Employee Assistance Program Counseling in the U.S. Government and Municipality Industry: Clinical and Work Outcome Risks and Results for 6,369 Cases at CuraLinc Healthcare

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Abstract: This applied study explored the role of behavioral health issues among workers in the government and municipality industry in the United States. It presents highlights for this industry group from a larger study in 2024 of eight different industries. 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 seven other industry categories was presented to provide context for this one industry. The 12.4 million employees in the government and municipality industry accounted for 8% of the total U.S. workforce in year 2024. The study 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 government group included 6,369 employee clients (8% of EAP full sample) who worked at 317 employer organizations. Longitudinal data at 30-days post use was obtained from 9,063 cases in the full sample (of which 814 were specific to government). The EAP user profile for workers in government – compared to the 7 other industries – was relatively the lowest in use of coaching (4%; other 96% used counseling), highest in use of in-person counseling at an office location (67%; other 33% used online video), highest in formal management referrals from a manager at work (6%; other 94% self-referral) and highest in using the EAP to address a work-related issue. In contrast, this industry was similar to others for the duration of use episode (51 days), client gender (65% women / 35% men) and average client age (40 years). When starting to use the EAP, many of the cases in government reported having clinical level symptoms on standardized measures for anxiety disorder (40% at-risk), depression disorder (27% at-risk), alcohol misuse disorder (10% at-risk) and low work productivity (49% at problem level). All three risk rates for the clinical disorders were the lowest of the eight industries. Thus, EAP users from government and municipal organizations were relatively the healthiest group when starting EAP use of all the industry groups in the study. Among those cases in this industry initially at clinical risk status on anxiety, 80% recovered to non-clinical status at follow-up. Among those initially at clinical risk status on depression 86%, recovered to non-clinical status. Among those initially having a work productivity problem, 84% recovered to no problem status at follow-up (the average case changed from 64 hours lost per month to 24 hours; vs. norm of 27 hours). The hours of restored work productivity was estimated to be a $2,521 value per month per case who initially had this problem. Most of the EAP risk rates and outcome improvement results were also found at comparable levels for employees in other industries. These findings indicate the EAP service was effective for most users from the government and municipality industry.

I. INTRODUCTION

This study profiles employees in the in the government and municipality 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]. Workers in the government and municipality industry type represent 7.9% of all U.S. workers [1]. This category of industry has over 12.4 million workers and all are in the public sector (note that the subgroup for education is excluded and considered separately in another paper and the military is excluded). The number of workers in the government category has three main groups, including 2.7 million federal government employees, 2.8 million state level employees and 6.7 million local municipal employees. Many of the jobs in this area focus on public administration and policy,

public health and related research, physical science and engineering, social sciences and foreign languages and business and technology. Public safety, judicial work and law enforcement are high profile segments of government and municipal organizations. This industry type has the distinction of having the highest level of unionized workers (33%). This group has a high level of compensation (wages and benefits) per hour per worker ($63) and most workers are full-time. The typical government worker is age 45 and this workforce has a gender mix 58% women and 42% men.

1.1. EAPs and the Government and Municipality Industry

Behavioral health disorders such as anxiety, depression and substance misuse affect about 25% employees each year in the United States (U.S.) [5-7]. 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 [8,9]. Most employers try to support their workers in a variety of ways including offering an employee assistance program (EAP) benefit [10]. 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 [11-13]. Recent national U.S. data from March of 2023 shows that overall, 64% of full-time workers have an EAP available to them as part of employee benefits package [14]. 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. – such as local and state governments and the federal government – also offer an EAP benefit to their workers [15,16].

The government and municipality industry has a long and rich history with EAP programs. Starting with the federal government, a large majority of public sector organizations in the U.S. – local and state governments – offer an EAP benefit to their workers [15]. Several factors account for this connection between EAP and the public sector. One is that public sector organizations have the highest level of unionized workers of all industries (33% vs. 6% average in private sector [1]) and that unionized workers tend to have better employee benefit packages overall than do non-union workers and that EAP is one of the benefits often included [1]. For example, according to U.S. Bureau of Labor Statistics (BLS) data in 2023, 74% of unionized workers have an EAP compared to 52% of non-union workers [3]. Offering an EAP benefit increases dramatically by size of the employer and public sector employers are usually much larger than the typical private sector employer that has under 50 employees [3].

The research literature on EAPs for public sector employer organizations includes close to 50 papers and has studies dating back to the 1980s and continuing over the next four decades [17-19]. This body of research can be grouped into several themes. The first theme involves the EAP experience for federal level government employees in the U.S., which has had an EAP in various forms since the 1970s. Thirteen studies exist that address various aspects of EAP use among federal employees, including those working in the Department of Health and Human Services [20], the Pentagon and the Department of Defense [21,22], the Postal Service [23-25] and the House of Representatives [26]. The Federal Occupational Health (FOH) program's EAP is the largest program in the world and it has been providing employee assistance services through internal contracts to many departments within the federal government for decades. It is a hybrid model that has a large internal full-time EAP staff and also an external vendor EAP since 2004 that provides counseling and specialty services to many different locations around the country and for wrokers stationed internationally. The website for federal employees lists 13 different departments that currently have EAP services from FOH.

The EAP from FOH has six research papers written about it. One paper from 2004 describes their development of EAP counseling services delivered over the telephone [27]. Another paper describes how the program evolved to better support employees following a natural disaster [28]. Four reports provided empirical evidence of clinical and work-related outcomes for employee users of the counseling. The 2004 outcome study [29] analyzed over 59,000 EAP counseling cases from 1999 through 2002 with longitudinal self-report data on work productivity as affected by the clients' emotional problems, (2) work productivity affected by the client's physical health, (3) the interference of physical or emotional issues on work and social relationships, (4) perceived health status, (5) job attendance/tardiness, and (6) global assessment of functioning. The results found significant improvement for the average case after use on all six of the outcomes. This 2004 study replicated their earlier 1998 study that had used the same set of measures but was conducted on a smaller sample of users [30]. A later project [31,32] analyzed case-level data from years 2016 to 2017 for a random sample of 4,800 EAP counseling users from FOH with self-reported longitudinal data on the Workplace Outcome Suite (WOS) set of brief measures [33] collected at the first session and again at 90 days after completing EAP treatment. The results again found significant improvement in all outcomes: 69% improvement in hours of work absenteeism (change from per case average of 10.3 hours absent per month to 3.2 hours); 24% improvement in overall life satisfaction; 23% improvement in work presenteeism; 10% improvement in work engagement and only 3% improvement in workplace distress.

The next theme in the research involves EAPs at the state government and local municipality level within the U.S. These nine papers addressed topics of how to implement EAPs within the larger organizational structures of local [34], county [35] and state goverments [36], as well as providing EAP to small businesses collectives (i.e., dairy farmers) [37]. Other studies were focused on outcomes and cost-benefit analyses for users of EAPs. A 1996 study found a positive ROI for the EAP serving the City of Los Angeles Water and Power Department [38]. A series of more recent papers tested the effectiveness of the internal EAP for the State of Colorado [39-41]. This project is important because it secured a $100,000 research grant and was able to hire outside investigators to conducted a quasi-

experimental longitudinal study using a design that included a group of users of the EAP and another group of employees who did not use the EAP but who were matched to the program user sample on basic demographics and starting levels of clincial risks and work problems.   Although only based on small size samples of less than 200 employees per group, the findings documented superior improvement over time for the EAP user group compared to the non-user comparison group on anxiety and depression symptoms and work absenteeism and work presenteeism. However, neither group had enough cases at-risk who were relevant to test for changes in the outcome measure for hazardous alcohol use. Note that these studies of EAPs for local and state level employees found postive results that were similar to the findings of the other studies of federal level employee users of EAPs.

The third theme for research on EAPs in government and municipal industry involves countries outside of the U.S. Global examples of EAPs in government were identified for Australia [42], Canada [43,44], Kenya [45], Taiwan [46] and South Africa [47-54]. Most of these 13 papers involved evaluations of the program utilization, user-level outcomes and cost-benefit of these EAPs.

The final theme in the research focuses on the roughly 1 in 4 employees within the government and municipal industry who work as police officers (>700,000), firefighters (1.2 million) and medical emergency first-responders (1.0 million). This subgroup comprises about 3 million combined of the 12.4 million total in this industry type (excluding education). These workers generate concern for the role that physical violence, injury and behavioral health issues can have in their daily work [55-58]. Similar to the profile of manufacturing and transportation industries, the majority of workers in law enforcement are men and gender differences are known for behavioral health risks [1-3] and some aspects of EAP use [59]. The development of mental health and substance use problems among law enforcement workers are associated with several work environment factors, including an unhealthy "first to respond, last to seek help" work culture, reliance on the work team for support, frequent shift work schedules and exposure to traumatic events and potential subsequent post-traumatic stress disorders. Although physically healthier and more resilient than the general worker when starting their careers, over time law enforcement officers are more likely than the general population to be depressed, experience familial strife, misuse alcohol, and attempt suicide and thus the need to develop healthy lifestyle practices is recommended [58]. Our literature review found nine reports that specifically examined how EAPs can support police, law enforcement and correction officers [60-67], firefighters [68,69] and emergency first responders [70,71].

In summary, the literature on behavioral health in the government and municipality industry has developed a good general understanding of why these workers need EAP services and how such services can best be delivered. There are also several investigations of the extent of clinical and work-related outcomes for these kinds of workers and related cost savings in return to the employers who sponsor the EAP.   Compared to most other industries, this literature on EAPs for government and municipality employees is larger, more international in scope, and has some higher quality research studies.   Yet only a handful of these past studies involved large sample sizes of EAP users, assessed behavioral health risk rates in the larger EAP user population or collected data with scientifically validated measures of clinical and work outcomes. In addition, most of these past evaluations were case studies of specific organizations and did not analyze EAP use and outcome data from multiple different employers in this industry in the same study. The present study was done to fill this gap in our understanding of these types of workers.

1.2. Highlights from EAP Study of Eight U.S. Industries – Focus on Government and Municipality

CuraLinc Healthcare has been in business since 2008 and now this company has over 4,200 employer customers that offer the EAP as a benefit to over 8 million employees. Clinical risk and work outcome data was also routinely collected on many of these employees. This company has conducted six other empircal studies examining a variety of aspects of their EAP services and outcomes [73-77]. In our newest study, we analyzed recent national data collected over a 7-year period from over 85,000 cases from this EAP [77] 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. The present study highlights key findings from the previous study for workers in the government and municipality industry. It also compares this industry category with EAP uers from seven other major industry categories. For simplicity, the rest of the paper will use the term "government" to indicate both government and municipality.

II. METHODOLOGY

For all of the details on the study methodology and analytical procedures, please see our earlier comprehensive report on all of the different industries in the U.S. [77]. Key methodological and measurement aspects of the study are summarized below.

2.1. Archival Business Data for 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. 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 [77]. 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 working in healthcare were the second most common industry in the sample (18% of cases). This was followed by the financial and business management industry (14%). Employees in the transportation industry represented 12% of the sample. The restaurants and retail trade industry workers accounted for 12% of the sample. Employees in the government and municipality industry group accounted for 8% of all cases. Workers in the education industry accounted for 9% of the sample. Workers in the technology industry represented 7% of all EAP cases.
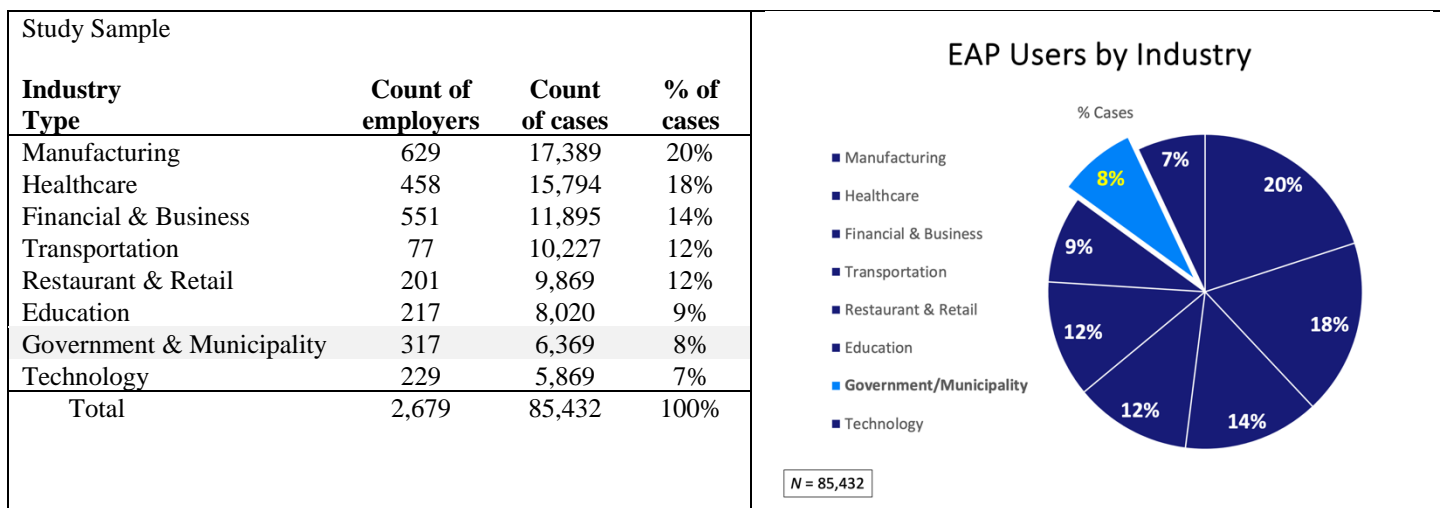
Study Sample

Industry Type	Count of employers	Count of cases	% of cases
Manufacturing	629	17,389	20%
Healthcare	458	15,794	18%
Financial & Business	551	11,895	14%
Transportation	77	10,227	12%
Restaurant & Retail	201	9,869	12%
Education	217	8,020	9%
Government & Municipality	317	6,369	8%
Technology	229	5,869	7%
Total	2,679	85,432	100%

Figure 1. *Mix of 8 Industries in EAP Study Sample*

Table 1 shows the employee demographics and the clinical use experience at the EAP for just the government and municipality industry subsample. This group included subtypes of mostly cities, local governments and municipal entities (*n* = 4,080 cases) as well as civic, charitable, and philanthropic service kinds of organizations in the public sector (*n* = 2,289 cases).

Table 1. *Profile of Cases on Demographics and EAP Use: Government and Municipality Industry*

Factor	Government & Municipality	
	n count	%
Total EAP users	6,369	100
Year of use of EAP	All	
2017	274	4
2018	707	11
2019	666	10
2020	824	13
2021	812	13
2022	585	9
2023	2,501	39
Client age	6,255	
Under 30 years	1,271	20
30-39 years	1,888	30
40-49 years	1,597	26
50 plus years	1,499	24
Average (range: 17-93)	40 years	
Client gender	6,262	
Female	4,080	65
Male	2,182	35
EAP service type used	All	
Counseling	6,130	96
Coaching	239	4
EAP referral source	All	
Self / family / other	5,996	94
Formal management at work	373	6
EAP modality of use	All	
In-person office (face-to-face)	4,200	66
Online video	2,169	34
EAP presenting issue	All	
Mental health – anxiety	887	14
Mental health – depression	765	12
Mental health – other	1,145	18
Substance use – drug or alcohol	194	3
Stress personal / other life issues	1,512	24
Marital or family relationship	1,197	19
Work stress or occupational	1669	10
EAP use duration (if valid data)	708	
1-30 days	193	27
31-59 days	349	49
60-89 days	87	12
90 plus days (max 308 days)	79	11
Average:	51 days	
Longitudinal follow-up	All	
Any outcome data – yes	814	13

2.4. 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 77]. When the 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 using two different measures over the seven-year study period. During Phase 1 (2017 to July 2021), the full 5-item Absenteeism Scale from the Workplace Outcome Suite was used. In Phase 2 (August of 2021 through all of 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. See the full study for details on how these measures were scored and standardized across time involving the two study phases [77].

III. RESULTS

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

Workforce Profile Comparisons. These characteristics of the government and municipality industry were compared to 7 other major industries on the same BLS data sources (see Figure 2). The average level of employee compensation for government workers at $63 per hour is higher than most of the other industries which ranged from $24 to $69. At 33% of workers enjoying union representation the government industry is the highest of all industries which ranged from only 2% to 28% (in education, which also has a majority of public sector employers).
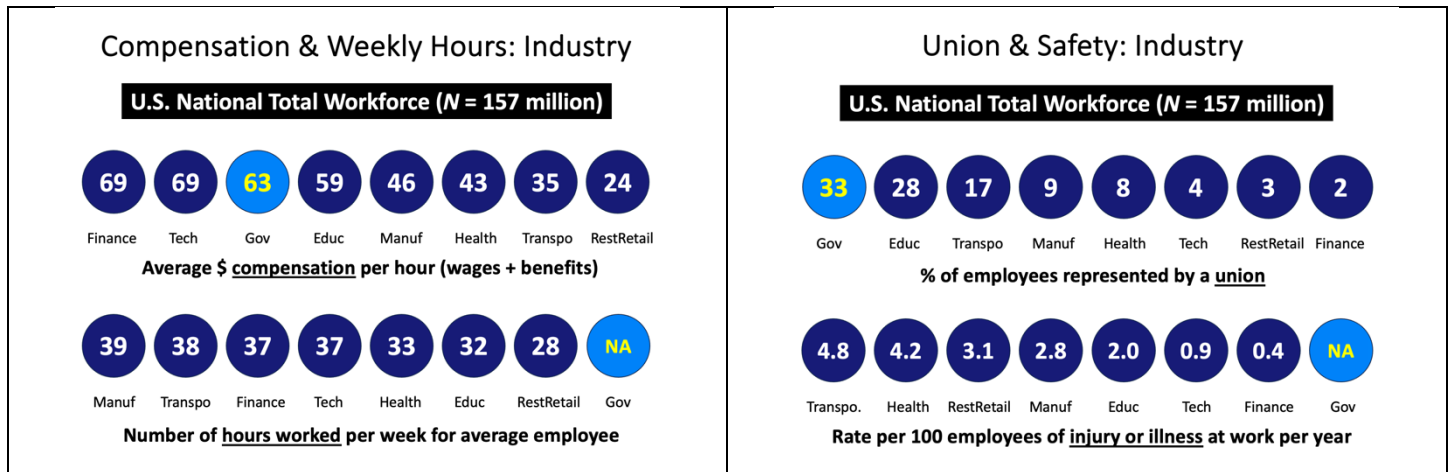

Figure 2. *U.S. National Total Workforce BLS Data by Industry*

Employee Age and Gender. The demographic characteristics of the government 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). The Employees in the government industry had an average age of 45 years in the BLS workforce data and an average 40 years in the EAP user study. This industry older than most of the others. Note this pattern for age by industry among the EAP users closely matches the average age by industry profile for the U.S. total workforce. Employees in the government industry had a gender mix of 58% women and 42% women in the BLS workforce data and 65% women and 35% men in the EAP user study data.

Employee Use of the EAP. The government 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 government industry chose to use a counselor at the EAP (96%) with only 4% using a mental health coach. This same emphasis on counseling was also observed for EAP users in all of the other industries. The government industry users had the lowest rate of using the coaching service (3.8% vs 5.1% to 7.6% in others). The vast majority of employees in the government industry were self-referrals (94). But the 6% of all cases being formally referred to use counseling by their manager at work was the highest of all the other industries, which ranged from 1% to 5%. The employees could

choose to engage with a counselor in-person at a local office clinical setting or remotely using an online video connection. Over two-thirds of employees in the government industry used the in-person modality and this was the highest percentage of all industries. The number of days, on average, for the EAP treatment episode was 51 for employees in the government industry. This duration was similar to the employees in other industries, which ranged from 46 to 54 days.
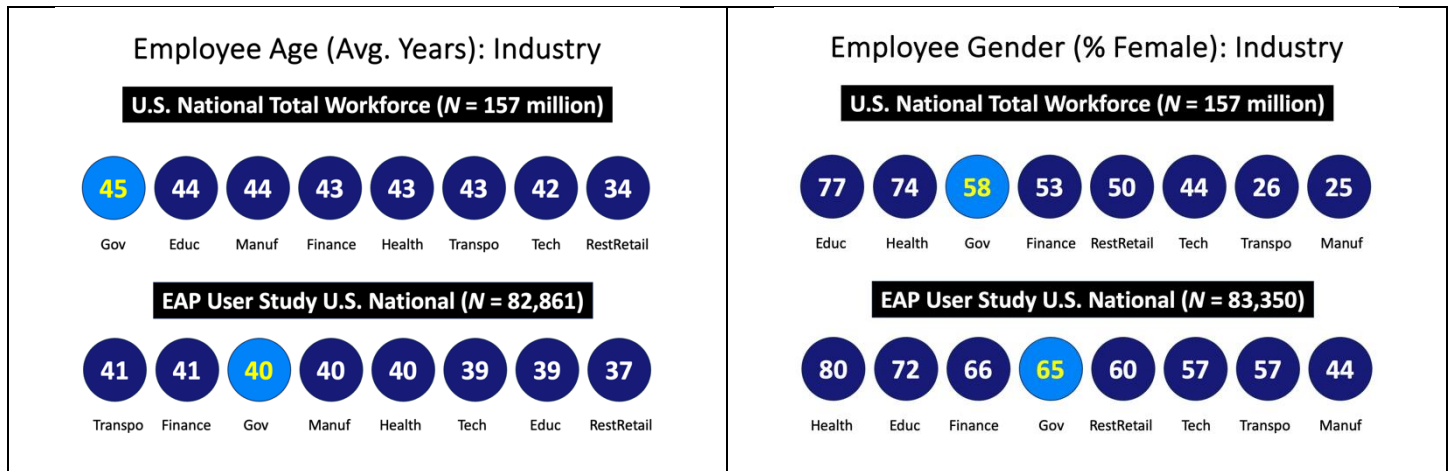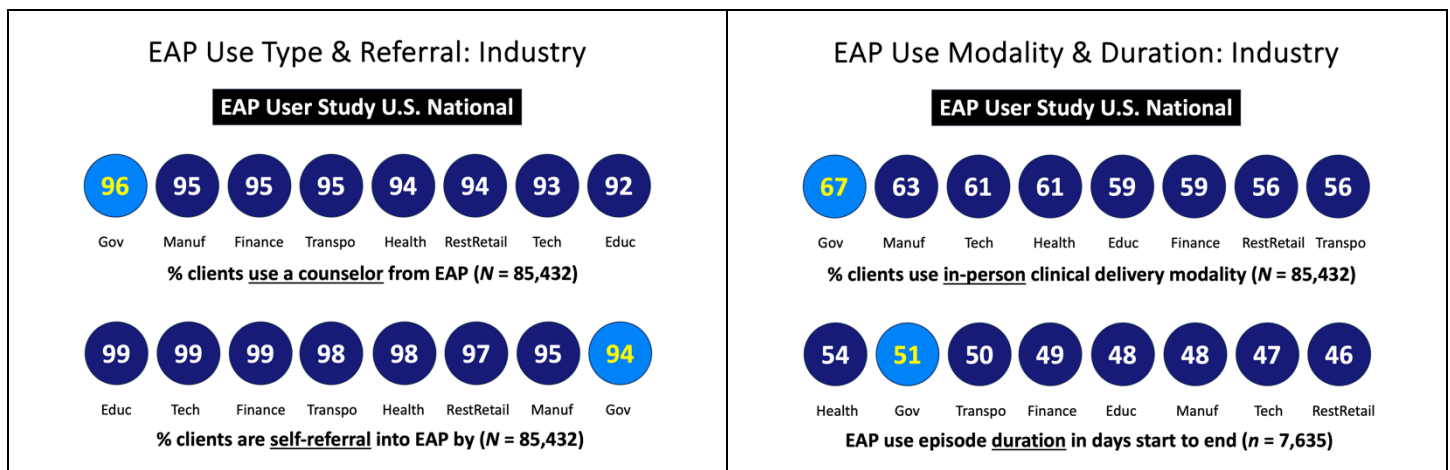

Figure 3. *Client Age and Gender of Employees by Industry in BLS Data and EAP Study Data*
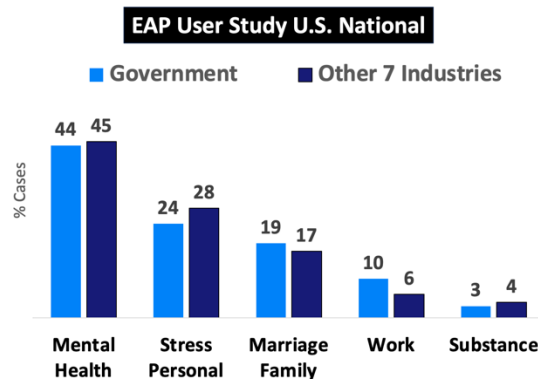

Figure 4. *EAP Use Characteristics by Industry*

EAP Use - Presenting Issue. The mix of five general types of presenting issues among EAP users in the government industry is shown in lower part of Figure 4. The most common issue type for EAP use was mental health, which accounted for 44% of the cases in the

government industry and 45% in the other industries. The next common issue type was stress and personal life problems, which accounted for 24% of the cases in government and 28% in the other industries. Problems with marriage or family accounted for 19% of the cases in government and 17% in the other industries. Issues involving substance abuse and addictions comprised only 3% of the cases in the government industry, which was similar to the 4% average among other industries. The work issues area was relatively more defining for the government worker case mix than for workers in other industries (10% > 6%, respectively).

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

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

Clinical Anxiety. About 4 in every 10 employees in the government industry met the criteria for clinical anxiety disorder when starting their use of the EAP service (see Figure 5). This 40% prevalence rate for anxiety disorder risk was the lowest compared to the other industries, which ranged from 41% to 47% at-risk. Reduction in anxiety risk was tested in the subsample of cases in the government 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 33% of all cases were at-risk at Pre for clinical anxiety but only 7% of all cases were at-risk at Post. The results found that 80% of these cases had recovered after EAP use to no longer be at-risk for anxiety. This recovery rate for government was better than most of the other industries, which ranged from 72% to 82% of cases who recovered from anxiety.

Clinical Depression. About 3 in every 10 employees in the government industry met the criteria for clinical depression disorder when starting their use of the EAP service (see Figure 5). This 27% prevalence rate for depression disorder risk was the lowest of all the industries of 27% to 36%. Reduction in this risk was tested in the subsample of cases in the government 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 18% of all cases were at-risk at Pre for clinical depression but only 5% of all cases were at-risk at Post. The results found that 86% of these cases in government had recovered after EAP use to no longer be at-risk for depression. This recovery rate for government was similar to the other industries in the study, which ranged from 82% to 93% of cases who recovered from depression.
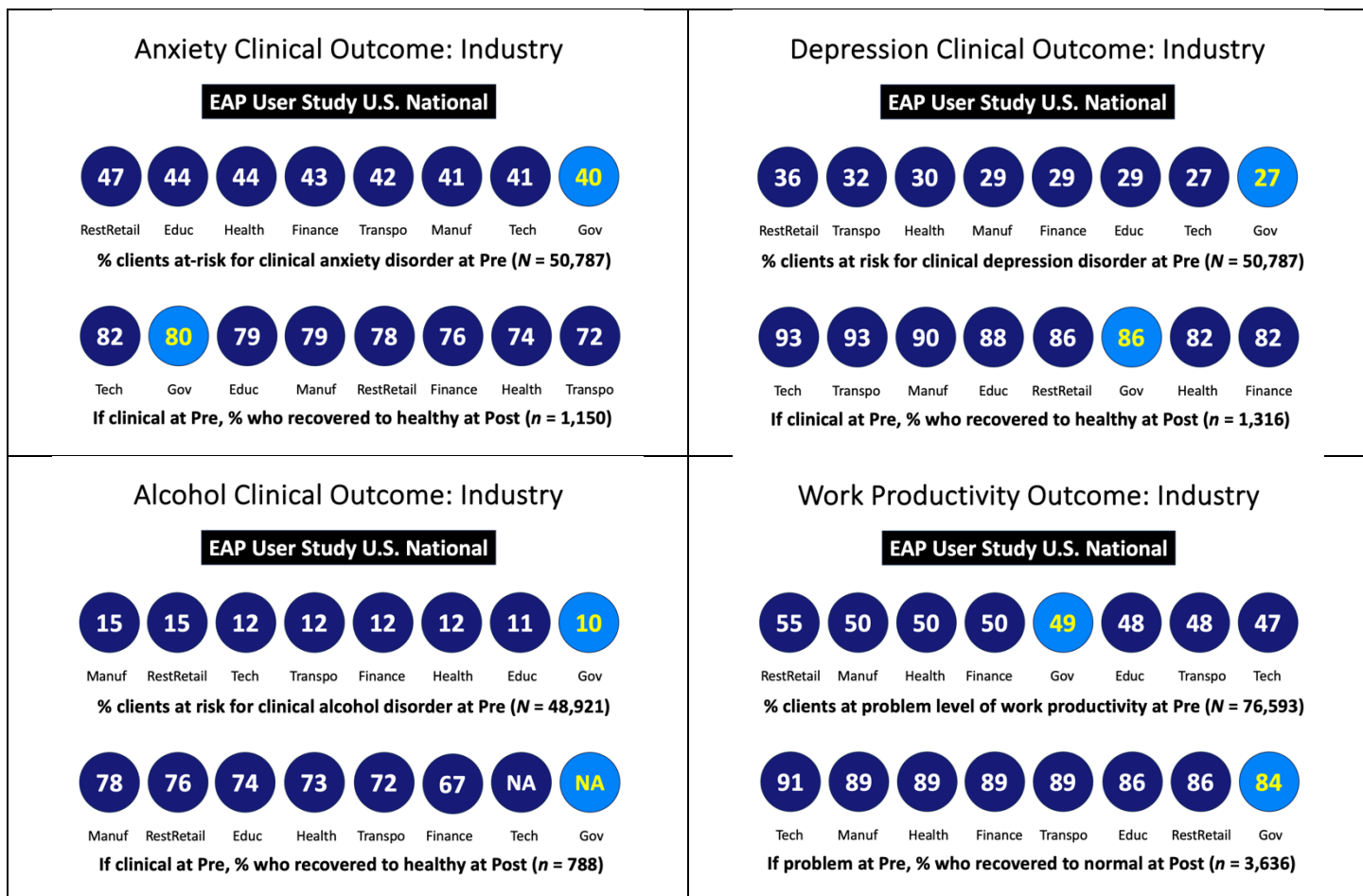
Figure 5. *Clinical and Work Outcome Results for EAP Users: By Industry*

Clinical Alcohol Misuse. About 1 in every 10 employees in the government industry met the clinical criteria for hazardous alcohol use when starting their use of the EAP service (see Figure 5). This 10% prevalence rate for alcohol disorder risk was the lowest compared to the employees in the other industries, which ranged from 11% to 15% at-risk. Reduction in this risk was tested in the subsample of cases in the government 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 4% of all cases were at-risk at Pre for alcohol misuse but only 2% of all cases were at-risk at Post. (Note: the number of cases in this industry was too few to reliably test for the recovery outcome.)

Problem Work Productivity. Half of the employees in the government 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 49% 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 government 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 47% of all cases had a work productivity problem at Pre but only 9% of all cases had this same problem at Post. The results found that 84% of these cases had recovered after EAP use to no longer have a problem with work productivity. This recovery rate for government was similar to 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 government industry with a work productivity problem had an estimated 64.45 hour of lost productivity during the month before using the EAP (based on a combined 51.26 hours of presenteeism and 13.19 hours of absenteeism). After the employee had completed treatment, this adverse outcome changed to be much lower at an estimated 24.22 hour of lost productivity during the month after using the EAP (based on a combined 22.77 hours of presenteeism and only 1.45 hours of absenteeism). The level of LPT hours at Post is lower than the 27 hour norm for the typical "healthy" worker. This is a difference of 40.23 hours of restored work productivity per month per employee initially with a problem on this outcome area.

The typical employee in the government industry in 2024 earned $62.67 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 $4,039 per case in lost work productivity (based just on compensation value alone). However, this cost burden was reduced by $2,521 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 government industry EAP cases are shown in Table 2.

Table 2. *Summary of Key Findings for EAP Cases in the Government Industry*

		EAP User Characteristics		
	Size:	8% of all EAP cases 2017-2023		
	Gender:	65% women and 35% men		
	Age:	Average 40 years		
Profile factors	Service:	**96% counseling** / 4% coaching		
	Referral:	94% self-referrals / **6% formally referred by manager at work**		
N = 6,369 employees	Modality:	**67% in-person office** / 33% online video		
	Duration:	7 weeks (51 days)		
		44% mental health		
	Issues:	24% stress and personal life		
	why used	19% marriage and family		
	EAP	**10% work-related**		
		3% 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 *all cases at Pre* (*n* = 2,770 to 5,649)	At-risk Pre:	**40%**	**27%**	**10%**	**49%**
	Industry Rank:	**No. 8**	**No. 8**	**No. 8**	**No. 5**
Reduction in prevalence of at-risk or problem status cases from Pre to Post *all cases with longitudinal data* (*n* = 213 to 614)	At-risk Pre: Post:	**33%** **7%**	**18%** **5%**	**4%** **2%**	**47%** **9%**
Change to no-risk status after EAP as percentage of subgroup at-risk at start *at-risk cases with longitudinal data* (*n* = 65 to 299)	Recovered at Post:	**80%**	**86%**	**NA**	**84%**

IV. DISCUSSION

This applied exploratory study focused on the government industry. The findings provide a profile of this workforce in the U.S. in general and also for EAP users specifically. Overall, about 1 in every 12 U.S. workers is in the government industry category (and is even more actually when adding in the education services category of public sector workers). The rate of union representation the government industry (1 in every 3 workers) was five times higher than the average for the private sector industries. The average level of employee compensation for government workers is higher than most of the other industries (only about 10% less than the top two other industries with higher compensation). The average age of government employees was the oldest in the BLS data but the average age in the EAP user data was in the middle of other industries (which only varied by 4 years between the youngest and oldest average age industries). The gender mix for government employees was 2:1 female to male but was in the middle of other industries for both data sources.

The EAP user profile for workers in government – compared to the 7 other industries – was relatively the lowest in use of coaching (most used counseling instead), the highest in use of in-person counseling at an office location, highest in formal management referrals from a manager at work and highest in using the EAP to address a work-related issue. This industry was similar to others for the duration of use episode (which again did not vary that much from lowest to highest). When starting to use the EAP, many of the cases in government reported having clinical level symptoms on standardized measures for anxiety disorder (40% at-risk), depression disorder (27% at-risk), alcohol misuse disorder (10% at-risk) and low work productivity (49% at problem level). All three of these risk rates for the clinical disorders were the lowest of all eight industries. Thus, the EAP users work for government and municipal organizations were the relatively healthiest group of cases. Among those cases initially at clinical risk status on outcomes in the total sample, over three-fourths had recovered to non-clinical status. Most cases also recovered from having a work productivity problem (change from 64 hours lost per month to 24 hours). 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 6,000 employee users who worked at over 300 employers in the government industry. Thus, this study has a high degree of external validity for the findings. Thus, employers in the government industry can be confident that these results are likely to accurately describe their industry. 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

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 [78]. 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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