organization's particular business needs through the application of specialized knowledge and expertise about human behavior and mental health. More specifically, an EAP is a workplace program designed to assist: (1) work organizations in addressing productivity issues, and (2)

> "employee clients" in identifying and resolving personal concerns, including health, marital, family, financial, alcohol, drug, legal, emotional, stress, or other personal issues that may affect job performance".

The primary goal of an EAP is to help employees achieve work-life balance and enhance workplace productivity through improved mental and physical health. According to Attridge, et al. (2009), the EAP movement has gained overwhelming momentum in the last two decades with EAPs in over half of the largest industries. Companies have relied on these services to help improve their bottom line.

EAPs from 1930s to 1960s

The concept of employee assistance programs is best understood through knowledge of their evolution from occupational social work and occupational alcoholism programs. Occupational social work programs, with its beginnings dating back to the early 20th century, consisted of social workers or in the early period, welfare secretaries, performing social services for employees in a work setting (Masi, 1982). Occupational alcoholism programs (OAPs), centered on helping employees with alcohol problems. OAPs most likely began to develop in the 1930s to early 1940s as more workers gained tools for recovery through Alcoholics Anonymous participation; these employees began to informally identify coworkers with alcohol problems thereby mentoring them to recovery; supervisors grasped this concept and its relation to cost savings from reduced accidents and reduced absenteeism (A. Hilbers, Ph.D., Ed.S., M.A., LPC, NCC, CEAP, CAC, personal communication, April 5, 2021). To avoid the costs related to constant

turnover, corporations determined it would be more cost-effective to provide rehabilitation to problem drinkers; hence, the beginnings of OAPs.

During the early years of OAPs, the workplace was deemed an appropriate setting for the detection of alcohol problems among employees. These programs were intended for alcohol-related problems only and were usually staffed by employees who were recovered alcoholics. OAPs were instituted at major industrial firms such as E.I. Dupont de Nemours Company, Kodak Park Works of Eastman Kodak Company, and Kemper Insurance which touched a large number of alcohol-impaired workers (Masi, p.5, 2011). OAPs continued to grow out of necessity rather than benevolence largely due to an uncharacteristic labor market during and after World War II (Richard, Emener, & Hutchison, 2008). During World War II, there was a severe shortage of male laborers in the workforce (Attridge, et. al, 2009) driving some companies to rehire employees who were previously terminated for alcoholism after they participated in Alcoholics Anonymous and maintained sobriety, while other companies were forced to hire alcoholics to maintain a stable workforce (Wrich, 1980).

After World War II, the service sector began to expand; the job market was high, but the quality of workers was still less than favorable due to personal problems suffered by those who participated in the war (Masi, 2011). Alcoholism, as an occupational health problem, continued to grow well into the 1950s due to the difficulty of readjustment for soldiers; therefore, occupational alcoholism programs were still needed. Most of the early programs trained supervisors to detect the symptoms of alcoholism (supervisory identification approach); however, the effectiveness of this approach was limited due to a variety of factors. The main problems with this approach were: 1) supervisors were not

diagnostic experts and, in some cases, reverted to personal biases to identify alcoholism; and, 2) supervisors seldom identified anyone above the worker level as needing assistance (Masi, 2011). Because of these difficulties, companies began to look at a different approach to occupational programming.

In the 1950s and 1960s, companies began to extend their alcoholism programs to include services for employees dealing with mental health problems (White and Sharar, 2003). In the 1960s, Lewis Presnall, director of labor management for the National Council on Alcoholism, developed a new approach to identifying employee decline which involved looking at performance on the job (Masi, 2020). This approach helped to not only identify those suffering from alcoholism, but also those who had non-alcohol related person problems that affected job performance. Presnall's approach helped companies to shift emphasis and in the mid-1970s, programs began to expand offerings to employees with addictions as well as those with mental health, and family-related problems.

EAPs from 1970 to Present

In the 1970s and 1980s, "broad brush" programs were developed. These programs differed from OAPs in that the word "alcohol", which stigmatized those who participated in an OAP program, was removed from the program title. Also, the focus of the "broad brush" approach was on identifying work-performance problems such as tardiness, absenteeism and diminished productivity which is the premise for today's EAPs (Wrich, 2017).

The idea of providing employee assistance was adopted to include a more wide-ranging approach. According to Dickman and Emener (1982), the EAP concept rapidly

expanded from an occupational alcoholism program concept to an EAP concept, which included response to other problems the employee was experiencing, both psychological and physical difficulties known to impede overall productivity and hinder human well-being. The core of the current movement, as well as the largest part of the daily casework, is rooted in problem identification, intervention, treatment, and recovery. The shift from OAPs to EAPs and the increased use of "broad-brush" programs led to many changes in the field (Masi, 2011). This new programming method tended to identify a wide range of employee behavioral problems in addition to alcoholism and increased services to include drug, marriage and family, emotional, financial, and legal problems (Richard, Emener, & Hutchison, 2009).

The Association of Labor Management Administrators and Consultants on Alcoholism (ALMACA) was the professional association for Occupational Alcoholism Program affiliates (A. Hilbers, personal communication, April 11, 2017). ALMACA eventually became the Employee Assistance Professionals Association (EAPA). EAPA is one of the two major professional organizations for employee assistance professionals. The other major organization for the EA field is EASNA (Employee Assistance Society of North America), which originated in Canada around the same time as EAPA.

In the late 1980s, EAPA developed a certification for EAP clinicians called the CEAP (Certified Employee Assistance Professional) involving a written exam and requiring verification of experience in the field. Both EAPA and EASNA recognized the CEAP as a valid credential for the EA field. EAPA's focus is primarily on serving professionals involved in the employee assistance field, whereas, EASNA's focus has traditionally been in providing organizational support and research to benefit

management and organizations; both organizations offer publications featuring current research related to the EA field (A. Hilbers, personal communication, April 11, 2017). EAPA developed a guiding philosophy which they call the core components for the EA profession. These elements work together to best address work productivity and employee personal concerns:

1. "Consultation with, training of, and assistance to work organization leadership (managers, supervisors, and union officials) seeking to manage troubled employees, enhance the work environment, and improve employee job performance;

2. Active promotion of the availability of EA services to employees, their family members, and the work organization.

3. Confidential and timely problem identification/assessment services for employee clients with personal concerns that may affect job performance;

4. Use of constructive confrontation, motivation, and short-term intervention with employee clients to address problems that affect job performance;

5. Referral of employee clients for diagnosis, treatment, and assistance, as well as case monitoring and follow-up services;

6. Assisting work organizations in establishing and maintaining effective relations with treatment and other service providers, and in managing provider contracts;

7. Consultation to work organizations to encourage availability of and employee access to health benefits covering medical and behavioral problems including, but not limited to, alcoholism, drug abuse, and mental and emotional disorders; and

8. Evaluation of the effects of EA services on work organizations and individual job performance" (eapassn.org).

Each of the elements in the core technology created a comprehensive approach that aided EAPs in its rapid growth as employers responded to the concerns of their employees. Managers began to quickly understand that when an employee entered the workplace, he or she did not leave behind alcoholism, depression, marital problems, family problems, financial concerns, stress, or any of the personal problems that affect his or her ability to perform. Hence, managers leaned on EAPs to provide coping resources and assist their employees with personal problems, while also offering a tool for effective management and a way to reduce costs associated with poor productivity.

In the 1990's and early 2000's, the workforce saw an increase in dual career families and employees working past retirement age and companies offering EAP services increased during this time (Attridge et. al., 2009). This trend has continued with close to 80% of U.S. companies offering EA programs in 2019 (SHRM, 2019). Figure 3 reflects the growth in companies utilizing EAPs.

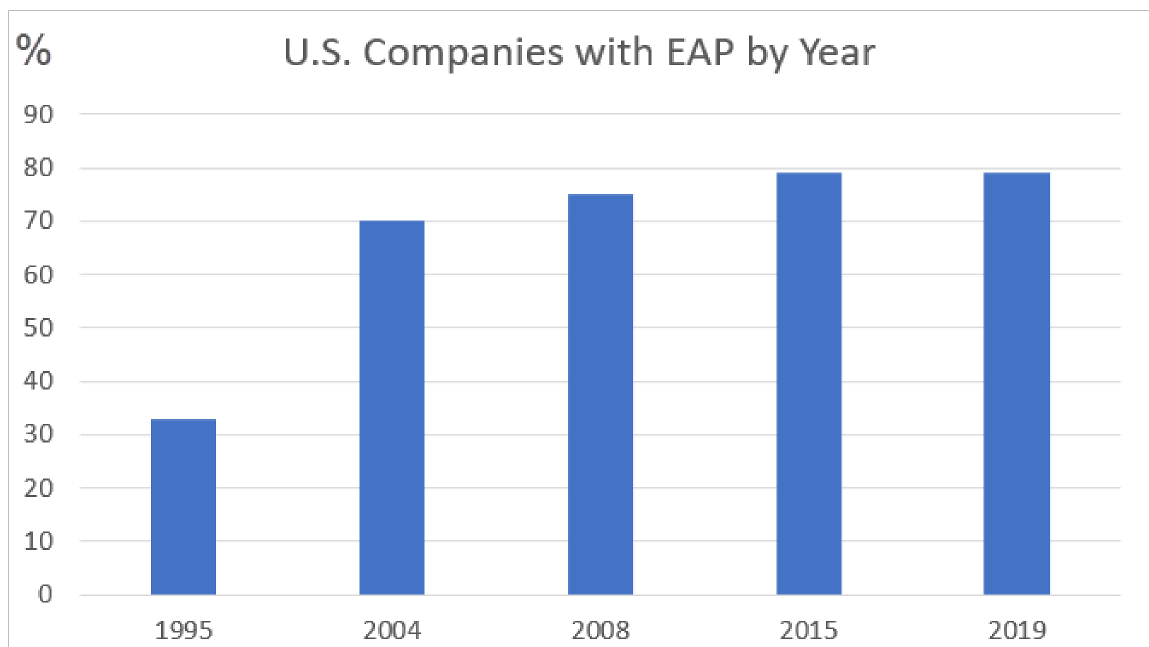

Figure 3. U.S. Companies with EAP by Year.

EAPs became a standard part of employee benefits package at most large companies and EAP services expanded to include childcare, eldercare, outplacement services, workplace violence and work-life balance (Attridge et. al., 2009). EAPs also became instrumental in expanding the delivery of mental health services to group health plan participants and in controlling plan sponsors' expenditures for these services. This comprehensive managed care approach expanded the focus of EAPs to enhance employee morale and productivity while controlling healthcare costs (Levy, et al., 2009). Because organizations focus on improved productivity and managing costs, this has prompted the present day EAP to evaluate EAP plan design to determine cost-effectiveness.

From the 1990s to present, the EA field has been faced with providing services to help employee client's process traumatic world events, workplace violence, and natural disasters. Employee assistance professionals learned to provide critical incident stress debriefing to help employees cope with the effects from these upsetting events. EA professionals have been called to action from across the city, state, and nation, in some cases, to provide services after devastating occurrences.

By the early 2010s, ninety percent of the Fortune 500 companies purchased EAPs and EAPs existed on almost every university campus as Faculty Staff Assistance Programs (Masi, 2011). Today, EAPs deliver services in a variety of formats to include in-person, tele mental health (phone or virtual/web-based). Studies have shown minimal or insignificant differences between these delivery formats (Masi, 2020).

History of EAPs in Alabama

The study author reached out to the Alabama chapter of EAPA to gather data on the history of EAPs in Alabama but was unsuccessful. The study author interviewed a local subject matter expert and long-time EAP counselor to attain the history of EAPs in Alabama, Anne V. Hilbers, PhD, EdS, MA, LPC, CEAP, CAC, NCC. According to Dr. Hilbers. Some of the EAPs and OAPs active in Alabama in the late 1970s and 1980s are listed below:

OAPs

- Alabama Power
- South Central Bell
- TVA
- Physicians Recovery Program
- Russell Corporation (transitioned to an EAP management model program in 1982)

EAPs

- Employee Assistance Services (EAS)
- Brookwood Hospital
- Jackson Hospital
- UAB

Dr. Hilbers was hired to direct the EAS program in 1981. EAS is a good example of the transition of occupation alcoholism programs to employee assistance programs. Most OAPs were internal company programs until the early and mid-eighties. According

to Dr. Hilbers knowledge, EAS was the first EAP to offer external service provisions to multiple employers in Alabama and at least one of the first in the southeast region.

When Dr. Hilbers assumed the directorship of EAS, she was the first graduate level therapist (M.A., Ed.S., ABD) employed by the program. When she assumed leadership at EAS, recovering alcoholics with high school diplomas were providing marriage counseling and mental health counseling for EAP contract clients. This was common practice during that era (White and Sharar, 2003). To boost the clinical quality and marketability among potential employer clients of the program she began to develop a team by hiring another master's level therapist.

When Dr. Hilbers' tenure ended in 1986, EAS had expanded their client base to include over 50,000 employees scattered throughout the southeast. The counseling staff had expanded to include several graduate level mental health therapists. Although recovering alcoholics remained on the staff, they were supervised by master's level or higher mental health professional staff. They were also restricted to substance abuse recovery counseling. By 1986, EAS services included two fully staffed locations and client companies included the City of Birmingham, Alabama Gas Co., Rust Engineering, Law Engineering, Sirote Permutt law firm, Russell Corporation, B. E. & K., The Birmingham News, Thompson Tractor, O'Neal Steel, and Vulcan Materials. This list is not inclusive of all the company clients of EAS.

History of University EAP in Alabama

The university EAP engaged for this research study was established as an internal EAP in the early 1980s. Based on historical records located in the files at the university

EAP, the program was developed after an 18 month investigation on dozens of EAPs in business and higher education and from a review of the institutions' health plan claims which demonstrated that alcohol abuse along with disability management, misuse of sick leave, stress and other factors were costing the organization several hundred thousand dollars each year. At the time the program was called the Faculty and Staff Assistance Program and was operated as a practice group with unlimited sessions.

The program name was later changed to the Resource Center and remained so until the name changed to the Employee Assistance and Counseling Center in 2013. This name change was made so that employees would have a clear understanding of the services the EA program provided. At the time of the name change, the program also changed its operational model from a practice group to an EAP model with statistical reports to gauge outcomes such as client utilization and satisfaction. In addition to providing services to university employees, the EAP secured external contracts (A. Hilbers, personal communication, November 7, 2016). The services grew to comprise the following:

General Services

- Family, Couples, & Individual Therapy sessions
- Group Therapy
- Art Therapy and Art Therapy Groups
- Life Coaching
- Monthly Lunch-n-Learn and other Educational Seminars
- Financial wellness counseling and seminars
- Gentle Yoga, Restorative Yoga, Pilates,

- Meditation
- Resilience Training
- Quiet Rooms
- Critical Incident Support
- Tobacco Cessation Groups and Individual Sessions
- Supervisor Consultations, Management Referrals
- Community Referrals
- Campus Wide Mental Health Screenings
- University Health Fairs, Annual Mental Health Fair
- Supervisor Training
- EMDR

Online Services

- Distance Counseling/Tele mental Health
- Mental Health Online Screening
- myStrength web and mobile tools for emotional health and wellbeing
- Monthly Lunch-n-Learn and Financial Education Series
- Meditation, Yoga, Stress Reduction
- Community and other Mental Health and Substance Abuse Resources

The EA program's staff consists of a director/counselor, program coordinator, clinical coordinator, art therapist, 9 counselors, and a financial wellness counselor. All members of the counseling team have master's and/or doctoral degrees in the mental health profession. The staff is equipped with licensure and/or certifications to include the designations of Licensed Professional Counselor (LPC), Licensed Marriage and Family

Therapist (LMFT), Art Therapy Registered-Board Certified Art Therapist (ATR-BC), National Certified Counselor (NCC), certified to clinically supervise counseling interns at both the Master's and Doctoral level, and specialized training, and/or certification in marriage and family counseling, financial counseling, alcohol and drug counseling, distance counseling, Eye Movement Desensitization and Reprocessing (EMDR), gerontology, employee assistance, critical incident stress debriefing, special needs populations, sexual addictions, play therapy and art therapy.

The EAP offers services to an employee base of 22,000+, University Facts and Figures, 2018-19). In 2019, the annualized utilization rate was 6% (includes 12 visits per presenting problem annually and wellness benefits offered by the EAP) and the top three primary presenting issues were typically 1) stress/emotional issues (44.2%), followed by 2) martial/partner relationship issues (21%), and 3) family issues (family conflict, child/teen, parent/child relationship, domestic violence, reaction to illness, affected by other's substance abuse or addition, affected by other's emotional problem (13.1%); this utilization rate (University Utilization Report 2019 Annual Summary, 2020).

Although the university started the EAP in the early 1980s due to concern for employee health and its effect on worker productivity, at that time the focus was more so on providing a counseling service to those with personal or work-related issues, rather than measuring outcomes. Later the EAP began to track client satisfaction and number of clients using the services, which the EAP converted into utilization rate (number of cases divided by the total number of employees who are eligible for the EAP benefit).

In 2016, the EAP implemented the Chestnut Global Partners' Workplace Outcome Suite (WOS) outcomes measurement tool. The WOS is offered to the EAP

industry at no cost; the tool has been psychometrically validated and tested for use in EAP settings (eapassn.org). Although, the university EAP has been offering mental health services since the 1980s, being able to measure its effects on work outcomes will demonstrate the importance of the service to the organization's bottom line.

EAPs have become an essential part of the employee benefits package because the service provides relatively short-term solutions to help employees resolve work-related and personal problems; however, this self-evident assessment is no longer sufficient when organizational leaders are making cost-effective business decisions (Pompe, Sharar & Ratcliff, 2015). Therefore, in addition to gauging client satisfaction, the WOS will allow the EAP to measure and evaluate work-related outcomes as a result of employee assistance services and demonstrate the EAP's value to the organization in quantifiable terms.

EAP Program Evaluation

Traditional and new measures for the effectiveness of EAP's are all are subjective to some degree (Hargrave, Hiatt, Alexander, & Shaffer, 2008). EAP's have traditionally been evaluated through the use of client satisfaction surveys, utilization reports and return on investment (ROI) formulas. Some EAPs have utilized typical quality assurance and quality improvement protocols utilized in inpatient/outpatient psychiatric and substance abuse programs when considering client outcomes for EAP clients (McLeod, & McLeod, 2001). ROI information was frequently utilized in program marketing since it purported to represent cost savings analyses to investors; for years, this type of evaluation was

utilized along with client satisfaction data (Attridge, et. Al, 2009). In the last 10 years, EAPs started utilizing outcomes-based evaluations that correlate with work outcomes and worker productivity.

Gaps in the Literature

The literature on mental health in the workplace, particularly studies and peer-reviewed articles on EAPs and the effects on work outcomes is moderate. The EAP industry has attempted to establish the best method to demonstrate EAP effectiveness on improved work outcomes for many years. Over the years, EAPs have used client satisfaction, service utilization and case studies to justify the industry's value to business organizations; hence, the literature review includes several older references.

Most of the literature on EAPs and evaluation of EAPs dates from the 1980s to 2005. The majority of literature on the WOS started in mid 2000s to 2010 and it appears that the more recent literature on the WOS is in the WOS Annual Reports from 2016-present. The study author was able to find more recent literature related to employee and workplace wellness. Although many of these articles focus primarily on physical health, the concept of improved health on work outcomes was applied to this study.

As a result of the COVID-19 pandemic, the literature on mental health in the workplace seems to be expanding; however, this study occurred prior to the COVID-19 pandemic, therefore the study author did not reference articles related to the pandemic.

Theoretical Framework

Maslow's Theory of Motivation and Organizational Development Theory (ODT) were used in this study. Specifically, Maslow's construct of motivation was incorporated with the elements of human relations theory: worker satisfaction, workplace organization and socialization, and the six concepts of ODT: 1) organizational development (an approach that attempts to improve the quality of work-life), organizational climate (personality of an organization), organizational culture (shared beliefs by members of the organization), organizational capacity (organization's systems), action research (steps for improving the organization), and organizational interventions (use of tools to help improve organizations). These theories were used collectively to understand the impact of employee assistance services on both individual users of the services and the organization the EAP serves.

Maslow's Theory of Motivation

The workforce is impacted by many environmental, physical, and mental health outcomes that may affect an employee's ability and sometimes their motivation to progress. Maslow's Hierarchy of Needs is a five-tier model of human needs which drive motivation; the tiers, from the bottom level to the top level, are physiological, safety, love and belonging, esteem, and self-actualization (McLeod, 2020). An EAP can provide the resources and tools needed for an employee to move forward in the workplace and the framework of Maslow's Hierarchy of Needs is applied to this concept as noted in Figure 4.

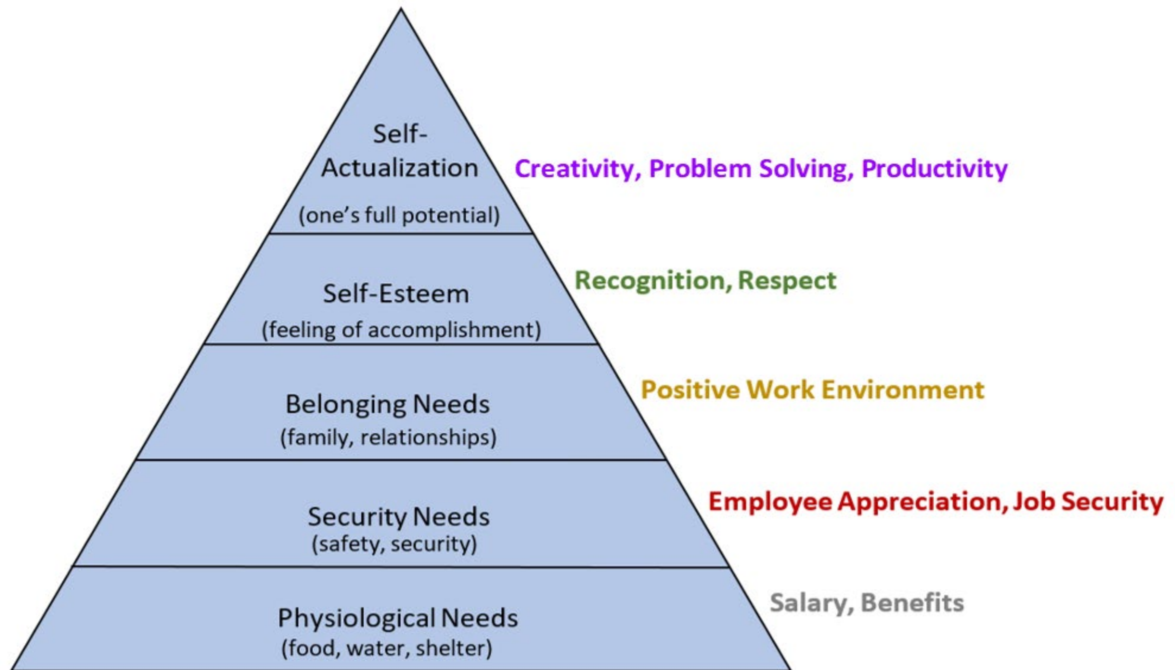

Figure 4. Maslow's Hierarchy of Needs Adapted for the Workplace

When an employee's needs are met at each step (both personal and work needs) this relieves emotional and mental problems associated with not meeting the need; therefore, resulting in better motivation to be productive in the workplace. An individual's mental, physical, and emotional attributes determines one's ability to do what is right in the workplace (Campbell & Dardis, 2004).

Physiological Needs: The basic step of physiological needs relates to an individual's ability to secure adequate compensation to provide for their own and their family's need for food, shelter and other necessities.

Security Needs: Once the physiological need is met, the next step is having security on the job in order to maintain the physiological needs of the employee and his/her family. Employees experience stability when they feel appreciated for their endeavors.

Belonging Needs: The third step in Maslow's hierarchy is belonging. Having a supportive environment at work and a stable environment at home will help the employee feel more assured and will likely increase their motivation towards work, and as a result improves their performance.

Self-Esteem: The next step, self-esteem and respect, can be fulfilled through recognition of contributions to the organization and personally through mental and emotional healing.

Self-Actualization: The final step of self-actualization occurs when all the lower needs are met. When this occurs, the employee's personal well-being is likely healthy and the employee's work performance is likely optimal.

Organizational Development Theory and Human Relations Theory

Organizational development is "a field of research, theory, and practice dedicated to expanding the knowledge and effectiveness of people to accomplish more successful organizational change and performance" (Glanz, Rimer, Viswanath, 2008, pg. 341). Human Relations Theory (HRT) founded by Elton Mayo, an organizational theorist, originated in the 1930s and focused on the human factor and the socio-psychological aspects the employee's behavior within the organization. Harvard researchers, under the leadership of Elton Mayo and Fritz Roethlisberger, studied workers in the mid 1920's to early 1930's at the Hawthorne plant of the Western Electric Company. As a result, the researchers discovered that focusing on the workers led to increased productivity known as the "Hawthorne Effect" (Wrench & Punyanunt-Carter, 2012). HRT maintains that attitudes, relationships, and social issues are vital in the performance of an organization

(Onday, 2016). The key assumptions of Human Relations Theory (Wrench & Punyanunt-Carter, 2012) are:

1) the theory acknowledges the importance of emotions and perceptions of individuals; therefore, the level of workers' productivity is determined by the human relations and interactions at work, rather than the physical and financial state of work;
2) the theory emphasizes the informal workplace organizations, meaning the employee's dominant need is belonging or being accepted by and having good standing within his/her work group. Poor mental health can result from exposure to poor work organization (Leka & Nicholson, 2019);
3) the above elements working together create worker satisfaction which lead to ideal worker productivity as noted in Figure 5.

Figure 5. Human Relations Components

Based on Elton Mayo's philosophy, the best way to manage an employee with a problem is to get to know the employee in an effort to appreciate the employee's history as well as his/her present circumstance and his/her manner of thinking. Mayo's research results were among the earliest to support the principles of humanism in organizational development.

Organizational Development Theory is derived the Human Relations approach. One of the key concepts of ODT, organization development, is to improve the quality of work-life through organizational diagnosis (Glanz et al., 2008). Intervention tools such as surveys are a critical aspect of ODT. ODT provides a unique perspective for this study because it focuses on organizational development through improving the quality of work-life by use of organizational beliefs, systems, use of survey tools and other techniques. The theory also touches on organizational diagnosis which is what the study will do by way of the WOS assessment tool and analyzing employee productivity after counseling intervention. The key concepts of ODT and the relevance for this study are outlined in Table 2.

Table 2

Summary of Organizational Development Theory Concepts

CONCEPT	DEFINITION	RELEVANCE FOR THIS STUDY
Organizational development	An approach that tries to improve the quality of work-life	Aim of EAP counseling is to help employees with work-life balance and ultimately improve work productivity levels
Organizational climate	The personality of an organization	The result use of the WOS may help identify areas of focus for work-life improvement
Organizational culture	Assumptions and beliefs that are shared by members of an organization	The result use of the WOS may help identify areas of focus for work-life improvement
Organizational capacity	Optimum functioning of an organization's systems	Employees working at ideal productivity levels result in optimal organizational performance
Action research	Steps for improving organizations	WOS used to assess employee productivity
Organizational development interventions	Specific techniques that are used to help improve organizations	WOS used to determine value of EAP programming and focus areas for work-life improvement

The Hawthorne studies were foundational for HRT and ODT. The two theories support the idea that emotionally healthy and socially accepted employees are more productive and engaged in the workplace and these ideologies set the foundation for programs like Occupational Social Work, Occupational Alcoholism, and ultimately present day EAPs.

Summary

The literature illustrates that the U.S. labor force is significant in size and continually increasing in diversity. This growth brings a variety of emotional, mental,

environmental, and physical challenges both for the individual worker and the organization. The literature reflects that organizations have provided well-being assistance (occupational social work, OAPs, EAPs) to their employees since the early 20th century to help meet these challenges resulting in today's focus on overall employee wellness. The research suggests the majority of organizations offer their employees access to EAP services, but the effectiveness of employee assistance services on the work outcomes and workplace productivity is not well known.

Concepts from Human Relations Theory, Organizational Development Theory and Maslow's Theory of Motivation have been used by organizations for years to improve employee performance and exhibit that when employees' lower level needs are met, they are inclined to show progress in their performance. Maslow's hierarchy of needs are goals that push people to enhance their circumstance and lessen tension (Rouse, 2004).

The results of the literature review support that organizations utilize EAPs to aid troubled employees. It also suggests that there is a need for improved measurement of work outcomes in EAPs to determine if employee assistance services correlate with improved workplace productivity. To address this phenomenon data were analyzed from a local university EAP. Chapter 3 presents the methodology used in the study.

CHAPTER 3

METHODOLOGY

This chapter includes a description of the research methods for the study. The topics covered include the: (a) Workplace Outcome Suite (b) research design (c) data collection; (d) study participants; (e) protection of participants; (f) validity of the WOS scale; (g) operational definitions; (h) data analysis; and (i) summary.

Workplace Outcome Suite

The Workplace Outcome Suite (WOS) is a brief assessment tool developed by the Chestnut Global Partners Division of Commercial Science. The WOS is "currently the only publicly available, free instrument that has been psychometrically validated and tested for use in EAP settings" (CGP, 2016). It was developed to facilitate practical research on EAP interventions (Lennox, et. al, 2010).

Since 2010, EAPs across the world have administered the WOS assessment tool seen in Appendix B. The annual report with pooled results from the WOS first started in 2016 and today, the report features over 35,000 cases with self-reported data collected before and after EAP counseling intervention (Morneau Shepell, 2020).

The WOS instrument has three versions: 1) 5-item scale, see Appendix A, 2) 9-item scale, see Appendix B, and 3) 25-item scale, see Appendix C. Each version consists

of five constructs that are of most importance when understanding EAP effectiveness by measuring the effects of personal issues on workplace functioning:

1. *Absenteeism* examines the number of hours absent due to a personal problem taking the employee away from work in the last 30 days.
2. *Presenteeism* assesses when the employee is at work but is not working at his or her ideal performance level because of personal issues.
3. *Work Engagement* refers to the degree to which the employee is engaged and dedicated to his or her job.
4. *Life Satisfaction* addresses an employee's general sense of well-being and satisfaction with life.
5. *Workplace Distress* measures the amount of anxiety or stress associated with work.

In all 3 versions of the WOS, absenteeism is reported in number of hours missed. The "remaining four constructs use the self-reported 1-5 Likert scale that examines various components of the effects of personal issues in relation to workplace functioning the Likert scale ratings are strongly disagree, somewhat disagree, neutral, somewhat agree, and strongly agree, with "1" indicating the least applicable response, and "5" indicating the most appropriate response" (Sharar, 2017, p 3). This methodology allows for statistical analysis of the data. A rating survey instrument adds familiarity for most individuals and gives the researcher the ability to make respondent comparisons (Suskie, 1996). In the 5-item version, "four of the 5-items correspond to latent variable measures of presenteeism, work engagement, life-satisfaction and workplace distress. These items

were selected based on highest factor loading from the original confirmatory factor analysis in the 25-item" (Lennox, et. al, 2018, p. 49).

Study Design

The WOS dataset employs a pre and post single group study design. The pre and post-test design examined possible changes over time. Pre and post single group study design is frequently utilized in applied research evaluations in the employee assistance field (Sharar and Lennox, 2014). A methodological benefit of using pre-and-post data is that it permits each client to act as his or her own control for other factors, such as demographic and other characteristics (Pompe, Sharar, Ratcliff, 2015). A major advantage of this design was that it could be used at no cost to the EAP and it was easy to administer and is a short 5 question survey. The WOS is also a tool designed specifically for the EAP setting. The tool focuses on the association of an employee's emotional well-being and performance to primarily determine workplace productivity rather than clinical outcomes. In 2018, Chestnut Global Partners reported that 600+ EAP members utilized the WOS.

At the time of this study the WOS offered 3 scales, WOS-5, WOS-9 and WOS-25. The WOS-5 scale was the primary instrument used in this study. Initially, the WOS-25 scale was used for data collection. Data was collected from January 15, 2017 to September 30, 2017 using the 25-item scale. However, due to poor response rate it was recommended by experts in the field that the WOS-25 be replaced with the WOS-5 which is the abbreviated version of the WOS-25 and has been tested and validated, (J. Harting, LCSW, CEAP & D. Sharar, PhD, personal communication, October 5, 2017).

In addition to the WOS-5 questions, an additional question related to utilizing other EAP services was included in the survey. The EAP also kept the existing client satisfaction questions as a part of the overall assessment; these 7 client satisfaction questions were included to measure the clients' utilization of and contentment with EA services.

Prior to implementing the WOS, the client satisfaction survey and utilization rates were the only measurements that the EAP employed. Neither of these measures connected the effects of counseling services on worker productivity. The traditional methods of determining EAP effectiveness have included utilization rates, client satisfaction surveys and website click-throughs; the WOS provides the EAP industry a method to objectively identify when EAP services successfully within the workplace (Sharar, 2009) and ultimately can be tied to an organization's financial performance.

Data Collection

A secondary analysis was conducted using data from an internal university EAP. The data were collected by a university EAP utilizing a pre-post assessment tool, WOS-5. The WOS-5 was administered to all new EAP clients who met the eligibility requirements from October 31, 2017 to July 1, 2019. The pre-post study allowed the researcher to examine the relationship between EAP intervention and work productivity. This model permitted the EAP to survey a client before introducing EAP counseling services and then 60 days after counseling services. This required attaining good contact information at the point of intake. The researcher hypothesized that EAP intervention is associated with improved work performance.

The pre-test data collection platform utilized self-administered paper-and-pencil version of the WOS-5 along with other intake forms during the employee client's first office visit. The employee client was provided a clipboard in the waiting area so that the client could provide answers. On average the WOS required less than five minutes for the client to complete the assessment; however, the intake forms altogether required more time to complete. After the intake forms were completed, the client submitted the forms to the EAP support staff. The support staff checked to make sure the survey questions were completed, and the recorded responses were then entered into the EAP software system at the time the pre-survey questions were responded to by the client. To maintain anonymity, the system assigned a unique identifier to each participant's responses. The identifier allowed linkage of the pre-test subject with the same post-test subject.

Collection of post-test data was conducted electronically. If the following parameters were met in the client demographic record, the client was sent a client survey via email:

1. The client has said Yes to surveys.
2. Client >= age 18 (this is for legal reasons).
3. Must have email address for electronic survey.
4. The following "Relationship to Employee" is to receive surveys.
    a. Employee Only
    b. EE and Family Member

The client survey email was sent to the client 60 days after the initial intervention. All post-test surveys were electronic. There were no U.S. postal mail surveys sent to clients. The following questions were added after the WOS questions:

1. Have you utilized other EACC services?

    a. Yes

    b. No

    c. NA

    If yes, please select all of the following that apply:

    a. Yoga

    b. Art Therapy

    c. Tai Chi/Pilates

    d. Meditation

    e. Groups

    f. EMDR

    g. Educational Seminars

    h. Career & life Enhancement Counseling

    i. Online / Resources/Services

    j. Distance Counseling

    k. Tobacco Cessation

    l. Mental Health Screenings

2. The existing Client Satisfaction Survey questions were included

    (using a Likert scale: Very Poor, Poor, Neutral, Good, Excellent, No Response)

    a. Initial contact with the EAP

    b. Treated with dignity, respect by counselor

    c. Contact was treated confidentially

    d. Extent to which the EAP helped with problem

e. Overall, how satisfied with EAP program
f. How likely to recommend EAP service to others?

To understand the nature of the sample, the following demographic and other questions were added to the survey:

a. Age at time case was opened
b. Gender
c. Education
d. Ethnic Background
e. Marital Status
f. Referral Source
g. Relationship to Employee
h. Referred by: (if Supervisor = Yes otherwise No)
i. Employee's Workplace - text
j. Job Type
k. Work Status
l. Shift
m. How long have you been in this job?
n. How long have you worked with this employer?
o. Have you been to the University EACC before?
p. Work Performance Problem
q. Work Performance Problem # 2
r. Personnel Actions Taken
s. Personnel Actions Taken # 2

t. Days Absent in Last 12 months
u. Lost time at work due to Injury in last 12 months
v. Are any of the following currently a problem?
w. Aware of EACC
x. Primary Concern
y. Secondary Concern
z. Other services utilized (with options for selection)

Study Participants

The participants for this study were clients of the university EAP (employees and/or immediate household members of employees). Employees or the employees' family members who presented to the EAP were asked to participate during the intake process. Sample selection was strictly based on clients who opted to voluntarily participate in both the pre- and post-survey. Subjects were not offered an incentive and could end participation in the study at any time. The clients who opted in were guaranteed confidentiality. Those surveyed were at least 18 years of age and had to opt-in to receive an invitation to participate in the study.

Protection of Participants

During the intake process, each new client received and signed a statement of understanding which addressed confidentiality, limits of confidentiality, and program evaluation. The program evaluation section stated that non-clinical data provided by the client may be used for EAP program evaluation research and that the client would not be

identified, and that the client's information was anonymous. For the WOS assessment data, a unique identifier was assigned to each participant's responses to ensure anonymity.

Validity of the WOS

The WOS-5 is considered a valid instrument designed to offer consistent outcome measures for assessing the usefulness and effectiveness of EAPs on the factors of absenteeism, presenteeism, work engagement, life satisfaction and workplace distress (Lennox, Sharar, Schmidt, Goehner, 2010). There have been two independent validation studies that tested the reliability of the WOS scales, the structural validity of the items, and the construct validity of the unit-weighted scale scores; the results of these studies supported the premise that EAP counseling services positively impact work related-outcomes as measured by the WOS. (Pompe, Sharar, Ratcliff, 2015).

Because many EAPs considered the WOS 25-item scale as too lengthy for typical EAP settings, the WOS 5-item version was developed. Lennox, et al. (2010) confirmed that the WOS-5, 5-item version of the original 25-item WOS, could be used to approximate the 25-item version without disproportionate loss of reliability, validity, or sensitivity.

Operational Definitions

Age. The age variable was obtained from the intake questionnaire. This variable was generated from responses to the "Date of Birth" field on the intake form. Each participant's actual date of birth was calculated as age in years, from date of birth to open

date (date the intake form was completed). All responses who indicated “yes” to receiving a survey and were 18 years of age and older received an invitation to participate in the survey. For analysis purposes, individual age was grouped as 1) 18-38, 2) 39-54, and 3) 55+.

Gender. The gender variable was obtained from the intake questionnaire. This variable was generated from responses to the “Gender _M _F” field on the intake form. The gender variable was coded as: 0= Data Not Available; 1=Male; 2=Female.

Education level. The education variable was obtained from the intake questionnaire. This variable was generated from responses to the “Education” field on the intake form. The education variable was coded as: 0=Data Not Available; 1=8 grades or under; 2=9th through 11th; 3=HS Graduate; 4=Some College; 5=College Graduate; 6=Advanced Degree.

Race/ethnicity. The race/ethnicity variable was obtained from the intake questionnaire. This variable was generated from responses to the “Ethnic Background” field on the intake form. The race/ethnicity variable was coded as: 0=Data Not Available; 1=American Indian or Alaskan Native; 2=Asian; 3=Black or African American; 4=Hispanic/Latino; 5=Native Hawaiian or Other Pacific Islander; 6=Two or More Races; 7=White; 8=Other. For analysis purposes, race/ethnicity was grouped as 1) White; 2) Non-White.

Marital Status. The marital status variable was obtained from the intake questionnaire. This variable was generated from responses to the "Marital Status" field on the intake form. The marital status variable was coded as: 0=Data Not Available; 1=Single; 2=Married; 3=Divorced; 4=Separated; 5=Widowed; 6=Life Partner; 7=Living w/Someone.

Workplace. The employee's workplace was pulled from company records. For analysis purposes, workplace was grouped as 1) Health System; and 2) University Campus.

Job Type. The employee's job type was pulled from company records. For analysis purposes, job type was grouped as 1) Administrative/Management; and 2) Non-Administrative

Primary and Secondary Presenting Problem. The presenting problem variables (1 and 2) were obtained from the intake questionnaire. This variable was generated from responses to the question "What Are You Most Concerned About Today?". The participant was asked to look at a list of 43 concerns and to circle the two things that were most concerning today. The participant was asked to put a #1 by the issue that was most significant today. The presenting problem variable was coded as follows: 0=Data Not Available; 1=Alcohol Abuse; 2=Drug Abuse; 3=Gambling; 4=Internet; 5=Sexual; 6=Abuse Other; 7=Family Conflict; 8=Child; 9=Teen; 10=Parent/Child Relationship; 11=Domestic Violence; 12=Reaction to Illness; 13=Living w Abuse or Addiction; 14=Living w Emotional Problem; 15=Family Other; 16=Marital/Partner Relationship; 17=Depression; 18=Anxiety; 19=Emotional Other; 20=Physical Abuse; 21=Sexual Abuse; 22=Emotional Abuse; 23=Post Traumatic Stress; 24=Trauma Other;

25=Relationship w co-workers; 26=Relationship w supervisor; 27=Workplace Violence; 28=Harassment; 29=Job Performance; 30=Work Related Other; 31=Medical Condition; 32=Financial Planning; 33=Debt; 34=Financial Issues; 35=Legal; 36=Childcare; 37=Older Adult Services; 38=Lifestyle / Work Life Balance; 39=Consumer Issues; 40=Travel/Recreation; 41=Home Repair; 42=Pet Care; 43=Education; 44=Work Life Other; 45=No Personal Issue; 46=Eating Disorders; 47=Stress; 48=Not Listed; 58=Grief; 61=Smoking; 62=Life Coaching. For analysis purposes, presenting problem was grouped as 1) Relationship; and 2) Emotional/Other

Work Status. The work status variable was obtained from the intake questionnaire. This variable was generated from responses to the "Work Status" field on the intake form. The work status variable was coded as: 0=Data Not Available; 1=Full Time; 2=Part Time; 3=As Needed; 4=Temporary; 5=Displaced; 6=Other; 7=N/A Family Member.

Shift. The shift variable was obtained from the intake questionnaire. This variable was generated from responses to the "Shift" field on the intake form and is defined at the time period during which the employees is assigned to work. The shift variable was coded as: 0=Data Not Available; 1=Days; 2=Evenings; 3=Nights; 4=Rotating; 5=Other; 6=N/A Family Member.

Length of Work. The length of work variable was obtained from the intake questionnaire. This variable was generated from responses to the question "How long have you been in this job". The length of work variable was coded as: 0=Data Not Available; 1=Under 1 Year; 2=1-3 Years; 3=4-6 Years; 4=7-9 Years; 5=10-15 Years; 6=16 or More Years; 7=N/A Family Member.

Prior EACC. The prior EAP variable was obtained from the intake questionnaire. This variable was generated from responses to the question "Have you been to the EAP before". The prior EAP variable was coded as: 0=Data Not Available; 1=Yes; 2=No.

Work Performance. The work performance variable (both 1 and 2) was obtained from the intake questionnaire. This variable was generated from responses to "Work Performance Problems" field on the intake form and the participant was asked to put a #1 and #2 next to the top two that applied with #1 being the most serious. The work performance variable was coded as: 0=Data Not Available; 1=Absent; 2=Tardy; 3=Safety Violations; 4=Problems Relating to Other Employees; 5=Quality/Quantity of Work Decreased; 6=Workers Comp Case; 7=Alcohol/Drugs Suspected on the Job; 8=Theft; 9=Other; 10=N/A Family Member; 11=NO PROBLEMS.

Personnel Action. The personal action variable (both 1 and 2) was obtained from the intake questionnaire. This variable was generated from responses to the "Personal Action Taken" field on the intake form and the participant was asked to mark the two most recent personal action events that applied, with #1 being most recent. The personnel action variable was coded as: 0=Data Not Available; 1=Employee was Counseled; 2=Verbal/Written Warning; 3=Suspension; 4=Placed on Administrative Leave; 5=Referred to EAP; 6=Termination; 7=Resignation; 8=No Action Taken; 9=N/A - Family Member; 10=Other; 11=Not Applicable.

Days Absent. The days absent variable was obtained from the intake questionnaire. This variable was generated from responses to the "Days Absent" field on the intake form. The participant was asked to indicate the days absent in the last 12 months. The days absent variable was coded as: 0=Data Not Available; 1=No Days; 2=1-5 Days; 3=6-10 Days; 4=11-15 Days; 5=16+ Days; 6=N/A-Family Member.

Injury. The injury variable was obtained from the intake questionnaire. This variable was generated from responses to the question "Have you lost time at work due to injury in the last 12 months" on the intake form. The injury variable was coded as: 0=Data Not Available; 1=Yes; 2=No; 3=N/A - Family Member.

Urgency. The urgency variable was obtained from the intake questionnaire. This variable was generated from responses to the question "Are any of the following currently a problem" on the intake form. The urgency variable was coded as: 0=Data Not Available; 1=Suicide; 2=Homicide; 3=Sexual Abuse; 4=Physical Abuse; 5=Psychosis; 6=Combination of Above; 7=None of Above.

Aware of EAP. The aware of EAP variable was obtained from the intake questionnaire. This variable was generated from responses to the field "Aware of EAP" on the intake form. The aware of EAP variable was coded as: 0=Data Not Available; 1=Prior Participation; 2=The Reporter; 3=Posters; 4=Monday Mailing; 5=Brochures; 6=Supervisor Suggested; 7=Co-Worker Suggested; 8=Family Suggested; 9=In Service Training/Orientation; 10=Other.

Referral. The referral variable was obtained from the intake questionnaire. This variable was generated from responses to the question "How did you hear about the university Employee Assistance Program" on the intake form. The referral variable was

coded as: 0=Data Not Available; 1=Supervisor Formal; 2=Supervisor/Personal Concern; 3=Self; 4=Family; 5=Co-Worker; 6=Other; 7= Physician.

Relationship. The relationship variable was obtained from the intake questionnaire. This variable was generated from responses to the field "Relationship to employee" on the intake form. The relationship variable was coded as: 0=Data Not Available; 1=Employee (Self); 2=Employee + Family Member; 3=Family Member; 4=Other.

Referred By. The referred by variable was obtained from the intake questionnaire. This variable was generated from responses to the field "Referred by" on the intake form. The referral variable was coded as: 0=Data Not Available; 1=Supervisor Formal; 2=Supervisor/Personal Concern; 3=Self; 4=Family; 5=Co-Worker; 6=Other; 7= Physician.

Data Analysis

Data were collected by a large university EAP from October 31, 2017 to July 1, 2019. The analysis was limited to EAP clients over the age of 18. A total of 866 subjects participated in this study, who met the criteria. Of the 866 subjects who opted to participate, 129 subjects completed both pre and post surveys. The total response rate was 14.9%. This study used descriptive and inferential statistics to address the research questions and hypotheses.

During the initial 8-month data collection period using the WOS-25 item scale (from January 2017 to September 2017), the EAP reported that 110 clients opted-in to the survey, but only 11 clients completed surveys resulting in a 10% return rate. Due to the

low response rate and based on guidance from the experts in the field of EAP and WOS, the EAP replaced the WOS-25 with the WOS 5-item survey in October of 2017. The biggest challenge reported by the EAP was obtaining completion of the post-test, despite having good locator information and informing the client of confidentiality at intake.

The study author utilized responses to the demographic questions such as race, gender, age, ethnicity, job type, and workplace to determine if there were other significant factors in the study. The researcher conducted analysis using SAS version 9.4 on the de-identified data. For research question one, a paired t-test was used to analyze the before and after "mean" scores and detect differences beyond chance levels for the WOS outcome measures. For research question two, demographic factors (age, race/ethnicity, gender), job type and workplace were factored in to explore if these variables were associated with the improvements in each of the five WOS outcomes; a paired t-test and ANOVA F test were used for the question two analysis. For research question three, a two-way ANOVA was used. The researcher created groupings for the variables: age, ethnicity, job type, workplace and presenting problem due to only having 129 respondents. The researcher also addressed the correlation between client satisfaction and overall work effectiveness as measured by the WOS.

Summary

This chapter explained the methodology of the study. The WOS, research design, data collection, study participants, protection of participants, validity of the WOS scale, and data analysis procedures were discussed in detail. Chapter 4 presents the results of the study.

CHAPTER 4

RESULTS

This chapter describes the results of the study. This study was initiated to determine the effects of an urban university's EAP counseling services on work outcomes and workplace productivity with the assumption that EAP counseling interventions are associated with improvement in employee absenteeism presenteeism, work engagement, workplace distress, and life satisfaction. Paired t-tests, ANOVA F tests, and a two-way ANOVA were used to compute the results. Tables were created to summarize the results. The following research questions were addressed:

Research Question One: Is there a significant improvement over time in the five outcomes measured by the WOS?

Research Question Two: Is there a significant improvement over time in the five outcomes measured by the WOS based on gender, age, ethnicity, job type and workplace?

Research Question Three: Is there a significant improvement over time in the five outcomes measured by the WOS based on primary presenting issue and gender, age, ethnicity, and job type and workplace?

The researcher initially wanted to analyze improvement over time based on length of work to gauge if participants with longer work tenure have better job satisfaction than

those with shorter tenure; however, there were too many missing responses for the length of work variable to derive any meaningful results.

The WOS construct definitions are listed in Table 3.

Table 3

Constructs and Definitions

WOS-5 Question #	**Construct**	**Definition**
WS1	Absenteeism	Hours Missed
WS2	Presenteeism	Concentration at Work
WS3	Work Engagement	Eager to Work
WS4	Workplace Distress	Dread Work
WS5	Life Satisfaction	Life Going Well

Descriptive Statistics

Data were analyzed with SAS 9.4 statistical software. A total of 866 individual clients were invited to participate with a response rate of 14.9% or 129 responses. Of the 129 individuals who completed both pre and post surveys, most of the sample were aged 18-38 years, of white race/ethnicity and were female. The sample characteristics are described below.

Sample Characteristics of Participants

Table 4 shows the sample characteristics for those who participated in this study. A total of 129 adults aged 18 years and older participated in the survey. The majority of the sample was White (65.9%), female (84.5%), between the ages of 18-

38 (51.2%), married (51.9%), had greater than a high school education (87.6%), self-referred (96.9%), had no issues with work performance (81.4%), and had no previous engagement with the EAP service (67.4%). The workplace and job type of the sample were evenly split between Health System (51.3%), University Campus (46.5%); Administrative/Management (48.8%), and Non-Administrative (47.3%). The primary presenting issue for most of the sample was in the emotional category (67.4%) versus relationship category (32.6%).

Due to the small sample size the following variables were grouped: age, ethnicity, workplace, and presenting problem. Age was grouped into the following age groups: 1) 18-38 years of age, 2) 39-54 years of age and 3) 55+ years of age. Race/ethnicity was grouped into the following race/ethnicity categories: 1) White and 2) non-White. Workplace was grouped into the following workplace categories: 1) Health System and 2) University Campus. Presenting issue/problem was grouped into the following two categories: 1) emotional/other and 2) relationship.

Table 4

Sample Characteristics of Participants

Descriptive statistics (N=129)	
Characteristics	Mean (SD) or N (%)
Age	39.5 (11.7)
Age Group	
18 - 38	66 (51.2%)
39 - 54	44 (34.1%)
55 +	19 (14.7%)
Ethnicity	
Asian	4 (3.1%)

Black/African American	34 (26.4%)
Hispanic/Latino	1 (0.8%)
Two or more Races	4 (3.1%)
White	85 (65.9%)
Missing data	1 (0.8%)
Ethnicity2	
Non-White	43 (33.3%)
White	85 (65.9%)
Missing data	1 (0.8%)
Gender	
Female	109 (84.5%)
Male	16 (12.4%)
Missing data	4 (3.1%)
Education	
Advanced Degree	55 (42.6%)
College Graduate	58 (45.0%)
HAS Graduate	2 (1.6%)
Some College	14 (10.8%)
Marital	
Divorced	13 (10.1%)
Life Partner	1 (0.8%)
Living with Someone	9 (7.0%)
Married	67 (51.9%)
Separated	5 (3.9%)
Single	31 (24.0%)
Widowed	3 (2.3%)
Referral	
Co-Worker	4 (3.1%)
Family	5 (3.9%)

Other	3 (2.3%)
Physician	4 (3.1%)
Self	108 (83.7%)
Supervisor Formal	2 (1.6%)
Supervisor/Personal Concern	2 (1.6%)
Missing data	1 (0.8%)
Relationship	
Employee & Family Member	14 (10.8%)
Employee Only	115 (89.2%)
Referred By	
No	125 (96.9%)
Yes	4 (3.1%)
Workplace	
Administration	1 (0.8%)
Callahan Eye Hospital	2 (1.6%)
Central Office	1 (0.8%)
College of Arts and Sciences	1 (0.8%)
Health Services Foundation	12 (9.3%)
Health System Other	5 (3.9%)
Health Systems Administration	1 (0.8%)
Other	1 (0.8%)
School of Health Professionals	1 (0.8%)
School of Medicine	3 (2.3%)
School of Nursing	1 (0.8%)
Campus/University	47 (36.4%)
Hospital	46 (35.7%)
University Other	4 (3.1%)
Missing data	3 (2.3%)
Workplace2	

Health System	66 (51.2%)
University Campus	60 (46.5%)
Missing data	3 (2.3%)
Job Type	
Administrative/Support	38 (29.5%)
Executive/Management	8 (6.2%)
Faculty	9 (7.0%)
Nurse	24 (18.6%)
Physician	3 (2.3%)
Professional Non-Faculty	25 (19.4%)
Service	4 (3.1%)
Skilled Crafts	6 (4.7%)
Technical	7 (5.4%)
Missing data	5 (3.9%)
Job Type 2	
Administrative/Management/Service	63 (48.8%)
Non-Administrative	61 (47.3%)
Missing data	5 (3.9%)
Work Status	
As Needed	3 (2.3%)
Displaced	1 (0.8%)
Full Time	114 (88.4%)
N/A Family Member	1 (0.8%)
Other	1 (0.8%)
Part Time	5 (3.9%)
Temporary	1 (0.8%)
Missing data	3 (2.3%)
Shift	
Days	116 (89.9%)

Evenings	1 (0.8%)
N/A Family Member	1 (0.8%)
Nights	2 (1.6%)
Other	3 (2.3%)
Rotating	3 (2.3%)
Missing data	3 (2.3%)
Length of Work	
Under 1 Year	2 (1.6%)
1-3 Years	6 (4.7%)
4-6 Years	6 (4.7%)
7-9 Years	1 (0.8%)
16 or More Years	2 (1.6%)
N/A Family Member	2 (1.6%)
Missing data	110 (85.3%)
Prior EACC	
No	88 (68.2%)
Yes	38 (29.5%)
Missing data	3 (2.3%)
WorkPerf1	
Absent	3 (2.3%)
N/A Family Member	2 (1.6%)
NO PROBLEMS	105 (81.4%)
Other	6 (4.7%)
Problems Relating to Other Employees	4 (3.1%)
Quality/Quantity of Work Decreased	5 (3.9%)
Tardy	2 (1.6%)
Missing data	2 (1.6%)
WorkPerf2	
N/A Family Member	2 (1.6%)

NO PROBLEMS	118 (91.5%)
Other	1 (0.8%)
Problems Relating to Other Employees	4 (3.1%)
Quality/Quantity of Work Decreased	1 (0.8%)
Tardy	1 (0.8%)
Missing data	2 (1.6%)
PersonnelAction1	
Employee was Counseled	2 (1.6%)
N/A - Family Member	2 (1.6%)
No Action Taken	1 (0.8%)
Not Applicable	115 (89.2%)
Referred to EAP	1 (0.8%)
Termination	1 (0.8%)
Verbal/Written Warning	3 (2.3%)
Missing data	4 (3.1%)
PersonnelAction2	
Employee was Counseled	3 (2.3%)
N/A - Family Member	2 (1.6%)
No Action Taken	1 (0.8%)
Not Applicable	6 (4.7%)
Referred to EAP	2 (1.6%)
Verbal/Written Warning	1 (0.8%)
Missing data	114 (88.4%)
Hours Absent	
No Hours	55 (42.6%)
1-5 Hours	32 (24.8%)
6-10 Hours	19 (14.7%)
11-15 Hours	5 (3.9%)
16+ Hours	5 (3.9%)

N/A - Family Member	1 (0.8%)
Missing data	12 (9.3%)
Injury	
No	118 (91.5%)
Yes	6 (4.7%)
N/A/ - Family Member	1 (0.8%)
Missing data	4 (3.1%)
Urgency	
Sexual Abuse	2 (1.6%)
Suicide	4 (3.1%)
Combination of Above	4 (3.1%)
None of the Above	116 (89.9%)
Missing data	3 (2.3%)
Aware of EACC	
Brochures	5 (3.9%)
Co-Worker Suggested	17 (13.2%)
Family Suggested	4 (3.1%)
In-Service Training/Orientation	27 (20.9%)
Monday Mailing	7 (5.4%)
Other	20 (15.5%)
Posters	3 (2.3%)
Prior Participation	28 (21.7%)
Supervisor Suggested	3 (2.3%)
University Publication	13 (10.1%)
Missing data	2 (1.6%)
Problem1	
Sexual	1 (0.8%)
Family Conflict	4 (3.1%)
Child	1 (0.8%)

Parent/Child Relationship	3 (2.3%)
Reaction to Illness	2 (1.6%)
Living w Abuse or Addiction	3 (2.3%)
Living w Emotional Problem	3 (2.3%)
Family Other	4 (3.1%)
Marital/Partner Relationship	29 (22.5%)
Depression	17 (13.2%)
Anxiety	23 (17.8%)
Emotional Other	10 (7.8%)
Post-Traumatic Stress	1 (0.8%)
Medical Condition	1 (0.8%)
Financial Issues	1 (0.8%)
Lifestyle / Work Life Balance	2 (1.6%)
Work Life Other	2 (1.6%)
Eating Disorders	1 (0.8%)
Stress	9 (7.0%)
Not Listed	2 (1.6%)
Grief	6 (4.7%)
Smoking	3 (2.3%)
Life Coaching	1 (0.8%)
Problem1 group	
Emotional/Other	87 (67.4%)
Relationship	42 (32.6%)
Problem2	
Abuse Other	1 (0.8%)
Family Conflict	6 (4.7%)
Teen	2 (1.6%)
Parent/Child Relationship	5 (3.9%)
Reaction to Illness	1 (0.8%)

Living w Emotional Problem	2 (1.6%)
Family Other	4 (3.1%)
Marital/Partner Relationship	7 (5.4%)
Depression	11 (8.5%)
Anxiety	13 (10.1%)
Emotional Other	10 (7.8%)
Emotional Abuse	1 (0.8%)
Post-traumatic Stress	2 (1.6%)
Relationship w co-workers	2 (1.6%)
Job Performance	5 (3.9%)
Work Related Other	3 (2.3%)
Medical Condition	3 (2.3%)
Financial Issues	4 (3.1%)
Lifestyle / Work Life Balance	11 (8.5%)
Education	1 (0.8%)
Work Life Other	2 (1.6%)
No Personal Issue	1 (0.8%)
Eating Disorders	1 (0.8%)
Stress	20 (15.5%)
Not Listed	1 (0.8%)
Grief	4 (3.1%)
Missing data	6 (4.7%)
Problem2 group	
Emotional/Other	96 (74.4%)
Relationship	27 (20.9%)
Missing data	6 (4.7%)

Client demographics correlated with the University's employee demographics with most clients reporting they were female gender and of White race/ethnicity. Employee demographics were taken from the University's 2018-19 Facts and Figures.

Table 5

Employee Demographics vs. Study Participant Demographics

Category	**University Employee Demographics (%)**	**Study Participant Demographics (%)**
Non-White Race/Ethnicity	41.1	33.3
White Race/Ethnicity	58.8	65.9
Female	65.6	84.5
Male	34.4	12.4
University Campus	57	46.5
Health System	44	51.2
Administrative/Management	48.8	40
Non-Administrative	47.3	60

Client demographics for the study correlated with the Workplace Outcome Suite pooled data for 2020 taken from the 2020 WOS Annual Report – WOS pooled participants data refers to an annual industry-wide aggregate report sponsored by EAPA and Chestnut Global Partners. For 2020, the study sample included over 35,000 employees with self-reported data collected over a period of 10 years, between 2010 and 2019. Comparing the study participants demographics to the WOS pooled data, most clients reporting they were female gender, self-referred and presented with an emotional/mental health problem, see Table 6.

Table 6

2020 WOS Pooled Demographics vs. Study Participant Demographics

	2020 Pooled WOS Data	**Study Participant Data**
Average Age	36	40
Gender *(Female | Male)*	68% > 32%	85% > 12%
Clinical Issue *(Emotional/Mental Health | Relationship)*	70% | 30%	67% | 33%
Referral Source *(Self | Work/Family Member/Other)*	85% | 15%	83% | 17

Improvement in Outcomes Over Time

Research Question One asked is there a significant improvement over time in the five outcomes measured by the WOS?

The overall results for all 5 WOS outcomes are shown in Table 7:

Table 7

Overall Statistics for WOS-5 Outcomes

WOS Scale	Pre Score	Post Score	N	*p-value*	Difference Percentage	Effect Size d	Effect Size Interpreted
Absenteeism	0.9	2.3	129	**0.0015**	155%	-0.286	Small
Presenteeism	3.0	**2.9**	129	0.756	-3.4%	0.027	None
Work Engagement	3.2	**3.4**	129	**0.034**	6.3%	-0.188	None
Life Satisfaction	2.39	2.36	129	0.779	-1.3%	0.025	None
Workplace Distress	3.2	3.7	129	**0.0001**	15.6%	-0.463	Small

Absenteeism worsened by 155% from baseline to follow up which was statistically significant with a small effect size. Presenteeism improved by 3%; however, presenteeism did not reach statistical or clinical significance. Work Engagement improved by 6%, which was statistically significant, but not clinically significant. Life Satisfaction decreased by 1% which did not reach statistical or clinical significance. Workplace distress increased by 15%, but this was in the unpredicted direction; this finding was statistically significant with a small effect size.

When comparing the study participants' mean scores to the 2020 WOS pooled means (35,000+ participants), the study participants had less absenteeism before the counseling intervention (0.9). Although workplace distress scores were higher than the WOS pooled means before counseling intervention; the rating of 3 relatively remained the same which equates to "neutral" on the Likert scale for the question "I dread going to work" which indicates the study population did not decline or necessarily dread going to work, rather they remained the same which was neutral.

Table 8

Study Participant Means vs. 2020 Pooled WOS Participant Means

	Study Participant Means		**2020 Pooled WOS Means**	
	Pre	Post	Pre	Post
Absenteeism	0.9	2.3	1.92	1.41
Presenteeism	2.95	2.91	3.29	2.40
Work Engagement	3.20	3.40	3.19	3.44
Life Satisfaction	2.40	2.36	3.04	3.71
Workplace Distress	3.18	3.66	2.22	1.90

Absenteeism Improvement Over Time

The post absenteeism percentage is significantly higher than the pre absenteeism percentage which makes it appear that absenteeism significantly worsened over time. However, analysis of the pre survey data revealed a mean of 0.9 hours (*SD*=2.1) absent due to a personal problem taking the employee away from work in the last 30 days. After clients participated in the EAP counseling intervention, the hours absent increased significantly to 2.3 (*SD*=4.5), with a mean difference of 1.4 (*SD*=4.8; *p*=0.015). The standard deviation at post indicates that majority of study participants scores are far from the mean which is true because 67% of the study population missed 0 hours post intervention. The study author notes that the pre score of .9 hours missed was fairly low and the post score of 2.3 is not very high which indicates that participants were absent less than one hour within a 30-day period before counseling intervention and only 2.3 hours within a 30-day period after counseling intervention; this does not show evidence of an absenteeism problem.

Table 9

WS1 Absenteeism Statistics

WS1 Absenteeism						
WS1Pre		WS1Post		Mean difference	Paired t test	Wilcoxon signed rank test
Mean (SD)	Median (min, max)	Mean (SD)	Median (min, max)	WS1Post - WS1Pre	p value	p value*
0.9 (2.1)	0 (0, 9)	2.3 (4.5)	0 (0, 24)	1.4 (4.8)	0.0015	0.0016

* Nonparametric test

To better interpret the unexpected absenteeism outcome the study author reviewed the frequency data. The table below shows frequency of responses:

Table 10

Absenteeism Response Frequency

Total number of hours a personal concern caused the participant to miss work with the past 30 days.

Pre Absenteeism	Frequency	%
0 hours missed	98	76.0
1	10	7.8
2	2	1.6
3	2	1.6
4	7	5.4
5	2	1.6
6	2	1.6
8	5	3.9
9	1	.8
Total	129	100.0

Post Absenteeism	Frequency	%
0 hours missed	87	67.4
1	6	4.7
2	5	3.9
4	7	5.4
5	1	.8
6	1	.8
7	1	.8
8	9	7.0
10	6	4.7
12	1	.8
14	1	.8
16	2	1.6
20	1	.8
24	1	.8
Total	129	100.0

The frequency details show most participants missed zero hours within the last 30-days at both pre and post survey. If the majority of participants scored a zero, this means scores can only increase from that point resulting in worsened absenteeism. Before counseling intervention 4% of the study population missed 8 hours or more and after

counseling intervention 16% missed 8 or more hours. The missed hours could have been due to employees taking vacation leave. The study author did not have access to company timekeeping records; subsequently, there is no way to know the true reason for the absence; however, the percentage of participants who missed 8 hours (1 day) or more at pre and post is relatively low and does not indicate an absenteeism problem.

Presenteeism Improvement Over Time

Examining presenteeism before and after the counseling session, there was no significant difference between pre and post survey scores (p=0.755).

Table 11

Presenteeism Response Frequency

My personal problems kept me from concentrating on my work.		
Scale	WS2Pre	WS2Post
Strongly Disagree	30 (23.3%)	24 (18.6%)
Somewhat Disagree	19 (14.7%)	27 (20.9%)
Neutral	18 (13.9%)	19 (14.7%)
Somewhat Agree	51 (39.5%)	54 (41.9%)
Strongly Agree	11 (8.5%)	5 (3.9%)

Table 12

WS2 Presenteeism Statistics

WS2 (Presenteeism)						
WS2Pre		WS2Post		Mean	Paired t	Wilcoxon
Mean (SD)	Median (min, max)	Mean (SD)	Median (min, max)	WS2Post - WS2Pre	p value	p value*
3.0 (1.4)	3 (1, 5)	2.9 (1.2)	3 (1, 5)	-0.04 (1.4)	0.7555	0.7081
* Nonparametric test						

Work Engagement Improvement Over Time

Clients reported a significant increase in work engagement after the intervention which was good. There was a mean difference of 0.2 (*SD*=1.1) between pre (*M*=3.2; *SD*=1.3) and post (*M*=3.4; *SD*=1.2) survey scores (*p*=0.03).

Table 13

Work Engagement Response Frequency

I am often eager to get to the work site to start the day		
Scale	WS3Pre	WS3Post
Strongly Disagree	15 (11.6%)	11 (8.5%)
Somewhat Disagree	20 (15.5%)	20 (25.5%)
Neutral	43 (33.3%)	32 (24.8%)
Somewhat Agree	26 (20.2%)	38 (29.5%)
Strongly Agree	25 (19.4%)	28 (21.7%)

Table 14

WS3 Work Engagement Statistics

WS3 (Work Engagement)						
WS3Pre		WS3Post		Mean difference	Paired t test	Wilcoxon signed rank test
Mean (SD)	Median (min, max)	Mean (SD)	Median (min, max)	WS3Post - WS3Pre	p value	p value*
3.2 (1.3)	3 (1, 5)	3.4 (1.2)	4 (1, 5)	0.2 (1.1)	0.0344	0.0361
* Nonparametric test						

Life Satisfaction Improvement Over Time

There was a slight decline in life satisfaction of 1%; however, there was no significant difference in life satisfaction scores before or after the intervention (*p*=0.779).

Table 15

Life Satisfaction Response Frequency

So far, my life seems to be going very well.		
Scale	WS4Pre	WS4Post
Strongly Disagree	11 (8.5%)	4 (3.1%)
Somewhat Disagree	27 (20.9%)	15 (11.6%)
Neutral	31 (24.0%)	26 (20.2%)
Somewhat Agree	48 (37.2%)	60 (46.5%)
Strongly Agree	12 (9.3%)	24 (18.6%)

Table 16

WS4 Life Satisfaction Statistics

WS4 (Life Satisfaction)						
W42Pre		WS4Post		Mean difference	Paired t test	Wilcoxon signed rank test
Mean (SD)	Median (min, max)	Mean (SD)	Median (min, max)	WS2Post - WS2Pre	p value	p value*
2.39 (1.3)	2 (1, 5)	2.36 (1.2)	2 (1, 5)	-0.03 (1.2)	0.7785	0.7601

* Nonparametric test

Workplace Distress Improvement Over Time

There was a significant difference in pre and post workplace distress scores, which on the surface indicate workers dreaded going to work. Survey scores significantly increased after the counseling intervention with a mean difference of 0.5 (*SD*=1.0; *p*<0.0001).

Table 17

WS5 Workplace Distress Statistics

WS5 (Workplace Distress)						
WS5Pre		WS5Post		Mean difference	Paired t test	Wilcoxon signed rank test
Mean (SD)	Median (min, max)	Mean (SD)	Median (min, max)	WS5Post - WS5Pre	p value	p value*
3.2 (1.1)	3 (1, 5)	3.7 (1.0)	4 (1, 5)	0.5 (1.0)	<.0001	<.0001

* Nonparametric test

To better interpret the unexpected workplace distress outcome the study author reviewed the frequency data. Table 18 below shows frequency of responses:

Table 18

Workplace Distress Response Frequency

	I dread going into work.	
	WS5Pre	WS5Post
Strongly Disagree	46 (35.7%)	43 (33.3%)
Somewhat Disagree	26 (20.2%)	32 (24.8%)
Neutral	28 (21.7%)	23 (17.8%)
Somewhat Agree	18 (14.0%)	26 (20.2%)
Strongly Agree	11 (8.5%)	5 (3.9%)

Although Workplace Distress increased in the unexpected direction, the frequency data shows the number of participants who strongly agreed with the statement "I dread going to work" prior to the counseling intervention actually reduced their workplace distress after counseling intervention by 54%. This indicates that the counseling intervention was effective for the study population that needed it most.

Improvement in Outcomes Over Time by Demographics, Job Type, and Workplace

Research Question Two asked is there a significant improvement over time in the five outcomes measured by the WOS based on gender, age, ethnicity, job type and workplace?

Absenteeism Improvement Over Time by Demographics, Job Type, and Workplace

There was a significant difference in absenteeism scores based on gender and job types. The mean difference of absenteeism was 1.5 (*SD*=5.3) in females and 0.3 (*SD*=1.0) in males (*p*=0.02). For job type, the mean difference of absenteeism was 2.1 (*SD*=6.0) for those in administrative/management positions and 0.4 (*SD*=2.7) for those in non-administrative roles (*p*=0.04).

Table 19

Absenteeism Mean Differences for Gender and Job Type

There is significant mean difference of WS1 between female and male (p = .0223).

Gender	N	Mean (SD)	T test
Female	109	1.5 (5.2)	0.0223
Male	16	0.3 (1.0)	

There is significant mean difference of WS1 between job types (p = .0415).

Job Type	N	Mean (SD)	T test
Administrative/Management/Service	63	2.1 (6.0)	0.0415
Non-Administrative	61	0.4 (2.7)	

Further analysis showed that absenteeism significantly improved by 14.7% in females but there was no improvement in males; 56% of females and 93.8% of males reported no change; and 29.4% of females and 6.3% of males had worse absenteeism scores after the intervention (*p*=0.02). Those in administrative positions improved absenteeism by 15.9% and those in non-administrative positions improved absenteeism by 11.5%.

There was no significant difference in improvements of the Absenteeism outcomes based on age groups, race/ethnicity, and workplace. Overall, 13.2% of the

sample improved their work attendance, 77% had no change and 35% of the sample deteriorated in work attendance, see Table 20.

Table 20

Absenteeism Change

The change of WS1 is categorized into three groups:	
WS1 change	N (%)
Improved (WS1Post < WS1Pre)	17 (13.2%)
No change (WS1Post = WS1Pre)	77 (59.7%)
Worse (WS1Post > WS1Pre)	35 (27.1%)

WS1_change	Age group			Chi-square test or Fisher's exact test
	18 - 38	39 - 54	55+	
Improved	11 (16.7%)	4 (9.1%)	2 (10.5%)	0.8038
No change	38 (57.6%)	28 (63.6%)	11 (57.9%)	
Worse	17 (25.8%)	12 (27.3%)	6 (31.6%)	

WS1_change	Gender		Chi-square test or Fisher's exact test
	Female	Male	
Improved	16 (14.7%)	0	0.0181
No change	61 (56.0%)	15 (93.8%)	
Worse	32 (29.4%)	1 (6.3%)	

WS1_change	Ethnicity		Chi-square test or Fisher's exact test
	Non-White	White	
Improved	6 (13.9%)	11 (12.9%)	0.5934
No change	23 (53.5%)	53 (62.4%)	
Worse	14 (32.6%)	21 (24.7%)	

WS1_change	Job Type		Chi-square test or Fisher's exact test
	Administrative	Non-Administrative	
Improved	10 (15.9%)	7 (11.5%)	0.1671
No change	33 (52.4%)	42 (68.8%)	
Worse	20 (31.7%)	12 (19.7%)	

WS1_change	Workplace		Chi-square test or Fisher's exact test
	Health System	University Campus	
Improved	9 (13.6%)	8 (13.3%)	0.9930
No change	40 (60.6%)	36 (60.0%)	
Worse	17 (25.8%)	16 (26.7%)	

Presenteeism Improvement Over Time by Demographics, Job Type, and Workplace

For Presenteeism, 31% of the sample improved their concentration at work, 41.9% had no change, and 27.1% of the sample deteriorated in work concentration due to a personal problem. There was a significant mean difference of presenteeism scores across age groups (p=0.003), specifically between 18-38 (Mean difference=0.3; SD=1.4) and 39-54 (Mean difference=-0.6; SD=1.2). A greater percentage of clients between the ages of 18-38 had improved their presenteeism scores (39.4%), followed by those with no change (36.4%) and worse scores (24.2%). However, a small percentage of clients between the ages of 36-54 had improved their scores (9.0%) and an equal percentage had no change or worse scores (45.5%) (p=0.004). see Table 21.

Table 21

Presenteeism Mean Difference by Age Group

Age Group	N	Mean (SD)	ANOVA F test
18 - 38	66	0.3 (1.4)	0.0025
39 - 54	44	-0.6 (1.2)	
55+	19	0.1 (1.4)	

Table 22

Presenteeism Change

The change of WS2 is categorized into three groups:

WS2 change	N (%)
Improved (WS2Post < WS2Pre)	40 (31.0%)
No change (WS2Post = WS2Pre)	54 (41.9%)
Worse (WS2Post > WS2Pre)	35 (27.1%)

WS2_change	Age group			Chi-square test or Fisher's exact test
	18 - 38	39 - 54	55+	
Improved	26 (39.4%)	4 (9.0%)	5 (26.3%)	0.0039
No change	24 (36.4%)	20 (45.5%)	10 (52.6%)	
Worse	16 (24.2%)	20 (45.5%)	4 (21.1%)	

WS2_change	Gender		Chi-square test or Fisher's exact test
	Female	Male	
Improved	29 (26.6%)	5 (31.3%)	0.8910
No change	46 (42.2%)	7 (43.7%)	
Worse	34 (31.2%)	4 (25.0%)	

WS2_change	Ethnicity		Chi-square test or Fisher's exact test
	Non-White	White	
Improved	10 (23.3%)	25 (29.4%)	0.1832
No change	15 (34.9%)	38 (44.7%)	
Worse	18 (41.9%)	22 (25.9%)	

WS2_change	Job Type		Chi-square test or Fisher's exact test
	Administrative	Non-Administrative	
Improved	17 (27.0%)	16 (26.2%)	0.9916
No change	27 (42.9%)	26 (42.6%)	
Worse	19 (30.1%)	19 (31.2%)	

WS2_change	Workplace		Chi-square test or Fisher's exact test
	Health System	University Campus	
Improved	14 (21.2%)	21 (35.0%)	0.1405
No change	28 (42.4%)	25 (41.7%)	
Worse	24 (36.4%)	14 (23.3%)	

Work Engagement Improvement Over Time by Demographics, Job Type, and Workplace

Overall, 36.4% of the sample improved their concentration at work, 41.1% had no change, and 25.5% of the sample deteriorated in their eagerness to engage at work. However, there was no significant difference in improvement in the pre and post survey scores for work engagement based on demographics, job type, and workplace (Table 23).

Table 23

Work Engagement Change

The change of WS3 is categorized into three groups:				
WS3 change		N (%)		
Improved (WS3Post > WS3Pre)		47 (36.4%)		
No change (WS3Post = WS3Pre)		53 (41.1%)		
Worse (WS3Post < WS3Pre)		29 (25.5%)		
WS3_change	Age group			Chi-square test or Fisher's exact test
	18 - 38	39 - 54	55+	
Improved	21 (31.8%)	20 (45.4%)	6 (31.6%)	0.1475
No change	30 (45.5%)	12 (27.3%)	11 (57.9%)	
Worse	15 (22.7%)	12 (27.3%)	2 (10.5%)	
WS3_change	Gender		Chi-square test or Fisher's exact test	
	Female	Male		
Improved	42 (38.5%)	5 (31.3%)	0.4233	
No change	42 (38.5%)	9 (56.2%)		
Worse	25 (22.9%)	2 (12.5%)		
WS3_change	Ethnicity		Chi-square test or Fisher's exact test	
	Non-White	White		
Improved	15 (34.9%)	32 (37.7%)	0.8409	
No change	19 (44.2%)	33 (38.8%)		
Worse	9 (20.9%)	20 (23.5%)		
WS3_change	Job Type		Chi-square test or Fisher's exact test	
	Administrative	Non-Administrative		
Improved	22 (34.9%)	23 (37.7%)	0.4674	

No change	29 (46.0%)	22 (36.1%)	
Worse	12 (19.1%)	16 (26.2%)	

WS3_change	Workplace		Chi-square test or Fisher's exact test
	Health System	University Campus	
Improved	22 (33.3%)	24 (40.0%)	0.7111
No change	28 (42.4%)	24 (40.0%)	
Worse	16 (24.2%)	12 (20.0%)	

Life Satisfaction Improvement Over Time by Demographics, Job Type, and Workplace

For life satisfaction, overall, 24.8% of the sample improved in life satisfaction, 45.7% had no change, and 29.5% of the sample had less life satisfaction. There was no significant difference in improvement in the pre and post survey scores for life satisfaction based on demographics, job type and workplace, see Table 24.

Table 24

Life Satisfaction Change

The change of WS4 is categorized into three groups:

WS4 change	N (%)
Improved (WS4Post < WS4Pre)	32 (24.8%)
No change (WS4Post = WS4Pre)	59 (45.7%)
Worse (WS4Post > WS4Pre)	38 (29.5%)

WS4_change	Age group			Chi-square test or Fisher's exact test
	18 - 38	39 - 54	55+	
Improved	19 (28.8%)	10 (22.7%)	3 (15.8%)	0.6170
No change	26 (39.4%)	23 (52.3%)	10 (52.6%)	
Worse	21 (31.8%)	11 (25.0%)	6 (31.6%)	

WS4_change	Gender		Chi-square test or Fisher's exact test
	Female	Male	
Improved	28 (25.7%)	3 (18.8%)	0.8867
No change	49 (44.9%)	8 (50.0%)	
Worse	32 (29.4%)	5 (31.2%)	

WS4_change	Ethnicity		Chi-square test or Fisher's exact test
	Non-White	White	
Improved	11 (25.6%)	21 (24.7%)	
No change	19 (44.2%)	39 (45.9%)	0.9835
Worse	13 (30.2%)	25 (29.4%)	

WS4_change	Job Type		Chi-square test or Fisher's exact test
	Administrative	Non-Administrative	
Improved	18 (28.6%)	12 (19.7%)	0.1954
No change	24 (38.1%)	33 (54.1%)	
Worse	21 (33.3%)	16 (26.2%)	

WS4_change	Workplace		Chi-square test or Fisher's exact test
	Health System	University Campus	
Improved	14 (21.2%)	18 (30.0%)	0.4347
No change	33 (50.0%)	24 (40.0%)	
Worse	19 (28.8%)	18 (30.0%)	

Workplace Distress Improvement Over Time by Demographics, Job Type, and Workplace

Overall, 43.4% improved, 45% had no change and 11.6% worsened in workplace distress which indicates they dreaded going to work. There was no significant difference in improvement in the pre and post survey scores for workplace distress based on demographics, job type, and workplace, see Table 25.

Table 25

Workplace Distress Change

The change of WS5 is categorized into three groups:				
WS5 change	N (%)			
Improved (WS5Post < WS5Pre)	56 (43.4%)			
No change (WS5Post = WS5Pre)	58 (45.0%)			
Worse (WS5Post > WS5Pre)	15 (11.6%)			
WS5_change	Age group			Chi-square test or Fisher's exact test
	18 - 38	39 - 54	55+	
Improved	23 (34.8%)	21 (47.7%)	12 (63.2%)	0.1653
No change	33 (50.0%)	20 (45.5%)	5 (26.3%)	
Worse	10 (15.2%)	3 (6.8%)	2 (10.5%)	
WS5_change	Gender		Chi-square test or Fisher's exact test	
	Female	Male		
Improved	47 (43.1%)	6 (37.5%)	0.1960	
No change	47 (43.1%)	10 (62.5%)		
Worse	15 (13.8%)	0		
WS5_change	Ethnicity		Chi-square test or Fisher's exact test	
	Non-White	White		
Improved	22 (51.2%)	34 (40.0%)	0.1741	
No change	19 (44.2%)	38 (44.7%)		
Worse	2 (4.6%)	13 (15.3%)		
WS5_change	Job Type		Chi-square test or Fisher's exact test	
	Administrative	Non-Administrative		
Improved	29 (46.0%)	27 (44.3%)	0.8191	
No change	28 (44.4%)	26 (42.6%)		
Worse	6 (9.5%)	8 (13.1%)		
WS5_change	Workplace		Chi-square test or Fisher's exact test	
	Health System	University Campus		
Improved	34 (51.5%)	22 (36.7%)	0.1968	
No change	24 (36.4%)	31 (51.7%)		
Worse	8 (12.1%)	7 (11.7%)		

Improvement in Outcomes Over Time Based on Primary Presenting Issue and Demographics, Job Type, and Workplace

Research Question Three: Is there a significant improvement over time in the five outcomes measured by the WOS based on primary presenting issue and gender, age, ethnicity, and job type and workplace?

Absenteeism Improvement Over Time Based on Primary Presenting Issue and Demographics, Job Type, and Workplace

There was a significant mean difference of absenteeism between job types when stratified by primary issues. Those who presented with emotional issues and had an administrative/management job had a higher mean difference (2.6; *SD*=6.7) than those in non-administrative positions (Mean difference=0.2; *SD*=2.6). This indicates that absenteeism worsened for clients who presented with emotional issues and had an administrative job, see Table 26.

Table 26

Absenteeism Differences between Job Types Stratified by Primary Issue

Primary issue	Job Type	N	Mean (SD)	T test
Emotional/Other	Administrative/Management/Service	45	2.6 (6.7)	0.0329
	Non-Administrative	40	0.2 (2.6)	
Relationship	Administrative/Management/Service	18	0.9 (3.8)	0.8346
	Non-Administrative	21	0.7 (2.8)	

Presenteeism Improvement Over Time Based on Primary Presenting Issue and Demographics, Job Type, and Workplace

There was significant mean difference of presenteeism scores across age groups and workplaces when stratified by primary issues. Those clients who presented with emotional issues and were between the ages of 18-38 had a mean difference of 0.6 (*SD*=1.4) which means they declined in presenteeism. Clients between the ages of 39-54 who presented with emotional issues had a decrease in scores (mean difference=-0.6; SD=1.3); which means they improved in presenteeism. There was no change in those between the ages of 55+ (p=0.0012). Those who presented with emotional issues and worked in the Health System had a decrease in presenteeism scores (mean difference=-0.3; *SD*=1.4) which means they improved in presenteeism and those who worked at the University Campus and presented with emotional issues had a slight increase in scores (mean difference=0.6; *SD*=1.3) (*p*=0.0021) which means they had a decline in presenteeism, see Tables 27 and 28.

Table 27

Presenteeism Differences between Age Group Stratified by Primary Issue.

Primary issue	**Age Group**	**N**	**Mean (SD)**	**ANOVA F test**
Emotional/Other	18 - 38	47	0.6 (1.4)	0.0012
	39 - 54	28	-0.6 (1.3)	
	55+	12	0.0 (0.9)	
Relationship	18 - 38	19	-0.3 (1.4)	0.4903
	39 - 54	16	-0.6 (1.1)	
	55+	7	0.1 (2.1)	

Table 28

Presenteeism Differences between Workplace Stratified by Primary Issue

Primary issue	Workplace	N	Mean (SD)	T test
Emotional/Other	Health System	48	-0.3 (1.4)	0.0021
	University Campus	39	0.6 (1.3)	
Relationship	Health System	18	-0.1 (1.4)	0.4358
	University Campus	21	-0.5 (1.5)	

Work Engagement Improvement Over Time Based on Primary Presenting Issue and Demographics, Job Type, and Workplace

There was no significant difference in scores based on demographics, job type or workplace and primary presenting issues.

Life Satisfaction Improvement Over Time Based on Primary Presenting Issue and Demographics, Job Type, and Workplace

For life satisfaction, there was a significant mean difference in scores between female and males when stratified by primary issues. Those who presented with emotional issues and were female had a slight increase in scores; hence, they improved life satisfaction (mean difference=0.04; *SD*=0.9). Those who presented with emotional issues and were male had a decrease in scores which means they declined life satisfaction (mean difference=0.7; *SD*=1.1) (p=0.4175), see Table 29.

Table 29

Life Satisfaction Differences between Gender Stratified by Primary Issue

Primary issue	**Gender**	**N**	**Mean (SD)**	**T test**
Emotional/Other	Female	75	0.4 (0.9)	0.4175
	Male	10	0.7 (1.1)	
Relationship	Female	34	0.4 (1.3)	0.7299
	Male	6	0.3 (0.5)	

Workplace Distress Improvement Over Time Based on Primary Presenting Issue and Demographics, Job Type, and Workplace

For workplace distress outcomes, there was a significant mean difference in scores between female and males when stratified by primary issues. For workplace distress, those who presented with emotional issues and were female had a slight increase in scores (mean difference=0.07; *SD*=1.3) and males had a decrease in scores (mean difference= -0.5; *SD*=0.7) (*p*=0.0500). Therefore, females who presented with emotional issues declined in workplace distress and males who presented with emotional issues improved in workplace distress, see Table 30.

Table 30

Workplace Distress Differences between Gender Stratified by Primary Issue

Primary issue	**Gender**	**N**	**Mean (SD)**	**T test**
Emotional/Other	Female	75	0.07 (1.3)	0.0500
	Male	10	-0.5 (0.7)	
Relationship	Female	34	-0.2 (1.2)	0.1058
	Male	6	0.7 (1.2)	

Client Satisfaction

In addition to the WOS-5 item survey, the study also consisted of a client satisfaction survey. The response rate for the client satisfaction survey was 9%. The results reflected that those who participated in the survey were satisfied with EAP services with 94% of the participates indicating that their initial contact with the EAP was "Good" or "Excellent"; 95% of the sample reported that they were treated with dignity, respect by their counselor; 95% reported that their contact was treated confidentially; 88% of the sample reported the extent to which the EAP helped with their problem was "Good" or "Excellent"; 87% were satisfied with the EAP program and, 88% were likely to recommend the EAP service to others, see Figure 6.

QUALITY ASSURANCE REPORT
FOLLOW UP SURVEYS

FOR
10/31/2017 TO 07/01/2019

	PERIOD #	PERIOD (%)	YEAR-TO-DATE #	YEAR-TO-DATE (%)
# SURVEYS SENT	994		994	
RETURNED SURVEYS	93		93	
RETURN RATE		9%		9%

Initial contact with the Employee Assistance and Counseling Center

	#	(%)	#	(%)
Very Poor	1	1.08	1	1.08
Poor	0	0.00	0	0.00
Neutral	4	4.30	4	4.30
Good	36	38.71	36	38.71
Excellent	52	55.91	52	55.91
No Response	0	0.00	0	0.00

Treated with dignity, respect by counselor

	#	(%)	#	(%)
Very Poor	1	1.08	1	1.08
Poor	1	1.08	1	1.08
Neutral	2	2.15	2	2.15
Good	15	16.13	15	16.13
Excellent	74	79.57	74	79.57
No Response	0	0.00	0	0.00

Contact was treated confidentially

	#	(%)	#	(%)
Very Poor	0	0.00	0	0.00
Poor	0	0.00	0	0.00
Neutral	5	5.38	5	5.38
Good	15	16.13	15	16.13
Excellent	73	78.49	73	78.49
No Response	0	0.00	0	0.00

Extent to which the EAP helped with problem

	#	(%)	#	(%)
Very Poor	5	5.38	5	5.38
Poor	3	3.23	3	3.23
Neutral	3	3.23	3	3.23
Good	27	29.03	27	29.03
Excellent	55	59.14	55	59.14
No Response	0	0.00	0	0.00

Overall, how satisfied with EAP program

	#	(%)	#	(%)
Very Poor	4	4.30	4	4.30
Poor	3	3.23	3	3.23
Neutral	4	4.30	4	4.30
Good	19	20.43	19	20.43
Excellent	63	67.74	63	67.74
No Response	0	0.00	0	0.00

How likely to recommend EAP service to others

	#	(%)	#	(%)
Very Poor	3	3.23	3	3.23
Poor	2	2.15	2	2.15
Neutral	6	6.45	6	6.45
Good	14	15.05	14	15.05
Excellent	68	73.12	68	73.12
No Response	0	0.00	0	0.00

Figure 6. University EAP Client Satisfaction Survey (10/31/2017 to 07/01/2019)

Summary

This chapter presented the results for the three research questions. The results partially support the research questions and hypothesis generated. Chapter 5 presents a discussion of the study.

CHAPTER 5

SUMMARY AND CONCLUSIONS

Discussion

Mental health is an increasing public health problem. In the U.S., even before the COVID-19 pandemic, close to 20% of adults experienced a mental illness, this reflects an increase of over one million people with a rise in suicidal ideations among adults during this same timeframe (Mental Health America, 2020). This public health problem impacts the workplace, but typically goes unnoticed because employees are inclined to do a good job of masking disorders at work; yet, mental health illnesses may show in an employee's work absenteeism, work presenteeism, work engagement, workplace distress and life satisfaction which impacts worker productivity.

Ineffective and disengaged employees can negatively impact both the employee and the employer. Negative impact for the employee can surface through job loss. Negative impact for employers can appear via loss profitability, higher operational costs, higher insurance costs, higher turnover, and even loss of customer loyalty. Harvard Health Publishing (2010) stated that unrecognized and untreated mental health has potential to impair an individual's health and career, while also reducing productivity at work; however, treatment can lessen symptoms for the employee and improve job performance.

The authors of Healthy People 2020 stated that individuals in the United States reported an average of 3.6 physically unhealthy days and 3.4 mentally unhealthy within a 30-day period. Because of these mental and physical challenges, most employers offer resources to their employees through wellness and Employee Assistance Programs to help remove obstacles to productivity and in turn enhance organizational effectiveness. However, measuring the true impact of EAP programs on worker productivity is key to determining positive ROI.

Findings and Implications

The statistical results of this study were not what the researcher expected compared to the stats of the pooled WOS data set of over 35,000 cases which demonstrated significant improvement in absenteeism, presenteeism, work engagement, workplace distress and life satisfaction. On the surface, the results of this study were not typical outcomes. The WOS Annual Report (Morneau, 2020) stated the expectation is that the prevalence rate on these outcomes would decrease after counseling invention (work absenteeism, work presenteeism and work distress) and scores for work engagement and life satisfaction would significantly increase because the employees would experience some clinical improvement. After analyzing the frequency data for the outcomes that worsened over time and had statistical significance, the study results actual demonstrate an improvement in those who needed it most.

The first research question explored significant improvement over time in the five outcomes measured by the WOS. The study reflected an increase in presenteeism and

work engagement; life satisfaction relatively remained the same; and absenteeism and workplace distress declined for the study population with statistical significance.

Although the statistics show that absenteeism worsened by 155%, the frequency details show the majority of participants missed “0“ hours within 30 days both before and after counseling intervention; this shows a “floor effect”, meaning the participants scores could only increase since they started at the lowest score of zero. Before counseling intervention 4% of the study population missed 8 hours or more, and after intervention 16% missed 8 or more hours. Because the study author did not have access to the organizations time keeping records, we do not know the reason for the absence. The absence could have been due to vacation. Regardless, the percentage of participants who missed 8 hours (1 day) or more is relatively low. Also, the post mean score of 2.29 for absenteeism is actually lower than the data reported by Pfizer (2007) which states that workers in the United States (with and without mental and physical health issues) average 4.4 lost workdays per year which equate to 3 hours per month. After reviewing the data closely, the data does not indicate an absenteeism problem at onset or post intervention for this study population. For life satisfaction, of the 36% who absolutely felt life wasn’t good at baseline, 40% improved after intervention. Overall workplace distress increased by 15% in the unexpected direction. However, when the study author reviewed the data closely, it showed the number of participants who strongly agreed with the statement “I dread going to work”, actually reduced after counseling intervention by 54% and of the 9% who absolutely dreaded work 16% improved after intervention.

Although there were only slight improvements in some of the outcomes, this coupled with a closer look at the frequency data supports the assumption that EAP

counseling intervention is associated with improvements in employee presenteeism, work engagement, life satisfaction and workplace distress. For this study, it also shows that absenteeism is not an issue for the study population either before or after counseling intervention because absenteeism data demonstrate that on average participants missed 0.9 hours (less than 1 hour) within a 30-day period at baseline and only 2.3 hours after invention. Although the percentage increase was significant, the actual hours missed within 30 days is minimal at both pre and post and may be viewed as ideal for some organizations.

The second research question explored significant improvement over time in the five outcomes measured by the WOS based on demographics, job type, and workplace. Overall, there was no significant difference in improvements of the outcomes based on age group, race/ethnicity, job types, and workplace with the following exceptions. There was a significant difference in absenteeism scores based on gender and job types. The researcher concluded that on average, females missed more hours than males. Further analysis showed that absenteeism significantly improved in females but there was no improvement in males. Although small, there was an increase in presenteeism across age groups, specifically an increase for those aged 18-38 and a slight decrease for those aged 39-54. The slight decrease in presenteeism for age group 39-54 was not expected; however, this could be due to mid-career burnout or getting closer to retirement age. These results indicate that the EAP should possibly look at their counseling strategies and implement different counseling interventions that can help yield improvements in absenteeism for males and presenteeism for those aged 39-54.

The third research question explored significant improvement over time in the five outcomes measured by the WOS based primary presenting issue and gender, age, ethnicity, job type, and workplace. There was a significant mean difference of absenteeism between job types when stratified by primary issues. Those who presented with emotional issues and had an administrative job had a higher mean difference than those in non-administrative positions. The research concluded that those with emotional issues and worked in an administrative job missed more hours than those in non-administrative positions. There was also a significant mean difference of presenteeism scores across age groups and workplaces when stratified by primary issues. Those clients who presented with emotional issues and were between the ages of 18-38 or employed at the Health System improved in presenteeism; however those who worked at the University Campus had a slight decrease in presenteeism which indicates that they were not as productive at work. The EAP could develop and/or promote programs, resources, and interventions to help University Campus employees with personal distractions while on the job (financial management, aging parents/eldercare, childcare resources or other resources). Regarding life satisfaction and workplace distress outcomes, those who presented with emotional issues and were female improved in life satisfaction and declined in workplace distress; and those males with emotional issues improved in workplace distress but declined in life satisfaction. This is an interesting outcome because one would think that if things improve at work, they will in turn improve in life satisfaction. This outcome should be further explored in future studies.

The study also collected data via the EAPs client's satisfaction survey. The study was able to collect overall satisfaction responses but could not dissect the responses by

individual participant. Overall, the responses regarding client satisfaction were favorable which does correlate with the participant outcomes when you look closely at the frequency data before and after the counseling intervention.

Limitations

The findings in this study are subject to several limitations. First, clients may have been hesitant to participate in the survey due to confidentiality concerns. Having cooperative subjects who will complete both the pre and post tests can be difficult to attract. For this study, 943 clients opted to participate in the survey, 866 clients completed the pre survey, but only 129 completed the post survey resulting in a 14.9% return rate. The response rate for the client satisfaction survey was also low, at 9%. The limited number of subjects could have contributed to a flawed evaluation. A larger sample size would have helped in achieving statistical significance and detecting small and sensitive changes between the pre and post-test.

A second limitation was in the data collection capability. The EAP collected the pre survey data on a paper form, support staff manually entered the ratings from paper form into an online system. It is essential for EAPs to implement an online pre and post survey to lessen human error in paper surveys and the transfer of that data (Lennox, Sharar, Burke, 2010). The EAP had limited staff resources to follow up with participants regarding completion of the post test. No incentives were offered to participants for completion of the pre or post-test. Also, the participants could have misinterpreted the questions or entered responses incorrectly, particularly for the absenteeism question.

A third limitation was that the study relied on self-reported data for hours worked and other work outcomes. Using a self-report instrument offers ease of data management; however, the self-reported data may also contribute to a potential compromise of the study's validity (Harris, et. Al, 2002). Although the WOS is a psychometrically validated tool and was designed to detect changes in work outcomes as related to EA counseling (Lennox et al., 2010; Sharar & Lennox, 2014), being able to access data from the organization's timekeeping system, with permission from the participants, would have been helpful in attaining accurate data on absenteeism and how this aligned with changes in the other outcomes.

A fourth limitation was not having a comparison group. There was no way to check the sample (129) against the full sample group (866) or against the regular university EAP clientele. If there was a comparison group, this could have helped to detect if another factor outside of the EAP intervention caused the slight improvement in work presenteeism and work engagement or caused the decline in absenteeism and workplace distress. The ability to compare results to a corresponding comparison group would have allowed the researcher to identify differences which could then be considered in the analysis. One of the main benefits of using before and after data is that each participant can act as his or her own control for other factors; the downside is that the pre post design can normally show if employees are improving at work, but it cannot explain the reasons for the change (Harris, et. Al, 2002), (Sharar & DeLapp, 2017). Also, the study was conducted utilizing an internal EAP at an urban university and findings may not be generalizable for other industries or universities who utilize external EAPs (Richmond, Pampel, Wood, 2017).

Lastly, the study participants' history was unknown; consequently, the study did not know what was going on with the participant at work or home at pre and post which could have influenced the outcomes.

Recommendations

Although not to the degree expected or exhibited in other studies, this study demonstrated that EAP intervention can improve aspects of work outcomes and worker productivity. The study showed slight improvements in presenteeism and work engagement and after a closer look at frequency data, it demonstrated improvements in absenteeism (even though there was no true absenteeism issue at pre or post), improvements in life satisfaction and workplace distress. Although all of the improvements were not clinically significant, the study still shows progress in the right direction and as a result supports the idea that EAPs can positively impact the employee's outlook on work and ultimately the employer profitability, operational costs, insurance costs, turnover rates, and customer loyalty. The researcher recommends the following strategies for this internal EAP and other EAPs in the future.

First, the WOS is currently the "only publicly available, free instrument that has been psychometrically validated and tested for use in EAP settings" (eapassn.org) and it should be utilized by all EAPs as a best practice and measure for workplace outcomes (Shepell, 2020). Applying one consistent evaluation tool will help the field to understand outcomes across program models and demonstrate the effectiveness of EAPs as it relates to an organization's bottom line. This within itself will advance the field.

Second, the internal EAP used for this study and other EAPs can utilize WOS outcomes to create targeted campaigns based on demographics, job types, and workplace to enhance awareness and knowledge and remove the stigma associated with counseling services.

Third, more research is needed that overcomes some of the limitations in this study. It is suggested that a time series analysis should be conducted at the university EAP to evaluate and compare data from this study (data collected from 2017 to 2019) to data collected from 2020 to 2022 (COVID-19 pandemic time period) versus data collected post COVID vaccine from 2022 to 2024.

Lastly, future research should explore whether different EAP models and industry settings affect workplace outcomes differently. Also, further study is needed to compare the impact of different types of EAP interventions on improved work outcomes. Applying outcome data rather than depending on client satisfaction surveys and subjective reports to demonstrate the effectiveness of EAPs is imperative for employee assistance programs to thrive and prove their value to large and small organizations (Lennox, Sharar, Burke, 2010).

Conclusions

Although slight, this study showed improvement in presenteeism and work engagement and through further analysis showed improvement in absenteeism, life satisfaction and workplace distress; thereby the study adds to the research literature and supports the premise that EA services are associated with improvements in worker

productivity (Merrick et al., 2007). Also, the WOS results coupled with the client satisfaction results support the value of investing in EAP for employers and employee.

The study author would like to note that since this study the university EAP has continued to collect data using the WOS. The data collection method is now fully electronic for both before and after counseling intervention. Since this change, the most recent WOS results for the university EAP indicated 43.2% improvement in work absenteeism and 24.4% improvement in presenteeism for the period of January through December 2020.

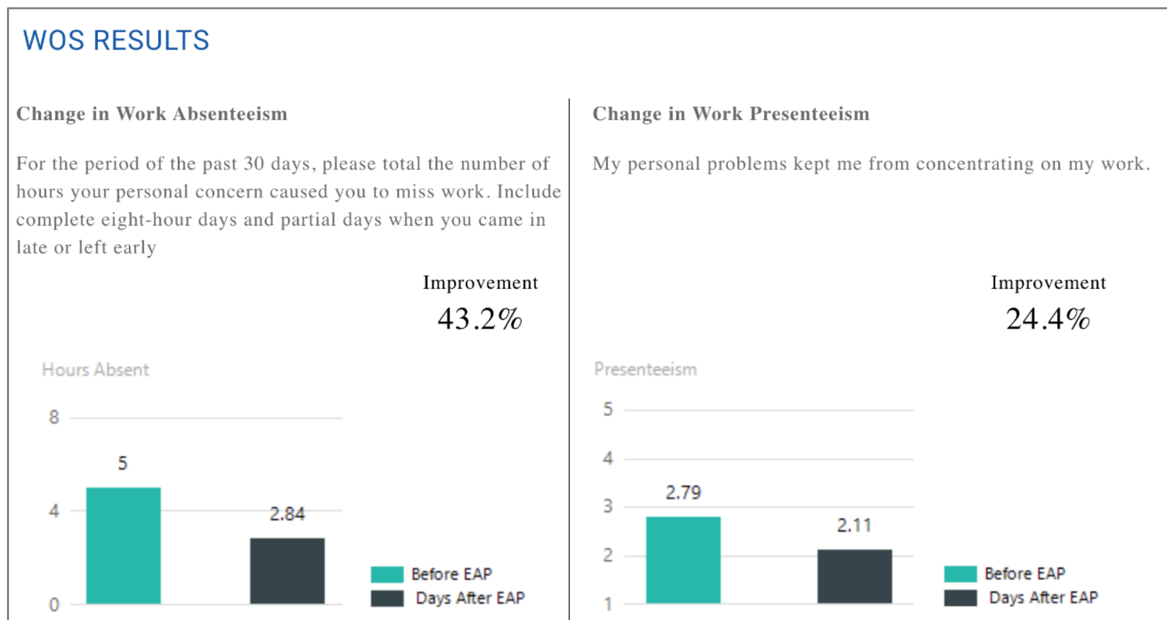

Figure 7. University EAP WOS Results January 2020 to December 2020

In closing, outcomes should become a part of every EAPs operational flow (Lennox, Sharar, Burke, 2010), the field will continue to benefit from more studies that utilize the WOS or another evidence-based tool that supports connections between EAP services and work outcomes, particularly tools that can be tied to time-keeping and performance records which will reduce the self-reported data.

LIST OF REFERENCES

Alabama Department of Labor. Demographics of the Civilian Labor Force. (2017). http://www2.labor.alabama.gov/Laus/CPS.aspx

Alabama Department of Labor, Labor Market Information Division, WIA Unit. (2020). http://www2.labor.alabama.gov/default.aspx

Alabama Department of Public Health. (n.d). www.alwomenscommission.com

Alabama Indicators of Health Status in Alabama The Office of Primary Care and Rural Health, Alabama Department of Public Health and The Alabama Rural Health Association http://adph.org/ruralhealth/assets/Diabetes2007.pdf

Alabama Labor Market Information News. (n.d.). http://www2.labor.alabama.gov/Newsletter/LMI%20Newsletter.pdf

Alabama Selected Indicators of Health Status (2007). https://www.alabamapublichealth.gov/ruralhealth/assets/ARACCombinedSelectedIndicators.pdf

Alabama Selected Indicators of Health Status (2007). https://www.alabamapublichealth.gov/ruralhealth/health-data.html

Alabama Workforce (n.d)., http://www2.labor.alabama.gov/Projections/workforce.pdf

Attridge, M. (2010). EAP cost-benefit research: 20 years after McDonnell Douglas. *Journal of Employee Assistance, 40*(2), 14-16.

Attridge, M., Amaral, T., Bjornson, T., Goplerud, E., Herlihy, P., McPherson, T., Paul, R., Routledge, S. Sharar, D., Stephenson, D., & Teems, L. (2009). EAP Effectiveness and ROI. *EASNA Research Notes, 1*(3).

Attridge, M., Amaral, T., Bjornson, T., Goplerud, E., Herlihy, P., McPherson, T., Paul, R., Routledge, S., Sharar, D., Stephenson, D., Teems, L. (2009). History and Growth of the EAP Field. EASNA *Research Notes, 1*(1), 2-4.

Beehr T. A. (2019). Interventions in occupational health psychology. *Journal of Occupational Health Psychology*, *24*(1), 1–3. https://doi.org/10.1037/ocp0000140

Blum, T., & Roman, P. (1995). Cost-effectiveness and preventive implications of

Employee Assistance Programs. Rockville, MD: U.S. Department of Health and Human Services.

Buckley, P. & Bachman, D (2017). Meet the US workforce of the future: Older, more diverse, and more educated Deloitte Review, *21* https://www2.deloitte.com/us/en/insights/deloitte-review/issue-21/meet-the-us-workforce-of-the-future.html

Cadorette, M., & Agnew, J. (2017). Mental Health in the Workplace. *Workplace Health & Safety*, *65*(9), 448. https://doi.org/10.1177/2165079917716188

Campbell, D., & Dardis, G. (2004). The be, know, do model of leader development. Human Resource Planning, 27(2), 26–39. Retrieved May 16, 2008, from EBSCOhost database.

Cancelliere, C., Cassidy,J.D., Ammendolia,C., & Cote,P. (2011). Are workplace health promotion programs effective at improving presenteeism in workers? A systematic review and best evidence synthesis of the literature. BMC Public Health, 11, 395.

Carter-Steward, J. (2009). Motivating the 21st-Century Worker: A Case Study of Maslow's Hierarchy of Needs as it Applies to the Current Generationally Diverse Workforce. Capella University.

Center for Business and Economic Research. Annual Estimates of the Resident Population for the United States, Regions, States, and Puerto Rico: April 1, 2000 to July 1, 2010 & Alabama County Population Projections 2010-2035; Retrieved from http://cber.cba.ua.edu/asdc/

Collins, K. M. (1998). Cost/benefit analysis shows EAP's value to employer. EAPA Exchange, 28(12), 16-20.

de Oliveira, C., Kavelaars, R. A., Jamieson, M., Bao, B. &, Rehm, J. (2020). Economic analyses of mental health and substance use interventions in the workplace: a systematic literature review and narrative synthesis. Lancet Psychiatry, *7*(10), 893-910.

DeSilver, D. (2017, November 30). *How the workforce changed since the Great Recession began*. Pew Research Center. https://www.pewresearch.org/fact-tank/2017/11/30/5-ways-the-u-s-workforce-has-changed-a-decade-since-the-great-recession-began/.

DeSilver, D. (2020, July 27). *10 facts about American workers*. Pew Research Center. https://www.pewresearch.org/fact-tank/2019/08/29/facts-about-american-workers/.

Facts & Figures. UAB. (n.d.). https://www.uab.edu/institutionaleffectiveness/data-library/facts-figures.

Federal Reserve Bank of St. Louis. (n.d.). *Labor Force Participation by State*. FRED. https://fred.stlouisfed.org/release?rid=446.

Fink, J., Zabawa, B., & Chopp, S. (2020). Employee Perceptions of Wellness Programs and Incentives. *American Journal of Health Promotion: AJHP*, *34*(3), 257–260. https://doi.org/10.1177/0890117119887687

Five Key Factors That Affect Employee Productivity. NBRI. (2019, December 11). https://www.nbrii.com/infographics/infographic-5-key-factors-affect-employees-productivity/.

Fullerton, Jr., H.N. (1999). Labor force participation: 75 years of change, 1950–98 and 1998–2025. *Monthly Labor Review*. https://www.bls.gov/mlr/1999/12/art1full.pdf

Gieger, A., & Parker, K. (2018). *For Women's History Month, a look at gender gains – and gaps – in the U.S.* https://www.pewresearch.org/fact-tank/2018/03/15/for-womens-history-month-a-look-at-gender-gains-and-gaps-in-the-u-s/.

Glanz, K., Rimer, B. K., & Viswanath, K. (Eds.). (2008). *Health behavior and health education: Theory, research, and practice* (4th ed.). Jossey-Bass.

Gomez, L. E., & Bernet, P. (2019). Diversity improves performance and outcomes. *Journal of the National Medical Association*, *111*(4), 383–392. https://doi.org/10.1016/j.jnma.2019.01.006

Grosch, J.W., Duffy, K.G., & Hessink, T.K. (1996) Employee Assistance Programs in Higher Education, Employee Assistance Quarterly, 11:4, 43-57, DOI: 10.1300/J022v11n04_03

Hagel, J. (2013, January 1). *The long-term effect of doing more with less: Doing less*. Journal of Accountancy. https://www.journalofaccountancy.com/issues/2013/jan/20126614.html.

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

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

Harvard Health Publishing. (2010). https://www.health.harvard.edu/newsletter_article/mental-health-problems-in-the-workplace

Hurd, M., & Rohwedder, S. (2011). Trends in Labor Force Participation: How Much is

Due to Changes in Pensions? *Journal of Population Ageing*, *4*(1-2), 81–96. https://doi.org/10.1007/s12062-011-9042-8

International Employee Assistance Professionals Association (EAPA) https://www.eapassn.org/WOS

Jacobs J C, Yaquian E, Burke S M, Rouse M, & Zaric G. (2017). The economic impact of workplace wellness programs in Canada. Occupational Medicine, 67(6), 429-434.

Lee, M.A & Mather, M. (2008). U.S. labor force trends. Population Reference Bureau, Washington D.C.

Lee, S. Y., Florida, R., and Acs, Z. (2004). Creativity and Entrepreneurship: A Regional Analysis of New Firm Formation. *Regional Studies, 38*(8), 879-891.

Leka, S., & Nicholson, P. J. (2019). Mental health in the workplace. *Occupational Medicine (Oxford, England)*, *69*(1), 5–6. https://doi.org/10.1093/occmed/kqy111

Lennox, R.D, Sharar, D., Burke, J. (2010). Conducting an EAP Evaluation Using the Workplace Outcome Suite. *Journal of Employee Assistance, 40*(4), 24-27.

Lennox, R.D., Sharar, D., Schmitz, E., & Goehner, D.B. (2010). Development and Validation of the Chestnut Global Partners Workplace Outcome Suite, *Journal of Workplace Behavioral Health, 25*(2), 107-131, DOI: 10.1080/15555241003760995

Lennox, R. D., Sharar, D., Schmitz, E., & Goehner, D. B. (2018). Validation of the 5-item short form version of the Workplace Outcome Suite. *International Journal of Health & Productivity, 10*(2), 49-61.

Levy Merrick, E. S., Hodgkin, D., Horgan, C. M., Hiatt, D., McCann, B., Azzone, V., Zolotusky, G., Ritter, G., Reif, S., & McGuire, T. G. (2009). Integrated employee assistance program/managed behavioral health care benefits: relationship with access and client characteristics. *Administration and policy in mental health*, *36*(6), 416–423. https://doi.org/10.1007/s10488-009-0232-0

Li, P., Sharar, D.A, Lennox, R. & Zhuang, W. (2015). Evaluating EAP Counseling in the Chinese Workplace: A Study with a Brief Instrument, *Journal of Workplace Behavioral Health, 30*(1-2), 66-78, DOI: 10.1080/15555240.2015.1000143

Lohaus, D., & Habermann, W. (2019). Presenteeism: A review and research directions. *Human Resource Management Review*, 29(1), 43-58. https://doi.org/10.1016/j.hrmr.2018.02.010

Lloyd, L. K., Crixell, S. H., Bezner, J. R., Forester, K., & Swearingen, C. (2017). Genesis

of an Employee Wellness Program at a Large University. *Health Promotion Practice*, *18*(6), 879–894. https://doi.org/10.1177/1524839917725500

Masi, D. A. (1982). Human Services in Industry. Lexington Books, D. C. Heath and Company.

Masi, D. A. (2003). Redefining the EAP field. The Journal of Workplace Behavioral Health, 26(1), 1-9.

Masi, D. A. (2011). Redefining the EAP field. *The Journal of Workplace Behavioral Health, 26*(1), 1-9.

Masi, D. A. (2011). Definition and History of Employee Assistance Programs. In Correct Understanding and Application of EAP Necessary for All Entities that Implement Measures for Mental Health. Kabushiki Kaisha Roudou Chousakai, Tokyo, Japan, June. https://archive.hshsl.umaryland.edu/handle/10713/3360

Masi, D.A. (2020). The History of Employee Assistance Programs in the United States. The Employee Assistance Research Foundation. https://archive.hshsl.umaryland.edu/bitstream/handle/10713/12002/The_History_of_EAPs_in_the_US_022520.pdf?sequence=5&isAllowed=y

McLeod, J., & McLeod, J. (2001). How effective is workplace counseling? A review of the research literature. *Counseling Psychotherapy Research*, 1(3), 184-191.

McLeod, J. (2010). The effectiveness of workplace counselling: A systematic review, *Counselling and Psychotherapy Research, 10*(4), 238-248, DOI: 10.1080/14733145.2010.485688

Mcleod, S. (2020, December 29). *Maslow's Hierarchy of Needs*. Simply Psychology. https://www.simplypsychology.org/maslow.html#:~:text=Maslow's%20hierarchy%20of%20needs%20is,hierarchical%20levels%20within%20a%20pyramid.&text=From%20the%20bottom%20of%20the,esteem%2C%20and%20self%2Dactualization

Meet the US workforce of the future: Older, more diverse, and more educated. Deloitte Insights. (n.d.). https://www2.deloitte.com/us/en/insights/deloitte-review/issue-21/meet-the-us-workforce-of-the-future.html.

Merrick, E., Hodgkin, D., Horgan, C., & Quinn, A. (2015). Employee assistance programs in private health plans: What do they offer? *Psychiatric Services (Washington, D.C.)*, *66*(3), 220. https://doi.org/10.1176/appi.ps.201400385

Merrick, E., Volpe-Vartanian, J., Horgan, C.M., & McCann, B. (2007). Revisiting employee assistance programs and substance use problems in the workplace: Key issues and a research agenda. *Psychiatric Services*, *58*(10), 1262-1264.

Mislinski, J. (4/8/20). Long-Term Trends in Employment by Age Group. *Advisor Perspectives,* https://www.advisorperspectives.com/dshort/updates/2020/04/08/long-term-trends-in-employment-by-age-group

Morneau Shepell. (2020). Workplace Outcome Suite (WOS) Annual Report 2020: Part 1 - Decade of Data on EAP Counseling Reveals Prominence of Presenteeism. White paper. Toronto, ON: Morneau Shepell. Author: M. Attridge. Available at: https://www.eapassn.org/WOS

Morneau Shepell. (2020). Workplace Outcome Suite (WOS) Annual Report 2020: Part 2 - Profiles of Work Outcomes on 10 Context Factor of EAP Counseling Use. White paper. Toronto, ON: Morneau Shepell. Author: M. Attridge. Available at: https://www.eapassn.org/WOS

Onday, O. (2016). Human Resource Theory: From Hawthorne Experiments of Mayo to Groupthink of Janis. *Global Journal of Human Resource Management, 4(*1), 95-110.

Otenyo, E. E., & Smith, E. A. (2017). An Overview of Employee Wellness Programs (EWPs) in Large U.S. Cities: Does Geography Matter? *Public Personnel Management*, *46*(1), 3–24. https://doi.org/10.1177/0091026016689668

Page, K. M., Milner, A. J., Martin, A., Turrell, G., Giles-Corti, B., & LaMontagne, A. D. (2014). Workplace stress: what is the role of positive mental health?. *Journal of occupational and environmental medicine*, *56*(8), 814–819. https://doi.org/10.1097/JOM.0000000000000230

Passey, D. G., Brown, M. C., Hammerback, K., Harris, J. R., & Hannon, P. A. (2018). Managers' Support for Employee Wellness Programs: An Integrative Review. *American Journal of Health Promotion: AJHP*, *32*(8), 1789–1799. https://doi.org/10.1177/0890117118764856

Peiró, J. M., Kozusznik, M. W., Rodríguez-Molina, I., & Tordera, N. (2019). The Happy-Productive Worker Model and Beyond: Patterns of Wellbeing and Performance at Work. *International Journal of Environmental Research and Public Health*, *16*(3), 479. https://doi.org/10.3390/ijerph16030479

Pfizer. (2016). *Pfizer Facts: The Health Status of the United States Workforce (2007). Workers Affected by Chronic Conditions: How can workplace policies and programs help?* Health Policy Institute. (2019, February 13). https://hpi.georgetown.edu/workplace/.

Pompe, J. and Sharar, D. Lennox, R.D. (2012). Evaluating the Workplace Effects of EAP Counseling. *Journal of Health & Productivity, 6*(12), 5-14.

Pompe, J.C., Sharar, D.A., & Ratcliff, M. (2015). Evaluating the Workplace Effects of

EAP Services. Mental Health Works, First Quarter 2015.

Price S. (2019). Working Toward Wellness: TMA's Physician Health and Wellness Exchange Tackles Burnout. *Texas medicine*, *115*(6), 30–31.

Richard, M.A., Emener, W.G., & Hutchison, W.S. (2008). A Review of Employee Assistance Programs: Wellness/Enhancement Programming, 4th Edition, Springfield, IL.

Richmond, M.K., Pampel, F.C., Wood, R.C., Nunes, A.P. (2017). The impact of employee assistance services on workplace outcomes: Results of a prospective, quasi-experimental study. *Journal of Occupational Health Psychology. 22*(2):170-179. DOI: 10.1037/ocp0000018.

Rimer, B. K., Glanz, K., & National Cancer Institute (U.S.). (2005). *Theory at a glance: A guide for health promotion practice*. Bethesda, MD: U.S. Dept. of Health and Human Services, National Institutes of Health, National Cancer Institute.

Rothermel, S., Slavit, W., Finch, R. A., et al. Center for Prevention and Health Services. (2008). An employer's guide to Employee Assistance Programs. Washington, DC: National Business Group on Health.

Rouse, G., Kimberly, A. (2004). Beyond Maslow's Hierarchy of Needs: What do People Strive for?" *Performance Improvement, 43*(10), 27-31.

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

Sharar, D., & DeLapp, G. P. (2016). EAPs Correlate to Positive Workplace Outcomes. *Employee Benefit Adviser (Online)*.

Sharar, D. & Lennox, R. (2009). A New Measure of EAP Success A workplace outcomes-based survey model provides validation. Chestnut Global Partners

Sharar, D., & Lennox, R. (2014). The workplace effects of EAP services: "pooled" results from 20 different EAPs with before and after WOS 5-item data. EASNA Research Notes, 4(1), 1-5. Available form: http://www.easna.org/publications

Sharar, D., Pompe, J. & Lennox, R. (2012). Evaluating the Workplace Effects of EAP Counseling. *Journal of Health and Productivity, 6*(2), 5-14.

Sharar, D.A. & DeLapp, G.P. (2017). EAPs Can and DO Achieve Positive Workplace Outcomes. WOS Annual Report 2016 https://archive.hshsl.umaryland.edu/handle/10713/6376

SHRM. (2020, April 24). *2019 Employee Benefits*. SHRM. https://www.shrm.org/hr-today/trends-and-forecasting/research-and-surveys/pages/benefits19.aspx.

Spetch, A. T. (2015). *Direction of Influence between Mental Health, Absenteeism, and Presenteeism during EAP Counseling*. Alliant International University. California School of Professional Psychology, San Diego.

State of Mental Health 2020, Mental Health America. (2020). https://www.mhanational.org/issues/state-mental-health-america

State of Workforce Report XI: North AlabamaWorks. (n.d.). http://www2.labor.alabama.gov/Projections/workforce.pdf

Stewart W.F., Ricci J.A., Chee, E., Morganstein, D. (2003). Lost productive work time costs from health conditions in the United States: Results from the American productivity audit. *Journal of Occupational and Environmental Medicine,* 45(12):1234-1246.

Suskie, L.A. (1996) Questionnaire Survey Research: What Works. Association for Institutional Research.

The International Employee Assistance Professionals Association. (2019). https://www.eapassn.org/

The Lancet (2017). Improving mental health in the workplace. *Lancet (London, England)*, *390*(10107), 2015. https://doi.org/10.1016/S0140-6736(17)32807-6

Toossi, M (2002). A Century of Change: The U.S. Labor Force, 1950-2050. *Monthly Labor Review*, 15-28. https://www.bls.gov/opub/mlr/2002/05/art2full.pdf

Torquati, L., Mielke, G. I., Brown, W. J., Burton, N. W., & Kolbe-Alexander, T. L. (2019). Shift Work and Poor Mental Health: A Meta-Analysis of Longitudinal Studies. *American journal of public health*, *109*(11), e13–e20. https://doi.org/10.2105/AJPH.2019.305278

U.S. Census Bureau QuickFacts: Alabama. Census Bureau QuickFacts. (2019). https://www.census.gov/quickfacts/fact/table/AL/BZA210217.

U.S. Census Bureau. (2019, September 26). *2018 Median Household Income in the United States*. https://www.census.gov/library/visualizations/interactive/2018-median-household-income.html.

U.S. Department of Health and Human Services. (2021). *Mental Illness*. National Institute of Mental Health. https://www.nimh.nih.gov/health/statistics/mental-illness.shtml.

U.S. Department of Labor, Bureau of Labor Statistics. (2016, September 1). *Labor force participation: what has happened since the peak? Monthly Labor Review*. U.S. Bureau of Labor Statistics. https://www.bls.gov/opub/mlr/2016/article/labor-force-participation-what-has-happened-since-the-peak.htm.

U.S. Department of Labor, Bureau of Labor Statistics. (2017). *Employment Situation Summary*. https://www.bls.gov/news.release/empsit.nr0.htm

U.S. Department of Labor, Bureau of Labor Statistics. (2018). Employment Projections Program. Table 2. Civilian noninstitutional population by sex, age, race, and Hispanic origin, 1988, 1998, 2008, and projected 2018; Retrieved from from http://www.bls.gov/opub/mlr/2009/11/art3full.pdf

U.S. Department of Labor, Bureau of Labor Statistics. (2018). Employment Projections Program. Table 1. Civilian labor force by sex, age, race, and Hispanic origin, 1988, 1998, 2008, and projected 2018; Retrieved from http://www.bls.gov/opub/mlr/2009/11/art3full.pdf

U.S. Department of Labor, Bureau of Labor Statistic. (2018). Employment Projections Program. Table 6. Median ages of the labor force, by sex, race, and ethnic origin, 1988, 1998, 2008 and projected 2018; Retrieved from http://www.bls.gov/opub/mlr/2009/11/art3full.pdf

U.S. Department of Labor, Bureau of Labor Statistics. (2018). Employment Projections Program. Table 3. Civilian labor force participation rates by sex, age, race, and Hispanic origin, 1988, 1998, 2008, and projected 2018; Retrieved from http://www.bls.gov/opub/mlr/2009/11/art3full.pdf

U.S. Department of Labor, Bureau of Labor Statistics. (2018). Employment Projections Program. Table 5. Civilian labor force, 1998 and 2008, and projected 2018, and entrants and leavers, actual 1998-2008 and projected, 2018; Retrieved from http://www.bls.gov/opub/mlr/2009/11/art3full.pdf

U.S. Department of Labor, Bureau of Labor Statistics U.S. Bureau of Labor Statistics. (2019). https://www.bls.gov/

U.S. Department of Labor, Bureau of Labor Statistics. (2019, October). *Labor force characteristics by race and ethnicity, 2018*. https://www.bls.gov/opub/reports/race-and-ethnicity/2018/pdf/home.pdf.

U.S. Department of Labor, Bureau of Labor Statistics. (2019, Jan 8). *Labor force characteristics by race and ethnicity, 2018*. Retrieved from http://www.bls.gov/

U.S. Department of Labor, Bureau of Labor Statistics. (2019, October 1). *Composition of the labor force*. https://www.bls.gov/opub/reports/race-and-ethnicity/2018/home.htm.

U.S. Department of Labor, Bureau of Labor Statistics. (2021). *Local Area Unemployment Statistics*. https://www.bls.gov/lau/

U.S. Department of Labor, Bureau of Labor Statistics. (2021). *Current Population Survey*. https://www.bls.gov/cps/

University EAP. (2020). (rep.). *University Utilization Report 2019 Annual Summary*.

Van Kirk, M. L. (2020). Employee Wellness Pilot Program. *Workplace Health & Safety*. https://doi.org/10.1177/2165079920976522

Vuong, T.D., Wei, F., Beverly C.J. (2015) Absenteeism due to Functional Limitations Caused by Seven Common Chronic Diseases in US Workers. *Journal of Occupational and Environmental Medicine,57*(7), 779-84. DOI: 10.1097/JOM.0000000000000452.

Wagner SL, Koehn C, White MI, Harder HG, Schultz IZ, & Williams-Whitt K. (2016). Mental health interventions in the workplace and work outcomes: A best-evidence synthesis of systematic reviews. International Journal of Occupational and Environmental Medicine, 7(1), January.

Wainberg, M. L., Scorza, P., Shultz, J. M., Helpman, L., Mootz, J. J., Johnson, K. A., Neria, Y., Bradford, J. E., Oquendo, M. A., & Arbuckle, M. R. (2017). Challenges and Opportunities in Global Mental Health: a Research-to-Practice Perspective. *Current psychiatry reports*, *19*(5), 28. https://doi.org/10.1007/s11920-017-0780-z

White, W. & Sharar, D. (2003). The Evolution of Employee Assistance: A Brief History and Trend Analysis. *EAP Digest, 3*(4), 16-22.

Williams, J., Tucker, C.M., Wippold, G., Roncoroni, J., Moutinho, M.E., Frederic, S.L, Ateyah, D. & W. (2020) Impact of a Health Empowerment-focused Program on Adult Employee's Motivators of and Barriers to Engaging in Healthy Behaviors, American Journal of Health Education, 51:3, 169-178, DOI: 10.1080/19325037.2020.1744490

Williams-Whitt, K., White, M. I., Wagner, S. L., Schultz, I. Z., Koehn, C., Dionne, C. E., Koehoorn, M., Harder, H., Pasca, R., Warje, O., Hsu, V., McGuire, L., Schulz, W., Kube, D., Hook, A., & Wright, M. D. (2015). Job demand and control interventions: a stakeholder-centered best-evidence synthesis of systematic reviews on workplace disability. *The international journal of occupational and environmental medicine*, *6*(2), 61–78. https://doi.org/10.15171/ijoem.2015.553

Workplace Outcome Suite. (n.d.). http://www.eapresearch.com/get-the-wos.html.

Wrench, J, & Punyanunt-Carter, N. (2012). "An Introduction to Organizational Communication," Open Educational Resource.

Wrich, J. T. (2017). Project 95 Broadbrush: lessons for 2017. *Paradigm magazine, 21*(3), 8-11, 18, 19.

Wrich, J. T. (1980). The Employee Assistance Program: Updated for the 1980s. Revised Edition. Hazeldon.

Wright, T.A., & Cropanzano, R. (2000). Psychological well-being and job satisfaction as predictors of job performance *Journal of Occupational Health Psychology,* ***5(***1), 84-94. DOI:10.1037/1076-8998.5.1.84

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APPENDIX A

WORKPLACE OUTCOME SUITE 5-ITEM SURVEY

Workplace Outcome Suite 5-Item Survey

WORKPLACE OUTCOME SUITE 5 ITEM VERSION

GENERAL INSTRUCTIONS
Below is a series of statements that refer to aspects of your work and life experience that may be affected by the personal problems you want to address at the EAP during the past 30 days. Please read each item carefully and answer as accurately as you can.

			NUMBER OF HOURS
AB	1.	For the period of the past 30 days, please total the number of hours your personal concern caused you to miss work. Include complete eight-hour days and partial days when you came in late or left early.	

		INSTRUCTIONS FOR ITEMS 2 5 The following statements react what you may do or feel on the job or at home. Please indicate the degree to which you agree with each of the statements for the past 30 days. Use the 1-5 response key to the right.	STRONGLY DISAGREE	SOMEWHAT DISAGREE	NEUTRAL	SOMEWHAT AGREE	STRONGLY AGREE
PR	2.	My personal problems kept me from concentrating on my work.	1	2	3	4	5
WE	3.	I am often eager to get to the work site to start the day.	1	2	3	4	5
LS	4.	So far, my life seems to be going very well.	1	2	3	4	5
WD	5.	I dread going into work.	1	2	3	4	5

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APPENDIX B

WORKPLACE OUTCOME SUITE 9-ITEM SURVEY

Workplace Outcome Suite 9-Item Survey

WOS 9-Item

WORKPLACE OUTCOME SUITE (WOS) – 9 ITEM VERSION

GENERAL INSTRUCTIONS
Below is a series of statements that refer to aspects of your work and life experience that may be affected by the personal problems you want to address at the EAP during the past 30 days. Please read each item carefully and answer as accurately as you can.

		INSTRUCTIONS FOR ITEMS 1-5 Please report for the period of the past 30 days the total number of hours your personal problems:	NUMBER OF HOURS
ABSENTEEISM	1.	Caused you to miss work altogether.	
	2.	Made you late for work.	
	3.	Caused you to take off early.	
	4.	Pulled you away from your normal work location.	
	5.	Required you to be on the phone, e-mail or internet while at work.	

		INSTRUCTIONS FOR ITEMS 6-9 The following statements reflect what you may do or feel on the job or at home. Please indicate the degree to which you agree with each of the statements for the past 30 days. Use the 1-5 response key to the right.	STRONGLY DISAGREE	SOMEWHAT DISAGREE	NEUTRAL	SOMEWHAT AGREE	STRONGLY AGREE
PR	6.	My personal problems kept me from concentrating on my work.	1	2	3	4	5
WE	7.	I am often eager to get to the work site to start the day.	1	2	3	4	5
LS	8.	So far, my life seems to be going very well.	1	2	3	4	5
WD	9.	I dread going into work.	1	2	3	4	5

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APPENDIX C

WORKPLACE OUTCOME SUITE 25-ITEM SURVEY

Workplace Outcome Suite 25-Item Survey

CGP WORKPLACE OUTCOME SUITE (WOS)

GENERAL INSTRUCTIONS
Below is a series of statements that refer to aspects of your work and life experience that may be affected by the personal problems you want to address at the EAP during the past 30 days. Please read each item carefully and answer as accurately as you can.

		INSTRUCTIONS FOR ITEMS 1-5 Please report for the period of the past 30 days the total number of hours your personal problems:	NUMBER OF HOURS
ABSENTEEISM	1.	Caused you to miss work altogether.	
	2.	Made you late for work.	
	3.	Caused you to take off early.	
	4.	Pulled you away from your normal work location.	
	5.	Required you to be on the phone, e-mail or internet while at work.	

		INSTRUCTIONS FOR ITEMS 6-25 The following statements reflect what you may do or feel on the job or at home. Please indicate the degree to which you agree with each of the statements for the past 30 days. Use the 1-5 response key to the right.	STRONGLY DISAGREE	SOMEWHAT DISAGREE	NEUTRAL	SOMEWHAT AGREE	STRONGLY AGREE
PRESENTEEISM	6.	I had a hard time doing my work because of my personal problems.	1	2	3	4	5
	7.	My personal problems kept me from concentrating on my work.	1	2	3	4	5
	8.	Because of my personal problems I was not able to enjoy my work.	1	2	3	4	5
	9.	My personal problems made me worry about completing my tasks.	1	2	3	4	5
	10.	I could not do my job well because of my personal problems.	1	2	3	4	5
WORK ENGAGEMENT	11.	I feel stimulated by my work.	1	2	3	4	5
	12.	I often think about work on my way to the work site.	1	2	3	4	5
	13.	I feel passionate about my job.	1	2	3	4	5
	14.	I am often eager to get to the work site to start the day.	1	2	3	4	5
	15.	I often find myself thinking about my work at home.	1	2	3	4	5
LIFE SATISFACTION	16.	My life is nearly perfect.	1	2	3	4	5
	17.	I am not very satisfied with my life as a whole.	1	2	3	4	5
	18.	So far, my life seems to be going very well.	1	2	3	4	5
	19.	There isn't anything about my life that I would change if I could.	1	2	3	4	5
	20.	I am very disappointed about the way my life has turned out.	1	2	3	4	5
WORKPLACE DISTRESS	21.	I often feel anxious at work.	1	2	3	4	5
	22.	Thinking about being at work makes me upset.	1	2	3	4	5
	23.	I am unhappy most of the time at work.	1	2	3	4	5
	24.	I dread going into work.	1	2	3	4	5
	25.	I can't wait to get away from work.	1	2	3	4	5

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APPENDIX D

INTAKE FORM

Intake Form Page 1

UAB Employee Assistance and Counseling Center (EACC) - Client Information

TODAY'S DATE: ___/___/___ AGE: ________

CLIENT FIRST NAME ______________ (MI) ____ (LAST) ______________ DATE OF BIRTH ___/___/___ GENDER: ___M___F

EMPLOYEE'S FIRST NAME ______________ (MI) ____ (LAST) ______________

ADDRESS ______________________________ CITY ______________ STATE _____ ZIP ____

EMAIL ______________________________ OK to Email? Y/N

HOME PHONE (____) _____-_____ OK to call Home? Leave VM? Y/ N Y/N

WORK PHONE (____) _____-_____ Ext _____ OK to call Work? Leave VM? Y/N Y/N

CELL PHONE (____) _____-_____ OK to call Cell? Leave VM? Y/N Y/N

Health Plan
___Viva UAB
___Viva Choice
___Viva Access/Health
___Blue Cross
___Peehip Viva
___Peehip Blue Cross
___Other______________

Education
1___8 grades or under
2___9th through 11th
3___High School Graduate
4___Some College
5___College Graduate
6___Advanced Degree

Ethnic Background
1___American Indian or Alaskan Native
2___Asian
3___Black or African American
4___Hispanic/Latino
5___Native Hawaiian or Pacific Islander
6___Two or More Races
7___White
8___Other______________

Relationship Status
1___Single
2___Married
3___Divorced
4___Separated
5___Widowed
6___Life Partner
7___Living w/Someone

Length of Time in Current Relationship______________

Relationship to Employee
1___Employee (Self)
2___Family/Household Member
3___Other

Referral Source
1___Supervisor Formal
2___Supervisor/Personal Concern
3___Self
4___Family
5___Co-Worker
6___Other
7___ Physician

Employee's Workplace
__UAB Campus
__UAB Hospital
__UAB Callahan Eye Hospital
__UAB Health Services Foundation
__UAB Health System
__Homewood School System
___Certified or Non-Certified
__VIVA
__ Displaced

Job type
___Administrative/Support
___Exec/Management
___Faculty
___Professional Non Faculty
___Service
___Skilled Crafts
___Technical
___Nurse
___Physician
___School System

Work Status
1___Full Time
2___Part Time
3___As Needed
4___Temporary
5___Displaced
6___Other
7___N/A Family Member

Shift
1___Days
2___Evenings
3___Nights
4___Rotating
5___Other
6___N/A Family Member

Have You Been To The UAB Employee Assistance and Counseling Center Before?
1___Yes
2___No

Work Performance Problems (Put a #1 and #2 next to the top two that apply to you, with #1 being the most serious)
1___Absent
2___Tardy
3___Safety Violations
4___Problems Relating to Other Employees
5___Quality/Quantity of Work Decreased
6___Workers Comp Case
7___Alcohol/Drugs Suspected on the job
8___Theft
9___Other
10___N/A Family Member
11___No Work Performance Problem /Personal

Personnel Actions Taken (Mark the two most recent events #1 and #2, with #1 being most recent.)
1___Employee was counseled
2___Verbal/Written Warning
3___Suspension
4___Placed on Administrative Leave
5___Referred to EAP
6___Termination
7___Resignation
8___No Action Taken
9___N/A - Family Member
10___Other
11___Not Applicable

Days Absent in Last 12 Months
1___No Days
2___1 - 5 Days
3___6 - 10 Days
4___11 - 15 Days
5___16 + Days
6___N/A - Family Member

Have You Lost Time at Work Due To Injury in Last 12 Months?
1___Yes
2___No
3___N/A Family Member

Are Any of the Following Currently a Problem?
1___Suicidal thoughts
2___Homicidal thoughts
3___Sexual Abuse
4___Physical Abuse
5___Combination of Above
6___None of Above

How Did You Hear About The UAB Employee Assistance and Counseling Center?
1___Prior Participation
2___The UAB Reporter
3___Posters
4___Monday Mailing
5___Brochures
6___Supervisor Suggested
7___Co-Worker Suggested
8___Family Suggested
9___In-Service Training/ Orientation
10___Other______________

May We Send You a Confidential Follow up Questionnaire by email?
1___Yes, send an email link connecting to a confidential survey
2___ No, I do not wish to participate

Do you have children? Yes/No
If so, please list their ages:
____

Emergency contact

Name______________________

Phone Number______________

What Are You Most Concerned About Today?

- Look at the following list and circle the two things that are concerning you most today.
- *Please circle ONLY the top two concerns that are most important to you today even if more seem to fit.*
- Put a #1 by the issue that is most significant to you today.

Substance Abuse or other Addiction (client)

___1. Alcohol Abuse/Addiction
___ 2. Drug Abuse/Addiction
___ 3. Gambling
___ 4. Sexual Addiction
___ 5. Eating Disorders
___ 6. Smoking
___ 7. Other___________________

Family Issues

___ 8. Family Conflict
___ 9. Child
___10. Teen
___11. Parent / Child Relationship
___12. Domestic Violence
___13. Affected by Other's Illness
___14. Affected by Other's Abuse/Addiction
___15. Affected by Other's Emotional Problem
___16. Family Other

Marital/Partner Relationship Issues

___17. Marital / Partner Relationship

Stress/Emotional Issues

___18. Depression
___19. Anxiety
___20. Grief
___21. Stress
___22. Anger Management
___23. Emotional Other

Trauma and Abuse

___24. Physical Abuse
___25. Sexual Abuse
___26. Emotional Abuse
___27. Post-Traumatic Stress
___28. Trauma Other

Work Related Issues

___29. Relationship with Co-workers
___30. Relationship with Supervisor
___31. Work Place Violence
___32. Harassment
___33. Job Performance
___34. Work Related Other

Medical Issues

___35. Medical Condition

Work/Life Balance Issues

___36. Financial Issues
___37. Childcare
___38. Older Adult Services
___39. Work Life Balance
___40. Education
___41. Work Life Other

No Personal Issues

___42. No Personal Issue

Other Issues

___43. Not Listed/Other___________

Revised December 2017

Intake Form Page 3

UAB Employee Assistance and Counseling Center - New Client Information

Date ___________ Legal Name____

Preferred First Name _____________________ If student, name of school______________________

Gender Identity (please choose all that apply) woman man transgender other __________________

Preferred Pronoun(s) __________________ (examples: he, she, they, ze, xie)

Married/Life Partner? Yes No If yes, how long? ______ Spouse/Partner's name____________________

Number of previous marriages/ partnerships_____________ Where did you grow up?_______________

Your occupation_____________________ Spouse/Partner's occupation_________________________

How long have you worked in your current job? ______ How long have you worked for this employer? ____

Please describe the problem that caused you to seek help at this time.______________________________

____

____

When did you first notice this problem?____

Have you ever been to counseling before? (circle one) Yes No If yes, when? ______________________

For what reason?____ Was it helpful? _____________

Estimate the severity of the problem: (circle one) Mild Moderate Severe

Have you ever been hospitalized for psychiatric or substance abuse treatment? (circle one) Yes No

If yes, when? ______where? ____________________________for what? _______________________

Are you currently under the care of a physician and/or psychiatrist? (circle one) Yes No

Physician name____

Please list any relevant medical conditions____

____

Please list current medications and their purpose____

____

Circle any of the following that apply to you:

Headaches	Trouble making friends	Sexual problems
Trouble making decisions	Mood swings	Unable to relax
Memory problems	Feel sad	Unable to have fun
Feel angry	Depressed	Feel tired
Feel tense	Stomach and intestinal issues	Insomnia
Shy	Trouble keeping a job	Nightmares
Always worried	Financial problems	Drink too much
Feel panicky	Thoughts of suicide	Work too much
Feel anxious	Feelings of inferiority	Eat too little
Palpitations	Extended family discord	Eat too much
Tremors	Immediate family discord	Sleep too much

Circle all of the following stressors that have occurred within the past year:

Death of spouse/partner	Minor law violation
Death of close friend/family member	Jail term/probation
New marriage/partnership	Pending court case
Change in # of arguments with spouse/partner	Change in finances
Marital/partnership reconciliation	Foreclosure on mortgage or loan
Marital/partnership separation	Change in residence
Divorce	Change in work responsibilities
Child leaving home	Trouble with supervisor/co-workers
Trouble with in-laws	Change in job
Change in family health	Job loss
Becoming a care giver for sick family/friend	Spouse/partner stopping work
Pregnancy	Retirement of self/spouse/partner
Gain of family member	Personal injury/illness
Outstanding personal achievement	Change in personal habits
Beginning/ending school	Sexual difficulties

AUDIT-C Questionnaire (circle one for each question):

How often do you have a drink containing alcohol?

Never   Monthly or less   2-4 times a month   2-3 times a week   4 or more times a week

How many standard drinks containing alcohol do you have on a typical day?

1 or 2   3 or 4   5 or 6   7 to 9   10 or more

How often do you have six or more drinks on one occasion?

Never   Less than monthly   Monthly   Weekly   Daily or almost daily

Intake Form Page 5

UAB EMPLOYEE ASSISTANCE AND COUNSELING CENTER

At the UAB Employee Assistance and Counseling Center, we are proud to offer our clients the option of working with an advanced Master's level or higher graduate counseling student. This approach is of benefit to clients by providing them the expertise and experience of the UAB Employee Assistance and Counseling Center clinical team while allowing advanced graduate students opportunities for supervised clinical experience to enhance their therapeutic skills. The client(s) would work with a graduate student and have a collaborative team of therapists, including an approved clinical supervisor, all working together for the benefit of the client. To enhance the therapeutic process, the clinical team collaborates on therapeutic goals and structures on an ongoing basis.

As with all therapy at the UAB Employee Assistance and Counseling Center, our clients' confidentiality is protected. All aspects of your treatment will be treated with the confidentiality dictated by the ethics of the counseling profession and state and federal guidelines.

The UAB Employee Assistance and Counseling Center clinical team will determine the appropriateness of each client(s) for working with a Master's level or higher graduate student in therapy.

Please indicate your interest in working with a Master's level or higher graduate student below:

____ Yes, I would like to work with a Graduate Student if considered an appropriate candidate.

____ I would like more information about working with a Graduate Student to make my decision.

____ No, I am not interested in working with a Graduate Student at this time.

Revised 10/10/16

Intake Form Page 6

WORKPLACE OUTCOME SUITE 5 ITEM VERSION

GENERAL INSTRUCTIONS
Below is a series of statements that refer to aspects of your work and life experience that may be affected by the personal problems you want to address at the EAP during the past 30 days. Please read each item carefully and answer as accurately as you can.

			NUMBER OF HOURS
AB	1.	For the period of the past 30 days, please total the number of hours your personal concern caused you to miss work. Include complete eight-hour days and partial days when you came in late or left early.	

INSTRUCTIONS FOR ITEMS 2 5
The following statements react what you may do or feel on the job or at home. Please indicate the degree to which you agree with each of the statements for the past 30 days. Use the 1-5 response key to the right.

			STRONGLY DISAGREE	SOMEWHAT DISAGREE	NEUTRAL	SOMEWHAT AGREE	STRONGLY AGREE
PR	2.	My personal problems kept me from concentrating on my work.	1	2	3	4	5
WE	3.	I am often eager to get to the work site to start the day.	1	2	3	4	5
LS	4.	So far, my life seems to be going very well.	1	2	3	4	5
WD	5.	I dread going into work.	1	2	3	4	5

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309.820.3570

1.800.433.7916 www.chestnutglobalpartners.org

UAB EMPLOYEE ASSISTANCE AND COUNSELING CENTER STATEMENT OF UNDERSTANDING

Welcome to the UAB Employee Assistance and Counseling Center (EACC). We are pleased that you have decided to use our service. The EACC is a voluntary confidential employee assistance and counseling service. Our service is an employee benefit designed to provide employees and their immediate household members with resources for resolving work-related and personal problems. The EACC provides employee assistance, confidential counseling, community referral, supervisor consultation, crisis management and a variety of educational programs. Licensed mental health professionals provide confidential individual, family and relationship counseling. Our goal is to assist our clients in clarifying issues, exploring options, and finding solutions. Our service is provided as an employee benefit of UAB, UAB Medicine, VIVA and the Homewood School System at no cost to our clients.

Assessment

As a new client, you will meet with an intake coordinator for an assessment. Your coordinator will explore with you the reasons that caused you to seek counseling and the goals you hope to achieve. At the end of this session your coordinator will suggest an appropriate follow-up plan for you. A follow-up appointment may be scheduled at the end of your assessment visit. Our clinical staff works as a team, consulting with one another, to increase the effectiveness of our service to you.

Should you have questions or need to re-schedule and appointment please call us at; (205-934-2281 or toll free within Alabama 1-877-872-2327)

Counseling

Counseling sessions are usually 45 to 50 minutes in length. Intervals between sessions will be scheduled depending upon your needs. Should you decide to terminate the counseling relationship, we recommend that you consult with your counselor to tie up loose ends and to allow for feedback concerning the counseling process.

Children under the age of 15 may be referred externally for individual counseling unless seen within the context of family therapy.

Scope of Benefit and Eligibility

The EACC provides services for all eligible persons, without regard to race, color, age, religion, sex, sexual orientation, national origin, disability, or veteran status. If it is determined by the clinical staff that an individual's needs exceed the scope of service or expertise available at the EACC, we will assist you to identify an appropriate referral to meet your needs. Services provided to you at the EACC are a benefit at no cost to you by UAB, UAB Medicine, VIVA and the Homewood School System. The EACC does not pay the costs of therapy or community resources/treatment services to which you may be referred. UAB, UAB Medicine, and VIVA employees and members of their immediate households are eligible for

Revised 1/26/17

____
Initial

up to 12 sessions each year. Detailed information regarding Homewood School Systems benefits is located on our web site; www.uab.edu/eacc.

Confidentiality

We understand that confidentiality is essential to your counseling progress. Our counselors are licensed master's level or higher mental health professional's ethically and legally bound to maintain your confidentiality. A written and electronic record (date, time, nature of meeting) of your contacts with the EACC will be maintained in a secure manner. Only EACC staff members have access to your clinical record, except as required by law or as described below. Should you need to access your file please contact your therapist. Your therapist will review the file with you and provide a written summary if requested.

Program Evaluation

The non-clinical data that you provide may be used for our EAP program evaluation research. You will not be identified, your information is anonymous.

Limits of Confidentiality

All information disclosed in counseling sessions is strictly confidential and will be released ONLY with your prior written permission, **except** as otherwise required by law. **The counselor's legal responsibility to disclose information includes, but is not limited to, the following conditions: suspected or known child, elder or disabled person abuse or neglect, mandatory reporting of health care providers experiencing psychiatric or substance abuse disorders that may present a danger to self or others to their licensing boards, threat of danger to another individual, imminent threat of suicide by the client, legal subpoena to present records to comply with a court order, mandatory state and federal requirements, and in any emergency medical circumstance that requires immediate medical attention. If you received couples or family counseling records require a written release by all parties or a Judge's order to be released.**

Due to the strict adherence to our policy of client confidentiality, we are unable to report suspected cases of sexual harassment in the workplace. **If you believe you have a sexual harassment complaint, UAB Policy encourages you to promptly report this situation to the designated official. If you are a UAB employee, contact the UAB Office of Human Resource Management Relations at 934-4458, Room 260X Administration Building, to report sexual harassment. If you are a UAB Medicine, VIVA or Homewood School System employee, ask your Human Resource Office for information on how to report sexual harassment.**

Legal Testimony

It is not the practice of the UAB Employee Assistance and Counseling Center to provide legal testimony for Employee Assistance and Counseling Center clients.

____
Initial

Our therapist are not trained as forensic experts so if you know that you will require the testimony of a therapist in a court case please let us know so that we can provide you with a referral to a therapist appropriately trained to represent your best interest in such situations. **You will be responsible for a fee of $250 per hour should one of our therapist's be called upon to provide testimony for you in a court of law. This fee also applies to any travel, preparation, and consultation time required of our therapist as a result of court action. The cost to you for record reproduction is $25 per page.**
The EACC does not offer a court approved **Anger Management Class**. If a client has been court ordered to participate in Anger Management Classes and/or Counseling for domestic violence or any other reason, the EACC may provide counseling only if in addition the client participates in an Anger Management Class elsewhere.

Your Responsibilities as the Client

This service is provided to you as a benefit at no cost to you by UAB, UAB Medicine, VIVA, and Homewood School System. It is your responsibility to attend all appointments as scheduled and on time. If you are unable to attend an appointment, please call as soon as possible to cancel, as there are others who need our services. If you fail to show up for 2 scheduled appointments without calling to notify us you will need to speak with your therapist regarding continued service or an appropriate referral.

As a client of the EACC, it is also your responsibility to maintain the confidentiality and anonymity of other clients that you encounter while visiting our offices.

If at any point you have questions or concerns regarding your service provider or the counseling process, it is your right and responsibility concerns to discuss those concerns with your counselor.

I have received a copy of the EACC Statement of Understanding, which contains information concerning the EACC and the counseling process, including but not limited to the following topics:

- Intake procedure,
- Counselor assignment and process;
- Scope of Benefit;
- Legal Testimony
- "No Show" Policy
- Confidentiality for the counseling relationship
- The Limits of Confidentiality
- Verification of attendance in cases of supervisor referral
- Confidentiality expected of clients towards other clients UAB Employee Assistance and Counseling Center clients
- Reporting of Sexual Harassment complaints

I understand that it is my responsibility to read this information prior to my first counseling session and to ask an Employee Assistance and Counseling Center counselor to further explain any portions which I do not understand. I also understand that by participating in the UAB Employee Assistance and Counseling Center services, I am agreeing to abide by the guidelines set forth in the UAB Employee Assistance and Counseling Center Statement of Understanding. I hereby acknowledge that I have read and understand this Statement of Understanding. I acknowledge that I have received a copy of this agreement.

______
Initial

I hereby release and hold harmless the University of Alabama at Birmingham, the UAB Employee Assistance and Counseling Center, VIVA, Homewood City Schools, and their employees, agents, and assigns from any and all legal liability that may arise from my participation in the services offered by the UAB Employee Assistance and Counseling Center or by Homewood City Schools as part of its contractual relationship with the UAB Employee Assistance and Counseling Center. I certify that this release has been made freely, voluntarily and without coercion and the information given above is accurate to the best of my knowledge.

____ ________________________

Participant Name (Please Print) Date

____ ________________________

Participant Signature Date

____ ________________________

Personal Representative Name (Please Print) Date

____ ________________________

Personal Representative Signature Date

If you are signing this form on behalf of someone other than yourself, please enclose with this form proof of your authority to do so and attach written documentation (i.e. Guardianship Order, Custody Order, Court Order) as appropriate.

____ ________________________

Witness Date

THANK YOU FOR CHOOSING TO USE THE UAB EMPLOYEE ASSISTANCE AND COUNSELING CENTER

WE LOOK FORWARD TO WORKING WITH YOU

The UAB Employee Assistance and Counseling Center
2112 11th Avenue South Suite 330, Birmingham, Al 35205; (205) 934-2281; FAX: (205) 975-7367;
http://www.uab.edu/eacc

APPENDIX E

CLIENT SATISFACTION SURVEY

Client Satisfaction Survey

Client Satisfaction Survey Questions

Initial contact with the Employee Assistance and Counseling Center

Very Poor
Poor
Neutral
Good
Excellent
No Response

Treated with dignity, respect by counselor

Very Poor
Poor
Neutral
Good
Excellent
No Response

Contact was treated confidentially

Very Poor
Poor
Neutral
Good
Excellent
No Response

Extent to which the EAP helped with problem

Very Poor
Poor
Neutral
Good
Excellent
No Response

Overall, how satisfied with EAP program

Very Poor
Poor
Neutral
Good
Excellent
No Response

How likely to recommend EAP service to others

Very Poor
Poor
Neutral
Good
Excellent
No Response

APPENDIX F

HUMAN SUBJECTS RESEARCH UNDER IRB NUMBER: IRB-300004278

Human Subjects Research Under IRB Number: IRB-300004278

Office of the Institutional Review Board for Human Use

470 Administration Building
701 20th Street South
Birmingham, AL 35294-0104
205.934.3789 | Fax 205.934.1301 | irb@uab.edu

NHSR DETERMINATION

TO: Banks, Josephine Jackson

FROM: University of Alabama at Birmingham Institutional Review Board
Federalwide Assurance Number FWA00005960
IORG Registration # IRB00000196 (IRB 01)
IORG Registration # IRB00000726 (IRB 02)

DATE: 30-Oct-2019

RE: IRB-300004278
Effectiveness of a University Employee Assistance Program Using the Workplace Outcome Suite and Client Satisfaction Survey.

The Office of the IRB has reviewed your Application for Not Human Subjects Research Designation for the above referenced project.

The reviewer has determined this project is not subject to FDA regulations and is not Human Subjects Research. Note that any changes to the project should be resubmitted to the Office of the IRB for determination.

if you have questions or concerns, please contact the Office of the IRB at 205-934-3789.

Additional Comments:

- Secondary analysis of de-identified Program Evaluation data.