

Employee Assistance Program Counseling in the U.S. Healthcare Industry: Clinical and Work Outcome Risks and Results for 15,794 Cases at CuraLinc Healthcare

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Abstract: This applied study explored the role of behavioral health issues among workers in the healthcare industry in the United States. It features highlights of our larger study in 2024 of eight different industries. The 24.9 million employees in the healthcare industry accounted for 16% of the total U.S. workforce. Recent data on number of worker, number of employers, worker age, gender, private/public sector, union representation, compensation, and safety from the U.S. Bureau of Labor Statistics for 7 other industry categories was presented to provide context for this one industry. The study primarily featured EAP data collected over a 7-year period from employee users of individual counseling or coaching from a single national EAP business in the United States (CuraLinc Healthcare). The full sample included 85,432 clients who worked at 2,679 employers. The EAP user sample for the healthcare industry group included 15,794 employee clients who worked at 458 hospitals and healthcare companies. Longitudinal data at 30-days post use was obtained from 9,063 cases in the full sample (including 1,602 from healthcare). The healthcare industry client sample was 80% women and 20% men, average age of 40 years, 94% used the EAP for counseling (6% for coaching), 98% were voluntary self-referrals (2% were formally referred to use counseling by their manager at work), 61% met with a counselor in person (39% online video) and the typical treatment episode lasted about 7 weeks (54 days). The reasons why employees in the healthcare industry used the EAP included issues of mental health (48%), stress and personal life issues (27%), marriage and family issues (16%), work-related issues (7%) and substance use problems (2%). When starting to use the EAP many of the cases in healthcare reported having clinical level symptoms on standardized measures for anxiety disorder (44% at-risk), depression disorder (30% at-risk), alcohol misuse disorder (12% at-risk) and low work productivity (50% at problem level). Among those cases initially at clinical risk status on outcomes in the total sample, severity scores from Pre to Post were reduced by almost two-thirds for anxiety, depression, alcohol misuse and hours lost work productivity. Among those cases initially at clinical risk status on outcomes in the total sample, over three-fourths recovered to healthy status after use. Among the half of the total cases who initially had a work productivity problem, the hours of lost work productivity per case per month changed from 64 hours to 24 hours. The hours of restored work productivity was estimated to be a \$1,731 value per month per case who initially had this problem. Most of these EAP use profile factors and outcome improvement results were found at similar levels for the other seven industries.

Index Terms: absenteeism, alcohol, anxiety, counseling, depression, employee assistance program, healthcare, hospital, industry, presenteeism, work

I. INTRODUCTION

This study profiles employees in the healthcare industry who used employee assistance program (EAP) services at one large national provider. The United States (U.S.) civilian labor market includes over 157 million workers in January of 2024 [1-3]. These employees work in hundreds of different industries [4]. The healthcare industry represents 16% of all workers in the total U.S. workforce and 24.9 million workers [5]. A small segment of this industry type also involves religious, civic, and other supportive organizations in the private sector [6]. In this industry has 3 in every 4 workers are women (74%; 26% men), the average worker is 43 years old and 8% of workers are represented by a union. The typical worker earns \$34 per hour in compensation and works 33 hours per week. Of the 2.1 million employers in healthcare, 99% are in the private sector. This industry has an annual rate of 4.2 cases per every 100 employees who experience a workplace injury or illness – which is one of the higher rates.

1.1. Behavioral Health and the Healthcare Industry

Behavioral health disorders such as anxiety, depression and substance misuse affect more than 1 in every 4 employees each year in the U.S. [7-9]. These disorders adversely impact organizational success in many areas, including increased health care costs, losses from excess absence and lost work productivity, employee turnover, workplace accidents, violence, disability, suicide and death [10,11]. Most employers support their workers in many ways including offering an employee assistance program (EAP) [12]. EAPs are designed to help workers resolve acute but modifiable behavioral health issues and use of individual confidential counseling can restore the emotional, mental and work performance of employees [14,15]. Recent national U.S. data from March of 2023 shows that 64% of full-time workers have an EAP available to them from their employer [16]. In the private sector, a total of over 3.2 million employers sponsor an EAP and the majority of public sector organizations in the U.S. also offer an EAP benefit to their workers [17,18].

The healthcare industry has research documenting a variety of working conditions that contribute to stress, burnout and behavioral health disorders among its workers [19]. Most staff at hospitals and health systems work long shifts and overtime and thus suffer from sleep deprivation and related health problems [20]. Other workplace risk factors involve threats and attacks from patients during the course of work involving verbal and physical violence [21]. A 2015 study of 11,000 hospital workers in the U.S. found that 39% had experienced workplace violence in the past year (mostly from patients) [22]. The workplace experience for healthcare workers in the U.S. became even less safe since the COVID-19 pandemic due to politically motivated members of public who attacked frontline health care workers for administering vaccines and related lifesaving medical care treatments [23,24]. Healthcare workers in other countries also reported increased workplace stress during the pandemic [25-28].

1.2. EAPs and the Healthcare Industry

The healthcare industry has a long history of collaboration with EAP programs dating back to the 1990s [29]. According to Csiernik and colleagues in their 2001 paper [30]: “Employee Assistance Programs have become integral components of health care institutions throughout North America. Their value in aiding employees and their family members contend with a wide range of work-related personal problems has been widely reported and acknowledged.” (p. 37). Others have described the purpose and operational aspects of setting up an internal staff model program to provide EAP counseling and organizational consulting to the employees working at a particular hospital or health system, with five employer examples from the U.S. [31-35], two from Canada [29,30], two from South Africa [36,37] and one from China [38]. Often these EAP staff model programs at hospitals are integrated internally with other allied programs such as nurse wellness, work/life, and financial and legal advice support services. The development of a congregational EAP designed to serve two churches in Canada also was documented [39].

Several of these papers have also presented the results of empirical tests of longitudinal changes in mental health clinical and work outcomes from before to after use of EAP counseling by healthcare workers. The internal program at Partners Health Care System in the U.S. examined the role of the EAP to screen clients for alcohol risks [33] and they also collected Pre and Post EAP counseling outcome data from over 500 hospital staff employees. Their results for the Workplace Outcome Suite [40] measures found significant reductions over time for the average EAP case for hours of work absenteeism and work presenteeism and also for improvements in work engagement and overall life satisfaction [34].

An outcome study conducted at the Mayo Clinic in the U.S. also found significant improvements after use of EAP counseling [35]. Data collected from 82 hospital staff who used individual counseling indicated that all of these users would recommend the EAP, 90% decreased their stress levels, 92% reduced their feelings of anxiety, 88% enjoyed an overall improvement in mood, and 95% developed new skills and none reported that their clinical symptoms got worse after treatment. Among the cases with work-related presenting issues at the EAP, 96% agreed the counselor understood the work culture and was able to provide helpful guidance and that 86% found that suggested strategies to reduce burnout were effective. Qualitative analysis of comments from the individual counseling clients indicated they highly valued the support provided by their clinicians. This study also evaluated the organizational consulting services provided by the EAP to managers and leaders at the hospital. These results (based on data from 50 clients) indicated the EAP services increased their confidence as leaders, supported their work, and provided tangible guidance to resolve staff and work team problems. Thematic analysis of comments concerning the organizational consulting services indicated that EAP supported leaders by listening and offering coaching on how to handle difficult situations and that having an internal program was appreciated.

Another outcome study of a hospital in Shanghai, China [38] examined the ability of EAP counseling to improve the mental health of the staff during the novel coronavirus epidemic in 2020 and 2021. Longitudinal self-report data was collected from over 650 EAP counseling users on the Symptoms Checklist 90 (SCL-90). In their total sample, significant reductions were obtained in the total mental health score and also for anxiety and depression disorder symptoms. Positive changes were also identified for various mental health conditions for different groups of workers, including physicians, nurses, and medical technicians but not among the office staff workers.

A related study surveyed over 26,000 public healthcare workers in the U.S. was conducted to learn why the EAP services available to them were *not* used during the COVID-19 period [41]. This large nationally representative sample was characterized by low salaries,

high workloads, and burnout and that all of these factors contributed to staff turnover in these public health agencies. Among a subset of the sample (over 13,000) who reported one or more reasons why they had not taken advantage of the no-cost licensed counselors at their local EAP the study results revealed: 51% felt that they did not need any counseling; 23% did not think that it would help; 11% had concerns about the quality of the and effectiveness of the counseling; 10 were not sure it would confidential (i.e., fears someone at work would find out about use of counseling); and 4% thought that the counselor would not be able to relate to their situation. These kinds of barriers to EAP use need to be better understood and overcome in the future. However, from a factual basis, the kinds of concerns identified in this study are all largely unfounded as multiple research studies have documented how EAP counseling is actually clinically effective for the vast majority of healthcare workers who have used it (and for workers in many other industries as well) and that standard healthcare patient-provider treatment privacy rules do apply to EAP counseling interactions. Nonetheless, it is important to know that personal stigma concerning mental health and especially addiction-related disorders can prevent people from seeking the psychological treatment they need.

A final theme of the research on EAP in healthcare settings involves violence experienced in the workplace and related psychological trauma [42,43]. A study of 120 critical incident response (CIRs) provided by a global specialty partner to EAPs (Crisis Care Network) examined six years of data from over 28,000 employee participants [44]. Their analysis revealed that death events in the workplace were the most common type of crisis and that 8% of their total activity to support death events in the workplace occurred for healthcare and social assistance workers. They also found that 4% of the CIRs delivered for events related to organizational layoffs and downsizing occurred for healthcare and social assistance workers.

In summary, the literature on behavioral health in the healthcare industry shows the nature of the work conditions can pose increased stress, safety, and behavioral health risks for these workers. The frequent contact between workers and patients also raises concerns for preventing violence and abuse and how to cope with post-incident trauma. This industry has received some research attention historically that was specific to EAP use and has several good examples of finding positive clinical and work outcomes for healthcare workers. Yet, these past outcome studies all used small sample sizes of EAP counseling users and generally were case studies conducted at single hospital employers. The present study was done to increase our understanding of EAP relevance and effectiveness for healthcare workers.

1.3. Highlights from EAP Study of Eight U.S. Industries – Focus on Healthcare

CuraLinc Healthcare has been in business since 2008 and currently this company has over 4,200 employer customers that offer the EAP as a benefit to over 8 million employees. We leveraged the available client background and operational data to construct profiles of eight different major industries. Clinical risk and work outcome data was also routinely collected on many of these employees. This company has conducted six other empirical studies examining a variety of aspects of their EAP services and outcomes [45-50]. In the newest study, we analyzed recent national data collected over a 7-year period from over 85,000 cases from this EAP [50] to profile employee users in eight different industries. We identified the prevalence rates among EAP users for clinical risks for common behavioral health conditions (anxiety, depression and alcohol misuse) and also the rate of employees with problem levels of work absenteeism and work presenteesion that manifest in hours of lost productive time. We learned how workers use employee assistance program counseling and coaching services. We also discovered how effective use the EAP was in reducing these behavioral health and work-related problems. For details on the study methodology and analytical procedures, please see our earlier comprehensive report on all of the different industries in the U.S. [50]. The present study highlights key findings from the previous study for workers in the healthcare industry and compares this industry to seven other industries.

II. METHODOLOGY

2.1. Archival Business Data and EAP Use Profile

Users were made aware of the service as a benefit open to all covered employees through a variety of digital, interpersonal and workplace promotional practices. There was no direct cost to the employees in this study, as access to the EAP was sponsored by their employer. Employees participated voluntarily and were not paid for using the services. The study period spanned 80 months, from April of 2017 through December of 2023, based on the start date of program use. The last case included in the study had a Post use data collection date of January 4 of 2024. The year of use was defined by date of when the employee contacted the program and completed the initial intake assessment (2017 to 2023). The case-level raw data was aggregated into one master dataset and analyzed for the present paper. The full sample included 85,432 clients who worked at 2,679 different employers in the United States.

Some data came from the operational business processes used by the staff and clinicians who provided the services. Part of this process involves recording core aspects of the business customer context, employee demographics and the clinical use experience. For this study we extracted the following information from the operational data system: name of employer/customer, industry, maximum clinical sessions allowed per case in the employer/customer contract, date of first use of the service, date of follow-up survey, employee age

(date of birth), employee gender, source of referral to the EAP (self or formal referral from management), type of EAP service used (counseling or mental health coaching), primary clinical issue (alcohol, depression, work and so on) and the modality of how the service was delivered via online video or in-person at the counselor’s office.

2.2. Counseling Intake and Intervention

As per the clinical practice model, every employee who requested support from CuraLinc was referred to a clinician with a specialty that matched their presenting issue or concern who also had confirmed appointment availability. All counselors involved in the delivery of the clinical treatment services were fully licensed and trained professionals, with earned master’s or doctoral degrees in social work, mental health or other related fields. Clients had a use model determined by their employer that limited the maximum number of counseling sessions allowed per treatment episode. This per case treatment limit ranged from a limit of 3 sessions to 10 or more (the average was 6 sessions of EAP counseling allowed at no cost to the employee).

2.3. Self-Report Outcomes Measures Collected at Pre and Post Use

During the initial assessment, the multiple self-report measures were collected, either over the telephone or from a brief online survey. After the treatment phase was completed, the EAP conducted individual follow-ups with clients about 30 days after the last clinical session to collect outcome measures and evaluate other quality of use metrics. The follow-up for coaching clients was at one week after the final session. Standardized measures of behavioral health and work outcomes were assessed using published and validated self-report scales. All of these measures had acceptable levels of psychometric validity and reliability. See the full study for details on how these measures were scored and standardized across time involving the two study phases [50]. When the research project started in 2017 it featured two clinical measures, one for general depression symptoms (Patient Health Questionnaire 2-item brief scale; PHQ-2) and the other for hazardous alcohol use and binge drinking (Alcohol Use Disorders Identification Test brief 3-item version; AUDIT-C). Later in August of 2021, an additional clinical measure was added to assess anxiety disorder symptoms using the brief 2-item version of the Generalized Anxiety Disorder scale (GAD-2). Two work-related outcomes were also measured throughout the entire project. Employee work absenteeism was assessed during Phase 1 (2017 to July 2021) with the 5-item Absenteeism Scale from the Workplace Outcome Suite and in Phase 2 (August of 2021 through 2023) the single-item work absenteeism question from the WOS was used. The outcome of work presenteeism was assessed using two different measures over the study period. During Phase 1, the 6-item Stanford Presenteeism Scale was used while during Phase 2, the single-item work presenteeism question from the WOS was used. The work absenteeism and presenteeism measures were combined into a single metric useful for conducting analyses in the severity of the work productivity problem. Following standard research practices established in the EAP field for this approach, an estimated specific number of hours of lost work productivity per case per month was created.

2.4. Study Full Sample of EAP Users by Industry Type

Figure 1 shows the mix of eight different industry types in the full study sample. Please see the source paper for details on how these types were defined [50]. Each industry group had many different specific employers included in the data, ranging from 77 employers for transportation to 629 employers for manufacturing. The total number of employers across all industries was 2,679. The most prevalent industry in the study was the manufacturing which accounted for 1 in every 5 cases in the sample (20% of the total). Employees in the transportation industry represented 12% of the sample. The restaurants and retail trade industry workers accounted for 12% of the sample. Workers in the education industry accounted for 9% of the sample. Employees in the government and municipality industry group accounted for 8% of all cases. Workers in the technology industry represented 7% of all EAP cases.

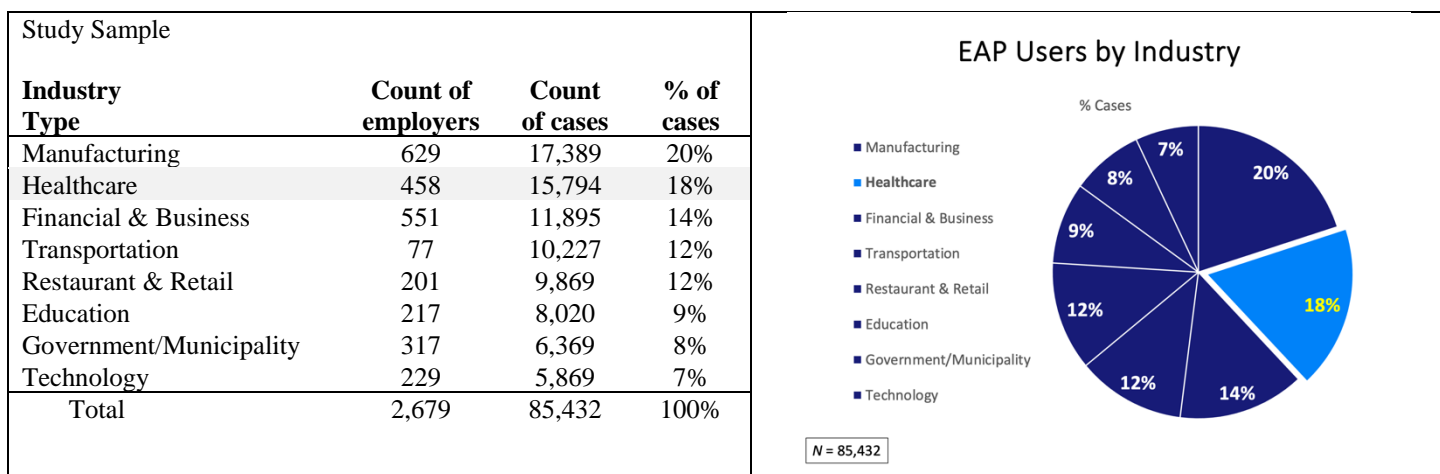


Figure 1. Mix of 8 Industries in EAP Study Sample

Employees working in healthcare were the second most common industry in the sample (18% of cases). This group included hospital systems, treatment providers for medical and behavioral health and healthcare insurance companies. Table 1 shows the employee demographics and use experience at the EAP for the healthcare industry subsample.

Table 1. Profile of Cases on Demographics and EAP Use in the Healthcare Industry

Factor	Healthcare	
	n count	%
Total EAP users	15,794	100
Year of use of EAP	All	
2017	258	2
2018	1,082	7
2019	1,061	6
2020	1,786	11
2021	2,427	15
2022	1,727	11
2023	7,453	47
Client age	15,256	
Under 30 years	3,129	21
30-39 years	4,920	32
40-49 years	3,673	24
50 plus years	3,534	23
Average (range: 17-87)	41 years	
Client gender	15,256	
Female	12,245	80
Male	3,156	20
EAP service type used	All	
Counseling	14,894	94
Coaching	900	6
EAP referral source	All	
Self / family / other	15,535	98
Formal management at work	259	2
EAP modality of use	All	
In-person office (face-to-face)	9,389	59
Online video	6,405	41
EAP presenting issue	All	
Mental health – anxiety	2,641	17
Mental health – depression	2,323	16
Mental health – other	2,469	15
Substance use – drug or alcohol	346	2
Stress personal / other life issues	4,337	27
Marital or family relationship	2,575	16
Work stress or occupational	1,103	7
EAP use duration (if post data)	1,290	
1-30 days	324	25
31-59 days	628	49
60-89 days	150	11
90 plus days (max 291 days)	188	15
Average:	50 days	
Longitudinal follow-up	All	
Any outcome data – yes	1,602	10

III. RESULTS

3.1. PART 1: Profile of the Healthcare Industry in General and EAP Users

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Workforce Profile. These characteristics of the healthcare industry are compared to 7 other major industries on the same BLS data sources (see Figure 2). The average employee compensation for healthcare of \$43 per hour per employee is toward the lower range of the other industries which ranged from \$24 to \$69. The average number of hours worked per week per in healthcare (33) is the middle when compared to other industries which ranged from 28 to 38. The level of union representation for healthcare at 8% of all workers is in the middle of the other industries which ranged from 2% to 33%. The rate of safety risks in the workplace for the healthcare industry at 4.2 is the second highest when compared to the other industries which ranged widely from 0.4 to 4.8 incidents per 100 workers per year and 2.8 for manufacturing.

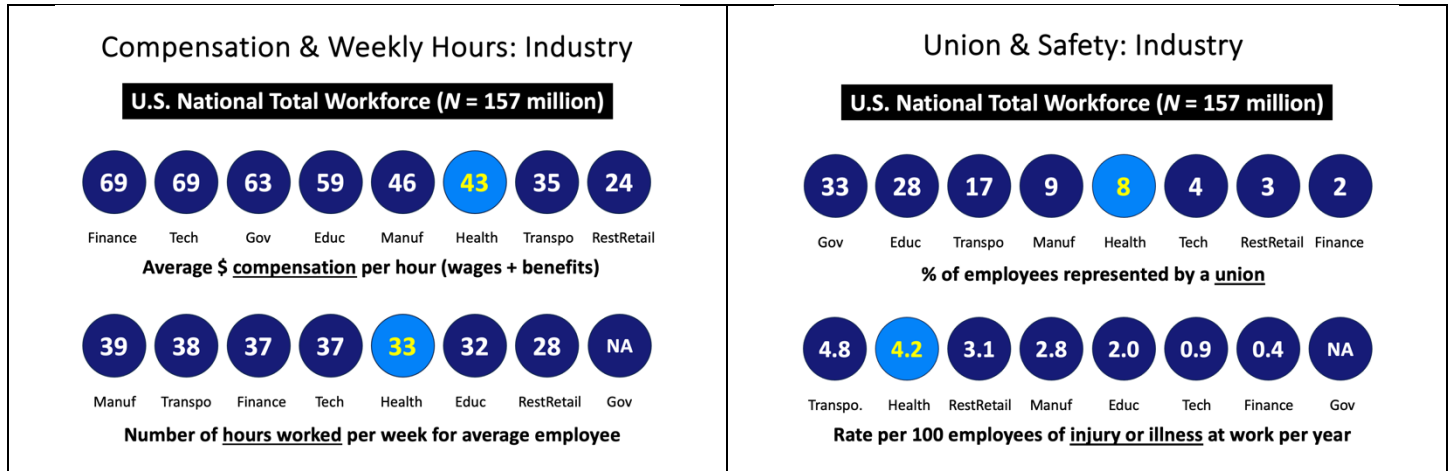


Figure 2. U.S. National Total Workforce BLS Data by Industry

Employee Age and Gender. The demographic characteristics of the healthcare industry are compared to 7 other major industries based on the same BLS data sources and also from the EAP user data (see Figure 3). Employees in the healthcare industry had an average age of 43 years in the BLS workforce data and an average 40 years in the EAP user study. This industry was in the middle of the range for age among all the other industries. Employees in the healthcare industry had a gender mix of 74% men and 26% men in the BLS workforce data and 80% women and 20% men in the EAP user study data. This industry had most women of all the industries in the EAP user data. Note this pattern of rank ordering of industries by gender mix is similar for the U.S. total workforce and the EAP data.

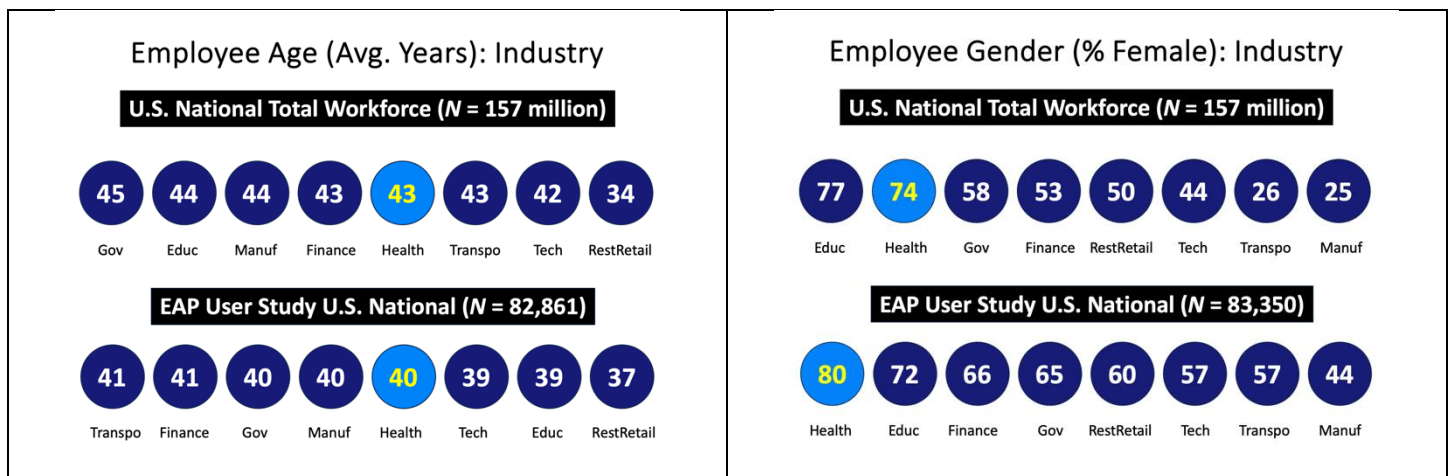


Figure 3. Client Age and Gender of Employees by Industry in BLS Data and EAP Study Data

Employee Use of the EAP. The healthcare industry group was also compared to the other industry types on how the EAP service was used (see Figure 4). The vast majority of the employees in the healthcare industry chose to use a counselor at the EAP (94%) with only 6% using a mental health coach. This same finding was also observed for EAP users in all of the other industries. The vast majority of employees in the healthcare industry were self-referrals (98%) with only 2% of all cases being formally referred to use counseling by their manager at work. This same finding was observed for EAP users in all of the other industries as the formal referral part of the total cases ranged from 1% to 6%. Users of the EAP could choose to engage with a counselor in-person at a local office clinical setting or

remotely using an online video connection. Most of the employees in the healthcare industry used the in-person modality (61%). This preference was generally consistent for employees in the other seven industries as well. The number of days, on average, for the EAP treatment episode was 54 for employees in the healthcare industry. This duration was the longest of all of the industries, which ranged from 46 to 51 days.

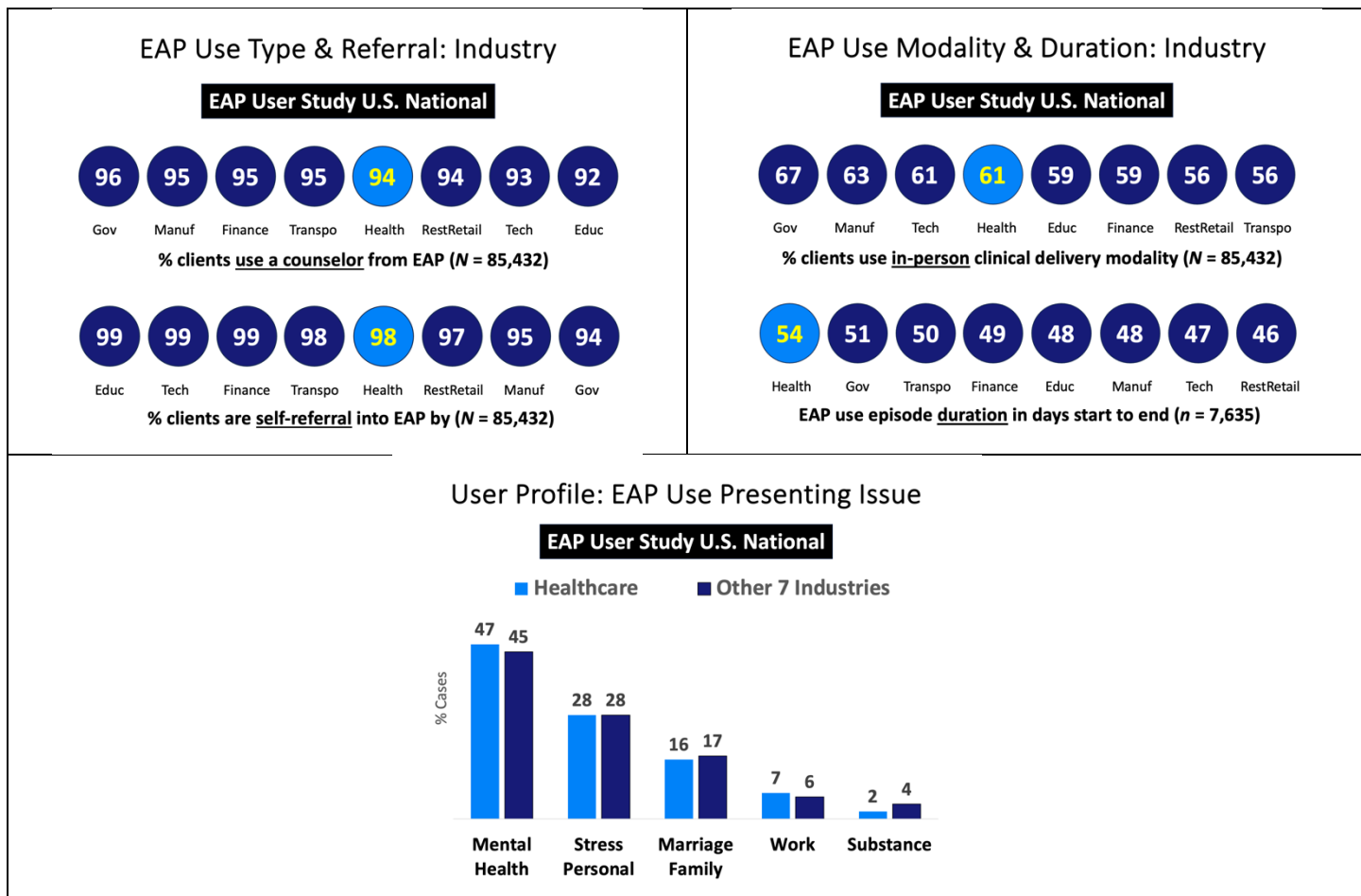


Figure 4. EAP Use Characteristics by Industry

EAP Use - Presenting Issue. The mix of five general types of presenting issues among EAP users in the healthcare industry is shown in lower part of Figure 4. The most common issue type for EAP use was mental health, which accounted for 47% of the cases in the healthcare industry and 45% in the other industries. The next common issue type was stress and personal life problems, which accounted for 28% of the cases in both healthcare and the other industries. Problems with marriage and family accounted for 16% of the cases in healthcare and 17% in the other industries. Problems with work or other occupational stressors accounted for only 7% of the cases in healthcare and 6% of cases in the other industries. Issues involving substance abuse and addictions comprised only 2% of the cases in the healthcare industry – which was half of the 4% average among other industries.

3.2. PART 2: Clinical and Work Outcomes for Employees Users of EAP in Healthcare Industry

The clinical and work outcome profile of the healthcare industry cases were compared to 7 other major industries.

Clinical Anxiety. More than 4 in every 10 employees in the healthcare industry met the criteria for clinical anxiety disorder when starting their use of the EAP service (see Figure 5). This 44% prevalence rate for anxiety disorder risk was at the lower end compared to the other industries, which ranged from 40% to 47% at-risk. Reduction in anxiety risk was tested in the subsample of cases in the healthcare industry who had data at both the start of use and again at the follow-up 30 days after the last counseling session and who had started at-risk on anxiety. Within this longitudinal subsample, the prevalence rate was 44% of all cases were at-risk at Pre for clinical anxiety but only 12% of all cases were at-risk at Post. The results found that 74% of these cases had recovered after EAP use to no longer be at risk anymore for anxiety. This recovery rate for healthcare was similar to results in other industries, which ranged from 72% to 82% of cases who recovered from anxiety.

Clinical Depression. Three in every 10 employees in the healthcare industry met the criteria for clinical depression disorder when starting their use of the EAP service (see Figure 5). This 30% prevalence rate for depression disorder risk was toward the middle range of 27% to 36% in other industries. Reduction in this risk was tested in the subsample of cases in the healthcare industry who had data at both the start of use and again at the follow-up 30 days after the last counseling session and who had started use being at-risk on depression. Within this longitudinal subsample, the prevalence rate was 25% of all cases were at-risk at Pre for depression but only 6% of all cases were at-risk at Post. The results found that 82% of these cases in healthcare had recovered after EAP use to no longer be at risk anymore for depression. This recovery rate for healthcare was toward the lower end of the results for the other seven industries in the study, which ranged from 82% to 93% of cases who recovered from depression.

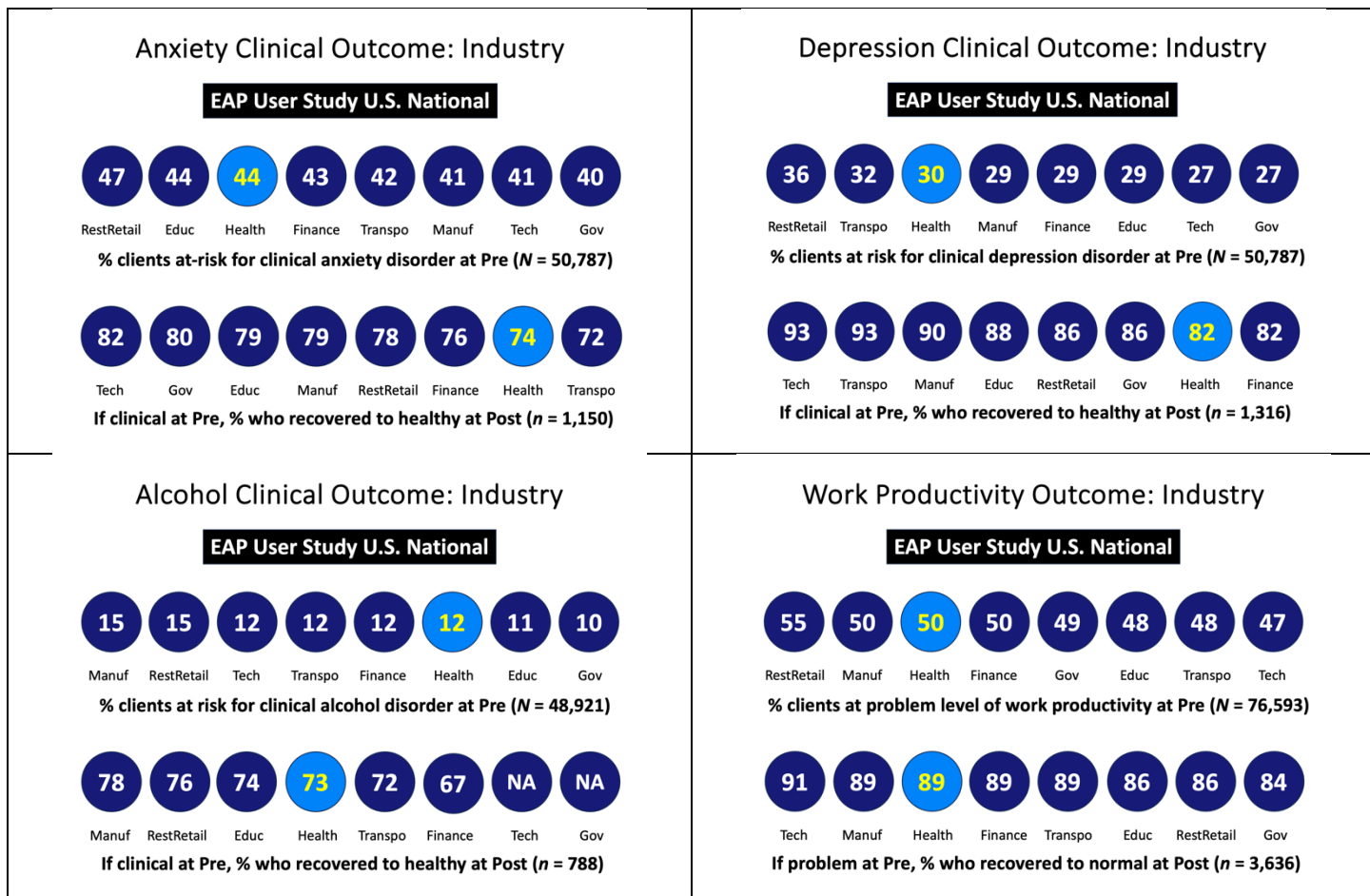


Figure 5. Clinical and Work Outcome Results for EAP Users: By Industry

Clinical Alcohol Misuse. About 1 in every 8 employees in the healthcare industry met the clinical criteria for hazardous alcohol use when starting their use of the EAP service (see Figure 5). This 12% prevalence rate for alcohol disorder risk was at the top when compared to the employees in the other industries, which ranged from 10% to 15% at-risk. Reduction in this risk was tested in the subsample of cases in the healthcare industry who had data at both the start of use and again at the follow-up 30 days after the last counseling session and who had started at-risk on alcohol misuse. Within this longitudinal subsample, the prevalence rate was 18% of all cases were at-risk at Pre for alcohol misuse but only 2% of all cases were at-risk at Post. The results found that 73% of these cases had recovered after EAP use to no longer be at risk anymore for alcohol misuse. This recovery rate for healthcare was in the middle of the six industries in the study with enough data to test, which ranged from 67% to 76% of cases who recovered from alcohol misuse.

Problem Work Productivity. Half of the employees in the healthcare industry met the criteria for abnormally low work productivity when starting their use of the EAP service (see Figure 5). These problem cases had excess levels of work presenteeism and/or work absenteeism. This 50% prevalence rate for work productivity problem similar to the other industries, which ranged from 47% to 55% of cases at a problem level for work productivity. Reduction in this risk was tested in the subsample of cases in the healthcare industry who had data at both the start of use and again at the follow-up 30 days after the last counseling session and who had started at a problem level on work productivity. Within this longitudinal subsample, the prevalence rate was 56% of all cases had a work productivity

problem at Pre but only 7% of all cases had this same problem at Post. The results found that 89% of these cases had recovered after EAP use to no longer have a problem with work productivity. This recovery rate for healthcare was better than most of the other industries in the study, which ranged from 84% to 91% of cases who recovered from having a work productivity problem.

Hours of Lost Work Productivity. In terms of specific hours, the typical EAP case in the healthcare industry with a work productivity problem had an estimated 64.30 hour of lost productivity during the month before using the EAP (based on a combined 51.98 hours of presenteeism and 12.32 hours of absenteeism). This is more than double the 27 hours of LPT for the typical “heathy” worker. After the employee had completed treatment, this adverse outcome changed to be much lower at an estimated 23.82 hour of lost productivity during the month after using the EAP (based on a combined 22.54 hours of presenteeism and only 1.28 hours of absenteeism). This is a difference of 40.48 hours of restored work productivity per month per employee initially with a problem on this outcome area.

The typical employee in the healthcare and heavy labor industry in 2024 earned \$42.77 per hour in compensation (wages & benefits) in 2024 [1]. Thus, the financial burden to the employer during the month before using the EAP for was \$2,750 per case in lost work productivity (based just on compensation value alone). However, this cost burden was reduced by \$1,731 after using the EAP. Depending on how many months the initial level of impaired work productivity may have continued on without the employee receiving any treatment, this savings amount could be much greater when multiplied over a 6 or 12 month period. Considering the modest total annual investment in an EAP service benefit, these kinds of workplace-related cost savings could quickly add up to a break-even ROI even at low levels of program utilization.

In summary, the key findings of study for the profile of EAP users and the four outcomes for healthcare industry EAP cases are shown in Table 2.

Table 2. Summary of Key Findings for EAP Cases in Healthcare Industry

		EAP User Characteristics			
Profile factors <i>N</i> = 15,794 employees	Size:	18% of all EAP cases 2017-2023			
	Gender:	80% women and 20% men			
	Age:	Average 40 years			
	Service:	94% counseling / 6% coaching			
	Referral:	98% self-referrals / 2% formally referred by manager at work			
	Modality:	61% in-person office / 39% online video			
	Duration:	7 weeks (54 days)			
	Issues: why used EAP	48% mental health			
		27% stress and personal life			
		16% marriage and family			
		7% work-related			
		2% substance use			
		Outcomes			
Test		Mental Health Anxiety	Mental Health Depression	Alcohol Misuse	Low Work Productivity
Prevalence of at-risk clinical or work problem status before EAP use <i>all cases at Pre</i> (<i>n</i> = 8,197 to 13,717)	At-risk Pre:	44%	30%	12%	50%
	Industry Rank:	No. 3	No. 3	No. 6	No. 3
Reduction in prevalence of at-risk or problem status cases from Pre to Post <i>all cases with longitudinal data</i> (<i>n</i> = 449 to 1,117)	At-risk Pre:	44%	25%	18%	56%
	Post:	12%	6%	2%	7%
Change to no-risk status after EAP as percentage of subgroup at-risk at start <i>at-risk cases with longitudinal data</i> (<i>n</i> = 134 to 621)	Recovered at Post:	73%	82%	73%	89%

IV. DISCUSSION

This applied exploratory study focused on the healthcare industry. The findings provide a profile of this workforce in the U.S. in general and also for EAP users specifically. The healthcare industry is the second largest segment of EAP users nationally. Workers in the healthcare industry are mostly women and most are of average working age. Workers in the healthcare industry are in the middle of the range across the eight industries for average level of employee compensation, hours worked per week, and union representation. The healthcare industry is the second highest in workplace safety incidents.

The EAP user profile for workers in healthcare – compared to the 7 other industries – was relatively similar for the mix of counseling or coaching, similar in use of face-to-face counseling modality, and similar on most of the presenting issues but was very low on using the EAP to address the subtype of alcohol and drug issues and was very low in formal management referrals to the EAP. The average duration of use episode for healthcare cases was the longest of the eight industries. When starting to use the EAP many of the cases in healthcare reported having clinical level symptoms on standardized measures for anxiety disorder (44% at-risk), depression disorder (30% at-risk), alcohol misuse disorder (12% at-risk) and low work productivity (50% at problem level). Among those cases initially at clinical risk status on outcomes in the total sample, over three-fourths recovered to healthy status after use. Among the half of the total cases who initially had a work productivity problem, the hours of lost work productivity per case per month changed from 64 hours to 24 hours (which is similar to the 27 hour norm for a typical worker). Most of these same EAP risk rates and outcome improvement results were also found at similar levels for employees in other industries.

These findings were obtained from a “real world” business context involving national data that was collected using validated scientific measures over seven years from a large sample of over 17,000 employee users who worked at over 600 employers in the healthcare industry. Thus, this study has a high degree of external validity for the findings. Thus, employers in the healthcare industry can be confident that these results are likely to describe their industry fairly well. Overall, the study results demonstrate both the need to supporting worker behavioral health and for considering an effective employee assistance program as one resources for employers to use to manage these kinds of worker wellbeing and work performance risks.

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DECLARATIONS

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Author Contributions: MA performed the statistical analyses of the aggregated dataset, conducted the literature review and drafted the manuscript. DP developed the study design, selected the measures involved, coordinated the data collection and led preparation of annual reports of preliminary results. All authors discussed the results and contributed to the final manuscript.

Conflict of interest/Competing interests: MA is an independent research scholar and consultant who received financial support from CuraLinc Healthcare for preparing this research manuscript. MA has also occasionally worked on other projects for this company. DP works for CuraLinc Healthcare company.

Ethical Considerations: The privacy of users was protected by having all program use and survey data deidentified before being shared with the independent consultant (first author) who conducted all statistical analyses. As this was an applied study of archival anonymized data collected from routine use of the service, additional informed consent from individual participants beyond their initial consent agreement in terms of use of the EAP service was not required. All data was collected as part of the normal business practices and not for a separate specific research project. Project approval from a university internal review board was not required. The use and analysis of archival operational data in this manner for applied research is consistent with the published ethical guidelines of the American Psychological Association [51]. All counselors involved in the delivery of the clinical treatment services were fully licensed and trained professionals.

Institutional Review Board Statement: No formal ethical approval of the study was required due to the retrospective archival naturalistic design of the study. All employees who used the counseling and completed the outcome measures participated voluntarily and had their personal identity protected as all unique identifiers were removed from the data prior to analysis. All counselors involved in the delivery of the clinical treatment services were fully licensed and trained professionals.

Informed Consent Statement: All data was collected as part of the normal business practices and not for a separate specific research project. Consent for participation in a research study and use of data for publication of study results was therefore not necessary.

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