

September 2015

# Bridging Public Health with Workplace Behavioral Health Services:

A Framework for Future Research and a Stakeholder Call to Action



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## ABSTRACT

Despite significant investment in behavioral health services by work organizations, the evidence-base supporting such services is lacking. Recent health care policy and delivery changes, such as those resulting from the Affordable Care Act in the United States, highlight the need for rigorous studies on such workplace behavioral health services and the employee assistance (EA) programs and professionals that deliver them. This paper proposes a new framework to promote and organize such research for the U.S. and around the world. The framework is partly informed by input from EA professionals and researchers, collected in a group meeting and a quantitative survey. The framework encourages collaboration across five stakeholder groups: work organizations, EA professionals, researchers, educators of EA professionals, and funding agencies that can support new studies. Specific recommendations (“calls to action”) are provided to these stakeholders to help promote and align EA studies with the broad field of public and global health (including the disciplines of workplace health promotion, occupational health, and organizational studies).



Bennett, J., Bray, J., Hughes, D., Hunter, J., Frey, J.J., Roman, P., Sharar, D. (2015).

***Bridging Public Health with Workplace Behavioral Health Services.***

Independent paper jointly sponsored by the Employee Assistance Professionals Association, The Employee Assistance Research Foundation, and the Employee Assistance Society of North America.

## 1. INTRODUCTION

Currently, work organizations invest billions of dollars in workplace behavioral health services (WBHS), yet the research basis for their effectiveness is lacking. WBHS encompass a wide array of services and programs offered by or through the work organization to both prevent and address the mental health and substance abuse risks and problems of employees and often their families. By devoting considerable resources towards WBHS, industry, government, and society as a whole appear to assume that WBHS, predominantly provided through Employee Assistance (EA) professionals, are effective. Given increasing resource constraints, these stakeholders can no longer afford to let this assumption pass untested. In the absence of science and evidence-based practice (EBP), work organizations choose programs almost entirely on the basis of cost, and providers have no tested standards for quality.

Similarly, target consumer groups (work organizations, employees, family members, and labor unions) do not know what to expect from service providers. EA/WBHS research has been difficult to conduct, partly because it requires significant collaboration with work organizations and professionals. Most research is provider-supported, subject to conflicts of interest, or not publicly disseminated. This paper seeks to energize a new collaboration to study an overlooked area of public and occupational health, one that has great potential for supporting a wide segment of society.

The implementation of the Patient Protection and Affordable Care Act and the Health Care Education and Reconciliation Act, jointly referred to as the Affordable Care Act (ACA), reinforces the need for rigorous EA/WBHS research. The ACA identifies mental health and substance abuse treatment services as “essential health benefits” to be included in all health care plans. Health care reforms under the ACA will extend access to, and parity for, mental health and substance abuse treatment services, which are key elements of WBHS. This will likely lead to a broad integration of WBHS into the mainstream health care system (Beronio, Po, Skopec, & Glied, 2013) and increased access to care for many Americans.

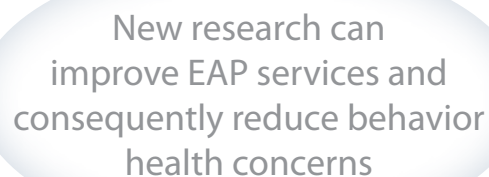
**THE PROBLEM:** Many adult workers who suffer from behavioral health concerns receive services through their work organizations. Despite widespread use of these services, there is little systematic research on their processes and effectiveness. The lack of research on EA/WBHS is a public health problem for four primary reasons. First, behavioral health issues have a profound impact on workforce productivity and employer costs,

as well as negative ripple effects into families and communities. Second, the payers for, and consumers of, EA/WBHS will benefit from knowledge about how these services work and how they can be improved. Third, EA/WBHS professionals lack evidence-based principles to guide the delivery and enhancement of services. Finally, the ACA has specific provisions for behavioral health and also relies on work organizations to help deliver these services.

**FRAMEWORK FOR A SOLUTION:** The science of EA/WBHS will benefit greatly from an influx of new perspectives and empirical methods from public health. We provide a framework to help stakeholders better understand the complex issues involved in EA/WBHS research and foster the collaboration necessary to conduct effective studies. The proposed framework follows the logic of conceptual models in other fields and was built in three steps. First, we gathered input from an expert and interdisciplinary panel of researchers in a Research Summit of 55 participants (EAPA, 2012). Second, the authors met as a working group to synthesize this input while also attending to previous research in the field (Attridge, 2012; Jacobson & Jones, 2010; Taranowski & Mahieu, 2013; Warley & Hughes, 2010) and a recent survey of EA practitioners and researchers (Frey, 2015). Finally, these data-gathering efforts borrowed from team science, (Glasgow et al., 2012), collaborative models (Bennett & Beaudin, 2000) and interdisciplinary approaches (Misra, Stokols, Hall, & Feng, 2011) to inform the final framework.

This framework requires attention from public health researchers because it provides them with an opportunity to understand, converse with, and potentially inform the field of EA/WBHS. Indeed, there is a growing interest amongst public health researchers in adult behavioral health concerns (Brook, Lee, Rubenstone, Brook, & Finch, 2014; Shim & Rust, 2013), but scant attention has been placed on the workplace as a focus for intervention. Partnerships between work organizations, EA/WBHS professionals, educators, and researchers can help solve a number of broad public health concerns that stem from workplace behavioral health issues.

**A CALL TO ACTION:** The primary goal of this paper is to stimulate new and rigorous research that can lead to improvements in EA/WBHS and, consequently, a reduction in behavioral health concerns in the population at large. The paper closes with a call to action to facilitate new studies in the field. The proposed framework is one starting point; readers are encouraged to borrow ideas and contribute alternate approaches. Regardless of any framework used, it is time to promote new research and develop and implement evidence-



New research can  
improve EAP services and  
consequently reduce behavior  
health concerns

based practice (EBP) in the EA/WBHS field. We hope that the framework, a review of specific populations and outcomes, and the call to action will lead to rigorous studies, advance the field, increase inter-disciplinary collaboration, and ultimately improve the overall health and quality of life for employees and their families.

## 2. THE PROBLEM

The behavioral health and related productivity of the American workforce is a major public health concern. National surveys estimate that between 15% and 20% of full-time workers have mental illness (Shim, Baltrus, Ye, & Rust, 2011; U.S. Department of Mental Health and Human Services, 2012), about 10% have alcohol use disorders (Frone, 2013), and both amphetamine and prescription drug abuse is on the rise (Drug Testing Index, 2013). Cost-of-illness and productivity-loss studies suggest that work organizations face considerable costs due to work stress, stress-related diseases, worker depression, and substance abuse (Anderson et al., 2000; Berto, D'Ilario, Ruffo, Di Virgilio, & Rizzo, 2000; Frone, 2013; Henke et al., 2010; Kessler et al., 2011; Rehm et al., 2009; Schultz, Chin-Yu, & Edington, 2009; Single, 2009). While the majority of these costs are borne by society (Frone, 2013), work organizations face significant burdens due to absenteeism, disability-related work leave, lost work productivity, medical claims, and presenteeism (i.e., present at work but with productivity impairment due to unaddressed health issues) (Kessler et al., 2011).

Hence, many work organizations provide WBHS (such as consultation, assessment, short-term counseling, and referral) through Employee Assistance Programs (EAPs) (Mercer, 2013). Despite growth in the use of EAPs (Stoltzfus, 2009), there has been little systematic public health research on their delivery, utilization, and impact of these services (Jacobson, Jones, & Bowers, 2011; Prottas, Diamante, & Sandys, 2011). Furthermore, while some research suggests that EAPs are effective (Csiernik, 2011), many studies have methodological shortcomings such as inadequate sample sizes, nonequivalent comparison samples, and potential conflicts of interest in that most EAP research is conducted by EAP stakeholders, often for marketing purposes (Attridge, 2012; Csiernik, 2005; Osilla et al., 2010).

Public health interventions and models for public health services and research can be applied to the study of EA/WBHS. The Triple Aim model for focusing simultaneously on care, health, and cost (Berwick, Nolan, & Whittington, 2008), models for mental health promotion (Druss, Perry, Presley-Cantrell, & Dhingra, 2010; Kobau et al., 2011; Power, 2010), and frameworks for EBPs (Jacobs, Jones,

Gabella, Spring, & Brownson, 2012) are all potentially useful approaches to studying EA/WBHS. Studies grounded in public health approaches can help work organizations, employees, families, and communities who would suffer without access to EA/WBHS or have no clear expectations about standards of care.

There are no established evidence-based EA/WBHS guidelines for different types of services, types of disorders, or different industries, occupations, and population segments (e.g., military and small businesses). Studies need to show service outcomes and the various factors that shape such outcomes (Merrick, Volpe-Vartanian, Horgan, & McCann, 2007). This includes workplace and public policies, the impact of prevention and intervention technologies, the status of professionalization in the EA/WBHS field, and the role of work culture, stigma, and help seeking (Henderson, Evans-Lacko, & Thornicroft, 2013).

The lack of a model for systematic research is a concern, given the many research needs and opportunities. Indeed, the very diversity of topics may prevent focus. This paper proposes three possible strategies that can help prioritize research activity among public health scientists.

First, a guiding framework can help focus studies that align both public health and EA/WBHS perspectives. Second, research on EA/WBHS delivery can benefit from interdisciplinary strategies

(Proctor et al., 2009; Smedley, Syme, & Institute of Medicine, 2000) and theoretical guidance (Glanz & Bishop, 2010). Many disciplines influence EA/WBHS, including mental health prevention and treatment, occupational health psychology, organizational science, social work, and economics. By joining together, they can integrate diverse theories in behavioral science.

Third, the study of EA/WBHS would greatly benefit once public health practitioners earnestly frame employee mental health as a public health issue. Although the Centers for Disease Control and Prevention has made recent efforts to focus on workplace health with initiatives such as Total Worker Health (U.S. Department of Health and Human Services, National Institute for Occupational Safety and Health., 2012) and The National Healthy Worksite Program (U.S. Department of Health and Human Services, 2013), they fall short by not focusing on EA/WBHS services, per se. Recent articles suggest a growing interest in stigma reduction and bridging behavioral health with public health (Druss et al., 2010; Hatzenbuehler, Phelan, & Link, 2013; Henderson et al., 2013; Satcher & Druss, 2010), but the focus of workplace efforts has been on physical well-being or on aligning with safety efforts, not behavioral health promotion.

There are no established evidence-based guidelines for EAP services

## 2.1 THE ROLE OF EMPLOYEE ASSISTANCE PROGRAMS

EAPs are ideally positioned to address behavioral health in the American workplace, as well as in other countries. According to the March 2013 National Compensation Survey (U.S. Department of Labor, 2012), more than half of American workers have access to an EAP, and the Society for Human Resource Management found that more than three-quarters of surveyed work organizations offered an EAP to their employees (Society for Human Resource Management, 2013). EAPs respond to a wide range of health concerns affecting workforce performance and productivity. Historically, EAPs focused narrowly on the problem of alcohol abuse in the workplace (Sonnenstuhl, Trice, Staudenmeir, & Steele, 1986) but evolved to provide a broad range of services to organizations, employees, and their families (Googins & Davidson, 1993). More recently, EAPs have embraced critical incident response, behavioral risk assessment, and an expanded range of organizational consultation services, including greater integration with wellness and physical health promotion (Bray, Karutzos, & MacDermind, 2010; Taranowski & Mahieu, 2013).

EAPs now offer comprehensive behavioral health resources and are well-equipped to address the essential behavioral needs of the American workforce (Osilla et al., 2009). Table 1 provides a list of seven EAP core-service areas, which are based on the traditional Core Technology of EAP (Jacobson & Attridge, 2010; Roman & Blum, 1998; Warley & Hughes, 2010). Unfortunately, rigorous research designed to determine the efficacy of these core services has lagged (Attridge, 2010; Jacobson, Pastoor, & Sharar, 2013) in ways similar to the lack of controlled research on employee health promotion (Lerner, Rodday, Cohen, & Rogers, 2013). In particular, the extent to which employees use EA/WBH services is not well-documented (Bray et al., 2010).

Data from a convenience sample of EA practitioners provided in Table 1 (Attridge & Burke, 2011) show the seven types of services clients use, the importance of those services to the EA profession, and potential market growth in such services. Screening and referral to treatment, the most commonly used service, has also the greatest growth in EBPs (Mahieu & Taranowski, 2013) with recent studies pointing to effectiveness (Sharar, Pompe, & Lennox, 2012). There have been developments in evidence-based technologies for other service areas such as prevention and the integration of EA with wellness (Ames & Bennett, 2011; Bennett & Lehman, 2003), but these have seen little uptake by work organizations.

Although some stakeholders outside the EA field have long had an interest in promoting effective EA/WBH services, they have not contributed to shaping a coherent research agenda. The

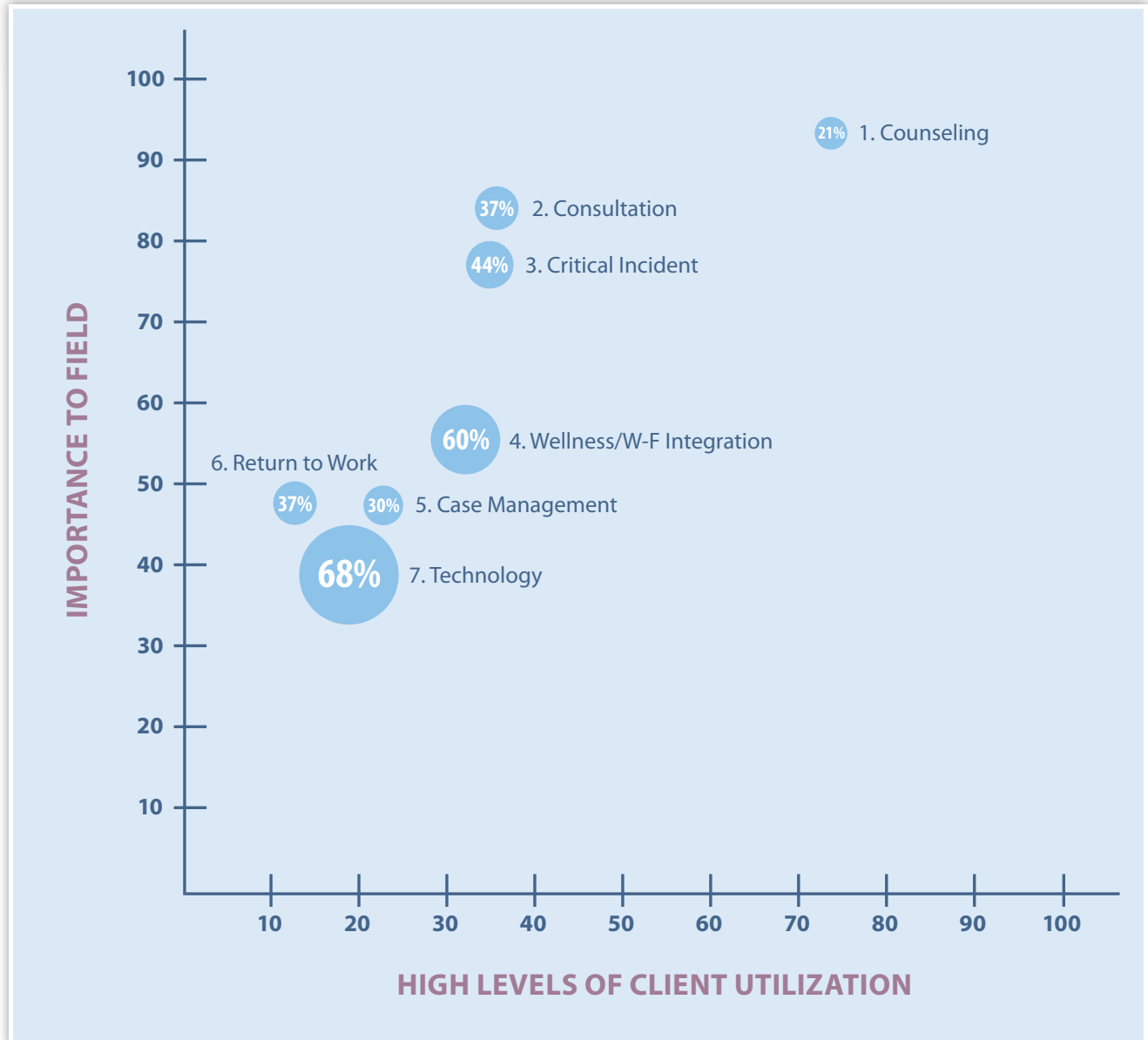
implementation of the ACA makes now an opportune time for these diffuse voices to drive this agenda. For example, in 2012, the U.S. Department of Health and Human Services (DHHS), Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment funded 30 grants to study Screening, Brief Intervention, and Referral to Treatment (SBIRT). These grants have spurred leaders within the EA field to adopt SBIRT into their EA/WPBS, even though the majority of SBIRT research has been conducted in medical settings (Babor et al., 2007). Also in 2012, the DHHS' Agency for Healthcare Research and Quality funded the Wisconsin Initiative to Promote Healthy Lifestyles. The project produced tools for work organizations, including a cost-effective behavioral screening and intervention program that assists healthcare professionals to screen employees for behavioral health and wellness issues (Lifestyles, 2014).

## 2.2 EMERGING POPULATION TRENDS

An important emerging trend in EA/WBHS is the growth in behavioral health services among National Guard and Reserve military personnel who have significantly higher risks than both the general population and active duty services (Erbes, Kaler, Schult, Polusny, & Arbisi, 2011; Proctor, Smith, Heeren, & Vasterling, 2014). In 2007, the U.S. Department of Defense released "An Achievable Vision: Report of the Task Force on Mental Health" (U.S. Department of Defense Task Force on Mental Health, 2007) with recommendations that helped establish the National Guard Bureau (NGB) Psychological Health Program (Joint Services Support), 2013). This program functions like an EAP, consisting of 196 licensed counselors who serve approximately 460,000 soldiers and airmen. The Reserve and National Guard have unique challenges unlike active duty members in the military health system. As citizen-soldiers and citizen-airmen, these individuals are not located on installations and also hold positions in the civilian workplace. Yet, at one point, the Reserve provided approximately 40% of all service members deployed to Iraq and Afghanistan (Litz & Schlenger, 2009). While the potential mental health sequelae associated with exposure to combat or domestic operations, including environmental or man-made disaster mitigation, have made psychological health counselors a critical component of the National Guard support team, there has been no systematic research on the impact of such services for this population.

Many other subgroups or high-risk populations can benefit from the research proposed later in this document, including young or "emerging" adults who are transitioning into the workplace and first careers. Youths aged 18-25 are at highest risk for mental health and substance use disorders (Christie et al., 1988) and are a target for increased health care coverage by

**Table 1. Seven Core Employee Assistance Services and Percentage of Providers Reporting Client Use, Professional Importance, and Increasing Business Value (adapted from Attridge & Burke, 2011)**



*\*Size of circles represents percentage reporting that the service will have increasing business value.*

1. Confidential access to a counselor for problem assessment, brief clinical support and referral for employees (and often family members)
2. Consultation with managers and other organizational level support
3. Critical Incident Response (CIR/CISD) for workplace violence, traumatic events and natural disasters
4. Integration of EAP with Work/Life and Wellness services to support families, prevention, and behavioral lifestyle change
5. High-risk case finding and long-term case management for employees with mental health and addiction issues
6. Return to Work, Stay at Work and workplace staff support for employees on STD/LTD disability leave for MH and addiction issues
7. Technology and web-enabled services for education, self-care and clinical support from EAP counselors.

the ACA (Cunningham & Bond, 2013). A SAMHSA-sponsored cross-site project (2008-2011) began to identify mechanisms through which these workers can be reached with EA/WBHS (Bray, Galvin, & Cluff, 2011). The documentation of growing health disparities among working-age minorities (such as Native Americans) can be applied to the study of EA and WBHS (Jacobson & Sacco, 2012). Further, EA services are significantly less available in small businesses (Harris et al., 2014; Larson et al., 2007) which typically have higher rates of substance abuse (Larson et al., 2007) that can be reduced through prevention/EA efforts (Reynolds & Bennett, 2015).

### 2.3 VISION STATEMENT

The urgent need for an EA/WBHS research agenda led the authors to develop the following vision statement:

Employee assistance professionals, programs, and resources provide a significant value to public health by virtue of reaching a wide segment of the population: work organizations, employees, and family members. Enhancing this value requires assessing best practices, effective services, causal mechanisms, and mediating factors that influence both clinical and productivity-related outcomes. Collaboration among researchers, work organizations, employees, educators, and professionals is needed to enhance the overall quality and efficiency of EA/WBHS services and improve the behavioral health and well-being of both the workforce and the workplace.

## 3. FRAMEWORK FOR A SOLUTION

The EA/WBHS field needs evidence-based research to discern what works, for whom, when, and with what outcomes. To help guide the establishment of this evidence-base, Figure 1 displays a framework for organizing future research efforts. The framework derives from the disciplines of translational research (Drolet & Lorenzi, 2011; Fishbein & Ridenour, 2013; Keramaris, Kanakaris, Tzioupis, Kontakis, & Giannoudis, 2008), implementation research (Fixsen, Blase, Naoom, & Wallace, 2009; Proctor et al., 2009), and team science (Stokols, Hall, Taylor, & Moser, 2008). From translational research comes the concept of advancing research from the “bench to the bedside”; that is, EBP which are originally developed in relatively controlled settings but eventually adopted in, or translated to, less controlled real world settings. From implementation research comes a recognition of the need to study the settings and processes of delivering or disseminating WBHS. From team science comes the vision and strategy to promote true collaboration between the multiple stakeholders involved in workplace research and practice.

## 3.1 AREAS OF INVESTIGATION

The framework shown in Figure 1 suggests Areas of Investigation (left panel) along two dimensions: (1) areas for focusing future EA/WBHS research, and (2) avenues for applying evidence to help guide or inform practice. These dimensions correspond roughly to the areas of implementation and translation research described above. Table 2 expands on this element of the framework and provides examples of possible, related research questions. The questions in Table 2 are clearly not an exhaustive listing; rather, they represent a starting point from which future research questions can be added. Along the horizontal dimension are three basic avenues for applying evidence to practice derived from translation research: (1) establish the evidence for existing models; (2) identify practices in other areas outside of the EA/WBHS field that could be transferred and applied to EA/WBHS (e.g., SBIRT from medical settings); and (3) establish an evidence-base for novel practices or approaches that are unique to the EA/WBHS field.

The other dimension (implementation) identifies three focal areas for such research: professionals, services, and programs and policies. Research on professionals focuses on the multi-disciplinary nature of the EA practice community; potential areas of study include exploring the relationship between professional certification and counselor adherence to EBPs (Aarons et al., 2010) or assessment of EA competencies (Jacobson et al., 2013). Service-level research focuses on the services themselves, such as assessing outcomes for specific types of counseling practices, ideally, through randomized clinical trials. Research focused on programs looks at EAPs as whole entities and might explore factors associated with successful implementation of EBPs and includes workplace policies (e.g., drug-free workplace), EAP supportive health promotion or prevention programs, national policies (e.g., on alcohol and drug control), standards of care (e.g., The Joint Commission [JCAHO]), and studies on factors shaping the field.

## 3.2 FIVE COLLABORATORS

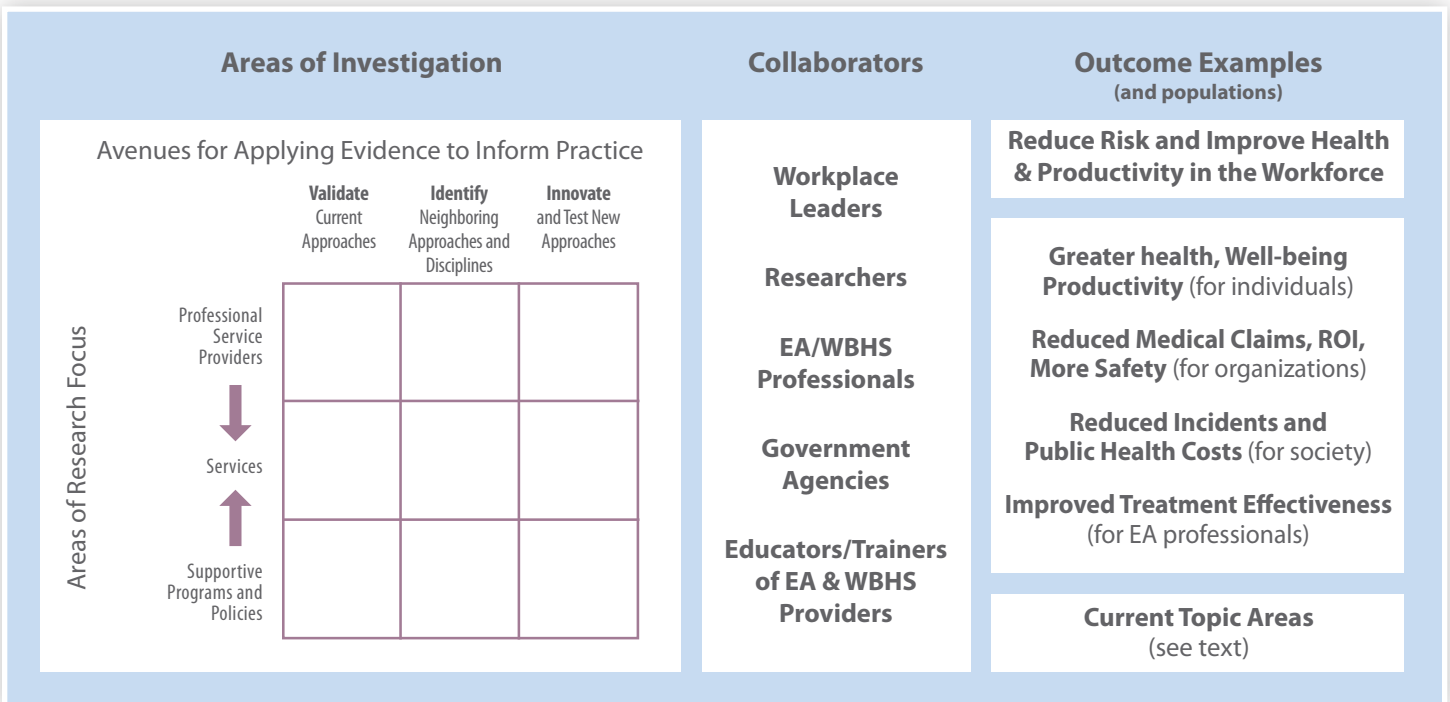
We believe that in order to advance research representing any of the cells in Table 2, it will be increasingly necessary to embrace the team science concept of multiple collaborators, each bringing a different perspective. Improving research on EA/WBHS is a complex endeavor and requires support and active participation from work organizations, employees, service professionals, and funding agencies. The authors of, and contributors to, this article represent five major constituencies who seek support for collaboration. These areas are: workplace leaders (i.e., organizational consumers) across all industries; EA/

WBHS professionals; researchers from disciplines that interface with EA/WBHS (e.g., public health, mental health, addiction, workplace health and productivity, risk management, human resources, administrative science); representatives from relevant funding and governmental policy agencies (e.g., the U.S. Centers for Disease Control and Prevention, the National Institutes of Health, SAMHSA, the Office of National Drug Control Policy) who can encourage research or have a role to play in relevant policy such as the ACA; and educators/academicians who prepare future generations of EA/WBHS professionals. Stakeholder interest overlaps with the areas of investigation, as shown in Figure 1. The three main Collaborators (mid-panel of Figure 1) are service professionals, workplace leaders who purchase and provide access to services (work organizations, human resource managers, insurance entities), and researchers who must coordinate with these other stakeholders to accomplish study goals. The positioning of collaborators in the center of Figure 1 is deliberate; we hypothesize that successful collaboration in both implementation and translational research is a necessary condition for sustainable and replicable positive health outcomes to occur. In addition to these three main collaborators, educators provide development of professionals for service

delivery and collaboration, and government agencies can support research and influence policies that bear on these types of collaborations. The Mental Health Parity and Addiction Equity Act of 2008, extended and reinforced by the ACA, is one example.

The ultimate goal of collaboration is to reduce risk and improve the health and productivity of the workforce; that is, achieve Outcomes (right panel, top of Figure 1). This will involve not only achieving outcomes of relevance to individual employees, for the organizations they work in, and to society as a whole, but also outcomes of greater effectiveness for EA/WBHS practitioners (right panel, bottom of Figure 1). That is, we conceive of improved health and productivity as a general rubric that has different meanings for the different collaborators and for those they serve. While employers might want to know the financial return on investment (ROI) from an EAP in their human resource benefits package, focusing on ROI as a primary outcome diminishes the collaborative intent of the framework and the value of other relevant outcomes (e.g., consumers knowing what works or practitioner EBP guidelines).

**Figure 1. An Organizing Framework for EA/WBHS Research**





### 3.3 OUTCOMES

Our proposed framework organizes research topics into a single matrix (Table 2) but does not provide a priority ranking of all the possible populations or outcomes that could potentially be studied. Possible populations include those noted above (military, emerging adults, minorities, small businesses) and also employees stratified by occupation or industry, family members, work organizations, labor unions, and customers/consumers. Potential outcomes of study are equally diverse and may include organizational results such as productivity, medical claims, disability, or safety incidents; public health metrics such as reduced disease prevalence or harm reduction; and individual outcomes such as quality of life, well-being, satisfaction, or disease/disorder resolution. Given the diversity of outcomes and associated measurement techniques (e.g., from administrative data to biological specimen collection to

employee self-report), interdisciplinary research is also needed to investigate which outcomes are most salient and how best to measure them.

One critical area pertains to productivity. Recent published investigations of self-report measures with sound psychometric properties (Koopmanschap et al., 2005; Lofland, Pizzi, & Frick, 2004; Prasad, Wahlqvist, Shikiar, & Shih, 2004) suggest it is viable to assess productivity outcomes that can be applied to WBHS studies. While it is not clear that these measures are sensitive to the impact of behavioral health on productivity, recent studies with the Workplace Outcome Suite suggest that EAP interventions may result in increased productivity (Sharar, & Lennox, 2014; Sharar, Lennox, & Burke, 2010). Clearly, additional studies are needed to advance productivity measurement to develop the right tools for assessing EAP relevant outcomes.

**Table 2. Areas of Investigation for Future Research Efforts (with example questions)**

	<b>Validate Current Approaches</b>	<b>Identify Neighboring Approaches and Disciplines</b>	<b>Innovate and Test New Approaches</b>
Professionals	<ul style="list-style-type: none"> <li>• How effective are training programs for developing EA professionals?</li> <li>• What are the core competencies of EA service professionals?</li> <li>• What attitudes do EA professionals have?</li> </ul>	<ul style="list-style-type: none"> <li>• How do different core disciplines within the EA profession approach their work (e.g., psychologists versus social workers)?</li> <li>• What key collaborations serve as best practices for WBHS?</li> </ul>	<ul style="list-style-type: none"> <li>• How does the profession view innovation?</li> <li>• What are the barriers to testing new approaches?</li> </ul>
Services	<ul style="list-style-type: none"> <li>• How effective are existing EAP protocols in core service areas (see Table 1)?</li> <li>• What is the impact of emerging technology on EA/ WBHS effectiveness?</li> </ul>	<ul style="list-style-type: none"> <li>• How can EAPs effectively adapt services used in other fields of public or occupational health?</li> <li>• Can EAPs apply other public health models, such as the Triple Aim?</li> </ul>	<ul style="list-style-type: none"> <li>• What types of studies are needed to develop innovative EA/ WBHS services?</li> <li>• Can health media make EA/ WBHS services more effective?</li> </ul>
Programs and Policies	<ul style="list-style-type: none"> <li>• How can researchers help EAPs test and adapt EBP?</li> <li>• What makes EAPs unique and requires special training to deliver services?</li> <li>• What policies are needed to enhance or regulate current approaches?</li> </ul>	<ul style="list-style-type: none"> <li>• Which programs benefit from collaboration with professionals outside the EA field?</li> <li>• What interdisciplinary projects will result in better uptake of EA/ WBHS?</li> <li>• How can workplace policies guide collaborations for better service delivery?</li> </ul>	<ul style="list-style-type: none"> <li>• How can national policy foster greater involvement amongst work organizations to get their participation in EA research?</li> <li>• What types of “disruptive technologies” will help vitalize the EA/ WBHS field?</li> </ul>

#### 4. CURRENT TOPIC AREAS

The proposed framework provides a general map for identifying research areas, the collaborations required, and the targeted outcomes. As the field evolves, we anticipate that different topical areas (key populations and outcomes) will become more salient or take on special interest. To identify current topics, listed below are findings from a Research Summit hosted by the Employee Assistance Professional Association (EAPA) in Baltimore, Maryland, in October 2012 (EAPA, 2012), which convened 55 researchers, EA professionals, and government representatives who identified the following key populations and/or outcomes of growing interest: veteran workplace integration, crisis intervention and mental health, health and productivity, alcohol and drugs, innovation research and development, refining the EAP value statement, and resilience. A summary of each is provided in the next section.

**Veteran Workplace Integration (VWI).** As noted above, under Emerging Trends (Section 2.2), increased research efforts with the military, and more specifically, veteran workplace integration, is a timely issue. Work organizations appear to be eager to accommodate returning Gulf War Era veterans but many have concerns about the productivity impact of physical and psychological injuries (Proctor et al., 2014; Tsai & Rosenheck, 2013). It is important to develop empirically tested methods to meet the needs of returning veterans and their family members, as well as the needs of their work organizations (cf. Hall et al., 2014).

**Crisis Intervention and Mental Health.** Since the September 11 terrorist attacks on the U.S., critical incident responses have become a standard EA practice (Paul & Thompson, 2006). Much remains to be learned about the effectiveness of specific interventions for a range of workplace critical incidents. The evidence on the early (but prevalent) practice of a Critical Incident Stress Debriefing approach suggests this intervention may have been inert at best and iatrogenic at worst (Attridge & VandePol, 2010; Bryant, 2007; Feldner, Monson, & Friedman, 2007). Similarly, the area of behavioral risk assessment and intervention requires further study, particularly for employees exhibiting high-risk behaviors that can damage overall work productivity and threaten workplace safety. This includes the study of bullying and violence, working under the influence of alcohol or drugs, sexual harassment, and related trauma.

**Health and Productivity.** Both business leaders and EA professionals have expressed interest in the emerging field of workplace health and productivity (Frey, Osteen, Bergland, Jinnett, & Ko, 2015; Selvik, Stephenson, Plaza, & Sugden, 2004; Towers Perrin, 2013). It is generally accepted that wellness interventions with an emphasis on prevention will enhance workforce productivity (Towers Perrin, 2013; Goetzel et al., 2014). However, the evidentiary basis of the relationship between specific wellness interventions and how an EAP impacts such interventions, remains to be demonstrated.

**Alcohol and Drugs (AOD).** The impact of drug and alcohol use and abuse in the workplace remains a major social concern (Frone, 2013). Historically, EAPs were developed to address these issues (Roman & Blum, 1998), but the effectiveness of the original EAP core technologies in the contemporary workplace needs review (Frey et al., 2013). Moreover, the impact of newer techniques, from primary prevention to evidence-based screening and brief intervention to relapse prevention, also justifies continued study (Ames & Bennett, 2011).

**Innovative Research and Development (R&D).** There is considerable interest in the development of new practices, including therapeutic application of communication technologies, telephone and web-based supported counseling, social media such as content specific blogs, and the utilization of smart phone applications (Anthony, Nagel, & Goss, 2010; Pulier, Wilhelm, McMnamin, & Brown-Connolly, 2012). Additionally, some practitioners are exploring the utility of predictive analytics (Wojcik, 2013). Research is needed on innovative methods to reduce existing stigma and engage workers to seek or accept services, moving beyond the “telephonic intake” commonly used by many EAPs. Broadly stated, the EA/WBHS field must build and enhance its capacity for ongoing, relevant research, especially with rapid growth in mental mobile health technologies (East & Havard, 2015).

**Refining the EAP value statement.** EAPs have long sought to establish their cost-benefit and ROI to workplace stakeholders. However, such research is lacking and not commensurate with current investments in EA services (Attridge & VandePol, 2010; Frone, 2013). A new generation of research on the economic value of EAPs should move beyond standard ROI approaches, examine the value of the EAP as a whole in addition to specific EAP services, and demonstrate the value of EAPs relative to

New studies can spur needed innovation in EAP services

other workplace programs with common outcome measures including, but not limited to, workplace productivity, employee safety, and quality of life outcomes related to the use of WBHS.

**Resilience.** There is growing interest among EA/WBHS clients and customers for programs that address resilience and the general capacity to strengthen well-being and competencies for handling workplace stressors (American Psychiatric Foundation, 2013; Spangler, Koesten, Fox, & Radel, 2012). At the same time, there is a dearth of research on resilience in adult working populations. The study of resilience focuses more on psycho-educational, preventive, and organizational-level strategies that EAPs may be best situated to deliver. The related areas of well-being and mental health promotion in work settings are also growing rapidly (Chen & Cooper, 2014; Czabala & Charzyńska, 2014) and could benefit from collaboration with EAPs. However, any reference to EAP/WBHS is missing in these studies, as well as in articles offering policy guidance for promoting workplace well-being (Schulte et al., 2015).

## 5. UPDATE: CURRENT RESEARCH CAPACITY

As a follow-up to the aforementioned 2012 Research Summit, a Practice-Based Research Network (PBRN) steering committee met to continue discussions about these and other topics. A survey project (conducted late 2014) assessed current research capacity and interest amongst administrators of EAP programs, as well as EAP researchers, professional educators/academics, and consultants (total N= 65).

Four key findings from the survey are relevant to the current paper. First, the majority of respondents identified that evidence-based research is important to their organization's mission and that a valid research base is important for the services/functions their organization provides. Second, even with such interest, few respondents indicated having received external research funding or had organizational commitments to pay for such research. When funding was obtained, it was most likely from government grants or contracts. Third, the vast majority of respondents had access to some type of data that could be mined for study purposes (including employee self-reports, human resource information, insurance data, employee disability, and employee performance review data). Fourth, the majority indicated that either they, personally or their organization, had an interest in collaborations on future research projects.

Taken together, these findings suggest great interest and capacity for conducting and collaborating on research but lack of financial resources to conduct such research. Hence, there

is currently little momentum to advance EA/WBHS research, despite the continued challenge of employee behavioral health, the ability for EA/WBHS capacity to address this issue, and the significant interest and ability to conduct research.

## 6. A CALL TO ACTION

The impact of work organizations on public health depends on healthy work environments and employee health and productivity. Such health is supported by the development and refinement of tools for managing behavioral health risks and promoting resilience (Colvin & Taylor, 2012). The framework proposed here can only serve these ends if the EA/WBHS field receives attention and support from public health advocates. Following from the vision statement above, we recommend the following call to action to engage work organizations, encourage dialogue, and stimulate research.

**For the leaders of work organizations:** (1) Ask for education about evidence-based services; (2) Utilize EBP in areas that enhance productivity; (3) Encourage employee full participation in studies of all types (polls, surveys, experiments); and (4) Encourage EA service providers to conduct credible workplace outcome evaluations with valid measures and acceptable response rates.

**For providers of EA services:** (1) Initiate direct dialogues with business leaders to assure delivery of effective services and use of evidence-based training; (2) Provide enhanced quality monitoring of the use of EAP sub-contractors and affiliates; and (3) Hold affiliates accountable for using evidence-based approaches.

**For researchers:** (1) Apply innovative experimental and quasi-experimental approaches to establish the effectiveness of EA/WBHS services in comparison to other workplace programs targeting similar outcomes; (2) Find innovative ways to persuade work organizations to support EA/WBHS-related research and to allow workers to participate under proper conditions; and (3) Use the framework provided in Figure 1 to plan interdisciplinary studies and business-provider-research collaborations.

**For grant funding agencies:** (1) Identify specific review panels for EA/WBHS research; (2) Ensure reviewers have appropriate experience in conducting EA/WBHS research to promote continuity and consistency in reviews; and (3) Support funding announcements that encourage research among the areas and collaborators in the framework.

**For educators and academicians:** (1) Develop advanced degrees and training curricula to promote the use of EBP among EA/WBHS professionals; (2) Develop cross-disciplinary programs that foster partnerships between different disciplines (e.g., management, psychology, social work, human resources); and (3) Articulate and synthesize theories and conceptual frameworks that can help advance research.

## 7. DISCUSSION

Continued neglect of research in EA/WBHS portends several problems, including stagnation for the field, ineffective education and training of new EA professionals, and lack of innovation. Without a commitment to high-quality research, public health stakeholders will continue to lack evidence-based standards to guide both professionals and consumers toward effective and optimal use of EA/WBHS. The scientific basis for valuing EA/WBHS remains limited, despite their widespread and routine use by millions of people. While traditionally the EAP is the most frequently used provider of such WBHS, market trends suggest that other disciplines are beginning to apply their own tools (e.g., wellness, work-family services) for similar services. The EA/WBHS marketplace is currently fragmented and needs a framework to advance our understanding of these services for the benefit of advancing public health.

This paper provides a framework for new studies, a list of research domains of interest to stakeholders, and a call to action to initiate a new era of research. The call to action is the most important as the field looks for new ways to enhance the behavioral health of the workforce, its impact on work organizations, and on public health in general. Readers are encouraged to use their role (as one of the five collaborators), and the ideas in this paper, to collaboratively build a public health evidence-base for EA/WBHS.

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