REFERENCES – Workplace Behavioral Health and EAP Services


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Taking the Pareto Path to ROI

Some studies have shown that EAPs have a positive financial impact that offsets their cost, but few of these studies have been published in peer-reviewed journals.

by Mark Attridge, Ph.D., M.A.

In Part 1 of this three-part series (Attridge 2010), I revisited the methodology and major findings of the 1990 claims-based cost-offset study of the employee assistance program at the McDonnell Douglas Corporation (Smith and Mahoney 1990). In this article, I reflect on the progress of the field in the 20 years since that study and describe the current state of outcomes and cost-offset research on EAP services. In the final article, I will offer some advice on how to more effectively assess the cost offset of EAPs using measures of workplace productivity.

A small number of other studies have been conducted in the 20 years since the publication of the McDonnell Douglas study that offer further evidence of the positive cost offset of employee assistance services. But even with this progress, the field continues to struggle with questions about the value of EAPs. What’s behind this disconnect between the research findings and the perception that there is not enough evidence? Does the field really not have a strong evidence basis for outcomes from EAP use and their associated financial cost offset? The answer is both yes and no.

A GROWING EVIDENCE BASE

On the “yes” side of this answer are several dozen outcome and cost-offset studies conducted over the past 30 years, most of which document the positive outcomes of EAPs in a variety of areas. This small literature base has already been reviewed several times (Attridge et al. 2009; Attridge and VandePol 2010; Bennett and Attridge 2007; Blum and Roman 1995; Cserniki 2004; EPA 2003; Holosko 1988; Roman and Blum 2002).

Because EAPs serve organizations, it is no surprise that the literature shows that they have a positive impact on several kinds of organizational-level outcomes. Various studies have found effects in the areas of crisis incident response, consultation to managers for workgroup problems, support for workplace changes, legal liability risk management, and synergistic support of other employee health programs through collaboration and integration of services.

Most of the outcomes research shows that EAPs provide several kinds of positive outcomes for individual users of EA services. These outcomes include reduced substance use and/or mental distress, improvements in general health and functioning, substantial improvements in work productivity (for most clients), and reductions in absenteeism (for some clients).

Evidence from about two dozen studies also shows that EAPs can contribute to long-term net reductions in overall health care costs for individual employees and their families, despite short-term increases in the costs of providing professional treatment for alcohol and mental health disorders. Several of the best examples of this evidence include research on EAPs at Abbott Laboratories (Daimas and Marks 2000), Chevron Corporation (Collins 1998), McDonnell Douglas (Smith and Mahoney 1990) and Southern California Edison (Corgin, Amral and Harlow 1996). Researchers at McDonnell Douglas even conducted another study (with their helicopter company division) and again found net claims-based cost savings for the provision of EAP-directed behavioral health care management services for employees with alcohol/substance abuse and psychiatric problems (Alexander & Alexander Consulting Group 1990).

Figure 1 presents themes that are common to many of these cost-offset studies. These themes reflect many elements of the components of the EAP Core Technology (Roman and Blum 1989). Note that all of the EAP cost-offset studies focused on small subsets of EAP cases that had serious mental health or alcohol abuse issues. Thus, health care claims-based cost offsets have been associated mostly with employees with relatively serious issues who were assisted by EAPs and received mental health and substance abuse screening, appropriate referral, and long-term case management (Ahn 1989).

THE PARETO PATH TO ROI

This pattern of key findings from the EAP research literature is an argument in favor of the “Pareto Path” to cost offsets. This term refers to the oft-cited economic principle that a small segment of a population is associated with a large share of an outcome of interest. This has also been called the 80/20 rule, meaning that (for example) 80 percent of health care costs are associated with 20 percent...
Figure 1: **KEY INGREDIENTS OF COST-OFFSET STUDIES OF EAPS**

- Outcomes assessed in several areas (e.g., health care claims, disability claims, work absence days, and employee turnover).
- EAP users with more severe mental health and substance abuse problems (often less than 10 percent of the full EAP caseload).
- The EAP intervention involved counseling, active case management, and collaboration with other care providers (e.g., medical, psychiatric, or substance abuse treatments).
- Long-term involvement of the EAP with high-risk cases (often for a year or longer).
- Financial savings of sufficient value to offset the cost of the EAP often were not realized until several years after the first contact with the EAP.
- Family members of employees with serious mental health and substance abuse disorders also had higher-than-average costs when the employee was untreated and experienced cost reductions when the employee received effective treatment.

These ingredients reflect many of the components of the EAP Core Technology. The components of the EAP Core Technology are as follows:

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 EAP 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 EAP services on work organizations and individual job performance.

Almost all of the EAP research on cost offsets has been released in non-peer-reviewed outlets, including unpublished case study reports of internal company evaluations.

Most EAPs today, however, tend to offer a "broad brush" approach to their services, including assessment, brief support, referral (if needed), and a wide range of other educational and support services. It is unlikely that these kinds of EAPs can yield the kinds of cost offsets found in studies of EAPs with a more narrow focus. This does not mean that a positive ROI is impossible to achieve, but that it requires an "old school" approach. Such an approach involves doing much of what the EAP Core Technology advocates—emphasizing alcohol- and psychiatric-related types of cases, work performance and returning to work, and close collaboration with other internal workplace supports and external treatment providers (Amatral and Attridge 2010).

The "Pareto Path" cost-offset outcomes found in the last 20 years of EAP research are remarkably similar to the findings from a much larger research literature on the cost offset of providing prevention and treatment services. This research has been conducted in the tra-
A more significant consequence of not publishing these works in scientific journals is that most of the studies have not survived a critical peer review. Thus, the methodological quality of much of this literature is either weak or unknown (Arthur 2001; Myers 1984; Pompe and Shinar 2008).

More generally, in the EAP field, there has simply not been enough emphasis on conducting outcome and cost-offset research studies of any kind of methodological quality. For example, a survey conducted in 1990 found that only 33 of 82 employee assistance programs (40 percent) conducted cost-offset analyses of their services (Houts 1991). How many of these programs then published their ROI findings is unknown—it was not assessed in the study—but it is assumed to be very few.

To illustrate this point, I examined all of the articles published in the last 20 years in the Employee Assistance Quarterly, the only peer-reviewed research journal in the EAP field (the title was changed in 2005 to the Journal of Workplace Behavioral Health: Employee Assistance Practice and Research). Between 1990 and 2009, this journal published 438 original articles, of which 41 (9.4 percent) addressed outcomes of EA services (e.g., satisfaction, clinical symptoms, work performance, and health care costs). Of these 41 papers, about half (21) presented some form of outcomes data, with the other half being reviews or best-practices commentary reports. Finally, of the 21 data-oriented studies, only 4 (0.9 percent of the total published articles) examined outcomes in terms of the dollar value to the organization and used a true cost-offset type of analysis (Blazetemple and Howat 1997; Hargrave and Hiatt 2005; McClellan 1990; Yamatani, Santangelo, Mauk, and Heath 1999).

Three of the four studies, which used a variety of different methodologies, determined that there was a positive ROI for the EAP services.

Thus, in the past 20 years, only about 1 in 10 studies in the EAP field's peer-reviewed journal focused on outcomes (broadly defined) and only about 1 in 100 studies examined the financial cost offset of such outcomes (see Figure 2). That is a pretty small slice of the research activity pie. It is no wonder, then, that questions remain about the validity of arguments in favor of the return on investment for EAPs.

In summary, only a few rigorous studies of EAP cost offsets have been conducted in the past 20 years. Like the McDonnell Douglas study, most of these studies found a net cost offset in the areas of health care claims costs, disability claims costs, and employee absence costs when examined over a multi-year follow-up period. These EAP studies mirror the pattern of effects found in the peer-reviewed research literature on the cost offset of mental health and substance abuse interventions.

Thus, while the evidence basis of the financial cost offset of EAPs has grown, it remains a small and largely unpublished literature. Much more can—and should—be done in this area.

What is perhaps of more interest to modern EAP practice is the emergence of reliable and valid self-report tools for measuring changes in employee work productivity. Taking the "Productivity
Path” to ROI is a promising strategy for EAPs, one that will be examined in the next article in this series.

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20 Years of EAP Cost Research: Taking the Productivity Path to ROI

This promising strategy can be accomplished with far fewer operational costs than traditional claims-based ROI studies — and in far less time.

By Mark Attridge, Ph.D., M.A.

In part 1 of this three-part series (Attridge, 2010a), I revisited the methodology and major findings of the 1990 claims-based cost-offset study of the Employee Assistance Program at the McDonnell Douglas Corp. In part 2 (see the last issue of JEA), I reflected on the modest progress of the field in the 20 years since that study. In this final article, I recommend an alternative strategy to produce a significant cost-offset for EAPs — one that is based on self-report measures of employee work productivity and work absence days for EAP clients.

Pareto Path to ROI — A Review

The Pareto Path to Return on Investment (ROI) model postulates that the business value of EAP is primarily driven from the relatively small number of EAP cases with more severe kinds of clinical problems (i.e., mental health and/or addictions), cases that tend to cost a lot in terms of health care and disability claims, when individuals are either left untreated or treated ineffectively.

However, when delivered effectively by the EAP, case-management and long-term support for pareto-type cases have been demonstrated to have a positive cost-offset for employers. In addition to McDonnell Douglas (Smith & Mahoney, 1990), several other studies have shown, over a multi-year follow-up period, to have a net cost-offset in health care and disability claims, and employee turnover (see review in the second article in this series; Attridge, 2010b). Furthermore, these EAP studies mirror the pattern of effects found in peer-reviewed scientific literature on the cost-offset of mental health and substance abuse interventions in general.

Given the frequent call for more ROI evidence, surprisingly few rigorous studies of EAP cost-offset have been conducted in the past 20 years. For example, only about 1 in every 100 research studies published in the last 20 years in the Employee Assistance Quarterly/Journal of Workplace Behavioral Health analyzed financial cost-offset of an EAP (Attridge, 2010b). There are many reasons why so few studies of this kind of research have been published, including the complexity of the study design, requirements of a multi-year time frame, a large employee population base, access to client outcome data sources, use of expert analysts, and so on. In other words, conducting traditional cost-offset research is not easy, it is very expensive, and most EAPs are not set up to do it.

The Productivity Path to ROI

However, instead of focusing efforts on the most severe cases, EAPs can center on making smaller improvements in the majority of EAP cases with less clinical severity who are also at risk for workplace performance problems. Taking this “Productivity Path” to ROI is a promising strategy that can be accomplished with far fewer operational costs than traditional claims-based ROI studies — and in far less time (i.e., several months compared to several years).

This strategy also aligns with the organizational trend that emphasizes a health and productivity approach to employee benefits and corporate wellness. This approach embraces self-report measures to determine employee absence, presenteeism, and work engagement (Goetzel, 2007; Kramer & Rickert, 2006; Loeppke et al., 2009).

Putting this strategy into practice requires the routine assessment of employee work absence and on-the-job performance, especially of work productivity or “presenteeism” (Chapman, 2005). However, this aspect can be easily accomplished through the adoption of any one of several validated self-report tools widely.
accepted by business leaders to measure employee work performance outcomes (Attridge et al., 2009; Baker, 2007; Kessler et al., 2003; Kopman et al., 2002; Lerner et al., 2001). In addition, a new set of core outcome measures — including five-item scales for employee productivity and workplace absence — is also available specifically for EAPs (Lennox, Sharar & Burke, 2009).

In addition to the advantages of lower cost, shorter time frames, and access to new measurement tools, there is also a strong evidence basis for the Productivity Path to ROI approach. In fact, changing workplace performance outcomes is a prime area — if not the most important area — for behavioral health workplace services. Research from large-scale HPM studies dramatically reveals that employer-related total costs from mental health and substance abuse disorders are overwhelmingly accounted for in the area of lost worker productivity, as opposed to the more traditionally studied areas of health care and disability claims, and workplace absence (Burton et al., 2008; Goetzel et al., 2004; Goetzel & Ozminkowski, 2006; Integrated Benefits Institute, 2004; Simon et al., 2001).

For example, the Integrated Benefits Institute (Perry & Molmen, 2009) found that most of the cost burden for employers in treating employees with depression was accounted for by diminished employee productivity (63%). This aspect exceeded the combined dollar value of losses to the organization from workplace absence (18%) and short-term disability (19%).

Productivity Path to ROI also makes sense because most EAPs are quite effective at re-establishing workplace productivity and reducing workplace absence in employees who use the EAP for brief counseling (Harlow, 2006; Jorgenson, 2007; McLeod & McLeod, 2001). Several examples of this kind of success are described below and summarized in Table 1 below.

### Work Performance Outcomes in Three EAP Studies

- **Study 1** — Workplace performance outcome data was collected from over 26,000 cases during a 9-year period from a large external EAP. The data revealed that the average rating on a 1-10 scale of the level of work productivity rebounded significantly from 4.8 from before use of the EAP to 8.3 after use of the EAP (Attridge, Otis, & Rosenberg, 2002). The post-EAP rating is close to the productivity level rating of 8.9 on the same scale that was obtained in a nationally representative sample of employees who had not used the EAP (Attridge, 2004). This study also found that almost half of the cases (48%) reported that they had been able to avoid taking time off from work due to using the EAP, with an average of 1.8 days of absenteeism avoided per case.

- **Study 2** — An EAP for government employees collected self-report employee productivity and absence data on over 59,000 cases (Selvik et al., 2004). Results revealed that the number of employees who reported having difficulty performing their work due to mental health factors was reduced from 30% to 8% of all EAP cases. There was also a significant reduction in work absenteeism days and tardiness, with absenteeism changing from 2.4 days to 0.9 days, respectively for

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**Table 1**: EAP Research Results for Improving Workplace Performance

<table>
<thead>
<tr>
<th>Study</th>
<th>Sample Size</th>
<th>Change in Number of Work Absence Days in 30 Days After EAP Use Per Average EAP Clinical Case</th>
<th>Percentage of EAP Cases with Improved At-work Productivity in 30 Days After EAP Use</th>
<th>Average Amount of Improvement in Work Productivity Per Clinical Case with Effect</th>
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<tr>
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<td>70%</td>
<td>42%</td>
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<tr>
<td>2</td>
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<td>40%</td>
<td>57%</td>
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<td>Average</td>
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<td>50%</td>
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</tr>
</tbody>
</table>
the 30 days before the EAP compared to the 30 days after EAP use concluded.

**Study 3** — A national study featured the analysis of pre-use data and post-use follow-up assessments obtained from over 3,500 employee users of a national external EAP provider (Baker, 2007). Among the approximately 40 percent of cases who had work performance problems before the use of the EAP, the average number of these work cut-back days was reduced from 8.0 to 3.4 after EAP use. This study also found that in the 25% of EAP cases that reported missing at least a half day or more of work before their use of the EAP, the average level of work absenteeism was reduced from 7.2 days to 4.8 days, respectively for the 30 days before versus the 30 days after EAP use concluded.

**Summary**

In my opinion, more EAPs should routinely use Productivity Path to ROI to measure changes in employee work performance. Outcome is often diminished for many employees when they seek help from EAPs, but it can usually be improved substantially after intervention from an effective counselor. Consequently, focusing on workplace performance outcomes presents EAPs with a good change of finding even meager positive results for the majority of its cases.

Compared to the Pareto Path to ROI that uses a high dollar value applied to a few high-severity cases, Productivity Path to ROI uses a more modest dollar value applied to a large number of lower-severity EAP cases. Indeed, a recent case study found a 3:1 ROI using this approach for their EAP (Hargrave et al., 2008). What also makes the Productivity Path to ROI especially appealing for EAPs is that it directly incorporates the work focus goals of the Core Technology of our field (Roman & Blum, 1985). Focusing on improving employee work performance as the basis for ROI is conceptually aligned with why EAPs are uniquely of value to the workplace.

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**References**


Profile of Outcomes Research Studies in the Employee Assistance Quarterly* (1990-2010)

<table>
<thead>
<tr>
<th>Outcome Topic</th>
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<td>Outcomes Data Measured</td>
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<tr>
<td>Outcomes as Cost-offset $</td>
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</tr>
</tbody>
</table>

The Figure 2 chart on page 14 in the 3rd quarter 2010 issue of the JEA was not accurate. The X-axis scale on the bottom should have read 0 to 10 and not 1-5, and the top bar stats were inadvertently removed. As a result, the stats inferred in the graphic only represented half of the amount of data mentioned in the text. This chart depicts the graphic as it should have appeared.

* Title changed to Journal of Workplace Behavioral Health in 2005.
Here's What Some Researchers Had to Say About the McDonnell Douglas Series

“There remain a small group of dedicated researchers in the EAP evaluation field who provide fact-based outcome studies on a regular basis. They are joined on occasion by individuals who write about their individual worksites to further enhance our limited knowledge. What I have noted in the past decade is there are now more studies being written examining external or combined internal-external programs where as in the past the information was almost exclusively written about internal programs. There were very few needs assessments that appeared in the literature in the past decade, and while case studies still remain predominant there has been more outcome and process evaluations studies published in the peer-review literature. My greatest concern remains that too few decision makers use these too few studies to base their programming decisions upon. Beliefs, which are typically skewed and too often premised upon attribution errors, continue to form the foundation for decisions regarding EAPs rather than the use of evidence based research.”

— Rick Csernak, PhD, RSW, Professor, School of Social Work, King’s University College at The University of Western Ontario, London, Ontario, Canada

“Having evolved from a practice-based foundation, the employee assistance (EA) field has struggled with some of the same problems related to research as the substance abuse field. Given our history, the EA field has always lacked a strong research-based foundation and has relied on related fields to guide research and evaluation methods. However, the EA field is not without its own unique set of best practices as described by the EA professional organizations and leading researchers. Dr. Attridge describes some of these methods in his important contribution to EA research on topics including, but not limited to EAP evaluation and cost-benefit analysis. As EA service definitions and measurement practices continue to be shared and discussed publicly, our field can move forward as a profession with empirical research that will support our work and sustain our programs. EAPs around the globe play an important role in supporting the quality of work-life for individuals and families, which in turn, supports employer’s goals for high performance and overall productivity. Without empirically based evidence, using standardized and accepted research methods and measures; the EA field may not be able to maintain its programs in the future. Today, the EA field is ripe for more research. With the recent activity in the field focused on evaluation and research, I am positive about the outlook for EAPs as a sustainable workplace partner and profession.

— Jodi M. Jacobson, PhD, LCSW-C, Assistant Professor Chair, Employee Assistance Program Subspecialization, University of Maryland, Baltimore

“Mark Attridge should be commended for his continued research in the area of cost benefit for EAPs. His writings clearly show the difficulties encountered in doing such studies. One of the major issues that we face in the field is confidentiality by the corporate client. The only cost benefit study that I could publish was done for the U.S. Department of Health and Human Services because everything that is done under federal auspices goes into the public domain. Any other ROIs that our company has done were for corporate clients who naturally did not want to disclose the data. I would therefore suggest that perhaps we should think of corporate consortiums for a singular study where data is not identified by company.”

— Dale Masi, PhD, MSW, CEAP, Professor Emeritus Maryland School of Social Work, Baltimore MD and President/CEO Masi Research Consultants Inc.

“Having been involved in the creation of ROI calculators almost 10 years ago, I have recently seen ROI research become less abstract and more pragmatic. Attempts of obtaining data are based more on employee user questionnaires for specific programs than trying to establish the ‘big link’ between EAP and cost savings in general. Yet, a wider project of making EA a more coherent and evidence-based profession is still a work in progress. In order to fully professionalize employee assistance, we must be able to quantify outcomes and thereby combat the trend towards commoditization. The next task is to develop the tools required to assess the financial impact on the organization as a whole instead of looking at cases in isolation. One of the reasons for this task is to avoid the ‘squeezing of the balloon’ phenomenon whereby isolated interventions combating absenteeism, for instance, lead to more presenteeism and vice versa. The metrics need to reflect that! Several variables are needed to establish EAP as a comprehensive program.”

— Wolfgang Settl, MD, MA, MBACP(Accred), Executive Director, The Validation Group Limited, United Kingdom
Chapter 2

The Business Case for the Integration of Employee Assistance, Work-Life and Wellness Services:
A Literature Review

Mark Attridge

SUMMARY. Employee assistance programs (EAP), work-life programs and wellness programs are three commonly provided kinds of interventions that have the goals of reducing healthcare costs, improving employee performance and fostering a healthier workplace culture. The integration of these kinds of programs is a recent trend that has the potential to offer additional synergistic benefits. New studies have linked comprehensive delivery services that support human capital needs with bottom-line financial success of the company. This evidence can be used to make the business case for offering EAP, work-life and wellness services in an integrated capacity. However, while promising, the scientific evidence thus far in this area has methodological limitations and there are critical aspects that require further study. [Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <docdelivery@haworthpress.com> Website: <http://www.HaworthPress.com> © 2005 by The Haworth Press, Inc. All rights reserved.]
The ultimate goal of any business is to sustain profitability. Managing the organization’s most important resource, its human capital, is never easy. Keeping that asset healthy and at work is a challenge. (Kate Winn-Rogers, 2003)

INTRODUCTION

Companies today face the challenges of paying for unprecedented increases in employee healthcare costs and benefits, maximizing the performance of their workers and managing the risks to the organization. This article argues that the integration of the three major kinds of health and productivity management (HPM) services—employee assistance programs (EAP), work-life programs, and health and wellness programs—offers a potent combination of tools for meeting these business goals. The use of these kinds of HPM programs in a comprehensive fashion can yield significant return on investment (ROI) for the company and improve the lives of the employees as well.

Part 1 of this article summarizes the costs of doing business that are relevant to HPM practices. Part 2 examines the drivers of these business costs with an emphasis on human capital. Part 3 addresses certain ways to improve human capital and focuses on the core practices and outcomes for EAP, work-life and health promotion/wellness. The business case for the integration of these three HPM services is presented in Part 4. The final section discusses critical issues, such as the limitations of the research literature and the key success factors for implementing an integrated program to achieve business outcomes.

PART 1: THE COSTS OF DOING BUSINESS

To run a profitable company, one of the fundamental tasks is to understand and manage the costs of doing business. Many of these costs are related to employees and their care. There are three main areas of costs relevant to HPM. These are employee healthcare and benefits,
workplace performance costs, and organizational risks. Each of these is reviewed next.

**HEALTHCARE AND BENEFITS COSTS**

*Medical Costs.* Annual increases in healthcare premiums have risen in the 8 to 14% range for the last 5 years and are expected to continue at that rate in the future as well. This is compared to overall annual inflation rates in the 3% range. More specifically, recent industry data (cited in Gold in this volume) shows a change from $4,355 in year 2000 to $7,009 in 2004 per employee health insurance premiums paid by employers—this is a staggering cumulative increase of over 60% in just five years. Companies are rightly concerned about healthcare costs and looking for healthcare programs and services that can help save money by reducing the medical cost trend.

*Mental Health Costs.* Mental health, particularly depression, is an increasingly large component of total healthcare costs. According to National Institutes of Mental Health (NIMH), about 22% of adults in the U.S. suffer from a diagnosable mental disorder. A recent national survey found that more than 1 in 4 Americans received some form of treatment for a mental health issue during the past two years (Harris Interactive, 2004). Pharmaceutical use and their costs for mental health conditions are at record high levels in the U.S. society. The landmark study on the Global Burden of Disease found that the impact of mental illness on overall health and productivity is substantial—ranking second only to cardiovascular conditions in loss of disability-adjusted life years (Murray & Lopez, 1996). According to the Surgeon General’s report on mental health, the significance of mental illness is “profoundly under recognized” (U.S. Department of Health and Human Services, 1999). In the HERO studies, depression and stress were found as the two leading modifiable risk factors for healthcare expenditures (Goetzel et al., 1998).

*Disability.* Employees can also have health consequences that can result in missing enough time away from work to qualify for paid benefits in the form of short-term and long-term disability (Contie & Burton, 1999). During the disability period, the employer typically pays a major portion of the employee’s normal level of compensation as well as paying for the medical care costs. Due to rising disability costs, total absence management programs are becoming more popular among large employers (Brunelle, 2004). These kinds of programs take an integrated
approach and feature efforts to coordinate a disability manager with staff from areas of safety and injury prevention, wellness staff, and EAP and work-life and emphasize pro-active processes to speed the return to work process.

Workers Compensation. When a worker’s physical or mental health is damaged due to their work or job environment, the employee can file a workers compensation claim. In such cases, when legitimately experienced, the company must pay wage replacement to the employee as well as the healthcare costs required for treatment. Indirect costs are also incurred, including lost productivity, increased hiring and training costs, supervisor time demands, overtime pay, and possibly product quality issues generated by less skilled replacement workers. Recent research by consultants at Milliman U.S.A. estimated that the dollar value of these indirect costs is three or more times greater than the direct costs of wage replacement and healthcare (Gallagher & Morgan, 2002).

WORKPLACE PERFORMANCE COSTS

Unscheduled Absenteeism. In addition to the costs of longer absences from work that qualify for disability or workers compensation benefits, are the substantial but often unmeasured costs of casual or unscheduled employee absence. These figures are typically smaller than STD in dollars per event but are experienced by a much larger segment of the employee population and therefore can be very costly. When employees are not at work, they are not producing what their job requires and this can also negatively affect the performance of their work team and result in many indirect costs as well. Recent trends in HR data management can make it even more difficult to track unscheduled absence in a careful manner. Paid Time Off (PTO) record systems, which feature a variety of reasons for employee absence (including vacation) that are all rolled into one measurement bucket, can obscure health-related absences.

Productivity and “Presenteeism.” One of the most basic contributions of an employee is his or her ability to be productive on the job. However, employee productivity is not always at a consistently high level and can vary according to many reasons. When health and personal or work-life problems interfere with an employee’s ability to perform at normal levels of high productivity, this is considered a “presenteeism” problem. The person is on the job but “out of it,” as noted in recent feature article in the Harvard Business Review (Hemp, 2003).
Although medical costs tend to get the most attention from employers, innovative recent studies reveal that direct medical costs actually account for only a minor portion of the total health and productivity-related costs faced by businesses. For example, one study examined archival cost data from medical claims, pharmacy, absence, short-term disability (STD) and employee-reported productivity on validated survey instruments that assess presenteeism (Goetzel et al., 2004). The results, based on over 370,000 employees, found that presenteeism losses accounted for the majority of per person annual total costs for 9 out of the top 10 most expensive health conditions (only heart disease had the majority of total costs accounted for by medical claims).

**Turnover.** In addition to the costs of absenteeism and presenteeism are losses from worker turnover. National data shows that employee turnover is frequent—21% for companies with 1,000 to 5,000 employees and 24% for firms over 5,000 employees, according to the 2000 Society of Human Resources Management (SHRM) Retention Practices Survey. The full dollar cost of turnover can vary by many factors, but some estimates range from $25,000 per case and a range of 75% to 150% of a worker’s annual salary depending on the type of job (John-son, 2001).

**ORGANIZATIONAL RISKS**

A third area of business costs concerns the somewhat intangible area of risk. For many organizations, there can be severe costs associated with large-scale organizational changes (mergers, downsizing, and such). There also can be significant legal liability and direct costs when there are crisis events at work (such as violence, accidents and harassment). Companies must also contend with the consequences of natural disasters and terrorism incidents and help their employees cope with these kinds of critical incidents. EAPs have historically been a valued resource for companies to help plan effective organizational change, to help managers address workforce issues, and to better prepare for and respond to critical incidents (Ginzberg, Kilburg, & Gomes, 1999). While there are few research studies that document the specific financial costs to employers for these kinds of risk-management problems, their potential for large losses is real nonetheless.
PART 2: THE DRIVERS OF BUSINESS COSTS AND THE ROLE OF HUMAN CAPITAL

It is clear that there are many costs of doing business that are a source of serious concern for employers. One of the ways to try to control these cost increases is to identify and understand the principal causal factors (drivers) of these costs. If the drivers are identifiable, then it may be possible to implement intervention programs and services to help improve these conditions and avoid or reduce their costs. So, what are the main drivers of healthcare benefit costs and of employee performance costs?

Epidemiological research indicates that healthcare costs are in part escalating in response to certain demographic and societal trends (Gold, 2004). The current U.S. workforce is characterized by increasing age, poorer overall health status, greater obesity, and “baby boomer” generation workers begging to retire and the “sandwich generation” workers (those with both child care and elder care needs) moving into their prime work years with a full plate of responsibilities at home. One can add to this demographic profile the larger societal influences of a faster pace of life and work, rapid technological advances, globalization, and just more time spent working (Lewis & Dyer, 2002). These conditions are all associated with increased health risk, illness burden and stress-related responses and thus can lead to greater demand for healthcare services.

Human Capital. While it is difficult for a business to directly influence these kinds of demographic and larger societal factors, a company can determine how it treats its employees. Indeed, business success today requires more than just the effective management of physical capital (such as machines, inventory, and property); it also demands the effective management of human capital. A cover story in Workforce (February 2001) notes a company’s success is “embedded in its people and what’s in their heads.”

One of the most cogent arguments for the business value of human capital is presented in Leveraging the New Human Capital. In this new book, Burud and Tumolo (2004) offer an extensive review of the literature that addresses the business case for providing comprehensive and integrated work-life, mental health, wellness and organizational culture kinds of services. Their analysis, involving review of findings from over 50 studies, suggests that human capital performance practices have “overwhelmingly positive effects on business objectives that are pivotal
to success: employee creativity, commitment, productivity, health, recruitment and retention” (p. 216). In the book, they also review 13 studies on the link between human capital practices and customer satisfaction and loyalty. Also reviewed are 21 other studies that correlate human capital practices positively with the financial success of the organization. Although most of the research reviewed in their book is not conducted with experimental scientific methods, the sheer number of applied studies with consistent findings is encouraging.

THE HUMAN CAPITAL INDEX RESEARCH
BY WATSON WYATT

Also encouraging is the recent work by international consulting firm Watson Wyatt. These studies examined human resources practices of companies and tracked their actual financial performance as a business over several years (Watson Wyatt, 2002). The first study was conducted in 1999 and included data from more than 400 U.S. and Canadian firms that were publicly traded, had three years of shareholder returns and a minimum of 100 million in revenue or market value. Interviews were conducted around more than 30 kinds of HR practices relating to people management. These were coded into a Human Capital Index, a composite single measure that could range from 0 to 100. Results showed that use of these HR practices were significantly correlated with a 30% increase in market value.

The second WWHC study was conducted in 2000 and targeted global businesses. The survey featured over 200 questions and the data was collected in six languages. The sample included more than 250 companies from 16 countries, representing all sizes and sectors of the economy. The findings showed that improvements in 19 key HR practices were associated with a 26% improvement in market value.

The third WWHC study, conducted in 2001, assessed more than 500 North American companies. This sample included some larger companies, with average market value of over $8 billion and over 18,000 employees. The analyses combined the European data with new data to create a study pool of more than 750 firms from the U.S., Canada and Europe. The results of the aggregated study showed the same pattern as the two previous studies. The higher the Human Capital Index score, the higher the financial performance of the company. A total of 43 key HR practices accounted for an increase of 47% in stock market value. More specifically, when the 5-year shareholder return was examined in each
of three subgroups, a clear pattern emerged. Those companies with the lowest one-third of HC Index scores had a 21% shareholder return; the medium group averaged 39% return. The highest scoring companies had a 64% average return. Thus, a threefold difference was found between the low and high scoring groups of companies. Of the top five HR practices most strongly associated with business growth, “a collegial and flexible workplace” and “excellence in recruitment and retention” are both associated with work/family, EAP and wellness kinds of services.

Perhaps the most compelling finding was from analysis of the time over time data from the 51 companies who were in both the 1999 and 2001 studies. Results showed that the Human Capital Index score from 1999 was significantly correlated with future financial performance, at \( r = .41 \). Similarly, the company financial performance record from 1999 was positively correlated with future financial performance, at \( r = .19 \). However, the human capital correlation was significantly stronger than the financial performance correlation. Thus, future business success was relatively better predicted by how the company treated its people than by its own past financial performance.

These three studies are quite interesting, but it must be noted that they are correlational in nature and offer no direct proof that when a company does the kinds of HR practices that are human capital friendly, they will be more financially successful. It could be that some companies have the kind of organizational culture (or some other factors) that contributes both to business profits and to having management practices and benefits that take good care of their employees. The causal chain is not clear from these studies.

**THE HUMAN CAPITAL AND HEALTH AND PRODUCTIVITY MOVEMENTS**

There are a number of larger movements in the business world and in academia during the past decade that endorse a human capital model and emphasize the role of health and productivity management.

*Consulting Companies.* In his 1999 book *Human Capital*, Towers Perrin consultant Thomas Davenport provides a compelling case for how companies can benefit financially from taking an active interest in the welfare and success of their employees. Towers Perrin has a human capital consulting group and features an integrated health model for understanding the bigger picture of how various health and benefits ser-
vices are interrelated (Winn-Rogers, 2003). Most of the other major human resources and healthcare benefits consulting firms such as Anderson, Aon, Deloitte & Touche, Mercer, Milliman U.S.A., and Watson Wyatt also have a formal business focusing on human capital management services.

**Institutes.** The Institute for Health and Productivity Management (IHPM) has been gaining momentum during the past few years. IHPM is an organization of employers, health providers, researchers, and pharmaceutical companies that is dedicated to establishing the value of employee health as a business asset and an investment in corporate success. It holds a number of specialized conferences each year and publishes a magazine featuring new research in this area. A similar role is performed by the Integrated Benefits Institute (IBI–see Parry, 2003). IBI focuses on collecting benchmark data from medical claims as well as from disability, workers compensations, absence management and productivity areas. The data is then linked together at the individual employee level and analyzed to reveal opportunities for identification of high-cost/high-risk employees and thus for more coordinated health interventions. IBI has participated in a number of case studies of companies that have saved millions of dollars (compared to projected trend increases) after adopting more integrated health management practices.

**Academic Research.** The American Psychology Society has produced a series of detailed white paper for its Human Capital Initiative. This academic-based organization has pulled together a great deal of theory and high-quality empirical research findings on how psychological processes and services can help individuals cope with a variety of basic issues, including aging, literacy, productivity, substance abuse, health, and violence.

Taken together, there is a movement taking place in the U.S. and to a lesser extent in other countries as well that features recognition of the health cost savings, workplace performance gains and personal outcomes that are generated from a wide range of human capital management practices.

**PART 3:**

**WORKPLACE PROGRAMS AS A DRIVER OF HUMAN CAPITAL**

The evidence reviewed so far in this article suggests that the costs of business are increasing and that a significant portion of these costs are
driven by human capital problems. The next question, then, is what are the drivers of human capital? More specifically, what kinds of interventions are effective at addressing and improving the various health, work and personal life problems faced by employees and their families? The following sections address this question by reviewing the practices and outcomes from employee assistance/mental health, work-life and workplace wellness programs.

EAP AND MENTAL HEALTH

The primary job of an EAP professional is to identify and resolve workplace, mental health, physical health, marital, family, personal addictions or alcohol, or emotional issues that affect a worker’s job performance (Collins, 2000). Most EAPs also offer consultative and educational services around legal and financial issues that affect employees. Other aspects of EAP include services that support individual supervisors with their management and work team problems. Some EAPs also lead more strategic consulting around organizational change and development issues. EAPs typically offer preventative and reactive services for critical incidents (Everly et al., 2001).

Prevalence and Use. Employees at most large businesses today have access to an EAP. A survey of Fortune 500 companies in 1997 found that 92% of firms offered EAPs—a historic high level of market penetration among large employers (Sciegaj et al., 2001). Similar findings come from a 2000 Society for Human Resource Management Benefits Survey. It found a majority of businesses offering EAP services ranged from 48% for small employers to over 90% for the largest employers. However, many very small employers only have access to EAPs through their health plan medical benefits package and that was only for 17% (based on Mercer/Foster Higgins National Survey of Employee Sponsored Health Plans) (Teich & Buck, 2003).

Effectiveness and Outcomes. There has been only a handful of high quality experimental research work completed in the field of EAP. A recent review of over 30 workplace mental health research studies conducted in the UK found varying levels of methodological rigor to the studies, but consistent evidence of clinical effectiveness, workplace performance improvements and very high client satisfaction from EAP counseling (McLeod & McLeod, 2001). Most of the best research conducted in the U.S. was prior to 1990 and focused largely on issues of alcohol prevention and treatment referral in workplace settings (Roman
When including studies with less rigorous scientific designs, there are several dozen empirical case studies of EAPs that show high levels of outcomes in areas of client clinical change, workplace improvements in absenteeism, productivity and turnover, and a few that document savings in medical, disability or workers compensation claims (see reviews by Blum & Roman, 1995; EAPA, 2003). More typical of EA measurement practices in the business side are non-experimental studies based on follow-up surveys of clients. These studies show high levels of personal health improvements and self-reported workplace performance improvements after use of the EAP (Attridge, 2003).

Clinical Effectiveness and Medical Cost-Offset from Mental Health. One of the functions of an EAP is to appropriately refer employees to mental health treatment providers. The value of this assess and refer model depends on the success of the therapeutic services provided by the mental health colleagues. This raises the question of whether mental health treatments generally produce positive clinical outcomes. The answer is yes, according to a landmark review study that examined over 300 meta-analysis articles (each article itself a review of other many original studies; see Lipsey & Wilson, 1993). Large-scale survey research of lay consumers of mental health services in the U.S. has also found generally positive outcomes (Seligman, 1995; Harris Interactive, 2004). The appropriate use of mental health services is often associated with lower overall medical costs. This “medical cost-offset” effect has been demonstrated in many studies (Shemo, 1985), although it is not without some debate on the subject (Miller & Magruder, 1999). Some employers—as noted in a recent special report in HR Magazine (Tyler, 2003)—are starting to understand that savings in total healthcare costs can come from providing comprehensive mental healthcare benefits.

WORK-LIFE

Modern work-life programs include a wide range of services (Gornick, 2002). Typically, these services include: Workplace flexibility policies, paid and unpaid time off, caring for dependents (child and aging parents), financial education and support, and community involvement (Lingle, 2004).

The increased demand for work-life programs started in the 1970s and comes from both the changing demographics of the workforce that included more women and recognition from employers that to attract
and retain valuable employees it was good to offer a climate that sought to balance work and life. Authors of a recent national study of the stressful lives of U.S. workers concluded that “companies should have comprehensive work/life balance initiatives to support their personnel” (Hobson et al., 2001, p. 38). Human resources managers are also advocates of work-life programs for a number of reasons. One is the increasing need to respond to elder care issues (Grillo, 2004). In addition, as more employers are shifting the costs of health insurance coverage to the employee (what has been called “healthcare consumerism”), employee use of work-life balance programs can be promoted as an integral part of a self-care approach. A Watson Wyatt consulting survey of U.S. employers found that 77 of respondents believed that work-life programs improve employee satisfaction; 54% believe that they enhance employee health and productivity and 39% say they reduce healthcare costs (cited in Sherman, 2004). Indeed, according to the Director of the Alliance for Work-Life Progress, in many companies “work-life strategies are taking root in response to evidence that it pays to treat employees like external customers” (Lingle, 2004, p. 37).

Effectiveness and Outcomes. The relatively recent development of work-life as an applied industry has not allowed the opportunity for high quality scientific investigations of the best practices or the outcomes of its core services. Most of the research conducted in this area has featured sociological surveys (for example, see the Families and Work Institute), case studies of major employers, or client outcome studies from the major vendors in the work-life field. Unfortunately, the field has not enjoyed the kind of federal government research support that other more developed fields have had. Despite these obstacles, there have been over 100 studies and reports on the use and impact of work-life practices (reviewed in Work & Family Connection’s annotated bibliography, 2003). The book by Burud and Tumolu (2004) also reviews many of the key studies in work-life.

HEALTH PROMOTION AND WELLNESS

The core practices of worksite wellness programs include (Mulvihiill, 2003): (1) strategic planning to prevent disease, decrease health risks, and contain rising healthcare costs; (2) health screenings and risk stratification; (3) risk-related health management interventions (exercise, behavior change programs, educational newsletters, Web, self-care books,
nurse advice lines, and health coaching, disease management; (4) evaluation and metrics.

Health Risks and Work Problems. One of the foundational tenets of this field is that it is better to prevent health problems than to treat them later on. Thus, there has been a serious effort to understand the relationship between the risks for certain health problems and other outcomes. This focus has led to the development and widespread use of health risk appraisal (HRA) survey instruments to measure risk and target appropriate interventions. Research from StayWell Health Management’s database of over 100,000 employees with HRA data shows a consistent pattern of findings. The greater the number of health risks, the greater the level of absenteeism and work productivity loss (Gold, 2004). Similar associations are consistently found between the number of chronic health conditions a person has and also for worse perceived health status and greater days missed from work and productivity losses.

Wellness Programs. Reviews of published research studies have generally found supportive empirical evidence that comprehensive worksite wellness programs can improve employee health and improve work productivity problems (Aldana, 2001; DeGroot & Kiker, 2003; Pelletier, 2001; Riedel et al., 2001). The scientific evidence to date offers documented correlations between: (1) multiple risk factors and lower productivity; (2) chronic illness and lower productivity; and (3) participation in health management programs and improved work performance (Lynch, 2003). Indeed, in his presentation “Making the Business Case for Worksite Wellness,” StayWell researcher Dan Gold (2004) notes that there are over 100 published research studies of comprehensive worksite health promotion efforts, with the majority finding positive clinical and cost savings outcomes.

Nurse Lines. When employees call a 24-hour nurse advice line with acute health issues, various research studies have shown results in areas of savings in medical costs from avoided unnecessary use of the ER and doctor office and also from reduced workplace absenteeism and presenteeism (Otis, Attridge, & Harmon, 2003). A randomized controlled experimental study found evidence of dollar savings in medical healthcare claims from implementation of telephonic nurse advice lines (Otis et al., 1998). Follow-up surveys of over 77,000 employee users of a nurse advice line service indicated that about a third reported avoiding missing a day of work and about half reported improvements in their productivity at work (Attridge, 2004).

In sum, the major components of worksite wellness programs and related health management services have been evaluated in many studies.
The results of these studies have generally been positive for the clinical effectiveness, improvements in workplace performance outcomes and healthcare cost savings. Of the three kinds of HPM programs reviewed in this article, wellness and worksite health promotion has the most empirical support.

PART 4:
THE INTEGRATION OF EAP, WORK-LIFE AND WELLNESS

Since the early 1990s, companies have begun to offer more comprehensive preventive services that better address the psychological and social needs of employees as well as their physical health needs (Bergmark et al., 1996). Recent industry surveys suggest trends toward integration between EAP and work-life and there are expectations of even greater formal and informal business integration in the future (Herlihy, Attridge, & Turner, 2002). It is common for many companies now to offer some form of integrated EAP-work/life partnerships (King, 2002). The inherent collaborative nature of the modern work-life function has been described as: “Not all of these programs, policies and practices typically reside in one neatly organized and appropriately resourced department or function. Nor does the work-life professional independently ‘own’ much of the terrain in which it operates. The work-life function is, therefore, a highly collaborative endeavor that helps connect the dots between many other human resource efforts” (Lingle, 2004, p. 37).

Although EAP and Work-life have already become more closely aligned, there are emerging opportunities for their greater integration with both health and wellness programs. “Perhaps one the most exciting developments in the health and wellness field are the migration toward integration and coordination with other employee benefit services” (Mulvihill, 2003, p. 15). EAPs have already been successful at collaborating with disability and workers compensation (Brunnelle & Lui, 2003; Handron, 1997; Smith & Rooney, 1999).

The research to date suggests that there are a number of advantages to integration both for the employer and for the employees.

Integration Is Good for the Employer. When EAP, work-life and wellness programs are integrated there can be advantages for the company. These include the areas of greater efficiencies in overall program management, less administrative costs from only working with one or with fewer vendors, and a greater emphasis on preventive services and early detection across providers. Another area for added value is the op-
portunity for increased program participation from cross-referral of employees from one service to another program. This process can lead to a boost in overall utilization for the individual programs when integrated (Herlihy, 2000). Integration can offer some operational cost savings and thus a better ROI. Ceridian, a provider of EAP stand-alone and a combined EAP and work-life product, estimates that their employer clients receive a higher ROI from the combined service than from the EAP-alone service (Stein, 2002). These ROI outcome measures include increased employee retention and productivity, reduced healthcare costs and the reduction of redundancies in program management. One key area of potential benefit to employers from integration is the opportunity for better risk management and more effective delivery of crisis prevention services. The more that different areas can work together who have contact with employees and family members at times of need, the sooner the company can respond to a critical situation.

Integration Is Good for the Employee. There can also be several advantages of integration for the employee. Increased employee satisfaction can come from making the combined program use more pleasant and practical to use. Employees have one point of contact and don’t have to repeat their problems over and over to different people. The EAPA studies of professionals and vendors also noted several advantages of integration for the employee. For one, for employees with a mental health concern, it can be less stigmatizing to first contact an integrated program or a work-life office than to directly go to the EAP. It can also lead to greater awareness of the full range of services available to employees across the various program offerings. For example, an employee who calls a nurse about a respiratory issue can be introduced to a smoking cessation program offered through the wellness program and also work with an EAP counselor to figure out how to get the level of family support needed for successfully completing the stop smoking plan.

THE INTEGRATED VALUE MODEL

In a previous article, a conceptual model was described that defined the business value for EAPs as having five levels (Attridge, 2001B). According to this model, EAPs should strive to document their value to the company through client-specific activity that (1) establishes the need for EAP services, (2) profiles the use of the EAP, (3) measures the outcomes from users of the program, (4) translates these outcomes into
business dollar value metrics, and (5) connects the EAP outcomes and mission to the “big picture” of the organization’s interest in managing risk and creating a healthy workforce. This model was developed from analysis of over 200 studies of EAP and other kinds of health services.

More recently, this model has been extended to better specify the major kinds of outcomes from EAP services and their financial and business value (Attridge, Amaral, & Hyde, 2003; Amaral & Attridge, 2004). This Business Value Triad model focuses on three major kinds of outcomes of importance to most companies. The first outcome area is health claims costs, the second is human capital costs, and the third is organizational costs. The health claim cost value component includes the impact of EAP and related services on medical, mental health, disability and workers compensation claims. The human capital value component includes the value of improvements in employee absenteeism and productivity/presenteeism and enhanced employee recruitment and retention (avoided turnover). The organizational value component includes behavioral risk management, liability risk prevention savings, better organizational culture and increased morale and secondary impacts on human capital gains and health claims savings.

For the present article, the Triad model has been further revised to reflect the synergistic added business value potential from the integration of EAP, work-life and wellness (see Figure 1). In this new conceptual

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**FIGURE 1.** The Business Value Model for the Integration of EAP, Work-Life and Wellness
model each of the three service delivery areas can contribute independently to all three kinds of outcomes—healthcare claims, human capital and organizational. This part of the model is based on the research literature already reviewed as generally supportive of these kinds of outcomes for each program type. But in addition, when the services collaborate and work together in an integrated fashion there is the potential for even greater business value to the company (as represented visually by the overlapping circle section in the middle of the figure). This new part of the model remains to be empirically validated, but it suggests the areas of outcomes than can be examined in evaluation opportunities ahead.

Thus, the scientific evidence for making the business case for health and productivity is promising, but it is by no means conclusive. What is interesting about the critical reviews of the literature is that the nature of how the program is implemented appears to be the most significant driver of getting results. This suggests the need to identify and focus on the high-risk employees within a company and to use a comprehensive intervention program that is embedded with a supportive “healthy-company” culture (Attridge & Gold, 2004). Yet, this is not easy! But it can be done.

Model Programs. Some of the best examples of such programs are listed in the National Registry of Effective Programs (NREP). There are currently four workplace-based programs that have been reviewed and deemed “model programs” by the U.S. Government. These include the following programs: “Coping with Work and Family Stress,” “Wellness Outreach,” “The Healthy Workplace,” and “Team Awareness.” Each of these evidence-based programs has a multidisciplinary emphasis that crosses the boundaries of health and wellness, work and home, and the awareness of alcohol and workplace performance issues common to EAP (Bennett, 2003). These programs have been shown in controlled experimental research conducted in workplace settings to be effective at a number of significant outcomes such as greater awareness and treatment seeking for alcohol issues, reductions in binge drinking, and overall health outcomes.

Success Factors. These kinds of integrated services require high-level organizational commitment to both get started and then to promote it well enough to drive a high enough level of participation to create the outcomes that in turn result in an ROI that justifies continuation of the enterprise (Anderson et al., 2004; Lewis & Dyer, 2002). David Hunnicutt, the President of the Wellness Councils of America (WELCOA), considers seven factors that are critical for the success of worksite wellness
efforts (Hunnicutt, 2003). These include: getting senior level leadership support, creating cohesive wellness teams from diverse parts of the company, collecting baseline data to assess needs and outcome impact potential, crafting an operating plan with a multiyear agenda, choosing appropriate interventions, creating a company culture that supports health, and consistently evaluating outcomes (including participation rates, changes in employee knowledge, attitudes and behavior, and financial ROI). Program success comes from a high level of collaboration between the company and the providers of the health and wellness programs.

Case Examples. This collaboration issue is illustrated by a study of America Online (AOL). High levels of employee participation in an integrated EAP and nurse advice line program along with the provision of self-care books and newsletters had an estimated $5:$1 ROI, based on net cost savings from healthcare and workplace outcomes (Fuller, Attridge, & Doherty, 2001). High program use came in part from a well-managed and internally directed promotional campaign involving all health and wellness partners working together (participation increased over a six-year period from one-third to over half of employees). Similar success was achieved and documented in the award-winning Fairview Alive! program (see this volume, pp. 263-279). Burud and Tumolo (2004) also profile four companies (DuPont, Baxter International, SAS, and FTN) that exemplify how different kinds of adaptive work-life/wellness strategies, when implemented in a systematic organizational fashion, can result in dramatic bottom-line success.

PART 5:
CRITICAL ISSUES

The evidence reviewed so far has the following logic chain: (1) there is a strong need to control rising business costs in areas of healthcare, employee performance and risk management; (2) human capital factors are a significant driver of these kinds of business costs; (3) human capital management programs based in EAP, work-life and wellness traditions are widely available and have been shown in most research to be effective at reducing these kinds of business costs; and (4) these programs have the potential to be even more effective when offered in combination and included in a comprehensive integrated model. The points, if valid, support a general business case for the integration of EAP, work-life and wellness programs (and possibly other allied services).
So then why do many of the providers of these kinds of services tend to have a difficult time convincing their purchasers (HR leaders, company medical directors, benefits managers) that these programs have business value—there is a positive return on their investment (ROI)? To answer this, one must consider several “reality factors” that can limit the opportunity for being able to make the business case.

**Healthcare Data.** The irony in this field is that although most employers and healthcare benefits purchasers want to know if health intervention programs have a measurable business value, the hard data available to answer this quite reasonable question is rarely available for such an analysis. One primary data source is healthcare claims records (often considered the gold standard) and yet this system was designed to pay medical bills and is simply not well suited to evaluation purposes. The reason is that most of it is stored in transactional databases and aggregated around the kind of benefit, or the place of service (ER, MD office, hospital, etc.), or type of medical diagnosis. In contrast, one of the requirements for effectively evaluating the impact of these kinds of programs is to collect data at the person or patient-centric level, versus the typical benefit-centric model that aggregates data across people or benefits (Otis, Attridge, & Riedel, 2000). Thus, in day-to-day business, healthcare data usually is either not available, is inaccurate, or is too costly to obtain retrospectively.

**Workplace Data and Self-Report Tools.** The evaluation of workplace outcomes is even more difficult than healthcare claims outcomes. The first issue is a general lack of workplace performance data to even study. Less than a third of businesses routinely measure workplace outcomes (productivity and absenteeism) in enough detail to be able to accurately study the data (IBI, 2002). The lack of company administrative records of workplace outcome data has necessitated a shift toward self-report measures. A variety of validated self-report measures are now available to businesses (see Goetzel et al., 2004). Fortunately, the validity of some self-report measures in this area is now supported by empirical research. For example, a recent study of over 5,000 employees found that self-report measures of work limitations (based on a 15-minute survey assessed retrospectively, concurrently or prospectively) were correlated with company administrative data on adverse events in terms of absenteeism hours, workers compensation claims, short-term disability claims, group health claims dollars and pharmacy claims dollars (Allen & Bunn, 2003). A number of published, validated survey tools of health and work factors are now in the public domain. Many of these instruments are profiled in the 2004 *Platinum Book* by IHPM. One
of the most popular tools is the Health and Productivity Questionnaire (see www.HPQ.org), developed by Ron Kessler of Harvard University and based on normative data from over 200,000 respondents around the world.

Research Design Limitations. Another limitation is that even if there is good data available on health or workplace measures, the data often cannot be interpreted because of ambiguity around the causal nature of the forces at play other than the program or service of interest to the evaluation. Applied research on evaluation of workplace health outcomes often suffers from inherent limitations imposed by the business settings in which the programs are implemented (for EAP field see Attridge, 2001A; for work-life field see Nord et al., 2002; for wellness field see Anderson, Sexner, & Gold, 2001). The manner in which the delivery of these programs is set up is often inappropriate to scientifically test their impact. Programs are commonly offered to all covered employees as part of a broader constellation of benefit services and without a control group (or even a matched comparison group), it is difficult to test the unique causal role of the program versus other factors. This same problem affects almost all benefit-related programs (such as general medical procedures, pharmacy management programs, disease management). The other problematic design issue is the instability of the context. There are frequent changes to benefits design and to company and vendor data management systems that can render data from one period incomparable to other periods.

CONCLUSIONS

Employers are faced with tight budgets and increasing costs in many aspects of their business. The use of employee assistance, work-life, and health and wellness programs can be effective tools to care for the human capital of the company—its employees. When these kinds of HPM programs are designed in a comprehensive fashion, employers can expect to see a business return on their investment in the areas of reduced healthcare costs, reduced losses in workplace performance costs, and in managing the human risks to the organization. Although there is a great deal of research in this area to support these ideas, the scientific rigor of the evidence base is just beginning to yield quality findings that can be used to build a solid base from which to build the business case. However, if the early returns from the pioneers who have taken the lead in this area are accurate, then one of the ways toward greater profitabil-
ity and financial success is found in fully embracing the stewardship of their human capital.

At the most basic level, for companies in the U.S., the underpinning of the business case for offering these kinds of health and benefits services has been capitalistic in nature. It is based on the goal of making the company more competitive in its ability to attract and retain employees and to better manage the mandated costs of doing business associated with healthcare (Georgia Tech Human Resources Department & WorkLifeBalance.com, 2004). Yet, considering the larger societal need for these kinds of services, the employee-sponsored delivery channel now in place in the U.S. is a rather limited solution. Macro-level historical analysis of societal factors in the U.S. suggests that despite the progress by some leading employers to provide comprehensive work/family programs, the present piecemeal approach to offering such programs is “woefully inadequate” (Grosswald, Ragland, & June, 2001). Perhaps there is a need for a much larger-scale model in which the government—rather than employers—is responsible for providing. This kind of “socialistic” approach for offering human capital support services is more akin to the basic funding and delivery models found in the UK and other industrialized countries. While such a model is thought provoking, perhaps the best that can be done today in the U.S. is for more employers to appreciate the value—the business case—for providing these kinds of services and embrace the opportunity to invest more in their human capital, one company at a time.

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Introduction

Many employees suffer from emotional issues, family and home life conflicts, mental health concerns, substance abuse problems, and other health disorders that can interfere with doing their work effectively. The nature of work itself can also sometimes contribute to employee performance problems. In addition, societal changes and community problems (such as natural disasters, violence, economic distress) can influence employee health and behavior. Whether the source is from the individual, the workplace itself or greater society, many employers have turned to employee assistance programs (EAPs) to help respond to these kinds of problems. This chapter addresses the topic of EAPs, and their role in occupational health and wellness. It is organized into three main parts. The first part presents an overview of the EAP. The middle part reviews the research evidence for EAPs. The final part describes major trends in the field of EAP. Global expansion is also examined as a future direction for EAPs.

Overview of EAP

Before examining the evidence for EAPs and the current trends in the field, it is necessary to first understand the nature of EAPs. Thus, this part of the chapter provides an overview of EAP (Attridge, 2009a). It includes a brief history of the field, the primary activities of an EAP, the unique qualities that distinguish an EAP, the contemporary business models and major market types, the promotion and use of EAPs, and the professional standards that guide the industry.
Definition of EAP

EAPs are defined as employer- or group-supported programs designed to alleviate employee issues (Employee Assistance Society of North America [EASNA], 2009). Most employees use EAP services on a voluntary basis through self-referrals. Most often, the EAP is used for assistance with mild to moderate problems that cause acute stress (e.g., family/marital relationship issues, work problems, and legal or financial concerns), rather than for the treatment of more serious mental health and substance abuse disorders. The goal of these programs is to have a positive effect on restoring the health and well-being of the employee which, in turn, results in a return to higher productivity and improves overall organizational performance. Modern EAPs are complex programs that often feature interaction with work/life and other behavioral health services to address a host of mental health and, substance abuse issues, as well as workplace performance problems among employees and their family members. EAPs can reach employees through a combination of different channels, including face-to-face visits with counselors, 24/7 telephone calls, Internet resources, and onsite workplace events. Several kinds of operating models are available for EAPs—those that involve staff who work as employees of the same organization where they provide EAP services, programs that rely on external staff who work for a different company (a vendor of EAP services), and a combination of internally staffed services and externally provided resources.

Brief History of EAP

EAP services initially arose out of a need for a stable and skilled workforce during World War II. During the 1940s, companies in the United States figured that it might be more cost-effective to rehabilitate problem drinkers than to have a “revolving door” employment policy of repeatedly hiring and firing impaired workers (Trice & Schonbrunn, 1981). Thus, these early EAPs focused largely on alcohol issues of employees by providing outreach to, identification of, and early intervention for employees struggling with alcohol-related problems. This approach led to the emergence of Occupational Alcoholism Programs. These workplace-based programs grew in acceptance and number throughout the 1950s and 1960s. Since then, the EAP field has grown significantly and now addresses employee health and behavioral health problems, as well as work/life challenges in addition to retaining a specialization of supporting employees with addiction problems. In recognition of this wider scope of services, most EAPs are considered “broad-brush” programs that are designed to support multiple kinds of employee, family and workforce performance issues.

EAP Industry Today

Today, EAP services are benefits offered by tens of thousands of employers and used by millions of employees in North America and across the globe.

EAP in the United States. As the birthplace of the EAP, the United States has the greatest coverage of EAP services. The majority of large employers provide EAP benefits to their employees and often their family members too (Mercer, 2008). According to a national benefits survey of private sector companies conducted in 2008, EAPs are provided by 89% of large employers (500+ staff), 76% of medium employers (100–499 staff) and 52% of small employers (1–99 staff) (Society for Human Resources Management, 2009). As it is a challenge to directly serve smaller employers, collectives representing many small businesses in certain geographic locations, or through trade group associations, can now purchase EAPs.
Employee Assistance Programs: Evidence and Current Trends

EAP in Canada. Similar to the United States, EAPs have become the primary channel for many Canadian workers to get their first access to mental health care and addiction treatment services. In Canada, these programs are called EFAPs—Employee and Family Assistance Programs—and are particularly popular in unionized environments, and medium to larger size organizations (Csiernik, 2002). A national survey found that EFAPs were present in 68% of Canadian employers with at least 100 employees (Macdonald, Csiernik, Durand, Rylett & Wild, 2006). Although similar in most regards, EFAPs in Canada tend to emphasize services to the organization (see next section) more so than programs in the United States, and to also provide more extensive clinical counseling services to individuals.

EAP in Europe. Survey data from 2007 indicates that approximately 10% of organizations in the UK, Germany, Switzerland, and Denmark have EAP services (Buon & Taylor, 2007). Anecdotal evidences notes that the present day rates of EAP service offerings in this region are now somewhat higher (Athanasiades, 2011). EAP services in Europe are delivered mostly by external EAP providers who offer a broad array of counseling and other services designed to help employees with personal and work problems (Grange, 2005). As with EAPs in North America, an important focus of the EAPs in the UK is maintaining and improving workplace effectiveness and performance.

EAP Services

EAPs differ greatly in the level of workplace support, the degree of program integration, and the range of services provided to the organization, management, union and employees. However, there are five kinds of activities that are performed to varying degrees by all EAPs (see Table 21.1). These primary activities include: (1) Services for individuals; (2) Services for managers and supervisors; (3) Services for the organization; (4) Liaison services to support other programs and services; and (5) Administrative

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<th>Table 21.1 Primary services offered by employee assistance programs</th>
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Source: Adapted from EASNA (2009)
services for the sponsor/purchaser. Arguably, the most essential function of a successful EAP is its ability to provide confidential counseling services, free of charge, when it is needed on a 24/7 basis to employees, management and their family members. A recent survey of EAP professionals in the United States found that this aspect of EAP services was ranked first in its importance to defining “what an EAP should be” (Attridge & Burke, 2011). Similarly, a recent survey of human resources professionals in Europe found that various kinds of individual counseling were the kinds of services they wanted most to be provided by the EA programs at their organizations (Buon & Taylor, 2007).

Having quick and easy access to professionally trained and licensed counselors from an EAP is a very important benefit to organizations, as mental health and substance abuse disorders are among the most common and most costly problems affecting the workplace and yet they are profoundly undertreated. According to national epidemiologic surveys in the United States, about 1 in 4 people each year in the general population have symptoms that meet clinical criteria for having mental and substance use disorders, and yet two-thirds of them do not receive any treatment at all for their condition (Kessler, Chiu, Demler, Merikangas & Walters, 2005; Wang et al., 2005). Similarly high prevalence rates for mental health and addiction disorders and lack of treatment are found throughout the world (World Health Organization, 2011).

To appreciate the “assess and refer” role of EAPs, consider that on a covered population basis, roughly 10% of all employees in the United States have claims each year for use of some form of outpatient or inpatient mental health or substance abuse treatment services (Dentzer, 2009). However, most of these outpatient “treatments” are delivered by primary care doctors and tend to feature a medication only approach. For example, in the United States in year 2007, of the patients who used outpatient mental health care services, 57% received only medications, 32% received both medications and psychotherapy, and only 11% received psychotherapy alone (Olson & Marcus, 2010). Based upon the thousands of studies supporting the clinical effectiveness of psychotherapy (Lipsey & Wilson, 1993), a superior response would be for more primary care doctors to encourage the use of mental health professionals who can provide effective “talk therapy” types of treatments. And, yet, this is precisely what EAPs do every day, when an EAP counselor makes a referral to outpatient counseling benefits for the 10–25% of clients who have issues serious enough to merit further treatment.

**Unique Qualities of EAP: The Core Technology**

Although EAPs share some similarities with other providers of mental health and addiction counseling and with consultation to the workplace, the field of EAP is grounded in its own core technology. The EAP Core Technology represents a set of practices that defines the distinguishing properties of delivering employee assistance programming (Roman & Blum, 1985, 1988; Roman, 1990). The key elements of these components are presented in Table 21.2, and described below.

**Work Focus.** The primary reason for an organization to purchase an EAP service is to improve the at-work performance of their employees. This focus on restoration of work function is important because personal and work problems can impair an individual’s ability to carry out their work effectively and efficiently (Grange, 2005). EAP counselors are expert at the identification of employees’ behavioral problems, and it includes assessment of job performance issues (tardiness, absence, productivity, work relationships, safety, etc.). Consequently, the EAP service should be judged primarily on the basis of the success of the service to positively influence client improvement in job performance. As seen later in this chapter in the section on outcomes, EAPs often have positive results in the area of improving employee work performance.

**Manager Training.** For the EAP to be successful, the program must be understood by key employees at the organization. Given the important role of supervisors and managers in noticing problems
among their staff and making an informal or formal (for cause) referral to the EAP counselor for assistance, another core technology component is the provision of expert consultation to supervisors, managers and union stewards on how to use EAP policy and procedures for both employee problems and for management issues.

Linkages and Referral. The EAP should know the range of resources available to assist employees from within the company (called micro-linkages) and also from the surrounding local communities as well (called macro linkages). The EAP should be able to offer direction to troubled employees for what to learn about, where to go and what to do in order to improve their situation. Offering this kind of information that is tailored to the individual’s problem and local environment is empowering and spurs the feelings of confidence and self-efficacy that is needed to effectively respond to the situation and to make behavioral lifestyle changes. Most EAPs use a thorough initial assessment process, and maintain a database of current and accurate resources appropriate for referral to fulfill this core component.

Alcohol and Drug Abuse. Harking back to its early roots, EAPs have always had a substance abuse and addiction focus. The workplace offers a useful context for the identification and referral for individuals with drinking and drug abuse problems (Roman & Blum, 2002). Most EAPs provide confidential services to management and workers with substance abuse and misuse problems. A 2003 survey of over 800 professionals in the EAP field (Attridge, 2003a) found that 89% of EA programs offered alcohol or drug screenings. Another finding from this survey was that 92% of the alcohol and drug cases identified were employees of the organizations they supported, compared to only 8% who were nonemployees. Of these employees with alcohol or drug issues, about two-thirds were self-referrals, with the remaining one-third referred to the EAP by their supervisors due to performance or safety problems.

While almost all EAPs offer alcohol and drug screenings and referral, the higher-quality EAPs also have staff specifically trained and certified in providing clinical assessments and case management for people with substance abuse problems (Malain, 2010). For example, in the 2003 survey, about half of EAPs (54%) offered EAP Substance Abuse Professional (SAP) services. As a result of the expertise of the SAP specialists (over half in the study had 15 years or more experience), and the required use of long-term follow-up services, the vast majority of clients (89%) working with SAP specialists from EAPs went on to complete substance abuse treatment. Although used infrequently today, the appropriate use of constructive confrontation techniques by EAP counselors can lead some employees to get past their denial and agree to enter treatment for their alcohol or substance abuse problems.

Table 21.2 Components of EAP original core technology

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<tr>
<td>1</td>
<td>The identification of employees’ behavioral problems includes assessment of job performance issues (tardiness, absence, productivity, work relationships, safety, etc.)</td>
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<td>2</td>
<td>The evaluation of employee’s success with use of EAP service is judged primarily on the basis of improvement in job performance issues</td>
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<tr>
<td>3</td>
<td>Provision of expert consultation to supervisors, managers, and union stewards on how to use EAP policy and procedures for both employee problems and for management issues</td>
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<td>4</td>
<td>Availability and appropriate use of constructive confrontation techniques by EAP for employees with alcohol or substance abuse problems to encourage treatment</td>
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<tr>
<td>5</td>
<td>The creation and maintenance of micro-linkages with counseling, treatment, and other community resources for successful referral of EAP cases</td>
</tr>
<tr>
<td>6</td>
<td>The creation and maintenance of macro-linkages between the work organization and counseling, treatment, and other community resources for appropriate role and use of EAP</td>
</tr>
<tr>
<td>7</td>
<td>EAP has a focus on employees’ alcohol and other substance abuse problems</td>
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Source: Adapted from Roman and Blum (1985, 1988) and Roman (1990)
Contemporary EAP Business Models and Markets

While the types of services offered through the EAP may vary in breadth from organization to organization, they are typically delivered through one of three basic staffing models. The **internal model** is defined by EAP staff who are employees of the organization. The **external model** is when the sponsoring company or organization has entered into a contract for EAP services with an outside vendor. The **blended or hybrid model** shares elements of both of the other models, and it usually has a full-time EAP staff resident at the host organization, and also has external contract personnel involved in the delivery of EAP services (such as a network of affiliate counselors, specialist for crisis event support, and so on). These EAPs operate in a range of market contexts that reflect these different delivery models. Seven markets for EAP business have been identified based on model, organizational context and size (Amaral, 2010). These market types include internal programs for private sector organizations, internal programs for public sector organizations, internal programs for universities and colleges, internal programs for unions and other member-based groups, external programs serving national and/or international markets, external programs serving specific regions or smaller markets, and hybrid programs resident in one organization but also selling EA services to other local organizations (these are often in hospital or health care systems). According to a recent industry report (Open Minds, 2011), significant consolidation exists at the provider level in the United States, with three-fourths of the total market for external EAP services being controlled by only 10 firms.

EAP Promotion and Use

According to industry norms, the number of employee and family members who use EAP counseling services in a year for clinical support represents about 3–5% of the total number of all covered employees (Amaral, 2008; EASNA, 2009). When one also includes use of the nonclinical kinds of services, then the overall EAP usage rate is higher (often doubled). However, this metric depends on how the EAP counts the many services they provide—such as clinical counseling services, management consultations, organizational services, crisis support services, information and referral assistance, education/training, and other services it provides. Even so, this level of EAP service utilization is relatively small when compared against the 100% of an employee population (and their family members) that has access to potentially using the service. However, a more realistic usage target may be the segment of the working population each year who have some form of mental health and/or addiction problem that interferes with their ability to function properly at work or home. A recent national survey in Canada found that 12% of employees met this definition as having a mental health issue in the past year (Thorpe & Chenier, 2011)

In practice, EAP utilization varies widely from company to company. It is determined largely by how it is set up and promoted. At the high end is the full-service traditional EAP that is staffed with a core group of EAP professionals (likely with Certified Employee Assistance Professional (CEAP) status) who are employees within the organization it serves. These kinds of programs tend to have the highest levels of use (in the range of 10–20% rate) due to their high visibility and the ability of EAP personnel to interact frequently on-site with management at the organization to collaborate on workplace health and risk issues. At the other extreme is the external EAP that is given away as a “perk” when the organization purchases a comprehensive health or risk insurance benefit package (the EAP fees are rolled into the total cost and hidden from the purchaser). These so-called free EAP programs are typically under-promoted (if at all) and consequently have very little usage (less than 1%). But this low level of use can be acceptable to the organization when the business goal is limited to providing risk-management coverage by having crisis incident support services on call if needed and to at least
“offer” its employees access to a counselor (Burke & Sharar, 2009). In this regard, the phrase “you get what you pay for” certainly applies to EAP services.

Research has shown higher levels of EAP use when company policy specifically features the EAP (Weiss, 2003). Indeed, part of an effective implementation process for the EAP involves formalizing the availability and role of the EAP by including it in the written HR practices and policies for the organization and then including it in regular promotional communications to the employees at work and at home (Csiernik, 2003b). Regular and ongoing promotion of the EAP within the organization is also important because some users of services come to the EAP as referrals given by others in the organization, such as supervisors, union stewards, human resources staff, safety officers, medical personnel, disability case managers, and staff in other areas. Despite frequent communication and promotion for the EAP, stigma and discrimination against people with mental health and addiction problems can dampen EAP use, even though it is convenient and available at no cost. The result is that many employees who could potentially benefit from using the EAP do not because of their fears of discrimination or shame from others where they work (Mood Disorders Society of Canada, 2009). EAPs have attempted to counter this stigmatization issue through offering services at private clinic office locations away from the worksite, over the telephone and online via the Internet (Butterworth, 2001). Some EAPs have also folded the entry point into the program under the umbrella of larger and less stigmatized workplace services, such as Work/Life programs or corporate health and wellness departments. The EY Assist program at global financial services firm Ernst & Young is an example of this approach (Turner, Weiner & Keegan, 2005). When they combined the EAP, Work/Life and HR/benefits Web sites into one central function, the result was a higher use rate of 25% annually for the combined new program, compared to the 8% for the EAP separately, and 12% for the Work/Life program separately as stand-alone programs the year before.

EAP Professional Standards

The EAP industry offers voluntary certification of individual professionals and accreditation of provider companies. The Employee Assistance Professional Association (EAPA) is the largest professional organization for EAPs, with over 6,000 members worldwide. It offers the (CEAP) designation. The CEAP is a voluntary credential that identifies individuals as EAP professionals who have met established standards for practice (EAPA, 2010), and who adhere to the code of ethics (EAPA, 2009). Over 5,000 individuals have earned the CEAP designation (EAPA, 2006). It should also be noted that the accreditation process for EA programs was designed to ensure that providers meet specific minimum standards for quality practice and that clinical staff possesses the required qualifications and experience needed in order to provide high quality service (Maiden, 2003). In partnership with the Council on Accreditation (COA), the Employee Assistance Society of North America first created the accreditation standards in 2001 (Stockert, 2004). The accreditation process provided by the COA includes a comprehensive self-study program followed by an on-site review conducted by trained and experienced EAP peer reviewers. The COA accreditation standards are now in their eighth edition, and include 12 primary components with over 50 sub-areas. To date, there are 57 EAP programs that have been accredited by COA (Attridge, Tannenbaum, Wolinsky, Slater & Goehner, 2009). Note that this number represents only a small fraction of the more than 1,000 external providers who sell EA services in Canada and the United States (Amaral, 2010). Finally, those interested in learning more about EAPs are encouraged to get the recently published guide to EAP, called Selecting and Strengthening Employee Assistance Programs: A Purchaser’s Guide (EASNA, 2009). This 62-page document is available at no cost as a download from the Web site of the Employee Assistance Society of North America. Also, this guide and other related resources for employers are reviewed in a journal article (Attridge, 2010d).
EAP Evidence

This part of the chapter examines the state of the empirical evidence for EAP services. More specifically, it discusses the applied nature of EAP research, the historical themes of research in the field over the last 25 years, typical research findings for EAP clinical effectiveness, client satisfaction and outcomes, the cost-benefit of EAP services and some calculation issues in determining return on investment or ROI based on workplace outcomes.

Nature of EAP Evidence

The EAP field is grounded in a body of empirical and clinical evidence generated from hundreds of studies of individual, group and organizational-level EAP services. There are several research-based books and texts specifically on EAP services (e.g., Attridge, Herlihy & Maiden, 2005; Masi, 1984; Oher, 1999; Richard, Emener & Hutchison, 2009; Shain & Groeneveld, 1980; Sonnenstuhl & Trice, 1990; Wrich, 1980) and one scholarly journal dedicated to the field of EAP (Employee Assistance Quarterly; which changed its name in 2005 to the Journal of Workplace Behavioral Health: Employee Assistance Practice and Research). Over the past 25 years, over 500 peer-review articles on EAP have appeared in this journal alone, with the collected works from special issues also published separately as 13 edited books. In addition to this scholarly influence, as an applied industry, technical knowledge about EAP has been developed and shared over the years through participation at regular professional meetings and articles in several trade industry publications. EAPA hosts an annual conference (often drawing over 1,000 attendees) and publishes the Journal of Employee Assistance. EASNA also holds an annual institute and its’ members receive the Journal of Workplace Behavioral Health.

The applied nature of the service delivery context for EAP being enacted within complex and changing organizations, however, has limited the rigor of research in this area (Attridge, 2001a). The result is that the vast majority of EAP studies have been conducted with nonexperimental research designs (Arthur, 2000; Attridge, 2001b; Csiernik, 1995, 2005a). More typical of EA research are studies that use a single-group design based on within-person changes over-time on clinical and work performance indicators, assessed by counselors and other similar outcomes assessed at follow-up from self-report surveys of clients. The quality level of research has waned, though, since major government funding for alcohol-related programs involving EAPs dried up after the heyday years of the 1980s. A chronic lack of funding to support more sophisticated research has led to debates within the field about whether it should be regarded as a true profession (based on open sharing of evidence and research) or an industry driven by commercial interests (Masi, 2011; Roman, 2007). Of course, to be fair, the field of EAP has elements of both of these identities.

Historical Themes of EAP Research

A recent 25-year retrospective analysis was prepared that discerned the most prevalent themes among the 545 articles published during this span in the Employee Assistance Quarterly/Journal of Workplace Behavioral Health (Maiden, Kurzman, Amaral, Stephenson & Attridge, 2010). The “Top 10” topics, in order by frequency, are provided in Table 21.3. The range of themes is representative of the major issues of how EAPs are established, operated and evaluated. The most common clinical issues during this period included alcohol abuse, drug abuse, psychological/emotional problems, critical incidents/trauma and relationship issues. The global growth of the field is also noted. The topic area of health
promotion and health benefits—the one most closely related to the larger theme of this Handbook on occupational health and wellness—is also among the top areas of concern for the field.

**EAP Clinical Effectiveness**

The evidence shows that EAPs are often effective in improving the personal and clinical issues that prompted using the service. A review of over 30 workplace counseling research studies found varying levels of methodological rigor among the investigations, but came to the conclusion that there was consistent evidence for the effectiveness of EAP clinical counseling services (McLeod & McLeod, 2001). Improvements due to individual level EAP interventions have been measured from counselor assessments conducted at “case open” and “case close” points in time for each client user of the service, and also through self-report surveys of clients after their use of the EAP (Csiernik, 2003a; Csiernik, Hannah & Pender, 2007; Dersch, Shumway, Harris & Arredonondo, 2002; Harris, Adams, Hill, Morgan & Soliz, 2002; Philips, 2004). For example, results from a follow-up survey of 1,050 clients of an external model telephonic-based EAP service found that 75% of users reported reduced stress, and 73% reported improved health and well-being (Attridge, 2001c).

Basic clinical indicators of mental health and well-being, such as the *Global Assessment of Functioning* (GAF; Jacobson, Jones & Bowers, 2011), are also commonly used in evaluating EAP clinical services. For example, a study by the largest internal EAP in the world (Federal Occupational Health), with data from over 59,000 employees of the US government, found that GAF scores improved over 10% on average from “case open” to “case close” (Selvik & Stephenson, 2003). Other measures of patient functioning have been incorporated with similar success into counselor-based assessments and follow-up surveys (Greenwood, DeWeese & Inscoe, 2005; Harris et al., 2002).
EAP Outcomes

Research on the experience of individual users of EAP services has consistently found high levels client satisfaction (Attridge, 2003b; Csiernik, 2003b; Csiernik et al., 2007; Dersch et al., 2002; Harris et al., 2002; McLeod, 2010; Philips, 2004). Satisfaction levels are routinely at the 95% level or higher for the percentage of users being satisfied overall with the EAP services (Sealy, 2011; Selvik & Bingaman, 1998; Siddell, 2007). As EAPs serve organizations, it is no surprise that the literature also shows that they have a positive impact on a variety of organizational level outcomes. Numerous studies have found positive effects for crisis incident response services (Attridge & VandePol, 2010), consultation to managers for workgroup problems (Bidgood, Boudewyn & Fasbinder, 2005), support for workplace changes like mergers and layoffs (Ginzberg, Kilburg & Gomes, 1999), and more synergistic support of other employee health programs through integration of services (Csiernik, 2005b). EAPs also routinely show positive outcomes for employers in areas of job performance, such as reductions in absence days and improvements in work productivity. In his recent review of the literature in this area, McLeod concluded that EAP “counselling has a consistent and significant impact on important dimensions of work behaviour” (2010, p. 245). Given the primacy of this outcome area as the most common value generated from EA services, three examples of workplace improvement for individual clients of EAP are presented below:

Workplace Outcome Study 1—Workplace performance outcome data were collected from over 26,000 cases during a 9 year period from a large external EAP. The results revealed that the average rating on a 1–10 scale of the level of work productivity had rebounded significantly from 4.8 at before use of the EAP to 8.3 after use of the EAP (Attridge, Otis & Rosenberg, 2002). The after EAP use rating of 8.3 is just under the normative productivity level rating of 8.9 on the same scale that was obtained in a nationally representative sample of employees in the United States who had not used an EAP (Attridge, 2004). This study also found that almost half of the cases (48%) reported that they had been able to avoid taking time off from work because of their use of the EAP. The duration of this effect was an average of 1.8 days of absenteeism avoided per case.

Workplace Outcome Study 2—The EAP for the US government collected counselor-assessed ratings of employee productivity and absence over a several year period on over 59,000 EAP clinical cases (Selvik, Stephenson, Plaza & Sugden, 2004). The results showed that the percentage of employees using the EAP that had difficulty performing their work due to mental health factors was reduced from 30% of all cases to just 8%. There was also a significant reduction in work absenteeism and tardiness, with absenteeism changing from an average among all EAP cases from 2.4 days to 0.9 days, respectively, for the 30 days before use of the EAP, compared to the 30 days after EAP use concluded.

Workplace Outcome Study 3—Another study featured the analysis of before and after data obtained from over 3,500 employee users of a national external EAP in the United States (Baker, 2007). Among the approximately 40% of cases who had work performance problems before the use of the EAP, the average number of days with impaired work productivity was reduced from 8.0 before use to 3.4 after EAP use. This study also found that, 25% of all EAP cases reported missing at least a half day or more of work before their use of the EAP. Among this group, the average level of work absenteeism was reduced from 7.2 days to 4.8 days, respectively, for the 30 days before EAP use versus the 30 days after EAP use concluded.

The effects obtained in these three large-scale research studies, when averaged together, indicate that for employee users of EAP counseling services: (1) the number of days being absent from work in the past month improved by 1.00 day; and (2) there was a 22% improvement in their work productivity over the past month.
EAP Cost-Benefit

As with other areas of occupational health and wellness, it is important to be able to show the value of providing services beyond just user satisfaction and clinical outcomes (Attridge, 2008a). Over the past 20 years, several dozen studies have demonstrated the financial cost-benefit of EAPs (see reviews by Attridge, 2010b; Attridge & Amaral, 2002; Blum & Roman, 1995; Christie & Harlow, 2007). These studies have examined savings from a range of outcomes, including health care claims costs, disability claims costs, avoided employee turnover, and workplace performance costs due to lost productivity and days at work. The common finding is that use of EAPs by employees with more severe clinical issues have contributed to long-term net reductions in overall health care costs for individual employees and their families that far exceed the cost of the EAP services, even when including the short-term increases in the costs of providing appropriate professional treatment for alcohol/drug and mental health disorders. Several of the best examples of this research are the cost-benefit studies of the internal EAPs at Abbott Laboratories (Dainas & Marks, 2000), Chevron (Collins, 1998) and Southern California Edison (Conlin, Amaral & Harlow, 1996). The landmark cost-benefit study of the EAP at the McDonnell Douglas Corporation (Smith & Mahoney, 1990; see critique by Attridge, 2010a) was replicated a year later at the company’s helicopter division. Again, the analysis of objective company data revealed net cost savings from several areas over a multiyear period for the employees with alcohol/substance abuse and psychiatric problems who experienced EAP-directed behavioral health case management services, compared to other cases without EAP support (Alexander & Alexander Consulting Group, 1990). A key mechanism behind the positive results in these studies is that the EAPs were effective at helping employees with substance abuse issues to navigate successfully through the many treatment options available, and with providing follow-up support and case-management assistance after treatment to reduce relapse issues and improve return-to-work efforts (Attridge, 2010b). Indeed, sometimes the “leverage” that comes from the EAP counselor being affiliated with the employer or union can help an employee with substance abuse troubles to finally get into treatment in order to keep his job or union member status (Attridge & Bennett, 2011).

With regard to calculating a specific dollar figure from a cost-benefit analysis, researchers have documented Return-on-Investment (ROI) estimates of $3 or more (up to $10) return for every $1 dollar invested in the EAP (Blaze-Temple & Howat, 1997; Dainas & Marks, 2000; Hargrave & Hiatt, 2005; Hargrave, Hiatt, Alexander & Shaffer, 2008; Jorgensen, 2007; McClellan, 1990; Yamatani, Santangelo, Maue & Heath, 1999). It is important to note that the source of the cost-benefit examined in these studies is limited to the small subset of the total EAP counselor caseload that has more serious addiction or mental health issues and that the cost savings are only realized over a multiyear period of time. In contrast, the financial benefits from improved work performance (i.e., reduced presenteeism and absenteeism) are present in many more EAP cases (both mild and more severe) than are cost-savings from health care claims or disability claim cases and they are evident soon after EAP use (Attridge, 2010c). Because of these factors, workplace-based cost savings from EAP usually comprise the largest part of the total dollar return to the employer when it has been included in ROI analyses with several other sources of cost savings (Goetzel, 2007; Goetzel & Ozminkowski, 2006).

ROI Calculation Example for EAP Workplace Outcomes

Even though it is a common and consistently positive outcome, some EAPs are hesitant to present an ROI to their customer organizations that includes workplace outcomes. Perhaps this reluctance is due to concerns of how to best convert the workplace outcomes into financial metrics that employers will believe (Gallagher & Morgan, 2002). However, consulting experience in this area shows
that this “dollarzing” problem can be overcome (Attridge, 2002, 2007, 2008b; Fuller, Attridge & Doherty, 2001). The following math example illustrates the steps involved in this kind of ROI calculation.

**Hourly Compensation Rate.** To start, one needs to assign a dollar amount to an hour of work. Let’s assume a company has an average hourly wage of $20 paid to the employee directly (i.e., what is paid in their paycheck). Using the hourly paid wage rate is adequate, but incomplete in most circumstances that involve other company-sponsored benefits as part of the total compensation to employees. For full-time employees, the dollar value of company-paid benefits is thus added to the hourly wage rate to yield the full compensation rate. For example, it is customary to add 25% of the paid wage rate as an estimate of the additional compensation value of benefits (i.e., health, disability, retirement) paid by the employer on behalf of the employee ($20 wage rate X 25% = $5 benefit load value; so $20 wage + $5 benefit load = $25 total compensation rate). One could further adjust this rate for the mix of employees with and without benefits.

**Assigning Dollar Value to Work Absence Outcome.** What is a day of work worth in dollars? Some analysts treat absence days as worth only the sum of the hourly compensation rate applied to a typical day of work (Trogdon, Finkelstein, Reyes & Deitz, 2009). But this ignores the value of the lost productivity when the employee is not at work. Instead, what more advanced researchers do is to add in the financial estimate of the dollar value of work productivity (see below) as part of the dollar value of an absence (Goetzel et al., 2004). While this approach creates a much larger dollar value, it is actually more realistic from a business perspective. Why have a worker at all if all he returns in financial value back to the business is a dollar amount that is equal to his level of compensation? This break-even logic is not used by the business to justify hiring a new worker; therefore, it should not be used in a ROI analysis.

**Assigning Dollar Value to Work Productivity Outcome.** What is an hour of productive work worth in dollars? Although this question can be answered in many ways, one simple approach has been to apply what is called a “Revenue Capacity Factor” (RCF) as a mathematical multiplier to the rate of employee compensation to reflect the capacity that an employee has to generate revenue or financial benefit (broadly considered) to the organization from their work. The RCF for each employee varies due to many factors, such as job grade and role within the organization, as more senior and more skilled employees are worth more (as this is usually reflected in their having higher compensation relative to other less tenured or less skilled staff). A conservative default RCF is 2.0. Thus, assuming a $25 per hour compensation rate X 2.0 RCF = $50 productivity value per hour for an employee working at normal productivity. For an employee who is at work but only working at 50% of his normal level of productivity (called presenteeism), this is a dollarized loss of $25 per hour ($50 per hour compensation X 50%). Applying this to the dollar value of work absence, missing one full day of work (at an 8 h work shift) is a productivity loss to the employer of $400 (8 h X $50 per hour as all of the productivity is lost). The loss of the compensation is then added to this lost productivity total as well (assuming the employee has a certain number of paid days off from work per year).

**EAP Outcome Return.** The estimated financial value of work productivity and work absence can now be applied to the outcomes data from the EAP. The financial value of the avoided further work productivity loss from EAP is $1,750 per case. This is based on 20 work days of 8 h per day in a month for a full-time employee (160 h) at 22% improvement per hour in productivity. This results in 35 h of productivity return at $50 value per hour. The financial value of avoided further work absence is $600 per case. This is based on a combination of two parts: Part 1 = 8 h for one day of avoided absence X paid compensation, which is 8 h X $25 per hour = $200; and Part 2 = the lost productivity that was due to missing work altogether and having zero productivity = 8 h of full productivity loss X $50 value of productivity per hour = $400; combined these two parts are worth $600.
**EAP Outcome ROI.** These two savings metrics are used to calculate the summary ROI figure, using the math below:

- Workplace Return per EAP clinical case = $1,750 productivity + $600 absence = $2,350
- Workplace Return Total = $2,350 per case X number of total clinical cases
- Assume annual clinical case use rate = 4% of covered employees
- Assume covered employee base of 1,000 lives
- EAP clinical case count = 4% X 1,000 = 40 cases at EAP relevant to outcomes
- Total Return = $2,350 per case X 40 cases = $94,000
- EAP fee = $30 per employee per year (PEPY)
- Total Investment in EAP = $30 X 1,000 employees = $30,000
- ROI = $94,000 Return / $25,000 Investment
- ROI = $3.1 : $1

Thus, for every $1.00 invested in the EAP, the return is $3.13 dollars. In practice, this figure can be adjusted, if needed, depending on if employees have paid time off from work or not (or if one contends that lost productivity during work absence is made up again in the future through extra unpaid overtime work), what is the appropriate RCF rate, what is the most relevant period of outcome effect duration (only 1 month in this example), and so forth. But regardless of how it is adjusted, considering that this ROI figure of $3.1 : $1 is derived only from the financial value of two kinds of workplace outcomes, it is undervaluing the true ROI from the totality of all of the services provided by the EAP. For example, it would be higher if the dollar value of EAP outcomes representing other areas of return, such as from health care cost savings, disability claims savings, avoided employee turnover cases, and so forth—were added to the full ROI analysis model.

### EAP Trends

This part of the chapter examines various trends in the field of EAP. Current initiatives are occurring for EAPs and alcohol issues, disability cases, work/life, wellness and prevention, employee engagement, and technology. Also presented are the findings of a new research study of EAP Trends from the perspectives of professionals in the field.

#### Trend 1: EAP and Alcohol Issues

The last several years have seen renewed interest in the early core technology EAP focus on alcohol and addictions (Attridge & Wallace, 2009). EAPs are being asked to do more in the area of early identification and encouraging access into professional treatment. The Screening, Brief Intervention and Referral to Treatment (SBIRT) approach is being used by many EAPs to identify and manage risky and hazardous alcohol use and dependence within the workplace (McPherson et al., 2009). EAPs are also providing training to other staff at partner programs (such as wellness and work/life) on how to use scientifically validated brief screening tools that can help identify mental health and substance abuse problems among clients of their programs (Bray et al., 2009; Goplerud & McPherson, 2011). These screening tools can be added to population health risk assessments, to intake processes in other health management or coaching programs, and at primary care settings. A driver of this trend for SBIRT activity by EAPs is that most experts now consider addiction to be a chronic, relapsing brain disease with a complex etiology and clinical course (Gearhardt et al., 2011; Saitz, Larson, Labelle, Richardson & Samet, 2008). This view of addiction demands a more sophisticated approach to treatment. Most addiction treatment providers offer patients with mild or moderate severity symp-
toms brief and episodic care, with little or no long-term follow-up (McLellan & Meyers, 2004). In contrast, chronic disease management care approaches—such as the Physician Health Plan addiction care programs in Canada (Brewster, Kaufmann, Hutchison & MacWilliam, 2008) and the United States (McLellan, Skipper, Campbell & DuPont, 2008)—have more than doubled the typical success rates of the best episodic addiction service programs. PHP has seen success rates for abstinence from alcohol and drug use as high as 85% of all program participants over 5 years. These PHP programs use a holistic model that includes qualified service providers, a progression from more intensive to less intensive care settings, case management, family centered care, and long-term monitoring to manage relapse. The success of this approach indicates that it is possible to improve outcomes in addiction treatment by adopting elements of the chronic care approach and strengthening linkages across the continuum of care (Norlien Foundation, 2011).

**Trend 2: EAP and Disability**

Another trend is for more EAP support of employees on disability leave for mental health and addiction disorders (Attridge & Wallace, 2010, 2011). Mental health disability affects between 1 and 2% of working adults each year, and is the fastest growing health-related disability in the United States and Canada over the past 20 years (Sroujian, 2003; Williams, 2006). The past decade has seen a dramatic rise in the costs of disability-related claims (Carruthers, 2010). Once an employee has a disability, employers and unions are required to make every reasonable effort, short of undue hardship to the company, to accommodate these workers. Implementing a Return-to-Work (RTW) program meets the employer’s legal duty to accommodate. The goal of RTW is to facilitate the return of disabled workers to safe, meaningful, and productive work. These programs are based on the philosophy that people can safely perform progressively more demanding levels of work while also participating in the process of recovery and getting medical and/or mental health care for their problem. These programs must be collaborative and sensitive to the particular challenges in preparing the employee to return to work after treatment for addictions in order to avoid a relapse (Pomaki et al., 2010).

An ally for disability case managers can be the EAP (Brunnelle & Lui, 2003). For the employee who is on disability leave, the EAP can provide RTW support services, such as preparing the supervisor and employee for reentry into the workplace. EAPs can also assist with psychological job analysis and provide supervisory consultation and educational services on an ongoing basis to assist those at the work site while the employee is away on leave. Due to the frequent comorbidity of mental disorders with other medical conditions, some employers now mandate a psychological clinical assessment as part of the requirement of anyone applying for disability benefits—not just those with mental disorder as the primary cause (The Hartford Group, 2007). The EAP may be able to perform these assessments or assist with making referrals to others who can provide it. Thus, the EAP can provide a valuable role in coordinating such care and supporting the employee and their family through this transitional period.

**Trend 3: EAP and Work/Life**

Collaboration with other benefits programs has been a growth area for EAPs in the past decade. Many EAPs now partner with a wide range of other workplace-based programs and benefits. The number of EAPs with “integration activity” increased from about 1 in 4 in 1994, to over 1 in 3 in 2002, and it is now present at the majority of all EAPs (Herlihy & Attridge, 2005). The most common integration partner has been with work/life programs and services. Work/Life programs include a wide range of
services (Gornick, 2002). Typically, these services include: workplace flexibility policies; paid and unpaid time off; childcare; eldercare; financial education and support; and community involvement (Lingle, 2004). Work/Life services focus on normal life experiences, such as finding appropriate care for aging parents and attempts to prevent more serious problems developing due to personal or work stressors an individual may be facing. Often, the focus of these services is saving the employee time by carrying out time-consuming research rather than tackling problems that the employee could not manage as effectively own her own. Part of the reason for this growth in integrated programming is a natural development response to the rise in the popularity of work/life programs and the benefits to the organization from greater collaboration between EAP and work/life (Attridge et al., 2005; Csiernik, 2005a). The EAP and work/life fields often share similar goals of supporting employees and working families, while also supporting the needs of the employer and the broader workplace (Jacobson & Attridge, 2010). Both fields have a work focus and embrace the notion that one’s work life and personal life influence each other. Both fields also typically report to HR or another department within the work organization, with services being managed internally but having most of their client-contact services provided by a network of external contractors. In many companies, EAPs and work/life services are provided by the same program or sold under the same contract; however, they may actually be business arrangements in which one program partners with another program to meet the needs of an organization. The 2011 Open Minds Industry Report noted a large increase since 2002 in these kinds of integrated models, with EAPs now being routinely bundled with providers of work/life services as a “one-stop shop” program for employer purchasers.

**Trend 4: EAP and Wellness/Prevention**

Although EAP and work/life are already closely aligned, EAP’s also have a growing role in supporting wellness and health prevention programs (Goetzel & Ozminkowski, 2006). According to (Mulvihill, 2003), the core practices of these programs include the following: (1) strategic planning to prevent disease, decrease health risks, and contain rising health care costs, (2) conducting health screenings and risk stratification, (3) providing risk-related health management interventions (exercise, behavior change programs, health coaching, educational materials, nurse advice lines, and disease management), and (4) ongoing evaluation and metrics. Wellness programs reach employees and their family members through many different channels, including office visits, phone calls, Internet resources, and onsite workplace events (such as wellness fairs and health risk screenings). Many EAPs now support employee in making lifestyle behavioral changes after learning the results of health risk appraisal (HRA) screenings (Birkland & Birkland, 2005). Employees struggling to change chronic behaviors related to weight loss, diet and nutrition, and smoking cessation particularly value this kind of encouragement and practical advice. EAPs also are playing an increasing role in identifying and treating chronic behavioral health conditions (such as depression and anxiety) that negatively affect productivity and quality of life (Caggianelli & Carruthers, 2007).

A recent survey of 200 professionals in the EAP field provides evidence of the role of EAP in supporting prevention and wellness (Bennett & Attridge, 2008). The study assessed the percentage of respondents that provided eight different types of “prevention services” at their EAP at least on a quarterly basis. The results revealed that the most frequently offered prevention services were alcohol screening/training (41%) or drug screening/training (40%). Other findings were that about 1 in 4 EAPs regularly conducted screening and training for depression (25%), for workplace violence/bullying (23%), and for other health management issues (such as anxiety; 17%). EAPs also conducted prevention-oriented trainings on fostering better relationships among work teams (32%), and at home in the area of personal/marital relationships (15%). In contrast, few EAPs conducted cardiovascular
screening/training (9%). Thus, in this study, roughly a third of EAPs delivered prevention services on mental health, substance abuse, and workplace behavioral risk issues.

**Trend 5: EAP and Employee Engagement**

EAPs can also get involved with company-wide efforts to improve the overall health of the organization by increasing employee engagement (Pugh & Dietz, 2008; Seidl, 2007). *Work engagement* is a term used to describe the extent to which employees are involved with, committed to, enthusiastic and passionate about their work (Macey & Schneider, 2008). Many organizations now engage in company-wide measurement of employee engagement levels and related constructs (Attridge, 2009b). The results of these measurement programs can then be used to improve HR practices and employee benefit services and other training programs, all of which are activities that EAPs can help to coordinate and implement as changes at the organizational level (Hyde, 2008). EAPs could add specific items on engagement to their intake and follow-up clinical assessment processes to measure changes in employee engagement for individual users of the EAP. The finding that strength-based styles of management and supervisory communication can improve employee engagement is good for the EAPs that have staff experienced at providing training in this area of positive psychology (Taranowski, 2009). Thus, the engagement movement has created a greater potential role for EAP to better serve their employer clients through offering assistance in measurement and training areas that support improved engagement at both the individual and the organizational levels.

**Trend 6: EAP and Technology**

There is an increasing use of new technological modalities to assist employees to better manage their health and to get access to related services. Web sites for EAPs are becoming more elaborate and now typically offer access to lists of counselors and other care providers, tip sheets, educational webinars, and a wide range of self-assessment tools (Richard, 2009). The use of Internet-based tools for the delivery of clinical services is less common, but is advancing as a new practice model (Klion, 2011). The early adopters of online clinical services have been more prevalent among Canadian EFAPs (Parnass et al., 2008; Wittes & Speyer, 2009) than among EAPs in the United States. In general, the technology for providing online therapeutic services for mental health and addiction treatment is widely available. This kind of clinical care is called a variety of names, including online therapy, cybercounseling, e-counseling, Internet-based therapy, among others (Christensen & Hickie, 2010). The majority of online therapy today takes place via exchanges of e-mail between the client and counselor. Less popular is the practice of online therapy that takes place in “real time,” often using chat-based computer interfaces (e.g., via Instant Messaging—IM) or specialized Web site tools for live videoconferencing sessions between client and counselor (Richardson, Frueh, Grubaugh, Egede & Elhai, 2009). Other applications in this area feature the interaction of multiple clients at the same time for supportive group therapy, with the interaction managed by a counselor (Griffiths, Crisp, Christensen, Mackinnon & Bennett, 2010).

One reason for the trend in techno-therapy is that the stigma associated with addressing addictions and delivering prevention programs is reduced when using the Internet, where it can be accessed at anytime, from anywhere with relative anonymity and privacy. Another reason is that these services are appealing to people who may otherwise go untreated because they do not like certain aspects of in-person therapy. In addition, many people already trust and use online technologies as an everyday part of their lives for banking, health care, social networking and other purposes and extending this
use to get help for psychological issues is a reasonable next step (Leibert & Archer, 2006; Young, 2005). A growing body of international research indicates that Internet-based delivery of mental health psychotherapy services for many common mental health conditions is as effective as traditional face-to-face treatment conducted in clinical offices (Attridge, 2011). More than a dozen high quality studies using a randomized control trial (RCT) experimental research design have tested the general clinical effectiveness of Internet-based psychotherapy (Griffiths & Christensen, 2006), and many more studies have been done using a variety of less rigorous research designs. All combined, the general finding is for positive clinical outcomes from online therapy (see reviews by Barak, Hen, Boniel-Nissim & Shapira, 2008; Reger & Gahm, 2009; Rochlen, Zack & Speyer, 2004). Thus, e-therapy has strong research support that provides evidence of its clinical effectiveness, particularly for common kinds of mental health cases with mild or moderate severity that typify EAP counseling services.

New Study on EAP Trends

A new research study explored the trends in EAP from the perspective of those in the EAP field (Attridge & Burke, 2011). This study surveyed senior level EAP professionals to explore trends in the use, importance, business value, and perceived viability of key kinds of EA services. The potential for providing more strategic consulting by EAPs at the organizational level was also examined. A final issue of interest was to determine which societal trends are shaping the future of the industry. Before getting to the results, the study procedures and sample are noted.

Study Methodology. Survey data were collected via a secure Web site from 150 professionals in the EAP industry from the United States and Canada. Most of these people were in senior management or clinical leadership roles, and were associated with the EAP field in a variety of ways, including working for external vendors of EAP services (51%), working for internal programs (23%), being an individual provider of clinical services (11%), being a consultant or academic (5%), or “other” (9%). Seven EAP services were included: (1) counseling with assessment, brief clinical support and referral, (2) management consultations and organizational support, (3) critical incident response, (4) integration of EAP with work/life and wellness, (5) high-risk case finding and long term case management, (6) support for employees on STD/LTD disability leave, and (7) technology and Web-enabled services. These services were rated on three issues: (a) estimated frequency of use, (b) importance to defining what EAP should be, and (c) trend in business value in the marketplace.

Study Results. The study identified three major groupings of services (see Table 21.4). The first cluster of services is called the Core EAP Services. These include counseling and referral for individual employees, manager consultations and organizational support, and critical incident response. The second cluster of services is called the “Pareto” EAP Services. The services involve using the EAP to find and support individuals in need of behavioral health expertise for treating high-risk conditions, and for assistance with return-to-work for mental health and addiction disability. The term “pareto” refers to the economic concept of a small segment of a population that is associated with a large share of an outcome of interest (in this case, a few cases that create a large annual cost in health care expenses and work performance losses). The third cluster of services is called Connecting EAP Services. These services use the Internet and other new technologies to connect employees to counselor and other resources, and also the benefits of integration of the EAP with Wellness and Work/Life programs to better engage individuals in self-care, prevention and family support services.

The Proactive EAP. While acknowledging the need to continue to provide the EAP core services and to expand the pareto and connecting kinds of services, there is also merit in adding a new set of services through which the EAP has a more proactive and strategic role within the organization (Burke & Paul, 2011). Many organizations are hungry for services that can help them address more complex
issues at the organizational level. Issues at the top of this wish list include how to foster greater employee engagement and productivity, how to retain talent and develop their executives, how to comprehensively support employees with high-risk complex health conditions, and how to create a healthy and psychologically safe work culture for all employees. This issue was examined in the study with a qualitative question:

> Given your knowledge of the marketplace, can the value of an EAP be enhanced by also offering services that provide more of a strategic, proactive and consultative approach to the organization?

The results found that 91% of the sample responded favorably to this question. Thus, more than 9 in 10 EAP professionals recognized the opportunity for EAPs to become more proactive and strategic in focus. Many of the respondents lamented the limitations of having a largely “reactive model” of EAP practices with use of the EAP being dependent upon self-referrals. Others felt that the basic model of service should be reengineered. EAPs could take better advantage of their positive reputation as being experts in handling psychological and behavioral issues in the workplace. Some commented that EAPs are too isolated and need to be more deeply integrated into wellness and other workplace sponsored employee and family support programs. This would mean that assessments and referrals could be done more rapidly and more systematically via shared technological tools and by more regular interaction between the staff in different programs. However, a caveat is in order because roughly 1 in 4 of the respondents—although still positive in general—also expressed some reservations about making this kind of proactive service offering a reality for their EAP business.

**Influences on the Future of EAP.** A second qualitative item asked about which societal trends are shaping the future of the industry: *In the bigger picture, what societal or business trend do you think will contribute most to the viability and success of the employee assistance industry in the future?* The results for this item yielded the following four themes. Technology was the most commonly cited influence, with social media, online services, instant access, and self-management via technology as key aspects. For example, a 67-year-old female clinical consultant had the comment that “Technology and web-enabled services for education, self-care and clinical support from EAP counselors

### Table 21.4 Results of Survey of 150 EAP industry professionals

<table>
<thead>
<tr>
<th>Service type</th>
<th>Outcome measure</th>
<th>Estimated level of use</th>
<th>Importance to defining EAP</th>
<th>Business value trend</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sample Size</strong></td>
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<td></td>
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<tr>
<td>Rating</td>
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<tr>
<td>Core EAP</td>
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<tr>
<td>Counseling</td>
<td>01–01–25–73</td>
<td>01–08–91</td>
<td>18–61–21</td>
<td></td>
</tr>
<tr>
<td>Crisis</td>
<td>01–15–49–35</td>
<td>01–21–78</td>
<td>09–47–44</td>
<td></td>
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<tr>
<td>Pareto EAP</td>
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<td>Connecting EAP</td>
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<tr>
<td>Integration</td>
<td>04–23–37–36</td>
<td>05–41–54</td>
<td>12–28–60</td>
<td></td>
</tr>
</tbody>
</table>

*Source: Adapted from Attridge and Burke (2011)*

*Note: Numbers in the table are the percentage of the relevant total sample for each outcome measure. The figures in the rows for each service type within each column add up to 100%*

- NO not offered, L low use, M medium use, H high use
- L low importance, M moderate importance, H high importance
- F fading value, S stable value, R rising value
[is needed] because of the societal focus on quick, easy 24×7 access that’s self initiated to address issues or secure information.” The second theme was of workplace change. Examples of change included health care reform and parity laws in the United States, the poor economy, increasing social and domestic violence, employee retention issues, an aging population, and globalization. For example, a 56-year-old male professor commented that: “We need more clarity about the role of the EAP in the medical insurance industry. Some health insurance plans offer EAP-type counseling as part of their services, although at no extra costs, but also without having the necessary EAP expertise.” The influence of the health and productivity movement on EAP was the third theme. This included issues of EAP partnering with other workplace programs and benefits, the impact of behavioral health issues on work performance, and creating a culture of health at the organization. A 52-year-old male CEO of an EAP commented that: “Promotion of employee mental health is just as important as physical health, which can lead to innovation and increased competitiveness.” The last theme for this item focused on concerns for the future viability of the industry. Examples included a need to restate the value proposition for EAP, changing the name from EAP to something else, and the need for more research and industry benchmarks to guide operational practices in order to avoid becoming a non-profession.

Summary

This chapter presents a research-based overview of employee assistance programs. The first part of the chapter provides an overview of EAP, with sections on the following: the history of the field, the primary activities of EAP, the unique qualities of EAP, the main models and markets, the promotion and use of EAPs, and the professional standards for the industry. This second part of the chapter examines the state of empirical evidence for EAP services. EAP is an applied field with active participation in various professional associations and meetings and it has an applied methodology to most of its research. The historical themes of research in the field over the last 25 years have focused on clinical issues of alcohol and drug abuse, psychological/emotional problems, and critical incidents/trauma and relationship issues. The research literature supports the clinical effectiveness of EAP and finds high levels of client satisfaction and positive outcomes in areas of health care costs and workplace performance. This final part of the chapter highlights several trends in the field of EAP, including renewed interest in EAP support for alcohol issues, disability cases, work/life, wellness and prevention, employee engagement, and technology. These themes were replicated and put into a more coherent interpretive model from the findings of a study of trends in EAP.

Conclusions

In conclusion, EAPs currently provide assistance to employees and their dependents for a variety of work-related and personal issues. These programs are found in most large and medium-sized organizations in North America. Individual counseling is shown by research to be the flagship of employee assistance, and is its most popular service component. EAP services are generally effective for the individuals who use them, and they tend to produce a positive financial ROI for the organization. But the present day version of EAPs is underpriced and underutilized, which suggests a need to change with the times and to innovate in ways that can bring more value to the organizations they serve. Several trends are driving EAPs to reexamine and redefine themselves. The 2011 trend study revealed strong agreement among EAP professionals concerning the opportunity for EAPs to play a more pro-active and consultative role in the workplaces they serve.
Along these lines, it may now be instructive to review how EAPs can support other aspects of occupational health and wellness. This is done by noting how EAPs fit into the topics of some of the other chapters in this Handbook:

- Chapter 6, on *Challenges Related to Mental Health in the Workplace* (by Dewa and colleagues), emphasizes the prevalence, variety, and deleterious impact of psychosocial issues common to working populations. This evidence supports why the need for EAP services in order to assist employees in the workplace with these kinds of problems.

- Chapter 8, on *The Problem of Absenteeism and Presenteeism in the Workplace* (by Howard and colleagues), goes into detail on the nature and extent of workplace performance problems of employees, which is a core technology focus for EAPs. Indeed, one of the most common positive effects for clients who use the EAP is a rebound in their work productivity levels and reduction in work absence.

- Chapter 10, on *Self-medication and Illicit Drug Use in the Workplace/Workforce* (by Fong), is devoted to the issue of drugs in the workplace. Alcohol and drug problems are an area that is the hallmark of what EAPs are good at supporting. Many EAPs today are involved with drug testing processes and offer case management to employees who self-refer for alcohol and drug problems.

- Chapter 11, on *Bullying and Violence in the Workplace* (by Jensen-Campbell and colleagues), examines a topic that is being addressed by most EAPs. How to best respond to bullying behavior of coworkers and to the issue of violence at work and at home is a frequent training issue, and a source of referrals to EAPs for consultation with managers and for counseling with affected individuals.

- Chapter 12, on *Mental Health Issues Related to Healthy vs. Non-Healthy Workplaces* (by Kirsh and colleagues), describes the organizational level issues concerning a positive work culture. This too is an area that some EAPs (particularly internal model EAPs) are getting more involved in supporting. This is a trend that likely will get more attention from EAPs.

- Chapter 13, on *Safety Issues and Enforcement in the Workplace* (by Sesek and colleagues), addresses areas that can involve the EAP, as well through the provision of worksite trainings, alcohol and drug testing support, and response for trauma resulting from serious safety incidents such as accidental deaths at the worksite.

- Chapter 15, on *Work-Family Balance Issues and Work-Leave Policies* (by King & Hammer), reviews a service area that is the most common integration partner for EAPs.

- Chapter 17, on *Health and Wellness Promotion in the Workplace* (by Shaw & Silje), focuses on the other major integration partner for EAPs in the last decade. EAPs have also become more involved with prevention goals through providing behavioral health risk assessments and related worksite trainings.

- Chapter 18, on *Job-stress Reduction Programs for the Workplace* (by Theorell and colleagues), examines issues of job stress and how to prevent and reduce the problems associated with stress at work. Many employees who seek out support from EAP counselors do so because of job stress. Similarly, many managers who consult with EAP staff are interested in learning how to reduce the stress from dysfunctional work team dynamics and corporate actions.

- Chapter 19, on *Primary and Secondary Prevention of Illness in the Workplace* (by Main and colleagues), is relevant to EAPs due to the growing recognition of the comorbid and exacerbating role of mental health and addictions in many medical illnesses. Some EAPs are also directly involved in supporting individuals to take effective action in their work and personal lives in ways that strive to reduce risks for mental health and physical health problems. Through the multidimensional assessment processes used at most EAPs, counselors can also help identify health risks that employees may not have been aware of and then direct the person to available resources.

- Chapter 20, on *Organizational Aspects of Work Accommodations in Mental Health* (by Schultz), one of the trend areas for EAPs who support employees on disability for mental health and
addictions issues. These EAPs often get involved in tailoring the return to work plans and interacting with the employee and the supervisor to encourage more effective accommodations are made once the employee is back at work so that they can stay at work.

**Future Directions**

Another significant trend that has only briefly been noted so far in this chapter is how EAP is going global. Due to its success, there is now market saturation, with many companies already having EAP services (at least among large and medium size employers) and also a mature product life cycle stage for traditional EA services in the United States and Canada. However, there remains significant growth for the EAP industry in other countries. This exciting developmental trend for the field is now reviewed. Indeed, various forms of EAPs are now active in many countries around the world (Maiden, 2001). As expected, the specifics of how EAP is defined and used varies based on the country’s legal system, culture healthcare system, treatment resources for mental health and substance abuse and views toward behavioral health and work/life balance issues. A recent book profiles EAPs in 50 different countries (Masi & Tisone, 2010). There are member chapters of the EAPA organization located in Australia, Canada, Greece, Ireland, Japan, South Africa, and the UK, and recent development activity for new member chapters in Chile and China. Over a hundred research articles have examined aspects of international EAPs (see Table 21.3). There has also been qualitative research on the progress of EAP development in many countries and regions, including Argentina (Lardani & Lorenzo, 2010), Australia (Kirk, 2008; Kirk & Brown, 2005), China (Yin, 2011) Europe (Hoskinson & Beer, 2005; Nowlan, 2006; Malhomme, 2008; Quinlan, 2005), Germany (Barth, 2006; Gehlenborg, 2001), India (Baskar, 2011; Henry, 2011; Siddiqui & Sukhramani, 2001), Ireland (Powell, 2001), Israel (Katan, 2001), and South Africa (Maiden, 1992).

In the European region a new professional association for EAP providers, called The Employee Assistance European Forum, was initiated in 2002 (Buon & Taylor, 2007). The activity of the EAPs in this part of the world is also the topic of new research project funded by a grant from the Employee Assistance Research Foundation (EARF, 2011). The study is entitled “EAP in Continental Europe: State of the Art and Future Challenges.” It will survey employers and employees in six European countries to examine the characteristics of existing EAPs and discover future needs of providers and customer organizations in the European region. A similar research project, also funded by EARF (2011), is now in progress by the US-based National Behavioral Consortium. It will survey EAP providers in North America to profile the operational characteristics and core business metrics that represent the current state of employee assistance programs. Thus, globalization offers many new opportunities for EAP (Burke, 2008). But there are also many contextual and cultural factors that must be appreciated for it to be successful. Indeed, as global EAP vendors have branched out into other countries, it has been necessary to use local counselors and other staff in order to provide services that match the language, cultural identity, and logistical needs of their customers. It is hoped that this indigenous staffing model will ultimately result in new innovations in EAP practices and products (Pompe, 2011). Alternatively, for the home-grown EAP programs that have started up recently in other countries that are trying to adapt aspects of existing EAP models and services from other places, it is a challenge to determine which elements of the core technology and primary services apply to their environment and will be effective (Masi, 2011). Just as each country is different, so must be the manifestation of EAP that supports the organizations in each country. Along with the escalating worldwide interest in EAP, the field is moving in several directions to enhance their value to organizations and better reach employees in distress. The evidence and trends reviewed in this chapter indicate that EAPs are uniquely connected to the workplace, and are able support organizational health and wellness in multiple ways.
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Presenteeism in the workplace: 
A review and research agenda

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Summary
Presenteeism refers to attending work while ill. Although it is a subject of intense interest to scholars in occupational medicine, relatively few organizational scholars are familiar with the concept. This article traces the development of interest in presenteeism, considers its various conceptualizations, and explains how presenteeism is typically measured. Organizational and occupational correlates of attending work when ill are reviewed, as are medical correlates of resulting productivity loss. It is argued that presenteeism has important implications for organizational theory and practice, and a research agenda for organizational scholars is presented. Copyright © 2009 John Wiley & Sons, Ltd.

Introduction

Absenteeism, generally defined as not showing up for scheduled work, has a long research history, due in part to its perennial cost to organizations and its status as an indicator of work adjustment (Harrison & Martocchio, 1998; Johns, 1997, 2008, 2009). However, it is only recently that presenteeism has become a subject of interest. Although some definitional confusion will be addressed in what follows, the most recent scholarly conception of presenteeism involves showing up for work when one is ill. Excitement concerning the subject has been fueled by claims that working while ill causes much more aggregate productivity loss than absenteeism (e.g., Collins et al., 2005) and by the idea that managing presenteeism effectively could be a distinct source of competitive advantage (Hemp, 2004).

In this article, I trace the development of interest in presenteeism and review its several conceptualizations. Then, I offer a definition to guide research that will contribute to both organizational theory and practice. The challenges involved in measuring presenteeism and related productivity loss are considered, and organizational, occupational, and medical correlates are reviewed. Finally, a research agenda for studying presenteeism is presented. A prominent subtext is that scholars in organizational behavior, human resources, organizational psychology, and health psychology have important theoretical and methodological skills that should be brought to bear in studying presenteeism.
Interest in presenteeism stems from two main but somewhat geographically distinct sources: (1) UK and European scholars in management (e.g., Simpson, 1998; Worrall, Cooper, & Campbell, 2000) and epidemiology or occupational health (e.g., Virtanen, Kivimäki, Elovainio, Vahtera, & Ferrie, 2003) who are concerned that job insecurity stemming from downsizing and restructuring forces exaggerated levels of attendance that result in stress and illness and (2) mainly (although not exclusively) American medical scholars and consultants, including those in epidemiology and occupational health, concerned with the impact of illness in general or specific medical conditions (e.g., migraine) on work productivity (e.g., Koopman et al., 2002). Among the latter camp, presentees are people who are “at work, but not working,” at least not up to their full capacity. In sum, the British and Europeans have mainly been interested in the frequency of the act of presenteeism as a reflection of job insecurity and other occupational characteristics, and the Americans have mainly been interested in the productivity consequences of this behavior as a function of various illnesses while ignoring the causes of showing up ill. Both lines of enquiry are legitimate, and one purpose of this review is to integrate these lines.

In medicine, pharmaceutical and other medical interventions have traditionally been evaluated in terms of two health-focused criteria, medical efficacy, and safety. In recent years, however, the increasing cost of health care, combined with the provision by employers of employee health plans, has led to a third criterion of interest, economic impact. Accordingly, employee health costs to an employer include the direct cost of any health plan, costs due to employee absenteeism, and costs due to reduced productivity among presentees not working at full capacity (Collins et al., 2005). The drive to find measures of productivity loss that are responsive to pharmaceutical intervention and might permit US Food and Drug Administration (FDA) approved productivity claims (Evans, 2004; Prasad, Wahlqvist, Shikiar, & Shih, 2004) has led to a proliferation of measurement instruments in a short period of time.

What Is Presenteeism?

According to the Oxford English Dictionary Online, the term presentee was first used by the American author Mark Twain in his humorous 1892 book The American Claimant. Subsequently, presenteeism made occasional appearances in business-related periodicals, including Everybody’s Business (1931), the National Liquor Review (1943), and Contemporary Unionism (1948). In all of these early uses, and through the 1970s, the term was clearly meant either to be the literal antonym of absenteeism, or to connote excellent attendance. It remained until the 1980s for more contemporary definitions to emerge, and, in fact, until the current millennium for the most contemporary.

Table 1 summarizes nine definitions of presenteeism given or implied in the literature, with illustrative references. It can be seen that although all of the definitions pertain to being physically present at work, they differ to a greater or lesser extent from each other, occasioning potential confusion. Presenteeism is variously portrayed as good (definitions a and b), somewhat obsessive (definitions c, d, and e), at odds with one’s health status (definitions e, f, and g), and often less than fully productive (definitions h and i).

It can be seen that a number of these definitions lack scientific utility. Thus, definitions a (presenteeism is the opposite of absenteeism) and b (presenteeism equals excellent attendance) are redundant, the former simply denoting the antonym of absence and the latter simply denoting low absenteeism. Similarly, definitions g and i, respectively, extend definitions f and h by allowing for the idea that presenteeism might involve attendance and associated productivity decrements in the face of
factors in addition to ill health (e.g., child care demands, office politics). This “definitional creep” beyond ill health is unhelpful, because it has no discernable boundaries and is unparsimonious.

Similar to Aronsson, Gustafsson, and Dallner (2000), the definition of presenteeism I employ is attending work while ill. This definition (f in Table 1) is the one employed by most organizational scholars and is also either explicit or implicit in all related scholarship published in the occupational health literature. Quite properly, the definition does not ascribe motives to presenteeism. Thus, although it remains an empirical question, it seems feasible that one might show up ill due to love of the job, or feelings of moral obligation, or job insecurity (cf. Johns & Nicholson, 1982, “the meanings of absence”). As will be illustrated later, there is some rudimentary construct validity evidence for measures centered on this definition in that they exhibit some face valid relationships with logical correlates (e.g., Aronsson & Gustafsson, 2005; Aronsson et al., 2000; Caverley, Cunningham, & MacGregor, 2007; Demerouti, Le Blanc, Bakker, Schaufeli, & Hox, 2009; Hansen & Andersen, 2008; Munir et al., 2007; Sanderson, Tilse, Nicholson, Oldenburg, & Graves, 2007).

Also quite properly, the definition given above does not ascribe consequences to presenteeism. However, one of the goals of this article is to integrate the interests of organizational scholars who have been concerned with precursors of the act of presenteeism and health scholars who have been concerned with the act’s consequences for employee productivity. As such, any resulting productivity loss implies productivity in comparison to what one would exhibit without the medical condition (e.g., outside the hay fever season); compared to being absent, a presentee might be relatively (or even fully) productive. Similar to the act of presenteeism, diverse motives might also underpin unequal degrees of productivity loss exhibited by people with ostensibly identical medical conditions.

It bears emphasis that occupational health scholars who are interested in productivity loss often label this loss itself as presenteeism (hence definition h in Table 1). However, this conflation of cause and effect under a single label is particularly unhelpful, because it strongly connotes that presenteeism is a negative event from the organization’s perspective, even though presentees will surely be more productive than absentees. Such framing (dominated by the intersection of medicine and economics) precludes more open and creative psychological and behavioral views of presenteeism. I assert that the causes and consequences of presenteeism must be established by empirical evidence, not by definition.

From an employee perspective, presenteeism is important in that it might exacerbate existing medical conditions, damage the quality of working life, and lead to impressions of ineffectiveness at work due to reduced productivity. In addition, many organizational practices and policies that are designed to curtail absenteeism could in fact stimulate attendance while sick. On the other hand, under some circumstances, presenteeism might be viewed as an act of organizational citizenship and garner praise. Hence, focusing narrowly on productivity loss, as opposed to productivity gain compared to absenteeism, is unduly restrictive.
From an organizational viewpoint, Hemp (2004) opines that the relative invisibility of presenteeism compared to absence makes its management an important source of competitive advantage, especially given an estimated $150 billion cost in the US alone. The vehicle for this is said to be state-of-the-art pharmaceutical treatment that attenuates productivity loss when attending while ill: ‘Emerging evidence suggests that relatively small investments in screening, treatment, and education can reap substantial productivity gains’ (Hemp, 2004, p. 50). Indeed, Burton, Morrison, and Wertheimer (2003) review evidence that pharmaceuticals can stem productivity loss accompanying presenteeism. Most researched medical conditions are episodic or chronic problems such as depression, migraine, and allergies. However, the specter of contagion due to acute medical conditions is also a source of worry (Lovell, 2004; Wessel, 2004), and an outbreak of the deadly sudden acute respiratory syndrome (SARS) in Toronto in 2003 prompted much public concern about employees (including medical personnel) showing up at work while exhibiting typical symptoms (Owens, 2003).

Presenteeism has the potential to serve as a catalyst for theoretical advances. For one thing, it has the capacity to contribute to the literature on absenteeism by addressing the gray area that exists between no productivity (i.e., absenteeism) and full work engagement. In part, this could occur by filling the serious gaps in our understanding of how absence episodes start and how decisions to return to work are effected. From a health viewpoint, the attention to presenteeism provides a vehicle for probing the loosely coupled but important connections among having a medical condition, defining oneself as ill, and engaging in work behaviors associated with assuming a sick role (e.g., Johnson, 2008).

The Measurement of Presenteeism and Associated Productivity Loss

In the literature, the act of presenteeism and any resulting productivity loss have been subjected to separate streams of measurement.

The act of presenteeism

Aronsson and colleagues appended to Statistics Sweden’s labor market survey the following question meant to probe the frequency of presenteeism: ‘Has it happened over the previous 12 months that you have gone to work despite feeling that you really should have taken sick leave because of your state of health?’ (Aronsson & Gustafsson, 2005; Aronsson et al., 2000). The response format consisted of never, once, 2–5 times, or over 5 times. Variations of this retrospective frequency measure have also been used by other researchers (e.g., Demerouti et al., 2009; Hansen & Andersen, 2008; Johansson & Lundberg, 2004; Munir et al., 2007; Sanderson et al., 2007). In the earlier Aronsson study, 37 per cent of respondents reported attending work while sick more than once. In the later Aronsson study, 53 per cent made the same declaration (38 per cent 2–5 times and 15 per cent more than 5 times). The reason for this increase is unclear.

Productivity loss ascribed to presenteeism

At least 14 health-related work productivity loss measures have been generated in recent years, and their most common impetus has been to serve as criterion variables in clinical trials meant to assess the impact of pharmaceutical treatment on work productivity (Amick, Lerner, Rogers, Rooney, & Katz, 2000). Several rather descriptive reviews of these productivity loss instruments have appeared in the literature (Amick et al., 2000; Lofland, Pizzi, & Frick, 2004, Prasad et al., 2004; see also table 1 of
Productivity loss instruments generally ask respondents to self-report some information concerning their health and to estimate how their health has affected their productivity. Some measures are “generic” in that they examine the impact of general health status on productivity; others pertain to specific health conditions such as migraine, allergies, or depression. On the productivity side, some instruments are qualitatively anchored while others ask for or impute some estimate of time lost or percentage of productivity decrement that is in principle translatable into dollars. While some instruments use a job analysis-like logic to measure the impact of illness on various aspects of work functioning (e.g., The Work Limitations Questionnaire [WLQ], Lerner, Amick, Rogers, Malspeis, Bungay, & Cynn, 2001), others rely on a global productivity rating (e.g., the World Health Organization Health and Work Performance Questionnaire [HPQ], Kessler et al., 2004), and single-item measures are common.

Current work loss instruments neither describe illnesses similarly nor share a standard outcome metric (Goetzel, Long, Ozminkowski, Hawkins, Wang, & Lynch, 2004). For instance, the short form of the Stanford Presenteeism Scale (SPS-6) is a 6-item scale to which respondents reply on a Likert format indicating degree of agreement pertaining to a primary health condition. A sample item is “Despite having my (health problem), I was able to finish hard tasks in my work” (Koopman et al., 2002, p.20). The WLQ (Lerner et al., 2001) asks respondents to report health conditions requiring medication or treatment by a physician and to estimate the impact of these conditions on multiple items pertaining to their time management, physical activities, mental and interpersonal activities, and overall work output. The five-point response scale ranges from “all of the time (100 per cent)” to “none of the time (0 per cent).” Scholars in the area readily impute percentages of productivity loss to such responses and attach dollar figures to the loss (e.g., Ozminkowski et al., 2004).

Recall periods generally vary between 1 week and 1 month, although periods of up to a year have been used (Goetzel et al., 2004; Ozminkowski et al., 2004). It is unclear how much stability might be expected for health-related work loss. Hence, Koopman et al. (2002) declined to measure the test–retest reliability of the SPS-6 as they assumed no stability over time, but Collins et al. (2005) annualized 4-week productivity decrement estimates.

Occasionally, work loss estimates have been correlated with objective productivity data, such as insurance claims processed, or with supervisory appraisals. Although some significant associations have been observed (Evans, 2004), it is not certain that these objective criteria are exactly commensurate with work loss estimates. This is because objective output and appraisals essentially reflect between-employee differences in typical performance while work loss estimates are meant to reflect within-employee differences. Thus, two call center employees who report a 20 per cent loss of productivity due to asthma might be starting from different baselines.

A few studies have compared the results stemming from the administration of two or more work loss instruments in the same sample. Limited convergent validity and substantial differences in the amount of lost productivity appear to be the norm. For instance, Ozminkowski et al. (2004) reported a correlation of only .30 between two instruments and a significant difference in productivity loss. Brouwer, Koopmanschap, and Rutten (1999) reported measures that differed up to a factor of 7 on reported hours lost and hours worked while ill, and Meerding, IJzelenberg, Koopmanschap, Severns, and Burdof (2005) found two to three times as many workers claimed productivity loss on one measure as opposed to another.

**Commentary on measurement**

**The act of presenteeism**

The retrospective, discontinuous frequency scales typically used to measure the prevalence of presenteeism are suboptimal. First, the scaling is too crude to accurately capture what is apparently a
fairly low base rate behavior. Second, it is well established that providing a particular range of responses when probing the frequency of behavior affects responses because the range connotes (often inaccurate) information about what frequency of behavior is normal (Schwarz, 1999). In light of these problems, Johns (1994) recommended using an open ended, fill-in-the-blank response format to measure self-reported absenteeism, and the same would apply for presenteeism (e.g., Caverley et al., 2007). Effort must be devoted to uncovering the appropriate time frame for presenteeism probes and understanding its temporal stability. Demerouti et al. (2009) reported test–retest reliabilities of .58 or greater for 6 month and 1 year intervals for the Aronsson frequency measure.

Productivity loss
Given various self-serving biases, work researchers have not much emphasized the development of self-report measures of job performance (Johns, 1999; Murphy & Cleveland, 1995). However, the necessity to isolate those performance and attendance effects that are attributable to health will often necessitate such self-report. This said, one of the most worrisome aspects concerning the measurement of work loss due to presenteeism is the potential for common method variance stemming from asking people to self-diagnose their health and then estimate its impact on their own productivity. The priming of the health probe, the drive to respond consistently, implicit theories about the connection between health and performance, and the inherent vagueness of what constitutes full productivity (Podsakoff, MacKenzie, Lee, & Podsakoff, 2003) all suggest that the impact of health on productivity might be exaggerated.

Speaking generally, multiple item productivity loss instruments that (at least conceptually) are based on a job analysis-like logic seem preferable, in that they require respondents to reflect on how their condition affects mental performance, physical performance, and so on (e.g., the WLQ, Lerner et al., 2001). Among other advantages, this requirement for more elaborate processing might counter method variance. Sanderson et al. (2007) reported that the WLQ was more sensitive than several simpler instruments (e.g., the SPS-6) to gradations of depression and changes in depressive symptoms.

The Correlates of Presenteeism

It has sometimes been assumed that any factor that constrains the opportunity to be absent could stimulate presenteeism (Koopmanschap, Burdorf, Jacob, Meerdink, Brouwer, & Severens, 2005), an assumption Caverley et al. (2007) call the substitution hypothesis. In part, this suggests that both behaviors might share some common causes (Caverley et al., 2007), with context dictating which behavior is enacted (Dew, Keefe, & Small, 2005). However, a complementary perspective might include a search for likely causes of perseverance (e.g., attitudes, personality) in the face of absence-inducing conditions. In what follows, the researched correlates and assumed causes of presenteeism are divided into (1) organizational policies, (2) job design features, and (3) presenteeism cultures.

Organizational policies and presenteeism
Organizational policies concerning pay, sick pay, attendance control, downsizing, and permanency of employment have all been suggested to foster presenteeism.

Pay, sick pay, and attendance control
It might be assumed that people who are better paid would be more inclined to indulge in absence and forego the tribulations of presenteeism. However, on the first point, there is considerable evidence that those earning higher wages generally exhibit less absenteeism (Johns, 1997).
data are lacking on presenteeism *per se*, Aronsson et al., (2000) reported that occupational groups exhibiting the most presenteeism were among the poorest paid, a finding not replicated by Hansen & Andersen, (2008). Aronsson and Gustafsson (2005) found that reported trouble handling domestic expenses was positively associated with presenteeism.

The details of sick pay and related attendance control systems should be related to the exhibition of presenteeism. Johns (1997) summarizes numerous studies showing that less liberal sick pay plans result in less absence. The associated expectation is that they could also stimulate presenteeism (Chatterji & Tilley, 2002). Lovell (2004) cites a lack of paid sick leave as a particular stimulus for presenteeism among female workers. She also notes that workers report going to work ill to “save” any sick leave they have for dealing with children’s health problems, something that is covered by few sick leave plans, especially for those earning low wages.

Grinyer and Singleton’s (2000) qualitative study illustrated how systems put in place to stimulate good attendance can contribute to presenteeism. Especially worrisome were fixed “trigger points” for a certain number of absence episodes that led to disciplinary action. Such trigger points stimulated presenteeism, and they also converted potential presenteeism into absence in that employees were concerned to return to work too soon (and thus risk going absent again) for fear of accruing two absence episodes instead of one. Munir et al. (2007) inferred similar trigger point dynamics in a quantitative study of four UK organizations.

**Downsizing**

Another policy decision that has been examined in relation to presenteeism concerns downsizing, the intentional reduction in workforce size for supposedly strategic reasons. On one hand, downsizing might be expected to stimulate absenteeism due to damaged job attitudes, perceptions of injustice, breached psychological contracts, and stress-related illness (cf. Kammeyer-Mueller, Liao, & Arvey, 2001). Conversely, it might reduce absenteeism due to fear of job loss, job design changes that make absence less viable (see below), increased workload, or flatter organizational structures that increase competition for promotions and demand visible symbols of commitment (cf. Simpson, 1998). Implicit or explicit is the idea that some portion of this increased attendance would comprise presenteeism—people attending work despite ill health and working long hours while not being very productive (Simpson, 1998).

Many studies reveal an *increase* in absenteeism following downsizing (Bourbonnais, Brisson, Vézina, Masse, & Blanchette, 2005; Firns, Travaglione, & O’Neill, 2006; Kivimäki, Vahtera, Pentti, & Ferrie, 2000; Kivimäki, Vahtera, Thomson, Griffths, Cox, & Pentti, 1997; Vahtera, Kivimäki, & Pentti, 1997; Vahtera et al., 2004), some also finding a shift to longer spells (Kivimäki, Vahtera, Griffths, Cox, & Thomson, 2001; Stansfeld, Head, & Ferrie, 1999). Vahtera et al. (2004) found that the rate of sickness absenteeism increased in occupational groups in which there had been the greatest amount of downsizing, but only among permanent employees. They inferred that temporary employees might have been engaging in presenteeism, as they were most vulnerable to job cuts.

**Permanency of employment**

In line with the Vahtera et al. (2004) results, a number of authors have speculated about how permanency of employment status, another condition stemming from policy decisions, affects presenteeism. Again, the general assumption is that, due to job insecurity, temporary and fixed contract workers will be more inclined to attend work when sick than will permanent employees. As with downsizing, most of the extant research involves speculation because inferences about presenteeism stem from the examination of absenteeism patterns rather than the more direct measurement of attendance while ill.
Several studies have found that contingent or non-permanent employees exhibit less sickness absence than their more permanent counterparts (e.g., Benavides, Benach, Diez-Roux, & Roman, 2000; Gimeno, Benavides, Amick, Benach, & Martinez, 2004; Virtanen, Kivimäki, Elovainio, Vahtera, & Cooper, 2001; Virtanen, Vahtera, Nakari, Pentii, & Kivimäki, 2004). Furthermore, in a prospective study that followed hospital employees who changed their employment from a fixed term contract to permanent status, it was observed that their recorded absence rate nearly doubled (along with their perceptions of job security) to approximate that of permanent employees (Virtanen et al., 2003). The authors inferred presenteeism on the part of the fixed term employees prior to conversion to permanency.

The results of three large-scale Scandinavian studies that measured presenteeism directly rather than inferred it from patterns of absence are of special interest. In an earlier study (Aronsson et al., 2000), permanent employees were more inclined than temporary staff to report having shown up at work while ill in the past year. In later studies (Aronsson & Gustafsson, 2005; Hansen & Andersen, 2008), no difference was observed for permanency status.

These results raise questions about the inferences that have been made about presenteeism solely from differential absence rates exhibited by permanent and temporary workers. More generally, the contradictory effects of downsizing and impermanent employment on absence suggest that the insecurity thesis requires greater scrutiny.

**Job design and presenteeism**

Job design features that have been examined with respect to presenteeism include job demands, adjustment latitude, ease of replacement, and teamwork.

**Job demands**

Job demands include physical, cognitive, and social features of a job that necessitate protracted physical and psychological effort. Demerouti et al. (2009) reasoned that employees in high-demand jobs would be inclined to attend when ill to maintain high levels of performance. In a longitudinal study of nurses, they found that high job demands were associated with presenteeism and burnout. This finding is interesting in light of mixed evidence that job demands are sometimes positively and sometimes negatively associated with absenteeism (Smulders & Nijhuis, 1999). Demands that compel attendance (such as care giving, see below) might result in presenteeism.

**Adjustment latitude**

Adjustment latitude refers to opportunities that employees have to reduce their work output or alter work procedures in response to being unwell (Johansson & Lundberg, 2004). However, the fine points of context count (Johns, 2006), and Vingård, Alexanderson, and Norlund (2004) note that the common cold that would permit attendance on many jobs (e.g., internet help desk) is counterindicated on a neonatal hospital ward.

It might be expected that adjustment latitude would be positively correlated with showing up at work unwell and also with any accompanying productivity reduction. In other words, individuals might be inclined to show up but take it easy on the job. Johansson and Lundberg (2004) were able to confirm only a very weak positive connection between adjustment latitude and presenteeism when requirements for attendance were controlled. However, both measures consisted of single items, and the recall period was a lengthy 12 months. This noted, Aronsson and Gustafsson (2005) found that less control over the pace of work was associated with more presenteeism. Johansson and Lundberg make the good point that people with ample adjustment latitude may not see themselves as being sick, as the opportunity for
adjustment might change the self-diagnosis. Also, it is surely possible that adjustment latitude (or its likely correlates) confers the opportunity to take time off rather than attend while feeling ill.

Ease of replacement
Research has also examined the impact on presenteeism of ease of replacement, defined as the extent to which work missed due to absenteeism has to be made up upon return to work. These studies (Aronsson & Gustafsson, 2005; Aronsson et al., 2000) illustrate that people are inclined to attend the job while ill when they know the work is piling up. This condition can stem either from lean staffing, high specialization, or a lack of cross-training. However, there are contextual subtleties to replaceability. McKevitt, Morgan, Dundas, and Holland (1997) found that UK specialist physicians working in hospitals gave a lack of backup as their major reason for not using sick leave. General practitioners, though, cited unfairness to colleagues as their major reason, even though medical practice partners constituted a ready source of backup. Following downsizing among Canadian civil servants, Caverley et al. (2007) found that lack of backup was the most common reason cited for presenteeism. A lack of backup or lean staffing may also be behind Hansen and Andersen’s (2008) finding that time pressure at work contributed to presenteeism. All in all, a nexus of heavy workload, associated time pressure, and lack of assistance seem to contribute to presenteeism.

Teamwork
Unfairness to colleagues is likely to be salient under self-managed, team-based work designs, giving added prominence to matters concerning attendance. Hence, Barker’s (1993) ethnographic study of a manufacturing firm’s conversion to self-managed assembly teams revealed the teams’ emerging obsession with reliable, on-time attendance by their members. Draconian monitoring by peers, that would seem to stimulate presenteeism, surpassed the managerial bureaucracy of the pre-team assembly line structure as a stimulus for reliable attendance. More directly, Grinyer and Singleton (2000) report qualitative data from a UK public sector employment office that strongly implicated the change to teamwork as a mitigating factor in presenteeism: “being the member of a team instilled an obligation to fellow team members which resulted in a reluctance to take sick leave” (p. 13). Many respondents in turn felt that the compulsion for presenteeism led to longer-term downstream sickness absence.

Presenteeism cultures

The rather striking occupational differences in the incidence of presenteeism observed by Aronsson et al. (2000) are suggestive of but not proof of variations in presenteeism cultures, since mediating collective mechanisms were not examined. The authors found, for example, that the base rate of attending work while ill was 55 per cent among pre-primary teachers, while those in engineering and computing specialties averaged 27 per cent. Also, nursing home aides, nurses, and school teachers were 3–4 times as likely to engage in presenteeism as managers, even controlling for a number of other ostensible causes of the behavior. Occupations in the caring, helping, and primary teaching sectors were most prone to presenteeism, suggesting a culture predicated in part on loyalty to and concern for vulnerable clients (i.e., patients and children). However, the authors also explain that these jobs were
among those most threatened by downsizing during the sampling period and perhaps most prone to understaffing. One proximal mediator of occupational differences in presenteeism might be professional self-identity (Van Maanen & Barley, 1984). McKevitt et al. (1997) cited unwillingness to accept a patient role as a contributing factor for high rates of presenteeism among physicians. Dew et al. (2005) conducted interviews and focus groups concerning presenteeism in a public hospital, a private hospital, and a small manufacturing firm, all located in New Zealand. They concluded that the public hospital exhibited a “battleground” culture in which a distant management did little to encourage attendance but in which professional identity, ethnic identity, and institutional loyalty fostered presenteeism. The private hospital was found to have a “sanctuary” culture in which there was little management pressure for presenteeism but a strong teamwork ethos and sense of loyalty to co-workers that motivated attendance in the face of stress and illness. Finally, they noted a “ghetto” culture in the manufacturing firm, with uncaring management and poor working conditions in which few employment options and attendant insecurity translated into attendance in the face of sickness. Parallels to the Nicholson and Johns (1985) typology of absence cultures are apparent in this research, in that the three sites manifested differences in the nature of emergent psychological contracts and the extent to which employees took attendance cues from each other.

Studying British managers in organizations that had experienced downsizing, Simpson (1998) found evidence of “competitive presenteeism” cultures dominated by higher-level male managers. Such cultures demanded long work hours, the foregoing of recuperation time after grueling business trips, and working while unwell. Younger males were seen to comply with presenteeism pressures, while women resisted them to the extent that the behavior was “more likely to be recognized by women but practiced by men” (Simpson, 1998, p. S48). This corresponds indirectly to the well-established finding that absenteeism tends to be higher among women than men (Côté & Haccoun, 1991). It corresponds more directly to an analysis of over 100 years of New York Times articles that pointed to US societal-level differences in expectations for attendance for women versus men (Patton & Johns, 2007).

Commentary on occupational and organizational correlates

Intuitively, it seems reasonable that organizational policies, the design of jobs, and the social climate of an organization might affect the propensity to attend while ill. However, as indicated, research has barely scratched the surface of these matters. The studies by Grinyer and Singleton (2000) and Munir et al. (2007) clearly suggest that policies meant to affect absenteeism can also affect presenteeism, and more such research is warranted. Inferences about presenteeism from absenteeism patterns, characteristic of the downsizing and job permanency literature, should be avoided, and both variables should always be assessed together. Among job design variables, ease of replacement and teamwork requirements show good promise and might be supplemented with direct measures of task interdependence, which would seem to stimulate presenteeism. Adjustment latitude appears to have suffered from weak measurement rather than inherent irrelevance to presenteeism. Finally, evidence on presenteeism cultures is encouraging in light of the dominant trend to view the behavior as a product of personal health.

Medical Conditions and Productivity Loss When Present

A number of studies have been conducted to estimate the extent and cost of productivity loss associated with various medical conditions. Some of this research has relied on representative populations and
examined the impact of a particular medical condition. Other work has been conducted in the context of organizational health audits designed to clarify how various illnesses affect individual productivity. The general logic underpinning such research is that various health problems might have a differential impact on the execution of particular work competencies or skills (Burton, Pransky, Conti, Chen, & Edington, 2004). There has been a plethora of such research in recent years, most of it funded by pharmaceutical interests. A review of some of this work can be found in Schultz and Edington (2007). What follows is a summary of some of the more ambitious and prominent projects.

Using the WLQ, Lerner et al. (2004) studied the impact of depression on work productivity in a mostly female sample recruited from health plan physicians’ offices. Compared with a group with arthritis and a healthy control, those with depression reported more specific work limitations and productivity reduction in the 6–10 per cent range compared to 2–4 per cent. In a follow-up, they were also more likely to have become unemployed or changed jobs to ones with lower earnings, perhaps due to reduced work effectiveness.

Allen, Hubbard, and Sullivan (2005) examined the impact of pain on presenteeism in a Fortune 100 company. Questionnaire respondents were deemed to suffer pain (28.6 per cent of the sample) if they reported some pain over the previous 4 weeks and felt pain on the day of the survey. Severity of pain was also measured. Severity showed a predominantly positive, linear relation to work limitations on all four subscales of the WLQ. Over 4 weeks, it was estimated that those meeting the pain criterion effectively lost 3.14 days of work due to presenteeism and 0.84 days due to absenteeism, versus 0.29 and 0.06 days for the healthy comparison group. The most burdensome conditions in the aggregate were deemed to be (in order) allergy, neck and spine problems, low back pain, depression, and arthritis. More broadly, musculoskeletal and “mental and nervous” problems topped the list.

Another large-scale corporate health audit at Bank One (now JPMorgan Chase) was reported by Burton et al. (2004). Using the WLQ, the study highlighted the particular impact of depression, especially on the WLQ mental/interpersonal dimension and on overall work output. Another Bank One study highlighted the toll of migraine on productivity, especially among women employees (Burton, Conti, Chen, Schultz, & Edington, 2002). At over $24 million, presenteeism costs exceeded those due to absence by $3 million.

In what its authors described as “the most comprehensive attempt by a company to assess the prevalence of work impairment from chronic health conditions” (p. 554), Collins et al. (2005) explain Dow Chemical Company’s attempt to assess the impact of health on presenteeism and absenteeism. Both variables were measured with the SPS, and some respondents also completed the WLQ. Among individuals with a chronic health problem, time lost to absence over a 4-week period ranged from 0.9 to 5.9 hours, depending on condition. Work impairment attributed to presenteeism ranged from 17.8 to 36.4 per cent and increased with the number of chronic conditions reported. This highest impairment was due to anxiety, depression, or emotional problems, followed by breathing problems (23.8 per cent) and migraines (23.4 per cent). The authors estimated that the average Dow worker’s health cost the company $6721 due to presenteeism, $661 due to absenteeism, and $2278 due to direct health care costs (2002 dollars).

Finally, Goetzel et al. (2004) integrated the results of five large independent studies of presenteeism that each measured multiple medical conditions. The average productivity loss across 10 conditions was 12 per cent, and the top five productivity sappers were migraine and headaches (20.5 per cent), respiratory problems (17.2 per cent), depression and mental illness (15.3 per cent), diabetes (11.4 per cent), and arthritis (11.2 per cent). These averages masked a considerable range in estimates across investigations (e.g., 20.2 per cent for migraines and headaches; average variation across conditions and studies = 12.1 per cent), not surprising given the use of different measures. Based on the US hourly average wage rate of $23.15 (2001), the average daily productivity loss due to health was estimated at $22, with a range from $11 to $33 depending on the prevalence estimate. In a striking
contrast to Collins et al. (2005), the yearly cost of the most “expensive” medical conditions was in the $200 range per person. Finally, Goetzel et al. (2004) estimated that anywhere from 18 to 61 per cent of employers’ total medical costs were attributable to presenteeism, although even the low presenteeism estimate exceeded cost due to absence.

Commentary on medical precursors of productivity loss

Variation across studies
One must be struck by the remarkable variation in the reported effects of presenteeism on productivity and the consequent costs associated with presenteeism. This is not exactly surprising given the variation in measures, procedures, and cost derivation techniques (Schultz & Edington, 2007). For instance, the cost differences between Goetzel et al. (2004) and Collins et al. (2005) are apparently attributable to different accounting procedures.

Productivity loss: Absence versus presence
There is considerable agreement across studies that presenteeism accounts for more aggregate productivity loss than absenteeism. On the face of it, this suggests an iceberg effect in which the more visible portion of work loss (absenteeism) is dwarfed by that portion beneath the surface (presenteeism). On one hand, this differential might reflect the fact that there are more organizational constraints on not showing up than there are on taking it easy on the job (cf. Johns, 1991). On the other hand, the self-estimation of productivity loss may be more prone to perceptual distortion than the enumeration of days absent, which people are in any event inclined to underreport (Johns, 1994; Van Goor & Verhage, 1999). The popular press has often interpreted the finding that presenteeism costs more productivity than absenteeism as a reason to be absent when sick (e.g., Nebenzahl, 2004), confusing aggregate findings with individual behavior.

Predictability: Absence versus presence
Several studies suggest that presenteeism is more “predictable” than absence. Thus, Caverley et al. (2007) found that health accounted for three times the variance in presenteeism compared to sickness absence. Collins et al. (2005) reported that a regression model containing demographic variables and 10 chronic medical conditions accounted for 18 per cent of the variance in presenteeism and 11 per cent of the variance in absenteeism. Parallel but weaker results were reported by Boles, Pelletier, and Lynch (2004). Related to this, Hackett, Bycio, and Guion (1989) reported that desire to be absent on a day when one attended (surely an occasion for presenteeism) was more predictable than actual absence. Again, the reasons for this differential are uncertain. Method variance might be at play (see below). As well, distributional and reliability differences between absence and presenteeism might contribute. Finally, absence has a variety of causes, only one of which is illness, and this would attenuate its association with medical conditions.

The depression connection
It is possible that depression and related psychological problems figure so heavily in presenteeism (see also Conti & Burton, 1994) in part because they are not seen as legitimate reasons to be absent. Johns and Xie (1998) found that workers in both Canada and China rated depression lower than the following factors as a good reason to be absent from work: Serious illness, family illness, doctor’s visit, minor illness, bad weather, poor transportation. This is in line with the Hackett et al. (1989) finding that personal problems and the doldrums (feeling low, being physically and emotionally fatigued) were better predictors of the desire to be absent on a given day than they were of actual absence. However, it
is also possible that the elevated depression–presenteeism connection is a manifestation of method variance such that the pessimistic mood and negative affectivity known to be associated with depression carry over into associated productivity estimates (Burton et al., 2004).

**Discussion**

Adelman et al. (1996) published a bellwether study that set the stage for subsequent research on presenteeism. The study was a clinical trial of the effects of the migraine drug sumatriptan on work productivity. Amick et al. (2000) describe the essence of the results:

> No differences were found when comparing the two groups...using only absence data. Researchers also asked a question about how effective the worker felt (from 0 to 100 per cent) when having migraine symptoms. The number of hours worked was multiplied by the self-reported percentage of effectiveness, and this generated additional time when the worker was not productive. When this additional lost productivity was added to the absence data, significant differences were observed [in favor of the treatment group] (p. 3155).

The Adelman et al. (1996) research was a symbolic tipping point in the study of presenteeism because it showed that productivity loss at work supplemented in a clinically responsive way the first work variable studied in clinical trials—absenteeism. The enthusiasm for this observation is apparent in the unbridled development and application of a host of productivity loss measures. Although these measures vary in quality, most have somewhat limited reliability and validity evidence. Furthermore, single-item measures, unwarranted dichotomization, selection on the dependent variable, questionable use of change scores, and rather facile conversions of self-report questionnaire responses into dollars are not uncommon in the health-focused research on presenteeism. However, rather than dwelling on these limitations, I want to discuss in this section the contributions that organizational behavior and human resources scholars, industrial-organizational psychologists, and health psychologists might make to presenteeism research, suggesting a tentative theory-driven research agenda.

* Toward a theory of presenteeism

Research and speculation concerning presenteeism have been markedly atheoretical. Thus, virtually all health-related research on the phenomenon has been dedicated to documenting the impact of self-reported illness on self-reported productivity. Similarly, the smaller amount of organizational research on the topic (often not measuring presenteeism directly) has focused on job insecurity as a cause of presenteeism and generated contradictory results, as demonstrated earlier.

Space limitations preclude the development of a formal theory of presenteeism. However, the model presented in Figure 1 is meant to suggest some of the key variables that might be incorporated into such a theory and to signal some of the phenomena that such a theory should address. The model assumes that fully productive regular attendance is interrupted by a “health event” that is either acute (e.g., the flu), episodic (e.g., migraine), or chronic (e.g., the onset of diabetes). To some extent, the nature of the health event will dictate whether absenteeism or presenteeism ensues. Thus, severe stomach flu is likely to provoke absence and the early diagnosis of diabetes is likely to prompt presence. In less extreme medical cases, context will come into play. Nicholson (1977) presented a theory concerning absenteeism that attempts to specify where given incidents might fall on a continuum of avoidability. Avoidability is seen to be a joint effect of the precipitating personal event and the context surrounding the event. Thus (borrowing from Nicholson), a sore throat will stimulate absenteeism for a singer and
presenteeism for a pianist. Contextual constraints on both behaviors (Johns, 1991) would be a key part of such choices, which ultimately reflect an interaction between the person (the exact illness) and the situation (in this case, occupation).

After accounting for the nature of the illness, it is proposed that work context factors and personal factors (attitudes, personality, gender) further influence the choice between absenteeism and presenteeism. Despite the spotty research on work context reviewed earlier, it is proposed that, on the margin, job insecurity, strict attendance policies, teamwork, dependent clients, a positive attendance culture, and adjustment latitude in the job tend to favor the occurrence of presenteeism, while easy replacement favors absence. Extant evidence suggests that the impact of job demands on this choice might be moderated by job control or backup provisions. Outside of illness, the role of personal factors has been little researched. However, it seems reasonable to expect that those with positive work attitudes and favorable justice perceptions would, on the margin, exhibit presenteeism, as would workaholics, the conscientious, and the psychological hardy. On the other hand, absenteeism might be
the default for the stressed and those with external health locus of control, the proclivity for adopting a sick role, and the perception that absenteeism is legitimate behavior. The logic pertaining to some of these predictions will be touched on in the prescriptions provided below.

Temporally, absenteeism and presenteeism have to be viewed as discrete events occurring in a sequence over time such that the occurrence of one behavior might affect the likelihood of the other (cf. Hackett & Bycio, 1996; Hackett et al., 1989). Hence, the dotted lines in Figure 1 show the potential impact of enacting presenteeism or absenteeism on the precipitating health event and subsequent attendance behavior. For instance, a couple of days of absence might alleviate the health problem and lead to fully engaged attendance. On the other hand, several days of presenteeism might exacerbate the health event and lead to absenteeism. Daily diary studies such as those used by Hackett and colleagues would be invaluable for studying such temporality.

Although both attendance behaviors might have some immediate consequences (e.g., harsh co-worker reaction to showing up at work with obvious signs of the flu), Figure 1 is meant to focus on more cumulative consequences to the individual that might follow chronic and episodic health events. While the impact of absence on individual productivity is straightforward, this is less so for presenteeism. Thus, a worker experiencing inequity who feels compelled to attend when ill due to a rigorous absenteeism policy is likely to be less productive than a person experiencing equity, even though both may be experiencing somatically identical health events. It is this psychological dimension to productivity loss that is missing from medical treatments of presenteeism. Although not shown explicitly in Figure 1, several other of the non-medical person variables listed might also affect the productivity of presentees. Again, it should be emphasized that the productivity of presentees need not be framed as a loss but can be seen as a gain compared to absenteeism.

Figure 1 also highlights the cumulative importance of attributions made concerning absenteeism and presenteeism, both by actors and by observers, such as managers and teammates. What do repeated acts of absence or presence signal about oneself? And how do others interpret such behavior? The perceived legitimacy of both behaviors would figure prominently in such attributions. There is much evidence that absenteeism is viewed as mildly deviant behavior, and this contributes to its under-reporting (Johns, 1994). This said, people view illness as among the most legitimate reasons for absence (Johns & Xie, 1998), although they tend to make fine distinctions about the legitimacy of various minor health conditions (Harvey & Nicholson, 1999). The legitimacy of presenteeism is unclear. On one hand, showing up at work in the face of discomfort might be seen as a consummate example of organizational citizenship behavior (Organ, 1988). On the other hand, much research suggests that people are generally disinclined to admit to lowered productivity (Johns, 1999), such as that which might accompany the act of presenteeism. However, reporting one’s productivity decrement in the context of a good medical reason provides for legitimacy.

Finally, Figure 1 suggests that the chronic exhibition of presenteeism or absenteeism might have subsequent effects on downstream health status, attendance dynamics, and organizational membership. In a health-based scenario, chronic presenteeism further damages one’s health, prompting a spiral of lowered productivity, increased absenteeism, and possibility disability. In an attitude-based scenario, dissatisfied or insecure employees feel pressured to attend when ill and sequentially lower their productivity, succumb to absence, and then quit. This continuum of withdrawal will be detailed below.

In the following paragraphs, some prescriptions for theory building concerning presenteeism are presented. Several of these prescriptions speak further to the attendance dynamics portrayed in Figure 1.

**A theory of presenteeism should recognize the subjectivity of health**
Theory in this domain must recognize the essential subjectivity of people’s evaluation of their own health status (Fleten, Johnsen, & Førde, 2004; Kaplan & Baron-Epel, 2003) and accommodate
well-established individual differences in the propensity for self-disclosure of chronic illness at work (Munir, Leka, & Griffeths, 2005), perceptions of how work affects health (Ettner & Grzywacz, 2001), and the tendency to adopt a sick role (Levine & Kozloff, 1978). As signaled in Figure 1, particularly useful would be applications of attribution theory that would predict how self-conceptions of health get translated into absenteeism and presenteeism and how others in the workplace react to these work behaviors. For example, those who tend to adopt a sick role are inclined to attribute much of their behavior to their health. Such persons would seem to be more inclined toward absenteeism than presenteeism, and more inclined toward productivity loss if present while ill.

**A theory of presenteeism should account for the relationship between absenteeism and presenteeism**

Extant research on presenteeism has made very scant use of existing and well-developed theory on absenteeism, a curious omission indeed. In doing the accompanying review, I encountered only three individual-level point estimates of the association between absenteeism and presenteeism ($r = .18$, Caverley et al., 2007; $r = .14$ and $r = .24$, Munir et al. 2007). (Employing controls and odds ratio statistics, Hansen and Andersen (2008) reported an even stronger positive association). As noted earlier, some researchers have assumed that factors that curtail absence stimulate presenteeism. Although this is plausible, it is far from necessary, and it implies unstated boundary conditions, conditions that good theory exposes (in this case, that the absence reduction is achieved by pressure to attend). It also bears emphasis that individual-level associations might not necessarily replicate at other levels of analysis. For example, Aronsson et al. (2000) reported that the occurrence of presenteeism tended to be highest in occupations in which absence was also elevated. Such a finding calls for replication as well as extension to the organizational level. Do organizations and other social units differ or concur in the sign between absenteeism and presenteeism?

**A theory of presenteeism should refine the job insecurity thesis**

As suggested in the model shown in Figure 1, the idea that job insecurity might curtail absence and motivate people to go to work when ill is compelling. However, as we have seen, studies of downsizing and impermanency of employment, both thought to stimulate insecurity, have revealed contradictory effects on absenteeism. The inference of presenteeism solely from differential absence rates carries an impossible burden of proof, and it places a particular premium on isolating sickness absence, because this is the appropriate baseline against which to infer presenteeism. In other words, any absence reduction due to insecurity must involve sickness absence if presenteeism is to be claimed, given that its definition pertains to attending while ill. Thus, studies examining the insecurity thesis should measure both absence and presence and measure job security directly (e.g., Probst, 2003) rather than infer its occurrence from organizational practices. Encouragingly, Caverley et al. (2007) reported an $r$ of $-.31$ between a single-item measure of job security and reports of going to work ill in the past year, similar to a finding by Hansen and Andersen (2008).

Several further observations pertain particularly to permanency of employment. First, inferring presenteeism from lower absence fails to account for the possibility that secure employment simply elevates the absence of permanent employees (Virtanen et al., 2001). This would be in line with the well-established finding that unionized workers have higher absence levels than those who are not union members (Johns, 1997). Next, past studies have not accounted for preferences for non-permanent employment, even though such preferences have been shown to have an impact on worker satisfaction and well being (Thorsteinson, 2003). Finally, the predominant logic ignores research suggesting that it can sometimes be the permanent employees who are insecure in the face of part-time or contract staff who can assume their jobs (Davis-Blake, Broschak, & George, 2003; George, 2003). Direct measures of absence, presence, and security would go a long way toward resolving these problems.
A theory of presenteeism should incorporate work attitudes and experiences

Despite its connection with illness, there is every reason to believe that presenteeism should show associations with work attitudes and experiences that affect other forms of organizational behavior. This suggests a motivational component of presenteeism similar to that which can be inferred for ostensible sickness absenteeism (Johns, 1997, 2009). For instance, presenteeism has been shown to be positively related to conservative attitudes toward taking absences (Hansen and Andersen, 2008). Also, it is negatively related to job satisfaction and positively related to job stress and burnout (Caverley et al., 2007; Demerouti et al., 2009; Koopman et al., 2002). Stress is worthy of particular attention. A meta-analysis by Darr and Johns (2008) reveals a rather modest negative correlation between work stress (specifically, strain) and absence. This small association might be due to the fact that stress is not seen as an especially legitimate reason to be absent (Johns & Xie, 1998), a potential recipe for presenteeism. Indeed, work stress is often implicated in the occurrence of depression and migraine, reliable correlates of presenteeism.

As suggested earlier, the study of presenteeism has the capacity to contribute to our understanding of the so-called continuum of withdrawal. This continuum posits that unfavorable work attitudes stimulate an adaptation cycle in which successively more elaborate forms of work withdrawal are exhibited until adjustment is achieved (Hanisch & Hulin, 1991; Hulin, 1991; Rosse & Miller, 1984). Thus, minor acts of withdrawal (e.g., daydreaming or surfing the internet on company time) are expected to foreshadow more serious acts such as absenteeism and, ultimately, turnover. There is fairly good empirical support for the right side of this continuum (Johns, 2001), in that elevated lateness is likely to precede absenteeism and elevated absence is likely to precede turnover (Harrison, Newman, & Roth, 2006; Koslowsky, Sagie, Krausz, & Singer, 1997; Krausz, Koslowsky, & Eiser, 1998). It is at the far left side of the continuum where presenteeism might offer some value added, in that any reduced productivity accompanying presenteeism could conceivably foreshadow no productivity, as evidenced by absenteeism. In fact, Harrison et al. (2006) recently demonstrated that the withdrawal of citizenship behaviors preceded lateness and absenteeism, and similar dynamics might be operative for some cases of presenteeism. The implication is that work attitudes would interact with medical condition to affect productivity loss in advance of absenteeism. Thus, job dissatisfaction would elevate the connection between severity of illness and productivity loss, which would normally be considered in-role performance. Also, it would exacerbate productivity loss when the option of absenteeism is unavailable. What is mainly cross-sectional research does show a negative relationship between employee performance and absenteeism (Bycio, 1992), results that are consistent with but not proof of progression of withdrawal.

Recent research has particularly implicated injustice and social disorganization in the workplace as solid predictors of absence (Johns, 2008, 2009), and it is interesting to consider their implications for presenteeism. A viable prediction is that those experiencing more injustice are less likely to exhibit the act of presenteeism but more likely to exhibit productivity loss when they do so. Low cohesion and poor consensus are antecedents of some of the highest absence rates, and such poor social integration is highly unlikely to stimulate attendance when ill.

A theory of presenteeism should incorporate personality

Personality and disposition exhibit modest associations with absenteeism. Thus, the conscientious, those high in positive affect, and those high on internal control are somewhat more prone to attend work (reviewed by Johns, 2008). What about presenteeism? In many cases, presenteeism connotes perseverance in the face of adversity. Such perseverance might be seen in the case of the conscientious, those with a strong work ethic, those with internal health locus of control, workaholics, and those who exhibit the trait of psychological hardiness. Also, compliance might be a factor, and those with low self-esteem might be prone to presenteeism. For example, Aronsson and Gustafsson (2005) determined that
those who found it difficult to say no to others ("individual boundarylessness") were prone to attend while ill. In fact, in the context of illness, such traits might account for more variance in presenteeism than in absenteeism, since illness might supply trait-related cues for these traits (Tett & Burnett, 2003). However, some fine points might be at work here. For example, conscientious people might be inclined to attend while ill but admit that their productivity suffers. Workaholics might also be inclined to attend but deny productivity loss.

Incorporating both personality and work attitudes into the study of presenteeism allows for the consideration of "good presenteeism" by those who are conscientious or satisfied with their jobs. Virtually 100 per cent of the medical and organizational literature treats the phenomenon negatively, either with regard to the organization or the employee. However, attending work while experiencing minor discomfort, even with reduced productivity, may be beneficial to both the employee and the employer compared to going absent.

A theory of presenteeism should attend to its social dynamics

Like much medical research, the health-related research on presenteeism risks undue emphasis on individual sickness. The history of absenteeism research suggests this is a bad idea, as real value-added has been gleaned from recognizing the behavior's social manifestations (Johns, 1997, 2001, 2002, 2003, 2008). Thus, the preliminary work on presenteeism cultures (Dew et al., 2005; Simpson, 1998) is to be commended and extended. Particularly interesting is the Dew et al. finding that rather different collective motives can underpin presenteeism.

One aspect of social dynamics that merits particular attention is gender, treated as a social category (cf. Simpson, 1998). There is a massive amount of evidence that, at least in western societies, women are absent more than men, and conventional explanations do not find strong research support (Patton & Johns, 2007). However, in a study analyzing over 100 years of absenteeism coverage in the New York Times, Patton and Johns (2007) concluded that there is a generalized social expectation that women will be absent more, based on gender stereotypes. Does this provide women with more perceived freedom to take time off when ill and thus engage in less presenteeism, an idea that would follow from women's established tendencies to engage in more health promotive behavior (e.g., Rodin & Ickovics, 1990)? Indeed, Simpson (1998) equates the act of presenteeism with "face time" and sees it as a typically male behavior. However, Lovell (2004) argues that a lack of paid sick leave contributes to presenteeism, and that women are less likely to receive paid leave. Also, depression and migraine are among the medical conditions associated most strongly with both absenteeism and presenteeism, and women are more inclined toward both illnesses than men (e.g., Burton et al., 2002). This scenario has women more inclined toward both work behaviors than their male counterparts, and there is some tentative evidence for this. Aronsson and Gustafsson (2005) found that women were somewhat more inclined than men to report attending while ill, and women were greatly overrepresented in occupations with the very highest presenteeism. Voss, Floderus, and Diderichsen (2004) determined that 37 per cent of women versus 56 per cent of men reported engaging in presenteeism. Burton et al. (2004) reported more productivity deficits for women on all WLQ subscales. Bramley, Lerner, and Sarnes (2002) presented data suggesting that women suffering from common colds were more inclined to miss hours due to absence and men due to presenteeism. Boles et al. (2004) found that women suffered considerably more productivity loss due to both absence and presence than men. More systematic research is needed on this subject, which has not been of central interest in the cited literature.

As suggested in Figure 1 ("other-attributions"), another aspect of social dynamics that bears scrutiny is the reaction of colleagues and clients to the act of presenteeism, both as encouragers and discouragers. As noted earlier, interdependent work designs (e.g., teamwork) and vulnerable clients might encourage presenteeism. Conversely, the popular press contains many stories in which employees bemoan the attendance of obviously contagious fellow workers. Serious research on such
matters would be welcome. The social consequences of accompanying productivity loss also deserve attention. Are co-workers and superiors aware of the connection between a person’s medical condition and his or her productivity? Are accommodations ever made, such as in job design or adjusted performance appraisals?

**Concluding Comment**

Hemp’s 2004 article in the influential *Harvard Business Review*, meant to introduce executives to the costs of presenteeism, signaled the arrival of the subject in corporate America. This attention is welcome, but the presenteeism phenomenon is too interesting and too important for theoretical and practical reasons to be left in the sole hands of medical researchers and health care consultants. Organizational scholars have the conceptual and methodological skills necessary to make important contributions in this area grounded in a firm understanding of how people interact with organizations. Now is the time to apply these skills.

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