

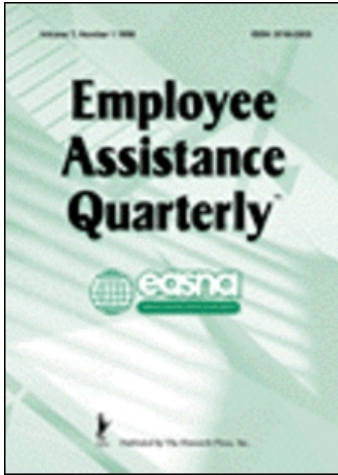
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An Overview of Employee and Family Assistance Programming in Canada

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An Overview of Employee and Family Assistance Programming in Canada

Rick Csiernik

ABSTRACT. This overview of Employee and Family Assistance Programming in Canada examines the nature and structure of 154 EFAPs from across Canada. Information was obtained regarding when programs were developed and who initiated the program, as well as who provides assistance and their qualifications. Details of program components, including coverage, access routes, use of volunteers, promotion, training and the utility of capping counselling services, are also discussed. *[Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <getinfo@haworthpressinc.com> Website: <http://www.HaworthPress.com> © 2002 by The Haworth Press, Inc. All rights reserved.]*

KEYWORDS. Employee Assistance Programs, Canadian mental health and family services, program evaluation, Census of Canadian EAPs, quality assessment

INTRODUCTION

The EAP has been established to assist any employee, immediate family member or retiree in resolving a personal problem. The services provided will be professional, confidential, and available at the earliest sign of need. This program intends to make a positive

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contribution to the growth and development of each individual who utilizes its services as well as the company as a whole.

*—Noranda Inc., Brunswick Smelter Division
Belledune, New Brunswick*

As conspicuous as Employee and Family Assistance Programs (EFAPs) are on the Canadian landscape, the programs themselves remain surprisingly unexplored. There are, in fact, only a few Canadian researchers actively working in this area. Early last decade, Walker (1990) interviewed several people to discuss differences between how American and Canadian EFAPs developed and provide assistance. In his discussion, Walker emphasized the importance and benefit of universal health care in Canada and the difficulty that American service providers had working within a managed care environment. He also postulated that this distinction allowed Canadian programs to spend more time focusing on resolving problems rather than on managing the costs of providing assistance. According to Walker, universal health care in Canada also means that there is no need to market addiction and mental health services and thus the focus is not on whether treatment centres will survive but rather on being able to see clients in a timely manner. However, Walker did not discuss the structure or nature of EFAPs in Canada in any detail. Similarly, McKibbon (1993a) provided an excellent overview and analysis of Canadian federal and provincial reports that impacted upon Canadian EFAPs, though he did not discuss actual programming either.

While Hartwell et al. (1996) have reviewed the prevalence, cost and characteristics of Employee Assistance Programs (EAP) from across the United States, no similar research has been conducted or financially supported in Canada. Despite this, Scott Macdonald of the Centre for Addiction and Mental Health, formerly the Addiction Research Foundation, has been active in Ontario. He and his colleagues, Steve Dooley and Samantha Wells, have surveyed Employee Assistance and health promotion programs in Ontario (1990), as well as drug testing programs both in Ontario (1994) and for the transportation industry across Canada (1991). As well, McKibbon (1993b) previously examined staffing characteristics of Canadian EAPs while Rodriguez and Borgen (1998) recently asked 62 program administrators from 54 organizations in Western Canada about their perspectives on the role of EAPs in the workplace.

Csiernik (1998) summarized the literature on individual case studies of Canadian EFAPs, reporting on problem profiles, utilization rates and

outcomes studies of 28 distinct programs. Since then, additional case studies and evaluations have been published on an Ontario transportation company (Macdonald, Lothian and Wells, 1997), the EAP Council of Hamilton-Wentworth (Massey and Csiernik, 1997), the wellness program at the University of Ottawa (MacDonald and Davidson, 2000), and a combined internal-external program at the St. Joseph's Health Centre in London, Ontario (Csiernik et al., 2001). Earlier Loo and Watts (1993) had examined the types of services offered and perceived benefits of 48 medium and large Canadian EAPs, while Rheaume (1992) asked 129 EAP practitioners in Quebec about the confidentiality of EAPs, the types of interventions used and future directions within a Francophone context.

Thus, there does exist a foundation of knowledge regarding the nature and structure of EAPs in Canada. However, there has been no successful attempt to review programs on a national scale. This study builds and expands on the previous efforts of researchers, providing a broader, though not yet comprehensive, foundation regarding Employee and Family Assistance Programs in Canada.

[The purpose of the EFAP] is the promotion of human wellness and the creation of healthier employees, families and communities.

—Suncor Energy—Oil Sands
Fort McMurray, Alberta

METHODOLOGY

A four-page survey was developed in conjunction with a national advisory committee of 21 persons representing labour, management and service providers. Along with basic demographic information the instrument asked when the program began, who initiated the EFAP, who provided services and what their qualifications were. Inquiry was made regarding referral routes, who was eligible to receive assistance and for what length of time. The instrument concluded with a 15-item checklist of program components. Four hundred surveys were distributed with the assistance of provincial and regional EAP associations. Of those, 154 were returned while 12 were undeliverable for a response rate of 39.7%.

Table 1 highlights the geographic location of the respondents (1a) and their respective work force sectors (1b). There were respondents

TABLE 1. Organization Demographics (n = 154)

Table 1a: Location of Organizations

Location	Frequency	%
British Columbia	5	3.2
Alberta	14	9.1
Saskatchewan	9	5.8
Manitoba	11	7.1
Ontario	62	40.3
Quebec	3	1.9
New Brunswick	12	7.8
Nova Scotia	9	5.8
Prince Edward Island	1	0.7
Newfoundland	11	7.1
Yukon Territory	2	1.3
Northwest Territory	1	0.7
National	14	9.1

Table 1b: Workforce Sector

Sector	Frequency	%
Government	40	26.0
Manufacturing	24	15.6
Education	20	13.0
Health Care	20	13.0
Forestry	8	5.2
Energy and Utilities	7	4.5
Law	7	4.5
Transportation	5	3.2
Mining	4	2.6
Sales and Service	4	2.6
Social Services	4	2.6
Communication	3	1.9
Construction	2	1.3
Corrections	2	1.3
Finance	2	1.3
Food Services	2	1.3

from all provinces and two territories though not from Canada's newest territory Nunavut. The greatest number of responses came from Ontario (40.3%) which also has the largest population and greatest number of organizations in Canada while Prince Edward Island, the smallest province, had only one (0.7%) reply as did the Northwest Territories. As well, there were 14 (9.1%) national organizations that returned the survey. Government organizations constituted one quarter of the replies followed by manufacturing (15.6%), health care (13.0%) and education (13.0%). It was also most interesting to note that 100 (64.9%) of the 154 responses came from the public sector. Ten (6.5%) of the respondents had fewer than 100 employees, 29 (18.8%) organizations employed between 100 and 500 persons while 21 (13.6%) had between 501 and 1,000 workers. Sixty-eight organizations employed between 1,000 and 5,000 persons (44.2%) while 12 (7.8%) had between five and 10,000 thousand workers and nine (5.8%) had over 10,000 employees. The range of work force sizes in the study was from seven to 60,000, with a mean of 3,144 and a median of 1,350 employees.

RESULTS

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

—Education sector, Alberta

[The purpose of our EAP is] to provide a work environment that supports our employees' well-being.

—Law enforcement, Ontario

Program Development

The growth and development of EFAP in Canada is a relatively recent phenomenon if the survey respondents represent the field. Only 16 (11.3%) programs were initiated prior to 1980. Nearly half, 65 (45.8%), were developed in the 1980s while another 56 (39.4%) were begun in the 1990s. There still also appears to be ongoing growth as five (3.5%) of the programs were developed in the past two years and 21, or 13.6% between 1997 and 2001.

Table 2 examines who initiated the EFAP for the work force. The majority of the workplaces in the sample (89.6%) were unionized and this is reflected in program initiation as more than half of the EFAPs were created by a joint labour-management committee or group. Management and/or human resources was responsible for beginning nearly one-third of the programs (31.1%) followed by labour (6.4%) and occupational health (5.8%). While occupational health services were extensively involved in Occupational Alcoholism Programs (Csiernik, 1992, 1997), this latter finding suggests a decreasing importance of health services in EFAP program development. Also, smaller organizations were more likely to have had their EFAP initiated by management while larger organizations were most likely to have a joint labour-management group as the driving force behind program development.

Service Delivery

Table 3 presents the three primary sources of providing assistance through an EFAP, internal volunteers (referral agents, union counselors, members of a 12-step fellowship), internal professionals (social workers, human resource professionals, occupational health nurses) and external professionals (multidisciplinary agencies, private practitioners, Assessment Referral Services or consortia), and the extent to which each option was used by the survey respondents. What was most surprising was not that the majority of programs (86.4%) used at least one professional counsellor outside of the workplace but how many now used a hybrid model. Nearly one-third of the organizations, 47, use a combination of internal volunteers, either referral agents, union counsellors or members of a 12-step fellowship, in conjunction with an internal coordinator or counsellor and at least one external professional

TABLE 2. EFAP Initiator (n = 154)

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

TABLE 3. Delivery of EFAP Services (n = 154)

	Frequency		%
	Sub-Total	Total	
1. Internal Volunteers		72	46.7
Referral Agents	64		41.6
12-Step Members	15		9.7
Union Counsellors	13		8.4
2. Internal Professionals		91	59.1
Social Workers	46		29.9
Occupational Health	46		29.9
Human Resources	35		22.7
3. External Professionals		133	86.4
Multidisciplinary Agency	86		55.8
Private Practitioners	56		36.4
Assessment Referral Service	13		8.4
Consortium	7		4.5

counsellor. Another 30 (19.5%) organizations use an internal professional supported by a third party, external counsellor. Only six (3.9%) organizations in the study used internal volunteers alone to provide assistance. It was also interesting to note that while 133 companies do use external counsellors or counselling agencies, just over one-quarter, 41, use external counselling as their sole mechanism for providing EFAP services. This number may also reflect the lack of participation by most major Canadian EAP providers in this study. It was also noted that the larger an organization, the greater the likelihood that an internal professional would be involved in providing services to the work force.

Labour initiated programs were the most likely to use internal volunteers to provide assistance (70.0%) followed by joint committee initiated EFAPS (56.1%) and by management initiated programs (31.2%). The number of internal volunteers used ranged from 1 (n = 4) to 300 (n = 1) with a mean of 40 but a median of only 15 and a mode of five. The larger or more geographically disperse an organization committed to peer supports was, the greater the number of volunteers that were recruited and become involved in the EFAP.

The amount of education and training provided to internal volunteers also varied widely. One organization only provided its internal volun-

teers with a half day of training before allowing them to be part of the EFAP while another required three weeks. One ($n = 10$) and two ($n = 6$) weeks of training were not atypical though nearly 40% of organizations using peer supports reported providing three days or less. Thirty-four organizations reported that their internal volunteers also received follow-up education and training lasting from a half day ($n = 1$) to two weeks ($n = 3$) with a mean of 3.6 days but a mode of one week. Follow-up, not surprisingly, was not as long as the initial education and training sessions were.

There was not a significant difference between which professional groups were employed as internal service providers, though which group initiated the EFAP was related to who provided the actual assistance. Occupational health nurses were used in 46 settings, as were social workers while human resource professionals provided EFAP services for 35 organizations. Five organizations used all three as internal counselling professionals, while 17 used a combination of occupational health and human resources. Social workers ($n = 32$) were the most commonly used, stand alone profession employed to provide counselling and were most likely to be found in EFAPs developed by a joint labour-management committee. There was no significant preference in programs where management initiated the program, which was also true for labour initiated programs, though all programs begun by occupational health personnel used medical personnel to provide assistance.

Those providing EAP services are a well-educated group in Canada (Table 4a). Nearly 80% of organizations use at least one counsellor with a master's degree while slightly more than 40% have at least one counsellor with a doctoral degree. As well, nearly 40% of service providers have specialized diplomas in addiction studies while one-third have EAP studies certificates, which is impressive as there is only one post-secondary institution in Canada that provides specialized EAP education (see Csiernik, 2000). Of the 154 respondents, 119 (77.3%) have counsellors who are members of a professional association with practice guidelines and ethical codes of conduct (Table 4b). Nearly two-thirds ($n = 76$) of organizations use registered social workers to provide assistance through their EFAP followed by certified psychologists ($n = 56$), certified alcohol and drug counsellors ($n = 46$), certified trauma specialists ($n = 41$), certified Employee Assistance professionals ($n = 33$) and certified occupational health nurses ($n = 22$).

TABLE 4. Service Provider Qualifications

Table 4a: Degree/Diploma (n = 139)

	Frequency	%
Community College	27	19.4
Undergraduate	33	23.7
Master's	111	79.9
Doctoral	56	40.3
Addiction Certificate	55	39.6
EAP Studies Certificate	47	33.8

Table 4b: Certification (n = 119)

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

Program Access

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

Each of the 154 programs in the study allowed those entitled to use the EFAP to do so voluntarily. Nearly three-quarters had an informal re-

ferral system in place with 74 (48.1%) encouraging peers to refer their colleagues to the program. Sixty-two organizations had a formal referral pathway to EFAP as an option while 49 (31.8%) also had a mandatory program usage component. However, there were only eight companies that had drug testing as a method through which EAP was accessed, and all eight were private sector organizations that used third party providers for their service delivery.

The capping of service has always been a contentious issue in EFAP. Four organizations did not respond to the question of if their EAP/EFAP provided for a maximum number of counselling sessions. Seventy-two (46.8%) did cap EFAP use while 78 (50.6%) did not (Table 5). Three (1.9%) organizations had a monetary cap rather than a limit on the actual number of sessions allowed. One organization allowed only two sessions, while two allowed for three, and four for four. In reality these are not EFAPs but rather assessment and referral services and it is somewhat of a misnomer to include them in the research. In each of these cases the average number of sessions was the cap. For organizations with a capped service from five to twelve sessions the average number of counselling sessions was 5.1, while for the 78 non-capped organizations the average was 5.0. Simply stated, there was no difference in the average number of sessions between the two groups. Capping did not provide any real savings and, in fact, where services were capped at eight, ten or twelve, average use by employees and family members was greater than in instances where no formal cap was in place. This finding was not influenced by whether the organization was public or private sector nor who initiated the program. EFAPs that used internal volunteers were the type of program most likely *not* to have a capped number of counselling sessions (50%). Just under one-third of programs using internal professional service providers did not have a cap in place while 80.8% of programs with an external service provider did have a formal cap on service provision.

Program Maintenance

The EAP committee was at one time the foundation of Employee Assistance Programming (Albert, Boyle and Ponee, 1984). In this survey 98 (63.6%) EFAPs were administered by a formally structured and sanctioned committee. However, the significance of this finding is that over one-third of EFAPs are not administered through any type of joint labour/employee-management group. Seven (70.0%) of the 10 EFAPs initiated by labour had a committee while 85.4% of those developed by

TABLE 5. Service Capping (n = 150)

Number of Sessions Allowed	Average Number of Sessions	Frequency	%
No Limit	5.0	78	52.0
2	2.0	1	0.7
3	3.0	2	1.3
4	4.0	4	2.7
5	3.4	11	7.3
6	4.8	23	15.3
8	5.3	11	7.3
10	6.4	11	7.3
12	8.0	6	4.0
Financial Cap	3.3	3	2.0

a joint committee continued to be administered by one. Just over one-third (n = 17) of the management initiated programs had an EFAP committee while only two (22.2%) of nine of those developed by occupational health services had a committee in place to oversee and monitor the program and to nurture and monitor its development. The larger an organization was the greater the likelihood of having a committee. The committees that did exist ranged in size from three members (n = 1) to 25 (n = 1) with a mean of 8.5, a median of 8 and a mode of 8 (n = 12). The EFAP committee also had a representative on the Occupational Health and Safety Committee in 69 organizations (44.8%).

Two aspects that are required for an EFAP to continue to develop and be used are program promotion and supervisor training. Table 6 illustrates the frequency of these program components among the 154 survey respondents. Over one-quarter of the programs did not do any type of regular promotion, with this slightly more the case for third party providers (27.1%) than programs using internal professionals (25.3%) or internal volunteers (20.8%). Twelve (7.8%) organizations stated that they conducted promotion campaigns as needed while four (2.6%) did them infrequently. Just under one-quarter of the organizations (n = 35) held an annual campaign while 19 (12.3%) ran quarterly campaigns and 10 (6.5%) had semi-annual promotion activities. While utilization rate is not necessarily a comprehensive indicator of the health of an EFAP, utilization rate was nearly two percentage points (23.1%) greater for or-

TABLE 6. Program Maintenance (n = 154)

Frequency of Activity	Program Promotion		Supervisor Training	
	Frequency	%	Frequency	%
Monthly	5	3.2	0	0
Bi-Monthly	4	2.6	1	0.6
Quarterly	19	12.3	6	3.9
Semi-Annually	10	6.5	4	2.6
Annually	35	22.7	25	16.2
As Needed	12	7.8	27	17.5
Infrequently	4	2.6	4	2.6
Never	43	27.9	62	40.3
Not Reported	22	14.3	25	16.2

ganizations that conducted promotion campaigns (9.6%) than for those that did not (7.8%). Similarly, 38 (24.7%) organizations reported not providing any type of new employee orientation on the existence or function of the EFAP. Those that provided an EFAP orientation for their new employees had a program utilization rate of 9.8% compared to 7.2% for those organizations that did not, a difference of 36.1%. Not surprisingly, the smaller the organization the less promotion that was conducted.

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

Program Components

When EAPs began to evolve, a basic program consisted of a policy, an orientation to the new program and the provision of service. Since then many extra features have been added. One hundred twenty-two (79.8%) EFAPs had a formal policy in place that provided written documentation and the framework upon which the program was based while 50 (32.5%) had done some type of formal program evaluation. How-

ever, this meant that one in five EFAPs in this survey had no policy statement and operated within the organization without a formalized mandate while two-thirds were not able to or chose not to provide some form of evaluative information regarding their program. Fifty-eight (37.7%) EFAPs also had a distinct substance abuse policy in place in conjunction with or separate from the EFAP policy, though only seven (4.5%) organizations had distinct drug testing programs. Nearly half (48.7%) of the respondents had a disability management program in place while a greater number (61.0%) had established a wellness program.

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

DISCUSSION

HLC is concerned with the personal well-being of all employees and their families. It is recognized that a wide range of personal problems may have an adverse effect on an employee's well-being and ability to perform his/her duties. Personal problems can include illness (physical or mental), emotional problems, stress, financial, family, marital, legal, or other problems such as substance abuse. HLC's EFAP is designed to provide accessible, professional and confidential help to all employees and their family members who are experiencing personal problems through a process of assessment, short-term counselling, referral and follow-up.

*—Health Labrador Corporation
Goose Bay, Labrador (province of Newfoundland)*

It was encouraging to learn that Employee and Family Assistance Programming remains a growing enterprise in Canada and that while third party professionals are a prominent mechanism through which assistance is provided, that peers and internal professionals remain important within many programs. The internal-external EAP debate may never be resolved but this study further indicates that there are distinct differences that arise depending on how the program is delivered. Prominent differences include the amount of service provided and the amount of program support offered. There tends to be less promotion, training and a greater likelihood to have a capped program when external professionals provide EFAP services than when the assistance is provided by internal staff or volunteers. What was also quite surprising to learn was the number of hybrid programs that now exist that use some combination of internal volunteers, internal counselling professionals and third party providers. However, if there is a group that has lost prominence in the development of programs and provision of services it is occupational health though there are still many organizations that have formal connections between their occupational health and safety committee and their EFAP.

This study's results also support earlier work that reported who develops or initiates an EFAP has an impact on the nature of the services that are provided to employees and their families (Csiernik, 1997). Labour and joint labour-management initiators were more likely to have a joint committee in place to administer the EFAP. Smaller organizations are more likely to have their EFAP begun by human resources while larger organizations are more likely to have their program initiated by a joint committee. EFAPs initiated by labour are the most likely to use internal volunteers while joint committees are more likely to have a social worker as the key service provider for an internally based program. Occupational health nurses are the preferred provider when occupational health begins the program and it is these types of programs that are also the least likely to be managed by a joint labour-management committee.

The study's most important finding, and one that supports previous beliefs and anecdotal reports, is that capping of EFAP services serves no real purpose. Excluding programs that provided a maximum of four sessions, it was discovered that uncapped services were actually used on average less than those with a limited number of visits. Those with caps of eight, ten or twelve actually had a greater number of average sessions than those with no capping policy. The caveat here is that the EFAP must be well-defined. It needs to be viewed by all parties as a short-term, problem and crisis-focused re-

source and not one that evolves into long-term psychotherapy. Nonetheless, there are situations where a longer-term counselling relationship is appropriate and terminating prematurely is detrimental, not only to the employee but also to his or her family as well as to the long-term interests of the organization. This study indicates that there is no abuse of uncapped counselling that is not artificially limited by placing a monetary cap on how much a counsellor may receive for working with an employee and/or his or her family.

What was disappointing, but important to discover, was the lack of program development in Canadian EFAPs. Twenty percent of organizations in the study did not have an EFAP policy, 36.4% did not have a formal committee, one-quarter did not provide new employee orientation, while nearly 30% did not engage in ongoing promotion and 40.3% did not provide any education or training to supervisors. A majority of these organizations had external providers providing all or some of the EFAP services to the workplace. A significant minority of those that did not provide these programming features did have an internal professional who was the primary service provider, though these organizations tended to be ones where the human resources department took the lead for EFAP. However, drug testing has not as yet caught on in Canada and remains a non-issue within all but a handful of organizations in the study. Many more organizations have instead adopted a disability management approach though wellness programming is still more prominent.

There are several articles that will follow using this population including an examination of utilization rates and how they are determined, a review of EFAP policy statements and a summary of EFAP evaluations that have been conducted but not published. An additional follow-up study will also be forthcoming on the nature and content of EFAP peer education and training. What remains the greatest challenge is to have large third party service providers become more active in this and other EFAP-related research. Despite initial assistance in the development of the survey instrument and assistance in promoting the project, with a few exceptions, third party participation was minimal. This is not only true in this study but has generally been the case in the Canadian EFAP field.

This brings us to the concluding point of why EFAP rather than EAP. Employee Assistance Programs have long served families, indirectly initially but now quite directly including active outreach and promotion. All but 10 companies (6.5%) in this study provided assistance to family members of employees. Family members were more accepted

for counselling than many other employee groups including part-time employees, probationary employees, seasonal employees, those laid off from the organization and those who had retired. The field is also well aware of the fact that employees bring work issues home with them and bring family issues into the workplace. The relationship between home and work is inseparable. The inclusion of the term family within EAP better promotes the reality of what programs are actually doing and the continuing interconnectedness of our working and personal lives at the beginning of the 21st century.

To employ a proactive and preventative approach to assist employees and their families to resolve personal, social and health problems on a voluntary and confidential basis.

—City of Windsor, Ontario

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