The Impact of the Implementation of an Employee and Family Assistance Program on Teacher Disability Leave in Ten British Columbia School Districts

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Abstract

Employee and Family Assistance Programs (EFAPs) are one way of providing health and wellness opportunities to employees. EFAPs are an important component of a wellness or health promotion program; many current programs focus on aspects of an employee's emotional health.

The purpose of this study was to determine the impact of implementing an Employee and Family Assistance Program on teacher disability leave. Short and long term disability leave statistics from ten provincial school districts were obtained from the British Columbia Teachers Federation. The years before a school district implemented an EFAP were used to form "pre-EFAP" means, while the year of implementation, together with all subsequent years constituted the "post-EFAP" means. Non-directional T-tests were utilized to compare these short and long term disability leave means.

The post-EFAP means were greater than the pre-EFAP means for both short and long term disability leave per 100 teachers. These differences, which are statistically significant ($p<.05$), indicate an increase in disability leave. The initiation of an EFAP, in the ten school districts examined, was followed by an increase in teacher disability leave. Therefore, this study revealed there are measurable differences in teacher disability leave after the initiation of an EFAP; the initiation of an EFAP is followed by an increase in disability leave.

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Dedication

To my husband, Hamish, for his encouragement, understanding and love.

To my daughter, Teya, for bringing me joy and laughter every day.

To my parents, Siegmund and Shireen Redenbach whose wisdom, strength and love will always be with me.

Introduction

Employee and Family Assistance Programs (EFAPs) provide counselling and referral services to British Columbia School District employees and their families. Over the last ten years EFAPs have become common in B.C.'s school districts; the program is a standard component of most district's benefit packages. As of April of 1997, 56 of the 59 districts offer their employees an assistance program.

Over the years, EFAPs have evolved from programs designed to assist those with alcohol abuse problems into programs which address numerous types of problems affecting job performance. Some of these problems include finances, family and marital issues and health concerns (Ansley, 1983; Hacker, 1986; Lew & Ashbaugh, 1992; National Institute on Drug Abuse, 1988; Roman, 1980).

EFAPs have been equated with wellness programs and the concept of health promotion. Promotional literature for EFAPs often make reference to promoting health and wellness. Examples of these references include the following:

> "An Interlock EFAP focuses not only on employee/family well being, but also on organizational health. The interlock model includes...health promotion" (Interlock Employee and Family Assistance Program, information package).
>
> "This model (Employee and Family Assistance Program/Assessment and Referral Service Model) facilitates an ongoing commitment to...health promotion activities. EFAPs create healthier workplaces by promoting greater awareness of health and wellness issues"

(EFAP/ARS Model - brochure)

"Employees have a right to *good health, in all respects*. The EAP (Corporate Health Consultants, Sooke School District provider) attempts to provide a vehicle for that good health..." (School District No. 62 EAP - brochure). Italics added.

However, the belief that EFAPs and wellness programs are synonymous is not entirely correct. EFAPs are one way of providing health and wellness opportunities to employees, but there are numerous other modes of delivery. Examples include the development and maintenance of a healthy diet, regular physical activity, back care and learning to reduce and manage stress more effectively.

Presently, the most popular way of addressing wellness concerns in the school districts is via EFAPs. EFAPs are an important component of a wellness program; specifically, they address an employee's emotional health. Counselling is typically provided for employees whose emotional health has deteriorated to a point where their job performance is being effected.

Wellness programs address health in a more holistic manner; the individual's physical, social, spiritual, occupational, intellectual and emotional dimensions of health are considered (Ardell, 1985). A goal of wellness programs is to enhance these various dimensions of health in a proactive manner; these programs optimally maintain harmony (Dickman, 1988). Wellness programs adhere to the principles of health promotion. The Action Statement for Health Promotion in Canada (1996) outlines the seven principles by which health promotion is guided. These are:

1. Health promotion addresses health issues in context.
2. Health promotion supports a holistic approach.
3. Health promotion requires a long-term perspective.
4. Health promotion supports a balance between centralized and decentralized decision-making.
5. Health promotion is multisectoral.
6. Health promotion draws on knowledge from a variety of sources.
7. Health promotion emphasizes public accountability.

An EFAP does not typically encompass all of the above principles. A purpose is unquestionably served by providing EFAPs to school district employees, however this purpose should not be confused with the vision of health promotion. Achieving Health For All: A Framework For Health Promotion (1986, p. 12) describes the vision of health promotion as the following:

> ... health promotion implies a commitment to dealing with the challenges of reducing inequities, extending the scope of prevention, and helping people to cope with their circumstances. It means fostering public participation, strengthening community services and coordinating healthy public policy. Moreover, it means creating environments conducive to health, in which people are better able to take care of themselves, and to offer each other support in solving and managing collective health problems.

The vision for health promotion would certainly encompass an EFAP. EFAPs are necessary vehicles in assisting employees to cope with difficult circumstances. However, the goals of health promotion are more

encompassing than those of an employee assistance program.

In British Columbia there are at least 15 different providers operating EFAPs in the school districts. The Victoria School District (#61) currently contracts Interlock to provide their EFAP, which has been operating since 1993. Prior to the initiation of their EFAP, the district organized a Wellness Coalition. This coalition has been working together since the spring of 1992 for "the purpose of building on our shared vision of healthy people and healthy places within a healthy organization" (Greater Victoria School District Wellness Coalition - Workplace Health Profile). The Victoria School District is one example which illustrates that a distinction does exist between EFAPs and wellness programs. This is important in order to evaluate these EFAPs. Without this differentiation, evaluation of the school districts' programs would involve measuring their success against the more holistic goals of a wellness program.

Several of the providers are small organizations serving only one school district, while others are very large, accommodating numerous school districts as well as many other organizations of considerable size. However, despite these differences in magnitude, EFAP providers appear to have in common a lack of objective evaluative tools. Most providers evaluate their programs by recording the rates of usage (increases in employee usage indicate success) and by having employees who utilize the service fill out questionnaires. The former method is effective only if one accepts that increases in usage indicates success, rather than failure; the latter method is a subjective manner of gathering information.

Disability leave is one indicator which is both measurable and more objective. Minimizing the occurrence of this factor is of importance to school

districts, especially in this current time of fiscal restraint. Examples of this concern can be found in School District #68, Nanaimo-Ladysmith and in School District #62, Sooke. David Lockyer, the Secretary-Treasurer for Sooke School District, estimated that last year (1995/1996) the district spent over $1 million for substitute teachers. Similarly, last year's sick leave bill in District #68, Nanaimo-Ladysmith totalled $2.9 million of the district's $92.5 million budget. In addition, substitute teachers who replaced sick teachers in District #68 were paid $1.2 million. Consequently, the Nanaimo-Ladysmith School District has formed a wellness committee whose purpose is to brainstorm ideas that would reduce sick leave costs for the district and meet the 1996/1997 budget commitment on the subject (School District #68, Communications Office - Fax, December 1996).

Many organizations which provide EFAPs report reductions in turnover, disability claims, grievances and accidents upon implementation of the programs (EFAP/ARS - brochure, Interlock - brochure, Warren Shepell - promotional package and Wilson Banwell - interview with an associate). EFAPs are designed to assist employees with personal problems. This support, in turn, results in increased job performance (Greene, 1985; Gould & Schneider, 1983; Stevens, 1986). If an employee is on disability leave, his/her job performance cannot be improving; this suggests that one indicator of EFAP success is the percentage of employees who are at work. This study examines the relationship between the implementation of EFAPs and short and long term disability leave in provincial school districts.

The study involves ten British Columbia school districts which have implemented EFAPs within the last nine years. All districts record disability leave data; from these data a comparison has been made between disability

leave before the EFAP and after the program's initiation. The impact of the implementation of EFAPs on disability leave in ten B.C. school districts is examined in this study. This study may be considered one part of a thorough evaluation; a complete process evaluation of the programs would involve multiple measures (cost-benefit study, client satisfaction, client records, peer review, etc.), whereas this study is focussing solely on disability leave rates. Nonetheless, this study does contribute to the existing body of research in the area of EFAP evaluation. The impact of implementing an EFAP has not been measured in terms of disability leave by the districts nor the providers in the past. This study answers the question of whether a relationship exists between the implementation of EFAPs and disability leave among teachers.

Rationale

The question of whether a relationship exists between the implementation of EFAPs and teacher disability leave is important in the evolving structure of EFAP knowledge. If a relationship is found to exist between these elements, this relationship could be one indicator used to evaluate the effectiveness of programs.

EFAPs and teacher disability leave have been chosen as the two variables for this study for the following reasons:

(a) to evaluate EFAPs, the program itself (i.e. whether or not it exists in a particular district) must be an element in the study;

(b) disability leave is measurable;

(c) measuring disability leave is as objective data as possible;

(d) measuring disability leave is a form of study which can be replicated

There is general agreement on the necessity of EFAP evaluation (Ansley, 1983; Burggrabe & Swift, 4(3), 1984; Jaffe, Stennett & Gladwell, 1988; Lew & Ashbaugh, 1992; Myers, 1984; Stevens, 1986; Stoer-Scaggs, 1990). Burggrabe and Swift present four reasons to evaluate an EFAP: (a) To continue or improve the effectiveness and efficiency of the program, (b) to justify the present or proposed size and "scope" of the program, (c) to "market" the EFAP concept, i.e. to use proven results as a motivation to establish new programs, and (d) to promote continued improvement in the EFAP field through establishing recognized performance standards. Myers makes evident the consensus on the necessity of EFAP evaluation. He states, "Faith alone will not maintain the current momentum in EAP expansion. Employers expect documentable results and they deserve to get them" (Myers, 4(3), 1984, p.22).

Although EFAP evaluation is agreed to be essential, most reports indicate that evaluation is the weakest element in many EFAPs (Ansley, 1983; Gould & Schneider, 1983; Myers, 4(3), 1984; United States Department of Health and Human Services, 1987; Stevens, 1986; interview with Karen Harper who works in the Pensions and Benefits Department of the British Columbia Teachers' Federation, January 1995). Myers (4(3), 1984) reviewed the literature pertaining to EFAP cost-effectiveness studies. Four conclusions became apparent throughout the review. First, there are few published research studies of EFAP cost savings. Second, approximately half of EFAP cost studies are focussed on alcoholics or problem drinkers (problems with alcoholism or excessive drinking constitute a small percentage of the school

district employees who seek out the services of an EFAP [interview with Rein Eberle, Chairman of EAP Committee for Sooke School District, 1994; interview with Dr. W. Craver, associate of Wilson Banwell, 1994; Interlock Quarterly Report - Victoria School District, January 1995]). In comparison, very little attention is placed on drug abuse, mental illness, compulsive gambling, family and marital concerns, legal and financial difficulties, and excessive stress. Third, about 75% of the research studies fail to provide sufficient methodological information to determine whether adequate, accepted research procedures were followed. Fourth, those studies that provided such methodological information confined the study to less than four cost variables, i.e. the studies covered only a portion of the employer costs that problem employees are believed to incur.

School districts with EFAPs cannot be expected to continue them without evidence of results. This is not restricted to cost savings results because employers also want confirmation that EFAPs are effective in preventing and alleviating employee suffering. Ascertaining whether a relationship exists between the implementation of EFAPs and disability leave is one way to seek evidence of EFAP results.

Hypotheses

The question of whether a relationship exists between the implementation of EFAPs and disability leave can be answered by determining whether measurable differences exist in teacher disability leave after the initiation of an EFAP. Three hypotheses have been formulated to cover the entire spectrum of possible answers. These are:

1. There are no measurable differences in teacher disability leave after the initiation of an EFAP (the null hypothesis - Ho).
2. There are measurable differences in teacher disability leave after the initiation of an EFAP. The initiation of an EFAP is followed by a decrease in disability leave (alternative hypothesis - H1).
3. There are measurable differences in teacher disability leave after the initiation of an EFAP. The initiation of an EFAP is followed by an increase in disability leave (alternative hypothesis - H2).

Delimitations

The results of this study cannot be completely generalized from the school districts' staff, faculty and their families, on whom this research is based, to the employees and families of organizations other than school districts. In addition, any conclusions concerning the effectiveness of EFAP providers will have to be restricted to the specific providers examined in this study.

Limitations

Although absenteeism records would be an objective, measurable indicator in determining the effectiveness of EFAPs, these data are not readily available. The school districts are not able/willing to provide information about employee absenteeism and disability leave. As a result, the British Columbia Teachers' Federation has been consulted as a resource for this information. The BCTF has made available a considerable amount of these

data. Statistics on short and long term disability leave are on file; however, absenteeism records are not compiled by the BCTF.

The ten school districts in the study have been examined from 1988 to 1994. One of these districts initiated its EFAP in 1989. Ideally, this district should have disability leave records from two years prior to the implementation of their EFAP included in the study. Unfortunately, the BCTF only retains disability leave records for seven years. Consequently, this study can only go back as far as 1988.

As mentioned above, ten school districts are included in the study. All of the records regarding these districts were collected during visits to the BCTF. Collection of data for these districts was completed over a four day period. These data were not computerized; all information was derived from microfiche and hardcopies and had to be tabulated manually. The BCTF's Pensions and Benefits Department agreed to allow the researcher to spend three or four days for the collection of data. An extension of the collection period in order to collect data on additional districts would have caused inconvenience to the department. Therefore, the study has been limited to ten B.C school districts.

Definitions

Absenteeism This term describes an employee not attending work. When an employee is not attending work (i.e. utilizing his/her "sick leave" time) he/she is considered absent.

Employee (and Family) Assistance Program A program which provides

recognition, treatment, referral and follow-up for an employee whose health/lifestyle problems seriously or continuously affect his/her job performance (Caliguri, 1989; Hacker, 1986; Hills, 1989; Jaffe et al., 1988; Kraft, 1991; Lew & Ashbaugh, 1992).

Note: Some programs are called "Employee and Family Assistance Programs" and their services extend to cover family members of the employee.

Short-term Disability Leave These figures represent employee leave taken after all banked sick leave time has been used. Each full-time equivalent (FTE) receives 15 days per year and this may be accumulated over years. In addition, short-term disability leave is considered less than six months.

Long-term Disability Leave These figures represent employee leave taken after all banked sick leave and six months of short-term disability leave have been used.

Pensionable Service These are statistics which represent the number of months of short-term disability leave taken by each employee. Each month is considered to be 20 days, i.e. 2.5 = 2.5 months = 50 days.

Review of Literature

Introduction

The topics covered in this literature review are wellness/health promotion, Employee and Family Assistance Programs (EFAPs), EFAPs in schools and the evaluation of EFAPs in schools. These concepts are interrelated and move from general to more specific. The findings in each area will be discussed, documenting findings by various research reports. Consensus and controversy within the findings will also be discussed in the review.

Wellness/health promotion, EFAPs, EFAPs in schools and the evaluation of EFAPs in schools will serve as subheadings in this review. First, wellness and health promotion will be defined and characterized. A brief outline of the major research conducted in the area of wellness will follow, as will a prediction of future trends.

The second subheading will be EFAPs. Literature in this area will be divided into seven sections: (a) definitions, (b) statistics, (c) goals, (d) benefits, (e) history (f) components, and (g) models. The literature suggests the work site is a logical place to implement wellness programs; one expression of a wellness program is an EFAP.

EFAPs in schools will be the third topic reviewed. Schools are indicated as an important place for EFAPs to be implemented in this section of the review. Four areas within this subheading will be discussed: (a) rationale, (b) benefits, (c) types of problems addressed, and (d) existing EFAPs in schools.

The final subheading presented will be the evaluation of EFAPs in schools. A weakness in the related literature is indicated in this section. Evaluative measures are lacking in many EFAPs. Various research reports will be used to verify this statement. Although many of the articles in this section do not make specific reference to school based EFAPs, the information is applicable to any organization developing and implementing an EFAP.

The question arises of whether measurable differences exist between before a school district implements an EFAP and after this implementation. This related literature search illustrates the researcher's consideration of relevant past research in the development of the question above.

Wellness/Health Promotion

Definitions and Characteristics

Wellness refers to a conscious perception that the processes and components of an individual are under control and working together as a unit (Dickman, 1988, p. 1). It is a deliberate approach to an advanced state of physical and psychological health. This is a dynamic or ever changing state of being.

Ardell (1985, p. 3) describes three major characteristics of enhancing and maintaining wellness:

1. A balanced approach. The major elements of wellness are commonly organized into six dimensions: (a) social, (b) emotional, (c) spiritual, (d) physical, (e) occupational, and (f) intellectual.

2. A positive and fun approach. The main force behind wellness lifestyles is near-term, attractive benefits. If this lifestyle did nothing to minimize illness or prolong life, it would be valuable as it improves the quality of existence and the satisfaction of being.
3. A systematic approach. People require a method to begin adopting wellness principles that will facilitate the early period of behaviour change maintenance. A plan of this type would include such elements as written goal statements, a list of benefits and barriers, a set of "benchmarks" to chart progress and a method of evaluation.

Health promotion is a phrase which is often used synonymously with the term wellness. Throughout this paper, the two terms will be used interchangeably. Health promotion is the process of enabling people to increase control over, and to improve, their health. To attain a state of complete physical, mental and social well-being, an individual or group must be able to identify and fulfil goals, to satisfy needs, and to change or contend with the environment. Health is a positive concept emphasizing social and personal resources, as well as physical capabilities (Ottawa Charter for Health Promotion, 1986). A considerable amount of literature addresses the concepts of wellness and health promotion; several of these publications (Achieving Health for All: A Framework for Health Promotion, 1986; Action Statement for Health Promotion in Canada, 1996; Allen, 1981; A New Perspective on the Health of Canadians, 1974; Rachlis & Kushner, 1989) will be included in the discussion chapter of this paper. Achieving Health For All ; A Framework For Health Promotion (1986), summarizes the spirit of the above documents with the following quotation:

[Health] becomes a state which individuals and communities alike

> strive to achieve, maintain or regain, and not something that comes about merely as a result of treating and curing illnesses and injuries. It is a basic and dynamic force in our daily lives, influenced by our circumstances, our beliefs, our culture and our social, economic and physical environments. (p. 3)

Major Research

Ardell (1985, p.13) lists five landmark research projects which indicate the substantial consequences of personal behaviours on health status. They include:

1. The Belloc and Breslow longitudinal study showing the impact of seven simple behaviours on life expectancy and morbidity levels (Belloc, Nedra, & Breslow, 1972).
2. The Paffenbarger reports demonstrating the benefits of exercise and similar habit patterns (Paffenbarger & Hale, 1976).
3. The Framingham studies on risk factors of heart disease (Robins & Hall, 1979).
4. The development, testing and refinement of the Health Hazard appraisal by Lew Robbins at Methodist Hospital in Indianapolis, Indiana.
5. The Surgeon General's first report on Smoking and Health (United States Department of Health and Human Services, 1964).

More recently, Blair and Connelly (1996) reported that moderate amounts and intensities of physical activity are associated with improved health and reduced risk of morbidity and mortality when compared with low

activity or fitness. Also in 1996, the first Surgeon General's report (United States Department of Health and Human Services) addressing physical activity and health was written. The main message of this report was that Americans can substantially improve their health and quality of life by including moderate amounts of physical activity in their daily lives. The research projects listed above attest to the impact of lifestyle on personal health. These types of data support investment in wellness practices.

Future Trends

Numerous trends which affect the wellness movement are identified by Ardell (1985, p.33). In The History and Future of Wellness (1985), Ardell also speculates on the consequences of these trends for the growth or decline of wellness. Some of the most important trends are presented below.

Health education will continue to evolve in a manner consistent with the proactive concepts of wellness. For example, the health care industry will take more responsibility for educating consumers on how and why to initiate behaviour change. This education is apparent in developments in wellness and health promotion which shift the power and responsibility from the professional health care system to the individual. In addition, there will be increased government regulations requiring health promotion and wellness programs as a means of controlling costs. There will also be changes in medical education with more focus on lifestyle and socio-environmental influences on health and illness. This focus on the importance of lifestyle and environmental influences on health will be evident in the education of children. Wellness lifestyle practices and knowledge skills will be integrated

into the routine of the learning environment. This ethic will pervade the classroom atmosphere.

Unfortunately, some trends identified by Ardell (1985) will lead to the declivity of wellness. The premature use of inadequately tested new technologies that have profit value could have harmful effects, counterbalancing rises in the general population's health status. Another negative trend could develop from the media fascination with dramatic medical practices which may make people more complacent about individual responsibility for self-care.

Three final trends were presented by Ardell (1985). First, there will be less specialization and more focus on the whole individual. Second, employers will become more deliberate and creative in their efforts to reduce health care costs. Lastly, the North American population is living longer. This trend may have two noteworthy implications: (a) The impact of these retirees on the cost to taxpayers for health insurance, and (b) a change in the culture of older people; different expectations, norms, values and attitudes of older citizens.

Employee and Family Assistance Programs

Definitions.

One way in which wellness can be incorporated into the workplace is through Employee and Family Assistance Programs (EFAPs). These counselling and referral programs respond to the emotional and occupational dimensions of wellness. The literature reviewed was consistent in the

definition of an EFAP. An EFAP provides recognition, treatment, referral and follow-up for an employee whose health/lifestyle problems seriously or continuously affect his/her job performance (Alcohol and Drug Addiction Foundation, 1978; Csiernik, 1995; Caliguri, 1989; Googins & Godfrey, 1987; Hacker, 1986; Hills, 1989; Jaffe et al., 1988; Kraft, 1991; Lew & Ashbaugh, 1992; Sonnenstuhl & Trice, 1986).

Statistics.

There are at least 8000 EFAPs in North America (Maiden & Hardcastle, 1986). In 1987, the United States Department of Health and Human Services released a report titled, "National Survey of Work Site Health Promotion Activities". It stated that 24% of all work sites surveyed offered an EFAP. Size was a significant factor in the probability of having an EFAP; the larger the work site, the greater the likelihood of an assistance program. With 66% of work sites interviewed offering at least one type of health promotion/wellness activity (e.g. EFAPs, exercise/fitness, smoking control, health risk assessment), it was concluded that work site health promotion activities are an accepted component of work in the United States.

Goals.

The goals of EFAPs varied; some were broad, others more specific. One broad goal was consistent throughout the literature: to restore acceptable performance of an employee whose job performance has been deteriorating (Balgopal & Patchner, 1988; Health Resources and Services Administration,

1986; Lew & Ashbaugh, 1992; McClellan & Miller, 1988; Roman, Blum and Bennett, 1987). Other articles presented more specific goals, which may be considered objectives to reaching the broad goal above. Hills (1989) lists three more specific goals of an EFAP:

1. To emphasize education and prevention over treatment.
2. To encourage the development of personal responsibility for health.
3. To recognize the employee's family context i.e. EFAPs should acknowledge the family as being involved in the employee's wellness, and consequently make its services available to them as well.

Benefits.

Throughout the literature, the benefits of an EFAP are said to include cost savings (Cayer & Perry, 1988; Chiabotta, 1985; Gould & Schneider, 1983; Kraft, 1991; Saint Louis Public Schools, 1983; Yamatani, 1988). Improvements in worker performance and productivity are also reported (Balgopal & Patchner, 1988; Brant, 1979; Cayer & Perry, 1988; Keohane & Newman, 1984; Yamatani, 1988) However, other benefits of a more humanitarian nature are also identified.

1. Supervisors who are trained to identify and correct personal problems through the program become better managers (Kraft, 1991).
2. Morale is boosted for employees who see the program as a sign that the employer cares (Balgopal & Patchner, 1988; Brant, 1979; Jaffe et al., 1988; Kraft, 1991).
3. Time and energy can be refocussed to address other management

responsibilities (Kraft, 1991).

4. Troubled employees can be helped rather than dismissed (Kraft, 1991).
5. Cooperation between labour and management is improved (Balgopal & Patchner, 1988; Brant, 1979)

History.

EFAPs have evolved and changed over the years. The first programs were started to help employees with alcohol problems that were affecting their job performance (Ansley, 1983; Hacker, 1986; Lew & Ashbaugh, 1992; National Institute on Drug Abuse, 1988; Roman, 1980). EFAPs were developed from the Occupational Alcoholism Programs (OAPs) of the 1940's. OAPs were often designed and managed by recovering employees who wished to help other alcoholic employees. Over time, the program title was felt to be stigmatizing because of the stereotypes associated with alcoholism (Lew & Ashbaugh, 1992; National Institute on Drug Abuse, 1988; Roman, 1980; Stevens, 1986).

In the 1970's, the controversy created either by the occupational alcoholism counsellors assisting recovering alcoholics with problems other than alcohol addiction, or by their not helping non addicted employees, resulted in a change. These concerns created an expansion of the services of the OAP and the program title was changed to Employee and Family Assistance Program. Since that time, the EFAP has provided assessment and referral assistance to all employees with a range of problems including financial, family, and mental health (National Institute on Drug Abuse, 1988).

Components.

There is controversy regarding specific elements of an EFAP (Ansley, 1983; Erfurt & Foote, 1977; Hacker, 1986; Health Resources and Services Administration, 1986). However, the Standards and Criteria for the Development and Evaluation of a Comprehensive Employee Assistance Program report (Health Resources and Services Administration, 1986) includes most of the components mentioned in other articles. This report lists five essential elements of an EFAP: (a) needs assessment, (b) program integration, (c) comprehensive services, (d) program administration, and (e) program evaluation. For each element, a standard is defined which indicates what is expected when an organization seeks to provide that EFAP element.

Models.

There are various EFAP models in existence. Each model has advantages and disadvantages and possible variations which may develop from the model. Following is a summary of the models outlined in the literature. Although there may be different names for these same models, for the purposes of this review, they have been classified as Models 1-4.

Model one:

In this first design, the EFAP coordinator is an employee of the organization. The coordinator's main job is to assess the problems of troubled employees and refer them to outside providers for appropriate assistance. The advantage of this model is that communication and ownership are kept

within the organization (Hacker, 1986; Kraft, 1991; Stevens, 1986).

Model one, variation one:

In this first variation of model one, the EFAP coordinator provides short term counselling (three to five sessions) for appropriate problems. The advantages of this model are that it saves insurance costs and more employees may request assistance because it is free. The disadvantage is that the requests may be too great for the coordinator, resulting in additional personnel being required (Hacker, 1986).

Model one, variation two:

In model one's second variation, the EFAP coordinator is an employee of the organization, as are the counsellors who provide some or all of the counselling instead of using outside resources. The advantages include more organizational control of the counsellors and increased accountability of the program. In this model the EFAP coordinator has more control over the therapy and its outcome. However, the disadvantage is that school personnel used as counsellors may lead to problems of confidentiality (Hacker, 1986).

Model two:

For the second program model, a contract is used with an outside provider for all EFAP services. The advantages of this design are cost effectiveness for small organizations and confidentiality assurance for the employees. Conversely, lack of control by the employing organization over the contract agency's service becomes a disadvantage of this design (Hacker, 1986; Kraft, 1991; Stevens, 1986).

Model two , variation:

In a variation of model two, the EFAP coordinator is employed by the organization. This person conducts the initial diagnosis and then refers the

employee to the service agency with which the organization has a contract; this agency then provides counselling or referral. An "in-house" EFAP coordinator adds personalization and an organizational commitment to the contract service, however, the number of people involved leads to confidentiality concerns (Hacker, 1986).

Model three:

The third type of EFAP model involves various employers or joint employer-management groups in a specific geographic area joining together to develop their own EFAP. This type of program has been referred to in the literature as a consortium. A consortium is physically located outside the organizations it serves. This model is advantageous because its members retain ownership of a service that they individually could not afford, either financially or time wise, to properly maintain. The disadvantage noted was that the consortium model is the newest and least documented, therefore its effectiveness has virtually no documentation (Csiernik, 1994).

Model four:

The fourth EFAP design is a peer referral. In this model, others in the profession who observe a colleague having problems can confront and persuade the individual to seek help. This model is appropriate for professions in which individuals do not have a direct supervisor and tend to work alone or with only a few peers (doctors, lawyers, university professors). For these professions this model is appropriate. However, this design does not provide for supervisory referral, follow-up, or organizational interventions (Hacker, 1986; Hills, 1989).

EFAPs in Schools

Rationale.

The increasing number of EFAPs in school districts indicates a need for employee assistance in many areas including financial, emotional, marital, substance abuse and quality of life programs (Jaffe et al., 1988; Lew & Ashbaugh, 1992). Lew and Ashbaugh (1992) discuss the need for school administrators to acknowledge the importance of faculty and staff morale. Uehling (1984) maintains that in order to foster a productive working relationship, an environment must be provided which enables employees to grow. All employees, including faculty, staff and administrators need to be recognized as individuals with needs that should be addressed. In addition, because school districts try to help students become productive adults who contribute to society as effective workers, an EFAP appears logical for a school district; the program assists employees to be effective teachers (Hacker, 1986).

School administrators are obligated to provide employees with the necessary resources for maintenance of well-being and personal and professional development. An EFAP will contribute to the satisfaction of this obligation (Lew & Ashbaugh, 1992).

Benefits.

Throughout the literature, the benefits of EFAPs in school districts were found to be very subjective, yet also consistent (Greene, 1985; Gould & Schneider, 1983; Stevens, 1986). The benefits listed generally include

improved levels of job satisfaction, enhanced job performance, improved staff morale, decrease in health insurance costs and a reduction in absenteeism. Although the benefits reported were congruent, the data gathering lacked a scientific approach.

Types of problems.

An EFAP in a school district can do more than help employees with their personal problems. It can facilitate access for employees and their families to community resources for all types of problems. Employee and Family Assistance Programs typically offer confidential assessment, counselling and/or referral in the following areas: (a) marital or family problems, (b) work related problems, (c) emotional problems, (d) substance abuse, (e) financial difficulties, (f) stress management, (g) bereavement, (h) legal assistance, (i) medical problems, (j) smoking cessation, (k) sexual harassment/abuse, (l) elder care/child care, (m) retirement planning (Goldberg, 1982; Gould & Schneider, 1983; Hacker, 1986; Jaffe et al., 1988; Lew & Ashbaugh, 1992; Stoer-Scaggs, 1990; Wilson Banwell & Associates brochure).

Existing EFAPs in schools.

A national survey was conducted by Jaffe et al. (1988), in which a brief letter and questionnaire were sent to 109 Canadian School Boards with a student enrolment in excess of 10, 000 students. The questionnaire requested information about the existence of an EFAP as well as the nature, scope and

evaluation of the program. Of the questionnaires sent out, 67% were returned. Approximately half of the completed questionnaires were from Ontario with the remaining half distributed around the other provinces.

The survey found that most boards (75%) have an EFAP or are considering developing one in the near future (11%). Large boards (3300 - 8000 employees) are much more likely to have an EFAP (94%) than either medium sized (1200 - 2650 employees) boards (74%) or small (900 - 1100 employees) boards (56%).

Most boards (67%) have EFAP services supplied by private consultants, either in a contract (71%) or fee-for-service basis (29%). The remaining boards have services supplied by board employees or a combination of employees and consultants.

From the literature and promotional materials shared by the school boards responding to the survey, Jaffe et al. concluded that the programs now in operation are very wide in scope. They are characterized by leadership and assistance that is flexible, understanding of current pressures, knowledgeable in many areas and project a caring attitude. In addition to this collective information, there are also numerous singular descriptions of EFAPs in schools (Goldberg, 1982; Gould & Schneider, 1983; Hills, 1989; Hyde & Guthrie, 1993; Jaffe et al., 1988).

Evaluation of EFAPs in Schools

The following three sections discuss the importance of evaluations, the current state of evaluations and the problems with evaluations. The information can be applied to any Employee Assistance Program. Many of

the following articles do not make specific reference to EFAPs in schools, however, the information is transferable to any organization developing and implementing an EFAP, including schools.

Importance of evaluation.

There is general agreement on the integrality of EFAP evaluation (Ansley, 1983; Burggrabe & Swift, 4(3), 1984; Jaffe et al., 1988; Lew & Ashbaugh, 1992; Myers, 4(3), 1984; Stevens, 1986; Stoer-Scaggs, 1990). Burggrabe and Swift present four reasons to evaluate an EFAP: (a) To continue or improve the effectiveness and efficiency of the program, (b) to justify the present or proposed size and "scope" of the program, (c) to "market" the EFAP concept, i.e. to use proven results as a motivation to establish new programs, and (d) to promote continued improvement in the EFAP field through establishing recognized performance standards. This last reason is expanded upon by suggesting that progress can be made by moving toward more comparable evaluations. Burggrabe and Swift (4(3), 1984) state that commonly used methods and techniques will allow clearer definition of the similarities and differences between programs. Myers makes evident the consensus on the necessity of EFAP evaluation. He states, "Faith alone will not maintain the current momentum in EAP expansion. Employers expect documentable results and they deserve to get them" (Myers, 4(3), 1984, p.22).

The current state of evaluations.

"In EAPs today, 'evaluation' is a label that is applied loosely to a number of methods for gathering and analyzing data" (Burggrabe & Swift, 4(3), 1984, p. 14). Burggrabe defines evaluation as a way to compare program components, activities or outcomes to standards of desirability; a way to see how closely the EFAP meets its goals and objectives. However, the literature acknowledges there are no clear standards by which the effectiveness of EFAPs can be addressed (Cayer & Perry, 1988, Csiernik, 1995). This is apparent in the EFAP Standards developed by the Association of Labor-Management Administrators and Consultants on Alcoholism, Inc. (ALMACA - see Appendix A). These Standards state, "There should be a periodic review of the Program to provide an objective evaluation of operation and performance. There should be an annual evaluation review of EFAP staff performance" (ALMACA). This is the extent to which evaluation is discussed in these Standards. These guidelines allow for many variations to be incorporated into evaluations; this is reflected in the different ways evaluation has been addressed (Ansley, 1983; Battle, 1988; Burggrabe & Swift, 4(3), 4(4), 4(5), 1984; Cayer & Perry, 1988; French, Zarkin & Bray, 1995; Goldberg, 1982; Hacker, 1986; Jaffe et al., 1988; Kim, 1988; Lew & Ashbaugh, 1992; Myers, 1984; Stevens, 1986; Stoer-Scaggs, 1990; Taylor, Holosko, Wayne Smith & Feit, 1988; Yamatani, 1988).

In 1995, Csiernik conducted a review of research methods used to examine employee assistance programs. Csiernik utilized Macdonald's (1986) five step procedure to evaluate 48 single work site EFAPs. Following are

Macdonald's five steps to a comprehensive EFAP evaluation:

1. Needs Assessment - Determine the overall program goals and direction
2. Program Development - Describe the program, its rationale and objectives
3. Input Evaluation - Determine if the program components have been correctly implemented
4. Outcome Evaluation - Determine if the program objectives have been achieved
5. Process Evaluation - Determine what the program is actually doing and how well

Although information exists on how to develop a needs assessment and what problems to consider, Csiernik (1995) found only four studies (Berman, Sulsky, Pargament, Balzer & Kausch, 1991; Cummings, Rosenkjar & Barash, 1989; Roberts-DeGennaro, 1989; Roberts-DeGennaro, Larazolo & Phillips, 1986) addressing the outcomes of formal EFAP needs assessments. Balzer and Pargament (1988) recommend using both direct (surveys, personal interviews and group interviews) and indirect (personnel, medical and organizational records; community service inventory) data collection techniques when conducting an EFAP needs assessment. Two of the aforementioned studies only use questionnaires and neither of them have adequate response rates (Csiernik, 1995).

The next step in Macdonald's evaluation hierarchy is program development. In the literature this can be found in the form of case studies. Case study has been the most popular method of examining EFAPs to this time. Csiernik's review of the literature found 24 EFAP case studies.

Regardless of its descriptive nature, case study is viewed as a less desirable form of inquiry, primarily because of an assumed lack of precision, objectivity, rigour and its general lack of outcome generalizability. In addition, there is no uniformity in how the various case studies have been conducted or how authors' collected and reported data (Csiernik, 1995). However, a case study can be constructed in a manner where it has construct, internal and external validity and reliability. It is particularly appropriate in situations where it is impossible to separate the phenomenon's variables from its context (Yin, 1989).

There is very little published research on existing EFAPs (Balgopal & Patchner, 1988; Battle, 1988; Csiernik, 1995; Taylor et al., 1988; Teram, 1988) This makes case studies a valid and useful procedure to begin building a database and to use as a precursor to further research in the field. However, future work needs to progress beyond the discussions of history, policy and procedure which characterize the case studies reviewed by Csiernik. More empirical data need to be collected, presented and analyzed to allow for more thorough evaluation of the appropriateness, effectiveness and efficiency of the EFAPs implemented (Csiernik, 1995).

The third step in Macdonald's evaluation hierarchy is input evaluation studies. Input evaluations are mainly a descriptive type of research that takes an inventory of resources an EFAP was intended to have and compares the list with those features the program actually has. Although a useful starting point, input evaluations are limited in that they do not assess the extent to which the EFAP's goals and objectives have been achieved. These type of evaluations are intended as elementary, internal evaluative tools; their natural limitations do not make them relevant for the literature (Csiernik,

1995).

Outcome evaluations are the fourth step in the evaluative hierarchy. Cost-benefit studies are the most common type of outcome evaluations reported in EFAP literature. Cost-benefit analysis is a basic form of outcome evaluation. It is usually a quasi-experimental pre-post design with no control group.

Csiernik found seven examples of cost-benefit studies in the literature (1995). Amongst these seven studies, there was no consistency regarding the criteria used to determine whether an EFAP provided a positive cost return. From one to six criteria were employed; there were no dominant criteria used, as five studies used sick leave, four used changes in health insurance cost while absenteeism, accidents, lost time, and health claims were each used in three studies. All seven studies indicated a benefit greater than the cost associated with implementing and maintaining the EFAP.

Csiernik (1995) notes several cautions to be considered before drawing conclusions and developing future studies based on the existing cost-benefit research. These include:

- the lack of uniformity in research methods employed
- the lack of consistency in selecting criteria
- evaluations were all conducted by internal professions (the providers themselves), which means there was some personal interest in demonstrating the worth and utility of the programs
- evaluations tended to be too brief, with only two being longer than two years in length
- subject selection "issues" raise questions regarding the validity of the results

The recommendation made by Csiernik concerning future cost-benefit studies was to have the evaluations conducted and published by internal volunteers and external professionals.

The fifth and final step in Macdonald's (1986) evaluative hierarchy is the process evaluation. Its purpose is also to examine how EFAP inputs are translated into outcomes, but then to move on and use this information to aid in understanding why intended outcomes were or were not achieved. This type of research contains both qualitative and quantitative methods (Csiernik, 1995).

There is little specific research on process evaluations. The literature reviewed by Csiernik contained many more articles on how to conduct an evaluation than on actual examples; there were six published studies that could be considered process evaluations. The important difference between process evaluations and other methodologies is the use of multiple measures. Two studies used five methods for collecting data, one used four, while three used three different methods. The data collection methods employed were: quasi-experimental design (e.g. one group, pretest/posttest), input evaluation, cost-benefit study, client satisfaction, client records, peer review and historical document reviews. Csiernik believes process evaluations using multiple measures, featuring quasi-experimental research designs, have great potential for assessing the impact of the EFAP on the work force.

Problems with evaluations.

Most reports gathered agreed that evaluation is the weakest element in many EFAPs (Ansley, 1983; Cayer & Perry, 1988; Gould & Schneider, 1983;

Holosko, 1988; Myers, 1984; United States Department of Health and Human Services, 1987; Spicer, Owen, & Levine, 1983; Steidinger, 1986; Stevens, 1986). Three problems common to EFAP evaluations are discussed in the literature. The first of these problems is "transposing traditional evaluation designs and principles into the unique EAP setting" (Burggrabe &Swift, 4(5), 1984, p.27). Since EFAP models are quite different from each other and have different goals (Hacker, 1986; Hills, 1989; Kraft, 1991; Stevens, 1986), it is difficult to develop a standardized evaluation tool. Most evaluations are developed individually, and reflect only the interests and needs of the organization or evaluator. Very little quantitative research has been conducted to verify EFAPs' effectiveness. The literature does not provide much guidance to work toward a commonly accepted definition of what an EFAP is; how it functions and what constitutes measurable success (Battle, 1988; Burggrabe & Swift, 4(5), 1984; Cayer & Perry, 1988; Taylor et al, 1988; Teram, 1988).

The second problem characteristic of many EFAPs is the lack of adequate resources and critical reflection (Balgopal & Patchner, 1988; Battle, 1988; Burggrabe & Swift, 4(5), 1984; Kim, 1988). Regardless of the necessity of an EFAP's evaluation, many staff and managers have difficulty reserving enough time to conduct evaluations. Funds to hire an outside evaluator are often not a budgeted item, therefore, the EFAP staff is usually responsible for carrying out the evaluation -- whether or not they have adequate time, preparation and skills for the task. The second part of this problem is critical reflection; most EFAP managers and counsellors are biased on their behalf. These individuals have a firm conviction that their services are needed and helpful. However, by avoiding critical questions (e.g. are there better ways to achieve the results claimed for the EFAP?), the programs could be being done

a disservice; until the effectiveness and efficiency of EFAPs can be shown objectively, their worth cannot be proven.

The third problem common to EFAPs is a lack of commonly accepted performance and outcome standards (Burggrabe and Swift,4(5), 1984; Cayer & Perry, 1988). Program models range from those focussed on alcoholism to "broad-brush" approaches to the preventative or wellness oriented EFAPs (Goldberg, 1982; Gould & Schneider, 1983; Hills, 1989; Hyde & Guthrie, 1993; Jaffe et al., 1988). Consequently, the goals of programs are as diverse as their natures, varying from the philosophy of maximising cost-savings, to the humanitarian approach, placing great value on a positive change in one's behaviour (Health Resources and Services Administration, 1986; Lew & Ashbaugh, 1992; Roman, Blum and Bennett, 1987). Methods of meeting objectives vary as well, as do ways of measuring the activities and their results.

In response to this variety of purpose, model and process in EFAPs, the "native" evaluation has emerged. The native evaluation has significance only in the program setting for which it was developed. These evaluations lack comparability and are also difficult to validate since it is rarely used in more than one setting. Another problem associated with native evaluations is that their use prevents the accumulation of a generic evaluation data base. This accumulation would facilitate the development of recognized standards by which to measure an EFAPs performance.

Method

Subjects

In this study, the short and long term disability leave of teachers from ten British Columbia school districts, over a period of seven years was examined. The districts used in the study range from small (e.g. Trail - 1994/95 - 233 teachers) to large (e.g. Victoria - 1994/95 - 1220 teachers). The age range of these employees is from approximately 22 to 65 years of age (there may be a small number of exceptions). The teachers' levels of education is at the post-secondary level. The socioeconomic background, ethnicity, political allegiances and religious beliefs are not specifically known. However, it is assumed that all of these districts combined produced a heterogeneous population. The districts examined were:

#11	Trail	#62	Sooke
#15	Penticton	#63	Saanich
#28	Quesnel	#65	Cowichan
#32	Hope	#69	Qualicum
#61	Victoria	#70	Alberni

(see note at end of method section)

Although only ten school districts were used in the statistical analysis, data had been collected from one additional district. School District #43 - Coquitlam, was eliminated because there was no data available prior to the initiation of their EFAP; Coquitlam's EFAP was implemented in 1988, and no records had been saved by the BCTF from 1987 or earlier.

Initially the researcher had planned for the study to incorporate data

from 24 districts. At this early stage in the study, the researcher had hoped to collect the data from the districts themselves. With the assistance of David Lockyer, Secretary-Treasurer of Sooke School District, letters and questionnaires (Appendix B) were mailed to the following districts:

#15	Penticton	#48	Howe Sound
#22	Vernon	#60	Peace River North
#23	Central Okanagan	#63	Saanich
#24	Kamloops	#64	Gulf Islands
#27	Cariboo-Chilcotin	#65	Cowichan
#28	Quesnel	#68	Naniamo
#31	Merritt	#69	Qualicum
#32	Hope	#70	Alberni
#39	Vancouver	#71	Courtenay
#43	Coquitlam	#72	Campbell River
#46	Sunshine Coast	#85	Vancouver Island North
#47	Powell River	#88	Terrace

Unfortunately, only 11 of the 24 districts responded, and of these 11 respondents, just three answered the 12th and final question of the questionnaire, "What are the number of days taken for sick leave per teacher?" This last question was the most pertinent to the study. The poor response rate to this question led the researcher to seek information from the BCTF instead of the districts themselves. Gathering data from the BCTF resulted in changes to: 1) the data collection method 2) the subject pool, i.e. ten districts studied instead of 24, and 3) the unit of measurement examined, i.e. disability leave instead of sick days. The change in the unit of measurement from sick days to disability leave is a beneficial change in that

disability leave more often reflects stress related leave; sick days can indicate illness (e.g. cold, flu), physical injuries, the "creation" of an extra long weekend, as well as stress related leave.

The second group of subjects in this study were the 15 EFAP providers which were mailed questionnaires (Appendix C). There were six additional providers of which the researcher was aware; however difficulties were experienced in contacting these organizations. The intent of these questionnaires was to determine the education, background, qualifications and special skills of the therapists employed. Ten of the providers responded by returning the completed questionnaire and including supplementary material describing their service.

Instruments

Four tools for measurement were employed to determine the effectiveness of the EFAPs. The first of these tools was a questionnaire titled, "Information on the Implementation and Effectiveness of School District Employee Assistance Programs" (see Appendix B). It was mailed to 24 school districts. The questionnaire consists of 12 questions pertaining to the following issues: the reason an EFAP was initiated; who provides the program; the cost of the program; the nature of the EFAP; the evaluation of the program; and the amount of sick leave taken by the districts' employees. This questionnaire was developed by Dr. Martin Collis, the Secretary-Treasurer of Sooke School District, David Lockyer and the researcher.

The second instrument used in this study was a letter sent to 15 of the organizations providing EAPs/EFAPs (see Appendix C). This letter included

five questions regarding the therapists employed by each organization. The questions addressed the following: level of education, prior work experiences, predetermined qualifications, employment status (i.e. part-time or full-time) and special skills.

Short-term disability leave statistics are used as the third instrument in determining the effectiveness of the EFAPs. These are statistics which represent employee leave taken after all banked sick leave has been used. Short-term disability leave is always for a period shorter than six months.

The fourth tool of measurement used to collect data was long-term disability leave. These figures represent employee leave taken after all banked sick leave and six months of short-term disability leave have been used.

Procedures

The first instrument discussed, the questionnaire titled, "Information on the Implementation and Effectiveness of School District Employee Assistance Programs", was mailed to the 24 school districts previously mentioned along with a covering letter written by the Secretary-Treasurer of Sooke School District, David Lockyer (see Appendix D) Mr. Lockyer mailed the questionnaires out of his office, using the Sooke School District's letterhead, to districts with which he had some connection or personally knew the secretary-treasurer.

The questionnaire was sent out in mid-April 1995, and by April 30, 25% had been completed (or partially completed) and returned to the Sooke district office. In mid-May a second letter was mailed out from David Lockyer

to the districts which did not respond and to those which only partially completed the questionnaire. Those who partially completed the questionnaire were sent copies of their questionnaire so they could simply fill in the missing data. The districts were also thanked for their participation. After this second letter, four more questionnaires were mailed back, for a total of 10 returned questionnaires. Therefore, 10 of the 24 questionnaires were partially, or completely, answered and returned.

The second tool of measurement, the letter mailed to 15 providers of EFAPs, was sent out from the researcher, on University of Victoria letterhead (see Appendix C). Recipients of the letter were asked five closed-ended questions and given the option of mailing the answered letter (space was left after each question for answers to be written) to the researcher's home address or to a box office at the university. Ten of the providers returned the completed questionnaire and included supplementary material on the stated goals, objectives and benefits of their EFAP.

Short-term disability leave records are the third tool of measurement utilized. This information was made accessible by the Pensions and Benefits Department at the BCTF.

The next trip made to the BCTF by the researcher and her supervisor was during the first week of July 1995. The Pensions and Benefits Department was willing to allow the researcher access to this information for several days; the department implied that longer than three or four days would be intrusive. The researcher was able to obtain the data used in this study over a period of four days in July 1995. All the information sought was in hardcopy format, or on microfiche. The records regarding short-term disability leave were titled:

"BCTF Salary Indemnity Plan
Annual Contributor Report for Teachers Pension Plans
for ___*___ "

*** e.g. 1993**

The section of the report of interest to the researcher was a column of numbers headed, "pensionable service". These figures represented months of short-term disability leave taken by a particular teacher during either the spring or fall of a specific year. An example of a pensionable service figure would be 2.14. This figure would represent a teacher who has taken 2.14 months of short-term disability leave during either the spring (January - June) or fall (September - December) of a particular school year. Each month is considered to have 20 days; therefore, in this illustrative example, the teacher would have taken 42.8 days of short term disability leave (2.14 x 20).

To obtain data from these short-term disability leave records, the name of the district being studied was written down, the type of disability leave (i.e. short-term), the period of time (e.g. January-December 1992), and the time of year (i.e. spring or fall). Then the numbers listed in the pensionable service column were recorded. Each of these numbers represents disability leave for one individual. After the pensionable service numbers were recorded, the amounts for the spring and fall were totalled.

Long-term disability leave records are the fourth tool of measurement utilized in this study. This information was also made accessible to me by the Pensions and Benefits Department at the BCTF. The records pertaining to long-term disability leave were titled:

"Ben
Great-West Life's Group Benefit Administration System
Disability Claim Detail
B.C. Teachers' Federation"

These records were broken down by district, as were the short-term figures. However, instead of dividing the claims by "fall" and "spring", they were catorgized by month. Another difference between the recording format of the short term disability and the long term disability was that long term is recorded by the number of days (e.g. 60 = 60 days). The voluminous nature of these records, coupled with the researcher's time restraint, led to collecting statistics from one representative month out of each year. The month chosen was June as this was an average month with respect to long term disability leave. The researcher determined June to be an average month by collecting data from two districts throughout the year of 1989 (January-December). These districts were #61 Victoria and #63 Saanich. Table 1 shows the figures from these districts in 1989.

To obtain data from the long term disability leave statistics, the district's name, the type of disability leave (i.e. long term), the period of time (e.g. 01 June 92 to 30 June 92), the individual's name or initials, the number of days of leave taken during the month in question, and the date the claim first began were recorded. The reason the claimant's name or initials was recorded was to keep track of how many different people were utilizing the system over the years of 1988 - 1994. Without recording the individuals' names, there would be no way for the researcher to review the data and ascertain whether the four claimants from June 1991 are the same claimants as those in June 1992, or whether they are four new people. After all the long term disability leave statistics were recorded, the days accrued for each district, in each year, were totalled. The long term disability leave data were usually divisible by 30 (e.g. 60 = 2 teachers, 180 = 6 teachers, 270 = 9 teachers) since most individuals on long term leave took an entire month, and there were a

Table 1

Days On Long Term Disability Leave Over An Entire Year (1989)

Month	#61 Victoria	#63 Saanich
January	205	30
February	180	30
March	160	30
April	180	50
May	180	60
June	210	60
July	240	60
August	270	60
September	210	30
October	217	30
November	270	30
December	240	30

maximum of 30 days to "take" in June.

In order to make the short and long term disability leave statistics meaningful, a fifth type of data were required. This final set of data were from the BCTF's Member Records; it lists the number of teachers in each district, in each year. Although this fifth source is not considered an "instrument", it was necessary in generating disability leave statistics. This information was critical in order to weight the disability figures (e.g. disability leave per 100 teachers), and thus, make comparisons between districts meaningful. The member records were organized to keep track of the number of teachers (actual teachers employed, not the number of full time positions in the district) in every school year. An example would be the number of teachers in School District #11 (Trail) during the 1988/89 school year was 205. Therefore, these records take into account periods from two separate calendar years. This contrasts the method of recording for disability leave which looks at one calendar year at a time (e.g. January 1989 - December 1989). Short and long term disability figures were weighted by examining the amount of disability leave in a particular year (e.g. 1989) and the average number of teachers in that district from two school years (e.g. 1988/89 and 1989/90). Two school years were necessary in the calculation as 1989 is part of both school years.

Design

The data in the questionnaires sent to the school districts were collected by having the completed questionnaires returned to the Sooke School District Office. As the questionnaires were returned, they were sent to the researcher by Mr. Lockyer. The answers from the questionnaire were summarized and recorded. The replies from the letters sent to the providers were collected by having the answers mailed back to the researcher. These answers were also be summarized and recorded.

The short and long term disability leave statistics were collected over four days from the British Columbia Teachers' Federation. The researcher was allowed access to recent statistics (1993-1994), which were in hardcopy format, as well as older statistical records (1988-1992), which were on microfiche. These disability leave statistics were recorded in a tabular format.

The data from Member Records regarding the number of teachers in each district were collected from reports which had previously totalled these numbers. The numbers are referring to the actual number of teachers working in the district, not the number of full time positions in the district. For example, the morning and afternoon kindergarten teachers would be counted as two teachers, not as one full time teaching position. Data were collected for the school years 1988/89 to 1994/95, with the exception of 1992/93. For an unknown reason, these data were not recorded by Member Records.

Data Analysis

The data were first weighted to have each district's numbers represent disability leave in a manner allowing easier comparison (e.g. each figure represents disability leave per 100 teachers in a district). The weighted data have been plotted on bar graphs to provide a visual summary of the information gathered (see Appendices E and F). Each school district is represented by its own bar graphs to illustrate the frequency of short and long term disability leave during each year in the study.

The analysis applied to these data was t-tests. T-tests are used to compare two means. The disability leave mean from the years before the EFAP implementation and from the years of, and after, the EFAP implementation in each district were compared. These t-tests were only applied to the weighted data. The t-tests were utilized to determine whether disability leave means before EFAP implementation were significantly different from disability leave means after EFAP implementation.

Note: At the time the data collection for this research project was conducted, there were 75 school districts. In December 1996, British Columbia amalgamated its 75 school districts into 59 districts. Therefore, the numbering scheme previously used has changed for numerous districts. This paper will remain consistent by using the same numbering scheme as was in place throughout the data collection period (July 1995). However, with regard to the 10 districts studied in this paper, four have new district numbers. For the reader's information, the following are the changes to the four districts in the study which were affected by the amalgamation:

Old Name and #	New Name and #
11 Trail	20 Kootenay Columbia
15 Penticton	67 Okanagan-Skaha
32 Hope	78 Fraser Cascade
65 Cowichan	79 Cowichan Valley

Results

Four sources of information were used in determining the following results. These were:

1. Questionnaire to 24 B.C. school districts
2. Letter/questionnaire to 15 EFAP providers
3. Short-term disability leave statistics
4. Long-term disability leave statistics

Due to the poor response rate of the school district questionnaire, and the omission by most of the districts of the last question ("What are the number of days taken for sick leave per teacher?), the results were not useful to the researcher. The letter/questionnaire sent to the providers gave rise to descriptive information about the therapists employed. The short and long term disability leave data collected from the BCTF is shown at the end of the Results chapter in tables 2 and 3. The data may also be observed in Appendices E and F in the form of bar graphs.

The data were analyzed using non-directional t-tests. The statistical software used for the analysis was SPSS (see Appendix G for the printout in its entirety). The question of whether a relationship exists between the implementation of EFAPs and disability leave was answered by determining whether measurable differences exist in teacher disability leave after the initiation of an EFAP. The years before a school district implemented an EFAP were used to form "pre EFAP" means (t1), while the year of implementation, together with all subsequent years constitutes the "post EFAP" means (t2). Three hypotheses cover the entire spectrum of possible answers to the aforementioned question. These are:

1. There are no measurable differences in teacher disability leave after the initiation of an EFAP (the null hypothesis - Ho: t1 - t2 = 0).
2. There are measurable differences in teacher disability leave after the initiation of an EFAP. The initiation of an EFAP is followed by a decrease in disability leave (alternative hypothesis - H1: t1 - t2 >0).
3. There are measurable differences in teacher disability leave after the initiation of an EFAP. The initiation of an EFAP is followed by an increase in disability leave (alternative hypothesis - H2: t1 - t2 < 0).

The critical t for both the short term and long term analyses was $\pm$ 2.26 (the degrees of freedom was 9 and the probability of a type I error was .05). The calculated t for short term disability was - 3.27. The calculated t for long term disability was - 5.70. Both of these calculated t's are greater than the critical t (using absolute values). This means pre-EFAP disability leave means are significantly different from post-EFAP disability leave means. These differences existed in both the short and long term statistics. Therefore, the null hypothesis is rejected. This rules out hypothesis #1 listed above.

The pre-EFAP mean for days on short term disability leave was 65.26 days per 100 teachers; the standard deviation was 31.78 The post-EFAP mean for days on short term disability leave was 116.12 days per 100 teachers; the standard deviation was 47.99. The standard deviation for paired differences was 49. 14.

The pre-EFAP mean for days on long term disability leave was 18.16 days per 100 teachers; the standard deviation was 9.05. The post-EFAP mean for days on long term disability leave was 35.27; the standard deviation was 8.51. The standard deviation for paired differences was 9.49.

The post-EFAP means are greater than the pre-EFAP means for both

short and long term disability leave per 100 teachers (i.e. pre - post = a negative number/ t value). These differences, which have been shown to be statistically significant, indicate an increase in disability leave. The initiation of an EFAP in the ten school districts examined, was followed by an increase in teacher disability leave. This rules out hypothesis #2 (H1: $t1 - t2 > 0$). The final hypothesis, #3 (H2: $t1 - t2 < 0$), is therefore the outcome of this study. It states: *there are measurable differences in teacher disability leave after the initiation of an EFAP. The initiation of an EFAP is followed by an increase in disability leave.* It is important to note that although this study indicates an overall statistical trend towards an increase in disability leave, there was variability in the ten districts. The bar graphs in Appendices E and F reveal that several districts appear to have a decrease in disability leave. This variation may be due to urban and rural differences or the EFAP provider quality in each district.

Table 2

Days On Short Term Disability Leave Per 100 Teachers

District	1988	1989	1990	1991	1992	1993	1994
11Trail	17.60	231.20	**115.00**	135.00	144.40	97.80	74.00
15 Penticton	37.40	149.20	105.60	**94.40**	57.20	62.60	69.60
28 Quesnel	9.40	60.40	49.00	**118.80**	103.40	47.00	69.40
32 Hope	0.00	108.80	0.00	**0.00**	0.00	52.60	170.80
61Victoria	43.40	100.60	87.40	122.40	88.60	**146.20**	200.20
62 Sooke	16.40	104.00	**161.60**	117.60	60.60	126.40	122.20
63Saanich	11.60	37.00	83.00	103.20	**81.20**	130.60	80.40
65 Cowichan	65.00	91.60	**196.80**	306.40	179.20	169.60	125.80
69 Qualicum	N/A	79.40	20.00	47.00	**144.40**	132.20	235.00
70 Alberni	20.40	**73.00**	63.00	66.40	117.20	112.00	61.60

Table 3
Days On Long Term Disability Leave Per 100 Teachers

District	1988	1989	1990	1991	1992	1993	1994
11Trail	14.63	14.22	**40.72**	29.39	26.09	52.86	26.09
15 Penticton	22.90	22.39	31.69	**29.90**	38.96	28.21	27.95
28 Quesnel	10.10	9.84	18.55	**9.29**	37.15	57.14	18.93
32 Hope	34.09	33.33	31.91	**31.58**	31.91	63.16	31.25
61Victoria	16.23	15.87	21.83	12.65	26.90	**32.58**	55.11
62 Sooke	7.25	14.05	**26.49**	38.22	31.58	30.80	61.35
63Saanich	7.52	14.22	6.59	6.37	**25.26**	5.95	29.88
65 Cowichan	28.85	7.04	**27.46**	43.13	57.08	60.81	62.50
69 Qualicum	27.27	25.86	36.14	35.86	**36.29**	33.21	42.11
70 Alberni	8.31	**16.48**	8.06	14.56	41.10	32.97	49.05

Note. Numbers in bold print indicate the year of implementation for the corresponding school district.

Discussion

The following is a discussion of the impact of implementing EFAPs on teacher disability leave in ten British Columbia School Districts. The discussion is presented in four sections: I) The Framework of Health Promotion, II) Interpretation of Results, III) Recommendations, and IV) Conclusions.

I The Framework of Health Promotion

The framework of health promotion is used in this discussion to explain the context in which EFAPs are being examined. When evaluating a program, one must identify the goals of this program and the context in which it operates.

Health promotion encompasses EFAPs. This relationship is integral when attempting to evaluate EFAPs. The following section is presented in three sections: A) EFAPs VS. Wellness Programs/Health Promotion; B) Health Promotion in Canada; and C) EFAPs Within the Health Promotion Framework.

A. EFAPs VS. Wellness Programs/Health Promotion

EFAPs provide counselling and referral services to the employees of B.C.'s school districts. These programs assist individuals in managing difficulties which affect job performance. Some of these difficulties include finances, child or elder care, and marital issues (Ansley, 1983; Hacker, 1986;

Lew & Ashbaugh, 1992; National Institute on Drug Abuse, 1988; Roman, 1980). It is noteworthy that these programs are typically reactionary; difficulties which have already developed are being carefully "managed". One way to describe the EFAP is as curative medicine; the concentration is on treating existing problems through curative medicine (Allen, 1981). In fact, Cayer and Perry (1988) refer to EFAPs as employee treatment services in their discussion of EFAP performance.

Wellness and health promotion both adhere to similar principles. Consequently, these two terms have been used interchangeably throughout the discussion. Health promotion encourages individuals and communities to choose and sustain lifestyles which foster health. Wellness programs recognize and address the physical, emotional, social, ecological, occupational, cultural and spiritual aspects of health (Action Statement for Health Promotion in Canada, 1996). An integral aspect of these programs is their proactive component. Ideally, wellness programs not only focus on changing negative health practices through individual behaviour modification, but also emphasize "treating the culture that causes us to have our poor health practices in the first place" (Allen, 1981, p. 12).

Although poor emotional health is not usually referred to as a disease, the three traditional approaches to disease prevention are relevant and applicable in this discussion. Primary prevention is targeted at preventing disease before it occurs, thereby reducing the incidence of disease. Secondary prevention is the early detection of disease in an asymptomatic period before it progresses and the treatment which may occur as a result of screening. Finally, tertiary prevention attempts to reduce complications of the disease by treatment and rehabilitation (Shah, 1994). Therefore, although EFAPs are

considered reactionary by the researcher, these programs may also be referred to as "preventative"; EFAPs fit the definition of tertiary prevention. Similarly, wellness programs are also accurately described as preventative; however, primary prevention would be the main objective.

As has been previously stated, although EFAPs and Wellness Programs are not equivalent modes of delivery, they are related. EFAPs tend to fall under the "umbrella" of health promotion. Without doubt, Employee Assistance Programs have a place within a Wellness Program. Even though wellness programs strive to be proactive, an EFAP would still be an important contributor because it assists individuals unaffected by the earlier interventions of that same wellness program.

A wellness program encompasses an EFAP. It is this relationship which forms the framework of this discussion. Therefore, in order to examine and evaluate EFAPs, it becomes necessary to clarify the context within which an EFAP ideally exists.

B. Health Promotion in Canada

Canada has a rich legacy in health promotion. In 1974, a report was produced by the Ministry of National Health titled, "A New Perspective on the Health of Canadians". This was the first national document to officially recognize that factors such as food, shelter, income, social equality, ecological stability and resource sustainability are more influential in maintaining health than doctors and hospitals. This realization was reiterated twelve years later, in 1986, with the Ministry of National Health and Welfare's

report, "Achieving Health for All: A Framework for Health Promotion". It stated: "Our system of health care as it presently exists does not deal adequately with the major health concerns of our time." This report detailed a three pronged strategy for "moving beyond the laboratory, the doctors' office, and the hospital to tackle the real present-day health challenges. The recommendations for promoting health were:

1. Foster public participation
2. Strengthen community health services
3. Coordinate healthy public policy

The "Ottawa Charter for Health Promotion" was also produced in 1986. An international conference in Ottawa sponsored by the Ministry of National Health and Welfare, the World Heath Organization, and the Canadian Public Health Association developed this document which contains a very similar list of strategies:

1. Build healthy public policy
2. Create supportive environments
3. Strengthen community action
4. Develop personal skills
5. Reorient health services

More recently, the "Action Statement for Health Promotion" was developed by the Canadian Public Health Association (CPHA) in 1996. This document was not intended to replace or update the "Ottawa Charter for Health Promotion" or "Achieving Health for All: A Framework for Health Promotion". The intent of this action statement was to focus Canadian efforts in the present conditions, which are so different from the optimistic period when the "Ottawa Charter for Health Promotion" was first written.

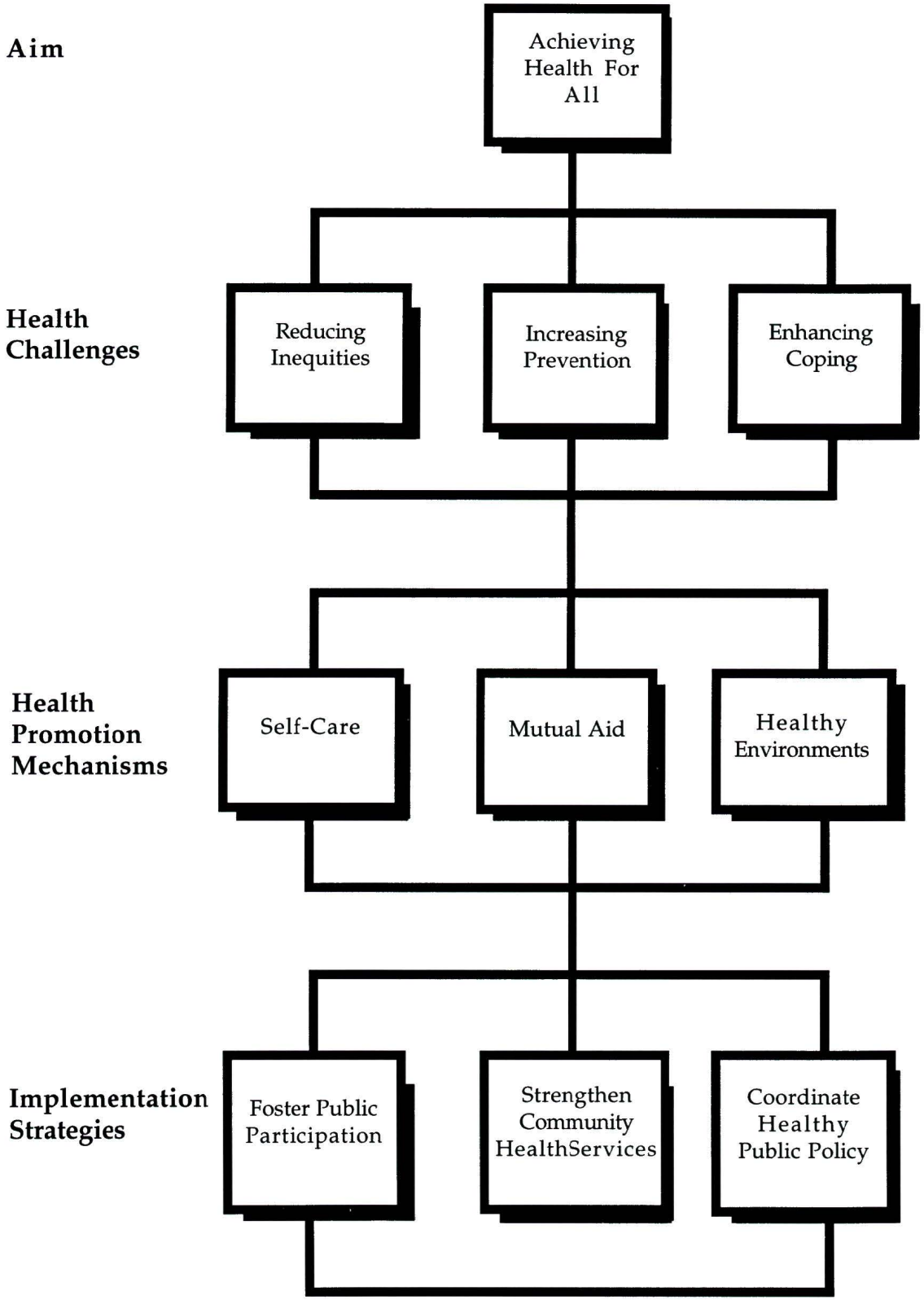
The "Ottawa Charter for Health Promotion" identified the necessities for health as peace, shelter, education, food, income, stable ecosystem, sustainable resources, social justice and equity. With information from current population health research, the "Action Statement for Health Promotion" recognizes that additional integral health determinants include:

> ...healthy child development; adequate incomes; a small gap between rich and poor; the absence of discrimination based on gender, culture, race and sexual orientation; life-long learning opportunities; healthy lifestyles; meaningful work opportunities with some control over decision-making; social relationships that respect diversity; freedom from violence or its threat; freedom from exposure to infectious disease; protection of humans from environmental hazards and protection of the environment from human hazards
>
> (Action Statement for Health Promotion, 1996, p.2)

Even though the "Action Statement for Health Promotion" is the most recent Canadian report regarding health promotion, the framework outlined in "Achieving Health for All: A Framework for Health Promotion", is still extremely relevant and useful in defining health promotion as an approach and as a concept to be used by all Canadians (this document will be abbreviated as the "Framework" from this point onward). The aim of health promotion in Canada is achieving health for all. The Framework (see Figure 1) identifies three major components which contribute towards reaching the aim of health promotion. These components are: 1) identifying the national health challenges, 2) health promotion mechanisms, and 3) implementation strategies.

The health challenges identified in the *Framework* were threefold:

Figure 1.
A Framework For Health Promotion



reducing inequities, increasing the prevention effort and enhancing people's capacity to cope. The first challenge was to find ways to minimize inequities in the health of low versus high-income groups in Canada. Disturbing evidence reveals that regardless of Canada's superior health services system, people's health remains directly related to their economic status (Rachlis & Kushner, 1989). Certain groups within the low-income bracket have a higher chance of experiencing poor health than others. Older people, the unemployed, welfare recipients, single women supporting children and minorities and immigrants all fall into this category. Not enough has been done to deal with these differences; therefore, the reduction of health inequities between high and low-income groups is one of the primary national health challenges.

The second health challenge listed in the Framework is increasing the prevention effort. This task involves finding new and more effective ways of preventing the occurrence of injuries, illnesses, chronic conditions and their resulting disabilities. The document defines prevention as identifying the factors which cause a condition and then reducing or eliminating these factors. Many of the prevention measures taken routinely in Canada today, were begun during the 19th century (e.g. immunization and the chlorination of drinking water). More recently, the preventative effort has been extended into the area of individual lifestyle and behaviour. However, because the causal relationships between behaviour and health are not as straightforward as they are between "germs" and disease, prevention is far a more complex undertaking than it has been in times past. Today's illnesses and injuries and the disabilities manifested from them, are the result of many interacting factors (Achieving Health for All: A Framework for Health Promotion, 1986).

The final challenge discussed is enhancing people's capacity to cope. In this century, chronic conditions (e.g. arthritis, hypertension) and mental health problems (e.g. depression) have replaced communicable diseases as the predominant health problems among Canadians in all age groups. These "new" health problems create a need to ensure Canadians are supported in the area of mental health. Surveys indicate that many Canadians find their lives stressful. Anxiety, tension, sadness, loneliness, insomnia and fatigue are often symptoms of mental stress. The challenge is to provide the skills and the community support needed by people with disabilities and mental health problems, to enable them to manage effectively, lead stable lives and improve the quality of their lives (Achieving Health for All: A Framework for Health Promotion, 1986).

Three mechanisms are presented in the Framework. These are: self-care, mutual aid and healthy environments. Self-care refers to the decisions made and the practices embraced by an individual specifically for the maintenance of his or her health (e.g. choosing a balanced diet, driving slower when roads are icy). Factors such as beliefs, access to relevant information and being in surroundings that are manageable, are all influential in making healthy choices.

The second health promotion mechanism, mutual aid, pertains to people's effort to deal with their health concerns by working together. It suggests people help each other, support each other emotionally, share ideas, information and experiences. Mutual aid may develop in the context of the family, the neighbourhood, the voluntary organization, or the self-help group. In Canada, there are numerous examples of mutual aid in action - Alcoholics Anonymous (AA), Block Parents and rape crisis centres are just a

few illustrations (Achieving Health for All: A Framework for Health Promotion, 1986).

The creation of healthy environments is the third mechanism in the Framework. This means changing social, economical or physical surroundings in ways that help to preserve and enhance health. The environment includes the buildings people live in, the air people breathe, and the jobs people do. It is also the education, transportation and health systems. When the environment is understood in this broad of a manner, environmental change easily becomes the most difficult of the three mechanisms or kinds of action required for the promotion of health (Achieving Health for All: A Framework for Health Promotion, 1986).

Policies and practices are necessary in order to support the concept of health promotion. Therefore, the Framework established a set of strategies; the implementation of which will enable Canadians to reach the goal of achieving health for all. These strategies are: fostering public participation, strengthening community health services and coordinating healthy public policy.

Fostering public participation means assisting people to assert control over the agents which affect their health. Creating conditions in favour of public participation allows the energy, skills and creativity of community members to be directed into the national effort to achieve health. Examples of public participation in Canada include: the Vancouver "Be Well" program, a network of seniors who established a self-help model to encourage participants to preserve their own health; Crocus Co-operative in Saskatoon which offers programs and counselling for post-mentally ill adults; and The Canadian Sickle Cell Society which has grown from a few volunteers into a

national organization devoted to educating, testing and counselling Canadians affected by sickle cell anemia. Fostering public participation helps people to respond to one of the leading challenges, that of enhancing people's capacity to cope. In fact, endeavours initiated by the public can provide effective responses to any of the national health challenges (Achieving Health for All: A Framework for Health Promotion, 1986).

Strengthening community health services is the second implementation strategy. "Achieving Health for All: A Framework for Health Promotion" (1986) states:

> We believe that there should be an expansion of this role and that it should be expressly oriented toward promoting health and preventing disease. At the same time, we recognize that adjusting the present health care system in such a way as to assign more responsibility to community- based services means allocating a greater share of resources to such services. (p. 10)

In accordance with the above statement, community health services will have to focus more on dealing with the major health challenges which have been identified. Community health services will also become a vehicle for health promotion, assuming a principle role in developing self-care, mutual aid and the creation of healthy environments. In particular, it is important that community health services become more involved in assisting people to cope with disabilities and mental health problems. For all Canadians striving to take responsibility for their own health, whether in groups or as individuals, community health services may appropriately assume a far more prominent role in the health promotion effort (Achieving Health for All: A Framework for Health Promotion, 1986).

The final strategy discussed in the Framework is coordinating healthy public policy. Self-care, mutual aid and healthy environmental change are more likely to occur when healthy public policies are in place. Healthy policies facilitate health promotion because they make it easier for people to make healthy choices. All policies which have a direct influence on health need to be coordinated. The list includes, income security, employment, education, housing, business, agriculture, transportation, justice and technology.

Conflicting interests may exist between the sectors listed above. Such conflicts are entrenched in our society. Tobacco is an example; the federal government is a proponent of a smoke-free environment. Conversely, there are Canadian farmers who cultivate this product for their livelihood. Changes in tobacco policies affect both farmers and smokers. In this situation, the creation of healthy public policy requires responding to an issue with serious health as well as economic implications. Therefore, coordination must exist (Achieving Health for All: A Framework for Health Promotion, 1986).

The strategies, together with the mechanisms, comprise the main aspects of the Framework. One strategy or mechanism alone will be of little significance. Only by having these aspects mutually reinforcing one another, assigning resources and setting priorities, can health promotion carry meaning and energy. (Achieving Health for All: A Framework for Health Promotion, 1986).

C. EFAPs Within the Health Promotion Framework

Now that EFAPs and wellness programs/health promotion have been differentiated, and health promotion in Canada has been described, an explanation of how EFAPs "fit" within the health promotion framework is appropriate. In the following section the researcher has determined whether, and to what extent, EFAPs are part of each aspect of the Framework.

In reference to the flowchart depicted in Figure 1, the majority of EFAPs primarily address one of the Framework's three health challenges: enhancing coping. EFAPs try to enhance people's ability to manage and cope with chronic conditions, disabilities and mental health problems. To a lesser degree, EFAPs may be involved in reducing inequities in the health of low versus high-income groups. This challenge could be partially met by making the EFAPs services accessible and inviting to all types of school district employees, regardless of each individual's income. EFAPs also address increasing the prevention effort, although not to their maximum potential. The prevention of illness has been explained by Allen (1981) as having four advancing steps. These are:

1) curative medicine - focus on treating severe illness through curative medicine.
2) precurative screening - focus on treating early symptoms through periodic screening.
3) individual behaviour change - focus on changing negative health practices through individual behaviour.
4) cultural medicine - focus on changing negative health cultures through cultural medicine.

EFAPs are effective in the first two steps of the prevention of illness. This has no doubt been beneficial. However, implementation of the third and fourth steps, with emphasis on the fourth, would make the programs much more preventative. EFAPs have been well developed to identify early symptoms in a "case by case" manner. It is the researcher's opinion though that EFAPs could become even more preventative by creating "cultural climates" which are conducive to health.

Regarding the Framework's health promotion mechanisms, EFAPs operate mainly within one of the three mechanisms. EFAPs facilitate self-care; employees are encouraged to make individual healthy choices. However, EFAPs do not usually facilitate mutual aid by creating social support. Social support would include sharing ideas, information and experiences with a network of related people. EFAPs also tend not to be involved in creating healthy environments by altering people's social, economical or physical surroundings in order to maintain and improve health.

Finally, in reference to the last section of the Framework, EFAPs do not usually assist with the implementation strategies. EFAPs do not typically work towards fostering public participation, strengthening community health services or coordinating healthy public policy. In sum, EFAPs have a strong connection with two of the nine aspects in the Framework (enhancing coping and self-care), and have less dominant links to others. Therefore, although these assistance programs are typically reactionary, they definitely contribute toward reaching the overall aim of "achieving health for all".

II Interpretation of Results

This study answers the question of whether a relationship exists between the implementation of Employee and Family Assistance Programs and disability leave in teachers. The information derived from this study is of little use unless the results are examined and interpreted. The following interpretation is presented in three sections: A) The Results and EFAP Theory, and B) Methodological Concerns, and C) Importance of the Results.

A) The Results and EFAP Theory

Reductions in turnover, disability claims, grievances and accidents are reported by many organizations which provide EFAPs (EFAP/ARS, Interlock, Warren Shepell and Wilson Banwell). EFAPs are developed to support employees with personal problems. The literature states that EFAPs result in increased job performance and reductions in absenteeism (Greene, 1985; Gould & Schneider, 1983; Stevens, 1986). When employees are on disability leave, job performance cannot be improving and absenteeism will not be reduced. Therefore, the researcher believed that the number of employees on disability leave would be one objectively measurable indicator of EFAP performance.

The results section of this paper reports that measurable differences do exist in teacher disability leave after the initiation of an EFAP. These differences suggest that the introduction of EFAPs is accompanied by an increase in disability leave (H2: $t1 - t2 < 0$). This finding contradicted numerous articles which explain the benefits of an EFAP to include cost-

savings (Chiabotta, 1985; Gould & Schneider, 1983; Kraft, 1991; Saint Louis Public Schools, 1983). However, the increases in teacher disability leave are more understandable when one reads Myers (4(3), 1984) review of the literature pertaining to EFAP cost-effectiveness studies. Four conclusions are deduced from his review. First, there are few published research studies of EFAP cost savings. Second, approximately half of EFAP cost studies are focussed only on alcoholics or problem drinkers (problems with alcoholism or excessive drinking constitutes a small percentage of the school district employees who seek out the services of an EFAP [interview with Rein Eberle, Chairman of EAP Committee for Sooke School District, 1994; interview with Dr. W. Craver, associate of Wilson Banwell, 1994; Interlock Quarterly Report, January 1995]) . Third, about 75% of the research studies fail to provide sufficient methodological information to determine whether adequate, accepted research procedures were followed. Fourth, those studies that provided such methodological information confined the study to less than four cost variables, i.e. the studies covered only a portion of the employer costs that problem employees are believed to incur. Myers review sheds some light on the reasons why this evaluative study appears to contradict the results obtained from some cost-effectiveness studies.

In addition to the cost-analysis studies, benefits with a more philanthropic nature are also identified in the literature. Examples of these include: morale is boosted for employees who see the program as an indication that the employer cares (Jaffe et al., 1988; Kraft, 1991), troubled employees can be helped rather than dismissed (Kraft, 1991), and supervisors who are trained to identify and correct personal problems through the program become better managers (Kraft, 1991). The results of this evaluative

study cannot be used to measure any of the above benefits. However, because the latter benefits are extremely subjective, measuring their existence was not a goal of this study.

B. Methodological Concerns

Although measurable differences were found to exist in teacher disability leave after the initiation of an EFAP, it can only be *suggested* that the program itself increased the disability leave. The above statement constitutes a methodological problem with this evaluation of EFAPs. Other factors besides the EFAPs may have impacted the amount of disability leave taken by the teachers. Some of these may include: 1) disability leave policy within each district 2) population aging 3) amount of advertising/promotion for the EFAP, and 4) attitudes within each school regarding disability leave.

Some of the above factors, and others, may have played a role in the disability leave statistics gathered in this study. Acknowledging and accepting their possible existence was the only way to examine ten provincial school districts over seven years. To examine the relationship between teacher disability leave and the implementation of EFAPs, in a manner which factors out all other possible influences on the independent variable, is ideal. Unfortunately, it is also impossible within the scope of this study.

Two considerations lead the researcher to conduct this study even though the aforementioned methodological problem existed. The first consideration was the rationale (see chapter 1) established for evaluating school district EFAPs by measuring teacher disability leave. The second

consideration was the fact that school district EFAPs have not been evaluated by measuring disability leave in the past.

C) Importance of the Results

There are three possible domains in which the results of this study may be important. The first area in which the results may be important is in the continuing evolution of EFAPs. EFAPs may conceivably benefit by evolving into a larger system - health promotion. The EFAPs examined in this evaluation do not appear to have a positive impact on disability leave. Yet, these programs do seem to have an appropriate place within the health promotion framework. As discussed in section I - C of this discussion, EFAPs are strongly associated with two of the nine Framework components, and may well influence others. Future development of EFAPs into programs designed to "achieve health for all" (i.e. strengthening the association between EFAPs and the other seven components) may possibly have the desired impact of decreasing disability leave.

A second area in which the results of this study could be of some importance is in the financial domain. EFAP providers claim to save organizations money by lowering rates of turnover, disability claims, grievances and accidents (EFAP/ARS, Interlock, Warren Shepell and Wilson Banwell). The results suggest the opposite might be true in this study; disability leave rates *increased* after EFAPs were implemented. It is important to acknowledge that this study is not attempting to illustrate "cause and effect"; its results merely point out the overall statistical trend toward an increase in disability leave after the implementation of an EFAP in the ten

school districts examined. This information, nonetheless, is important because it means EFAPs could be funded based on inadequate information.

The results of this evaluation are derived from ten school districts, however, nearly all of the province's districts offer EFAPs. Information from these results will be of interest to all districts in British Columbia which have an assistance program. Upon every school district there are considerable fiscal restraints placed. For this reason, increases in teacher disability are of great concern to the provincial school districts.

Although the researcher was unable to make comparisons to other budgetary components, the following statistics on the cost of substitute teachers are of interest and illustrate the previously mentioned fiscal concerns: 1) Last year (1995/96) School District #62, Sooke, spent over $1 million for substitute teachers (David Lockyer, Secretary-Treasurer for Sooke School District), and 2) School District #68, Nanaimo-Ladysmith, spent $2.9 million of the district's $92.5 million budget on sick leave last year. In addition, School District #68 spent $1.2 million on substitute teachers to replace sick teachers. As a result, the district recognized the need to reduce sick leave costs in order to meet the 1996/1997 budget commitment; to meet this need, the district formed a wellness committee (School District #68, Communications Office - Fax, December 1996).

The results of this study do not prove causation, i.e. EFAPs cause disability leave to increase, however, it can be stated that the implementation of EFAPs in this study did not result in reductions in disability leave. School districts are constantly under pressure to be fiscally responsible. This pressure is applied from within districts upon themselves, as well as from the general public. These pressures would suggest that school districts give some

consideration to the factors that are associated with disability leave.

The third domain in which the results of this evaluation may be important is that of humanitarian concerns. Benefits such as increased productivity and staff morale have been claimed by various EFAP providers (Interlock information package, Warren Shepell promotional package, interview with Rob Peacey, Victoria Pacific Coast Savings Manager and Debbie Ottenbright ,Victoria P.C.S. Vice President of Human Resources). These types of humanitarian benefits might be difficult to attain in an environment where disability leave rates are increasing.

III Recommendations

The researcher has two main recommendations for the application of the results. These recommendations are presented in two sections: 1) Accountability of Current EFAPs and 2) Evolution of EFAPs. The first section will give recommendations for conducting a more ideal evaluation of EFAPs in the school districts. The latter section will recommend that EFAPs evolve into health promotion programs.

A. Accountability of Current Programs

The first recommendation is that school districts allocate more resources to evaluating EFAPs. The programs need to be accountable to their respective districts; this accountability should not be determined by the EFAP provider themselves. School district EFAPs should be regularly evaluated by an external, unbiased third party. School districts need to determine the

criteria upon which EFAP performance should be based. To answer this question, districts must first ascertain what they expect EFAPs to do; based on these goals, districts must also decide how they want to evaluate the program's effectiveness. The type of objective information collected from the ten districts in this study might be one of the criteria that would appropriate for school districts to use in the future.

This study was limited by time and access to data. The researcher realizes evaluations can never be conducted under perfect conditions. However, attempts can be made to create circumstances which are more desirable than those of past evaluations. The following are three recommendations which would improve successive evaluations. First, the process of recording disability leave statistics should begin several years before the implementation of an EFAP. This provides a baseline for comparisons at a later date. Second, conduct evaluations which consider not only disability leave statistics, but also absenteeism records and substitution costs. These figures were "unavailable" for this study; school districts were unwilling to divulge this information to the researcher. Nevertheless, these data do exist; accessibility depends upon the willingness of several treasurers to assist in the evaluative process. Hopefully, this opportunity will present itself in the future.

A final recommendation for subsequent EFAP evaluations would be to include a larger number of school districts; perhaps a province-wide evaluation would be feasible. Again, the motivating factor is the issue of sensitivity. Results from 75 school districts over ten years would be more meaningful than results from ten school districts over the same period.

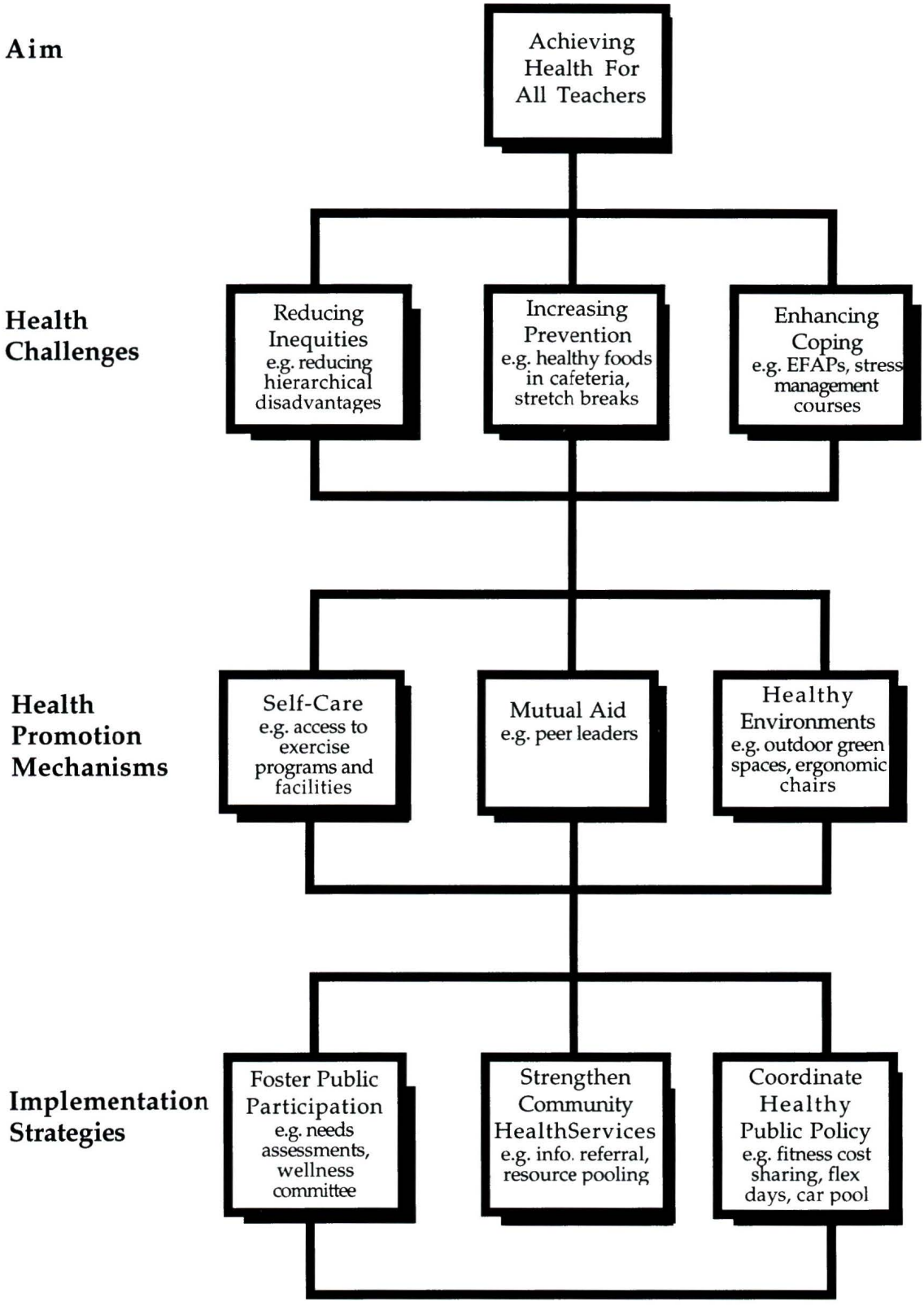
B. Evolution of EFAPs/Health Promotion Framework Encompassing EFAPs

The second recommendation of the researcher is an "either/or" proposition. It would be beneficial, in the researcher's opinion, to either have EFAPs evolve into health promotion programs, or to have EFAPs recognize their significance within the health promotion framework and work in conjunction with other aspects of a wellness program toward the same overall aim of "achieving health for all". If either of the above options were adopted within the school districts, all of the nine Framework components would become applicable to some degree. The flowchart on the following page (Figure 2) gives some examples of how each of the nine Framework components could be part of a health promotion program in the school districts.

If EFAPs begin to evolve into health promotion programs, or if a health promotion framework encompassed the EFAPs, two of the Framework's nine components would be exceptionally critical: increasing prevention and creating healthy environments. The first critical component is addressed in the following story. This story is well known among prevention workers and summarizes the problems associated with reacting to ill-health.

> You know, sometimes it feels like this: There I am, standing by the shore of a swift-flowing river, and I hear the cry of a drowning man. So, I jump into the river, put my arms around him, pull him to shore, and apply artificial respiration. Just when he begins to breathe, there's another cry for help. So I jump into the river, reach him, pull him to shore, apply artificial respiration, and then just as he

Figure 2.
A Framework For Health Promotion
Examples for School District Applications



> begins to breathe, another cry for help. So back in the river again, reaching, pulling, applying, breathing, and then another yell. Again and again, without end, goes the sequence. You know, I'm so busy jumping in, pulling them to shore, applying artificial respiration, that I have no time to see who the hell is upstream pushing them all in.
>
> (Zola, 1970)

The above excerpt is an illustration of why EFAPs need to become more proactive. Presently, the EFAPs studied typically *react* by rescuing "drowning" employees. Key to present and future hopes for improving health is prevention. Most people do not pay much attention to their health until they become ill. Unfortunately, illness, not health, is the more fascinating topic (Rachlis & Kushner, 1989).

In many ways the current structure of EFAPs closely parallels the operation of the medical system. Good health is taken for granted. Then, when people get sick, they automatically seek treatment, which, if successful, strengthens the belief that medical care is the most important factor determining one's health. In the same vein, when treatment fails, or is unavailable, people often think the solution is more research to find cures.

The way financial resources are allocated in health care reflects the above attitudes. Fear of disease, and the erroneous notion that health care is responsible for people's well-being, has encouraged the development of an enormously expensive sickness treatment system. When compared with the notoriety of curative medicine, prevention seems very simple and undramatic. Curative medicine is much more obvious and exciting; the results appear almost immediately. In contrast, with preventative interventions, results may not surface for 25 - 30 years. Consequently,

sickness treatment programs often receive more funding than preventative programs (Rachlis & Kushner, 1989).

In the opinion of the researcher, EFAPs need to make many of the same adaptations as Canada's health care system. Good health must not be taken for granted and funding should be directed towards the most effective approach, regardless of whether it is the most exciting or dramatic.

The second component which is critical to the evolution of EFAPs, or the inclusion of EFAPs in newly developed health promotion programs, is creating healthy environments. Most Canadian professionals involved in health promotion know that personal choices are often limited by circumstances beyond the individual's control. The choices made regarding health are heavily influenced by society and culture. An objective for EFAPs could be to create an environment conducive to healthy behaviours. It is imperative to remember that healthy environments should support all the aspects of health - physical, mental, social, ecological, cultural, and spiritual (Action Statement for Health Promotion in Canada, 1996). Some examples of how EFAPs could strive toward creating healthy environments are:

- healthy foods in cafeteria
- lockers and showers (for walking/riding to work)
- facilitate access to exercise programs
- provide all teachers with ergonomic chairs, desks, chalkboards and computers
- serve fresh fruit, bagels and juice at staff meetings instead of coffee and doughnuts
- provide an outdoor green space with benches for teachers to retreat to on breaks and lunch hours

- proper ventilation and lighting throughout schools
- design a staff room which is enjoyable and relaxing, e.g., couches, an aquarium, artwork)
- initiate stretch breaks for the beginning of each class
- flu shots administered by school nurse to all teachers every fall
- regular mandatory lunchtime seminars (perhaps once per month) addressing wellness issues - adequate sleep, regular exercise, proper nutrition, environmental concerns, family dynamics, substance abuse, financial planning/management
- a school district library of books, audio and visual tapes, and computer programs dealing with wellness issues

The above list is certainly not exhaustive; it could be the responsibility of the EFAP to determine which changes would be appropriate and feasible for each particular school district. Over time, the changes implemented would become societal and cultural norms which enhance health. Health would be promoted by generating living and working conditions that are safe, stimulating, satisfying and enjoyable (Ottawa Charter for Health Promotion, 1986; Achieving Health for All, 1986; & Rachlis & Kushner, 1989).

The literature is replete with numerous reviews examining health promotion programs and their impacts (Anderson & Staufacker, 1996; Eddy, Fitzhugh, Wojowicz & Wang, 1996; Ericksen, 1996; Foote, 1996; Glanz, Sorensen & Farmer, 1996; Heaney & Goetzel, 1996; Hennrikus & Jeffery, 1996; Murphy, 1996; Roman & Blum, 1996; Shephard, 1996; & Wilson, Jorgensen & Cole, 1996). The previous references may be useful in assisting with future program development and evaluation. The evolution of EFAPs into health promotion programs would also be aided by gleaning information from such

documents as, "Healthy People 2000: National Health Promotion and Disease Prevention Objectives". This report was released in September 1990 by Dr. Louis W. Sullivan, Secretary of Health and Human Services. One section of this report is titled, "Healthy Schools 2000"; a subheading of this section, "Objectives Related to Schoolsite Health Promotion for Faculty and Staff" lists the following ten objectives:

1. Increase the proportion of worksites offering employer-sponsored physical activity and fitness programs.
2. Increase the proportion of worksites that offer nutrition education and/or weight management programs.
3. Increase the proportion of worksites with a formal smoking policy that prohibits or severely restricts smoking at the workplace.
4. Enact comprehensive laws on clean indoor air that prohibit or strictly limit smoking in the workplace and enclosed public places.
5. Increase the proportion of worksites which adopt drug and alcohol policies.
6. Increase the proportion of worksites that provide programs to reduce employee stress.
7. Increase the proportion of workplaces that offer health promotion activities for their employees.
8. Increase the proportion of worksites that mandate employee use of occupant protection systems, such as seatbelts, during all work related motor vehicle travel.
9. Increase the proportion of worksites that offer high blood

pressure and/or cholesterol education and control activities.

10. Increase the proportion of worksites that have a voluntarily established policy or program for the hiring of people with disabilities.

Although the report explains these objectives in more detail, the list above is sufficient in illustrating the type of components a health promotion program should strive to include.

Pelletier's "Review and Analysis of the Health and Cost-effective Outcome Studies of Comprehensive Health Promotion and Disease Prevention Programs at the Worksite: 1993-1995 Update" (1996) found that most of the research to date (1) indicates favourable health and cost outcomes; and (2) tends to support rather than refute earlier and less rigorously designed studies. However, this review also noted that not all health promotion and disease prevention programs in the worksite are health and/or cost-effective. Negative results and methodologic limitations of studies were included and extensively discussed in the review. It appears there is a need for further research in the area. The research to date suggests positive results; however, future program implementations and subsequent evaluations of health promotion programs would hopefully lead to more conclusive results.

IV Conclusions

This evaluation makes a new contribution to the existing body of research regarding EFAPs. The results of this study establish the relationship which exists between the implementation of EFAPs and teacher disability

leave. This relationship suggests that the introduction of EFAPs is accompanied by an increase disability leave. These increases in disability leave were determined to have both financial and humanitarian consequences. Based on the results of this evaluation, the EFAPs in the ten districts examined did not fulfil one of the major objectives in their providers' promotional literature; this objective was reducing absenteeism.

In this study, EFAPs were usually not accessed until a problem had developed. This put them in a reactionary position. The role of EFAP employees was predominantly some form of counselling, with minimal focus on other forms of health delivery. Regardless, EFAPs do work toward reaching our federal governments overall goal of achieving health for all. However, these programs should be considered one component within a larger system. This "larger system", as identified by our federal government, is health promotion.

The health of school district employees would be more positively impacted if EFAPs were accompanied by other components of a health promotion program. Two components which would be of particular significance are increasing prevention and creating healthy environments. The manifestation of these components has been briefly discussed in this evaluation; thorough explanation and proposed implementation would be material for further studies in the area of teacher wellness.

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Appendix A

RESOURCE INFORMATION ON EMPLOYEE ALCOHOLISM / ASSISTANCE PROGRAMS

ASSOCIATION OF LABOR-MANAGEMENT ADMINISTRATORS AND CONSULTANTS ON ALCOHOLISM, INC.

1800 N. Kent Street, Suite 907
Arlington, Virginia 22209
(703) 522-6272

PROGRAM STANDARDS

The standards presented here for Employee Alcoholism/Assistance Programs (EAPs) were developed in response to a need for guidelines by which organizations or consultants can develop and implement new Programs or evaluate existing ones.

The National organizations involved in the development of these standards are: The Association of Labor-Management Administrators and Consultants on Alcoholism; National Council on Alcoholism; and Occupational Program Consultants Association; two federal agencies: the National Institute on Alcohol Abuse and Alcoholism, the U.S. office of Personnel Management; and the AFL-CIO and other segments of organized labor.

PROGRAM STANDARDS

1. POLICY AND PROCEDURE

1.1 Policy Statement

An organization shall adopt a written policy statement on alcoholism and other problems covered by the EAP. This will be signed by the chief executive and union head where appropriate, and will reflect management and labor attitudes and agreements as to the Program's objectives. The policy should state that alcoholism is a disease responsive to treatment and rehabilitation and specifying the responsibilities of management, union representatives, and employees as they relate to the Program. The EAP need not in any way alter management's responsibility or authority or union prerogatives. Participation in the EAP will not affect future employment or career advancement, nor will participation protect the employee from disciplinary action for continued substandard job performance or rule infractions.

1.2 Confidentiality

Written rules will be established specifying how records are to be maintained, for what length of time, and under what conditions, and what use, if any, can be made of records for research, evaluation and reports. Client records maintained by an EAP should never become part of an employee's personnel file. Adherence to federal regulations on the confidentiality of alcohol and drug abuse records (42 CFR Part 2) is required of Programs even indirectly receiving federal funds.

1.3 Procedures for individuals referred by management and/or union representatives

Each EAP will prepare written procedures for action initiated by management and/or union representatives. This will provide for assessment by EAP staff,

evaluation by professionals, referral for treatment, feedback to and from the referral source and follow-up. For alcoholism cases there should be a follow up at least monthly for a minimum of one year.

1.4 Procedures for voluntary use of the Program by employees/family members

Procedures for individuals who refer themselves will provide for assessment by EAP staff, evaluation by professionals, referrals for treatment and follow up. The Program will initiate no contact with management concerning individuals who refer themselves, consistent with confidentiality regulations.

2. ADMINISTRATIVE FUNCTIONS

2.1 Organizational position of the EAP

Operation of or responsibility for the EAP should be positioned at an organizational level high enough to ensure the involvement of senior management and/or union leadership in sustaining the Program.

2.2 Physical location of the EAP

The physical location of the EAP should facilitate easy access while ensuring confidentiality.

2.3 Record-keeping system

Each EAP will have a record keeping system carefully designed to protect the identity of the client, while facilitating case management and follow up and providing ready access to statistical information.

2.4 Relation of the EAP to medical and disability plans

There should be a review of medical and disability benefits to ensure that plans adequately cover appropriate diagnoses and treatment for alcohol, drug, and mental health problems. Where feasible, coverage should include out

patient and day treatment care. The EAP staff should be familiar with provisions of the medical and disability benefit plans so they can advise clients clearly as to the extent, nature and cost of the recommended treatment and reimbursement available.

2.5 Malpractice/liability insurance

The organization should conduct a legal review of all aspects of the Program. The purpose is to ensure that there should be adequate protection for all EAP staff and the Organization against possible malpractice/liability claims.

2.6 Qualifications of EAP staff

The EAP should combine two primary qualifications:

1. Appropriate managerial and administrative experience.
2. Skills in identifying problems, interviewing, motivating, referring clients, and, where appropriate, in counselling or related fields. Experience and expertise in dealing with alcohol related problems are essential.

3. EDUCATION AND TRAINING

3.1 Communicating EAP services to employees and their families

It is important that employees and their families are informed about the organization's EAP and the services it offers and are continually updated by various educational techniques on its existence and availability. Information about the EAP should be made available to all new employees and their families.

3.2 Employee Education

An organization should have a major commitment to ongoing education about alcohol use and alcoholism. Additional efforts should be made to educate employees about other recognized problem areas.

3.3 Orientation of management and union representatives

Management and union representatives should be thoroughly informed about their key role in utilizing the EAP services. Orientation for management and union representatives should be updated regularly.

4. RESOURCES

4.1 Resource file on providers of assistance

Each EAP should maintain current information about alcoholism treatment services and other resources. These include alcoholics anonymous, Al-Anon, Ala-teen, and other self-help groups, appropriate health care, community services and other professionals.

5. EVALUATION

5.1 Program review and evaluation

There should be periodic review of the Program to provide an objective evaluation of operation and performance.

5.2 Staff performance evaluation

There should be an annual evaluation review of EAP staff performance.

Appendix B

Information on the Implementation and Effectiveness of School District Employee Assistance Programs

Name of District: _____ # of Employees _____

1. Does your School District have an EAP? Yes ☐ No ☐

   (If No, disregard the remainder of the Questionnaire but please return it to sender)

2. When did your school district initiate an EAP? _____

   Why did your district implement an EAP?

3. Who is you current EAP provider? _____

   How did you select this provider?

   Have you employed any other providers? If so, when and why did you change?

4. What is the cost of your current program? (1993/94 costs)

   (a) CUPE $ _____ for _____ total FTEs

   (b) Teachers $ _____ for _____ total FTEs **or**

   (c) All staff $ _____ for _____ total FTEs

5. (A) What specific concerns is your EAP designed to address? Please check.

(i) Family problems ☐

(ii) Marital concerns ☐

(iii) Substance abuse ☐

(iv) Financial problems ☐

(v) Legal problems ☐

(vi) Stress management ☐

(vii) Elder care/management ☐

(viii) Lifestyle problems (nutrition, exercise, back care) ☐

(ix) Co-worker/work site problems ☐

(x) Bereavement counselling ☐

(xi) Other (please specify)

_____

_____

_____

(B) Does your EAP offer proactive prevention programs?

(i) Exercise ☐

(ii) Nutrition counselling ☐

(iii) Lecture series/seminars (other than Pro-D) ☐

(iv) Specific stress management activities
e.g. progressive muscle relaxation, meditation, etc. ☐

(v) Investment planning ☐

(vi) Other (please specify)

_____

_____

6. Who is covered by your EAP?

Administrators ☐

Teachers (Full time) ☐

Teachers (Part time) ☐

Support Staff (Full time) ☐

Support Staff (Part time) ☐

7. How many people in your district are covered by your EAP? _____

8. Are any tools for evaluation of this program being utilized?

(a) By the School District? ☐

(b) By the Provider? ☐

If yes, what information is measured by these tools?

Qualitative

(A) User satisfaction reports ☐

(B) Provider's summary or impressions ☐

Quantitative

(A) Number of people who formally accessed the program _____

(B) Total no. of hrs. of counselling provided by therapists _____

(C) What percent of eligible participants actually access the EAP in a given year?

89/90 ____% 90/91 ____% 91/92 ____% 92/93 ____% 93/94 ____%
Please give a close approximation where possible)

9. Do you have any formula or insight for measuring the cost effectiveness of your EAP? Please comment.

10. How does your provider bill your school district?

(i) Designated prepayment (lump-sum) ☐

(ii) Set fee per scheduled visit ☐

(iii) Combination of the above ☐

Comments:

_____

_____

What is the ratio of payment?

(i) School district covers total cost ☐

(ii) Participants cover total cost ☐

(iii) Cost is shared {School district ____%
{Participants ____% ☐

11. Is there a maximum number of subsidized visits (or sessions) an individual may have in one year? If so, what is it?

Comment if necessary:

_____

_____

12. What are the number of days taken for sick leave per teacher?

	89/90	90/91	91/92	92/93	93/94
Short term	____	____	____	____	____
Long term	____	____	____	____	____
Total	____	____	____	____	____

Appendix C

«Name»
«Company»
«Address»
«City and Province»
«Postal Code»

June 28, 1995.

Dear Madam/Sir

I am a graduate student at the University of Victoria. Studying the growth of Employee Assistance Programs in British Columbia school districts has been a focus of mine over the past several months. These programs appear to be a service which has evolved from a "bonus" into a necessity. I am especially interested in the professional expertise of the therapists facilitating this assistance. It would be very much appreciated if you would take the time to answer the following questions and return the answers to me at the university.

1) What is the type and level of education of your therapists?

2) What would constitute a typical background of one of your therapists? (i.e. prior work experiences)

3) Are there predetermined qualifications therapists must meet before they may work for your company?

4) Are your therapists full-time, part-time or both?

5) Do any of your therapists have special skills? (e.g. back care, nutrition counselling, exercise prescription)

Your cooperation would be very useful in determining the breadth of knowledge and experience that EAP therapists are currently offering. Please return the answered questions to the UVIC address on the letterhead. Please also request for your returned letter to be placed in the graduate student mailboxes. I look forward to hearing a response back from you. Thank you for your time.

Sincerely,

Ann Marie Redenbach

Appendix D

April 18, 1995.

Dear

RE: Employee Assistance Plan

Our school district has had an employee assistance plan for approximately six years. We have alternated providers of the program and we have financed it in a number of different ways. While we are familiar with aspects of our employee assistance plan, we have very little data comparing our plan to others in the province. If you are operating an employee assistance plan, I am sure you will have similar questions to the ones you will find in the attached questionnaire. I believe, when you review the questionnaire, you will realize that answers to the questions will likely give you greater insight into your own employee assistance plan.

I would be pleased to collate the data from all of the surveys and forward a copy to you regardless of whether you have an employee assistance plan or might be in the position of considering one. I am sure that the summary of the coverage will provide all of us with a greater knowledge of employee assistance plans that are in place throughout the province and will enable us to operate in a more fiscally responsive way.

If you decide to participate please complete the questionnaire by April 30. Thank you for your time and attention to this matter.

Yours Truly,

David Lockyer
Secretary-Treasurer

DL:md

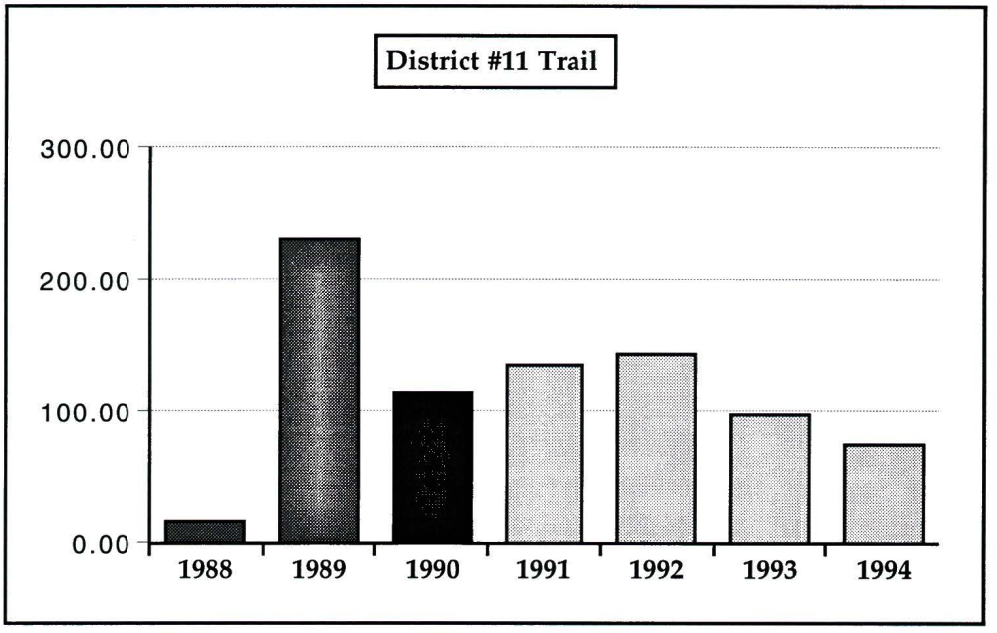
Appendix E

Days On Short Term Disability Leave Per 100 Teachers

Pre-EFAP

Year of EFAP Implementation

Post-EFAP

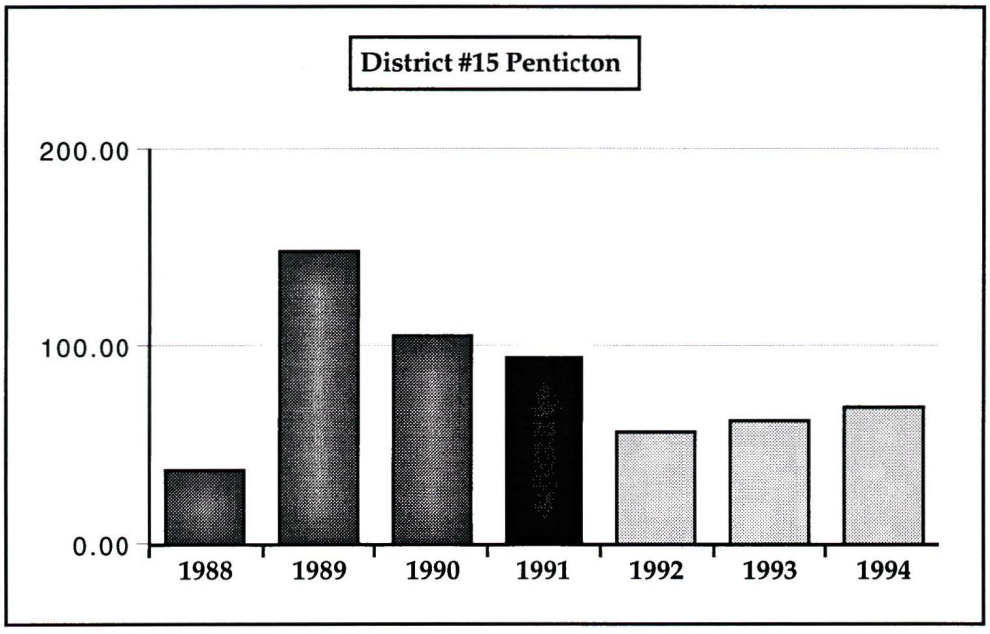


Days On Short Term Disability Leave Per 100 Teachers

Pre-EFAP

Year of EFAP Implementation

Post-EFAP

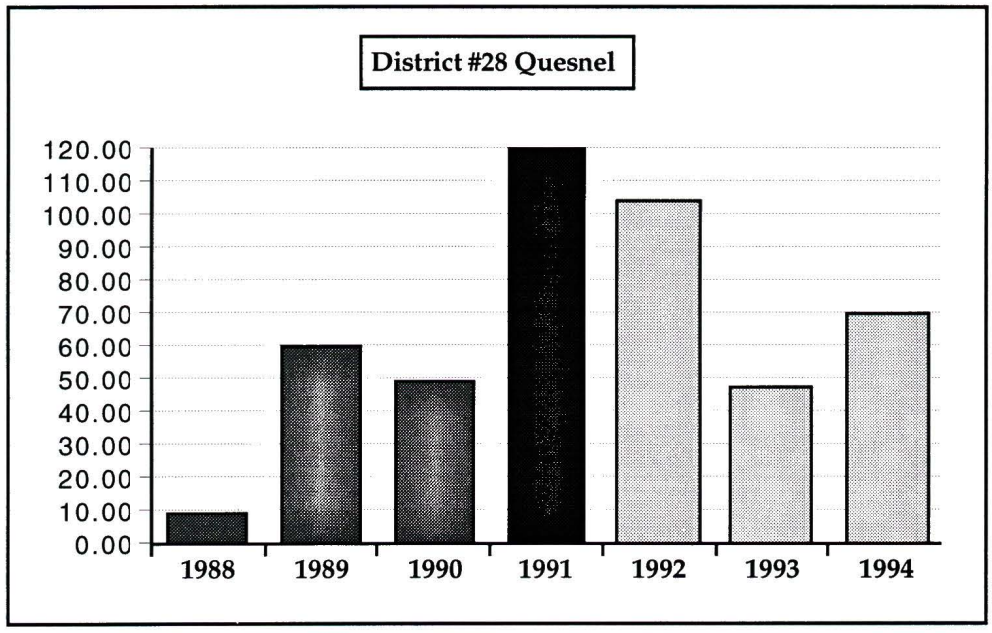


Days On Short Term Disability Leave Per 100 Teachers

Pre-EFAP

Year of EFAP Implementation

Post-EFAP

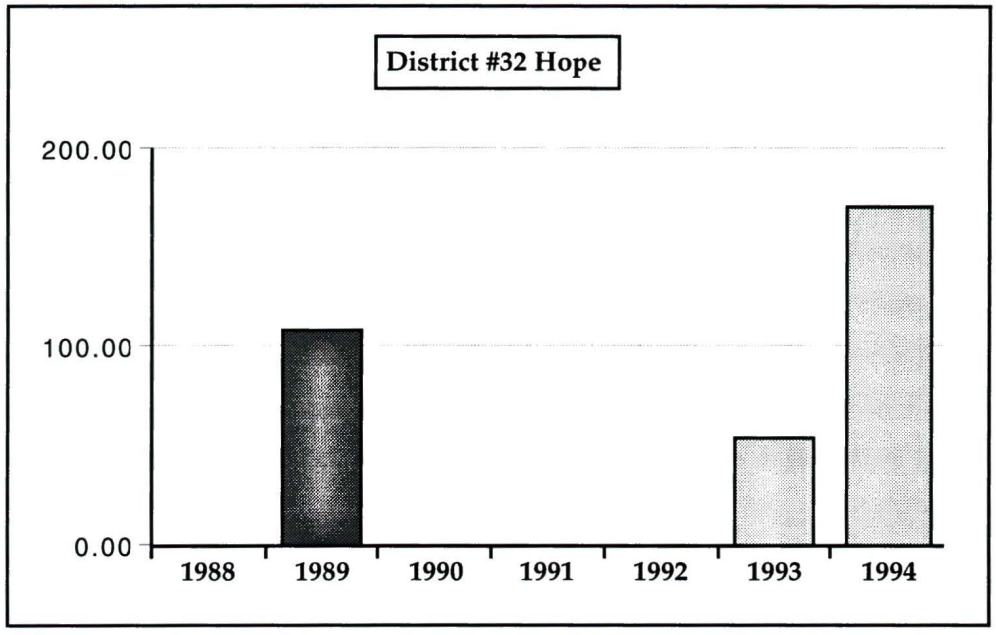


Days On Short Term Disability Leave Per 100 Teachers

Pre-EFAP

Year of EFAP Implementation

Post-EFAP



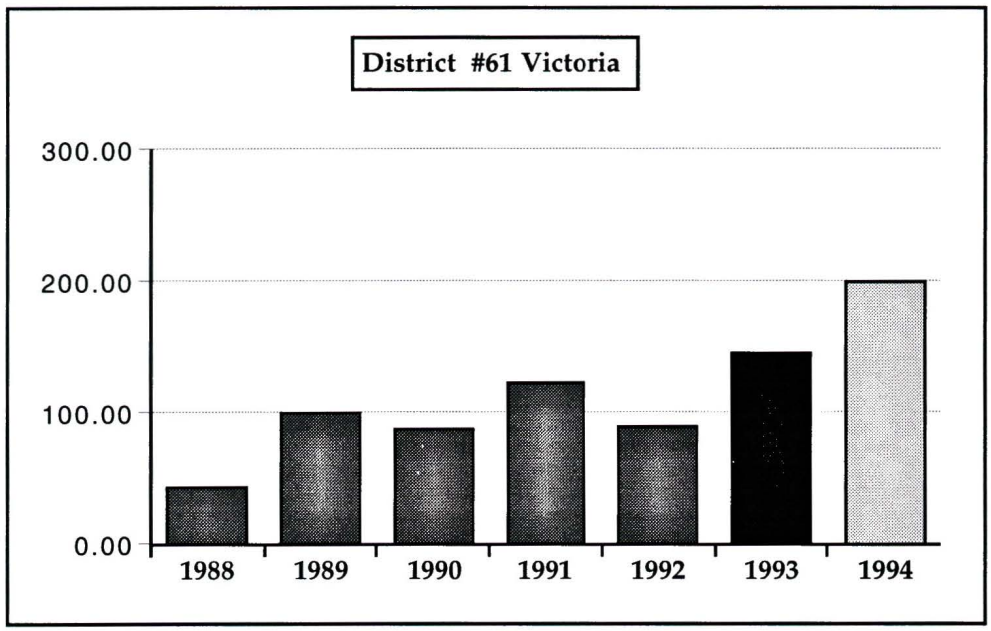
Year of Implementation was 1991

Days On Short Term Disability Leave Per 100 Teachers

Pre-EFAP

Year of EFAP Implementation

Post-EFAP

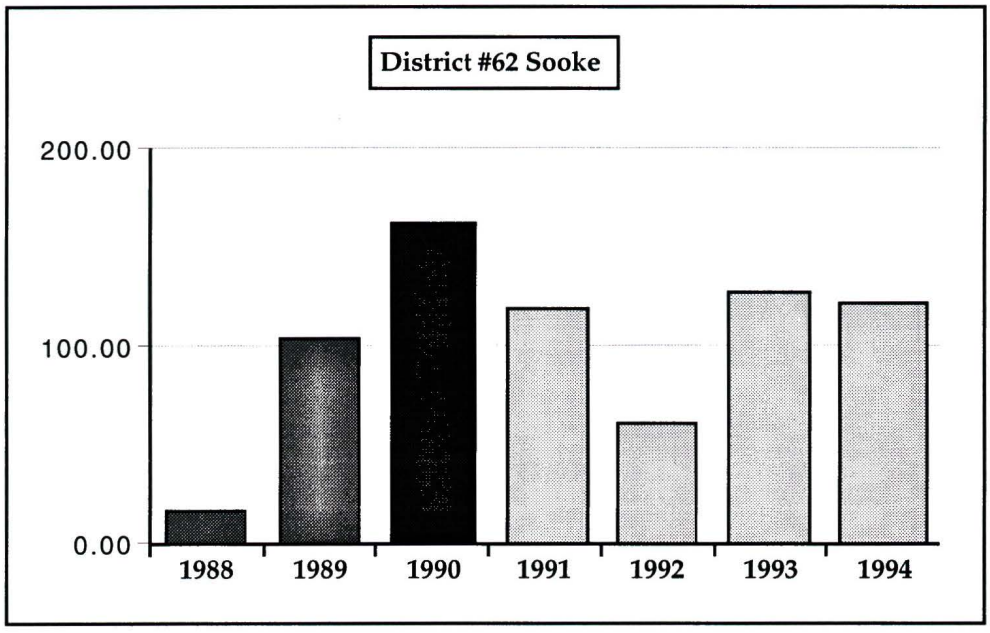


Days On Short Term Disability Leave Per 100 Teachers

Pre-EFAP

Year of EFAP Implementation

Post-EFAP

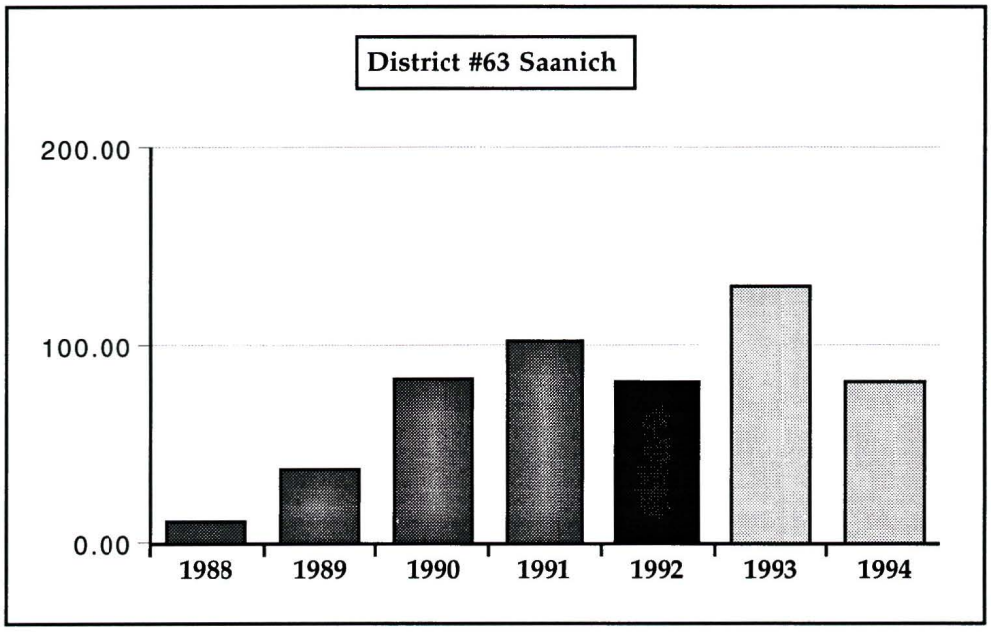


Days On Short Term Disability Leave Per 100 Teachers

Pre-EFAP

Year of EFAP Implementation

Post-EFAP

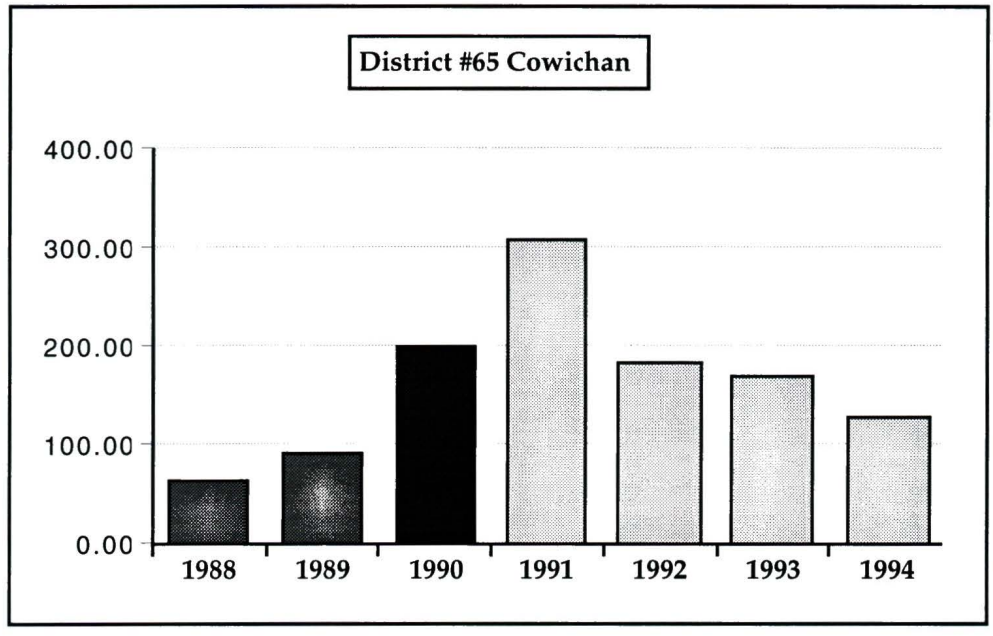


Days On Short Term Disability Leave Per 100 Teachers

Pre-EFAP

Year of EFAP Implementation

Post-EFAP

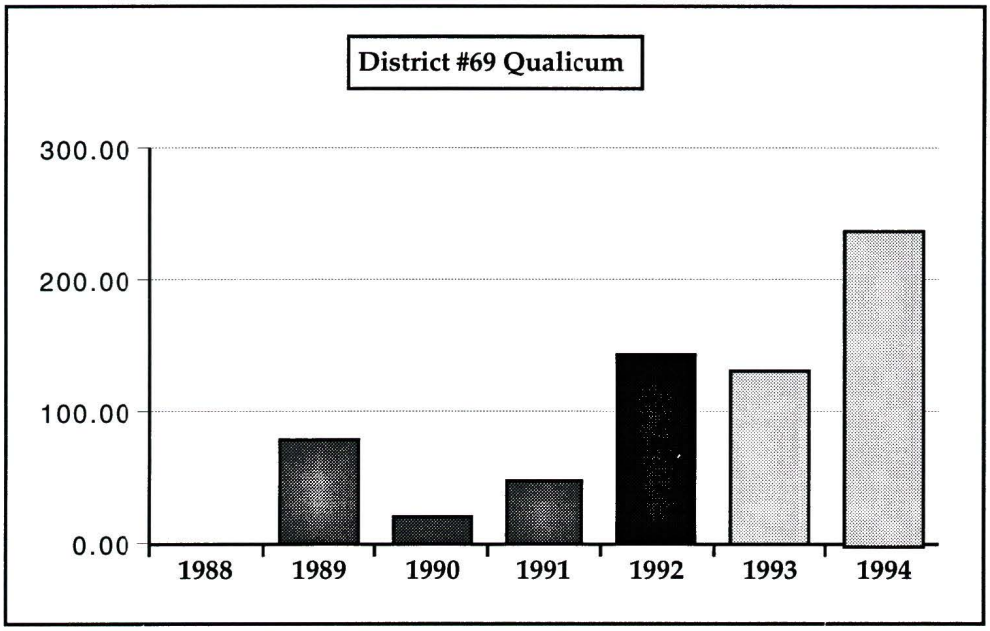


Days On Short Term Disability Leave Per 100 Teachers

Pre-EFAP

Year of EFAP Implementation

Post-EFAP

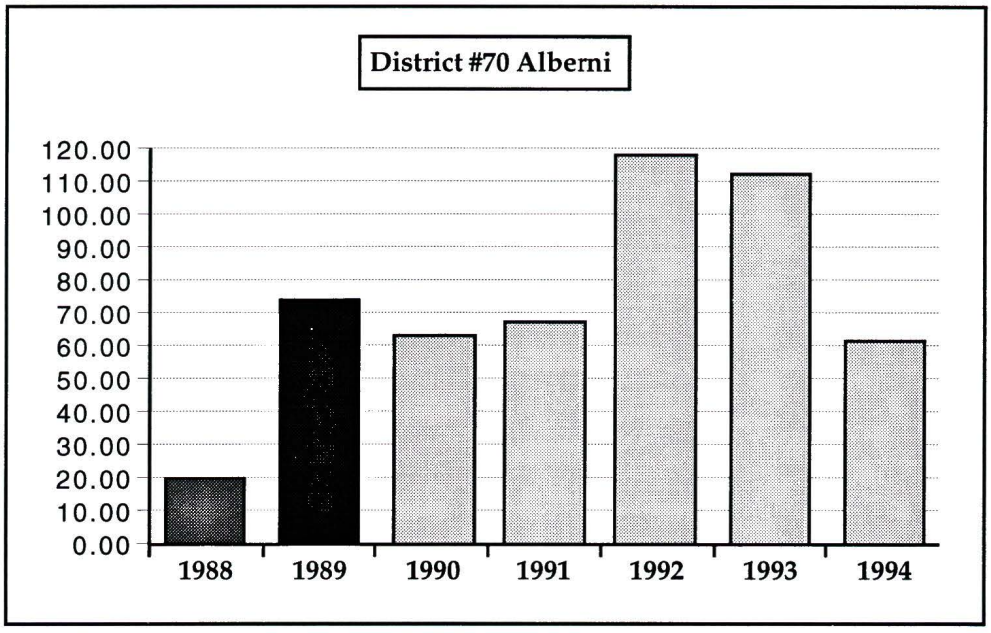


Days On Short Term Disability Leave Per 100 Teachers

Pre-EFAP

Year of EFAP Implementation

Post-EFAP



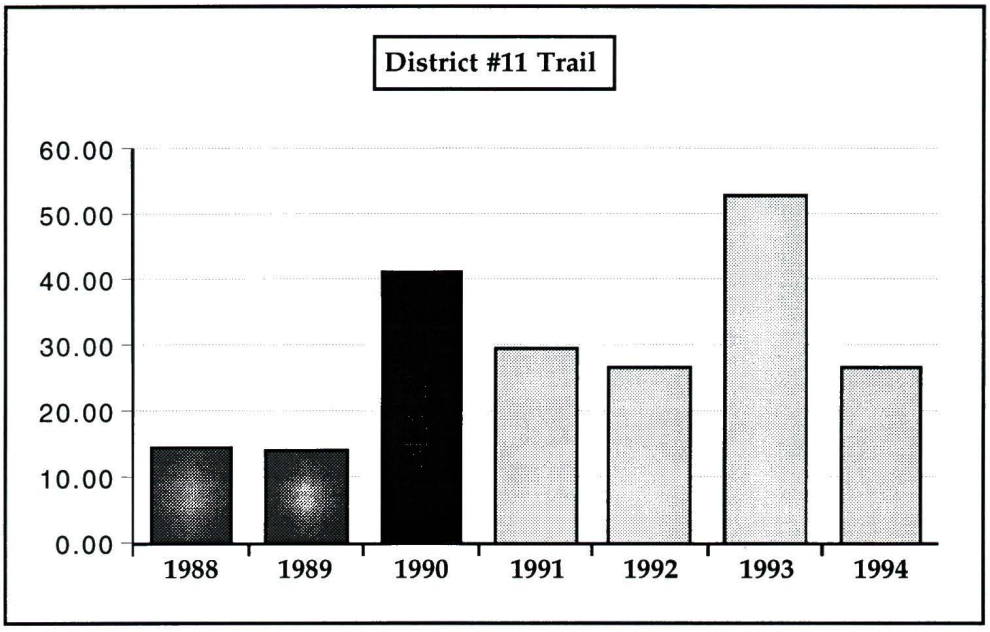
Appendix F

Days On Long Term Disability Leave Per 100 Teachers

Pre-EFAP

Year of EFAP Implementation

Post-EFAP

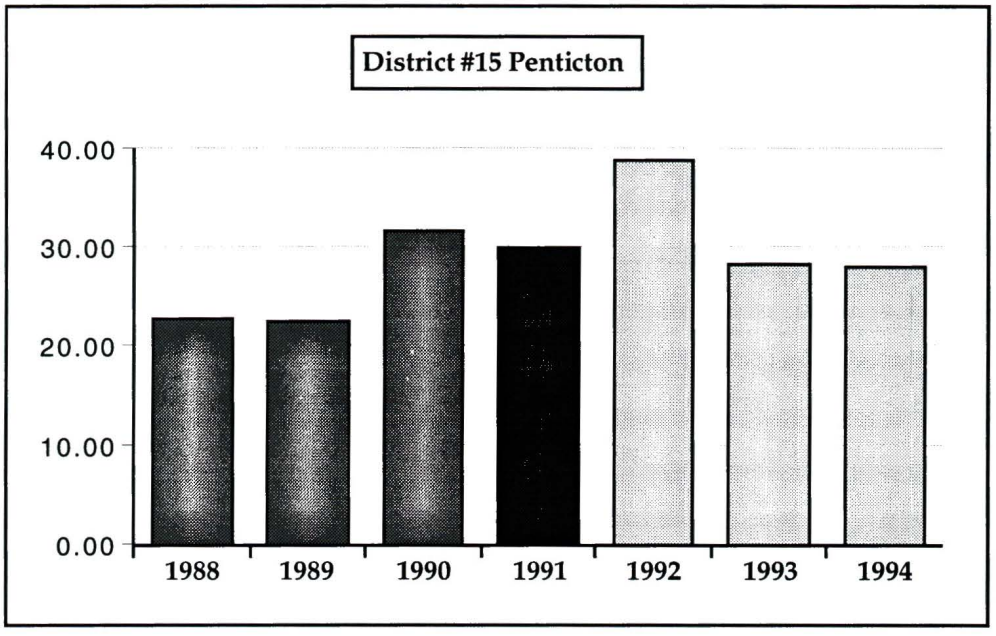


Days On Long Term Disability Leave Per 100 Teachers

Pre-EFAP

Year of EFAP Implementation

Post-EFAP

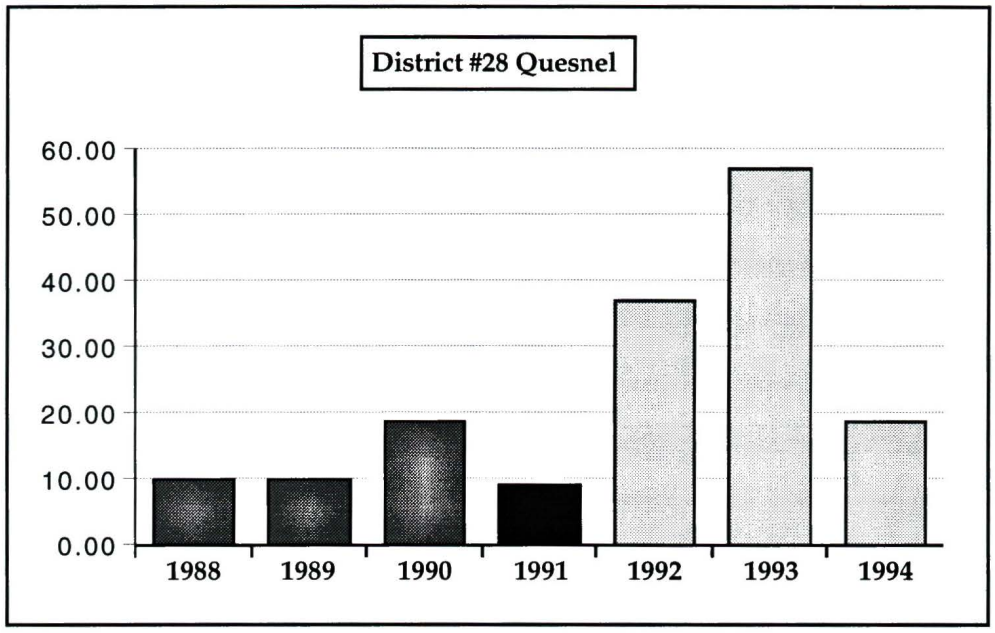


Days On Long Term Disability Leave Per 100 Teachers

Pre-EFAP

Year of EFAP Implementation

Post-EFAP

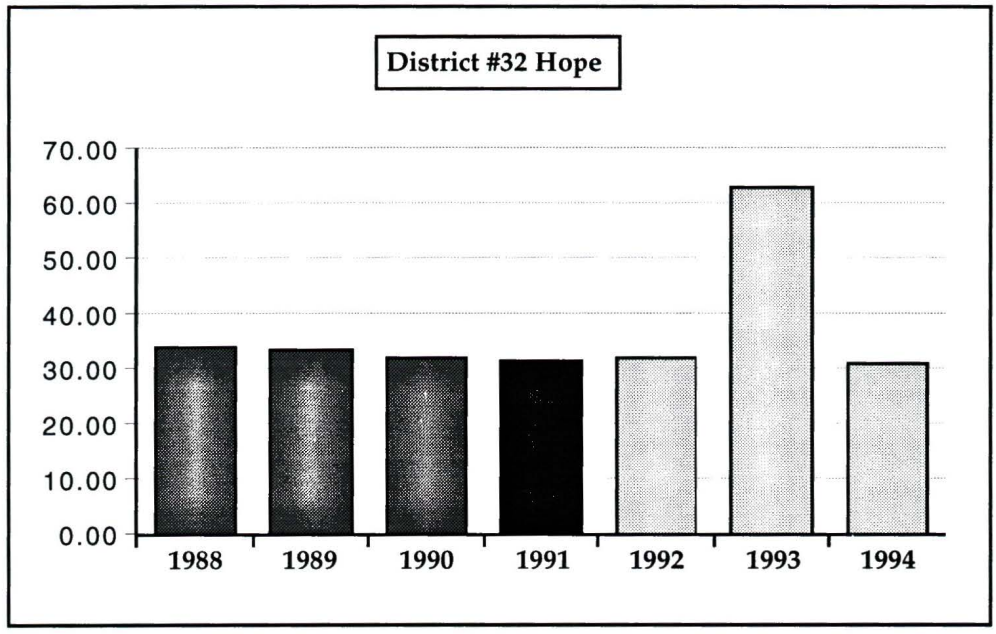


Days On Long Term Disability Leave Per 100 Teachers

Pre-EFAP

Year of EFAP Implementation

Post-EFAP

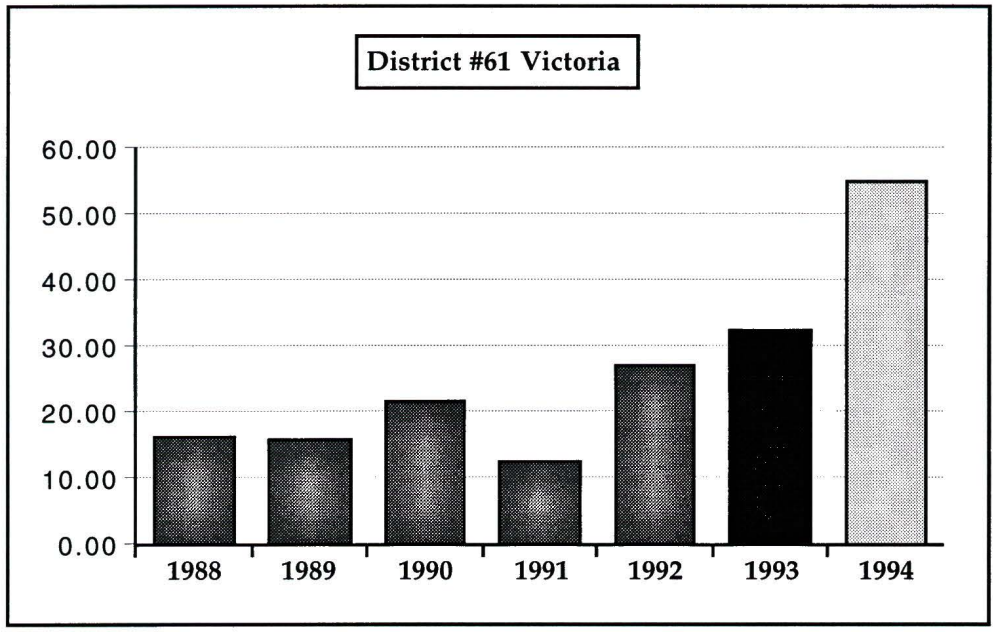


Days On Long Term Disability Leave Per 100 Teachers

Pre-EFAP

Year of EFAP Implementation

Post-EFAP

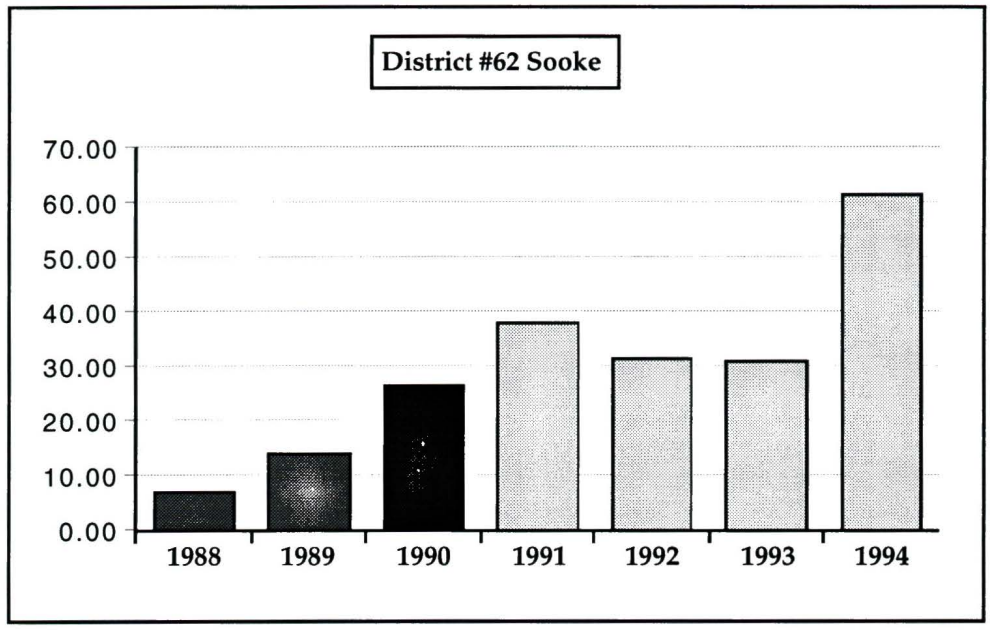


Days On Long Term Disability Leave Per 100 Teachers

Pre-EFAP

Year of EFAP Implementation

Post-EFAP

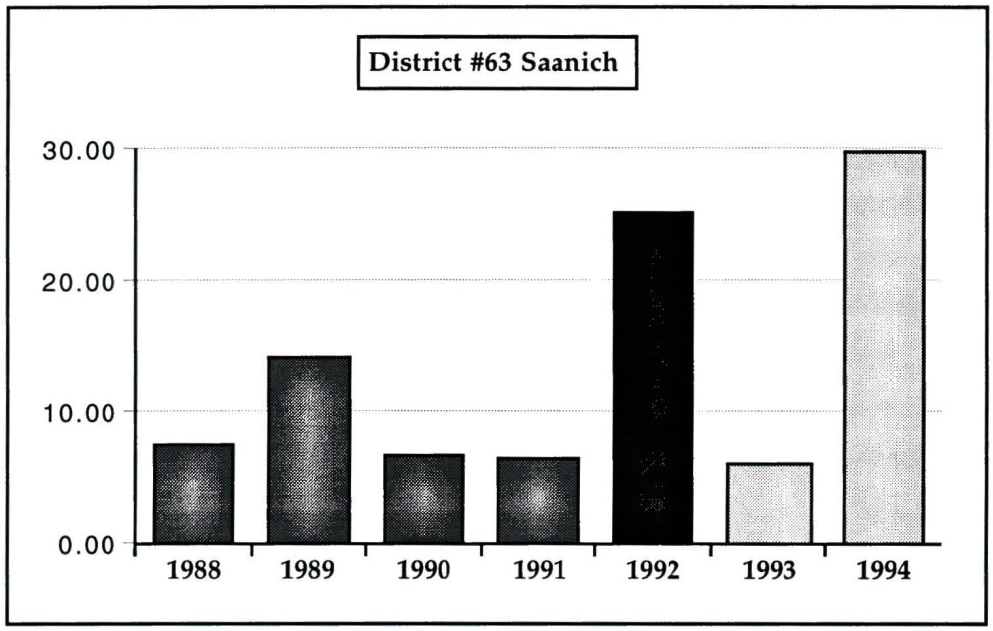


Days On Long Term Disability Leave Per 100 Teachers

Pre-EFAP

Year of EFAP Implementation

Post-EFAP

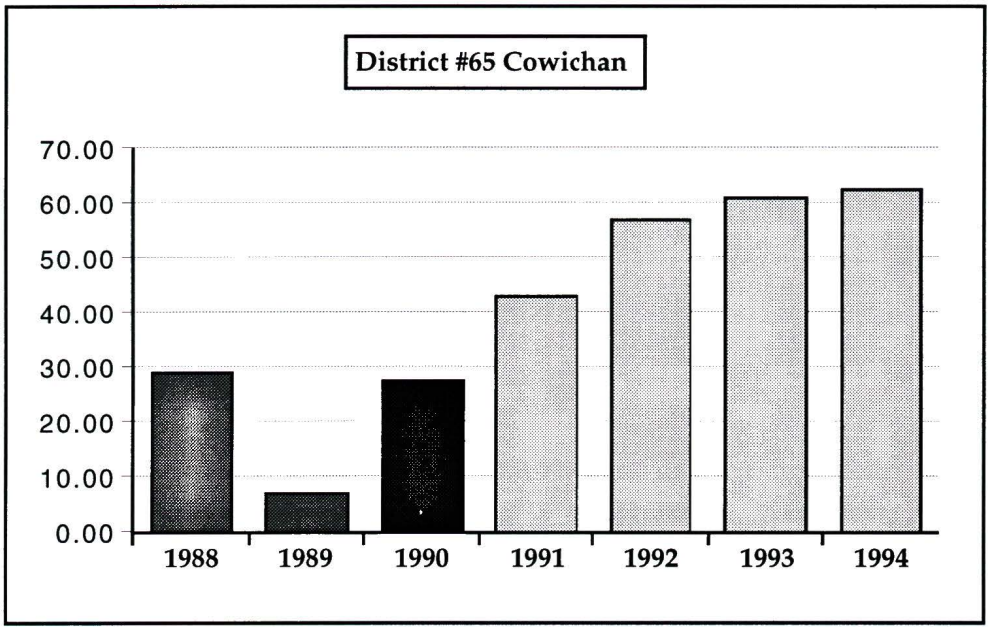


Days On Long Term Disability Leave Per 100 Teachers

Pre-EFAP

Year of EFAP Implementation

Post-EFAP

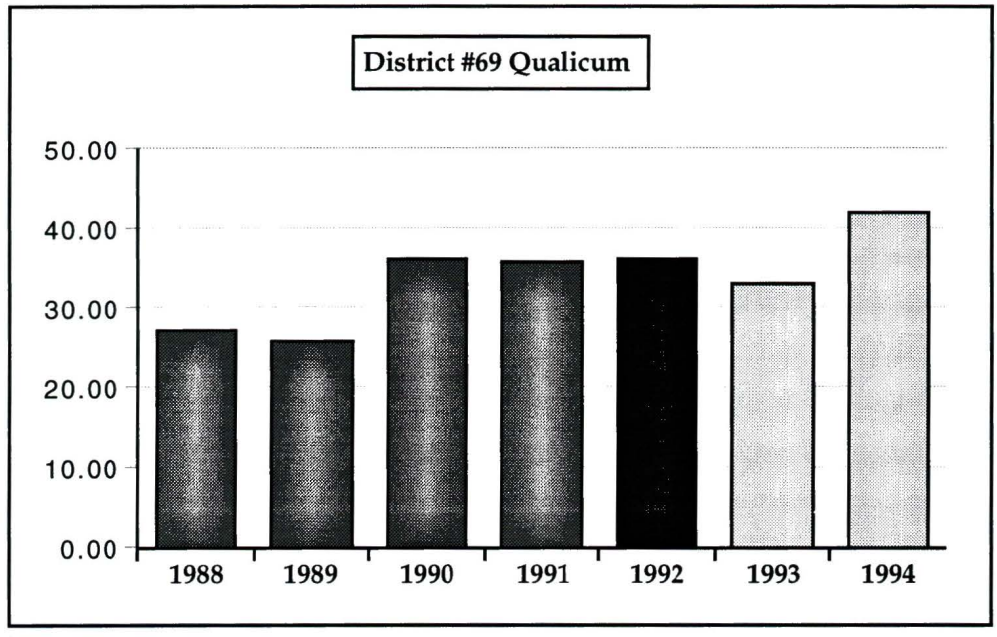


Days On Long Term Disability Leave Per 100 Teachers

Pre-EFAP

Year of EFAP Implementation

Post-EFAP

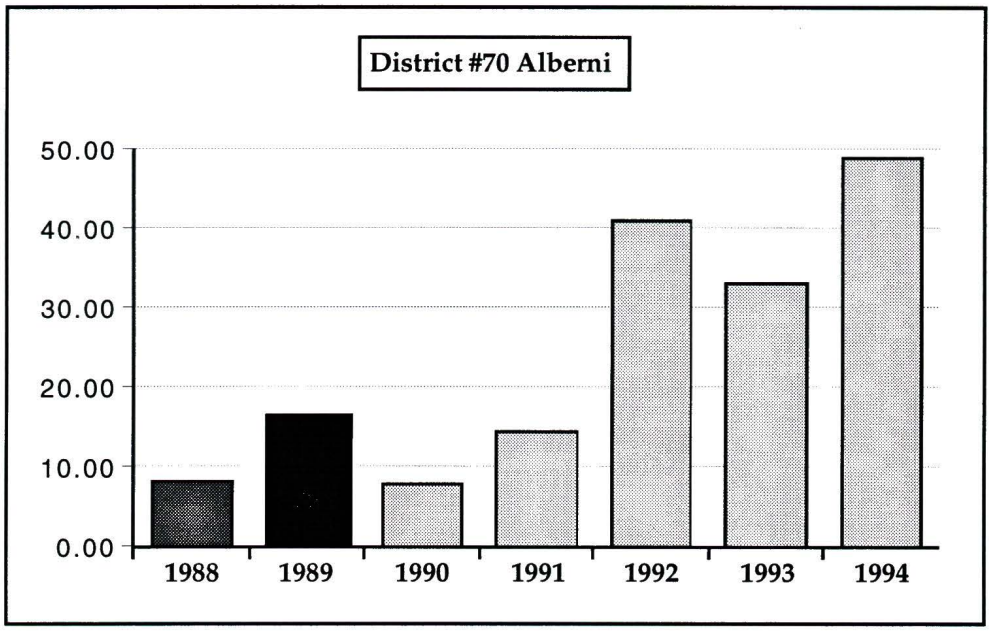


Days On Long Term Disability Leave Per 100 Teachers

Pre-EFAP

Year of EFAP Implementation

Post-EFAP



Appendix G

Jun 97 SPSS for MS WINDOWS Release 6.1

t-tests for Paired Samples

Variable	Number of Pairs	Corr	2-tail Sig	Mean	SD	SE of Mean
PRE ST D	pre short term weighted day			65.2570	31.780	10.050
	10	.294	.409			
POS ST D	post short term weighted day			116.1200	47.985	15.174

	Paired Differences				
Mean	SD	SE of Mean	t-value	df	2-tail Sig
-50.8630	49.139	15.539	-3.27	9	0.010
95% CI (-86.015, -15.711)					

Variable	Number of Pairs	Corr	2-tail Sig	Mean	SD	SE of Mean
PRE LT D	pre long term weighted day			18.1600	9.054	2.863
	10	.418	.230			
POS LT D	post long term weighted day			35.2740	8.508	2.691

	Paired Differences				
Mean	SD	SE of Mean	t-value	df	2-tail Sig
-17.1140	9.488	3.001	-5.70	9	.000
95%CI (-23.902, -10.326)					

VITA

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Place of Birth: Vancouver, British Columbia, Canada

Educational Institutions Attended:

University of Victoria	1989 to 1997
Christ College Irvine	1987 to 1989

Degrees Awarded:

B.A.	University of Victoria	1993

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Title of Thesis:

The Impact of the Implementation of an Employee and Family Assistance Program on Teacher Disability Leave in Ten British Columbia School Districts

Author [redacted]

Ann Marie McInnis
September 22, 1997