

**EMPLOYEE ASSISTANCE PROGRAMME IN HEALTH CARE:
A FRAMEWORK FOR BEST PRACTICE AND QUALITY
MANAGEMENT**

by

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Thesis submitted in fulfilment of the requirements for the degree

**PHILISOPHIAE DOCTOR IN COMMUNITY HEALTH
Ph.D. (CH)**

in the

**DEPARTMENT OF COMMUNITY HEALTH, FACULTY OF HEALTH SCIENCES,
UNIVERSITY OF THE FREE STATE, BLOEMFONTEIN, SOUTH AFRICA**

May 2011

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DECLARATION

I hereby declare that the work submitted here is a result of my own independent investigation. Where help was sought, it was acknowledged. I further declare that this work is submitted for the first time at this University/Faculty towards a Ph.D. degree in Community Health and that it has never been submitted to any other University/Faculty for purposes of obtaining a degree.

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Dedicated to:

Teresa, my loving wife, for all her patience and support. Thank you for being such an understanding wife.

To all the other health care workers looking after and caring for their patients.

ACKNOWLEDGEMENTS

I wish to gratefully acknowledge the assistance and contributions of the following people and institutions, without whom the completion of this study would not have been possible:

- Prof. Gert van Zyl, Dean, Faculty of Health Sciences, University of the Free State, promoter in the study, for his continuous support, encouragement and valuable guidance throughout the period of study.
- Prof. Andre Venter, co-promoter, for the time and effort he put into the study, and his valuable perspectives, advice and guidance. I am privileged to have had these two colleagues involved in the study who are so dedicated and supportive.
- The University of the Free State and the School of Medicine, UFS, for financial support to make this study a reality.
- The staff of the Frik Scott Library, in particular Ms Radilene le Grange, and Ms Elma van der Merwe for assisting me in my literature searches.
- The colleagues in my department for their support and assistance during the research process.
- The Free State Department of Health as well as the private hospital companies for allowing me to conduct focus group discussions in their respective health care institutions.
- The participants in the focus group discussion who came to the table to share their experiences and knowledge with us despite their busy schedules. Without their valuable perspectives and inputs this study would not have been realised.

- The participants in the Delphi survey who patiently rated and provided valuable comments on all the questions in each of the six rounds of the Delphi survey.
- All the other people who worked hard to make it possible for me to complete this study.
- And, above all, my Heavenly Father, for receiving the strength, perseverance and determination to complete the study from Him.

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LIST OF ACRONYMS

ACRONYM	EXPLANATION:
AA	Alcoholic Anonymous
CQI	Continuous quality improvement
EAP	Employee assistance programme
EAPA	Employee Assistance Professions Association
EAPs	Employee assistance programmes
IOD	Injury on Duty
ISO	International Standardisation Organisation
ROI	Return on investment
SOPs	Standard operating procedures
TQM	Total quality management

CHAPTER 1

ORIENTATION TO THE STUDY

1.1 INTRODUCTION

Employees are appointed in organisations in order to perform certain functions so that the goals of the organisation may be realised. Only when employees are emotionally, mentally and physically healthy, can they be productive within an organisation. In order to keep employees healthy, several options are available, such as providing occupational health services and supporting employees by means of an employee assistance programme (EAP). Different categories of health care workers are appointed in the health care industry to provide different levels of service to fulfil the health needs of the community they serve. The type of services, as well as the complexity of the health needs, will determine which category of staff should be appointed in a specific health care institution. In order to address the health needs of a patient, a high level of human interaction between the health care worker and the patient is inevitable. Therefore, job satisfaction, commitment to work and healthy employees are important factors in ensuring that health care workers are productive and provide optimal health care. Currently, the pressure to perform is creating a much more competitive, as opposed to caring, environment. This pressure could have negative influences on the well-being of health care workers (Ho 1997:117). Gammie (1997:66) reminds employers in the health care industry to realise that employees, as the human resources component, are one of the most valuable resources in this industry. The outcome of the health care, which is provided within a health care institution is, therefore, dependent on the productivity of this valuable resource. The health and well-being of health care workers have become an increasingly legitimate and significant management concern since the employer cannot rely on the employee's responsibility to take care of his or her own well-being (Ho 1997:1880).

The health care industry is in a constant state of change due to factors such as the emergence of new diseases and the improvement in technology and treatment options. Another macro-environmental factor that could play a role in the changing South African environment is the promulgation of the new National Health Act (61/2006) together with the introduction of such new concepts such as patient and user rights, all of which could result in industrial and organisational changes. The other concepts addressed by this Act, especially those that could lead to organisational changes, could result in additional work pressure which, in turn, could give rise to an increase in work-related stress. A specialist branch of the British Association of Counselling reported that 'organisational change was one of the main factors found to drive the growth in work place counselling' (Alker and McHugh 2000:308). Assisting employees through all these changes and associated stress is necessary to ensure that healthy employees remain productive within the organisation. Alker and McHugh (2000:313) conducted a study in three companies, all of which experienced major organisational change in structures and practices, while an EAP was successfully introduced as a human resource strategy during that period.

In South Africa, current legislation, such as the Occupational Health and Safety Act (85/1993), Labour Relations Act (66/1995), Basic Conditions of Services Act (75/1997), and the Skills Development Act (97/1998), are structured to ensure that the health and general well-being of the employee are taken care of. Du Plessis (2001:102) is of the opinion that legislation in South Africa could enforce processes in the workplace in order to reflect the values of a new democracy, such as transparency and empowerment. The possible inclusion of new values in an organisation could raise the question as to whether the introduction of the EAP as a human resource management strategy could be seen as appropriate. Berridge and Cooper (1994:17) and Alker and McHugh (2000:308) already inquired as to whether the introduction of an EAP could be seen as a strategic or humanistic rationale. It is, therefore, necessary to investigate the history and development of the EAP internationally in order to understand the arguments of these authors.

1.2 THE HISTORY OF EAP

Employee assistance is not a new concept. Alker and McHugh (2000:304) stated that the first EAP, which was based on a person-centred approach, was established around 1917 and was initiated primarily because of a humanistic concern for employees. Evidence of later versions of the EAP can be found in the establishment of the Alcohol Anonymous (AA) programmes in 1935 (Elliot and Shelley 2005:125; Reddy 1994:60). These programmes focussed on assisting people suffering from alcohol abuse and dependency (Elliot and Shelley 2005:125; Reddy 1994:60). Counselling in the early stages was viewed as a mechanism for managing employees' personal problems and alcohol dependency. It was only in the 1960s and 1970s that the providers of EAPs expanded their services to assist employees with additional problems that contributed to poor job performance (Elliot 2005:126). It is clear that the EAP's initial concern was humanistic in nature, with absenteeism, productivity and staff turnover as secondary concerns (Alker and McHugh 2000:307).

As previously mentioned, the initial EAPs started as programmes to assist employees with alcohol abuse problems. Over time, however, these programmes were transformed from the initial counselling services to work-based programmes delivering various services to troubled employees whose performance at their workplaces might have been negatively affected (Clemmet 1998:18). Further changes that were introduced over the years, were the inclusion of family members as clients, a multi-team approach to a variety of problems (Macdonald, Csiernik, Durand, Wild, Dooley, Rylett, Wells, and Sturge 2006:55), outsourcing to external service providers (Du Plessis 2001:111; Macdonald *et al.* 2006:55), and establishing programmes with a greater focus on preventative actions (Csiernik 2005:17; Macdonald *et al.* 2006:62). The above-mentioned changes are in keeping with the recommendation made by Berridge and Cooper (1994:4) that any EAP should have a wide scope providing a broad range of services to employees and their families, including those who are not part of the organisation. The main focus should thus be on the promotion of an employee's health in a holistic manner with a view to improving mental well-being and job performance, as well as enhancing life satisfaction. This focus is in line with a

statement made by Reddy (1994:60) that employee assistance is a concept and a philosophy rather than a specific tool used to support employees with regard to their health and performance, or for meeting the identified needs.

1.3 DEFINING AN EAP

When examining the definitions used to describe an EAP, researchers seem to agree that, currently, there is no single generic definition available as this science is still evolving (Alker and McHugh 2000:304; Elliot and Shelley 2005:126; Gammie 1997:66; Reddy 1994:73). However, the following definition, suggested by Berridge and Cooper (1994:4), encapsulates all the major facets of the majority of systems:

An EAP is 'a programmatic intervention at the workplace, usually at the level of the individual employee, using behavioural science knowledge and methods for the recognition and control of certain work- and non work-related problems which adversely affect job performance, with the objective of enabling the individual to return to making her or his full work contribution and to attaining full functioning in personal life'.

In order to comply with the above definition, the range of services provided within the EAP had to be expanded considerably. In 1985, Roman and Blum (in Steele 1998:5) described what they considered to be the 'core technologies' of the EAP. These core technologies redefined the tasks and boundaries of an EAP (*cf.* 2.3) and, by doing so, they aimed to give further guidance as to what the field of EAP should encompass. Berridge and Cooper (1994:10) reviewed the core technologies of Roman and Blum and were of the opinion that these technologies should not be prescriptive. They summarised the core technologies as follows:

- Identification of impaired job performance, which leads to the identification of an employee experiencing a problem
- Consultative assistance to managers
- Constructive confrontation of the employee experiencing a problem
- Individual micro-linkage between problem employee and EAP resources

- Organisational macro-linkage between EAP resources and the employer
- Corporative culture integrates EAP as a formal method of assisting organisations in order to cope with problems caused by changes
- Improvement of job performance as the main criterion of success of the EAP.

Beidel (2005:301) questioned the fact that EAPs are risking the loss of their unique identity with the integration of services into the organisation's other value-added activities, as well as expanding the boundaries beyond the core technologies. On the other hand, Evan (1995:sp) found that the core technologies as proposed by Roman and Blum in 1988 were accepted by companies, but that additional services that do not fit into the core technologies were implemented as frequently. The EAP has continued to evolve since its core technologies were described in 1985, but the question, today, is whether or not the EAP currently is applicable to employees in the health care sector.

1.4 EAPs IN VARIOUS INDUSTRIAL SECTORS

Since the health care sector finds itself in a unique situation where clients' health status are at risk, the examination of various other industries is warranted in order to determine how the EAPs are utilised in those industries. Various factors, such as the international culture and the industrial environment within which an organisation functions, will contribute to the decision as to which type of EAP should be implemented (Emener, Hutchison and Richard 2003:313). Similarly, some of these factors could be applicable to the health care sector. However, Courtois, Dooley, Kennish, Paul and Reddy (2004a:92) stated that, outside the USA, companies need to be creative in order to adapt EAPs and the core technologies to meet the specific demands of the cultural circumstances. In South Africa, the mining sector has already adapted the EAP as a supportive mechanism for addressing the needs of the mining communities (Du Plessis 2001:103). However, the basic traditions of the EAP remained in place and Du Plessis (2001:100) stated that, in 2001, 'the usefulness of importing EAP models that focus heavily on clinical work has up until now been limited in the South African context'.

Vosloo and Barnard (2002:54) are of the opinion that the focus of the EAP moved from 'a purely clinical focus' towards addressing behavioural problems on a wider scale. Du Plessis (2001:112) supports the notion of adapting the EAP outside the USA by suggesting that to *South Africanise* the EAP by incorporating unique issues should be considered, such as the socio-political environment, as well as the following three inter-related factors:

- The values/cultural changes at the workplace
- Productivity and motivation in the context of world-class manufacturing
- New relationships envisaged by the current Labour Relations Act (66/1995) of South Africa.

The question that needs to be addressed is whether or not these EAP principles and core technologies could be included and adapted into a best-practice EAP for the South African health care industry. The main challenges for this consideration are the constantly changing working environment of health care workers, the organisational change due to restructuring and how to adapt an EAP to best address the needs of the employee, while still maintaining its value for the organisation (Courtois *et al.* 2004a:95; Csiernik, Hannah and Pender 2006/2007:55). Therefore, a framework for a best-practice EAP for the health care sector should be based on sound foundational and practical principles.

If it is possible to reach an agreement with regard to the need for EAPs in the health care sector, the question remains as to how effective these EAPs would be and what value they would add to the health care industry. The number of EAPs has been steadily increasing in worksites of all sizes (Hartwell, Steele, French, Potter, Rodman and Zarkin 1996:808) and French, Roman, Dunlop and Steele (1997:312) highlights the fact that, as the prevalence of EAPs increases, so, too, does the need for models to evaluate aspects of these programmes. Smewing and Cox (1998:273) expressed their concerns about the evaluation of EAPs by stating that 'the literature relating to their evaluation is small and often based on inappropriate methodology'. The lack of effective evaluation means that it is necessary to continue the search for a way of measuring the effectiveness of EAPs.

1.5 THE EVALUATION OF THE QUALITY OF EAPs

It is imperative that organisations have proper business plans in place before implementing an EAP. These plans should include the scope of the EAP, as well as the way in which it will be evaluated. However, Gammie (1997:67) argued that organisations often fail to identify why an EAP is being purchased and do not prepare a set of service criteria and objectives according to which EAP providers can be researched and compared. Gammie (1997:78) continues by stating that organisations failed to evaluate the EAPs because there is a lack of knowledge and understanding with regard to why EAPs should be evaluated. He is also of the opinion that there is a lack of requirements from senior management with regards to assessing the programmes, making it difficult to translate the EAPs into quantifiable terms. This statement opens the debate on the actual measurement of the quality of health care.

There are several arguments about what quality health care actually entails, while there are already various methods available for measuring the quality of health care provided (Arah, Klazinga, Delnoij, Asbroek and Custers 2003:393; Blumenthal 1996:892; Campbell, Rowland and Buetow 2000a:1614). The actual measurement of the quality of health care becomes more complicated when all the interdependent factors that could determine the health status of an employee are considered, such as the environment and health care provision (Arah, Westert, Hurst and Klazinga 2006:6). Boyce (1996:101) conceptualised that health care measurement demands a balance between components of structure, process and outcome measures, with health outcome as the golden standard. These three measures could be used to evaluate EAPs as a means of ensuring that companies know that the intended EAP will be running smoothly, efficiently and that the quality of the service provided is of a high standard (Highley and Cooper 1994:49). Courtois, Hajek, Kennish, Paul, Seward, Stockert and Thompson (2004b:50) identified certain key aspects that could influence the development of common measurable outcomes of an EAP. These key aspects include client satisfaction, employer satisfaction, customer services, reporting and utilisation of the programme. However, the question is whether or not these key aspects would provide adequate information with regard to the quality of the EAP or

whether or not more aspects should be evaluated. Arthur (2000:553) confirmed that the necessary components for an ideal evaluation have been identified by researchers, but that EAP evaluations 'suffer from serious methodological inadequacies' (Loo 1994 in Arthur 2000:553). Despite the above-mentioned inadequacies, these components need to be standardised before the value of the quality measurement methods can be calculated (Courtois *et al.* 2004b:51; Daniels, Teems and Carrol 2005:53). There are two additional complicating factors involved in deciding on appropriate quality measurement methods: the fact that the standardised EAP model does not currently exist (Elliot and Shelley 2005:126; Gammie 1997:66; Ho 1997:188); and a programme could consist of several components targeting the entire workforce and their families (Ho 1997:188), complicating the evaluation of the quality of such a programme.

Michalak (2002:165) is of the opinion that the correct choice of a quality assessment method for an occupational health service will depend on the need and capacities of such a unit and organisation. The same conclusion can be drawn for an EAP. The ultimate goal of any health care programme is to provide the highest quality service in the most cost-effective manner possible. An EAP should be well planned, effectively implemented and the quality should be managed by means of a relevant system. The result of an effective and well-monitored EAP should be a workforce with fewer problems and higher morale. However, the identification of a 'clear outcome-orientated' evaluation model is almost impossible (Highley and Cooper 1994:46). The need to identify the most important or essential elements of an EAP, as well as the measurement framework used to evaluate the quality of an EAP in the health care sector, was the major driving force behind this study.

1.6 PROBLEM STATEMENT

Employee assistance programmes have been recognised as an important tool in human resource management and these programmes are not new to the health care sector (*cf.* 1.2). The concept of employee assistance is evolving rapidly, but there seems to be limited focus on it as a business strategy. The lack of strategic focus causes a great deal of difficulty with regard to establishing the appropriate systems and infrastructure that has meaningful outcomes (Vosloo and Barnard 2002:56). Several health care institutions have developed EAPs or have appointed outsourced EAP providers to provide specific services for their health care workers. These institutions could pose the question as to whether or not those EAPs are appropriate and effective for their health care workers within the service delivery environment or whether or not it is necessary to develop and adapt a more appropriate programme for this sector. Research shows that no perfect EAP model exists (*cf.* 1.5). The fact that the needs and situation of each health care institution are not exactly the same makes the question of the appropriateness of specific EAPs more relevant.

One similarity in all health care institutions is that health care workers in their respective institutions are working with other people or patients presenting with certain health needs. More significantly, not all health care institutions have the same patient profiles or provide the same type of health care. Therefore, the profile of health care workers will differ from institution to institution, as well as the problems with which they are presented. On the other hand, there may be a few similarities between institutions due to the common nature of health care provision and human nature. Being a health care worker is a demanding and highly stressful job that produces severe psychological pressure. Therefore, the assistance of health care workers requires a unique approach.

In light of the availability of services provided by EAP providers and the suggested core technologies of an EAP (*cf.* 1.3), health care institutions need to develop their own EAPs according to the employee profile and the problems experienced within their organisation. The question is not only which EAP core technologies are

appropriate for a best-practice EAP for health care workers, but also which of these continue to add value to the core business of a health care institution.

One possibility is to combine the most important issues into a framework which could form the basis for a best-practice EAP for the health care sector in South Africa. The question, however, remains as to whether or not this approach will be acceptable and appropriate for the South African health care environment.

1.7 OVERALL GOAL, AIM AND OBJECTIVES OF THE STUDY

Researchers have different interpretations when using the terms 'goal', 'aim' and 'objectives' during the research process. For the purposes of this study, the researcher will use the term 'goal' to describe the broader concept to which the aim of the study was directed. The goal is a more abstract concept, while the aim is usually measurable. Bak (2004:16) identified two kinds of aims, namely (a) an academic aim as the central aim, stating why the issue is worth an academic investigation; and (b) the strategic aim. This strategic aim flows from the study and can also be applied to the non-academic role-players with a focus on the possible or practical relevance of the study. The next step is setting objectives to achieve the aim. The objectives can be classified into primary objectives, which are focused more broadly on how to achieve the aim, as well as process objectives, which are focused on the actual processes to be followed in order to achieve the goal of the study. For the purposes of this study, the two types of objectives were combined in order to explain the means by which the aim was to be achieved.

1.7.1 Overall goal

The overall goal of this study was to make a meaningful contribution to the field of EAPs by means of an in-depth investigation into the appropriateness of an EAP designed to assist health care workers in dealing with problems, at home or in the workplace, which could potentially have a negative impact on their job performance.

1.7.2 Aim of the study

The aim of this study was to explore the appropriateness of the concepts used in EAPs, as well as the current practices of employee assistance in the health care sector in South Africa, in order to develop a framework for a best-practice EAP for health care workers in the private and public health care sectors, which includes a practical framework to manage the quality of these services.

1.7.3 Objectives of the study

In order to achieve the aim of this study, the following objectives were pursued:

- Conducting a literature review on the current EAP practices, challenges, constraints and evaluations to gain deeper insight into what could be of value for the health care sector
- Conducting an empirical research study by means of focus group discussions in order to develop and consolidate a framework for a best-practice EAP for the health care sector based on information, experiences and insight gathered
- Finalising the criteria to be included into the framework for a best-practice EAP and its quality management framework by making use of the Delphi survey technique
- Proposing an acceptable framework for a best-practice EAP, including the management of the quality of services provided in the health care sector, which can be adapted by any health care institution according to their individual needs.

The objectives of this study can be classified as descriptive (to obtain a detailed overview of the concept of an EAP as used in any industry), and exploratory (to gain insight into the actual situation in the health care sector in South Africa).

1.8 CONCEPTUAL FRAMEWORK

Maxwell (1998:77) explained that the conceptual context consists of systems of concepts, assumptions, expectations, beliefs and theories to support a research project. The conceptual context that supported this research is summarised in Figure 1.1 (All the figures and tables are the researcher's own work developed, saved and transferred as pictures in this document).

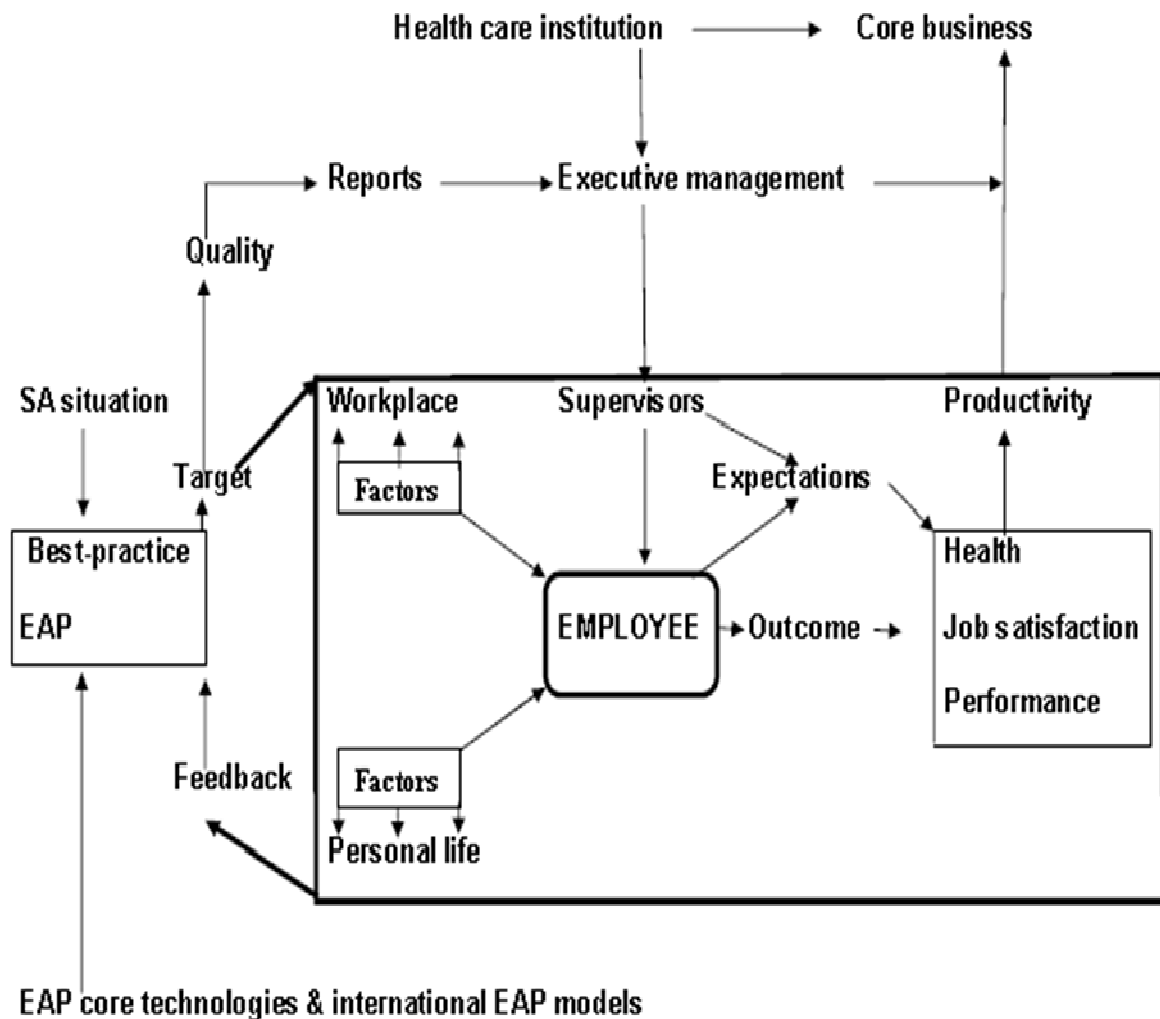


Figure 1:1 Conceptual framework of this study

1.9 RESEARCH DESIGN AND METHODOLOGY

In this section, a summarised description of the research design and methodologies used in this study is provided to orientate the reader with regard to the most important issues of the study. A more detailed discussion can be found in Chapter 4.

1.9.1 Approach and design of the study

The terms 'qualitative' and 'quantitative' are used to identify different approaches to research and methods used during the research process. Henning, Van Rensburg and Smit (2004:3) mentioned that the major distinction 'between the qualitative paradigm and the better known quantitative paradigm lies in this quest for understanding and for in-depth inquiry'. In contrast to quantitative research, the 'variables' are usually not controlled in qualitative research because 'it is precisely this freedom and natural development of action and representation we wish to capture' (Henning *et al.* 2004:3). Variables play a central role in describing and analysing human behaviour and cannot be ignored. It is appropriate for Henning *et al.* (2004:6) to conclude that, in qualitative research, researchers wish to discover more about the behaviour of people, their settings and the reasons why they act in specific settings. The purpose of qualitative research is to explore a phenomenon in greater depth and to gain an understanding thereof (Maxwell 1998:75). With this purpose in mind, McMillan and Schumacher (2001:165) stated that the design of qualitative research involves the careful selection of subjects, followed by specific data collection techniques, for example, questionnaires, observations and interviews, as well as acceptable procedures for collating the data. Together, these components form the research design of the qualitative study.

The researcher used a qualitative research approach in this study. The design of the study is both descriptive and exploratory since descriptive designs are used to provide a detailed picture of the issue under investigation as it occurs, which serves as a starting point to develop the required knowledge. The approach and design of this study made it possible for the researcher to explore the EAPs in their natural

setting, while collecting and reporting on the opinions and views of the research participants who have experienced the practical implications of employee assistance in their respective health care institutions. It provided an opportunity for the researcher to gain a better understanding with regard to the meaning and processes of EAPs and to evaluate the quality of the services being provided.

1.9.2 Methodology and data collection

An applied research approach was followed because 'the purpose of applied research is to contribute knowledge' (Patton 2002:217) that will assist relevant role-players in gaining a better understanding of the nature of the phenomenon under study in order to establish effective interventions. With the applied research approach, the researcher wanted to gain a deeper understanding of the nature of the EAP in practice in order to develop a best-practice EAP and quality management framework. This framework could be used as a possible intervention targeting the managers as policy makers of health care institutions. The researcher chose a case study approach in conducting the qualitative research, since a case study involves 'examining a bounded system over time employing multiple sources of data found in the setting' (McMillan and Schumacher 2001:36). In conducting qualitative research, it is acceptable to focus the data analysis on one phenomenon 'regardless of the number of sites of participants for the study' (McMillan and Schumacher 2001:398). The researcher planned to provide a detailed description of the EAP as a case, with interpretations by the researcher with regard to lessons learned (Guba and Lincoln 1989 in McMillan and Schumacher 2001:37).

The study consisted of a preliminary phase, which involved preparing for the actual study, followed by Phases I and II. Phase I mainly concentrated on the descriptive and explanatory nature of the study. The first method used in Phase I consisted of an extensive literature review on EAPs worldwide. Henning *et al.* (2004:27) states that 'a literature review is used first and foremost in the contextualisation of your study to argue a case'. The literature review was followed by five focus group discussions held with a variety of health care workers employed as supervisors in public and private

health care institutions. The purpose of these focus group discussions was for the researcher to develop a more in-depth understanding with regard to health care workers' thoughts on EAPs and their practical implications for the health care industry. These discussions also highlighted issues that participants deemed significant for such programmes. The researcher also studied the ways in which health care workers collectively made sense of EAPs and how they construct meaning around them. The outcomes of the literature review and the focus group discussions were used to construct the criteria which were then included into the framework for a best-practice EAP.

During Phase II of the study, the above-mentioned criteria were finalised by means of a Delphi survey. Twelve participants were invited as experts to rate the criteria presented as questions. These questions were sent out in questionnaire format to the various participants in what was called 'rounds'. During each round, the participants were required to rate their level of agreement with each question to be included in the framework for a best-practice EAP, using a three-point Likert scale (1 = considered to be critical, 2 = could be considered, 3 = not to be considered). Six rounds of the Delphi survey were used to ensure that consensus or stability was reached on all the questions.

1.9.3 Data analyses

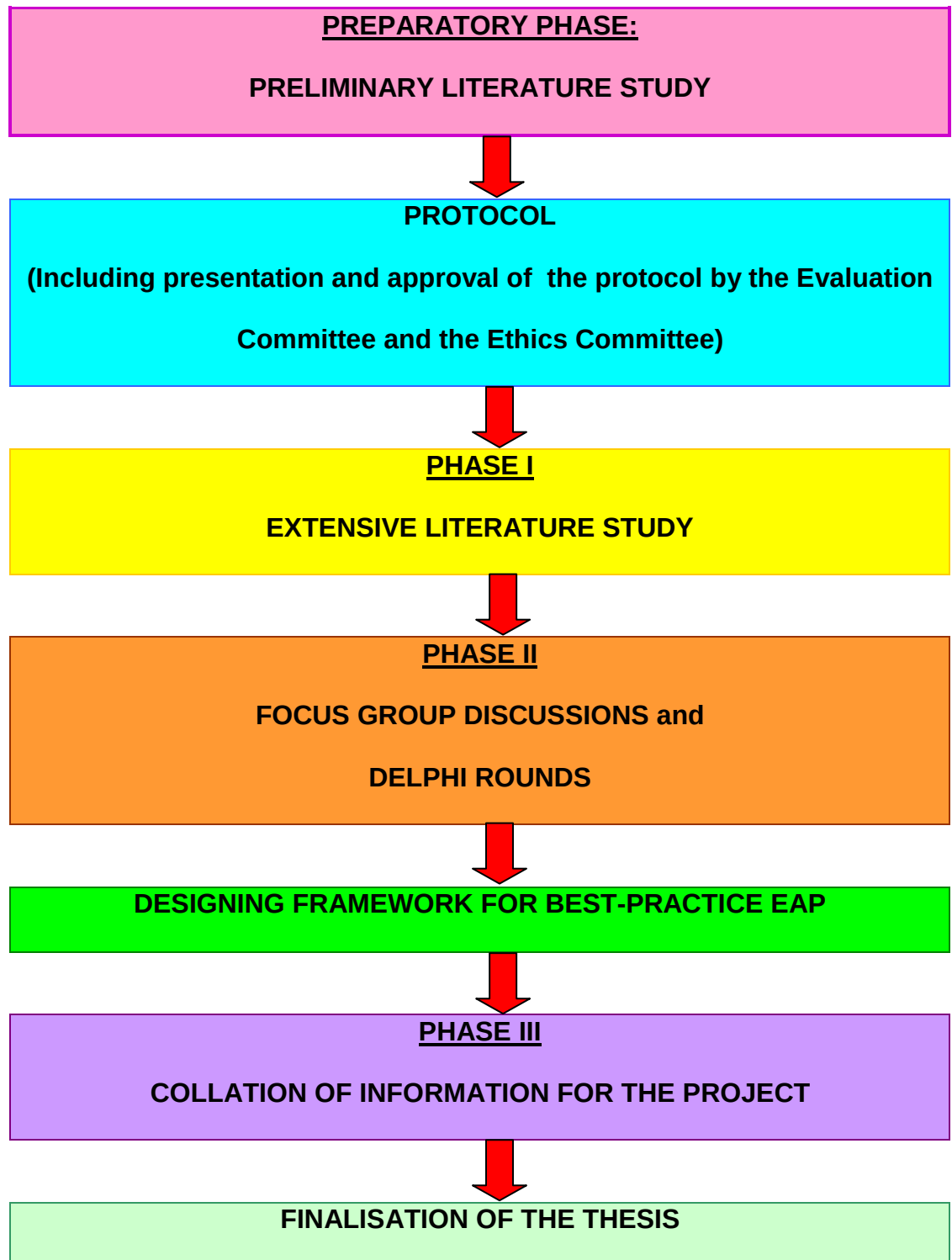
The generic features of qualitative data analysis are based on an interpretative philosophy with a focus on how the research participants derived meaning from the studied phenomenon. This is done by analysing the participants' words, feelings, attitudes and experience. An inductive approach, which entails allowing the research results to emerge from the frequent or significant themes found in the raw data without any restraints, is the best way of constructing the phenomenon, using the mentioned participants' inputs (Nieuwenhuis 2007:99).

The data obtained by means of the focus group discussions were analysed by the researcher himself. The initial analysis was done by means of a deductive approach where the categories of information pertaining to the data were formulated in advance with the use of a pre-set coding system developed from the literature review (Nieuwenhuis 2007:99). The researcher used this pre-set coding system as a starting point to analyse the focus group discussions. The analysis, however, was supplemented by means of an inductive approach. This implies that new themes were allowed to emerge from the data, complementing the initial deductive approach. The analysis was done using NVivo8 computer software with a set of criteria for the framework as an outcome of the analysis.

The Delphi survey was used to finalise the criteria for the framework for the best-practice EAP by means of consensus and stability. Consensus refers to 80% agreement amongst participants with regard to a question, while stability refers to no changes with regard to the rating for that specific question. The analysis of all the rounds of the Delphi survey was conducted by capturing all the participants' ratings for each round on an Excel spreadsheet (Appendix K), and controlled, anonymous feedback was provided through individualised reports. The Delphi survey provided quantitative information with regard to the subject of the study, as well as qualitative information due to the fact that additional comments on the questions relating to the pertinent topics were provided by the participants.

After the last round of the Delphi survey, a final set of criteria were compiled which were used to develop the framework for a best-practice EAP.

TABLE 1.1 SCHEMATIC OVERVIEW OF THE STUDY



1.10 TRUSTWORTHINESS, RELIABILITY AND VALIDITY

Qualitative research applies several methods to ensure trustworthiness, reliability and validity in a qualitative research project (Nelson 2008:319). Some of the aspects used to address trustworthiness, reliability and validity are credibility, transferability, dependability and confirmability (Bryman 2001:32, Guba and Lincoln 1981 in Nelson 2008:319). The researcher used a variety of strategies in this research and more information is provided in Chapter 4.

1.11 ETHICAL CONSIDERATIONS

Due to the nature of the research, it is of paramount importance for qualitative researchers to be sensitive to the ethical principles and guidelines (McMillan and Schumacher 2001:420). Ethical aspects, principles and guidelines were considered during the research design and planning phases (Sieber 1998:127) and more detail is provided in Chapter 4.

1.12 THE VALUE OF THE STUDY

- The outcome of the research project will be of value to the health care sector, especially since it proposes a structured, best-practice EAP framework for the health care sector.
- The proposed framework will serve as a generic platform for managers in the health care sector to adapt the EAP in order to address their specific needs at organisational level.
- The quality management framework will contribute to ensuring that the quality of the EAP is evaluated, as well as guaranteeing better management of EAPs within health care organisations.
- It would be possible to produce meaningful managerial reports on the EAP implemented in health care institutions.

- If a best-practice framework were to be followed, it would also possibly allow for inter-organisational comparisons to be made regarding the effectiveness of the programmes.

1.13 ARRANGEMENT OF THE THESIS

The arrangement of the thesis is as follows:

- Title page
- Declaration
- Acknowledgements
- Table of contents
- List of tables
- List of figures
- List of acronyms
- Chapter 1: Orientation to the study
- Chapter 2: Literature review on EAP
- Chapter 3: Literature review on quality in health care
- Chapter 4: Research methodology
- Chapter 5: Results and data analysis
- Chapter 6: Discussion of the findings
- Chapter 7: Conclusions and recommendation
- References
- Summary
- *Opsomming*
- Appendices

1.14 CONCLUSION

Current labour legislation in South Africa is compelling the management of health care institutions to think more carefully about the ways in which they manage the various categories of health care workers, the most valuable resource, working in their institutions. The human resource component is a unique component of the business, which may be exposed to many hazards in the workplace, as well as having to deal with their own personal problems. Providing employee assistance to deal with such problems through a formal programme (EAP) is nothing new. It is evident from the literature that there is no definite definition of an EAP and that no two EAPs are structurally alike. Furthermore, the measurement of the quality of EAPs is widely debated.

Chapter 1 provided the introduction to, and overview of, the research, specifically the development of a framework for a best-practice EAP and the quality management of such programmes for the health care sector. It was deemed necessary not only to explain the importance of EAPs, but also the importance of evaluating such programmes in terms of their overall quality. The qualitative research approach, as well as the methods to be used, was explained. It consisted of (a) a literature review and focus group discussions with relevant health care supervisors to identify the criteria for the framework; (b) designing a questionnaire for a survey, using the Delphi survey technique in which experts in the fields of EAPs, health care management, human resource management, labour relations, and quality assurance were asked to rate questions relating to the new proposed framework; and (c) the formulation of a report, using the information gained from the phases of this study. The outcome of this study is a report that will contain the necessary recommendations for the framework for a best-practice EAP. The arrangement of the report was set out and explained. The significance and value of this study were also discussed, as was the design of the study.

The next chapter, entitled 'The History and Development of the Employee Assistance Programme' will provide a description of the relevant published literature. It will focus on the history and development of employee assistance as a formal programme from its inception to its current format status. Emphasis will be placed on the ways in which the various components of EAPs are being used in the health care sector, as well as investigating how applicable these components are to this sector.

CHAPTER 2

THE HISTORY AND DEVELOPMENT OF THE EMPLOYEE ASSISTANCE PROGRAMME

2.1 INTRODUCTION

Health care organisations consist of a variety of systems with people and other resources working towards a common goal in order to provide a service to a specific community (Tarride, Zamorano and Varela 2008:1120). These organisations appoint employees as health care workers in specific jobs to perform certain duties and they are expected to be productive within the organisation (Chima 2005:63). However, this is easier said than done. Health care workers are human beings and their employer should recognise that they are individuals who may be exposed to various hazards within the workplace while performing their duties. Employees also have personal lives outside the organisation where they might be faced with personal problems (Elliott and Shelley 2005:125). Rotarius, Liberman and Liberman (2000:24) are of the opinion that these problems could influence the employees to such an extent that their work performance is affected. Meyer and Davis (2002:22) agree by stating that 'every year, one out of every seven employees is faced with personal problems that seriously affect his or her job performance'. Therefore, employees should be assisted in dealing with their problems in order to remain productive in the workplace.

2.2 HISTORY OF EMPLOYEE ASSISTANCE

Employee assistance began in the 19th century in the USA as an attempt to deal with alcohol abuse in the workplace (Arthur 2000:551). However, around 1917, no real distinction was made between employee assistance and other counselling services (Alker and McHugh 2000:303). The movement to assist employees was significantly expanded during the 'early 1940s in post-Prohibition America' (Reddy 1994:60) with the founding of Alcoholics Anonymous (AA) (Csiernik 2009:153; Elliott and Shelley

2005:125), as well as during World War II (Csiernik 2009:154; Lawrence, Boxer and Tarakeshwar 2002:2). The earlier programmes had a humanitarian and pragmatic goal in identifying employees who performed poorly in the workplace as a result of alcohol problems and assisting them in returning to the workplace and being productive (Chima 2005:60; Haaz, Maynard, Petrica and Williams 2003:3).

Since then, the employee assistance movement has grown steadily (Reddy 1994:60; Rotarius *et al.* 2000:25) and has been significantly expanded in order to help the alcoholic worker. Employers realised that on-the-job alcohol consumption compromised job performance, but that the initial intervention programmes failed to address the 'corollary problems associated with alcoholism', as well as 'the mental health problems experienced by troubled but non-alcoholic workers' (Lawrence *et al.* 2002:2). Gradually, employee assistance evolved, fuelled by union demands, and began assisting with employees' emotional, mental and financial problems caused by alcohol and drug abuse (Kemp 1985:378; Lawrence *et al.* 2002:2). During the 1960s and 1970s, organisations showed an increasing interest in deteriorating job performance, and employee assistance services were expanded accordingly in order to cover additional problems employees might have (Elliott and Shelley 2005:126; Lawrence *et al.* 2002:2; Merrick Volpe-Vartanian, Horgan and McCann 2007:1262). Thus, over time, the focus of employee assistance shifted towards job performance and related factors.

The term 'employee assistance programme' (EAP) was established by the American, James Wrich, who used the concept of a 'broad-brush approach' for the first time (Csiernik 2009:155). The term was formally adapted in 1974 by the National Institute on Alcoholism and Alcohol Abuse, while the Institute noted that the deterioration in job performance also could be related to other personal problems (Hartwell *et al.* 1996:804). The scope of the EAP was broadened beyond alcohol abuse to include several services aimed at addressing all types of personal problems an employee might experience. The EAP became a workplace-based programme 'designed to address behavioral, health and other problems that affect the employees' well-being

or job performance' (Merrick Hodgkin, Hiatt, Horgan, Azzone, McCann, Ritter, Zolotusky, Thomas and McGuire 2010:87).

The EAP continued to evolve by shifting towards primary prevention programming (Fogarty 2010:42). With the development of the EAP, the possibility for it to become more integrated with the holistic approach of a wellness programme arose (Csiernik 2005:21) as well as an integration with other employee wellness strategies (Eishen, Grossmeier and Gold 2005:265). Csiernik (2005:22) continues that a 'more employee centered approach' should be taking place. The stigma of the EAP simply being a programme for alcohol and drug abusers was removed by means of broadening the scope of the services within the EAP to address additional problems which seriously affect job performance (Kemp 1985:378). The promotion of EAPs changed accordingly to ensure that employees were aware that the services rendered were aimed at assisting with life problems and processes. These promotional processes were necessary in that they had a 'de-stigmatizing effect' on the EAPs (Merrick *et al.* 2010:86). The stigmatisation of EAPs may be attributed to the fact that these programmes are often seen as being associated with troubled employees and the final step before dismissal. Therefore, in order to reduce the stigma attached to the EAP, it is critical to promote the EAP in the correct manner by focusing on the preventative nature of the programme (Fogarty 2010:46).

Recently, it was found that EAPs were significantly more prevalent in larger worksites, but with distinctive differences created by the type of industry (Merrick *et al.* 2010:86). It was also discovered that worksites with relatively more educated and unionised employees are more likely to have an EAP (Hartwell *et al.* 1996:808). The prevalence of EAPs in American organisations has been quoted as being 11.8% in 1988 and 33% in 1994 (Arthur 2000:551). It was reported that in 1989, 75-80% of the top *Fortune 500* companies made use of EAPs (Luthans and Waldersee 1989 in Arthur 2000:551). In 2009, it was reported that 65% of US employers offer EAPs as an employee benefit, mainly by the large firms (Anon 2009:6).

Since the inception of the initial employee assistance, aimed at addressing alcohol-related problems, the EAP industry has continued to grow in its assistance of employees in various industries with the broad-brush approach used today. This approach ensures that employers can offer employees more than simply alcohol-related assistance. A more detailed consideration of the rationale for an EAP is, therefore, necessary.

2.3 THE RATIONALE FOR EAPs

Gammie (1997:66) showed that an escalating number of employers now recognise human capital as a valuable resource and, consequently, there is an increasing realisation that the well-being of employees is a significant determinant of organisational prosperity. Ho (1997:177) suggested that the health of the employee becomes an increasingly legitimate and important management concern. Chima (2005:70) not only confirmed that the health of the employee is a personal matter, but also recognised that the workplace might affect the lives of employees in a number of ways. The concept of a healthy organisation is, therefore, directly linked to the health of the employee working in that organisation, as human resources are needed to achieve 'the desired organizational results' (Tarride *et al.* 2008:1220). In fact, Ginn and Henry (2003:26) are of the opinion that employees may view employment as an investment in human capital and may consider changing jobs if they feel they are wasting their time. From this perspective, employers should consider the fact that employees could view an EAP as an investment in themselves and will, therefore, tend to think more positively about their organisation. Employers should not underestimate their role in promoting a healthy lifestyle amongst employees (Kumar, McCalla and Lybeck 2009:81).

Reddy (1994:60) argues that, although EAPs were originally a shop floor initiative with strong support from labour unions, it was not long before they were adopted by management. However, the original policy of employee assistance as a benefit or entitlement has changed from the 1980s to a position where it has become a mechanism for managing employees' personal problems (Alker and McHugh

2000:305). The main purpose of an EAP has changed to assisting employees and their family members who can develop social, personal, interpersonal, behavioural, work or health problems that could affect their work performance, their health and safety and/or the productivity of the workplace (MacArthur, Rickard and Lewis 2009:11). Kumar *et al.* (2009:584) confirmed the statement that an EAP can assist employees with a variety of 'behavioral health issues that could adversely impact their work and personal lives'. The EAP, therefore, became a tool for management and labour unions to provide employees with the means to improve their job performance and health (Csiernik 2005:12). Healthy and satisfied employees are expected to perform better in the workplace. With this viewpoint in mind, managing the health of employees has now been transformed into a business issue as the focus has shifted towards employees as an asset (Kirsten 2010:48; Prince 1999 in Ginn and Henry 2003:26). With the EAP in place, the benefit of productive employees 'should increase to a point where the cost they bring to the organisation (e.g. compensation and human resource interventions) is recouped and their net productivity increases' (Birkland and Birkland 2005:331). The increasing interest in EAPs experienced during the last few decades created the philosophy within an employee assistance programme to rehabilitate previously proven and trained employees rather than to terminate their services. This philosophy is deemed more desirable, both economically and socially (Kemp 1985:378).

There is currently a paradigm shift from pathogenesis to salutogenesis in employee wellness (Emener, Hutchison and Richard 2003:277). The current changes experienced in the work place (Wright and Thompson 1997:36) are major driving forces for the EAP to focus more on the building of human capacity than just focusing on the prevention and treatment of illnesses and deficits (Antwi and Analoui 2008:603). Capacity building refers to the ability to perform tasks as required by the organisation and the modern EAPs are well equipped to assist the human resource department with capacity building amongst employees. In South Africa, legislation passed recently promotes capacity building in the work place as well (du Plessis 2001:102).

To summarise, the purpose of the EAP changed from the initial focus on the employee with an alcohol abuse problem to assisting all employees and members of their immediate families (Muto, Fujimori and Suzuki 2004:571) who may have developed counterproductive behaviour in the organisation. The assistance could be in the form of an immediate assessment, counselling or appropriate referral and treatment of the problems that have resulted in this counterproductive behaviour (Csiernik 2003a:17). Kirk (2005:81) summarised the rationale for and description of adopting an EAP in an organisation by using the following six major approaches:

Humanistic:

The approach is driven by the general desire to help and treat employees and to reduce the potentially damaging effects of the work environment.

Efficiency:

This approach is based upon a precise calculation of financial return, taking into consideration several factors, such as financial implications, productivity and absenteeism, as well as intangible outcomes, such as innovation and creativity.

Political:

With this approach, the focus is more on management's control of the attitudes and behaviour of employees which are reflected in the involvement of EAPs in staff performance and training (Hardaway, Wence Bingaman and Selvik: 1996:sp).

Excellence:

In developing a culture of excellence, it is important to ensure the health and productivity of employees by means of treatment.

Human resource management:

This approach is described as 'the "outsourcing" of the traditional welfare role of the human resource practitioner' (Kirk 2005:81).

Industrial relations:

This approach views the employee as an individual in employment, with the EAP being more prominent in the legal, disciplinary and grievance procedures.

2.4 THE CHANGES

Currently, EAPs are well-established in several countries (Du Plessis 2001:111; Kirk and Brown 2003:142; Masi 2003:75; Reddy 1994:61; Vosloo and Barnard 2002:56). However, Chima (2005:61) is of the opinion that the traditional workplace is faced with 'profound challenges and opportunities' where continuous, and often dramatic, metamorphoses are prevalent. Daniels *et al.* (2005:37) warned EAP providers that the EAP industry is not only expanding, but that it is also faced with the challenge of distinguishing itself within the health care industry, in general, due to the changing working environment, opportunities and challenges.

The health care industry did not escape the dramatic metamorphosis experienced in the workplace that resulted in restructuring (Leatt *et al.* 1997 in Ginn and Henry 2003:23). Wall (2010:145) confirmed that health care is undergoing dramatic changes all over the world and expressed her concern about the negative consequences of this restructuring for health care workers. The health care changes could result in a change in the described demand-control model of Karasek and Theorell (1990 in Tyssen 2007:603). Tyssen (2007:603) continued that a balanced demand-control model can be one of the critical elements for maintaining mental and physical health. The same conclusion was reached by Finegan and Laschinger (2001 in Wall 2001:146), as well as Lee, Steward and Brown (2008:235), who stated that autonomy, workload and resource availability (Seo *et al.* 2004 in Wall 2010:146) can be affected by health care changes, including policy changes. A change in these factors can increase the level of job stress and mental health problems. Furthermore, the health care changes can result in health care workers constantly having to adapt to new relationships both inside and outside the organisation. These adaptations could be another major source of stress to employees and the possible deterioration of job performances (Bazzoli *et al.* 2000 in Ginn and Henry 2003:23). The above-

mentioned changes in health care can be categorised in the following ways as described below.

2.4.1 Internal/organisational changes

(Arthur 2000:552; Lawrence *et al.* 2002:2)

- Increased stressors related to the workplace, such as exposure to extremely stressful working conditions, long working hours, and having access to controlled substances that could easily be abused
- Lack of job security with corporate downsizing
- Demands to keep up with increasingly complex electronic technology
- Workplace violence
- The threat of employee litigation.

2.4.2 External/individual changes

Individual problems usually present themselves in broader contexts (Chima 2005:61; Rotarius *et al.* 2000:26):

- Situational crises
- Social- and health-related developments, such as autoimmune deficiency syndrome (AIDS) and the shortage of child care
- Employees with a lack of job-related skills to be repositioned with new practice knowledge, skills and roles
- A conglomeration of diverse groups, who exhibit differences in race, gender, ethnicity, national origin, age, physical abilities, qualities and sexual orientation
- Individuals with disabilities
- Disaffection with one's job or supervisor
- General immaturity
- Alcohol/substance abuse
- Family disagreements
- Emotional problems/physical ailments.

Wall (2010:156) stressed the fact that the health care environment has become more market orientated and cost conscious, with health care managers searching for new ways of gaining a competitive edge. This approach puts even more stress on the health care worker and a broader range of assistance services are needed for employees.

It is evident that the EAP is a reality and that organisations have experienced the impact and benefits of the various services rendered (Triner and Turner 2005:2). In view of the initial purpose of the EAP at inception and the current challenges faced by organisations, EAP providers can identify ample opportunities to expand their services (Kirk and Brown 2003:138; Macdonald *et al.* 2006:55, Anon 2003:3). Zarkin, Bray and Qi (2000:78) cautioned that 'EAPs should not engage in long-term treatments, nor do they provide healthcare services'. Roman and Blum (in Steele 1998:5) clarify the functions of the EAP in what is described as the seven core technologies of an EAP. These technologies are defined as follows (Beidel 2003:1):

Core technology 1:

'Consultation with, training of, and assistance to work with organization leadership (managers, supervisors, and union stewards) seeking to manage the troubled employee, enhance the work environment, and improve employee job performance, and outreach to and education of employees and their family members about availability of EAP services.'

Core technology 2:

'Confidential and timely problem identification/assessment services for employee clients with personal concerns that may affect job performance.'

Core technology 3:

'Use of constructive confrontation, motivation, and short-term intervention with employee clients to address problems that affect job performance.'

Core technology 4:

'Referral of employee clients for diagnosis, treatment, and assistance, plus case monitoring and follow-up services.'

Core technology 5:

'Consultation to work organizations in establishing and maintaining effective relations with treatment and other service providers and in managing provider contracts.'

Core technology 6:

'Consultation to work organizations to encourage availability of, and employee access to, health benefits covering medical and behavioral problems, including but not limited to alcoholism, drug abuse, and mental and emotional disorders.'

Core technology 7:

'Identification of the effects of EAP services on the work organization and individual job performance.'

These technologies 'delineate the tasks that are practiced only by EAP professionals' (Bocchicchio 2006:97) and guide the structure and service delivery of an EAP (Megranahan 1995:54). These core technologies were also endorsed by the Employee Assistance Professionals Association (EAPA) (Bocchicchio 2006:91). Not all the core technologies are equally accepted by all staff members. An example is the core technology regarding the role of EAPs in the training of supervisors which is contentious because of mixed results (Capece and Akers 1995:sp). Several researchers indicated that, due to the above mentioned supervisor training, employees with drug abuse problems are identified and entered into EAPs much earlier (EAP & Counselling Associates 1999:sp, Lapham, McMillian and Gregory 2003:187). On the other hand, supervisors gave an indication that the EAP should not be involved in managerial related training (Buon and Taylor 2008:431). Beidel (2003:2) concluded that employee assistance can be regarded as best-practice when the Core Technologies are the centre of the service delivery and operations. Csiernik,

Atkison, Cooper, Devereur and Young (2001:48) suggested that the structures and processes for an EAP should be created in such a way that the programme can adapt to the ever changing world of health care.

The next section will discuss the need for and elements of a best-practice EAP suitable for the changing world of health care as suggested by several authors (Beidel 2005:301; Berridge and Cooper 1994:10; Csiernik *et al.* 2006/7:45; Macdonald *et al.* 2006:62).

2.5 THE EMPLOYEE ASSISTANCE PROGRAMME UNIQUE TO THE WORKPLACE

Muto *et al.* (2004:571) reminded organisations that an EAP is a work-based programme 'operating within an organization to provide access to counselling or treatment for employees who require these services'. It is a fact that no two EAPs are alike (Arthur 2000:550; Barret 2010:39; Fogarty 2010:42). However, there are inherent commonalities between EAPs, including the core technologies as endorsed by EAPA (Steele 1998:4). That being the case, Fogarty (2010:42) is of the opinion that many EAPs do not adequately address the basic core technologies. Mannion (2006:111) confirmed that these basic elements are absent in a number of EAPs. He expressed his concern with the additional introduction of foreign elements into EAPs because 'we run the risk of undermining and eventually destroying the field completely' (Mannion 2006:111), but acknowledged that the need for change does exist. Beidel (2005:289) argued that an EAP may be challenged in order to blend 'its services to the unique culture of its host or sponsoring organization'. The EAPs that are implemented in certain organisations are unique to each individual workplace and the most appropriate EAP for an organisation should be developed based on its specific needs and appropriate assessment (Csiernik 2004:22; Elliott and Shelley 2005:130). In order to address Mannion's concern about the lack of core technologies in EAPs, Csiernik (2003:16) suggested that several issues should be considered before an EAP is developed for an organisation, including the assessment of the environment of the organisation, as well as the specific needs of the employees.

Csiernik (2004a:22) proposed a five-step approach, as suggested by Macdonald (1986 in Csiernik 2004a:22), on the best way of instituting an EAP. Each step can be further divided into other activities. The steps are set out below.

2.5.1 The needs assessment

The purpose of the EAP needs assessment, which should be conducted during the development phase, is to determine overall programme goals and direction and should be aimed at identifying worksite, environmental, programmatic, personnel and stress-related factors (Csiernik 2004a:22).

2.5.2 Programme development

The programme should describe the intention of the programme, as well as its components, rationale and objectives. The programme should be formalised in a written policy presenting several guidelines to be followed and signed by senior management (Csiernik 2003a:16).

2.5.3 Evaluation of programme

This step is divided into input, outcome and process evaluation; thus making up the last three of the five steps. The possible evaluation processes also should be planned during the planning phase. Input evaluation aims to determine whether the various components of the programme have been correctly implemented, while outcome evaluation aims to determine whether the programme objectives have been achieved. Process evaluation, on the other hand, aims to determine what the programme is actually doing and how well it is doing it (Csiernik 2004a:26). A combination of the input, process and outcome evaluations provide valuable information that can be used in association with other evaluation methods within the broad spectrum of the programme performance measurement, theory development and marketing of the EAP (Gerstein and Bayer 1988:296)

The distinct nature of the health care sector is characterised by the World Health Report, published in 2000 (Veillard, Champagne, Klazinga, Kazandjian, Arah and Guisset 2005:487), in which three overall goals of a health care system were identified, namely (a) 'achieving good health for the population', (b) 'ensuring that health services are responsive to the public', and (c) 'ensuring fair payment systems'. The first two goals could place health care in a unique environment, which means that health care workers are exposed to unique health hazards and risks. Furthermore, the health care sector should maintain a satisfactory level of performance that 'corresponds with societal, patient and professional norms' (Veillard *et al.* 2005:488). Shanafeldt (2002 in Tyssen 2007:599) found that it is possible for physicians to neglect their own health and, subsequently, provide sub-optimal care to patients. Being exposed to health hazards, with additional pressure to perform optimally, can create work stress, causing poor motivation, dissatisfaction and high rates of absenteeism (Diez-Pinol, Dolan and Sierra 2008:599, Eischen, Grossmeier, and Gold 2005:277). Other undesirable outcomes could range from physical to mental and even social pathology, which can be amplified by other organisational and professional factors, such as work schedule, work load equity and burnout (Buxton 2003:306, Diez-Pinol *et al.* 2008:606). An important contributing factor is that medical doctors have access to addictive medical substances for self-treatment and a number of them suffer from substance abuse (Tyssen 2007:603). Such addictive behaviours can be very costly for the employer (Chan, Neighbors and Marlatt 2004:1883). Employees encountering problems with regard to coping with such uniquely hazardous environments, counter-productive behaviour, and increased work stress, should be assisted. Loo and Thorpe (2004:95) recommended that health care organisations should 'go beyond band-aid solutions targeting symptoms to address the underlying major organisational and occupational sources of stress'. Many of these health risks are likely to be caused by individual factors, as well as working conditions. Tyssen (2007:605) is of the opinion that it is possible to avoid such working conditions, and health care administrators should address organisational factors, such as 'pressure of time and interruptions during work'. Macdonald *et al.* (2006:57) suggested keeping the focus on individual factors, since this is crucial in addressing these behavioural health risks before employees develop severe

disabilities. Beidel (2005:284) suggested using an integrated approach in addressing quality in the unique situation, since an integrated EAP could mitigate the work stress 'through its effective engagement with the organization's planning efforts and decision makers at the front end'. Bidgood, Boudewyn and Fasbinder (2005:237) emphasised the importance that an EAP should demonstrate the value it adds to a health care institution on an ongoing basis.

It is evident that no two organisations or EAPs are alike and that the health care sector is no exception. The unique nature of the health care sector should be taken into consideration when developing an EAP for a health care organisation. During the planning phase, an integrated approach to employee assistance should be high on the agenda. The next section will elaborate on the concept of an integrated model for an EAP.

2.6 INTEGRATED MODEL FOR AN EMPLOYEE ASSISTANCE PROGRAMME

Although employers have become more interested in presenteeism where employees are at work, but are limited in their job performance by health and personal problems, absenteeism is still a popular business indicator (Kirsten 2010:253). Both presenteeism and absenteeism can be addressed in various ways, for example, services rendered through the EAP and occupational health. These services should be rendered to ensure that health care workers "realise and perform to their full potential" (Bye 2003:9). The challenge faced by the EAP is the complexity with regard to integrating and blending these services into the unique culture of the organisation (Beidel 2005:289). There is evidence for the successful integration of services to improve the health status of employees (Stephenson and Delowery 2005:320). Csiernik (2005:12) suggests a model called the Integrated Model of Occupational Assistance in which he proposed the five constituent elements of wellness as an approach:

- Physical health
- Emotional or psychological health
- Social health
- Intellectual health
- Spiritual health.

The aim of an integrated health management is to (a) measurably improve the health of employees, (b) provide good working conditions resulting in (c) increased morale, motivation and performance and, finally, (d) reduce health-related costs in a holistic approach (Kirsten 2010:254). Before integration can commence, it is critical to review the formal EAP within an organisation.

2.7 FORMALISATION OF AN EAP

Fogarty (2010:42) was optimistic when he suggested that an EAP should be a core component of an organisation's employee health management strategy. As with any strategy, it should be formalised to ensure that it is effectively implemented. The following are suggested methods to formalise an EAP within an organisation.

2.7.1 A formal written policy

Csiernik (2003a:16) strongly recommended having a written policy statement, developed prior to the implementation of a programme and specifying the goal of the EAP in order to avoid possible adverse legal actions (Soto 1991:540). The written policy document should provide supervisors, managers, and union shop stewards with the necessary means and guidance for dealing with employees who need assistance. Furthermore, the EAP policy should formalise the purpose and objectives of the service, as well as the relationship between the EAP and other organisational functions (Masi 2003:78). It should be reviewed and updated on a regular basis (Csiernik 2003a:16).

2.7.2 Introductory statement of principles and intent

The opening statement of the above-mentioned organisational EAP policy should include a descriptive introductory statement defining the relevant responsibilities and introducing procedural issues (Csiernik 2003a:17). Another issue that should be included in the opening statement is the scope of the EAP with regard to coverage of employees and their families, as well as the range of issues that will be covered (Berridge and Cooper 1994:4). The main focus should be the promotion of employee health in a holistic manner. There are several other issues to be addressed, but these could be included as separate headings within the formal written programme. Such additional issues to be addressed in the introductory statement are (Csiernik 2003a:18):

- The endorsement of the programme by role-players
- Confidentiality
- Employer is limited to addressing employee's problems only when productivity is at stake
- The fact that the existence of an EAP neither alters management's responsibility or authority, nor does it alter union prerogatives.

The written statement should be signed by executive managers, members of the EAP committee and senior labour leaders.

2.7.3 Mission and objectives of programme

The next step in the formalisation process is the development of a clearly defined mission statement supplemented by specific objectives (Masi 2003:76). The objectives of an EAP could be categorised to address the following aspects (Berridge and Cooper 1994:5; Ho 1997:178; Lloyd, Doyle and Grange 1999:194):

- To improve the mental and, subsequently, physical health of the workforce in order to improve workforce effectiveness and employee productivity
- To reduce unnecessary costs
- To enhance the corporate image of the company
- To improve general employee satisfaction.

Therefore, the ultimate objective of this programme is to maintain the homeostasis of the workforce and to assist in balancing the professional and personal lives of the employees (Rotarius *et al.* 2000:25). Clemmet (1998:17) summarised the objectives of the EAP by placing the focus on the improvement of mental well-being, better functioning at work and the enhanced job and life satisfaction of employees.

2.7.4 Ethics and values

An organisation's EAP needs to adopt its own code of ethics. Furthermore, the EAP's professional staff and affiliates should adhere to the codes of ethics of their respective professions and avoid conflicts of interest in performing their duties (Masi 2003:76). These codes should be written down and should be available to everyone in the organisation.

2.7.5 Target groups and rights

The next step is to identify the target groups for the EAP, as well as the rights and responsibilities of all the role-players. The rationale for organisations to provide troubled employees with assistance is 'that it is more desirable, both economically and socially, to rehabilitate proven and trained employees than to terminate or replace them' (Chima 1995 in Chima 2005:60). The target groups of an EAP should be emphasised and could include (Masi 2003:81):

- All employees of the company/authority, as well as their family members
- Superiors and managers
- The company/authority as an organisation and its units.

Some organisations even extend their services with regard to the use of the company programme to part-time employees, probationers, seasonal workers, retirees and employees who had been laid off. This approach is in line with the concept that there is an inseparable relationship between home and work (Csiernik 2002:31), as well as the social responsibility of an organisation towards a community at large.

The results from the study of Reynolds and Lehman (2003:247) suggested that a 'heightened awareness and support for both the EAP and policy seems to be a key in such a program's attractiveness'. It is, therefore, important for organisations to ensure that their employees are aware of the existence and benefits of the EAP (Masi 2003:79) as this could lead to a higher level of willingness amongst employees to utilise the EAP. In the current economic climate, employees at ground level appear to be more aware of benefits of such programmes (Anon 2010a:4). Reynolds and Lehman (2003:340) also stated that employees from different racial groups, as well as from both genders, have been associated with an unwillingness to seek mental health treatment in general. Schmid *et al.* (1990 in Reynolds and Lehman 2003:239) noted that there are also cases where troubled employees do not seek help because they are not aware of the existence of an EAP in the organisation or because they have a negative feeling towards the programme.

Employers should provide and maintain a safe and healthy workplace in accordance with the applicable legislation, such as the Occupational Health and Safety Act (85/1993), and take appropriate actions. Employees suffering from alcohol- or drug-related problems might pose a hazard and/or risk in the workplace and should have the right to take appropriate measures in addressing these risks, as well as their work performance (Masi 2003:77). The National Health Act of South Africa (61/2006) addresses the rights and responsibilities of users of health care, as well as employees. Additional EAP policies are valuable, not only as a means of protecting

the rights of employees (Soto 1991:540), but also as a way of formalising the overall management of a programme. Issues to consider for inclusion in the policies are referral systems, access to the services, protecting confidentiality (Harlow 1998:sp, Highley and Cooper 1994:54), and the monitoring and evaluation of the EAP (Csiernik 2003a:34). Some of these policies are discussed in the next section.

2.7.6 Policies and procedures

Chima (2005:63) is of the opinion that it is critically important for EAP professionals to develop more comprehensive policies and procedures at an organisational level. These policies and procedures are valuable in ensuring that the essential ingredients for an effective EAP are spelled out (Arthur 2000:550; Csiernik 2003b:34). There may be a perception that formal policies are not required when service delivery is provided off-site (Csiernik 2003b:42; Macdonald *et al.* 2006:62). However, Csiernik (2002:30) emphasised the significance of having the necessary policies and procedures in place in order to clarify issues, such as how to access the services, formalise the follow-up procedures and monitor and evaluate the programme. The following policies and procedures are necessary for a successful EAP in an organisation:

2.7.6.1 Procedures for access/referral

Employees face many barriers when they consider seeking assistance in dealing with their personal problems. Browne (1986 in Reynolds and Lehman 2003:239) identified at least two major barriers faced by employees, namely (a) 'employee reluctance to self-refer' and (b) 'company referral processes'. Several studies (Berridge and Cooper 1994:11; Csiernik 2003a:18; Soto 1991:537) suggested that written procedures should formalise all the referral procedures, including the self-referral/voluntary use, organisational referral via formal systems with formal usage, managerial/supervisory referral, trade union or professional association referral, as well as the follow-up system. Such formalised policy and procedures should be helpful as O'Connel (1987 in Gerstein and Bayer 1988:295) argued that supervisors are not always in favour of referring employees to the EAP. It is crucial that these formal procedures for

accessing and referral to the EAP minimise the barriers for timeous initiation or use of the EAP services and give priority to employees with urgent needs or those in emergency situations (Masi 2003:80).

2.7.6.2 Confidentiality

Confidentiality is one of the cornerstones of the EAP and, therefore, clear procedures and a strong commitment by all staff members to ensure confidentiality are regarded as a priority. Csiernik (2003a:20) proposed a list of explicit rules that could support confidentiality within the EAP and that should be included in the written procedures to avoid any adverse legal actions (Soto 1991:540). Some of these rules should address:

- How supervisors would be responsible for documenting declining work performance and referring troubled employees to the EAP
- How records are to be maintained
- Who will have access to the programme
- Which information will be released, to whom, and under which circumstances, as well as the type of release form used
- How employee EAP records will be used for purposes of monitoring, research, evaluation and internal and external reports (Harris, Adams, Hill, Morgan and Soliz 2002:60).

Rules could be created to ensure confidentiality, for example, ensuring that statistical reports never have names attached and that these reports should always be aggregate in nature so that no person or individual/work unit can be recognised. Two other rules that could be used to ensure confidentiality include keeping work performance records prepared by the supervisors separate from EAP records, as well as ensuring that EAP records never become part of an employee's personnel file.

The requirements of legislation, such as the Promotion of Access to Information Act (2/2000), should be used to govern access to, use of, and release or disclosure of information about clients along with guidelines set by professional authorities. Masi

(2003:76) took this a step further by recommending that the EAP's confidentiality policy 'requires clients to sign a statement indicating their understanding of confidentiality rights and limitations'. Employees should be informed in advance about the types of information that can conceivably be collected on them in the EAP referral, treatment, and return-to-work process (Soto 1991:540), and all exemptions should be clearly indicated.

2.7.7 Communication

Csiernik (2003:21) identified communication as a process for maintaining focus on and within the programme and ensuring the much-needed continued support and usage. He mentioned that 'communication should regularly occur between the EAP committee and senior management and labor, employees, the health and safety committee, medical department, EAP provider and EAP associations' (Csiernik 2003:21). These communication sessions should include information updates with regard to the programme, but within the confines of confidentiality.

2.7.8 EAP sequence of processes

Megranahan (1995:59) summarised the practices and processes to be identified and the following figure was adapted from his approach:

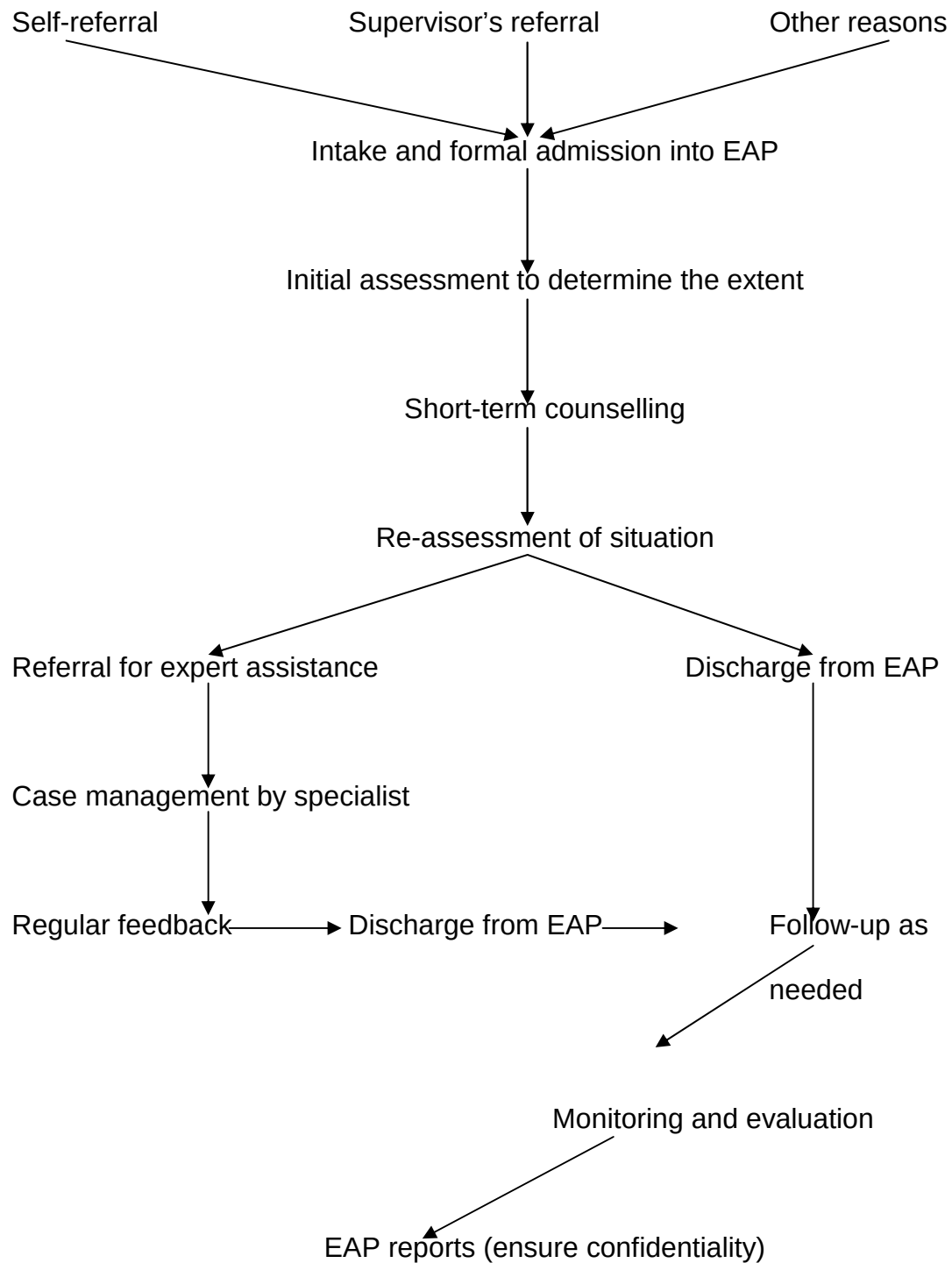


Figure 2.1 The EAP sequence of processes and activities (Adapted from Megranahan 1995:59)

2.8 GOVERNANCE OF AN EMPLOYEE ASSISTANCE PROGRAMME

2.8.1 A multi-party committee

Masi (2003:77) emphasised the significance of the proper governance of an EAP. She suggested that, if an EAP is not governed by a board of directors, the organisation should consider having an advisory board for the EAP. Megrnahan (1995:55) recommended that a team representing a cross-section of EAP role-players, such as line managers, trade union representatives, as well as human resources and occupational health staff members, should be appointed in an organisation to make crucial EAP-related decisions. The decision making function should follow the shift of the functioning of the committee from a management to an advisory function (Csiernik *et al.* 2006/2007:54). Csiernik (2003a:20) supported the recommendation by suggesting that a committee, giving equal representation to management, labour and interested third parties, is created to govern the EAP. The essential qualifying characteristics for EAP committee members should be an interest in and a concern for helping fellow employees (Csiernik 2003a:21).

2.8.2 Roles and responsibilities

Dealing with troubled employees could be a sensitive issue and a low utilisation rate could be attributed to the stigma attached to the use of an EAP (Meyer and Davis 2002:22). In order to act responsibly within an EAP environment and promote the EAP as an employee-owned tool, the roles and the responsibilities of the EAP committee should include, *inter alia* (Csiernik 2003a:24):

- Performing the initial needs assessment and determining the structure of the EAP
- Assisting with the writing of the policy statement for the EAP
- Remaining up-to-date with regard to community resources and the cost for available counselling or treatment, as well as working within the community to upgrade the level of services

- Interpreting programme policies and providing advice accordingly to role-players
- Assisting with the selection of an external EAP or service provider if required
- Preparing promotional materials and conduct orientation sessions for role-players
- Developing a monitoring system and evaluation process for the EAP
- Ensuring that confidentiality is maintained and working towards anonymity by monitoring all procedures
- Maintaining open lines of communication and producing regular reports, including an annual report of EAP activities.

2.9 TYPES OF EAPs

Csiernik *et al.* (2006/2007:55) stated that organisations do not look the same in 2006 than in 1989. The changing structures, sizes, values and needs of work organisations tend to influence the structures of EAPs (Beidel 2005:287; Kirk 2005:80; Lawrence *et al.* 2002:12). The primary reason for employers purchasing EAPs is to optimise the utilisation of services provided by an EAP in order to meet the objectives of improving worker health and productivity. A second aim should be to receive the most value from the behavioural health care expenditure (Azzone, McCann, Hiatt, Hodgkin and Horgan 2009:353). EAPs have also changed and evolved to address the needs of the organisations of today. As a result of these changes, particular types of models for an EAP were found in the literature (Gammie 1997:66; Hartwell *et al.* 1996:804; Evans and Trice 1995:sp, Kirk and Brown 2003:138; Lloyd *et al.* 1999:183), which will be described below.

2.9.1 Internal EAP

Historically, the services of an EAP were provided through an internal model (Azzone *et al.* 2009:353). Macdonald *et al.* (2006:62) explained that an internal EAP forms part of the structure of an organisation and its staff members have an intimate knowledge of the functions of the organisation. These internal EAPs were viewed as very

convenient since the services were rendered on-site by staff members employed by the same organisation. Research conducted by Chan *et al.* (2004:1886) found that 'services utilization is more permissible in the work setting' while the majority of employees was self-referred. The EAP staff tends to be more knowledgeable with regard to an organisation's unique operating systems and possible stressors (Macdonald *et al.* 2006:62). Since the EAP staff members are knowledgeable with regard to the organisation, they tend to be more cautious in their work situation and recommendations because 'they must live with the changes they recommend' (Chima 2005:70). The staff working in the EAP also has the ability to build more casual relationships with various departments and staff members (Csiernik *et al.* 2006/7:53). An internal EAP is preferred by many health care institutions and regarded as superior, but it is not the only type of EAP to be used (Smewing and Cox 1998:sp) as will become evident in the next sections.

2.9.2 External EAP

During the mid-1990s, there was a tendency to move away from having internal EAPs to utilising services provided outside the organisation (Macdonald *et al.* 2006:55). The tendency was caused by the demand for 'greater employee benefits' (Lawrence *et al.* 2002:2), as well as the newly adapted broad-brush approach, while organisations did not have all the resources to render such services. An external EAP involves a contract between the organisation and an independent EAP provider (Kemp 1985:379). The services of the external EAP are delivered as a package (Merrick *et al.* 2010:86).

Two disadvantages identified by Chima (2005:70) include the fact that (a) external service providers do not have an intimate understanding of the crucial aspects of an organisation and (b) they tend to recommend drastic changes since they do not have to deal with the outcome of the decisions. Research conducted by Csiernik (2002:29) indicated that external EAPs tend to focus less on promotion and training and are more likely to have a capped programme. A capped programme provided by an external EAP could benefit the smaller organisations. Muto *et al.* (2004:574)

emphasised that small-scale organisations could benefit from external EAPs because it generally cost less and promoting external EAPs amongst small-scale organisations will become increasingly important. Another benefit mentioned by Csiernik *et al.* (2006/7:53) is that external EAP providers tend to enhance the perceptions of neutrality and confidentiality. He further suggested referring employees with more complex problems to externally based counsellors.

In his study, Steele (1998:6) found that internal and external EAPs do offer the core technologies as suggested by Roman and Blum (1988 in Steele 1998:5). However, Merrick *et al.* (2007:1263) criticised the broad-brush approach by external EAP providers by indicating that they have 'diluted EAPs' traditional focus on substance use problems. The fact that service delivery has changed to address other health risk behaviours and has moved away from the narrow focus on substance abuse has already been discussed in this chapter. Often, the internal EAP does not have all the necessary resources required for dealing with the presenting problems and these employees need to be referred to outside service providers. This approach introduces the concept of a combined EAP.

2.9.3 Combined EAP

Merrick *et al.* (2007:1262) conceptualised the combined EAP as a programme in which short-term, in-house counselling should be provided as a diagnostic and a therapeutic process (Deitz, Cook and Hersch 2008:316), followed by a referral to service providers outside the organisation to render behavioural health treatment if necessary. A combined programme involves a relationship between an internal network of counsellors, occupational health physicians and external service providers for short-term focused counselling or specific treatment programmes which may not be available internally (Birkland and Birkland 2005:328). It was found that many of the programmes now used a hybrid model where assessments were conducted internally and other services were rendered by outside providers (Macdonald *et al.* 2006:55). Daniels *et al.* (2005:38) made a valid statement when claiming that EAP providers are moving away from the traditional model of service delivery within an organisation. The

movement tends to favour contractually provided services outside the organisation in order to provide a wide range of services as required by organisations. A combined programme is also considered to be a cost-effective solution for some organisations (Hughes 2006/2007:30).

Csiernik (2002:29) concluded that his research study found that there are distinct differences depending on which EAP model is used, while Hosie, West and Mackey (1993:358) confirmed that the different types of EAPs are structured differently to meet different goals. These differences need to be taken into consideration before a decision is made with regard to a specific model.

2.9.4 Placement and driver of the EAP

The physical location of an EAP may be on the worksite or locations away from the worksite, depending on the type of EAP implemented by the organisation (Gammie 1997:67; Kemp 1985:379). If the EAP is provided on the worksite, it offers convenience of access, while locations away from the worksite increase the sense of privacy and confidentiality (Kemp 1985:379).

Megranahan (1995:55) argued that 'the most common selector and driver of an EAP service will be the EAP personnel, human resource department, or occupational health department'. Frequently, the EAP is housed within the human resources, medical or benefits department, and Beidel (2005:299) proposed that the best and most dynamic placement of the EAP should be within the human resource structures. This approach can create the opportunity for integration and partnership. However, he is well aware of the ever-changing business environment and suggested that 'as the organisation changes over time, so too may the need for organizational positioning of the EAP' (Beidel 2005:300).

2.9.5 Capping of sessions

Csiernik (2002:26) highlighted the contentious issue of the capping of services within an EAP. He gave examples of organisations that capped EAP utilisation, especially when using external service providers, but questioned whether the capping of services was a norm within an EAP. The norm for deciding on the level of capping differs from organisation to organisation. Chan *et al.* (2004:1884) suggested that services could be capped from three to eight sessions to assess, provide treatment and/or refer an employee. Merrick *et al.* (2007:1262) confirmed that these three to eight sessions are for short-term counselling only, and that this approach was favoured by both internal and external providers (Kirk and Brown 2003:139). However, the literature mentions that the contractual agreement for external providers generally includes a cap of around six individual sessions of counselling per employee, whereas internal providers are less likely to set limits on the number of sessions provided (Kirk and Brown 2003:139). Greenwood, DeWeese and Inscoe (2005:2005) found that a greater number of sessions did not necessarily result in a more positive outcome. Csiernik (2002:30) argued that the capping of services serves no real purpose and his study revealed that there was no abuse of uncapped counselling in Canada.

2.10 STAFF MEMBERS OF THE EAP

An EAP typically includes a multi-disciplinary team of professionals to render the wide range of services needed by an EAP (Bailey and Troxler 2009:358). Csiernik (2002:30) studied several organisations and concluded that the preferred service providers are occupational health nurses when the occupational health service initiates the EAP. He also found that EAPs are often initiated by labour organisations and that these internally based programmes are more likely to use internal volunteers. In such cases, a social worker is more likely to be the key service provider, usually governed by a joint committee.

Masi (2003:78) is well aware of the importance of having an adequate number of staff trained in EAP (the program managers as well as counsellors) and insisted that the programme should have a formula for adequate staffing. The staff formula should make provision for two kinds of consultancy functions of the EAP profession: internal and external (Brueggeman 2002 in Chima 2005:70). Various categories of health care workers are used in the EAPs, for example, occupational health nurses, social workers and human resource professionals (Csiernik 2002:22). The staff providing services within the EAP must be professional service providers. Care should be taken to ensure that the health care professionals working in the EAP are licensed and registered (credentialing) with their respective professional boards (Bailey and Croxley 2009:358, Bidwood, Boudewyn and Fasbinder 2005:235). The importance of formal training for EAP staff members was raised in several articles. Kirk and Brown (2003:139) identified the need for the staff within an EAP to work towards developing workplace wellness in addition to worker wellness. Therefore, a dual relationship should be considered within the EAP with the organisation and employees as clients. The result of this dual relationship demands that staff members should be both professionally trained in counseling interventions and familiar with organisational dynamics and interventions. Kirk and Brown (2003:139) concluded that there could be counsellors who may not have received formal training, but that the majority has usually had some form of training. The lack of training was addressed by Lawrence *et al.* (2002:13) who stated that there is a role for graduate training programmes in the fields of psychology, social work, and counselling. Some organisations use counsellors with master's degrees (Hosie *et al.* 1993:358) or 'higher of any professionally recognised and regulated profession' (Csiernik *et al.* 2006/7:54). The appointment of trained counsellors could result in the increased confidence of employees in EAPs (Lloyd *et al.* 1999:194). Apart from EAP knowledge and skills, Chima (2005:66) suggested that additional knowledge of routine and non-routine technologies of an organisation is essential to the EAP staff member in order to make meaningful contributions to the health of the corporation. However, it is uncommon for EAP providers to have any training in organisational structure or design. South Africa is not excluded from the lack of EAP specific training, licensing and credentialing. Du Plessis (2001:107) found that EAP staff members, such as social workers, are

working with employees in the work place with generic training and limited previous experience. Specialist training for EAP practitioners started in 1986 and it was offered by one university only. Even in 2000, social workers' practices in the work place in South Africa are based on generic training.

Lastly, the consideration of different cultures is the norm in clinical practice and it should be part of best-practice in behavioural health care. It is recommended by that EAP practitioners should demonstrate experience with cultural diversity (Bidgood *et al*/ 2005:239, Owens 2006:94).

2.11 HUMAN RESOURCE DEPARTMENT

One of the main functions of human resource management is to facilitate changes in strategy and structure when new human resource policies and programmes are introduced (Ginn and Henry 2003:24). The introduction of such a new programme could include an EAP. Csiernik (2002:30) considered the human resource department as the most likely department to start the EAP in smaller organisations. There are no definite rules regarding the role of the human resource department in the EAP, but Ginn and Henry (2003:25) argued that an EAP works best when it is consistent with the organisation's stage of development and support of other existing human resource policies and programmes. Alker and McHugh (2000:315) supported the involvement of the human resource management (HRM) department by asserting that the perception exists that 'middle managers within the HRM department seem to take on the responsibility for promoting the EAP'. They also concluded that the EAP may assist human resource management in dealing with the difficult 'residual welfare role' (Alker and McHugh 2000:318). From these arguments, it is evident that the human resource department has a crucial role to play, but that this will depend on the strategies and structures of an organisation.

2.12 CONCLUSION

It is clear from the literature that EAPs were initially developed with the specific goal of assisting employees in dealing with alcohol-related problems. However, the demands and needs of employees and organisations have changed dramatically over the years. These changes were the driving force behind the rapid growth of EAPs worldwide. Usually, competition is associated with growth and, therefore, the need has arisen for EAPs to change and adapt their strategies to survive in a competitive environment. Researchers such as Roman and Blum, faced the challenges by compiling the seven core technologies (*cf.* 2.3.2). The goal of creating these core technologies was to drive and sustain employee assistance for the current and future international workplace (Beidel 2003:2). These actions and core technologies were supported by the EAPA. However, Daniels *et al.* (2005:38) expressed their concerns that EAP practices have not yet been standardised. The competition amongst EAP providers has put the main focus on the cost element, with some going as far as offering free or embedded EAPs with the purchasing of other health plans (Burke and Sharar 2009:60). The free or embedded EAPs could derail the development of appropriate quality and performance measures. In addition, Daniels *et al.* (2005:8) are unsure as to whether performance measures that are not standardised will lead to formal quality programmes. They recommended that more research should be conducted on quality measures for EAPs since, without acceptable quality measurements, organisations 'may only place value on the price of EAP and not quality' (Daniels *et al.* 2005:39).

The next chapter will discuss the concept of quality assurance and the measurement thereof in health and more specifically in behaviour health care.

CHAPTER 3

QUALITY ASSURANCE AND EVALUATION OF EMPLOYEE ASSISTANCE PROGRAMMES

3.1 INTRODUCTION

An EAP delivers a variety of services to its clients and can, therefore, be classified as a health care service delivery entity in the service industry. The need for the delivery of quality services to customers was a critical aspect during the 1980s (Kaplan and Norton 1996:87). Addressing the quality of health care should be a priority for any health care manager (Sajid and Baig 2007:545). However, the management of the quality of health care is easier said than done, but there is an increasing body of evidence to guide the implementation of proven quality intervention models (Kilpatrick, Lohr, Leatherman, Pink, Buckel, Legarde and Whitener 2005:347; Muller, Bezuidenhout and Jooste 2006:470; Pan and Kuo 2010:824). Evidence of these types of quality intervention models can be seen in several quality improvement methods that were developed and adapted from the production and manufacturing industry in an attempt to improve health care (Eagle and Davies 1993:853; Macdonald 1992:7; Wolfersteig and Dunham 1998:351). In spite of the availability of the above-mentioned methods, Kilpatrick *et al.* (2005:347) spoke on behalf of the policy makers when they emphasised the feeling of frustration due to the fact that these quality interventions are not being implemented to address all the major aspects, but instead are being used to improve only a few measurable aspects of the business. It must be noted that, even if quality interventions are not implemented on a broad basis, the simplest quality interventions could improve the quality of health care. However, health care institutions often struggle with the implementation of such interventions in general (Weiner, Alexander, Shortell, Baker, Becker and Geppert 2006:308).

There are several factors that could contribute to the difficulty of implementing quality interventions. One such factor is the lack of an acknowledged best-practice approach to quality improvement in health care (Buetow 2003:417). Another complicating factor is that health care provision is a very complex exercise provided through a multi-disciplinary approach (Muller *et al.* 2006:470). Lastly, Kilpatrick *et al.* (2005:348) are of the opinion that the lack of a business case for quality in health care is another complicating factor, as organisations do not measure health care interventions in terms of a financial return on their investments in a reasonable timeframe. Despite these factors and difficulties, the concept of quality improvement in health care should not be ignored. In fact, quality becomes increasingly important in health care for reasons such as the increased demand for cost effectiveness (Antti-Poika 1995:298), as well as the impact on the overall satisfaction of the end-user (Mayer, Purkayastha, Athanansiou and Darzi 2007:122). There is always the ethical imperative to enhance the quality of care provided to patients and to meet the expectations of such patients (Varkey, Reller and Resar 2007:735). The need for quality interventions resulted in the adaption of systems for the health care industry, such as continuous quality improvement (CQI) and total quality management (TQM) which, as mentioned previously, was developed for the manufacturing and production industries (Antti-Poika 1995:298; Eagle and Davies 1993:851; Muller *et al.* 2006:512). However, Blumenthal (1996c:1329) is not convinced that sufficient evidence is available to prove that systems such as TQM improves the quality of health care. Despite the arguments stipulating the need for quality interventions at the beginning of this chapter, it is questionable as to whether the implementation of such quality systems will ultimately improve the quality of health care. Amaratunga, Haigh, Sarsaheer, and Baldry (2002:141) suggested that more than just quality improvement tools are necessary and advised organisations with regard to the necessity for a balanced, strategic management system for quality improvement in order to ensure that organisations are healthy and effective.

A balanced, strategic management system for quality improvement should consist of organisational structures, responsibilities, policies and procedures, as well as the necessary resources (Antti-Poika 1995:298). By implementing such a system, an organisation aims to manage all the aspects of quality within its structure. An organisation cannot, however, manage quality improvement programmes until there is a way to measure it. Furthermore, measurement can take place only if an organisation is able to monitor the processes (Arah *et al.* 2003:377). Jackson (2001 in Schmidt, Bateman, Breinlinger-O'Reilly and Smith 2006:120) took this approach a step further by emphasising that 'what gets measured, gets attention'. Once all of the relevant role-players within the process have been identified and the various roles specified (Muller *et al.* 2006:473), such measurements will receive the necessary attention.

An EAP is part of health care and should not be ignored during the development of evaluation processes. Therefore, the need to monitor EAPs is of paramount importance from a managerial perspective (Amaratunga *et al.* 2002:145, Klazinga, Stronks, Delnoij, and Verhoef 2001:433) in what is known as performance management. Performance management is an evolutionary process that should be adjusted as experience is gained in the use of methods used to measure performance (Amaratunga *et al.* 2002:149). It should be viewed as a system that demonstrates the good, the bad and required improvements for future actions (Amaratunga *et al.* 2002:150). Performance measurement is not the end, but rather the beginning of addressing quality in health care.

This chapter will take the form of a discussion on quality and performance management in health care and will also elaborate on the quality management of an EAP.

3.2 DEFINITION OF QUALITY

In service delivery industries, quality is perceived as the comparison between the customers' expectation of a required service and their perception of the quality of the delivered service (Chaung 2010:369). Therefore, the quality of any service is conceptualised as an overall assessment of the services by customers (Ganguli and Roy 2010:405) usually conducted through surveys (Aday, Begley, Lairson, Slater, Richard, and Montoya 1999:sp34). Health care can be classified within the service industry and patients have certain expectations before utilising the services. Afterwards, they will have developed a perception of their experience which can be classified as their expressed satisfaction or dissatisfaction with that service. Therefore, the assessment of patient satisfaction with regard to the health care provided is a sensitive indicator of quality. Such an assessment of patient satisfaction is, however, not the ultimate quality assessment method to be used, since it is not the only aspect in determining whether or not quality health care was provided. The World Health Organisation (WHO) developed a framework for a definition of quality in health care and recommended that the quality should be determined through a process of benchmarking its efficiency, cost effectiveness and social acceptability (Wilkinson *et al.* 2004 in Sajid and Baig 2007:545). Judging from the WHO statement, the conclusion can be drawn that using the customer/patient's perspective of the service is just one component of quality assessment in health care. Researchers have investigated quality in health care for several decades in search of an appropriate and meaningful definition (Palmer 1991 in Blumenthal 1996a:892). Bodenheimer (1999:488) suggested using the definition of quality accepted by the Institute of Medicine:

The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.

It should be noted that the above-mentioned definition is just one of several definitions used to explain quality in health care. It is not always possible to use one definition to explain quality, since quality of health care has many dimensions and the various stakeholders involved in health care prioritise different components as crucial (Auras and Geraedts 2010:137). Even the users of health care can be seen as co-producers of health care itself. It has become evident that the definitions used by different stakeholders have some common key concepts embedded within them. It is not the purpose of this study to re-define quality in health, but it is significant to have a short, yet meaningful, discussion in order to understand the complex interaction between these common concepts. Researchers have provided several examples in their attempts to clarify the interaction between these concepts. In the following section, the opinions of these researchers with regard to the way in which they have formulated the complexity of these components will be addressed.

In 1982, Gronross redefined quality in the service industry by introducing a model that involved two dimensions for the measurement of service quality, namely technical and functional quality (Chuang 2010:370). Blumenthal (1996a:892), as well as Brook, McGlynn and Shekelle (2000:282), built on Gronross's theory in redefining quality in health care and noticed two similar aspects that should be included in the definition, namely (a) scientific-technical quality (appropriateness of services and skill of provider) and (b) the art of care provided (interpersonal care between provider and patient). Campbell *et al.* (2000a:1612) also included these important aspects in their definition, but separated the structure and the outcome of health care from the actual health care provided, stating that these two aspects are not components of health care, but instead may be seen as dimensions of health care. Mayer *et al.* (2007:124) considered quality from another perspective and were of the opinion that quality of care is a complex interaction between processes of care, as well as patient and clinical outcomes, resulting in a productive health system. These examples emphasise the complexity of several concepts used to define quality in health care.

It can, therefore, be concluded that it is almost impossible to use a single definition for quality in the service industry, in the same way that it is inappropriate to use only one method for managing quality. The next section will use these concepts to discuss quality and to elaborate on quality management with a specific focus on health care.

3.3 THE CONCEPT OF QUALITY MANAGEMENT

In the previous section of this chapter, it was indicated that quality in health care relates to the effectiveness of services provided by a health care system, the desired outcome, as well as the success in meeting the expectations of the users (*cf.* 3.2). In order to manage quality in health care, it is necessary to measure the actual performance of a health care system. These measurements can be performed using the components as described by Donabedian (often considered to be the father of quality measurements): (a) structure, (b) process and (c) outcome (Donabedian 1982 in Varkey *et al.* 2007:735). Each of these components covers a vast variety of elements and there are various types of performance measurement frameworks used to measure all the elements for the purposes of improvement (Pransky, Benjamin and Dembe 2001:296). It would, thus, be appropriate to develop a conceptual framework for performance management before continuing the discussion on the methods used in quality improvement.

3.3.1 Conceptual framework for performance management

A performance management system translates organisational strategy and goals into reality by showing what is actually taking place in the organisation versus what was planned (Lai 2010:694). Performance management consists of performance measurement, planning, implementation and the evaluation of the improvement (Dey, Hariharan and Despic 2008:445). Arah *et al.* (2003:391) studied the conceptual frameworks used for quality in health care in different countries. They came to the conclusion that there were as many frameworks as there were countries studied. However, the main focus remained on performance measurement with a proliferation of health care indicators (Arah *et al.* 2006:5). The World Health Organisation (WHO)

promotes a performance management framework and Table 3.1 captures some of the components that should be considered for inclusion in such a framework.

Table 3.1 Performance measurement framework for a health care system

Goals	Focus
1.1 Improve health of population	1.1.1 Average health status of population
	1.1.2 Reducing health inequalities
1.2 Responsiveness to expectation	1.2.1 Respect for person
	1.2.2 Client orientation
1.3 Fairness in financial contribution	1.3.1 Distribution
	1.3.2 Resources

Adapted from Arah *et al.* (2003:389).

Within the conceptual framework, the main goal of performance management is to meet national professional standards based on scientific evidence (Casparie 1998:205). Setting the mentioned standards can be seen as an important step in achieving the mentioned goal and these standards should be measurable (Casparie 1998:204). Boyce (1996:103) stressed the fact that performance management systems should be accompanied by explicit objectives to ensure measurement adequacy. The development of a conceptual framework is crucial to ensuring that people understand the detail of such systems, including the measurability, using appropriate indicators (Campbell *et al.* 2000a:1612).

3.3.2 Conceptual framework for quality management

Several researchers added additional dimensions and principles to performance management to extend the framework in order to cover more quality-related aspects. Examples can be found in the work of Chin and Muramatsu (2003:8), where they categorised the purpose of quality management into (a) accountability, (b) quality improvement needs, and (c) empowerment of customers. Another example is the

proposal by Mayberry, Nicewander, Qin and Ballard (2006:103) with which they challenged the health care sector to pursue the following six major goals within quality management:

- *Safety*: to avoid unnecessary injuries to patients inflicted during the health care processes
- *Timeliness*: to reduce harmful delays for both those who receive care and those who provide care
- *Effectiveness*: to provide services based on scientific knowledge to all who could benefit and refrain from providing services to those not likely to benefit (avoid under-use and over-use respectively)
- *Efficiency*: to avoid the wasting of equipment, supplies, ideas and energy
- *Equity*: to provide care that does not vary in quality due to personal characteristics, such as gender, ethnicity, geographic location and socioeconomic status
- *Patient-centredness*: to provide care that is respectful of and responsive to individual patient preferences, needs and values, ensuring that patient values guide all clinical decisions.

Other principles suggested by researchers include accessibility, relevance and appropriateness, as well as continuity of care (Muller *et al.* 2006:492). During the establishment of a conceptual framework for a quality management system, it is crucial to have clarity regarding questions, such as (a) the actual purpose of the system, (b) what should be measured, (c) how to deal with the data, and (d) the actual distribution of the results (Bird, Cox, Farewell, Goldstein, Holt and Smith 2005:5). Questions such as these will determine which principles are relevant and should be addressed within a particular quality management system.

Once the principles regarding quality have been decided upon, the next question to be addressed within quality management systems is the availability of data. Organisations should ensure that good data are available to enhance the 'planning-action-evaluation' process within the quality management system (Figure 3.1)

(Birkland and Birkland 2005:345). The proposed planning-action-evaluation process promoted the three steps essential to quality management, while Antti-Poika (1995:300) identified and added a fourth step, namely adjustment, as illustrated in Figure 3.1. The management of data throughout the entire process, including data collection, analysis and interpretation should be a continuous process and all the processes should be regulated by relevant policies (Muller *et al.* 2006:508).

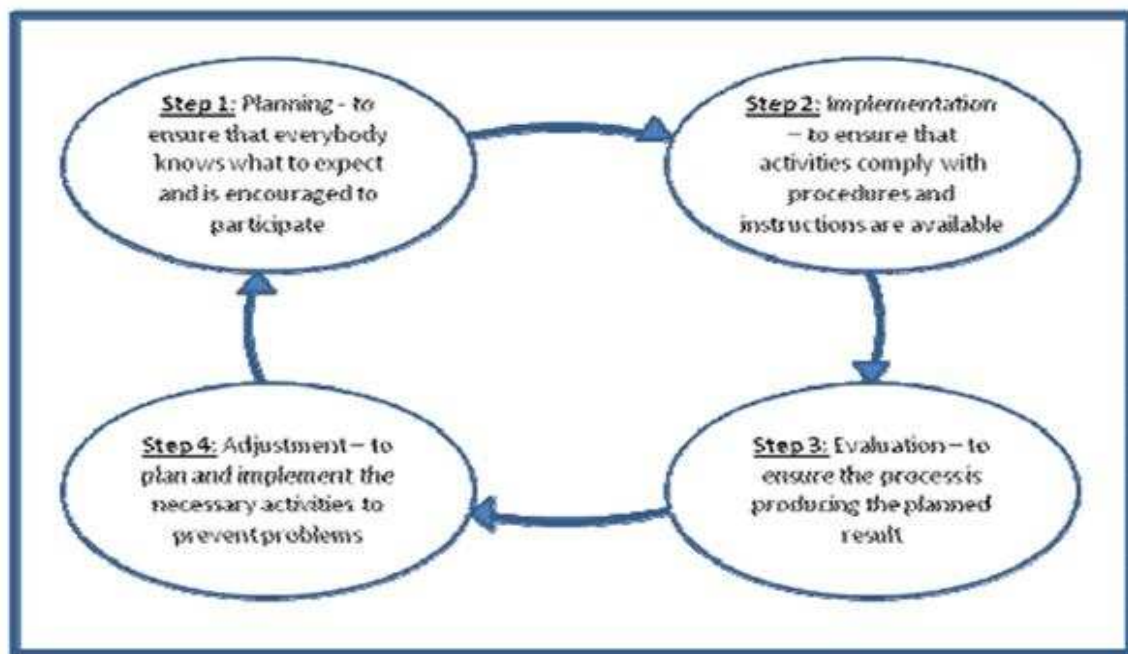


Figure 3.1 The four-step quality management approach

[Adapted from Birkland and Birkland (2005) and Antti-Poika (1995).]

This four-step quality management approach is usually used to improve simple processes or activities. The effectiveness of these steps will be evident when one evaluates the extent to which the planned activities were realised. It is recommended that the four-step quality management approach is applied in a broader and more complex context, for example, the degree to which the objectives of the programme are achieved rather than simply concentrating on the activities that are easily measured (Beckmerhagen, Berg, Karapetrovic and Willborn 2004:15). As the four-step quality approach is used within the broader and more complex context,

performance indicators can be used to measure the effectiveness of a programme as these give an indication as to whether or not the objectives are being met (Arah *et al.* 2003:392).

All of the additional elements and principles as discussed need to be considered when establishing a conceptual framework for quality management. Such a conceptual framework will clarify concepts within quality management and will streamline the planning and implementation processes. To conclude, it is evident that quality management should involve several components of the organisation. The recommendations made by Wolfersteig and Dunham (1998:351) to address quality through a balanced, multi-dimensional approach will be discussed in the next section.

3.3.3 The integrated approach

Health care involves a complexity of processes, but the integration of these processes is vital to ensure continuity of care. As continuity is considered to be one of the elements of quality in health care (*cf.* 3.3.1), there is a growing interest in the move towards the integration of the processes in health care to improve quality (Blumenthal 1996b:1148). Such integrated care could enhance client satisfaction, efficiency and outcome, while decreasing costs (Minkman, Ahaus, Fabbriotti, Nabitz and Huijsman 2009:66). As health care becomes more integrated, it will become more difficult to address quality of health care, using separate quality improvement methods. The integration of separate quality improvement methods within health care processes is not easy and the health care industry experiences difficulties with regard to the integration of quality improvement methods. In order to address these difficulties, a dynamic, yet balanced approach, to quality management is proposed with the focus on addressing quality through an integrated cause-and-effect system (Fernandes and Pacheco 2007:141).

A balanced quality management process can be conceptualised as a balanced approach between components, such as structure, process and outcome measures, with the latter always seen as the 'gold standard' (Aday *et al* 1999:sp29, Boyce 1996:101; Brook, McGlynn and Clearly 1996:966). Currently, a great deal of emphasis is placed on outcome measurements (Brennan 1998:723) and these types of measures are vital in the monitoring of the quality of health care (Boyce 1996:103; Ibrahim 2001:43). Statistics is an important source of information in outcome measurements. Appropriate analysis, interpretation and utilisation of statistics should be the backbone of the quality assurance process (Taylor 1988:724). Although these measurements can be seen as the cornerstones of a quality management strategy, several variations are found in the literature (Baranski 2002:125; Mearns and Havold 2003:408). Both these authors recommended that performance measurements should be based on input measures (measures of the hazard burden), process measures (leading indicators), and outcome measures (lagging indicators) in a balanced approach. Another variation of a balanced approach, as suggested by Santiago (1999:1572), is that quality can be assessed by examining adherence to standards or, alternatively, by using scorecards along the following four axes: (a) clinical outcomes, (b) functional outcomes, (c) patient satisfaction, and (d) financial outcomes. A third variation of addressing the integration of quality management can be found in the five domains of health system performance identified by Arah *et al.* (2003:382), namely (a) acceptability, (b) accessibility, (c) appropriateness, (d) competence, and (e) continuity. Yet another variation in quality management, introduced by Blumenthal (1996c:1328), is the concept of producing reports in health care, but he warned that it could be confusing and cumbersome to health care providers. Agreement between health care providers with regard to the actual standards and purpose for such quality reports is desirable (Csiernik *et al.* 2001:40).

A balanced approach therefore implies that input, structure and output measures are combined and viewed as a balanced unit, as such measures could have an impact on each other (Dey *et al* 2008:462, Giuffrida, Gravelle and Roland 1999:97). Ibrahim (2001:432) concluded the debate on the integration of quality management by indicating that more research efforts are needed into the actual construction of a core

set of diverse and independent measures or a comprehensive programme consisting of performance indicators, as well as ways in which to evaluate the effectiveness of these indicators. Organisations should consider the appropriate principles to ensure that they adopt a balanced approach to quality management. The aim of the next section is to discuss how quality is managed within the field of EAP.

3.4 QUALITY MANAGEMENT AND THE EAP

Behavioural health care is part of the service industry and represents a continuum of services to promote the well-being of people through intervention in human behaviour (Aday *et al.* 1999:sp27). An EAP can be classified as a component of such a continuum (Chaifetz 2010:5; Fogarty 2008:11; Hargrave, Hiatt, Alexander and Shaffer 2008:290). If the EAP is considered to be part of behavioural health care, there is a need for the development of a specific framework to address quality and performance within an EAP. The development of such a framework is problematic due to the lack of standardisation in the EAP field and the difficulty in drawing comparisons between organisations (Courtois *et al.* 2004b:47). Another concern, as explained by Highley (1996:6), is that many EAP providers have a perception that EAP benefits could not be quantified. These stumbling blocks, however, have not hampered the development of quality assessments for EAPs. Researchers have continued to search for ways of combating the negativism, and Michalak (2002:165) identified factors, such as determining the correct choice of quality assessment methods, based on the needs and capacities of an organisation. In the early years of EAP evaluation, Macdonald already proposed a five-step approach for the comprehensive evaluation of EAPs (Macdonald 1986 in Csiernik 2004:22). The first two steps, namely the needs assessment and programme development, were used to determine the goals, objectives and rationale for an EAP. French, Zarkin and Bray (1995:sp) confirmed that the initial steps are critical and should consist of a detailed process description of the EAP. Both authors agreed that only after the initial description of the EAP can the last three steps be implemented in the format of an evaluation of the inputs, processes and outputs (Aday *et al.* 1999:sp30). Many of these measures are used by

simply adding the numbers in each category (using statistics) or in monetary terms (real or standardised monetary value assigned to each unit) (McGlynn 2008:sp). Kirk and Brown (2003:140) suggested the same format for evaluation, but added that cost benefit analyses seemed to be the most frequently studied outcome measure (Csiernik 2004:27). There are also several other cost analysis systems available (Bell, Urbach, Ray, Bayoumi, Rosen, Greenberg and Neumann 2006:699). The cost benefit analysis is done by calculating all the direct and indirect costs of the EAP in total Rand value and then comparing it with what the costs would have been in the absence of an EAP (Masi 1997:385). Another very common method used is the return on investment (Reiter, Kilpatrick, Greene, Lohr and Leathermann 2007:52) (Courtois *et al* (2004b:50)) recommended that the quality management system should address the key aspects of the EAP that could have a major influence on the quality of the programme itself.

Another example of a stumbling block in quality management and the ways in which researchers have tried to address it, is the concept of utilisation of the EAP by the intended employees and supervisors. Korr and Ruez (1986 in Csiernik 2003c:46) emphasised the importance of quantifying the number of people that utilise an EAP before a programme can be evaluated. There are different opinions on the actual measurement of utilisation and some are considered to be incorrect (Masi 1997:382). Kendall, Rice, Gale, Trice and Yarbrough (2006/2007:124) used a simple method of calculating the utilisation as the number of employees registered as EAP clients in conjunction with the number of consultations by managers. Csiernik (2003c:58) developed a rather complicated EAP Utilisation Scorecard which provides a more comprehensive representation of the activities of an EAP. There is uncertainty, however, as to whether such a complicated scorecard will make a meaningful contribution towards the already complex phenomenon of quality in health care (Courtois *et al*. 2004b:46). Yet, the utilisation of the EAP by employees is a critical component of EAP evaluation. On the other hand, Shakespeare-Finch and Scully (2004:74) were not of the opinion that levels of utilisation of an EAP are the most valid way of determining the success of the programme as it only measures the

'accountability' of an EAP. Even so, measuring the utilisation rate could still be an acceptable starting point for the formal evaluation process of an EAP.

The evaluation of an EAP could provide the following information (Highley 1996:6):

- Justification for having an EAP
- Whether the EAP has achieved the objectives set
- Determine the effectiveness and quality of the EAP services
- The need to introduce quality improvement cycles
- Determine whether the EAP is correctly design to address the needs of the health care institution

In conclusion, it is evident that the evaluation of EAPs has come a long way since the inception of these types of programmes. It is also clear from the literature that efforts have been made to create acceptable frameworks in order to address the stumbling blocks in quality management systems for these programmes. Due to the fact that behavioural health care as a service industry is extremely complex, it is not surprising that there currently is no standardised quality management system available that is accepted by all the role-players in EAPs (Daniels *et al*/2005:38). It appears, therefore, that it would be difficult to develop and implement a standardised quality management system for all the EAPs in various health care institutions, but certain generic elements could be included as standardised measurements. The practicality of the development of standardised measurements should be researched, but previous research (Berridge and Cooper 1994:4; Clemmet 1998:17; Csiernik 2004:32, Gammie 1997:66) has found that organisations would rather use several quality management systems in the industry than spend valuable resources on research to develop standardised quality measures. The standardisation of these systems can also be questioned. The following section will discuss three of these quality systems, ranging from the earliest to the most recent developments in EAP evaluation.

3.4.1 Audit

Beckmerhagen *et al.* (2004:16) defined an audit as:

a system in which various interrelated processes and resources are directed towards achieving predetermined goals (e.g. compliance with requirement or identification of areas for improvement).

Karapetrovic and Willborn (2000:681) provided more clarity with regard to an audit when they stated that it consists of the collection and evaluation of objective evidence against pre-determined audit criteria. In practical terms, an audit is the process 'of observing the practice and comparing it against the standard' (Macdonald 1992:8). An audit process can be summarised as (Macdonald 1992:8):

- Establishing standards
- Observing the practice
- Comparing the practice against the standard
- Implementing the required changes
- Formulating new standards.

These five steps are the cornerstones of what is called the audit cycle and are the simplest methods of quality evaluation. These cycles can be initiated by the organisation on a formal and/or informal basis and can be performed on various levels. Quality audits are usually used as a tool for assessing the effectiveness of quality improvement efforts, as well as for the evaluation of compliance with quality standards (Karapetrovic and Willborn 2000:679). These assessments could include remedial actions to solve problems or address deficiencies (Muller *et al.* 2006:491) or to bring the underperformed practices in line with the set standards (Paxton, Whitty, Zaatar, Fairbairn, and Lothian 2006:108). Therefore, an audit can be conceptualised as a system with a set of interdependent processes (or activities), using human, material, infrastructural, financial, information and technical resources to achieve

objectives related to the continuous improvement of performance and quality in health care.

An international collaboration on standards was initiated, which resulted in the establishment of the International Standardisation Organisation (ISO) in 1947. The collaboration also resulted in the development and acceptance of the well-known ISO 9000 standards in 1987. The ISO 9000 quality system is a management system which can be applied to almost any industry (Bell, McBride and Wilson 2001:16). The standards used in ISO 9000 were originally developed for the manufacturing industry, but they were adapted in 1994 to accommodate service delivery industries, such as the health care sector. These standards are used for certification purposes by accredited certification bodies (Muller *et al.* 2006:474). In addition, standards such as these could be used for benchmarking when conducting an individual audit. Self-auditing or using an outside organisation to conduct audits is an essential basis for continued improvement and further development of the services (Highley 1996:6). Organisations can use similar standards for conducting regular audits in order to report on their EAP. These audit reports could provide management with appropriate quantitative and qualitative information to identify possible amendments to the organisation's EAP and thereby continuously improve the effectiveness once an EAP is operational (Clemmet 1998:17; Greatbanks, Elkin and Manville 2010:582, Harris *et al.* 2002:60). Using qualitative methods to evaluate an EAP is not a new concept and can be used to great effect (Masi *et al.* 2000 in Greenwood *et al.* 2005:2) such as to call for an increased use of additional impact information as was described by Greatbanks *et al.* (2010:582).

The advantage of a regular audit and review process is that it is a major driving force for continuous quality improvement in EAPs. The disadvantages of auditing include the lack of available literature on and standardisation of the effectiveness of audits in the EAP environment, nevertheless Beckmerhagen *et al.* (2004:14) have called for continuous improvement audits to be conducted despite the identified shortcoming. Macdonald (1992:11) recommended that audits be constructive and friendly and be based on prior agreement on the standards.

3.4.2 Benchmarking

Daniels *et al.* (2005:39) are of the opinion that decision makers lack the necessary information and tools to make informed decisions on the effectiveness of the EAP without standardised performance measurement systems and benchmarking tools. Benchmarking, which was introduced in order to improve the competitive advantage of organisations, is a method that has gained considerable popularity over the last ten years, especially in Japan (Mehregan, Nayeri and Ghezavati 2010:877). Lai (2010:695) defined benchmarking as:

a process in which an organization tries to learn from the best-in-class organization, determines how the best-in-class achieves superior performance levels, and utilizes those practices as benchmarks to their own organisation.

The process of benchmarking analyses the gap between current practices, which then serve as the baseline, and best-practices, which is the benchmark. On completion of the analysis, the next step is to identify what can be learned from the new ideas that were identified and to then institute continuous improvement programmes utilising these learned lessons (Balm 1996 in Mehregan *et al.* 2010:877).

Benchmarking is thus an accepted quality assurance system, which can be adopted for the specific purpose of quality assurance in EAPs. The benchmarking process can be conducted using a competitive or process benchmarking approach (González, Quesada, Mack and Urritia 2005:313). Megranahan (1995:56) recommended the following generic stages within any of the two benchmarking approaches, namely a focus on, and identification of, the practices to be benchmarked; analysis of each practice; identification of practices that are of such a standard that they can be used for comparative purposes in establishing the benchmark; and a detailed qualitative and quantitative analysis of certain processes, such as assessment and short-term counselling processes. Once the benchmarks have been established, it is important to communicate what has been learned within the organisation and inform the

potential users as to what the benchmarks are. The final stage is the implementation of the quality review process.

It is strongly recommended that benchmarking should be used as an essential component of continuous quality improvement strategies with the aim of comparing the performance of organisations in order to identify the most effective and efficient operations and to learn from one another (Lai 2010:695).

3.4.3 Accreditation

Quality in health care can be further assessed by evaluating its adherence to certain standards (Santiago 1999:1572). An accreditation programme and the process of accreditation can be classified as such a system. Since 1970, several health care accreditation programmes and organisations have emerged. The programmes have developed internationally to such an extent that, in some countries, accreditation is an accepted and critical element of quality improvement activities (Greenfield and Braithwaite 2008:172).

Accreditation programmes are developed by identifying the core accreditation elements and standards are then set for these elements. The next step is the development of a number of criteria for each of the standards to ensure that an organisation can measure itself against the standard. The process of accreditation is performed through the measurement of compliance with the defined set of criteria (COHSASA 2000:sp). Care should be taken not to confuse the accreditation process with the auditing process. The difference between the two involves the type of standards that are utilised. During an auditing process, general, non-specific industry standards, such as the ISO 9000 standards, are used while, for the accreditation process, the organisations are assessed, using standards that were specifically developed for an industry such as health care (Muller *et al.* 2006:482). A further difference is that, within the accreditation environment, the concept of quality also refers to the effective utilisation of resources to achieve appropriate objectives. In an

audit, this term refers to the adherence to certain standards as agreed by role players.

Internationally, accreditation programmes in health care have increased dramatically in recent years (Heidemann 1999 in Walshe, Wallace, Freeman, Latham and Spurgeon 2001:368). Michalak (2002:165) mentioned that an accreditation programme is used for the accreditation of hospitals and that different systems of accreditation are based on the fulfilment of numerous accreditation standards. A programme, such as an EAP for health care workers in a health institution, could be considered to be a system within that hospital and could be part of the accreditation process. Identifying the correct criteria for the accreditation standards for measurement purposes is regarded as a necessity. If the criteria are too detailed, the comparison is not feasible. On the other hand, if the accreditation approach is too extensive, the idea of accreditation might be lost. Walshe (2001:368) expressed his concern about the absence of research used to demonstrate the value of accreditation. Another concern might be that accreditation is designed to reduce risk and proving its effectiveness is inherently difficult (Brennan 1998:715). Despite these concerns, the process of accreditation serves as a mechanism for quality assessment and improvement in many different spheres of health care (Dalrymple and Scherrer 1998:10). It could be even more valuable if it is used in conjunction with a benchmarking process (Hartley and Jorgenson 2003:91).

The need for an accreditation programme in the field of EAPs arose from the lack of standardised practice guidelines to assist with the description of what constitutes a well-functioning EAP. Another need for an accreditation programme stemmed from the fact that the environment of EAPs is largely unregulated and many EAP providers do not provide the necessary services that define a true EAP. During the 1980s, a set of standards was developed to address this issue (Pacinella 2003:29). Subsequently, the accreditation process for EAPs has evolved significantly and, in 2003, four groups of organisations had already established themselves in standard development (Hartley and Jorgensen 2003:90). As with the accreditation process in hospitals, EAP accreditation is a widely debated concept with limited consensus and consistency on

the impact and value of such programmes (Greenfield and Braithwaite 2008:172; Shaw, Kutryba, Braithwaite, Bedlicki and Warunek 2010:341). One of the reasons for the limited consensus can be found in a qualitative study conducted by Sharar and Hertenstein (2005:56). They identified the lack of compliance with quality standards of practice as a critical issue within the EAP profession. Several other obstacles were also identified in utilising accreditation as a quality improvement method in the field of EAPs (Sharar and Hertenstein 2005:60) such as:

- Exclusion of outcomes
- Lack of demand from employers
- Lack of involvement of employers
- Pragmatic drawback, since accreditation might consume already scarce financial resources, as well as the energy and time of the EAP staff.

In the case of accreditation for the health care industry, Marcelissen and Weel (2002:173), as well as Sharar and Hertenstein (2005:59), concluded that the accreditation of a health programme certifies that such a programme has utilised standardised key practices, which should improve accountability. It implies that accreditation is a process in which a programme is certified to be structured in such a way that a constant level of quality is achieved in the comprehensive package of services. It has become more evident that patient-centred aspects are continuously being incorporated into accreditation programmes to further improve accountability (Auras and Geraedt 2010:135).

The accreditation of an EAP will give an organisation 'peace of mind' in that its EAP has met recognised standards of operations and professional conduct. Sharar and Hertenstein (2005:59) further remarked that an accredited EAP might provide 'an official statement to employers that their EAP provider is in compliance with recognized standards of quality'. The accreditation process could be a positive move towards establishing such standards – Stockert (2003:44) had no doubt that to have common, industry-wide standards of best-practice is important, since they could also identify weaknesses in an EAP (Hartley and Jorgensen 2003:90). This movement

towards having industry-wide standards could facilitate the much-needed continuous quality improvement in the field of EAPs, but might not be the most optimal method in doing so.

The next section will explain why having a single quality improvement method, such as benchmarking between best-practices or an accreditation process for EAPs, is not necessarily the most effective method in quality management, and why organisations rather should consider a comprehensive approach towards quality management.

3.5 BALANCED APPROACH

The latest trend is for health care organisations to adopt multi-dimensional performance management systems (Chen, Yamauchi, Kato, Nishimura and Ito 2006:339, Harris *et al.* 2002:60). A balanced approach is needed between the critical aspects of quality measurements with the adaptation of possible quality assurance approaches to ensure that the performance management systems remain focused on critical issues. Such a balanced system was developed by Kaplan and Norton (1996:7) in the 1980s, called the Balance Scorecard method. It is a recognised quality measurement tool which can be successfully applied across multiple and diverse industries (Hepworth 1998:561). The Balanced Scorecard was initially developed to complement financial reporting and the emphasis was on financial, as well as non-financial, measures as part of an information system that was available to all employees (Kaplan and Norton 1996:8). These measures are aimed at monitoring organisational performance across four linked perspectives that are associated with the creation of value for the organisation (Kong 2010:286). The four perspectives are (Chen *et al.* 2006:341; Mearns and Havold 2003:409; Muller *et al.* 2006:480):

- Financial perspectives
- Internal business processes/internal management
- Customer/service user
- Learning and growth/continuous improvement.

The measures in these four perspectives represent a balanced approach between external measures for customers and internal measures of critical business process, innovation and growth, which can be found in the Balanced Scorecard method (Kaplan and Norton 1996:7). The main purpose of the Balance Scorecard is to translate a business unit's mission and strategies into tangible objectives and measures. These measures are balanced between the outcome measures (i.e. the results from the past) and the measures that should drive the performance in the near future. Kaplan and Norton (1996:10) concluded that the Balance Scorecard approach is structured in such a way that it creates a balance between important objective, easily quantifiable outcome measures and other subjective, sometimes judgmental performance drivers of the outcome measures. However, the developers of the system warned that the Balanced Scorecard is not a controlling system, but that it should rather be used as a communication, information and education system (Kaplan and Norton 1996:25). Eventually, the application of the Balanced Scorecard translates an organisation's vision, strategies and values into a comprehensive set of measureable performance measures (Kaplan and Norton 1996:25; Muller *et al.* 2006:481).

The Balanced Scorecard method can be utilised in the health care environment as was proven by Chen *et al.* (2006:348) who tested the Balanced Scorecard method with success. It is possible to adapt the Balanced Scorecard method and this is advisable in order to reflect the objectives of different organisations (Kong 2010:286). An example of such an adaptation can be found in the work of Santiago (1999:1573) in which he suggested adding a fifth perspective to the four perspectives as stipulated in the Balanced Scorecard of Kaplan and Norton, namely 'Outcome'. This fifth perspective is in line with the concepts used in quality measurement in health care as previously discussed in this chapter. Evidence of adaptation can also be found in the fact that there is already a third-generation Balanced Scorecard (Manville 2007:162). The first-generation Balanced Scorecard combined financial and non-financial indicators within the four perspectives. The second-generation Balanced Scorecard emphasised the cause-and-effect relationship between measures and strategic objectives. The third-generation Balanced Scorecard develops strategic control

systems by adding action plans/targets and linking these to incentives (Gurd and Gao 2008:8).

The Balanced Scorecard method should be viewed as a conceptual tool (Sasse 2005 in Gurd and Gao 2008:16) and the four perspectives should be considered as a template rather than a 'strait-jacket' (Kaplan and Norton 1996 in Kong 2010:291). The downside of the Balanced Scorecard is the lack of understanding by managers with regard to how it can be used effectively (Speckbacher 2003 in Greatbanks *et al.*, 2010:573). Kaplan and Norton (1996:192) identified four possible barriers that could result in the lack of understanding or the actual implementation of the Balanced Scorecard, namely (a) the vision and strategies of an organisation are not actionable; (b) the strategies are not linked to specific departmental, team and individual goals; (c) the strategies are not linked to resource allocation; and (d) the lack of feedback on how strategies are being implemented and whether it is working. In order to address the lack of understanding, Kaplan and Norton (1996:199) suggested several approaches, such as a strategic alignment from top to bottom, as well as educating and involving the people who will be responsible for implementing the Balanced Scorecard methods. Another method to strengthen this approach is to link the formal compensation system of the employees to the scorecard measures. Such an approach might lead to organisational commitment to learn and understand the Balanced Scorecard, resulting in a balanced performance across a broad set of leading and lagging indicators (Csiernik 2004:30, Kaplan and Norton 1996:222).

The adaptability of the Balanced Scorecard system is the main attraction for a complex programme such as an EAP. Furthermore, with the Balanced Scorecard, it is possible to measure intangible aspects of behavioural health care which organisations usually find difficult to measure (Greatbanks *et al.* 2010:573). Questionnaires can be considered as a standard data collection tool regardless of the setting (MacAlister 1999:465) and it is useful to measure intangible aspects of behavioural health care. Questionnaires could be useful in the self evaluation of employees entered into the EAP. The assumption is that the most reliable information

regarding the assistance offered by the EAP will come from the person who had a problem and actually used the service (Harris *et al.* 2002:60).

There appears to be compelling evidence that the focus should move away from a single measurement system, while moving towards a basket of measurements that are required for the balanced measurement format. The multi-measurement focus could provide much-needed information with regard to a wide range of activities, but it should be a structured approach, using established rules of engagement and scientific methods (Varkey *et al.* 2007:738; Wiener 2006:310). Such a multi-measurement approach, which can be seen as an alternative to the Balanced Scorecard, is the SERVQUAL model which has been specifically developed for the service industry. Ganguli and Roy (2010:406) are of the opinion that SERVQUAL is probably the 'most widely-known and researched scale of service quality' with the main focus of the model on the human interactions during the service encounter. Parasuraman (1988 in Pan and Kuo 2010:828) developed the model as his research revealed that a customer's assessment of service quality fits into ten potentially overlapping dimensions. In 1988, Parasuraman *et al.* developed a redefined model that involves 22 quality items spread among five service dimensions: (a) reliability, (b) responsiveness, (c) assurance, (d) empathy and (e) tangibles (Chaung 2010:369; Ganguli and Roy 2010:405; Pan and Kuo 2010:828; Sajid and Baig 2007:547). Measuring the outcome of health care, and for that matter an EAP, in terms of morbidity and mortality, can only provide unilateral assessment of the competency of such a system or programme. The adoption of a balanced approach in the quality management of an EAP will not only enable the management of an organisation to ensure the highest quality of service within such a programme, but it can also create much-needed transparency and trust in the programme.

The majority of methods for quality assessment, if not all, require an appropriate set of indicators (Michalak 2002:169). Despite several challenges, these sets of indicators should be developed and tested in-house, while ensuring that the indicators are in line with the organisation's mission (Chen *et al.* 2006:342). For example, any indicator that is used in a Balanced Scorecard should not only fit in with the four

perspectives, but should fit into an operational framework to facilitate the necessary identification of problems (Mearns and Havold 2003:408). The adaptation of such an indicator system could eventually lead to improvements (Chiu, Yang, Lin and Chu 2007:23). A detailed list of key performance indicators will not be provided in this chapter. It is not the purpose of this chapter to discuss all the indicators in detail, but rather to clarify the concept and introduce the adaptable approach in health care. Ultimately, choosing the effective key performance indicators for the system should fit in with the mission of the organisation and this is often a major challenge. An indicator in itself is a well-defined concept and is defined as:

a retrospectively measurable element of practice performance for which there is evidence or consensus that it can be used to assess quality of care provided and hence change it (Campbell, Braspenning, Hutchinson and Marshall. 2003:817).

Thus, indicators can be seen as management tools for managers to use in the processes of monitoring and evaluation, as well as in the decision-making process (Klazinga *et al.* 2001:433). Baranski (2002:125) emphasised the use of performance indicators to provide stakeholders with information on the effectiveness and efficiency of workplace health management. For indicators to be effective, that data must be available and it must be clear as to what the indicators are supposed to measure (Campbell, Cantrill and Roberts 2000b:427). It should further be specified who should utilise these indicators (Mant 2001:475). The chosen indicators should not be used to measure poor performance, but should rather be used to identify possible problem areas for further investigation and to activate a quality assurance system, such as the planning-action-evaluation system (see Figure 3.1). An example is to determine, by utilising a simple descriptive method like counting, the number of specific problems seen in the EAP (Guiffrida, Gravelle and Roland 1999:96). It might be possible to link specific problems to a common cause resulting in the implementation of a quality improvement cycle to address the identified cause. The challenges in establishing a balanced approach with neatly fitted indicators are multiple, and Santiago (1999:1571) and Chen *et al.* (2006:339) identified the need to address the following:

- Identify key performance indicators that measure quality
- Understand the design of quality indicators so that they assess the critical aspects of quality
- Understand how these measurements are causally linked to each other leading to the desired results
- Decide what will be done with these measurements and how they will serve all the role-players.

Indicators are used in different ways to manage quality in health care, but in the past, the focus was mainly on two aspects of care, namely clinical and financial (Santiago 1999:1573). Some health care providers are adopting multi-dimensional performance assessment systems with a wide variety of indicators as assistance due to the fact that quality in health care can also be viewed as multi-dimensional (Hudelson, Cleopas, Kolly, Chopard and Terneger 2008:31). Furthermore, indicators can be used as a mechanism for benchmarking (Chiu *et al.* 2007:21) and thereby create a link between two different quality performance systems. Ibrahim (2001:431) warned, however, that the development of performance indicators needs careful planning and that before a decision can be made, three questions must be answered: (a) what is important in the EAP, (b) what can be measured, and (c) what should be the degree of scientific soundness of the measurement in terms of validity and explicitness of the evidence base. The use of quality indicators is crucial in capturing definite quantitative results of quality improvement efforts (Silimperi, Franco, Veldhuyzen, van Zanten and Macaulay 2002:72). The indicators of performance do not measure quality itself but it is the human interpretation of indicators that measures quality (Kazandjian, Wood and Lawthers 1995:41). An example is the monitoring of the relapse rate of health care workers that can give an indication on whether there is a problem with the quality of the services provided by the EAP. It is, however, not recognised as a good measurement standard as there are many factors to be considered for the relapse before a final decision is made on the quality of services within the EAP (McGlynn 2008:sp). It would be possible to develop specific indicators for measuring quality in

an EAP, but these should be in line with the quality management method and strategy of the organisation.

3.6 CONCLUSION

An EAP should be well planned, effectively implemented and the quality of the programme should be managed by means of relevant systems. The result of an effective and well-monitored EAP should be a workforce with fewer problems and a higher morale – with higher productivity and greater flexibility for the organisation (Highley and Cooper 1994:46). The effective EAP needs to add maximum value in human resources and other organisational areas (Highley 1996:7). Numerous quality performance methods have been developed (Eagle and Davies 1993:185; Grol 2000:297), but their effectiveness has not been unequivocally proven. One approach to measuring quality is the use of a comprehensive scorecard model in an integrated manner, consisting of a critical set of indicators and linked to organisational strategy (Wolfersteig and Dunham 1998:353).

Daniels *et al.* (2005:53) called for further research to create innovative programmes, as well as the development of strategies for implementation. These research activities within organisations should move beyond the content of the quality framework to modify the context within the performance environment (Arah *et al.* 2003:393). The quality framework should not replace the actual performance and these two approaches should stimulate a culture of continuous improvement. The call from Daniels *et al.* (2005:53) for further research motivated the researcher to conduct a qualitative research project into a framework for a best-practice EAP and the quality management thereof in the health care sector. An effective EAP benefits all those involved.

CHAPTER 4

METHODOLOGY

4.1 INTRODUCTION

Research is described as a combination of processes used to search for and generate knowledge (Lategan 2005:11). These processes are conducted according to scientifically accepted guidelines, called the research design, which includes the collection, analysis and interpretation of data (Bryman 2001:28; Mouton 2001:53). Research in health care focuses on producing practical knowledge as research outcomes, which can assist with real-time decision making and problem solving (Chenail 1992:sp). These outcomes are generated by researchers, using quantitative and/or qualitative research.

Historically, quantitative research is deeply rooted in clinical research (Pompe and Sharar 2008:217) in order to have control over the circumstances and variables (Cohen and Crabtree 2008:331, Henning *et al.* 2004:3). A quantitative research approach is specifically used to test a theory by performing hypothesis testing in a deductive form of reasoning (Schurink 1998:241) and to generalise the outcome of research to a larger population (Grim, Harmon and Gromis 2006:525).

Qualitative research, on the other hand, focuses on the generation of theory, using an inductive approach to be tested only at a later stage (Golafshani 2003:600). Generalisation, as well as the testing of theories, is not a priority in qualitative research (Bryman 2001:20; Strauss and Corbin 1990 in Soklaridis 2009:720). In summary, the distinction between a qualitative and quantitative paradigm lies in the quest for understanding and in-depth enquiry (Henning *et al.* 2004:3). However, it is not uncommon to have a quantitative and qualitative research design in a research project complementing each another. Table 4.1, adapted from Babbie and Mouton

(2001:272), illustrates the significant differences between qualitative and quantitative research methodologies.

Table 4.1 The questions asked with regard to the characteristics of qualitative and quantitative research

Questions	Qualitative methods	Quantitative methods
What is the approach to the setting?	Natural setting within the whole context	Controlled setting with selected samples
What is the aim/purpose of the research?	Thick description with interpretive understanding	Quantitative description, which is explanatory and based on prediction
What is the research strategy/nature of research process?	Inductive Contextualisation Unknown variable Flexible guidelines	Hypothetico-deductive Generalisation Known variable Established guidelines
How would the data be collected?	Informative, small groups Open-ended, interviews, observation	Representative, large groups Standardised instruments
What type of data analysis would be used?	Inductive	Deductive
How are the results presented?	Personal voice and words, interpretation with individual quotes	Numbers and statistics in a formal voice type

4.2 THE QUALITATIVE RESEARCH APPROACH

The researcher was confronted with concerns regarding the EAP in a hospital setting. These concerns included the feasibility, appropriateness and effectiveness of such an EAP for the specific institution. Questions and concerns that led to this study included the following:

- Should health care institutions invest already limited resources in the implementation of an EAP for its employees?
- What is the actual role of the EAP in a human resource strategy?
- Do employees utilise the EAP in accordance with its intended purpose?
- Does the EAP contribute any value to the institution?
- Do employees benefit from services being rendered by the EAP?

All of these questions focus on the EAP as a social phenomenon, but more specifically, on two domains, namely (a) what the best way is of rendering EAP services within a health care institution, and (b) how an institution monitors the quality and value of the EAP. A qualitative research design provided the researcher with an opportunity to explore the EAP as a social phenomenon in a natural setting and to collect and report on the informed opinions and views of the research participants (Maxwell 1998:75). Furthermore, the researcher wanted to identify unanticipated influences to generate new grounded theories as health care is constantly changing, which might have an impact on employee assistance. Many health care workers might have different opinions about employee assistance and the associated influences, but they might lack the understanding of underlying processes. Very often, health care workers generate too much information on employee assistance, resulting in disorganised, confusing and overwhelming employees, as well as disrupted services. A qualitative research paradigm was used to gain a deeper understanding of the reflections of supervisors and managers in the health care sector with regard to the activities that are taking place around the EAP, as well as how it is understood and experienced (Soklaridis 2009:719). Furthermore, it is important to organise and present these reflections in a structured and practical manner.

4.3 RESEARCH DESIGN

Any decision with regard to the design, analysis or reporting of a study depends on the purpose of a study. The research designs in qualitative research can be classified into basic, applied, summative, formative and action research (Patton 2002:213). The purpose of this study leaned towards an applied research approach since the researcher wanted to contribute knowledge to the EAP in the health care sector in order for the managers to have a broader concept of the EAP, thereby allowing people in the health care sector to utilise the EAPs more effectively (Patton 2002:217). In order to elaborate on an applied research approach, the researcher decided to use an exploratory, descriptive research design to provide a better understanding and detailed picture of employee assistance as it occurs naturally in the health care setting (Bickman, Rog and Hedrick 1998:14). This approach placed the study in the framework of naturalistic ontology (Bowen 2005:210; Schurink 1998:240). Naturalistic research has five principal types of interactive modes of inquiry, namely biography, phenomenology, ethnography, grounded theory and case study design (Babbie and Mouton 2001:279; Fouche 2005:268; Leedy and Ormrod 2005:144; Lodico, Spaulding and Voegtler 2006:267; Nieuwenhuis 2007:71; Schurink 1998:240).

The researcher decided on a case study design, since the focus of the research study was on the 'how' and 'why' questions relating to the EAP with regard to the health care sector. The second reason for this approach had to do with the fact that it was not possible for the researcher to manipulate the behaviour of the participants in the study. There was interaction between the researcher and the participants, but without 'attempts to manipulate the phenomenon of interest' (Golafshani 2003:600). Lastly, the research design allowed for the research to 'cover' the contextual conditions relevant to the EAP under examination (Baxter and Jack 2008:545). These reasons are summarised in the criteria for a case study presented by Merriam (1998 in Shank 2002:54), namely particularistic (case studies focus on a particular phenomenon), descriptive (end-product of case study is a rich, thick description of the phenomenon), and heuristic (case studies illuminate the reader's understanding of the

phenomenon). Babbie and Mouton (2001:281) mention that, in an attempt to understand the influences on subjects' perspectives and behaviours, case studies take multiple perspectives into account within their contexts. Therefore, the EAP was investigated within the health care sector, since it could depend on complex human behaviour and interaction between employees, employers and patients. However, it is not always easy to define the boundaries between the EAP as a phenomenon and the health care sector as context (Yin 2003 in Baxter and Jack 2008:545). The researcher did not want to give a mere description of the EAP as a case, but tried to identify patterns, relationships and the dynamics within an EAP. Furthermore, the researcher wanted to unravel the complexity around human behaviour and a formal EAP programme (Henning *et al.* 2004:32), as well as the dynamics around the EAP (Nieuwenhuis 2007:76) in order gain a better understanding of the phenomenon. The point of departure in deciding on a design was based on the following research question:

If the best-practice EAP is developed and adapted for a health care institution, can a balanced, quality management framework be developed and implemented based on the best-practice EAP?

The design of the study consisted of empirical and non-empirical study methods to collect the required evidence (Mouton 2001:57). The design had a descriptive and exploratory focus to provide a detailed description of employee assistance as the phenomenon under investigation as experienced by health care workers. The research was conducted in phases and Phase One consisted of a literature review (Chapters 2 and 3). The details of each study method used in the rest of the phases are discussed later in this chapter.

4.4 THE FOCUS GROUP DISCUSSION AS RESEARCH TECHNIQUE

Phase Two of the study consisted of an empirical study, namely a focus group discussion, which is a recognised data collection method in the format of a group interview. Focus group discussions started in the 1920s as a market research technique (Khan and Manderson 1992:56). The process consists of a discussion session of about 6-10 participants for about 60-120 minutes (Patton 2002:385). A number of related questions on a specific topic are the focus of the conversation under the facilitation of a moderator (Patton 2002:386; Stewart and Shamdasani 1998:505). It is, therefore, viewed as a collective, rather than an individual, research method (Patton 2002:388). The participants of these groups are selected because they are known to have been involved in a particular relevant situation (Bryman 2001:337).

Focus group discussions as a research method can be used for many reasons and the researcher regarded the following as significant for this study (Stewart and Shamdasani 1998:506):

- Generating impressions from experienced participants on the social phenomenon with a focus on the relevance thereof on existing concepts
- Obtaining (and confirming) important additional issues/elements deemed important by participants
- Stimulating new ideas and creative concepts regarding the social phenomenon not already identified.

Khan and Manderson (1992:56) and Shank (2002:124) suggested a fourth reason for conducting focus group discussions, namely to gain a deeper understanding of the perceptions and beliefs of participants through probing into critical aspects. With a deeper understanding of perceptions and beliefs it is possible to make meaningful interpretations of the collected data. This approach is crucial when interpretation is needed of the perceptions of employees and supervisors regarding the EAP.

Apart from conducting focus group discussions as a data-capturing method, there were several other advantages of conducting focus group discussions. An important advantage is that participants become an active part of the process of analysis. They develop perspectives as a consequence of talking with their fellow participants who express similar experiences (Kitzinger 1995:300). In addition, it is possible for participants to build upon the responses of their fellow participants (Schurink, Schurink and Poggenpoel 1998:325). Lastly, the group synergy fosters more creativity and provides for a greater range of thoughts, ideas and experiences (Nassar-McMillan and Borders 2002:sp).

The target population for focus group discussions involves individuals who all possess specific characteristics to ensure a certain group dynamic appropriate for the study objectives (Steward and Shamdasani 1998:512). Sofaer (2002:333) mentioned that sampling is a critical element of a successful study. Warren (in Henning *et al.* 2004:71) suggested three approaches to sampling participants in qualitative research, namely theoretical, snowball and convenience sampling, but Henning *et al.* (2004:71) added purposive sampling as a fourth approach. She stated that purposive sampling contains elements of theoretical sampling, which searches for people who can assist in building the substantive theory. Purposive sampling is a sampling procedure with the aim and power of identifying and selecting information-rich participants with certain characteristics to ensure an in-depth study rather than 'empirical generalization' (Onwuegbuzie and Leech 2007:240; Patton 2002:230; Stewart and Shamdasani 1998:511).

Within the purposive sampling approach, there are several sampling strategies that can be used. Two relevant strategies for this study are maximum variation sampling and theoretical sampling (Miles and Huberman 1994:28; Patton 2002:243; Smit and Cilliers 2006:307). Maximum variation sampling is conducted as a means of gathering information from a wide range of participants in order to obtain a variation of inputs on the phenomenon. With theoretical sampling, the participants are selected because 'they represent a theoretical "population"' and could be regarded as spokespersons to give relevant inputs on the phenomenon being studied (Henning *et al.* 2004:71). In

addition, they are selected based on their potential representation of important theoretical constructs. However, they do not represent a specific population and the results cannot be generalised.

There is no perfect combination of individuals in a focus group, but the main focus should be on the group dynamics and the research objectives (Stewart and Shamdasani 1998:512). Several authors are in favour of a homogenous group to ensure the mentioned group dynamic (Khan and Manderson 1992:57; Grim *et al.* 2006:520; Grudens-Schuck, Allen and Larson 2004:sp). Schurink *et al.* (1998:314) are of the opinion that such a group increases the validity of the outcome. The maximum variation sampling strategy, as suggested by Patton (2002:243), Miles and Huberman (1994:28) and Smit and Cilliers (2006:307), assured that groups demonstrated a degree of diversity with regard to gender, professional background, and racial groups, but the sampling strategy kept the group homogenous since it remained focused on the health care sector. This diversity of the groups contributed towards a wide variety of attitudes and beliefs, while it stimulated the much-needed conversations within the group (Khan and Manderson 1992:62; Kitzinger 1995:300; Patton 2002:243).

Bryman (2001:339) is of the opinion that it is unlikely that just one focus group discussion will serve the needs of the researcher, since there is always the possibility that the responses are particular to that one group. Grudens-Schuck *et al.* (2004:sp) supported this statement with an emphasis on conducting multiple sessions from a diverse population in order to understand the perspectives of a variation of participants. Livingstone and Lunt (in Bryman 2001:340) used the concept of saturation as another criterion in determining the number of focus group discussion sessions. They determined the number of focus groups by 'continuing until comments and patterns began to repeat and little new material was generated.' Theoretical saturation is the accepted term and means that once the major categories for analysis have been saturated, it is appropriate to halt the group discussion and data collection.

It is the responsibility of the researcher to develop a research instrument with a clear structure to allow probing and group discussion to extract in-depth data that would otherwise be missed by other research methods (Grim *et al.* 2006:527). A well-framed research question was needed not only to guide the type of selection of participants, but also to ensure that a clear and identifiable agenda was drafted (Stewart and Shamdasani 1998:510). Furthermore, Sofaer (2002:333) stated that focus group discussion sessions can be successful only when conducted by a skilled and flexible facilitator, but Stewart and Shamdasani (1990 in Schurink *et al.* 1998:319) indicated that there is no best 'type' of facilitator.

For the purposes of validity and reliability (Huysamen 1994:198), as well as the refinement of methodology (Joubert 2007:50), it is mandatory to test out any newly developed research tool by means of a pilot study. In qualitative studies, the purpose of a pilot study is to determine whether the data gathering methods and tools, such as a questionnaire, will render relevant data as identified in the objectives of the study. However, a statistically correct pilot study does not play as important a role in qualitative studies as in quantitative studies (Strydom and Delport 2002:337). The details of the pilot study are discussed later in the chapter.

The limitations of the focus group discussion received thorough attention during this study. The limitation of the generalisation of results to the larger community is one of the disadvantages of this method of data collection (Stewart and Shamdasani 1998:509). On the other hand, the purpose of the focus group discussions was to generate data in order to establish the basis for a framework for a best-practice EAP and was not meant to be generalised across other domains. A concern raised by Patton (2002:387) is the fact that there is a possibility that controversial and highly personal issues could cause the participants to be hesitant to speak. Concerned employees, employee assistance and the supervisors' experience could be seen as controversial or personal issues, but the facilitator was experienced and addressed these issues prior to and during the sessions. A third limitation that was considered while conducting the focus group discussion was the fact that the facilitator had less control over the participants than within an individual interview (Schurink *et al.*

1998:324). Participants had the opportunity to influence the course of the discussion because of their interaction. As a result, it was possible that the participants could have influenced one another. Fourthly, another possible limitation of the focus group discussions could have been a perceived lack of confidentiality while speaking in a group (Kitzinger 1995:300). Lastly, Kitzinger (1995:300) also mentioned that one of the disadvantages of focus group discussions is that 'the articulation of group norms may silence individual voices of dissent'. The researcher considered all these limitations before and during conducting the focus group discussions to ensure that the data was gathered in a scientifically acceptable manner.

4.5 CONDUCTING THE FOCUS GROUP DISCUSSIONS

After considering the recommendations in the literature, as well as available resources, the researcher initially decided to conduct four focus group discussions in various health care institutions. The researcher conducted the focus group discussions with participants in health care institutions as the natural environment (Morgan in Bryman 2001:341) to gain an in-depth understanding of the participants' perspectives on the EAP as social phenomenon (*cf.* 4.4). A maximum number of twelve and a minimum number of six participants were sampled to participate in four focus group sessions in order to share their experiences and opinions with regard to the EAP.

The sampling approach was based on the fact that the EAP is a management prerogative used by all levels of employees and the focus group discussions were held with managers and supervisors experienced in employee assistance from the public and private health care sectors. The researcher used a combination of maximum variation sampling, as well as theoretical sampling strategies (*cf.* 4.4). The combination of the two selection strategies was used to identify supervisors with diverse characteristics, such as working in public and private institutions, level and types of health care services provided, as well as the category of health care worker, in an effort to include the spectrum of supervisors in a health care institution (see Table 5.1). The participants were also supervisors dealing with troubled employees or

those who have had experience in dealing with an EAP. These supervisors were seen as having characteristics, opinions or experience with regard to the EAP and related circumstances and were selected for their potential to provide meaningful contributions relevant to the EAP as the social phenomenon being studied (Mays and Pope 1995:111). To ensure homogeneity in the focus groups, the researcher selected participants from various institutions on the basis that they were all supervisors (common characteristic) in their respective working areas. This was done to avoid domination of one participant over the others and to stimulate interaction within the group.

Particular care was exercised regarding the number of participants in a group. If the sample size is too big, it could prohibit the extraction of thick, rich data. On the other hand, a sample size that is too small makes it difficult to achieve data saturation or informational redundancy (Onwuegbuzie and Leech 2007:242). The decision to include six to twelve participants was taken since that particular group size will enable the participants to share their experiences without reservations, while providing sufficient diversity of perceptions (Schurink *et al.* 1998:314).

The following health care institutions were selected to participate in the study:

A. From the public sector

- Provincial Department of Health – Provincial Head Office, Bloemfontein
- Universitas Academic Hospital – Bloemfontein (tertiary hospital)
- Pelonomi Hospital – Bloemfontein (regional hospital)
- Free State Psychiatric Complex – Bloemfontein (psychiatric hospital).

B. From the private health care sector:

- Rosepark Hospital – Bloemfontein
- Medi-Clinic Hospital – Welkom
- Netcare Kroon Hospital – Kroonstad.

The first focus group discussion consisted of participants selected from Universitas Academic Hospital, Pelonomi Hospital and the Provincial Department of Health in the Free State Province. The rest of the sessions were conducted with participants in their respective institutions as stipulated above. The researcher decided to remove Netcare Kroon Hospital from the study since no approval was obtained to conduct the study in the specific institution. In order to stay within the number of focus group discussions as agreed, it was decided to replace Netcare Kroon Hospital with Bayview Hospital in Mossel Bay. Reasons for the inclusion of this specific institution pertained to the fact that the hospital is not run by a major health care company, the type of health care services provided, as well as its involvement in student training.

The researcher contacted the executive manager of each hospital personally to explain the purpose of the study and to request approval to conduct the study in his/her respective institution. A formal information leaflet regarding the study and focus group discussion was left with the manager and after approval was obtained, the researcher requested the executive manager to identify supervisors in certain working areas with experience dealing with troubled employees and/or the EAP and who are willing to participate in a focus group discussion. These supervisors represented a theoretical population most suitable to providing information-rich data. The researcher then selected some of the nominated supervisors based on criteria, such as gender, position in the management structure, and working area. The researcher ensured that the supervisors represented a wide range of categories of staff (Bryman 2001:340) and included nursing personnel, administrative personnel, paramedical personnel and support/hotel functions personnel.

The selected supervisors received an information leaflet (*cf.* Appendix A) and consent form (Appendix B). All the participants were asked to complete and sign the consent form before they were permitted to participate in the focus group discussions. The details of the supervisors who participated in the focus group discussions can be found in Table 5.1.

Based on the literature study and personal experiences of the researcher, an agenda for the focus group discussion was drafted. Twelve questions were included in the agenda as suggested by Stewart and Shamdasani (1998:513) (Appendix C). The questions were drafted in such a way that the group's discussion remained focused on the main research question, yet still gave the participants the freedom to express their own opinions and share their experiences to generate rich data. The questions were designed to ensure that there would be some comparability between the various focus group discussions. Factors that were considered during the compilation of the agenda were (Bryman 2001:346):

- The sensitive nature of concerned employees and the subsequent EAP to be used as a management tool
- The levels of interest in a best-practice EAP
- The level of knowledge and experience amongst participants in the field of EAPs
- Important issues to the participants and the specific information needs of the researcher.

The following areas were covered by the focus group discussion agenda:

- The necessity of an EAP for the health care industry
- The necessary elements of an EAP
- Practical implementation issues
- The evaluation of the EAP
- The impact of the EAP in an institution.

The questions proceeded through four stages: introductory, transition, key and wrap-up (Grim *et al.* 2006:527; Schurink *et al.* 1998:318). The last part of the agenda consisted of an open invitation to address issues that were not covered by the questions or that had not been discussed by participants. Each question on the agenda was allocated a specific time period so that each session would not continue for more than 120 minutes.

The focus group discussion agenda was subjected to a pilot study to ensure that the items and questions in the focus group schedule were precise, clear and unambiguous, and in the case of the focus group questions, free from bias (Strydom 1998:183). A pilot study was conducted by making use of three staff members from the department in which the researcher was working. The purpose of the pilot study was to ensure that the questions were understood by participants. Only minor adjustments were made to the questions after the pilot study.

Each focus group discussion was held in the respective hospital, except for the first session, which was held in Pelonomi Hospital. The focus group discussion sessions were held in the boardroom or a meeting room of the hospital behind closed doors and were scheduled to start at 10:30. The discussions were facilitated by an experienced facilitator, being a professional nurse herself. Participants were seated around the table in such a way that it was possible for them to have eye contact with one another, as well as with the facilitator. The facilitator sat at one end of the table. The use of the table was convenient since it enabled the participants to show more body language without being self-conscious (Schurink *et al.* 1998:318). A number was placed in front of each participant and they were requested to refer to the number and not the name of participant during the discussions. The researcher, as observer, occupied a back seat away from the ring of participants, but ensured that he had a full view of all participants in order to make field notes. Each session started with an introduction by the facilitator explaining the purpose and methods to be used for the focus group discussions. A tea break with refreshments was arranged one hour into the session. The participants were allowed to speak about their work situation during the tea break.

It was not the aim of the focus group discussions to reach a consensus as to what should be included in a best-practice EAP. On the contrary, the discussions were focused so as to obtain as much information as possible from participants' experiences and feelings with regard to specific aspects of the EAP (Schurink *et al.* 1998:315). Despite the fact that the methodology and questions were designed to produce good, focused conversation, the researcher anticipated that participants

would insist on having their say with regard to the EAP (Grudens-Schuck *et al.* 2004:sp). The facilitator used an impartial approach to maintain a balance between the needs of the participants to express their opinions and the natural features of conversation. Her approach allowed the participants to let off steam, make jokes and have a few laughs, while the sessions could have functioned as a debriefing session as well. The questions were structured to encourage open, unbiased discussion rather than short, abrupt responses (Grudens-Schuck *et al.* 2004:sp). It was critical to ensure that questions would not evoke extremely strong, emotional feelings in order to avoid unnecessary conflict within the group. Only on a few occasions was it necessary for the facilitator to re-direct the conversation away from possible conflict. However, it was not necessary to make any changes to the questions/agenda during the course of the five sessions since they stimulated conversations as it was intended to do.

Each focus group discussion was audio-taped by making use of a small digital recorder after the process was explained to the group. The facilitator negotiated in advance for the shared protection of all participants (Smit and Cilliers 2006:307) and set the ground rules to which all had to adhere. The rules included issues, such as confidentiality, anonymity, privacy and disclosure. The facilitator stressed the fact that focus group data were collective group data and would be treated as such. This was done to ensure that participants were relaxed during the discussion without worrying about victimisation. All participants gave permission for the discussions to be recorded and nobody left any of the sessions. The researcher as observer took field notes of the interactions between participants and concluded each session by thanking participants for their participation and explained the way forward.

4.6 DATA ANALYSIS

Data management is a critical element in qualitative research and consists of various processes with regard to the collection, capturing, storage and retrieval in a systematic manner (Poggenpoel 1998:334.). Three main types of data are used in qualitative research analysis, namely transcribed interviews or conversation, written field notes of the researcher's observations and reflections recorded by the researcher. Qualitative data analysis is based on an interpretative philosophy on the making of meaning with regard to the specific phenomenon under study. An inductive analytical process is recommended for such an interpretative approach to allow research findings to emerge from the data by analysing participants' perceptions, attitudes, knowledge, values, feelings and experiences (Nieuwenhuis 2007:99). The findings from an inductive approach emerge in the format of frequent, dominant themes inherent in the raw data without being restrained. It is important to keep in mind that qualitative research is conducted by means of words and numbers. Words could have multiple meanings and are meaningless unless the reader moves backwards and forwards between them (Miles and Huberman 1994:56). Therefore, it is crucial to put specific key words into perspective rather than analysing them as stand-alone entities. It is also possible to use a deductive approach, where the categories are formulated in advance (Nieuwenhuis 2007:99).

Several data analysis strategies in qualitative research are available. A content analysis strategy is one of the accepted data analysis strategies in a case study research approach, using a pattern recognition method. The pattern recognition method is initiated by reading the transcribed data and dividing the data into meaningful analytical units. Recurring words or themes are used to identify core consistencies and meanings (Patton 2002:452). These meaningful segments are coded, using a unique coding system made up of descriptive words or symbols (Nieuwenhuis 2007:105). When using an inductive approach, researchers develop these codes as they code the data. A prior coding system is used in a deductive analysis approach. In prior coding, codes are identified before reading through the data. For example, a list of codes was developed with the aid of a literature review.

A researcher has enough raw data when the raw case data have been accumulate until saturation is achieved. Saturation is one of the key issues when qualitative research is conducted, but Morse (1995:147) emphasised the fact that there are no rules or guidelines that guide the process of analysis regarding saturation. Merton (in Grim *et al.* 2006:522) argued that 'topical saturation' must be obtained. This means that focus group discussions must continue until the groups no longer produce significant or new information and data adequacy has been achieved (Morse 1995:147).

The process of analysis for this study initially began with a deductive approach and was followed by an inductive approach. The initial deductive approach consisted of the development of a coding framework during the literature review phase of the study. A list of *a priori* codes (descriptive words) were drawn up from recurrent words and phrases identified during the literature review. The inductive approach was used during the second and third phases of the study. During these phases, the researcher allowed new themes and information to emerge from the data.

After the initial literature review, data was generated through the focus group discussions (*cf.* 4.5). These discussions were recorded on a digital recorder. The researcher transcribed each recording verbatim and saved it onto a computer. A copy was printed of each transcription for the sake of record keeping. The researcher read through each transcript several times after which he started the coding process. During the analytical process, the researcher also used an inductive approach in the format of *in vivo* coding by discovering and allowing patterns and themes to emerge from the data (Miles and Huberman 1994:65; Nieuwenhuis 2007:99; Patton 2002:453). The deductive approach was continued by coding the data, using the coding framework developed during the literature review phase of the study. Afterwards, both coding systems were combined into a master coding system (Appendix D), using NVivo8 computer software.

The analyses continued, using content analysis, which included the identification and grouping of meaningful and recurrent word phrases, the observation of behaviour during focus group discussions and nonverbal communication to formulate meaning, called themes or perspectives (Grudens-Schuck *et al.* 2004:sp; Kilcullen 2007:99; Nieuwenhuis 2007:101; Stewart and Shamdasani 1998:517). Each section of the discussions was coded, using this comprehensive coding scheme. Furthermore, the researcher used cross-case analysis by grouping together answers from various participants and focus groups to the questions asked, while analysing different perspectives on a certain theme. This was done by grouping words and phrases together (Grudens-Schuck *et al.* 2004:sp). Individual case analysis was not considered as a means to avoid confusion (Patton 2002:440). The themes that emerged were analysed into clusters, themes and broad categories (Kilcullen 2007:99) and a short description was written for each category. Where possible, subcategories were developed.

Figure 4.1 shows the summarised pathway of the data analysis.

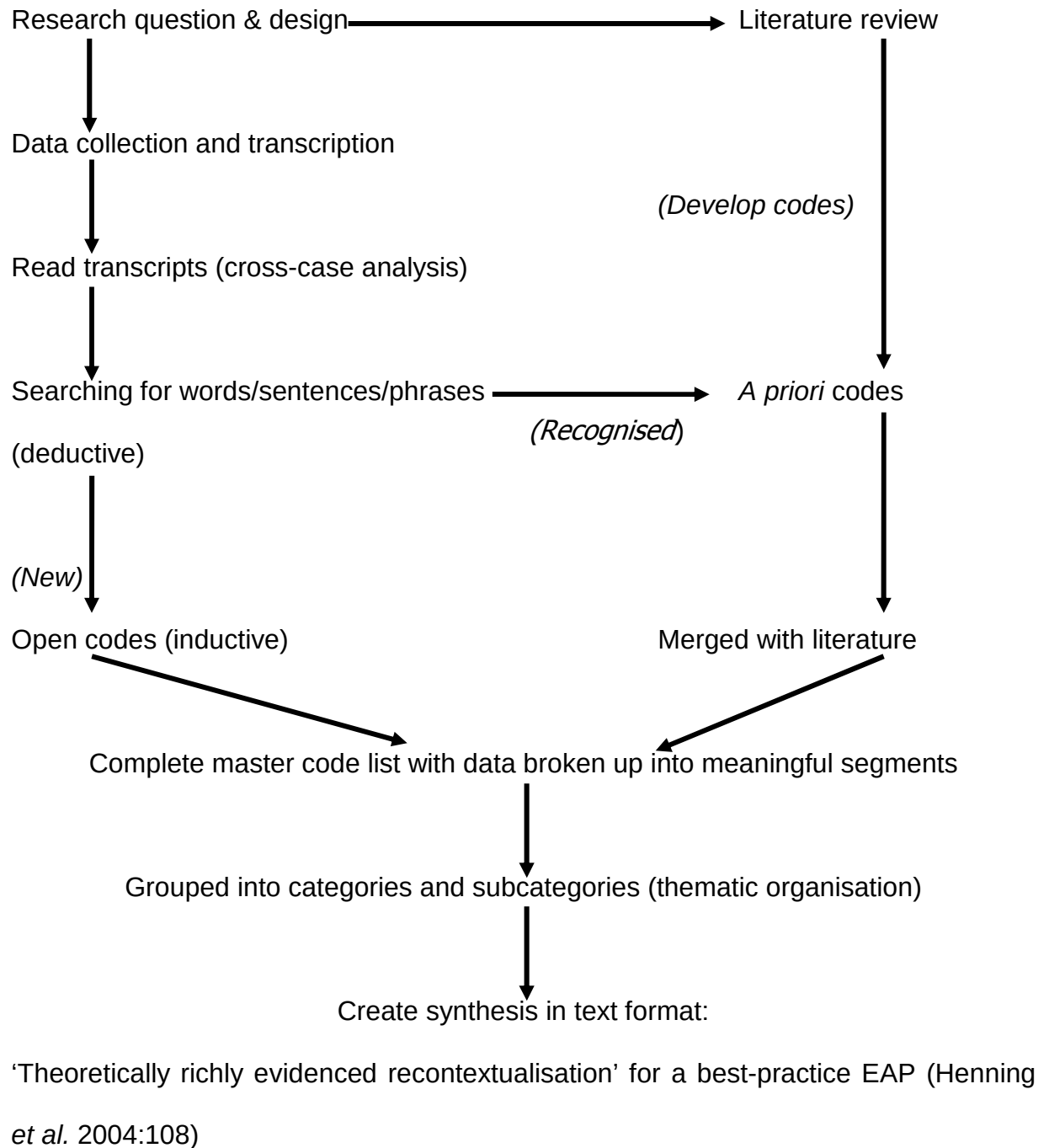


Figure 4.1 Data analysis pathway [Adapted from Henning et al. (2004:104).]

The focus group discussions were conducted over a period of six months. After each focus group discussion, the researcher reviewed the content, as well as the field notes of each session, while monitoring each session for possible saturation. Therefore, it was possible to consider additional focus group discussion sessions if data saturation was not achieved. The researcher did consider the number of times that issues were discussed to determine saturation. Saturation was defined as the accumulation of sufficient rich data to make sense of the EAP as a social phenomenon, build a comprehensive and convincing theory with no gaps around it, while no new information was emerging from the raw data (Goldie, Dowie, Cotton and Morrison 2007:612; Morse 1995:148). During the fourth focus group discussion, new information did emerge and the researcher decided to arrange a fifth focus group discussion. After the fifth focus group discussion, it was decided that saturation had been achieved since no new information was emerging and repetition of codes appeared.

It was not possible to unitise all the discussions from the sessions. The process of conducting multiple focus group discussions made unitisation even more difficult. However, the researcher identified common themes by considering responses to particular questions in all the discussions (Stewart and Shamdasani 1998:518). Deviant case analysis was important and, therefore, minority opinions and examples that did not fit in with the overall codes and themes received as much attention. In coding the script of a group discussion, it was worth using special categories for certain types of narrative, such as jokes and anecdotes, and types of interaction, such as 'questions', 'deferring to the opinion of others', 'censorship', or 'changes of mind' as part of the analysis (Kitzinger 1995:302). The last step was to classify the content of the discussions into categories established to maintain meaning.

The researcher treated the data as suggestive rather than conclusive (Sofaer 2002:334). While this method of data analysis does not produce substantive theory that has some level of generalisability, it produces thick, rich descriptions that can assist in understanding the issues regarding the EAP (Kilcullen 2007:99; Patton 2002:437). The data analysis was used to establish possible criteria to be included in

a framework for a best-practice EAP. The next phase of the study was to submit the criteria derived from the focus group discussion analysis to a panel of experts in the format of a Delphi survey. The next section is a discussion of the Delphi survey with the subsequent rounds to achieve consensus on criteria to be used in the framework for a best-practice EAP.

4.7 THE DELPHI SURVEY AS RESEARCH TECHNIQUE

The literature review on EAPs (*cf.* Chapter 2) revealed the counterarguments and lack of agreement with regard to what an EAP should consist of. It is, therefore, necessary to combine opinions and judgments to address this lack of agreement (Powell 2003:376). The Delphi survey was identified as an appropriate method of finalising the elements of a best-practice framework for an EAP for the health care industry. The use of the Delphi survey is not new in health care research (Loo 2002:762). Its flexibility and adaptability made it the appropriate method of finalising the framework for a best-practice EAP by using the method of consensus amongst a panel of experts (Powell 2003:376; Smith 2010:247).

The Delphi survey was developed in the 1960s with the aim of seeking expert opinions with regard to specific situations (Dalkey and Helmer 1963 in Clayton 1997; Loo 2002:762). The technique was named after the legend of the Greek Delphi oracle, which had a network of informants considered to be one the most truthful (Kennedy 2004:505). Before a major course of action was taken, the oracle at Delphi was consulted to assist with correct and timely decisions (Loo 2002:762). De Villiers, de Villiers and Kent (2005:642) defined the Delphi survey as a method during which a researcher collects opinions from subject-matter experts on a particular topic. Furthermore, it is a group facilitation technique that seeks to achieve consensus with regard to the opinion of experts through a series of structured questionnaires referred to as rounds (Ali 2005:718; Baker, Lovell and Harris 2006:61; Hasson, Keeney and McKenna 2000:1009; Kreithier and Kinicki 1998:375). However, little consensus remains as to who is an expert but concluded that 'experts are multifaceted' and it is not easy to justify their inclusion (Baker *et al.* 2006:61). Furthermore, it is argued that

the Delphi survey does not meet the standards set for other scientific methods (Sackman in Jones and Hurter 1995:379). Keeney, Hasson and McKenna (2006:208) addressed this concern by suggesting that it is often necessary to design the Delphi survey according to the aims and objectives of a research study.

Jones and Hunter (1995:377) highlighted several studies in which the Delphi technique was used to clarify particular issues in health service organisations. However, Hasson *et al.* (2000:1013) warned that there are no clear guidelines for a Delphi survey. De Villiers *et al.* (2005:639) and Baker *et al.* (2006:61) identified three types of Delphi surveys, namely conventional, real-time and policy. The conventional Delphi is the classic version where a questionnaire is sent to a group of experts, followed by a second questionnaire based on the outcome of the first questionnaire. During the rounds, the proposals are refined and prioritised. The real-time Delphi is a short variant, which takes place during the course of a meeting in order to summarise the responses of the respondents immediately. The purpose of a policy Delphi is to gather options and supporting evidence rather than reaching a final decision with regard to the process.

The conventional Delphi was the most appropriate survey for the final phase of this study. It was necessary to give participants an opportunity to offer their opinions and to achieve consensus with regard to relevant criteria emerging from the previous phases of this study to be included in a best-practice EAP. The use of a conventional Delphi technique as a last phase for this study rendered the results more significant and the decision to use the Delphi survey to achieve consensus on the framework for the best-practice EAP is not uncommon in health and social research (Hasson *et al.* 2000:1013).

The major advantage of the Delphi survey is that it is an inexpensive and reliable tool for obtaining the opinion of experts with regard to a controversial issue, such as employee assistance. The technique offers the experts a certain amount of freedom in expressing their opinions on a specific issue (De Villiers *et al.* 2005:642). Another advantage of the Delphi survey is that it provides a communication process via the

electronic media without the need for experts to travel extensively to a meeting place; thus further avoiding direct face-to-face confrontation (Clayton 1997:sp). On the other hand, the anonymity of the Delphi survey could be seen as a disadvantage, since it might result in a lack of accountability with regard to the views expressed. However, this is not unique to the Delphi survey in that the same could be said of any other anonymous data collection process (Powell 2003:378). A second disadvantage of the Delphi survey is that it can be a very time-consuming exercise and this may encourage hasty decision making by experts. A third disadvantage of the Delphi survey that should be considered is that consensus can be assisted through providing individual and group feedback after each round. It is unknown as to whether or not experts were influenced by both individual and group ratings (Clayton 1997) and it was not possible to determine whether this was the case during this study. But one cannot ignore the possibility because Romm and Hulka (1979:310) found that the final outcomes were influenced by the response of individual experts.

Selecting knowledgeable people as experts to participate in the Delphi survey is a challenge and the process of selecting appropriate experts is crucial to ensuring the effectiveness of the Delphi survey (Ali 2005:731; Baker *et al.* 2006:62; Clayton 1997; Loo 2002:764). De Villiers *et al.* (2005:640) defined an expert as someone who possesses the relevant knowledge and experience, as well as the respect from their peers, with regard to their opinions. The discussion on sampling for the Delphi survey continues with the consideration as to whether the group should be homogenous or heterogeneous. Baker *et al.* (2006:66) mentioned that researchers recently suggested the need for a heterogeneous group of participants because it is a method used to address the validity of the study and makes the results worthwhile (Mead and Moseley 2001 in Baker *et al.* 2006:66). Loo and Thorpe (2004:90) suggested a panel of fifteen to thirty experts, but when using a heterogeneous group of experts Clayton (1997:sp) and Loo (2002:765) suggested that five to ten experts participate in the Delphi survey. Baker *et al.* (2006:66) warned against a too large number of participants because 'the larger the samples the further from the original Delphi concept researchers stray'. They stated that the original number of experts was seven. It is also more difficult to achieve consensus amongst a large number of

heterogeneous participants (Baker *et al.* 2006:66). The consensus is that a sample of less than twenty participants should be selected (Jeffery *et al.* 2000; Mullen 2003 and Phillips 2000 in Baker *et al.* 2006:66).

The development of the questionnaire is one of the critical steps of the Delphi survey because the survey is based on a series of questions sent to the participants for evaluation and rating. De Villiers *et al.* (2005:641) identified two methods of devising the statements for the first questionnaire. The first method is to draft questions for rating by the participants based on other sources, such as a literature review used in this study. The second method is to send open-ended questions seeking their opinions and to then draft closed-ended questions based on their opinions. The subsequent questionnaires are sent to the experts in the form of rounds.

The classic Delphi survey consists of four rounds (Young and Hogben 1978 in Hasson *et al.* 2000:1011) with the aim of achieving consensus amongst the selected experts with regard to a series of questions (Jones and Hunter 1995:376; Keeney *et al.* 2006:209). Consensus can be defined as a gathering around median responses with minimal divergence (De Villiers *et al.* 2005:639). There are no recognised guidelines on the level at which consensus should be set, but the research topic might be useful in determining such a level (Keeney *et al.* 2006:201). The use of a percentage level to indicate consensus seems to be the most commonly used method (Powell 2003:379). Studies suggest that consensus should be from 51% (Loughlin and Moore 1979 in Hasson *et al.* 2000:1011) to 80% (Green *et al.* 1999 in Hasson *et al.* 2000:1011). Even 100% is suggested by Williams and Webb (in Powell 2003:379) if it is a case of life or death. Crisp (in Hasson *et al.* 2000:1011) questioned the value of using percentage to determine consensus, suggesting that 'the stability of the response through a series of rounds is a more reliable indicator of consensus'. Duffield (in Powell 2003:379) supported the notion that consensus can also be considered 'according to the stability of responses between rounds'. The process of providing feedback on the outcome of the previous round is seen as very important because it is the only method of indirect communication between the experts (Murphy

et al. 1998 in Powell 2003:378), which could, however, influence the participants (*cf.* Romm and Hulka 1979:310).

4.8 UTILISATION OF THE DELPHI SURVEY

The use of the Delphi survey in this study, which was used as a tool for achieving consensus, was justified because it was the final phase in determining the elements of the best-practice EAP. Furthermore, it was not a stand-alone research method. The Delphi survey formed part of the triangulation process (see 4.10) within the entire project, which consisted of appropriate questionnaire development, testing and careful selection of experts. The previous phases of the study consisted of a literature review and focus group discussions with supervisors with regard to their opinions and experiences of an EAP. The data generated during the previous phases of this study were used in the Delphi survey, while the objectives of the study guided the researcher in the development of the Delphi survey procedures.

The researcher used the conventional Delphi survey method because it is the classic technique used for the prioritisation of issues based on consensus by participants. The conventional Delphi survey also gave the participants the opportunity to re-evaluate their opinions about issues on the EAP as they received feedback from their colleagues (Ali 2005:731). The participants were encouraged to express their opinions without the threat of peer pressure (Ali 2005:731) and they did so anonymously. This was achieved by ensuring total confidentiality during the rounds even if the opinions of some of the participants were included in the next round as new information. Without face-to-face pressure, the debate and exploration on the best-practice EAP continued, while the main aim was to achieve consensus with regard to the criteria for the best-practice EAP.

The researcher decided against the use of a representative sample of experts based on statistics, and used the concept of 'the qualities of the expert panel' as representativeness instead (Powell 2003:378). The sampling technique will be discussed later in this section, but it was used to obtain representative opinions as the

importance and potency of the results of the Delphi survey largely depended on the selection of experts. This approach resulted in a heterogeneous panel of experts who provided a wide base of knowledge and alternatives in the field of general management and employee assistance. The researcher decided on a heterogeneous group of twelve experts to participate in this Delphi survey. Furthermore, this decision was based on the complexity of the EAP, the wide range of executive managers involved in several aspects of the EAP, the possible differences between the public and private sectors, as well as the purpose of establishing a framework for a best-practice EAP for health care workers. An expert panel was identified by making use of the following set of criteria and purposive sampling (Loo 2002:767):

- Practical experience in the field of EAP management and service provision through knowledge, qualifications or registration
- International expert on EAP
- More than five years' experience in health care administration/ management
- Expertise in strategy development and evaluation strategies
- Experience in human resource management/labour relations
- Qualification in and working knowledge and experience of occupational health
- Working knowledge and experience in quality assurance
- Managerial or advisory position to influence policy making
- Expression of no conflict of interest in this study.

The following three criteria were used to exclude possible participants:

- Individuals who have already provided inputs into the study
- Individuals who have expressed a conflict of interest
- Individuals who did not give consent to participate.

The participants consisted of EAP providers and executive managers. Reasons for their inclusion are that they have experience in (a) dealing with troubled employees in the work place and (b) making final decisions. Decision making is a managerial function (Clayton 1997:sp) and these providers and managers are responsible for making crucial decisions in ensuring that an organisation achieves its goals; therefore

making them ideal participants. Employees, as the users of an EAP, might also have a view of what an EAP should consist of, but the critical decision making, such as the implementation of an EAP, lies with the executive managers. With their critical decision-making power and experience with regard to making decisions that affect their employees, it was appropriate to use executive managers as experts in the survey. The researcher wanted to use experts who have an interest in the EAP as a research topic. On the other hand, he tried to remain impartial with regard to the participants so that the information obtained reflected current knowledge and/or perceptions (Goodman 1987 in Hasson *et al.* 2000:1010).

After the establishment of the criteria on the general characteristics of the desired panellists, the researcher initiated the nomination process by identifying possible participants, such as authors of articles, presenters at conferences, members of employee assistance associations, managers/providers of EAP, as well as executive managers of health care organisations, as suitable experts. The experts selected included a variety of managers from the public and private health care sectors, as well as from a variety of professions, EAP providers, and an international expert. This was done to minimise the possibility of a particular interest or preconceived opinion dominating the process (Jones and Hunter 1995:379). The international expert on the panel is an EAP specialist and an academic with extensive involvement in the development of EAP programmes. Two local experts were executive managers of EAP, while a further three of the experts were human resource managers who had experience with EAPs in the past, or is currently involved with EAPs. Two of the experts were executive managers who have EAP in their institutions while the third executive manager was involved in the EAP committee of a tertiary hospital. The details of the participants and the applicable criteria can be viewed in Appendix E.

An e-mail requesting the above-mentioned individuals to participate in the Delphi survey, as well as an information document on the Delphi survey, was sent to all identified participants (Appendix F). The purpose of the document was to obtain informed consent from participants, as well as to motivate them to participate in all the rounds in a timely manner. The participants were informed that a Delphi survey

usually consists of a few rounds and that it was necessary to obtain their commitment for the entire process. They were requested to complete, sign and return consent forms to the researcher. All twelve participants agreed to participate, but one participant (an EAP manager) did not reply after the first questionnaire was sent despite several attempts to contact the participant. A decision was made to replace the participant since it happened before the first round was concluded. No incentives, such as money or gifts, were used to encourage participation.

The first round of the Delphi survey consisted of closed-ended questions and the participants were requested to begin the rating process during Round 1 (Appendix G). The classical open-ended questions in which the participants were invited to give opinions as proposed by Jones and Hurter (1995:377) were not used. However, the questionnaire allowed the participants to add comments and new information as they saw fit. The researcher used the outcome of the literature review and focus group discussions to develop the questionnaire for the first round. The participants were required to rate their level of agreement with each question, using a three-point Likert scale (1 = Considered to be critical, 2 = Could be considered, 3 = Not to be considered). The rating process, thus, started in the first round, rather than in the second round as used in the classic Delphi survey (Powell 2003:378). The questions were included under the following sections:

- The introduction of an EAP
- Structure and requirements of an EAP
- Policies and procedures of an EAP
- EAP processes and activities
- The evaluation of an EAP.

The researcher used electronic communication media (e-mails) to send and receive the questionnaires in order to save time. The researcher gave the participants sufficient time (four weeks) to complete the first round after considering the number of questions in the questionnaire (186 statements). This also gave the participants enough time to re-think their ratings and to provide comments if necessary. Although

a few participants completed their questionnaires within days after receiving the questionnaire, more than half of the participants did not respond before the four-week deadline. A reminder was sent to the participants a few days before the deadline. Follow-up e-mails and telephone calls were used after the deadline to encourage participants to complete their questionnaires. Despite these efforts, the first round took eight weeks to complete due to the fact that three participants returned their completed questionnaires much later than expected. The delay was caused mainly by one participant who, despite having agreed to participate in the Delphi survey and who returned a completed consent form, did not return the first round questionnaire. As it became evident that this participant was not going to respond in a reliable manner, another expert was identified to fill the vacancy before the first round was completed. The late substitution was, therefore, the reason for the first round being extended to eight weeks.

The questionnaires for the subsequent rounds were drafted based on the analysis of the previous round (Ali 2005:720; Loo and Thorpe 2004:90). The process continued via e-mails. The participants were requested to rate only those questions on which consensus had not been achieved in the previous rounds. Each questionnaire consisted of the overall rating per question, but each participant's questionnaire was individualised by showing him/her where he/she rated that particular question (see Appendix H for the questionnaire compiled for participant number 1). Participants were encouraged throughout the survey to provide additional comments as deemed necessary. These comments were analysed for possible inclusion as new questions to be rated during the next round. It was necessary to include new questions in the questionnaire for Round Two based on comments provided by participants in Round One. After Round Two, no new information was presented by the participants.

A decision was made to continue with the rounds until consensus or stability had been achieved with regard to which criteria should be included in a framework for the best-practice EAP. In this study, the researcher decided that a controversial topic, such as an EAP, would need a level of 80% consensus amongst participants on any statement. The researcher did not only consider the achievement of an 80% level of

consensus, but also considered stability to be an outcome. Stability was considered to be achieved if it appeared that there was no progress to be made with regard to a specific question. Convergence of opinions, as well as divergence with regard to the expert's point of view, was highlighted after each round (Powell 2003:379). Apart from consensus on the questions, the Delphi survey allowed an additional in-depth exploration of the participants' viewpoints, which was considered for inclusion in the framework for the best-practice EAP.

The feedback provided to the participants after each round consisted of another individualised report (see Appendix I as an example), which included the combined rating of all the statements where consensus or stability was achieved for each statement/question and an indication of that participant's rating of each statement. The participant could use this reporting method to compare his/her rating of each statement to the overall outcome of all the participants, while the report ensured confidentiality of each participant.

After the first round, the participants did respond within the time limit set by the researcher. It was necessary to conduct more than one round to ensure maximum inputs and reflection from the participants (Clayton 1997:sp). In fact, consensus and stability on all the statements were achieved after the sixth round. The final report was drafted, which included the outcome regarding whether consensus or stability (with the actual rating) had been achieved, and was sent to all the participants (see Appendix J). It could also be seen as a debriefing mechanism used to conclude the survey.

4.9 DATA MANAGEMENT

All the data for each round were captured on an Excel spreadsheet (see Appendix K – example of Rounds 1) by the researcher himself immediately after the completed questionnaire was received from a participant. A spreadsheet was created for each round and the questions, where consensus or stability had been achieved, were removed from that spreadsheet. Only the remaining questions for that specific round

were captured on the spreadsheet. A colour-coding system was used to identify non-consensus (yellow), changes made by participants (red), consensus (pink) and stability (green) on the various questions. All the comments received from participants for each question were captured separately on a questionnaire after each round, with the new questions for Round Two clearly indicated. These comments were used in the final analysis of the Delphi survey and the drafting of the best-practice framework. After the completion of the Delphi survey, a complete questionnaire containing all the questions with an indication as to when consensus or stability had been achieved was drafted in the format of a report (cf. Appendix J).

4.10 TRUSTWORTHINESS, VALIDITY AND RELIABILITY

Trustworthiness is one of the most important aspects of qualitative research. Babbie and Mouton (2001:277), Bryman (2001:272), de Vos *et al.* (1998:351) and Lincoln and Guba (1985:300) identify the following aspects of trustworthiness that are relevant to this study: credibility, transferability, dependability and confirmability.

Credibility can be addressed by means of triangulation. Triangulation refers to an approach to data collection that is deliberately sought from a wide range of different, independent sources and often by different means (Mays and Pope 1995:110). Patton (2002:247) recommended two types of triangulation, the first of which is known as data triangulation. This refers to an approach which uses the combination of more than one complementary and independent source of data 'so that the results will converge' (Loo 2002:768). The second method is known as methodological triangulation where multiple research methods are used in a project. Furthermore, credibility can be addressed by what is called respondent validation. This is a process whereby the researcher provides the participants in the study with an account of his/her findings to ensure that the researcher has correctly understood the social world of the participants. This is frequently used by qualitative researchers to ensure good communication between their findings and the perspectives of the participants. Shank (2002:92) emphasised the importance of feedback by referring to validity as the truth by saying:

validity, in essence, is about the notion of truth – is what the researcher says has been observed, in fact really what has happened? In other words, is the observational record true?

Qualitative research typically entails an intensive study of a small group of participants resulting in contextual uniqueness (Bryman 2001:272). Thick description is the end-product for providing others with 'a data base making judgements about possible transferability of findings to other milieux' (Guba and Lincoln in Bryman 2001:273) and, therefore, addresses the concept of transferability. Dependability in qualitative research can be addressed by adopting an auditing approach. Confirmability involves the recognition of objectivity in qualitative research, but the researcher must show that he/she has acted in 'good faith' and 'not overtly allowed personal values or theoretical inclination manifestly to sway the conduct of the research and findings deriving from it' (Bryman 2001:274).

Validity and reliability are two other crucial topics in the field of research. However, there is no general consensus in the literature about how the traditional topics of validity and reliability should be addressed in qualitative research (Shank 2002:91). Mays and Pope (1995:109) highlighted the criticisms of qualitative research while mentioning researcher bias, lack of reproducibility and the lack of generalisability as the major concerns. Maxwell (1998:92) defines bias in qualitative research as 'the ways in which data collection and analysis are distorted by the researcher's theory, values and perceptions'. The researcher must be open about possible biases and predilections, or perspectives that might influence the process of the research (Shank 2002:93).

Trustworthiness, validation and reliability were addressed in this study, using the principles as discussed above. Firstly, credibility was addressed in this study by the means of triangulation, proper record keeping, and sending the data, as well as the interpretation of the data, back to the participants. The researcher applied data and methodological triangulation by using various data sources, such as published literature, opinions of supervisors provided during the focus group discussions, as well as the rating and comments from experts provided during the six rounds of the

Delphi survey to finalise the content for the best-practice framework. Respondent validation was used in this study whereby the researcher provided feedback to participants in the focus group discussions in good time in the form of transcribed reports and requested feedback from them. Respondent validation during the Delphi survey consisted of separate, individual reports on the outcomes of each round, indicating the questions on which consensus or stability had been achieved (see Appendix I as an example). These reports were sent after each round to ensure accuracy of the analyses.

Secondly, transferability was addressed by collecting sufficiently detailed descriptions of data followed by detailed reporting on the outcome of the analyses. Rich data mean that the data are detailed. Additional opportunities were provided for participants to provide clarification where the meaning of what was being said was not clear (Shank 2002:92). This was done by asking members of the focus group discussion to explain some statements they had made in the comment columns in the Delphi survey questionnaire, as well as the individualised reports sent to participants after each round. The data from the focus group discussions in this study were captured verbatim and field notes were added. Multiple reviews of the interview notes and tapes furthermore ensured accuracy. The facilitator received copies of the transcriptions, which were then compared to the recorded conversations in order to ensure accuracy. Afterwards, copies were sent to participants of the focus group discussions, who provided e-mail addresses, to read the transcripts and to confirm the authentic nature thereof. The data were analysed, using methods as explained (*cf.* 4.7). The process of purposive sampling also addressed transferability (*cf.* 4.4.2).

Thirdly, dependability was addressed by keeping a complete set of records of all the phases of the research process (audit trail).

Fourthly, confirmability was addressed by ensuring that the researcher acted in good faith and did not overtly allow personal values or theoretical inclinations manifestly to sway the conduct of the research and findings deriving from it. Bracketing, which refers to the 'bracketing of the researcher's personal view or preconceptions' as

suggested by Groenewald (2004:16), was used by not allowing the researcher's meaning and interpretation of an EAP to enter the world of the participant. Another example of bracketing was the use of an independent facilitator to conduct the focus group discussions, while the researcher acted as an observer, making field notes. The researcher's reporting style could have a notable effect on the confirmability of the study; therefore, every effort was made to ensure that the reconstruction of the participants' perceptions was reported in a way that rendered it authentic.

Lastly, the researcher used the following additional methods to address bias as suggested by Maxwell (1998:93) as well as Mays and Pope (1995:110):

- Searching for discrepant evidence and negative cases: The researcher identified the findings which diverged from those predicted by the previously stated theory and used them to revise the existing theory.
- The researcher as research instrument: The researcher has an extensive understanding of the concept of employee health and assistance in the health care sector. The necessary sensitivity with regard to the language used by participants and its meaning within the broader concept of employee assistance was achieved through the verbatim transcription of focus group discussions with field notes filling in the gaps and completing the detail of the data. This eliminated the possibility of impressionistic research and concentrated on direct observation of words and behaviour *in situ*.
- Quasi-statistics: Quasi-statistics refer to the use of simple numerical results that can be readily derived from the data (Maxwell 1998:94). The researcher used this method to assess the amount of evidence in the data to make a particular conclusion. An example of quasi-statistics can be found in the percentage of focus group discussions that was devoted to a particular theme. Another example was the actual criteria used to draft the questionnaire for the first round of the Delphi survey from the literature review and focus group discussion (*cf.* 4.6). In addition, the rating process used during the Delphi survey was of a quantitative nature and was used to determine consensus amongst the participants.

- Comparison: This was conducted by performing the study at several sites. The researcher held the focus group discussions in the public and private health care institutions, while the Delphi survey involved national and international experts as participants. Goodman (1987 in Hasson *et al.* 2000:1013) argues that the use of participants who have knowledge and an interest in the topic may help to increase the content validity of the Delphi survey, while the use of successive rounds of questionnaires helps to increase the concurrent validity.

Research without rigour is worthless. Therefore, to ensure rigour in this study, the researcher made use of the following steps as recommended by Mays and Pope (1995:110):

- A systemic and proper research design to ensure congruence between the research question and methods used
- Independent, yet direct data collection with appropriate sampling mechanisms
- Concurrent data analysis and plausible interpretation to ensure intimate understanding of the theory and research setting
- Communication of the results presented with evidence from the actual data gathered.

Any ideas emerging as new data during the research process were subjected to a theoretical thinking process, rather than being ignored. These new data were verified by comparing them with existing data, as well as by means of an additional research step in the form of a Delphi survey. New data generated through the Delphi survey were also compared with existing data (literature review and focus group discussions) and new questions were posted for verification during the next round of the Delphi survey. As a conclusion, all these steps can also be seen as verification strategies to ensure trustworthiness, reliability and validity of data; thus, ensuring rigour.

4.11 ETHICS

Research should always be conducted according to ethical principles, especially when human beings are being used as research subjects. The ethical principles used for quantitative and qualitative research are similar and the next few paragraphs explain the aspects that were addressed in this study.

Confidentiality was maintained at all times. No names of participants in this study appeared on any data set, presentations or reports. The focus group discussions were typed out by the researcher himself and only the unique number of the participant was used. The concept of quasi-anonymity (Keeney *et al.* 2006:209; McKenna 1994 in Hasson *et al.* 2000:1012) was used in the Delphi survey where the researcher knew who each respondent was, but an individual panel member's responses were unknown to other participants. A coding system was used to track respondents and their responses from the first to the last round.

None of the phases of the research was conducted without the necessary written approval and informed consent (see Appendices B and F). The researcher provided all participants and authorities with a detailed information document (*cf.* 4.5 and 4.8) explaining the study and allowing participants to decide whether they would like to participate or not. Only after a signed consent document was received from the participant, was he/she included in the study. In addition, approval was obtained from:

- All the heads/managers of the health care organisations included in the study
- All participants of the focus group discussions
- All participants of the Delphi survey.

The study was approved by the Ethics Committee of the Faculty of Health Sciences, University of Free State (Project number: ETOVS 34/08).

4.12 PILOT STUDY

A pilot study is the pre-test phase of any research project. It consists of several steps to evaluate the entire research design, using a small number of independent participants outside the formal research study to ensure the feasibility of all the planned research processes (Leedy and Ormond 2005:110; Strydom 1998:179). These steps include checking the logistics and instruments to be used in the study, the actual field work to be conducted, as well as data gathering and analysis methods (Joubert 2007:50). These actions contribute towards the reliability and validity of the study (*cf.* 4.10). By carefully evaluating all the aspects of the study, testing the methodology, identifying strong and weak points of the research, and modifications made for improvement, the main study can continue without any unnecessary alteration during the critical phases of the study (Strydom 1998:187).

In this study, the various phases were piloted to test several processes and instruments used during the study. The focus group discussion agenda and the Delphi questionnaire were subjected to a pilot study, using three participants in the researcher's department who are familiar with employee assistance programmes and hospital management systems. Special emphasis was placed on the fact that the instruments should render relevant data regarding the EAP as a social phenomenon.

In a pilot study for a qualitative research project it is important to select the appropriate participants for the pilot study in order to obtain useful inputs to justify any modification to the study (Strydom 1998:182). A statistically correct pilot study was not used as such measures are not deemed necessary in qualitative research. As a result of the pilot study, a conclusion session was added to the focus group discussions agenda and a few statements on the Delphi questionnaire were restructured to ensure that all participants would have the same interpretation of the specific statements. All the documentation used in the focus group discussions and Delphi survey were sent to a language practitioner to ensure grammatical correctness. Some grammatical errors in the questions were corrected. The format of the questionnaire was changed to make it more user-friendly.

4.13 SUMMARY

Research is needed not only to identify gaps in knowledge, but also to fill these gaps by answering the main research questions and subsequent questions. Research can be of value and used in practice only if it was based on sound principles. Proper planning of each step of the research project is one the most crucial aspects in ensuring sound and useful research (Lategan 2005:32; Mouton 2001:45). These planning processes should be used to establish clear guidance on how to conduct the research. The researcher used the planning process to identify appropriate qualitative research methods for all the phases to ensure valid and useful outcomes.

This chapter provided an overview of quantitative and qualitative research in the health care sector. More emphasis was placed on qualitative research and the reasons as to why this method was appropriate to this study. The most important reason for using qualitative research was that in-depth knowledge on the EAP in the health care sector was needed to address several questions and concerns raised about this phenomenon. A detailed explanation on the data collection processes, as well as the ways in which the data were managed and analysed, was also provided in this chapter. The next chapter will continue to provide the analysis, interpretation and discussion of the data.

CHAPTER 5

DATA ANALYSIS, INTERPRETATION AND DISCUSSION

**Section A: Focus group discussion
 (p. 119-153)**

**Section B: Delphi survey
 (p. 154-169)**

5.1 INTRODUCTION

Data for this study were collected by utilising three processes, namely a literature review, focus group discussions and a Delphi survey. The empirical part of the study consisted of five focus group discussions with the agenda for the focus groups based on the outcome of the literature review. The focus group discussions were followed by a six-round Delphi survey to achieve consensus on the criteria to be included in the best-practice EAP framework (*cf.* 4.1). This chapter deals with the analyses of the data gathered during the focus group discussions and the Delphi surveys.

5.1.1 Summary of methodology followed

The focus group discussions were conducted with groups of supervisors from the public and private health care sectors, all of whom were selected according to specific criteria. The researcher analysed the data gathered during the literature review and focus group discussions by identifying certain themes and categories. The literature review followed a deductive approach (*cf.* 4.6) as the researcher identified certain themes from the literature before the focus group discussions were held. The inductive approach (*cf.* 4.6) was used during the focus group discussions as new themes and categories were allowed to emerge from the data. The next step of the study was to present the analysed data from the literature review and focus group

discussions in the format of a questionnaire to a panel of various experts for consensus, using a Delphi survey. The panel of experts for the Delphi survey consisted of twelve executive managers, EAP providers and quality assurance experts. The aim of the Delphi survey was to achieve consensus amongst the panel as to which elements should be included in the framework for a best-practice EAP. Consensus was defined as an 80% agreement amongst participants' ratings, using a three-point Likert scale. Consensus and stability was achieved on all the questions after six rounds. This chapter deals with the analyses of the data gathered during the focus group discussions and the Delphi survey.

SECTION A: FOCUS GROUP DISCUSSIONS

5.2 ANALYSIS OF THE DATA FROM THE FOCUS GROUP DISCUSSIONS

The aim of the focus group discussions was to gather rich, in-depth data not only on the themes identified in a deductive approach through the literature review, but also to identify new themes emerging from the data. The focus group discussions were guided, using an agenda (see Appendix C) drafted from the literature review. The actual questions that were to be asked during the focus group discussions were not provided to participants before the start of the session as recommended in a guideline document drafted by Eliot and Associates (2005:3). Wong (2008:257) supported the recommendation, stating that a facilitator should use a question guide (agenda) to guide the discussion. This document is not drafted to allow the participants of the focus group discussions to prepare beforehand. However, it is recommended that participants should receive enough information before the focus group discussion in order for them to make an informed decision as to whether or not they would be willing to participate in the focus group discussions (Bailey, Derbyshire, Harding, Middleton, Rayson and Syson 2007:80). In order to adhere to the last recommendation, the researcher communicated the aim, objectives, purpose and methodology of the sessions to the participants at the time when informed consent was obtained. After conducting the focus group discussion, an interesting remark was made by some of the participants in one group. They stated that they would have

preferred to receive the questions before the actual discussion in order for them to prepare for the sessions. The researcher and facilitator believed that providing the participants with the aim and objectives of the focus group discussion would be sufficient in helping them to prepare for the focus group discussion.

The data analysis process allowed for categories and possible new themes to emerge from the transcribed focus group discussion data and patterns were identified within the categories through content analysis (*cf.* 4.6). The content analysis process, during which the researcher himself transcribed the recordings verbatim, began directly after each focus group session. As some of the participants spoke Afrikaans, the transcriptions were translated into English by a professional translator. These translated transcripts were read by the facilitator to verify the correctness of the transcriptions. The researcher read the transcriptions a number of times to familiarise himself with the data. Thereafter, the field notes made by the researcher as an observer during the discussions were added in an additional column on the transcription documents (*cf.* Appendix L as an example). The next step involved coding the transcriptions, using an inductive approach. The process identifies recurrent words and phrases. The codes were organised according to the themes identified during the literature review. These themes were:

- The need for an EAP
- The requirements for an EAP
- The types of EAP that can be used
- The evaluation of an EAP
- The impact of an EAP on an organisation.

During the coding process, patterns amongst the codes were identified and these were grouped into categories. The themes, categories and selected sections from the transcriptions were captured in NVivo8 software. The benefit of this software is that all the coded data is grouped together in an organised manner and can be viewed as categories or subcategories. Figure 5.1 is a summarised version of the analytical processes followed during the focus group discussions.

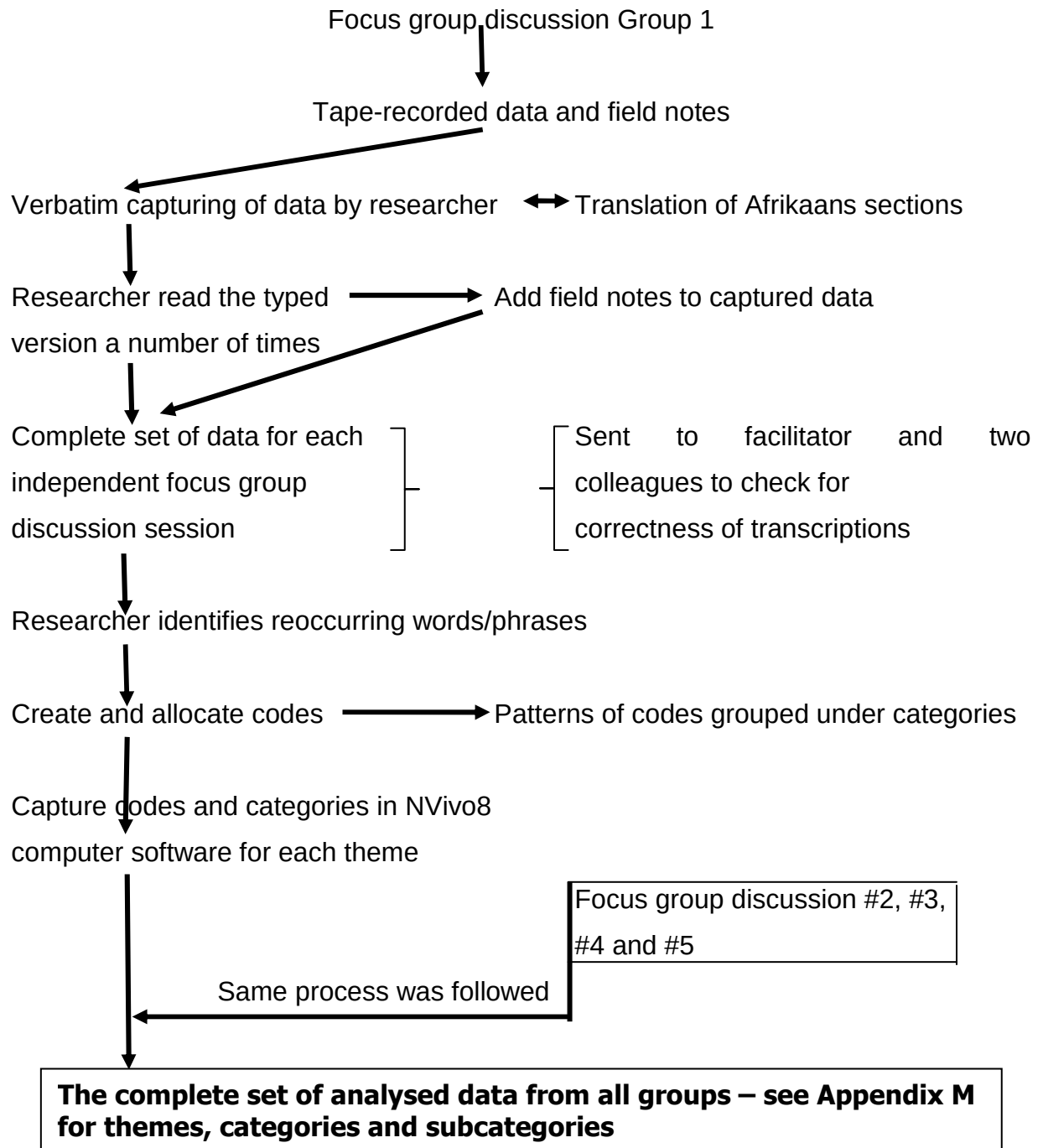


Figure 5.1 The analytical process with regard to the focus group discussions

5.3 RESULTS OF THE FOCUS GROUP DISCUSSIONS

The researcher attended two qualitative research courses presented by experienced qualitative researchers at the University of the Free State to gain experience in qualitative research before starting this research project. This acquired knowledge, together with previous experience, assisted the researcher with the analysis of the data.

The initial discussion in this section focuses on the practical outcome of conducting the focus group discussions and is followed by an analysis of the data.

5.3.1 Practical experiences with the focus group discussions

The suggestion by Wong (2008:258) that the same seating arrangements should be used during the different focus group discussions was adhered to. See Figure 5.2 for the seating arrangements. The groups consisted of between six and twelve participants. For smaller groups, one table was used and for the group of twelve participants, two tables were pushed together as illustrated in the schematic representation (Figure 5.2). The researcher found the seating arrangements advantageous and practical for all five focus group discussions. This arrangement allowed for the easy observation of group members in order for the observer to make field notes. In addition, the facilitator expressed her satisfaction with the arrangements in a debriefing session between the facilitator and researcher, which took place after each discussion session. She was of the opinion that she could see all the participants and that interactions were well-coordinated. As illustrated in Figure 5.2, two types of recording devices were used during the sessions. A digital recorder was placed in the middle of the table (Olympus DS-30 without any extended microphones) and a National tape recorder was used as backup. The conversations continued in a normal vocal tone and the quality of the digital recordings was good. After the transcriptions, copies of the digital recordings were backed up on a computer and the tape recordings were deleted.

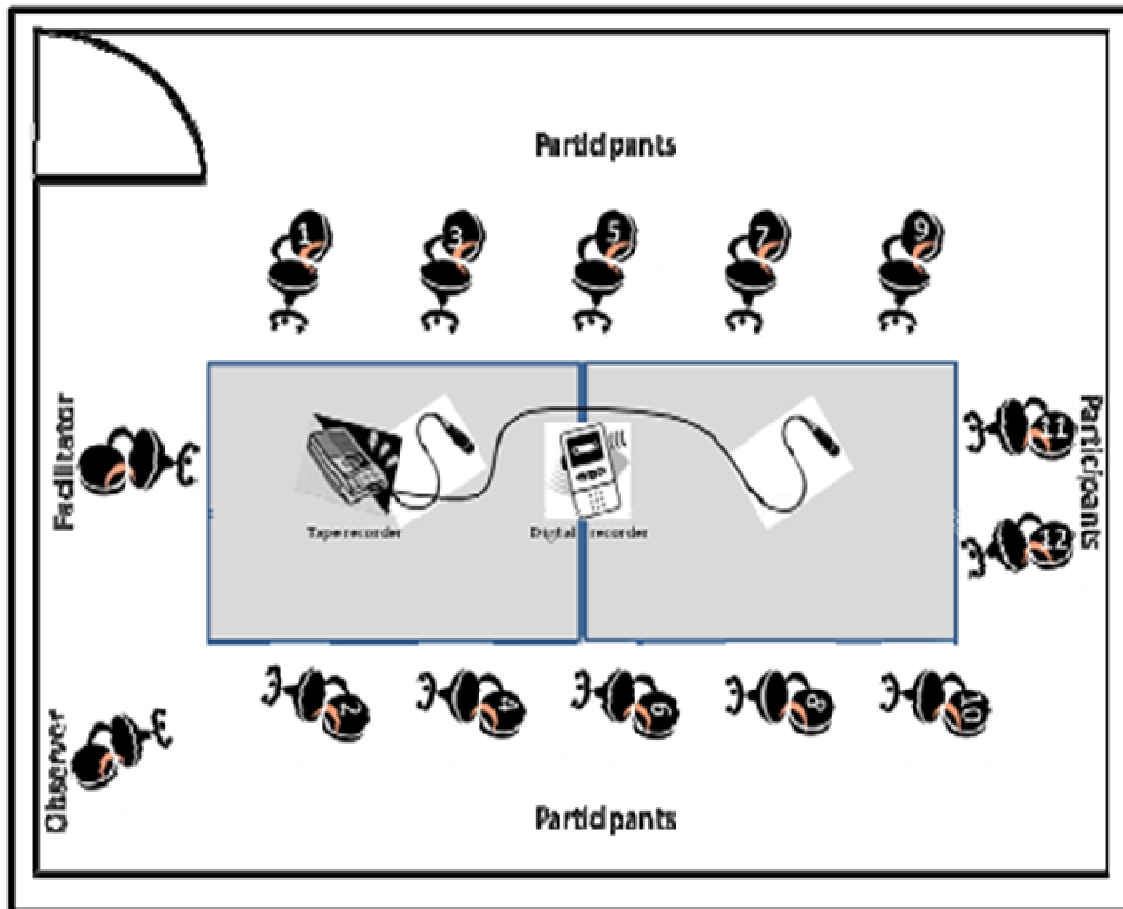


Figure 5.2 The arrangements for the focus group discussions with six participants

The researcher was present during the sessions, but a decision was taken beforehand that he would not participate in the discussions. It had been suggested that a researcher should not participate in the initial group discussion, but could partake at a later stage (Kitzinger 1995:sp). The researcher only made some concluding remarks at the end of each session as to how the data would be processed and what the next steps of the research project would be.

The size of the groups in this study consisted of between six and twelve participants. The researcher found that a focus group consisting of six to eight people was the most optimal as discussions in these smaller groups had a natural flow and the facilitator could manage and coordinate the inputs from various participants with

ease. The participants of the smaller groups rarely interrupted one another and, when interruptions did occur, it was because the participant wanted to make a particular statement. Furthermore, the facilitator was able to manage these interruptions with ease. Summaries and field notes made by the observer were easy to capture. Management of the groups consisting of more than eight participants were more difficult. At times, during these sessions, the facilitator struggled to identify the participant who was trying to speak, as participants continued to interrupt one another. On several occasions, the facilitator also had to re-direct the flow of the discussion to the point under discussion on the agenda because the discussions took a totally different direction.

During this time, the facilitator and observer also concluded that a focus group consisting of more than eight members is not desirable. Observations by qualitative researchers such as Krueger and Casey (2000 in Rabiee 2004:656), Schurink *et al.* (1998:317), and Wong (2008:257) support the fact that smaller focus groups should be used. They recommended that the optimal number of participants should be between four and eight. One of the reasons why the facilitator in this study had difficulty in managing the participants in the larger groups was due to the complexity of the topics under discussion. This observation was confirmed by Bryman (2001:341) and Campbell (2008:3) who asserted that large groups tended to fragment into smaller groups or that certain topics could even create a 'wall of silence' in large groups. Despite the difficulty in managing the participants in the larger groups, the discussion from the large groups produced valuable data as arguments amongst participants stimulated extended conversations, even to the extent that the facilitator did not have time to identify the participants who were talking at the time.

Five focus group discussions were held with supervisors from five different health care institutions. In the literature, there is no consensus on the ideal number of focus group discussions, but theoretical saturation had been achieved after five focus group discussions, as suggested by Rabiee (2004:656). A case study approach was followed with the participants of the focus group discussions. This allowed them to express their experiences, opinions and perceptions with regard to an EAP, and also

gave them the opportunity to offer an in-depth view on EAPs from a supervisor's perspective.

5.3.2 Demographic details of participants

The health care institutions and the demographic details of the supervisors are presented in Table 5.1. The number of participants in the focus group discussions ranged from six to twelve members. Most of the participants were female and were professional nurses working as supervisors. However, a variety of other categories of health care workers also participated in the focus group discussions. Only focus groups 3 and 4 consisted of more professional nurses than other categories of health care workers.

For the majority of the participants, this was their first experience in a focus group discussion. Many of the participants admitted to finding the initial discussions stressful, but claimed that the feeling disappeared after a few comments were made. Based on the observations, it took a while longer for the participants to start disagreeing with one another and to relax sufficiently for their body language to emerge. This only happened after the first number of questions had been discussed. By the end of the discussion, two comments made in Afrikaans (translated into English for the purposes of this document) in response to the facilitator's announcement that the last question will be asked, indicated that the participants in the group had enjoyed the session: *Ons raak nou eers opgewarm* ('We're only getting warmed up now'), supported by the second participant, *Ons begin dit nou eers geniet* ('We're only starting to enjoy it now').

Table 5.1 Participants in the focus group discussions (FGD)

<u>Characteristics</u>	<u>Total</u>	<u>FGD 1:</u> <u>Public</u> <u>sector</u>	<u>FGD 2:</u> <u>Private</u> <u>sector</u>	<u>FGD 3:</u> <u>Public</u> <u>sector</u>	<u>FGD 4:</u> <u>Private</u> <u>sector</u>	<u>FGD 5:</u> <u>Private</u> <u>sector</u>
Male	<u>7</u>	1	2	2	0	2
Female	<u>36</u>	7	6	4	9	10
<u>Total:</u>	<u>43</u>	<u>8</u>	<u>8</u>	<u>6</u>	<u>9</u>	<u>12</u>
Professional nurse	<u>25</u>	2	5	4	7	7
Human resource officer	<u>5</u>	1	1	1	1	1
Social worker	<u>3</u>	1		1		1
Administrative officer	<u>3</u>		1		1	1
Medical officer	<u>2</u>	2				
Tradesman	<u>2</u>		1			1
Clinical psychologist	<u>1</u>	1				
Occupational therapist	<u>1</u>	1				
Pharmacist	<u>1</u>					1

5.3.3 The approach to the analysis

The initial analysis of the data was conducted by means of a case analysis process during which the data from each focus group discussion were captured and analysed separately (Patton 2002:440). For more details on this process, see Figure 5.1 (*cf.* 5.2). The researcher used the same set of themes for the evaluation of all five focus group discussions. As codes emerged from the data during the analysis, categories were created for each theme. Furthermore, the codes classified under each category were divided into several subcategories. The data analysis process allowed for categories and possible new themes to emerge from the data and identified patterns

within the categories through content analysis (*cf.* 4.6). One new theme that emerged from the data was 'The requirements for an EAP'.

After the initial case analysis, the researcher also conducted a cross-case analysis as suggested by Patton (2002:440). During the cross-case analysis, the responses and answers from different focus group discussions were grouped together and data sets were thus not analysed as separate entities. This approach ensured that the rich information that emerged from the data contained all the aspects and perspectives of different groups of people. The end-result of the analysis was a single, completed set of analysed data from the five focus group discussions.

As per the experience of Rabiee (2004:656), saturation was also evident after the five focus group discussions, since no new codes or subcategories were identified and clear patterns emerged. Furthermore, almost all of the data could be coded, using the existing codes and subcategories (repetitious information) created during the analysis of the initial focus group discussions. The rest of this section presents a detailed discussion on the themes, categories and subcategories as they emerged from the data.

5.3.4 Themes and categories identified from the focus group discussions

A content analysis strategy was used, during which the collected data were divided into meaningful analytical units. Thereafter, a pattern recognition method was used by grouping similar codes together. The grouping resulted in the creation of categories and subcategories for each theme. The themes and categories that emerged during the analysis of the data are summarised in Table 5.2. The subcategories for each category can be viewed in Appendix M.

Table 5.2: Themes and categories identified from the five focus group discussions

<u>Theme 1: The need for an EAP</u>	
Category:	
1.1	The rationale for an EAP
1.2	The objectives of an EAP
1.3	The scope of the EAP
<u>Theme 2: The requirements for an EAP</u>	
Category:	
2.1	An introductory statement from management
2.2	A joint EAP committee
2.3	The role of a joint EAP committee
2.4	The requirements for EAP policies
2.5	The types of EAP policies needed
2.6	Possible EAP entry processes
2.7	Marketing of the EAP
<u>Theme 3: The types of EAPs</u>	
Category:	
3.1	The types of EAP providers
3.2	The characteristics of EAP providers
3.3	The categories of staff needed
3.4	The types of services to be provided by the EAP

Table 5.2: Themes and categories identified from the five focus group discussions (continue)

<u>Theme 4:</u>	<u>The evaluation of the EAP</u>
Category:	
4.1	Programme evaluation – general aspects
4.2	Programme evaluation – aspects to be evaluated
4.3	Programme evaluation – methods of evaluation
<u>Theme 5:</u>	<u>The impact of EAP</u>
Category:	
5.1	The impact on the employee
5.2	The impact on the organisation

5.3.5 Theme One – The need for an EAP

The introductory questions on the agenda were well prepared and put all the participants of all focus group discussions at ease. After the introductory questions were asked, there was no doubt amongst participants that an EAP would be beneficial to any health care organisation. The discussions began almost directly after the questions were asked and no disagreements amongst participants were raised. The participants responded to one another with comments and no silent moments occurred after these first three questions were asked. All the comments provided by the participants were classified under the following three categories:

5.3.5.1 Category 1.1 – The rationale for an EAP

Six subcategories emerged from the codes of which the unique environment of the health care sector with its numerous health and safety risks was regarded to be one of the most important reasons for establishing an EAP for employees in these organisations (*cf.* 2.3). Ensuring that organisations have healthy and satisfied employees who are productive, was a priority for the participants. In this regard, one

of the participants made the following statement: *So, surely we want to see that our investments are fine ... in order to give a good service.* It was also evident that participants viewed employees as valuable assets. An example of this can be found in the following statement made by one of the participants: *Our employees are our most valuable asset and we need to keep them healthy.*

5.3.5.2 Category 1.2 – The objectives of an EAP

During the discussions, the participants attached weight to the desired outcomes of an EAP. These responses were grouped as a separate category, namely 'The objectives of an EAP'. The participants, however, did not provide specific elements that should form part of the objectives. Instead, broad statements were given and these were classified by the researcher into four subcategories that could serve as possible objectives. One subcategory was identified in all five sessions and was, therefore, classified as one of the main objectives of an EAP, namely to act as a support system for the employees.

An example of this subcategory can be seen in the following statement: *... in recent times, it becomes more important to people to have a good support network at your work ... So, at the end of the day, you'll sit with an employee who is willing to walk the extra mile for you.*

The next two objectives that emerged were to assist with the retention of personnel ('To retain personnel') and to assist with the control of absenteeism.

As one participant stated: *I would say an EAP helps quality control regarding absenteeism from an HR point of view.* The focus of these two objectives was directed at employees. The fourth objective that was identified was to provide someone who is willing to listen.

The four objectives that emerged from the data in this study are not exactly the same as those suggested in the literature, but participants mentioned some of the concepts recommended in the literature (*cf.* 2.6.3).

5.3.5.3 Category 1.3 – The scope of the EAP

The following direct question was asked during the discussion sessions: 'What should the scope of the EAP be?' The initial reaction from the majority of the participants was to focus on who should have access to an EAP. After some discussion, however, the participants realised that an EAP is more complex than they had initially realised. Lengthy discussions and arguments followed, which lead to the eventual identification of fifteen subcategories (see Appendix M for details).

It was evident that the participants did not reach consensus with regard to the scope of an EAP. Examples from the discussions that confirm this were statements such as:

At the EAP, we look at a person as a whole. Is it only to the employee and his or her spouse and children? Or, you know, would it be for her family or whatever. There should be a limit, you know, only children, spouse, mother.

In two of the focus group discussions, controversial statements, such as *So, the scope will also be to approve appointments in the end* were made. This statement, with which two of the participants in one of the groups disagreed, initiated intense discussion and the other participants used several arguments and body language to try to convince them otherwise. In the end, the group agreed that it was necessary for the scope to include the controversial statement. A participant in this group concluded that, *So, the scope will also be to approve appointments in the end* and several loud yeses were recorded from the other participants. These types of arguments coincide with a conclusion made by Kirk (2005:93) in her study that the lack of a broader strategic intent is associated with a lack of clarity of expectation concerning the usefulness of the EAP to the organisation.

Despite the arguments and disagreements on the scope of the EAP in several of the groups, one participant concluded that, *I think the scope would be very wide because each individual has very unique problems*, much to the agreement of all the other participants in the group. This concluding statement is in line with the recommendation made by Steele (1998:2) when he stated that the EAP is moving more towards the broad-brush approach rather than simply focusing on alcohol-related problems. Nowadays, EAPs even focus on supervisors in that they are provided with training on such human-resource-related topics as cultural diversity and sensitivity, as well as disability (Chima 2005:74). None of the services directed at supervisors were mentioned during any of the five focus group discussions as being part of the scope of an EAP.

5.3.6 Theme Two – The requirements for an EAP

During the focus group discussions, it was evident that the participants felt strongly about certain criteria that should be in place before an EAP can be formalised by the employer. These criteria can be viewed as necessary requirements for a well-functioning EAP. The criteria identified and formulated in the discussions were as follows:

5.3.6.1 Category 2.1 – An introductory statement from Management

The role and responsibilities of the executive management within an EAP surfaced on several occasions during the focus group discussions despite the fact that the agenda included a specific question on this issue. These comments were coded separately under the appropriate categories and were not included under this deductive category. In analysing the data, the researcher included only those statements made under the specific item on the agenda pertaining to the role of management in EAPs. Eight subcategories for this question on the agenda (see question 2 on the agenda in Appendix C) were identified during the analytical process (see Appendix M).

Participants in three of the five focus groups were very keen on the inclusion of a definite introductory statement regarding management's supportive role in an EAP. One of the participants stated:

To me, that is a critical issue in this whole thing. If management doesn't support and if they don't stand and honour those people who do the work, then it's always a hassle and conflict ...

The participant was interrupted by another participant who wanted this discussion to include a challenge towards management: *Maybe one could say that EAP... success is based on the support of the management.*

One of the focus groups spent a great deal of time discussing disciplinary measures and the fact that entering the EAP should not be seen as punitive: *Maybe it should also have a statement there that it is not punitive. It is to help workers and it should not be mixed with discipline.* Several practical examples of real-life cases were used by participants to highlight the need for a statement on disciplinary measures to be included in the introductory statement by management. These comments made by the participants are relevant, since they could have serious implications when taking into account the current labour relations legislation requirements in South Africa. The participants did not discuss the requirements of the Department of Labour in detail, but one participant made a valid suggestion:

I think it is vital, especially when you mentioned labour relations because sometimes it might happen that this particular person ... Someone is quick to penalise or punish the particular person without giving him the proper chance of maybe correcting his own mistakes of which some of them might be personal and the question might be that, did you consult all the stakeholders before you can institute a punishment on this particular person? Maybe some information one can get from the Labour Department to say: 'Look, involve EAP on this particular person before you can start institute [sic] disciplinary procedures'.

5.3.6.2 Categories 2.2 and 2.3 – A joint EAP committee

Csiernik (2003a:20) promoted the establishment of a joint EAP committee in the workplace as an example of best-practice within the EAP. Although the majority of the participants were able to see a role for a committee of this nature, not everyone agreed. Some of the institutions that participated in the focus group discussions have an EAP committee in place and the majority of participants were positive about the role of such a committee. One participant, employed in an institution that does not have an EAP or an EAP committee, was very sceptical about this concept. The rest of the group members argued with this participant, but were unable to persuade her to change her mind. They tried to convince her of the benefits of having such a committee with lengthy arguments.

Despite the arguments, she concluded that *to support people and create a resource or a committee to support people is a wonderful idea but, in reality, it is not always so practical.*

In the literature, it is stated that focus group discussions are used to stimulate debates and express ideas (Bailey *et al.* 2007:79) and, when used in an integrative way, lead to collective understanding (Smit and Cilliers 2006:304). This case is an example of the way in which several valid arguments and experiences of participants were used to share opinions about the appropriateness of a joint EAP committee in an organisation. It was not the purpose of the focus group discussions to reach consensus on a topic such as the need for a joint EAP committee. In fact, the purpose was to explore the opinions and experiences of the participants with regard to the need for such a joint committee (Kitzinger 1995:sp). All of the discussions around this issue of a joint EAP committee provided excellent data on how the people involved think and what they perceive as important. Therefore, it is a critical aspect in the analysis of the data to recognise such prominent events in the focus group discussions. It provides valuable insights as can be seen from the experience of this participant who was of the opinion that a joint EAP committee would merely be a waste of time, just as any other committee where no decisions are made is a waste of

time. All of the arguments around this topic will be used to address crucial issues when the joint EAP committee is proposed as a criterion for the best-practice EAP.

The possible roles of an EAP committee were highlighted in the following comments:

(1) I also think it is cost-effective if everyone is involved in one joint committee instead of first going to this one and then wait for human resources and then wait for that report. So it is then a streamlined process; (2) We all have to cooperate ...; (3) ... to maintain balance. A statement made by one of the participants, who expressed the following viewpoint with regard to one of the major roles of the joint committee, was supported by everyone in the group:

It should also be the responsibility of the EAP committee to draw up the policy because it is not that one person drawing up the policy. It is a team and it should be consensus. This is how we want the program to run in the institution. So therefore there are more people needed to do that.

It was evident that the issue of a joint EAP committee was controversial and during the discussions certain practical concerns regarding the operation and function of a joint committee were raised. One of the issues involved the mandate of the committee, as expressed by one of the participants: *There should also be a very clear mandate to the EAP committee ... This mandate should exclude interference by a management member.* Another issue which was highlighted on several occasions was that of confidentiality. One participant summarised this as follows:

And I think there must be something like a confidentiality clause for all the committee members like, for instance, should you do something that you are not supposed to do. Then we do got [sic] a letter stamp on it and say that you've signed this confidentiality clause.

Csiernik (2003a:21) suggested that the committee's primary function should be directed towards the operations of the EAP rather than being involved in individual assessment or counselling processes. Several possible functions were mentioned by participants that could be classified as operational, while others could be classified as service rendering. Using these suggestions and taking Csiernik's (2003a:21) suggestions into account, eleven subcategories were identified by the researcher during the analysis of the data (see Appendix M).

5.3.6.3 Categories 2.4 to 2.6 – Requirements for EAP policies, types of EAP policies and entry processes and procedures

There was no hesitation amongst participants in any of the groups when faced with questions regarding the policies and procedures of an EAP. All the participants were supervisors and it was clear that they were used to working according to formal policies and procedures: *That is why I still say you must have guidelines. The other person must be guided step by step ... because they do not yet have the ability to take responsibility for it themselves.* This statement is typical of a concerned supervisor who wants to guide his/her fellow employees in the right direction. It could also be an expression of frustration due to employees being unable to take responsibility without formal guidance in the form of policies and procedures.

Several types of policies and procedures that are needed were discussed and all five groups concentrated heavily on the responsibilities of the supervisors, as well as on confidentiality. Practical aspects, such as referral methods, entry into the EAP and the responsibilities of employees were also cited as important policies and procedures needed to formalise the functions of an EAP. One participant concluded that an EAP cannot be implemented without the necessary policies and procedures having been developed and formalised: *And I think those procedures that we mentioned before should be in place and that will ... hmm ... I mean ... hmm ... will deal with this.* There definitely was a degree of uncertainty (indicated by several 'hmm' sounds in-between words) in the statement, as if the participant was not really sure what kinds of procedures are needed to formalise the activities of the EAP. However, the need for

formal policies and procedures was identified by Beidel (2005:284), who also concluded that it is necessary to have formal policies to integrate the EAP successfully into other systems of an organisation.

5.3.6.4 Category 2.7 – Marketing of an EAP

Only two subcategories emerged from the marketing category. Participants in three focus group discussions mentioned that it would be necessary to market the EAP within an organisation.

5.3.7 **Theme Three – The types of EAPs**

Since their inception, EAPs have evolved a great deal and modern-day programmes follow a holistic approach towards employees and employers (*cf.* 2.5). Different types of EAPs are used in the organisations of the focus group participants. This made their contributions valuable as they were able to share their experiences and opinions about EAPs currently in place in their institutions.

5.3.7.1 Category 3.1 – The types of EAP providers

The response from most of the focus group participants with regard to the following question on the agenda ‘How/by whom should an EAP be provided?’ was to identify service providers as being internal and external. These two types of EAP providers are the two most commonly mentioned in the literature (*cf.* 2.8). External service providers were identified as being important role-players by all the focus groups. As the discussion on service delivery by EAP providers progressed, the participants in the focus groups came to the conclusion that the most optimal way of rendering a service would be through a combined (internal and external service providers) system. One participant remarked, almost apologetically:

Sorry, there are options about outsourcing and in-sourcing. You can have half of each in one programme. So there are options that can be worked out in a particular institution. There is a way of having both in one programme.

This model is also recommended in the literature as the preferred option with regard to service delivery (cf. 2.8.3).

5.3.7.2 Category 3.2 – The characteristics of EAP providers

During the focus group discussions on the various types of service providers, a new pattern emerged when the participants started identifying the characteristics of the people who are responsible for the provision of EAP services. Eighteen subcategories emerged from the data for this category as participants mentioned characteristics, such as being professional, having good communication skills, and being responsible. Several groups also identified and discussed aspects, such as creating trust and the fact that employees should have enough confidence to use all of the services of an EAP, as two of the participants explained: (1) *... build up a relationship and ... they deal with their problems as well. They gained their trust ...* and (2) *But it depends on how you run your programme; you will win or lose the confidence of the people. They will be confident to come, utilise the service depending on how you treat them. So you will sell yourself and ... you need to understand the dynamics of personalities, relationships.*

There was a general agreement amongst participants that the service providers should have an intimate knowledge of the industry to which they are delivering a service. One of the group participants described this as follows: *It is also important that the person who provides the service must understand the world of health.*

A statement in one of the groups as to whether or not junior staff members should be allowed to render services in the EAP raised several counter arguments. The participant initially stated: *One mistake that we should not make is to allow junior workers to work in the programme.* During the discussions that followed, it became evident that the participants regarded 'junior' as not having the necessary experience

in years, as well as being in a lower position or rank in the organisation. After several arguments, the majority of the participants agreed that junior staff should not be allowed to render services in the EAP. The participant summarised the reasons for his initial statement as follows:

I don't want to be helped by somebody who has just finished ... hmm ... their studies and sometimes we, as employers, make the mistake by advertising these posts on a junior level and that is where you make the mistake so that people don't want to utilise the programme later.

No further reactions or counterarguments came from the other members of the group after this statement was made, but their body language showed that not all of them agreed with the statement. The issue of the seniority of EAP providers also surfaced in another group: *I do think it is going to be more senior level person*. A negative case (*cf.* Chapter 4) appeared in the third focus group as a counterargument was raised regarding the seniority of an EAP service provider. One participant in this group felt that junior personnel must be involved in the EAP. The reason provided for the statement is that senior members might retire, thereby causing the system to collapse or leaving a gap in the system. The participant's statement was well supported by the rest of the group.

Several groups considered training and professionalism to be characteristics of service providers, but none of the groups discussed these characteristics in relation to the characteristic of seniority. The training of EAP service providers is high on the agenda of EAP providers, as demonstrated by the fact that Vosloo and Barnard (2002:56) asked for more formal training and development of EAP practitioners in South Africa. The need for any type of training for EAP providers were discussed in Chapter 2 (*cf.* 2.9) and after the focus group discussions, it is evident that it is a contemporary issue in need of an answer.

5.3.7.3 Categories 3.3 and 3.4 – Categories of staff needed and types of services

Considering the question as to who should provide services within the EAP, participants provided the facilitator with a list of possible professions that should render services within an EAP. Several repetitions began to surface as focus group discussions followed each other. After the third session, no new categories of staff members emerged from the data. Only two subcategories, namely social workers and psychologists, resulted in more detailed discussion and these professions were discussed in all the groups. This outcome reflects the recommendation made by Vosloo and Barnard (2002:55) that these professions should be responsible for the necessary counselling services. The authors did, however, make the point that the roles of these professions are changing. The importance of having a full-time social worker appointed in an EAP was emphasised by addressing actual service delivery rather than merely performing a referral function. One participant argued that, *I think, if we got a full-time EAP member that a social worker appointed, then we can do therapeutic services from social work side and prevention services. Working only on the referral system, it makes it difficult.* In one group, the members were not sure about including a psychologist as part of the team, as one participant raised the question: *And the ... hmm ... psychologist? Should it be a clinical psychologist or industrial psychologist? Maybe an industrial psychologist.* There certainly was some doubt in the participant's mind about the choices, but he/she did not provide reasons for the indecision. The next participant felt that the inclusion of a psychologist is debatable, but also failed to provide reasons for her statement: *It is debatable. I think we are not used to using industrial psychologists. But that is what is happening in the private sector.* A decision as to whether or not a psychologist should be part of the team could not be made in that specific group, but one participant concluded the argument with: *But I think even here it is unlikely that they will have all these people but they'll need to have access maybe to them.* This is a negative case (Chadderton and Milne 1994:5) that needs to be highlighted since the other four groups recommended that a psychologist should be included as a team member of an EAP. This is also an example of how the participants did not influence or persuade one

another to change their perceptions or decisions, but instead came to an agreement on some common ground.

An unusual category mentioned by one participant is the involvement of academic staff: *I think we should also have some academic institutions like yourself involved. That is up to date.* This category could be linked to the issue of training discussed in the previous section as the participant asked for regular updates. The next comment confirmed this observation as one participant cited the reason for getting the academic staff involved as: *Training and development.* Several participants uttered 'Oh' as they began to understand the reason for the unusual inclusion. This is an example of the benefit of focus group discussions where an issue was put on the table by one participant and the following interactions between participants provided meaning on the issue to other participants.

One participant in one of the focus groups verbalised the concept that anyone can render a service if the culture of Africa is considered within the context of service delivery. However, the discussion did not continue after the participant made her point:

If we are, as we are seated here I am sure we are aware in one way or the other we, anybody who can render EAP. Let me take an example, a typical example of our culture. If an individual at home is doing something wrong, you know you have the right to call the elderly members of the family to come together and then, you know, reprimand this individual. Doesn't matter what problem it may be.

During this statement, the rest of the participants listened attentively and afterwards agreed by nodding their heads. Although no additional comments were made, it was clear that they had respected what she had said. This statement was a once-off statement, but could be considered as critical. The participant provided insight into certain cultural aspects of a specific cultural group and the way in which they can be used to the benefit of an employee. The researcher found no similar codes in any of the other four focus group discussions. Such statements about the EAP in the African

context cannot be ignored, especially when a qualitative research approach is used. This statement also shows the significance of analysing the focus group data on more than one level (on an individual level as well as in terms of group dynamics) to avoid losing the finer nuances and intricacies suggested by Nieuwenhuis (2007:108).

The response to the agenda question on the types of EAP services followed the same pattern as the previous question in the sense that saturation was reached after the first couple of focus group discussions. However, as the discussion progressed, it became evident that the types of services needed must be delivered to employees in a holistic manner. The types of services identified by the focus groups extended further to include the delegation of traditional managerial functions of supervisors to the EAP: *And I think approval of sick leave.*

Financial assistance to employees as a service of an EAP raised concerns amongst some of the participants: *I think if one goes to financial [sic], you are on thin ice ... I think financially when one starts to speak about finances, you have to make sure.* The issue of financial assistance was clarified by the participants to mean the giving of financial advice rather than monetary assistance: *But it is what we have said in the beginning that is so important that personnel will understand it is not about financial help, it is advice. That is what it is about.*

An important issue was raised when four of the five groups mentioned that the focus of EAPs must be on prevention: (1) *But to add on that we ... EAP ... should be more on the preventative side. We should not wait for that time until there is a problem and call on an employee. Try and see things and prevent them before they actually happen* and (2) *I think prevention is very important. Really, I think it can play a very big role.* This viewpoint is in accordance with the view of Roman and Blum (2002:50) who stated that the focus of workplace programmes, such as the EAP, should be mainly on primary prevention. Therefore, the aim of the EAP should be to prevent problems rather than dealing with the problems. In the studies they conducted, Ames and Janes (1992 in Roman and Blum 2002:50) raised a concern about the tendency of workplace programmes to place the focus primarily on secondary prevention with

the aim of reducing existing problems. Sparling's (2010:3) study, conducted in 2010, revealed that currently, there is a definite movement towards primary prevention as worksite health promotion programmes are integrated and linked to programmes, such as EAPs.

5.3.8 Theme Four: The evaluation of the EAP

The topic on the evaluation and quality assurance of EAPs has been greatly debated in the literature by a number of researchers, but no agreement has been reached on a definite model (*cf.* 3.4). Specific questions were asked in the focus group discussions to identify the participants' views with regard to this much-debated issue. Care was taken during the process of selecting the participants for the focus group discussions to include some supervisors who are in charge of quality assurance in their workplaces. Even though these experts were included in the groups, the initial reaction to the question 'Which methods of evaluation could be used in the evaluation process?' did not elicit an immediate response from the participants. The facilitator had to repeat the questions several times and on several occasions the questions were met with complete silence.

5.3.8.1 Categories 4.1 and 4.2 – Programme evaluation: general aspects and aspects to be evaluated

Some general remarks were made with regard to the evaluation of, and quality assurance within, an EAP, which resulted in the identification of seven subcategories (see Appendix M). The time period at which the evaluation of an EAP should take place was discussed in all the groups. One participant summarised the concept as follows: *I think it must be a continuous evaluation of each step.* However, general agreement that an organisation should not wait until the end of the process before starting with the evaluation was reached in each of the focus groups: *And I think one should not wait until the end to evaluate.* Another group, who came to the same conclusion, emphasised the fact that evaluation needs to be a continuous process that involves evaluating the entire programme rather than just the outcome: *I think the*

evaluation process must, from the beginning, from the minute that person gets nominated for, to join the EAP. It should be a process right through until we reach an outcome. In one of the groups, the manner in which the initial evaluation of an EAP should be conducted, was also highlighted when one of the participants commented that *I think also in the beginning, especially when you start it and the thing must get on its feet, you are going to need big evaluation in the programme itself because it is a first time.*

The evaluation of the outcome of EAPs was important to the participants in all the groups. A participant, who regarded this as the most important area to be evaluated, stated that:

I think the most important area really that needs to be assessed is when the person is already in the programme, is the exit programme, because with the exit, you would be able to see or you would be able to know if whatever you have done with your client, was it successful? ... So, with me, I feel that the exit one is the important one.

There were different interpretations of the concept 'outcome' and what it entails. One participant's statement that, *I want to add on that the person's performance and his functionality after leaving the programmes should be monitored for a prescribed time* was strongly supported by all the other participants sitting around the table. As discussed in Chapter 3, the literature also currently fails to agree on what could be defined as a successful outcome of an EAP (cf. 3.1). Several other subcategories emerged as participants continued to elaborate on what they thought are important aspects to be evaluated in an EAP. Eventually, a lengthy list of thirty-five subcategories was created (see Appendix M). It is impossible to discuss all thirty-five subcategories, but three subcategories were identified in all five groups. The outcome of the employee was discussed at the beginning of the paragraph and the other two were (a) self-evaluation and (b) the evaluation of staff working in the EAP.

With self-evaluation, participants meant that employees should evaluate themselves rather than simply concentrating on their satisfaction with the programme. As one of the participants explained:

I think self-assessment will also be good because then they (employees) can see how do they, self, feel they are coping with stress. How they are coping with conflict. How, it would be interesting to see this, the self-evaluation, correlates with the evaluation of the people around the sort of the observers or whatever.

This suggestion shifted the evaluation process towards a more employee-orientated approach and removed the sole responsibility for providing assistance to employees from the employer or system. The employee can give an objective opinion of him/herself after having used the services of the EAP. Shumway, Dersch, Harris and Arrendondo (2001:79) investigated the concept of self-evaluation by the employee, which they thought to be controversial. They recommended a combination of the two types of measures, namely outcome and satisfaction, using self-evaluation measures. In their opinion, doing so will offer the 'best of both' worlds.

In contrast to the extended coverage in the literature on measuring customer satisfaction in the EAP, only two groups discussed and recommended that this aspect should be included. Only one comment pertaining to this aspect was made by a participant in one of the groups and came across as somewhat uncertain: *One can also evaluate the users of the service. You know that they score the service, satisfaction score or customer care.* No-one agreed with the participant or made further comments on the issue of customer satisfaction. It is significant that all five groups concentrated heavily on the effectiveness of the EAP, yet very little attention was paid to measuring customer satisfaction of the actual services.

The only other aspect that was discussed in all five groups was the fact that staff working in the EAP should conduct regular evaluations of themselves as suggested by one participant:

The positive of the good of the office of the EAP is as good as the person who is giving the particular intervention itself ... So, the very same people who are working there, they need to be evaluated in terms of their output in that office.

Participants provided other reasons for performing staff evaluations, such as (a) the satisfaction of EAP staff in the workplace, (b) the level of support received by staff and (c) possible staff turnover. As all the participants were supervisors, it was not surprising that they emphasised the evaluation of staff working in the EAP, as employees' performance measurements are part of their duties. They seemed to be familiar with the concept and need for evaluation of staff working in EAPs as part of the process of quality assurance.

Another aspect that received a great deal of attention during all the focus group discussions was confidentiality. However, during the discussions on the aspects to be evaluated, the need to measure whether or not confidentiality had been maintained was only discussed four times in two separate groups. Confidentiality is a crucial aspect of the EAP since it bears serious ethical and legal implications. No-one suggested methods of measuring these crucial aspects, but one participant provided a solution when he/she suggested using numbers, rather than names, in reports.

Four of the group discussions paid attention to the evaluation of the type of problems presented by employees who use EAPs. The following statement was made by one of the participants in this regard:

I think also the pattern of the problem that arises, so that preventative measures could be in place. Let's say they check it monthly or every third month so that we can put preventative measures so that they should not fall in the very same trap.

This statement not only emphasised the need to evaluate the types of problems dealt with in the EAP, but also linked the preventative aspect of the EAP with the evaluation process (*cf.* 5.3.7.2). The literature also supports this observation as stated by Csiernik (2004a:22). In addition, it is critical that organisations regularly conduct

needs analyses to ensure that the services rendered by its EAP are in line with the requirements of the employees and employer (cf. 2.4.1).

An aspect that was discussed extensively in the literature (cf. 3.4), namely the evaluation of the utilisation of EAPs by employees, was touched upon in only two of the group sessions: *So yes, one must look at how many people make use of it.* In general, the participants did not consider this aspect as important in the evaluation process. Participants felt that it is more important to evaluate the effectiveness of the programme and the value it adds to the organisation, as one participant commented:

When you look at the programme itself, does the programme really add value and if the programme is evaluated, there is not really financial value added, but actually financial because productivity is better and attitude maybe is better.

The wide variety of aspects recommended by the participants to be included in an evaluation of best-practice emphasises the potential impact of an EAP on an organisation.

5.3.8.2 Category 4.3 – Programme evaluation – methods of evaluation

In the previous section, it was mentioned that some of the participants in the focus groups were employed in the quality assurance units of their organisations. Despite this expertise in the groups, a number of silences followed the facilitator's question with regard to which methods can be used to evaluate EAPs. One of the reasons for these hesitations could be that the participants did not have an understanding of what was meant by 'methods of evaluation'. However, none of them asked for clarification with regard to the question, or what was required from them. Another reason could have been that they were not familiar with the methods available to evaluate quality in health care or that they did not use recognised quality measurement methods. Although it took a while in each group, several methods were eventually mentioned and discussed.

The use of statistics was cited by all the groups as a valuable method of evaluation. One participant tried to give a clearer understanding of its applications in the field of EAPs by stating that:

I am statistical. I would want to know what type of problems was there? Which, were the channels sufficient? How many were successful? How many were not successful? What were the recommendations? When I look back, I'll want to see that type of things. You must go and look, was your policy sufficient and you must have space for change. This, this part has worked well, but here is where we have shortcomings.

The use of questionnaires and surveys were discussed in four of the five groups. These methods have the advantage of placing some emphasis on the employees and staff working in the EAPs rather than simply focusing on the system as such. A participant made the following statement immediately after the facilitator posed the agenda question on methods for evaluation of EAPs:

The persons who did in fact made use of the programme, that they specifically give an evaluation to the company to say a questionnaire or survey or something to measure whether the services that had been provided are ...

The participant did not complete the sentence and it therefore seems that he might have been unsure about what should be measured by a questionnaire. This example further strengthens the perception that the participant was uncertain about possible evaluation methods that could be used in this field.

As the discussions progressed, the participants began to mention alternative methods of measurement, which led to more in-depth discussions. As the methods were put on the table, the participants began to debate the possible benefits of the evaluation of EAPs:

I think it is going to be very, very difficult, but I sit and think, you know at the end of the day because the boss is going to see us as a cost implication. So cost implication

in terms of maybe what did it cost you to, to have this intervention? Time is money and that is how it is, but also what has maybe cost implication in the sense that our number of absenteeism was much lower since the programme has been implemented.

This is an excellent example of the benefits of a focus group discussion for whereas the participants appeared to be very unsure of themselves at the start of the discussion, they soon began to grasp the concept as the discussions continued. The participants and the discussions began to complement one another and valuable information began to emerge from the groups.

Most of the initial discussions focused on methods of a quantitative nature, but as the discussions progressed, the groups began to probe deeper and deeper. In one of the groups, the participants took the evaluation process to another level when one participant suggested that a combination of quantitative and qualitative methods should be used: *And I think maybe both quantitative and qualitative methods can be used so that we can see how many people are for the EAP and we dealt with that one and how do they really feel about the whole EAP process.* The idea of the qualitative evaluation of an EAP was also mentioned in two other groups who suggested the use of an anonymous feedback system: (1) *They must all be evaluated in a way either by anonymous feedback or, you know, by doing a survey they are unaware of. What is the general situation you can do a good evaluation? Does it work or not?* and (2) *So, it would have been nice to a degree not detail, but get feedback to a degree to know if there is anything from your side that you can help with.* One of the participants made a valid statement: *... One must have different methods for different problem.* This, however, might have practical implications due to possible limited resources within an EAP.

An acknowledged method of quality improvement was discussed in only two of the focus group discussions. Coincidentally, both of these groups discussed the same method, namely that of the quality improvement cycle. A comment from a participant in one of these groups was as follows:

Maybe looking at the people of compliance, people that really help people that ... did not comply or the reasons why people didn't ... almost be like quality assurance circle to get back to see if some of the problems can be solved.

In the second of these two groups, the topic emerged when a participant asked the rest of the group members: *Can we not compile a quality circle of that?* Only one participant in that group responded with *Yes, where your shortcomings can be identified.* After these two statements were made, the discussions took a different direction and did not return to this topic. This indicated the lack of knowledge or experience with recognised quality improvement methods. Another example of the lack of knowledge was found in the discussions on indicators. The concept of indicators was discussed in only one of the discussion groups where it surfaced twice during the session, but no in-depth discussion was held on the topic. The statements made in this group were the following: (1) *Especially when it is a hospital problem, a general problem. Then you can have such lead indicators* and (2) *For XXX Hospital, we measure this and this and this and that is why you work ultimately.* Although the various types of indicators are supposed to be well-known concepts that are used in health care (cf. 3.5), it seems as if questions on how often they are used in the day-to-day running of health care facilities and the role they actually play in the quality improvement activities of health care institutions can be asked.

The focus group discussions confirmed the lack of consensus on how EAPs should be evaluated as many different opinions were raised during the discussions. The participants could not reach consensus on the most appropriate methods for the evaluation of EAPs. A valid conclusion was drawn by one of the participants who stated:

Then you can come up with something. Evaluating can be based on many aspects... I think with that you can use several assessment methods, evaluation methods.

By using more than one method, an organisation could adapt a more balanced approach to the evaluation of an EAP. Manville (2007:164) made the same type of recommendation in a study proposing that organisations could benefit from more holistic measurement and management frameworks rather than simply using a few evaluation methods. Such a holistic approach can be referred to as a Balanced Scorecard approach as discussed in Chapter 3 (*cf.* 3.5). A balanced approach to evaluation could address the basic components, such as inputs, processes and activities, outputs, outcomes and long-term effects, providing managers with a performance story and a balanced set of measures on the functioning of an EAP.

5.3.9 Theme Five: The impact of the EAP

A question on the impact of the EAP on an organisation was posted as the concluding question of the agenda. Two categories emerged from the data, namely the impact on employees and, secondly, the impact on the organisation itself. All five groups agreed that the EAP could be used to retain employees as seen in one participant's statement, which was supported by the rest of the group: *I just want to add that this can be a retention tool as well, you know. If an employee are [sic] being looked after with a salary and holistically this can make a change to go out or to stay in.* The use of the EAP as a retention tool is not a unique concept. Ginn and Henry (2003:25) suggested using wellness programmes as a retention tool. Improved productivity of employees within the organisation was another issue discussed in all the groups:

The impact will be, I think all the unit managers will agree, it will reduce our work and stressors in the wards when you know there is someone who is at least working with this member of staff or this group of people to increase your productivity in the end, because you later find you do not even want to see the guy when he comes in, in the morning because you know what is going to happen. So, that is the first thing. I think it will remove a lot of stress from us and from the group in which they work.

The issue pertaining to the stigma associated with EAPs was discussed briefly in only one of the groups. The first statement made by a participant in this group was:

I think if the EAP works well it can also take the stigma out of a lot of things. If people see that HIV people are helped there or people with stress or people with depression or whatever they won't be scared to expose themselves to tell that I've got this problem because they feel we going to be helped there and it makes a difference.

This statement was well supported by the rest of the participants in the group. A second statement on this topic made by this group referred to the marketing aspect of EAPs:

The whole marketing and rollout of the EAP is a bit difficult because what you need actually is your happy people who went through the programme to advertise yourself. So, maybe we should also start support groups of members who has [sic] left the EAP. Just to be a referral system. Currently there is still a stigma on the EAP and we haven't got happy customers to say: 'You know, I've been there and it has helped me, please go there'. So a support group if you exit this programme, there should be something nice.

Merrick *et al.* (2010:86) proposed similar promotional strategies to address the stigma attached to EAPs. Although the aspect of stigmatisation associated with EAPs was not discussed adequately during these focus group discussions, it is an important aspect that cannot be ignored.

5.3.10 Conclusion

An overwhelming and strong conclusion from the focus group discussions was the expressed need for supervisors to have employee assistance in place and to assist employees in coping with personal as well as work-related problems. A second conclusion that emerged during the data analysis process was the need to formalise employee assistance by developing a formal policy for access to prevent employees from abusing the benefits of the EAP. However, several themes, categories and subcategories emerged from the data, while a great deal of the data had already

been coded into themes identified during the literature review. Therefore, it can be concluded that using focus group discussions as a data-gathering method produced excellent in-depth information regarding the EAP, the phenomenon under investigation. However, it was disappointing that more practical information was not provided by participants on the evaluation of EAPs.

The outcomes of the focus group discussions were used to develop the questionnaire for the Delphi survey. The next section will discuss the analysis of the Delphi survey.

SECTION B: DELPHI SURVEY

5.4 ANALYSIS, INTERPRETATION AND DISCUSSION OF DATA FROM THE DELPHI SURVEY

The analysed data consisting of themes, categories and subcategories from the focus group discussions was used to identify the key concepts to be included in the framework for the best-practice EAP and quality management. The subcategories provided the detail for drafting the questions for the first round of Delphi questionnaires. This approach is a modification of the classic method used for the Delphi survey where the first round consists of open-ended questions, which allow the participants to express their opinions. The process of rating questions according to their level of importance usually starts only during the second round of a classic Delphi survey.

The criteria used to extract the applicable subcategories from the focus group discussion analysis were:

- The aspect must be quoted three (3) or more times in different discussions, irrespective of the number of focus group discussions in which it appeared
- The aspect must be quoted twice, but in different focus group discussions
- Other aspects identified during the literature review and which authors deemed crucial.

These key concepts were sent to twelve experts in various fields in the form of a questionnaire to be tested and to achieve consensus, using the modified classic Delphi survey. Consensus for the Delphi was defined as an 80% agreement amongst participants' ratings of questions, using a three-point Likert scale. Stability was considered to be when all participants made no changes to their ratings for a specific question (*cf.* 4.7). A response rate of 100% from participants was achieved through all six rounds of the Delphi survey. However, the deadlines for the submission of the completed questionnaires were extended a number of times to accommodate some

of the participants, which resulted in an extended period for the Delphi survey. Initially, four months was planned for the survey to be conducted, but it took nearly six months to complete the six rounds. A summarised version of the outcome of all the rounds can be seen in Table 5.3.

It is important not only to discuss the analyses, but also to focus on the significance of certain information provided by participants at various stages of the survey. The aforementioned information, which was deemed valuable, is highlighted in context with the rest of the analyses. The aim of this part of the chapter is to provide the results and the analyses of the empirical part of this study. It will continue with a detailed discussion on the analysed data to confirm the content needed for a framework for a best-practice EAP.

5.4.1 Round One of the Delphi survey

The first round of the Delphi survey consisted of 187 questions which were drafted and sent via e-mail to the twelve Delphi survey participants (*cf.* Appendix G). A timeframe of four weeks was given to participants to rate the questions by means of a three-point Likert scale (*cf.* 4.8) and return their completed questionnaires. During the pilot study, it was estimated that it would take a participant about forty-five minutes to complete the questionnaire, although one participant replied that it had taken him two hours to complete the first round. The first three completed questionnaires were received within a week and the last questionnaire was received after eight weeks. It must be pointed out that the delay did not have a negative impact on the outcome of the first round as the overall rating of the other eleven participants was not yet calculated and the report for the first round was not yet compiled before the substitute participant received the first round questionnaire.

Consensus was achieved on 42% of the questions in the first round. No questions were removed from the questionnaire as all the questions were deemed relevant by the participants. One participant did not understand one of the questions and for this reason he/she did not rate it. The non-rating by this participant did not influence the

overall rating as the specific question had a widely distributed rating. After an explanation was provided, the participant rated the question in the second round. Participants were encouraged to provide comments on each question. Space was provided for this purpose after each section on the questionnaire. Eighteen (18) new/additional questions were drafted from these comments and these questions were included in the second-round questionnaire. Due to this addition, a total of 205 questions were rated by the participants during this Delphi survey.

5.4.2 Round Two of the Delphi survey

All twelve of the participants were willing to continue with the Delphi survey after the initial round. The questions on which consensus was achieved were removed for the second round, which resulted in 126 of the overall 205 questions (61%) remaining in the questionnaire (see Appendix N). The relatively high number of questions on which no consensus could be achieved in the first round could be an indication of the controversial nature of a possible framework for a best-practice EAP. The second-round questionnaire was individualised in the sense that it contained information on the overall rating per question, as well as each participant's rating for each question (see Appendix H). Each participant also received a report on the outcome of questions for which consensus and stability had been achieved during the first round. To avoid confusion amongst the participants, this report was sent to the participants only once their completed questionnaire for round two had been received. This process was repeated by the researcher for all subsequent rounds of the survey.

In the second round, participants were given three weeks to review their ratings and return the completed questionnaires. Again, there was a time delay as the last of the completed questionnaires was received five weeks after they had been sent out. This time no obvious reason was found for the delay. The second round of the Delphi survey resulted in consensus on another 70 questions (55% of questions sent during the second round). No stability was achieved due to the fact that the ratings of all 126 questions changed in the second round. None of the participants were satisfied with their initial ratings and they all made a number of changes. It is the purpose of a

Delphi survey to focus on the opinion of identified experts and gather their responses systematically by providing continuous feedback after each round of receiving completed questionnaires (De Meyrick 2003:7). The purpose of the Delphi survey had been achieved as participants changed their rating after they received their individualised feedback from the first round. The changes in the ratings implied that the experts were moving towards a collective judgement on criteria needed for a best-practice EAP (De Meyrick 2003:9). Comments were provided by participants on the content or relevance of the questions, as well as on why they decided to change their ratings. Those comments provided even more insight into why consensus or stability had been achieved amongst participants with regard to the criteria.

5.4.3 Round Three of the Delphi survey

On completion of the first two rounds, accumulative consensus had been achieved in 73% of the 205 questions. It was thus necessary to continue with a third round of the Delphi survey as the criteria for consensus and stability was determined before the start of this survey as stipulated in the literature (*cf.* 4.8). Fifty-six (56) questions were included in the third round (see Appendix O). Two weeks were allocated for the participants to review their ratings. Again, there was a delay as one participant, for no apparent reason, returned the completed questionnaire only three weeks after the questionnaires had been sent out. All twelve participants once again changed one or more of their ratings. Of 56 questions used for the third round, the participants achieved consensus on 24 questions and stability had been achieved for the first time during this Delphi survey on three questions. As a result, there were still 22 questions left and a fourth-round questionnaire was compiled. It is recommended that a Delphi survey should stop after three rounds when there is evidence of convergence of opinions (Fink, Kosecoff, Chassin and Brook 1984:980), but it was necessary to continue into the fourth round as convergence of opinions had not been evident.

5.4.4 Round Four of the Delphi survey

Fourteen (14) percent of the questions (29 questions) were transferred to the questionnaire for the fourth round of the Delphi survey (see Appendix P) and again, participants were given two weeks to review their ratings. In the previous rounds, all communication with participants had taken place via e-mail, but one participant experienced problems with his e-mail. One of the advantages of a Delphi survey is the utilisation of electronic media for communication purposes (*cf.* 4.7), but even electronic media in the current era has its disadvantages. The participant phoned the researcher and the changes to the ratings were made telephonically. The participant then confirmed the new ratings by faxing the questionnaire back to the researcher. Telephonic feedback was given to the researcher by this participant for all the subsequent rounds, but the participant did not follow it up by faxing the completed questionnaire back to the researcher, despite reminders. After three weeks, the twelve completed questionnaires were received and consensus had been achieved on another nineteen questions and stability on three questions. A very high cumulative percentage of consensus and stability of 97% had been achieved after four rounds. One participant included a request in a reply e-mail, asking the researcher to consider stability on the remaining questions as it appears to him that there is now consensus and stability. There were, however, participants who were still changing their ratings and, therefore, the researcher could not consider stability of the process at this time. For the first time in all four rounds of the Delphi survey, there was one participant who did not change any of the ratings. However, during the fifth round, this particular participant made a change to one of the ratings. Two other participants made only one change each during the fourth round.

5.4.5 Round Five of the Delphi survey

The remaining seven questions were sent out for a fifth round (see Appendix Q). For the first time, the round was completed before the predetermined two-week timeframe. This could be an indication that the participants were frustrated with the lack of consensus achieved or it could be due to the small number of questions

remaining. Although this was experienced only in the fifth round of this Delphi survey, McKenna (1994 in Keeney *et al.* 2006:207) observed that response exhaustion from participants can occur as early as the second round. Six of the twelve participants decided that they were satisfied with their ratings and did not make any changes. The other six participants made one change each to their ratings. After the fifth round, no consensus had been achieved on any of the seven questions, but the participants did not change their ratings on three questions, implying stability in these cases.

5.4.6 Round Six of the Delphi survey

Round six consisted of the remaining four questions (see Appendix R). Only four of the twelve participants changed their ratings, resulting in final consensus on two questions and stability on the other two questions within one week. Therefore, consensus and stability had been achieved on all 205 questions and the Delphi survey was concluded after six rounds.

5.4.7 Summarised outcome of the Delphi survey

The recommendation from the literature is that a Delphi survey should end after three rounds (*cf.* 5.4.3). In this survey, however, a cumulative consensus and stability had been achieved after six rounds only. A high rate of consensus (95%) was achieved on all 205 questions, while stability was achieved on only eleven (5%) of the questions (*cf.* Table 5.3). The participants provided a great deal of comments on the questions submitted in each of the rounds. Some of the comments were provided as reasons why participants changed their ratings, while other comments served to debate the value or usefulness of a specific question that was asked in the survey. These comments were not circulated to the participants after each round of the Delphi as it was considered that this may have a biasing effect on the other participants.

Table 5.3 Summarised outcome of the six rounds of the Delphi survey

Round	Number of questions sent to participants	Number of consensus achieved	Number of stability achieved	Percentage consensus/ stability achieved	Number of new questions created and added	Cumulative percentage of consensus/ stability achieved
1	187	79	0	42	18	42
2	126	70	0	56	0	73
3	56	24	3	47	0	83
4	29	19	3	76	0	97
5	7	0	3	43	0	98
6	4	2	2	100	0	100

5.4.8 Detailed outcome of the Delphi survey

The final part of this chapter consists of a more detailed discussion of the different sections of the questionnaire that was used for the Delphi survey.

5.4.8.1 Section A: Introduction of an EAP

Consensus amongst the participants was achieved on the majority of questions dealing with the rationale and objectives of EAPs within the first two rounds. For the objective 'To retain employees in an organisation' consensus was achieved in the third round and for the new question 'To provide a service that is in line with the institution's core values, including the provision of quality care to its patients' consensus was achieved in the fourth round.

The section on the scope of the EAP seemed to be more problematic since the participants could not agree on the statement that the scope of an EAP should be very broad with a variety of services provided. One participant questioned the lack of consensus on the question and, during the fifth round, commented that *This is the basic definition of an EAP – not sure why consensus did not occur*. The lack of consensus amongst the participants is not in line with proposals from the literature. Johnson (2008:264) identified several reasons as to why the scope of the EAP has expanded considerably over the past few decades to include a broad range of services, such as depression, stress, relationship problems, marital problems, compulsive gambling, career issues, financial and legal concerns, lactation centres, child care and care of the elderly, health and wellness, and violence, to name a few. This broad-brushed approach allows the organisation to make use of a range of benefits and approaches to addresses complex problems (Choi 2005:47). Participants in this Delphi survey contradicted themselves in that they achieved consensus on the fact that the EAP should view employees in a holistic manner within the first round, but then could not agree that a wide range of services should be provided.

Tying in with the above-mentioned issue is the question as to whether an EAP should address employees' personal problems, and consensus was only achieved after five rounds. Addressing an employee's personal problems that interfere with his/her job performance is the main purpose of an EAP as suggested by Roman and Blum when they identified the six core technologies of an EAP (Roman and Blum 1988 in

Schonberg and Lee 1996:204). This question can be linked to the fact that the introductory statement from the executive management for the EAP should highlight the importance of such a work-based programme to assist employees with personal problems in the workplace.

A negative case to consider is the fact that it took the participants six rounds to decide that it is not within the scope of the EAP to assist with the appointment of employees. The participants provided the following reasons for excluding this criterion from a best-practice EAP: (a) three participants were of the opinion that the appointment of employees is a human resource function and not that of the EAP, (b) two participants emphasised the importance of confidentiality and that assisting with the appointment of employees could compromise the crucial aspect of confidentiality, as well as creating trust in the EAP. The literature review that was conducted found no evidence that the EAP should be used to assist organisations with the appointment of new employees.

The expectation was that consensus on these questions would have been achieved much earlier in the Delphi survey as they are the critical elements of an EAP. The participants in this Delphi survey consisted of EAP providers and executive managers and it could be that EAP providers and managers have different perspectives on what is meant by 'employees' personal problems'. Some of the participants either favoured a 'hard' or 'soft' approach to human resource management (Druker, White, Hegewisch and Mayne 1996:405), which resulted in the late achievement of consensus. The 'hard' human resource approach simply uses employees as another resource to achieve certain targets without any other consideration. The 'soft' human resource approach treats employees as human beings working in a specific workplace, while considering multiple factors that could influence them. The rating of these questions can also be perceived as a lack of support from management towards EAPs when it comes to employees' personal problems. This perception is a cause for concern, but the results cannot be generalised. One participant concluded with the following comment in the questionnaire:

Health institutions generate circumstances that bring about major pressure on employees. In addition to the normal pressures experienced in work places, employees are put under additional stress due to circumstances related to health care institutions – volume, critical time and dynamics of treatment processes.

It could mean that health care institutions are unique and that EAPs should be adapted accordingly.

5.4.8.2 Section B: Structure and requirements for an EAP

Apart from Question 6.5, consensus on all the questions pertaining to the requirements and the role of the in-house EAP committee was achieved within two rounds, 'To be involved in the discussion of problematic cases/employees within the EAP.' Stability was achieved amongst participants on this question in the last round of the survey. Participants were of the opinion that such an EAP committee should be an administrative committee rather than being a service-rendering committee, as one participant commented: *Only if you want to undermine all the work you have done in developing the programme – the EAP committee is an administrative group, not a counselling group.* One participant's comment summarised all the other comments received on the question: *Case information is confidential and only a clinical review team, which is not an EAP committee, in my opinion would be able to discuss a case. An EAP committee is programme focused rather than case focused.*

The proposed manner in which services should be provided in an EAP did not suit the participants as they struggled to achieve consensus on several questions in this section. The only early consensus achieved on this topic was that these services should be provided by a multi-disciplinary team. It was difficult for participants to achieve consensus on whether the EAP should be provided by an internal or external service provider. No consensus was achieved on the latest trend, namely a combination of internal and external service providers as suggested by Birkland and Birkland (2005:327), as well as by Merrick *et al.* (2010:86). There were general agreements in the focus group discussions amongst supervisors that this approach is

the better option. It must, however, be pointed out that several of the participants agreed that this is the best option as statements such as the following were made: (1) *This is the best model – primary care internal, special needs external* and (2) *I wrote a paper about a decade ago arguing why this was the best model in terms of employee services – surely not the cheapest, but the best rarely is*. The main concern from the participants was the confidentiality issue as one participant commented: *This will not satisfy the need for complete confidentiality*. This concern was probably the reason why only stability could be achieved with regard to the question.

While the characteristics of EAP providers did not pose a problem for participants, no consensus was achieved on some of the categories of service providers needed for an EAP:

- Occupational therapy (OT): From the experience of one participant came the following comment: *I hate to be difficult, but at least OTs are not trained in EAP work and I have never personally worked in an in-house or outsourced EAP with an OT*. Two participants were also of the opinion that occupational therapists are not part of the EAP team because they are *not ... core psychosocial counselling professionals* and *Maybe the role of the occupational therapist needs to be reviewed*.
- Financial advisor: One participant acknowledged that *A large number of problems are financial*. However, another participant commented that *Companies cannot provide for more financial gains. (Law requirement – not a financial institution)* – but may have understood this question incorrectly.
- Medical practitioner: One participant viewed services rendered by medical practitioners as being too specialised for an EAP and two participants were concerned about the medical care provided within an EAP: *Emphasis put on general services that can turn EAP into a small health ailment clinic*.

- Administrative staff member: No consensus, but only stability in round six indicated that executive managers are not concerned about the administration of the programme. However, one participant asked the question, *Short-sighted to leave the admin member out – who's going to do some of the admin work related to EAP?* One participant suggested that *Total admin can be done by registered nurse*. Statements such as these and no consensus achieved raised questions on the opinion regarding people in higher positions and their insight into the administrative duties involved in EAPs.

5.4.8.3 Section C: Policies and procedures for an EAP

The participants did not experience any problems with regard to any of the questions in this section and consensus was achieved on all questions. Only a few comments were made by participants.

5.4.8.4 Section D: EAP processes and activities

The participants struggled to achieve consensus on some of the questions regarding the types of services to be rendered within an EAP. Consensus was achieved only in the fourth round on several of the proposed services to be rendered within an EAP. A question can be asked about managers' awareness of the problems experienced by their employees. However, the comments provided by the participants provided no insight into this question. It must be remembered that the Delphi panel consisted of EAP providers and executive managers, which could have made the decisions more complex. Another example is the fact that no consensus was achieved on the need for psychiatric services within the EAP, but consensus was achieved during an earlier round on the question as to whether a psychiatrist should be a member of the team. No consensus was achieved on the financial adviser being a member of the team, yet in the third round, the participants achieved consensus regarding the need for financial advisory services. It shows some discrepancy on the decisions made by the participants.

During the first round, one of the participants proposed that an EAP should include general support services, such as allowing employees to visit the Department of Home Affairs for ID documents, birth registrations, passports and motorcar registrations. The proposed service was included in the questionnaire for the second round, but the other participants were not impressed with this suggestion. Some of the participants' comments received after the second and third rounds were as follows: *Too general. Can become extremely messy and I can only describe this as serious scope creep. It will almost require to redefine EAP continuously.* Consensus was achieved only in round six on this question and the outcome was that it could be considered for inclusion. This is an example of how the participants changed their opinions as the Delphi survey continued into the last few rounds.

5.4.8.5 Section E: The evaluation of the EAP

The importance of a formal evaluation process for an EAP from a managerial and provision point of view can be seen in the manner in which consensus was achieved. An example is the fact that consensus was achieved during the first round on all six questions pertaining to the requirements for the evaluation of an EAP. Almost the same pattern occurred regarding questions on the components of an EAP that should be evaluated. Thirty questions were asked in this subsection and within the first two rounds, consensus was achieved on all of these. All twelve participants gave the same rating for nine of these questions (100% consensus rating). In this Delphi survey, such a high level of consensus was a rare occurrence. In fact, for the preceding 153 questions, only twelve questions reached the 100% consensus mark. Furthermore, the participants did not provide many comments on these questions. The few comments that were received emphasised the positive aspects of evaluating EAPs such as: *Encourage employee participation in feedback, as well as suggestions of programmes/service they want.*

The last part of the Delphi questionnaire dealt with questions on the best methods to be utilised in the evaluation of an EAP. The questions in this subsection did not achieve the same consensus as the subsection on the components of the EAP that

should be evaluated. There seems to be a difference of opinion regarding the benefits, advantages and disadvantages of the evaluation methods as promoted in the literature (*cf.* Chapter 3), and those recommended by the participants in the focus group discussions. It should be noted that even in the literature, there are differences in opinion on this issue and it was, therefore, one of the aims of this survey to search for consensus from the participants on the types of methods deemed to be the most practical. During the Delphi survey, not everyone agreed on method or combination of methods that would be the most effective for the evaluation of an EAP. Evidence of the disagreement can be found in the manner in which consensus was achieved on some of the questions – consensus was achieved only in the third and fourth rounds. One example of this was the question on a recent development in performance measurement, namely the Balanced Scorecard approach. The question did not achieve consensus, but stability was achieved in the fourth round. The reason for this could be that some of the participants were not familiar with this concept, but no-one indicated that this had been an issue in the comments column. Furthermore, one participant agreed with a concern raised in the literature about the benefits of 'soft success criteria' (Thakkar, Deshmukh, Gupta and Shankar 2007:54) as he commented in the first round: *Hard to do this with soft services like counselling*. In the second round, another participant commented: *Probably the most feasible of all*. Four participants considered this approach to be critical, but claimed that an organisation should consider using evaluation methods that fit in with its quality assessment strategy.

The participants provided several comments on the questions aimed at addressing additional issues, such as confidentiality when it comes to formal record reviews, as one participant commented: *Need to build in strict confidentiality*. Despite the high level of consensus with regard to the components of an EAP that need to be evaluated, a disturbing comment made by a participant highlighted the need for careful planning, as well as good motivation for an evaluation system of an EAP. The participant provided a concluding comment in the section for additional comments on specific methods to be used in the evaluation of an EAP: *None of the above are essential, but I will go with the majority. This will make the evaluation of EAPs a highly*

professional job and will probably restrict it to external or professional outsourced entities. Comments such as the latter emphasised the necessity to provide meaningful information in evaluation reports to executive management.

5.5 CONCLUSION

The literature review revealed the evolution of the EAP since its inception as a mechanism for dealing with alcohol in the workplace to a current comprehensive programme dealing with a variety of employee-related problems. The variety of employee problems and possible services that might be rendered makes it difficult to advise an organisation on the best options available regarding an EAP for health care workers. The participants of the focus group discussions confirmed that there is a definite need for a formalised EAP in their institutions. In the participants' institutions, there were either internal or external EAPs, but no combination of these. The perceptions and experiences of the supervisors working in the health care industry on employee assistance were in line with current literature but, at the same time, highlighted the uniqueness of this industry. A positive outcome was the identification of the need to evaluate the quality of several aspects of an EAP by the participants. The disappointing outcome in this process was, however, the limited information provided by the participants on the actual evaluation of an EAP. They did not provide in-depth information as to how the evaluation should be conducted and which methods should be used for this purpose. The outcome of the focus group discussion highlighted practical but critical issues, such as current labour relation practices and disciplinary measures to be considered when an EAP is formalised for health care workers.

The issues identified in the literature review and the focus group discussions were consolidated and were then presented to a panel of experts to achieve consensus on the crucial elements of a best-practice EAP, as well as ways in which the quality thereof can be evaluated. A low rate of consensus was achieved during the first (42% on all the questions) and second rounds (73% on all the questions). This could be an indication of the lack of standardisation with regard to the elements of an EAP that

are still experienced worldwide by organisations and EAP providers. Furthermore, it could provide an indication of the variety of problems experienced within organisations and why health care institutions should be able to adapt a suitable EAP from a best-practice EAP framework according to their needs. The next chapter will discuss the establishment of a best-practice EAP framework for the health care sector.

CHAPTER 6

THE FRAMEWORK

6.1 INTRODUCTION

The aim of this study was to establish a framework for a best-practice EAP and a system that can be used to manage the quality of such a best-practice EAP in the health care sector (*cf.* 4.2). The results from the literature review, the five focus group discussions with the supervisors in the health care industry and the Delphi survey conducted with experts confirmed that there is a need for EAPs in the health care industry. It was established from the research that the needs of the various health care institutions within this industry differ and that a single generic EAP for the health care sector would therefore not suffice. A number of generic elements of an EAP that could be included in a framework were identified. This framework could then be adapted by the various health care institutions in order to create an EAP that would fulfil their particular needs.

The purpose of the first section of this chapter is to review the most important background information that needs to be considered in the development of a framework for a best-practice EAP and the quality management system for such a programme as determined by the outcome of the research for this study. The second part of this chapter will develop the actual framework in more detail, as a contribution to the body of research in this particular field, in order to address the aim of this study. During the development of the best-practice framework it became necessary to conduct additional literature reviews in order to verify the inclusion of certain aspects in the framework. Therefore, it was essential to include a number of additional references in this chapter.

6.1.1 Review

Since the introduction of employees' assistance for alcohol-related problems in the early 1900s, EAPs continued to evolve in order to address a variety of problems that have a negative impact on the productivity of employees (*cf.* 2.2). This evolvement of EAPs resulted in a holistic approach towards the health of employees.

It is evident from the literature that, as part of behavioural health care, the EAP still plays a vital role in assisting employees with a variety of problems (*cf.* 2.5). Several generic components of EAPs were identified and discussed during the focus group discussion sessions, which are in line with the recommendations found in the literature. In the Delphi survey, these components were rated by the experts. These outcomes provided guidance as to which components should be considered as crucial for EAPs in the health care sector. During this study, it became evident that there are different needs amongst people and health care institutions and therefore the different health care institutions should be able to adapt their EAPs to suit their distinctive needs.

Managers in health care institutions need to make informed decisions not only with regard to the necessity of implementing an EAP in their institutions, but also with regard to the way in which this should be done. However, the lack of scientific evaluation of EAPs prevents the management of health care institutions from making these informed decisions (*cf.* 3.4). Once an EAP is implemented, it is important to have a formal quality assurance system in place to ensure that the services are of the highest standard and that they create value for the organisation (*cf.* 1.4). The measurement of quality in health care, and especially behaviour health care, is complex, rendering the development of a quality management system even more complicated (*cf.* 3.3). These complexities were confirmed during the focus group discussions and the Delphi survey conducted in this study. During the focus group discussions, it became evident that supervisors were more concerned about the actual functioning of an EAP rather than with the quality and impact thereof. Thus, a

system to ensure and improve the quality of such a programme was not a priority for them.

The aim of this study was to establish a best-practice EAP and the quality management thereof from a supervisor's perspective as middle and lower level managers are actively involved in human resource strategies. Another reason for using a supervisory perspective in this study is that supervisors usually have more knowledge with regard to their employees and have the potential to impact on the behaviour of employees (Young, Bartam, Stanton and Leggat 2010:184) as they are primarily responsible for dealing with employee problems on a daily basis. The role and inputs of all managers, including middle management as used in this study, is thus crucial in assisting with the strategic planning, development and implementation of an EAP. Furthermore, it became clear that from the discussions that inputs from the employees working in health care institutions cannot be ignored as the participants in the focus group discussions recognised that a formal needs assessment of employees should be conducted before an EAP is implemented in a specific health care institution.

6.1.2 The approach

Firstly, a conceptual framework, based on a literature review, was developed to guide an inquiry into EAPs in the health care sector (*cf.* 2.1). The next step was to establish a theoretical framework based on the results of the empirical part of this study. Therefore, the theoretical framework developed in this study is a hypothetical description of the complex processes involved in the creation of an EAP and a systematic way of organising further inquiry.

6.1.3 Aspects of the framework for a best-practice EAP

The main elements of a best-practice EAP that should be considered by health care workers are summarised in Figure 6.1. Each element will be discussed in the rest of this chapter with accompanying illustrations.

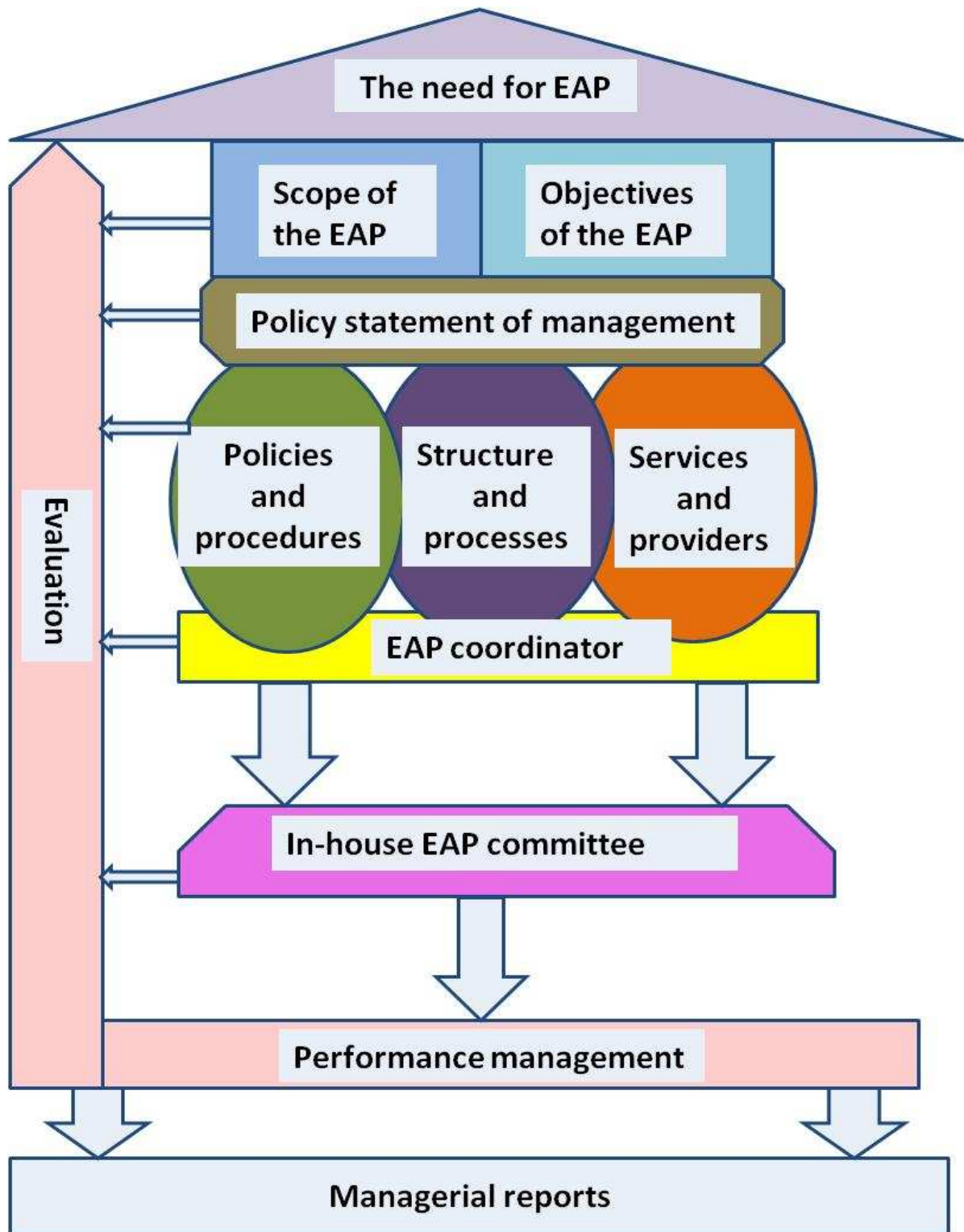


Figure 6.1: Summary of the main elements of a best-practice Employee Assistance Programme (EAP)

6.2 THE NEED FOR AN EAP IN A HEALTH CARE INSTITUTION

Health care is a service delivery industry; therefore, its focus is predominantly on customer-driven principles. In a health care institution, the patients are the customers in need of health care services, but health care workers working in these institutions might have needs and expectations for personal health services. Some of these needs and expectations are of such a nature that they can only be addressed by a formal EAP. The process of determining the kind of services needed must be guided by a formal assessment of the expectations of these health care workers. Figure 6.2 illustrates the motivations for an EAP as well as the expectations of employees as reasons for conducting a formal needs assessment in the institution. The next section will provide more information on these two components.

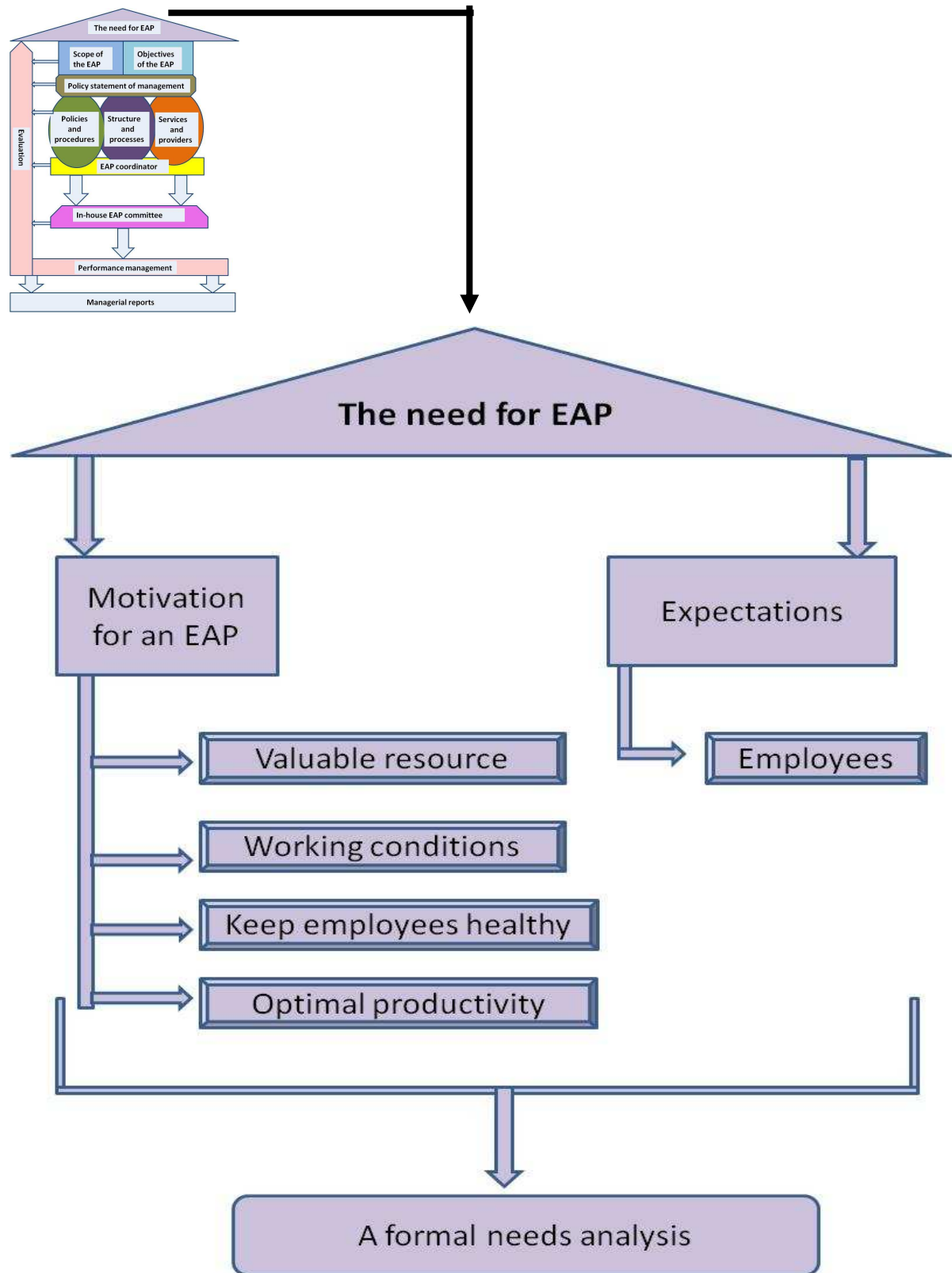


Figure 6.2: The need for an EAP in a health care institution

6.2.1 Motivations for an EAP

A health care institution must define specific reasons for the development of an EAP for that institution. These reasons will assist with and provide the foundation for the strategic planning process. The implementation of an EAP without the proper motivation and/or planning is an unacceptable business practice. The following reasons can be considered during the planning phase of such a programme:

6.2.1.1 *To emphasise that employees are one of the most valuable resources of a health care institution*

The health care workers in a health care institution are a major investment and must be considered to be one of the most valuable assets to the industry. It can therefore be argued that it is the employers' social responsibility to demonstrate the value that they attach to this resource by providing the appropriate assistance to the employees when necessary. The health care industry applies generally acknowledged criteria such as training, the promotion of self-development, and remuneration incentives to demonstrate the worth of health care workers to an institution. The provision of additional assistance in managing certain personal and work-related problems or issues through formal EAPs will further demonstrate that health care workers are valued by management. The services provided by the EAP will allow a health care institution 'to be perceived as a caring employer' (Buon and Taylor 2008:440; *cf.* 1.1) and ensure that the focus is not limited to the business or profits. Lastly, the activities within an EAP should empower the employees to perform better as functional units within their respective workplaces.

6.2.1.2 *To acknowledge the unique risks associated with working in a health care environment*

Each workplace is unique and has its own risks. This is also true for health care workers working in unique environments. Health care demands a disciplined approach as patients' lives are at stake. Health care workers are exposed to

traumatic situations on a daily basis as well as to the escalation of general stress associated with delivering health care to patients. These situations include, *inter alia*, becoming emotionally involved with patients, even though health care workers behave professionally at all times. They need to manage patients who are terminally ill and may even know these patients on a personal level. In general, health care workers are trained to deal with patients and their unique needs, but receive very little or no training on how to deal with the associated emotional stress themselves. Because health care workers are generally very focused on their patients, they often ignore the effect this has on their own health. They even have a tendency to forget that they, as people caring for their patients, might also have problems. It is thus important for employers to provide support to employees in order to deal with emotional and stress-related issues which arise from working in a health care environment. The issue of shift work, which is an integral part of delivering health care services, also needs to be considered (*cf.* 2.4.3). Employers cannot assume that shift workers are coping. They need to provide the required assistance for these workers as deemed necessary. Lastly, health care workers might also work in conditions that pose a high risk to their personal health as they need to care for patients with potentially fatal communicable diseases such as Acquired Immune Deficiency Syndrome (Aids), multi-drug resistant tuberculosis (TB), and haemorrhagic fever diseases.

Exposure to these high-risk situations and perceptions about an unsafe working environment can compromise the professional ethics of health care workers and result in the inadequate quality of care for patients suffering from these diseases. This unique environment with its various risks must be taken into account when planning for an EAP as health care workers need unique assistance and support in dealing with these exceptional circumstances.

6.2.1.3 *To keep employees healthy in a health care institution*

It must be the goal of management to ensure healthy employees who are able to render quality services to the relevant communities in need. However, the requirements of keeping employees healthy are multi-factorial as health is influenced by more than just their workplace. The employer does not have a limitless responsibility towards the health status of its employees. The major role of an EAP is to keep employees healthy by empowering them to take responsibility for their own health.

Health care workers' personal life cannot be separated from their professional life. A well-balanced approach to these two aspects of life will ensure that health care workers render quality care to their patients. To optimise balance, it is the employer's responsibility to identify the type of assistance and services that are required.

6.2.1.4 *To ensure optimal productivity of health care workers for sustainable service delivery to patients*

The health care sector is constantly under pressure to provide quality service to patients. Productive health care workers greatly assist in sustaining the provision of such a quality service. Addressing the productivity of employees was a key element in the initial creation and funding of EAPs by employers (*cf.* 2.1). The behavioural health care services provided by an EAP play an active part in empowering employees to deal with their respective problematic situations in order to become productive once more. Health care institutions should utilise all the resources available to them in order to ensure that their employees are assisted to 'realise and perform to their full potential' (Bye 2003:9; *cf.* 2.5).

6.2.2 Expectations of employees in the health care industry

Employers appoint health care workers in health care institutions to specific positions in order to perform specific activities with certain responsibilities pertaining to the health of a third party, namely the patient. The health care workers, on the other hand, expect to work in a safe and healthy environment as well as receive remuneration for services rendered. Furthermore, health care workers expect assistance from employers in performing their duties. Such assistance could be in the form of orientation, induction and in-service training. Assisting employees to cope with personal and work-related problems can also be viewed as support to employees in order for them to perform their duties effectively (*cf.* 2.1). The next section will deliberate on the assessment of a specific EAP in health care institutions.

6.2.3 Performing a needs assessment

A formal needs assessment must be conducted in each health care institution to determine the specific needs to be addressed by the EAP. Such a formal needs assessment is the required first step in the development of an EAP for a health care institution. Different methods can be adopted to perform the needs assessments such as the use of an anonymous questionnaire. This will promote the collection of information on the needs of health care workers in an unbiased manner as employees can express their needs without fear.

The outcome of this comprehensive needs assessment determines the scope and exact requirements for the EAP. If a mismatch exists between the services rendered by the EAP and the perceived needs of the health care workers as potential participants, it could have a serious negative impact on the effectiveness of the EAP. A needs assessment would also assist everyone in the health care institution to understand the concept of employee assistance and would improve the awareness and promotion of the services provided amongst the health care workers in the institution.

The needs assessment must be conducted on a regular basis, for example, every two years in order to make changes to the EAP. Some of the needs assessments may be generic for the health care industry, for instance, in hospitals functioning on a similar level of care. Nevertheless, it is considered best-practice to follow up an initial needs assessment with regular assessments as part of the planning process. Based on the initial and subsequent needs assessments, the critical issues that require assistance, growth and support will be identified. The identification of these three issues will allow the health care institution to prepare and implement the appropriate systems required to address the identified needs.

6.3 THE STRATEGIC APPROACH

Upon conclusion of the needs assessment, an institution needs to embark on establishing the structure and functions of an institutional EAP as part of its strategic approach. The strategic approach should provide guidelines that can be employed to address the following aspects: (a) the scope of the EAP; (b) the objectives of the EAP; and (c) an introductory statement by the management of the institution. These three aspects will be discussed in more detail.

6.3.1 The scope of an EAP

The scope of an institution's EAP clearly indicates that the EAP is a programme endorsed by the institution's executive management to assist all health care workers with social, behavioural, work-, or health-related problems which could affect their work performance, health and safety or productivity within that institution. Institutions may decide to extend the above-mentioned assistance to family members.

As a general rule, the scope of an EAP cannot be cast in stone since it needs to be adjusted according to the changing needs of an institution and the experience gained with the EAP. If, for example, the institution experiences an epidemic of a highly communicable disease with associated deaths, the emotional impact needs to be calculated and considered for assistance by the institution's EAP. Another example of changing needs might be when the institution goes through a period of retrenchment. It is also critical to point out that an EAP needs to be an impartial, independent programme and that it cannot function as an extension of other management tools. The summarised details of the scope for the best-practice EAP is illustrated in Figure 6.3. The next section discusses the crucial aspects that need to be considered when developing the scope of an EAP for a health care institution.

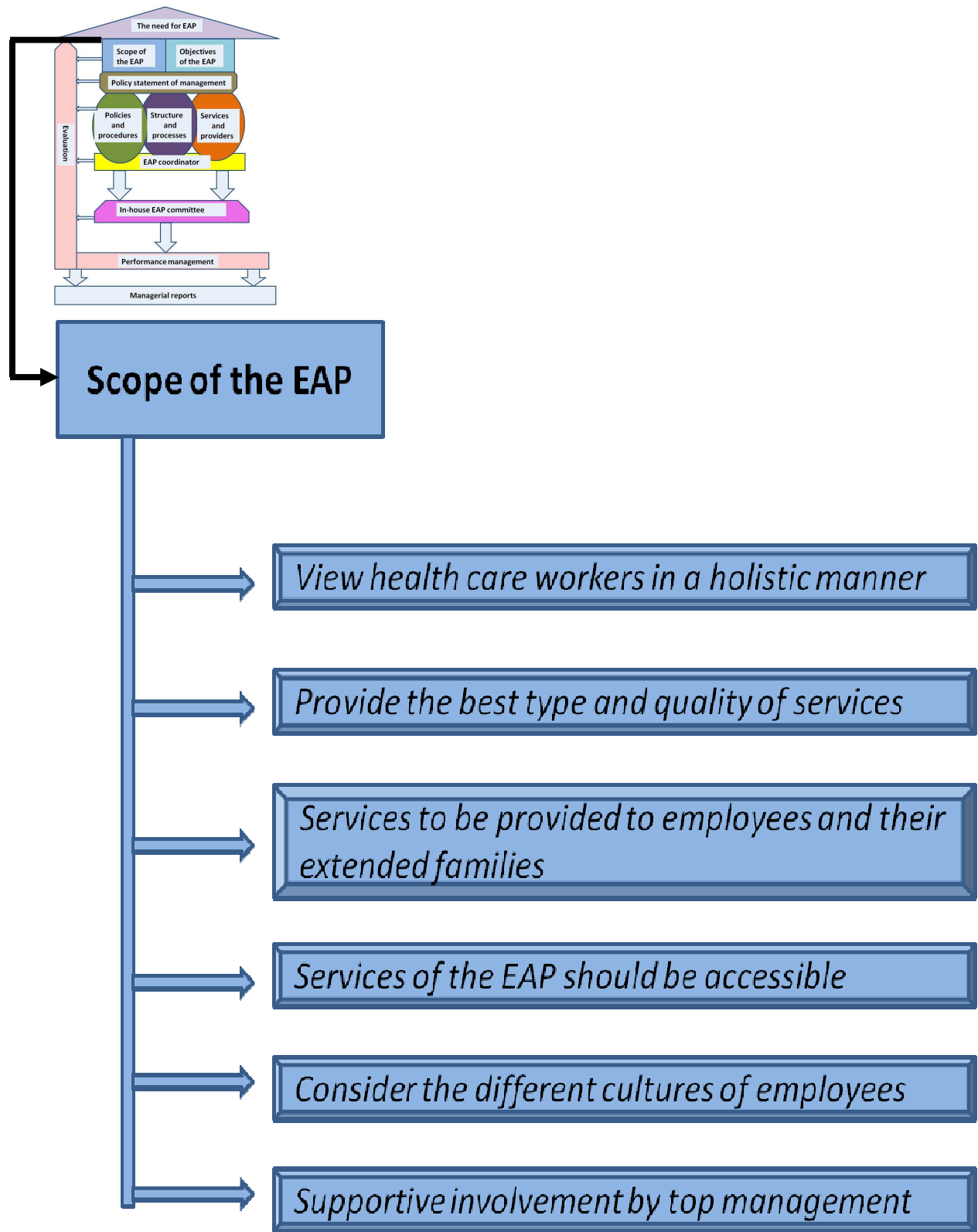


Figure 6.3: The elements to be considered when developing the scope of an EAP

6.3.1.1 An EAP should view health care workers in a holistic manner by focusing on both their personal and work-related problems

The focus of EAPs in health care institutions is often on absenteeism in the workplace and does not take the reasons for this absenteeism into account. A holistic approach would entail focusing on work-related as well as personal problems since the two cannot be separated due to the fact that the one usually impacts on the other (*cf.* 2.5). In order for an EAP to be effective, it is crucial to identify the root causes of the problems of health care workers so as to determine whether it originates from a personal or work-related cause. It is this integrated approach towards work-related and personal problems that makes the EAP a unique manner of counselling since it should consider both aspects as being equally important.

A further point that needs to be considered to ensure that the EAP of an institution follows a holistic approach is to link it with occupational health, human resources and other well-being strategies of that institution (*cf.* 2.1). The scope of an EAP should further be focused on pro-active health enhancement programmes in a comprehensive manner. Furthermore, an EAP can be a significant factor in identifying organisational problems and can assume the role of a change management agent. It must be pointed out that, in this process, care should be taken not to create a negative motivational climate within an institution by advising employees against the institution's policies and procedures.

6.3.1.2 The scope of services that will be provided to employees and their extended families as part of an EAP must be clearly stipulated

The purpose of an EAP is to render predetermined services to specific groups of people whose health and welfare are at risk. A frame of reference should be included in the scope of an EAP that refers to the circumstances under which the EAP will render services to an employee. Broader details of these conditions can be accommodated in the form of a policy and procedure or standard operating procedure (SOP). Family members can be the cause of an employee's inability to cope with the

work situation. An institution therefore needs to take cognisance of this and should allow for an EAP to involve family members where needed, otherwise the programme will not be effective. The procedures regarding family members need to be clearly defined as there could be a tendency to exploit the programme. As all institutions have limited resources at their disposal, an expectation cannot be created amongst employees of endless support with regard to their problems. The need for boundaries in terms of available services must therefore, as previously stated, be clearly defined and communicated.

6.3.1.3 *An EAP must provide the optimal array and quality of services available within the scope of the institution's resources*

An EAP should be structured not only to provide the troubled health care worker with the best available care in relation to the institution's resources, but should also provide all health care workers with the necessary preventative services to deal with possible problems proactively. If the EAP is perceived as not providing optimal assistance for the workforce of an institution, the troubled health care worker, as well as the supervisor, may become disconcerted because problems tend to re-emerge amongst the same health care workers. The EAP practitioners may also become discouraged if experts are not available to ensure optimal treatment of complicated cases. Employees with complicated problems may end up entering the EAP repeatedly without ever being able to solve their problems. These repetitive problems result in a vicious cycle which could have serious labour-related implications.

Institutions must guard against offering a substandard EAP programme if the resources available to them will allow for a higher level of quality care. It is unacceptable in health care institution for not solving the problems of employees if the employees were not offered the best care allowed for by resources available to the institution.

6.3.1.4 *The services of the EAP should be accessible to all the people stipulated in the scope of the programme*

An EAP should be easily accessible so as not to create additional tension for the already troubled employee. Standard operating procedures will ensure that services are available and utilised as intended. Accessing the EAP itself should be non-threatening and health care workers should be able to view it as an extension of their working relationships with the health care institution. However, an institution must stipulate that the EAP services are not to be misused or used for other business processes such as disciplinary actions.

6.3.1.5 *An EAP should allow for the cultural diversity of employees in terms of the services provided*

The consideration of different cultures is part of best-practice in behavioural health care and EAP practitioners should demonstrate experience with regard to cultural diversity (*cf.* 2.9). The effectiveness of an EAP in providing assistance to employees may fail due to cultural differences if these are not recognised and addressed. Not all interventions may be acceptable to employees of different cultures. An example is the counselling of an employee with regard to the management of their finances. The counsellor needs to take into account that it may be part of the employee's culture to provide financial support for the rest of his or her extended family.

While diversity is advantageous it can leave the door open for misuse, confusion or the creation of additional problems. An example is the health care worker who prefers to follow a traditional route and visit a sangoma (traditional healer) versus the health care worker who takes a Western approach and requires the services of a registered clinical psychologist. Preferences such as these may create conflict amongst health care workers, their supervisors, and the EAP, which can lead to complicated situations to be managed by an institution. It is therefore critical that guidelines are developed which link directly with the values of the institution. When in place, these

guidelines can be used as a way of preventing allegations of insensitivity and/or complaints of exclusivity.

It is critical that EAP practitioners are properly trained, credentialed and knowledgeable to ensure sensitivity towards cultural differences (*cf.* 2.9).

6.3.1.6 *A statement regarding the executive management's support for the EAP must be included*

It is crucial for the executive management to offer the programme personal support rather than simply providing principle approval or financial support. Moreover, it is suggested that an EAP should not be implemented if management does not support the EAP with their presence at every step (*cf.* 2.6.2). From the outset of the EAP, it should be clear to the health care workers that the executive management of the health care institution is in full support thereof. EAP practitioners should know that they have the support of the executive managers to resolve cases which have reached the limitations of the EAP services or once it becomes evident that the EAP will not be able to produce the desired results.

There are different means by which management can demonstrate their support. However, they should guard against direct involvement with the operational running of the EAP.

6.3.1.7 *Additional non-critical issues that can be considered for inclusion*

EAPs evolved from the initial assistance to employees with alcohol-related problems to include a much broader scope, known as a broad-brush approach (*cf.* 2.8.2). If the spectrum of services is too wide, there is always the risk of a 'shopping trolley' approach with possible manipulation or misuse of the programme. The value added to an institution with such a broad-brush approach should also be questioned. It is not always possible to offer a wide spectrum of services due to limited resources. The scope of services offered should focus on the core business objectives of what was

intended with the EAP and counselling by taking into account the size of the institution as well as its available resources. An institution should, however, guard against having a scope that is too narrow because this will restrict the effectiveness of the EAP and limit the desired outcome of having a well-balanced workforce. An EAP offering a limited number of services can be perceived as a 'curative' initiative aimed simply at troubled employees rather than as a preventative programme aimed at increasing the general productivity of employees.

The results of this study clearly indicate that EAPs have no role to play in the appointment of employees in health care institutions. The most important reason for this is that it is the responsibility of the human resource department to appoint staff and that the appointment processes should not involve too many people. The question, however, remains as to whether the right person has been appointed to the position in the first place and EAP practitioners could prove to be of great value in conducting such an evaluation. Participants in the focus groups were of the opinion that an EAP could assist with appointing the right person for the job by performing an evaluation of all appointments. A concern was also raised in the focus group discussions about a too close association between the EAP and the human resource department since this can have a negative influence on the utilisation of the services provided by the EAP. The participants in the Delphi survey confirmed these concerns with one participant going as far as asking, 'You do want a(n) utilisation rate above 0.1%, don't you?'

6.3.2 The objectives of an EAP

An EAP can be a powerful vehicle for facilitating the appropriate conduct and participation of employees and supervisors. The objectives must encourage such conduct. Although the employer might view the implementation of an EAP as a retention strategy, the objectives of the EAP must be aligned in such a manner that they form part of the health care workers' value proposition.

The summarised details of the objectives of the best-practice EAP are illustrated in Figure 6.4. The next section discusses the crucial aspects that need to be considered for the objectives of a best-practice EAP.

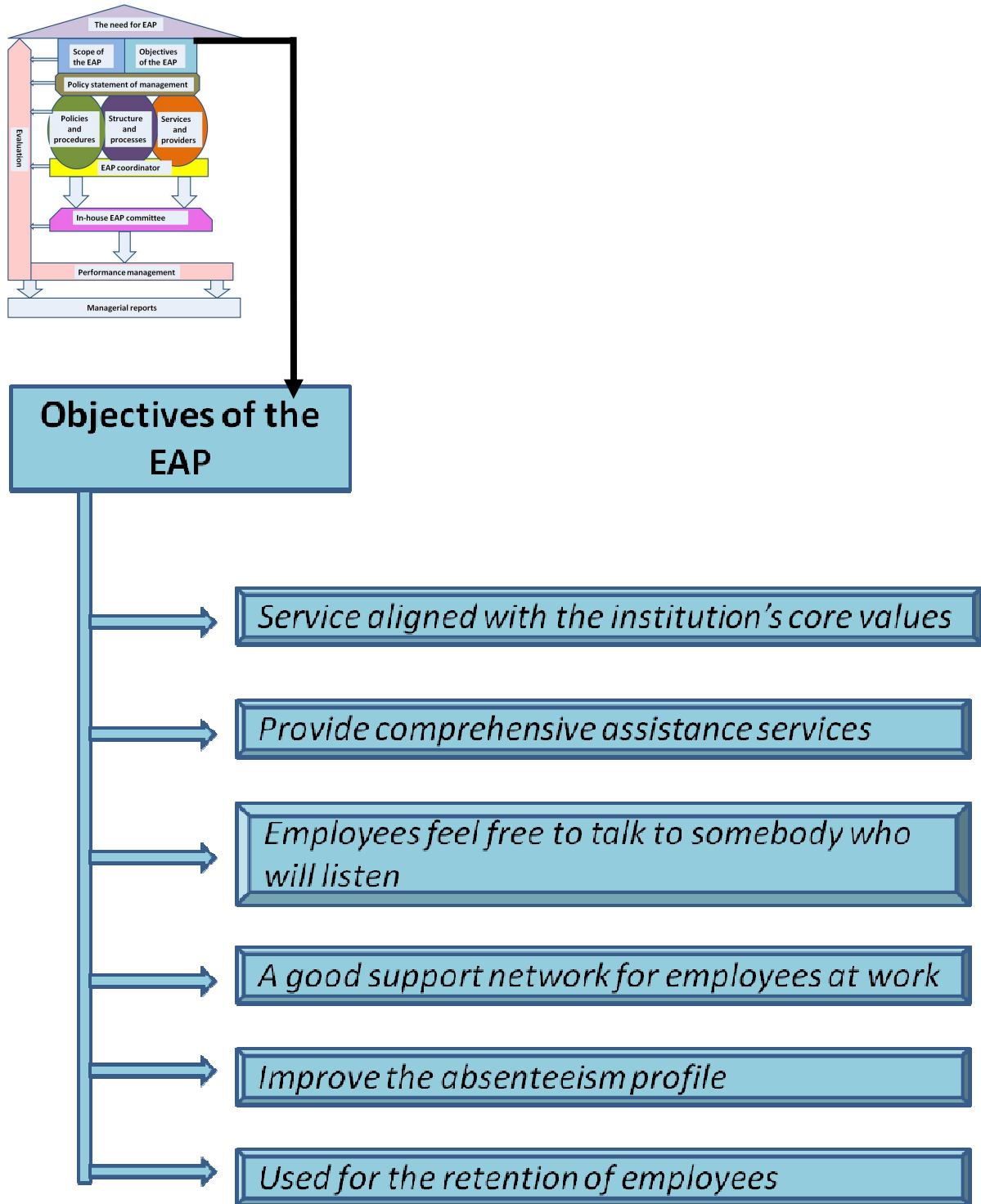


Figure 6.4: The elements to be considered for the objectives of an EAP

6.3.2.1 *To provide a service that is aligned with the institution's core values of which providing quality care for patients is non-negotiable*

The EAP must be planned, structured and implemented in such a manner that it is aligned with the institution's core values. If the EAP is not linked to the values of the health care institution, the EAP could run the risk of failing as there might be no commitment and buy-in from everyone within the institution.

6.3.2.2 *To provide comprehensive assistance services that offer meaningful support to employees*

It is seen as the responsibility of the employer to deliver a support service to employees as a means of ensuring their optimal productivity (*cf.* 2.2). The aim of health care institutions must therefore be to provide assistance to health care workers to enable them to change their behaviour and to be as productive as possible. The introduction of an EAP would convey a message of caring from the employer to the health care workers and provide reassurance that the institution is aware of the needs of its employees. A caring environment such as this should motivate the health care worker to 'walk the extra mile' for the health care institution and the patients it serves.

6.3.2.3 *To provide a service where employees feel free to talk to somebody who they know will listen to their problems*

The troubled health care worker should feel free to talk to somebody they trust and who they know will assist them with their problems. The need for an open-door policy is not only applicable to supervisors, but also to the EAP practitioners. However, an EAP cannot focus only on listening to problems; it must be a comprehensive system that gives employees meaningful comprehensive services.

6.3.2.4 *To provide a good support network for employees at work*

The establishment of a good support network is critical due to skill shortages in the health care sector. The EAP itself would not be able to render all the essential support services, but it should aim to establish a good network of additional support for health care workers. The utilisation of support networks should generate appropriate, productive conduct at employee level.

6.3.2.5 *To improve the absenteeism profile of an organisation*

An EAP can assist employees in dealing with some of the non-medical reasons for being absent from work. Although ill health is often presented as an excuse for being absent from work, the real causes often include a number of other reasons such as a lack of motivation, personal needs and domestic/school commitments. Identifying the real reasons for absenteeism and assisting employees to deal with these might be an important reason as to why senior management and the human resource department would support an EAP. There is strong evidence to suggest that absenteeism can be decreased by the implementation of an EAP (*cf.* 2.5). An EAP can also serve as the initiator of a quality control programme for absenteeism.

6.3.2.6 *To be used for the retention of employees in the institution*

The utilisation of an EAP as an employee retention tool is a key historic function in North America from whence it originated (*cf.* 2.2). Linking an EAP to the staff retention strategy is critical since this is a good way of measuring the value which the EAP added to the institution. The retention of health care workers in a health care institution is possibly a significant objective, but it should not be considered as the most important role of the EAP. On the other hand, such an objective and strategy can provide a competitive advantage when a health care institution is benchmarked against other health care institutions.

6.3.3 An introductory statement by the executive management

The endorsement of an EAP by the executive management of the health care institution must be evident from the inclusion of an introductory statement made by its members in the formal EAP document. The summarised details of the elements for an introductory statement by the executive management for the best-practice EAP are illustrated in Figure 6.5. The rest of this section will discuss the critical issues of these elements.

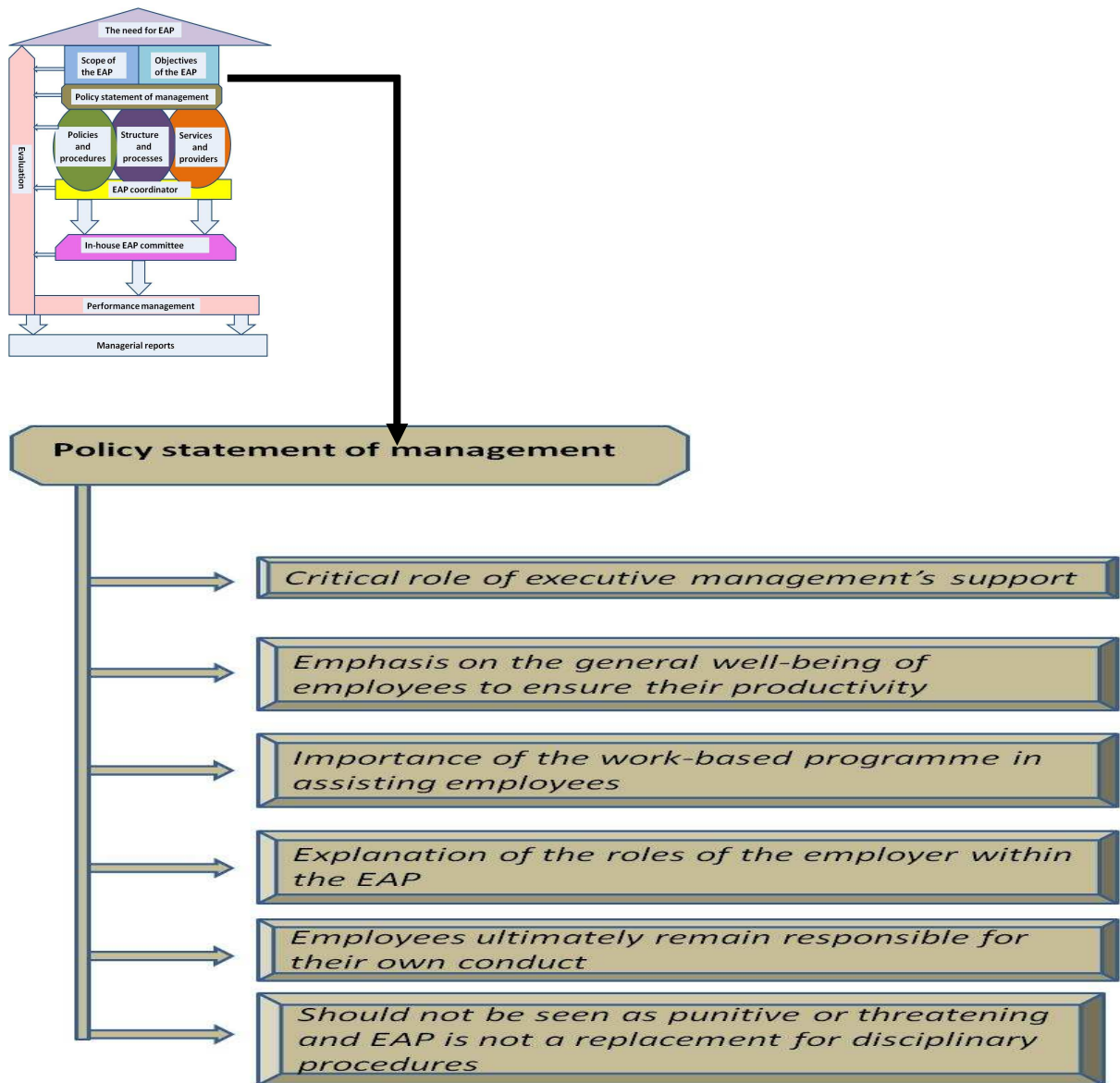


Figure 6.5: The elements to be considered for inclusion in the introductory statement by the executive management of an EAP

6.3.3.1 *The critical role of the executive management's support for the health care institution's EAP*

The commitment by the executive management to support the EAP in their health care institution must be visible to everyone. Evidence of such support can be made visible in the introductory statement as well as by involving key staff members in the critical decision-making processes regarding the programme. A positive attitude and commitment by the executive management will ensure that EAP practitioners demonstrate similar characteristics. On the other hand, criticism of the programme by the executive management will result in conflict between health care workers, their supervisors and EAP practitioners as well as conflict within the programme. Regular consultation between role-players and the executive management will minimise possible conflict and frustration experienced by EAP practitioners. The executive management must guard against involving themselves in the daily operations of the EAP. There are, however, exceptions where they may need to play a part such as where a deadlock appears in a case or when a specific case has exhausted the institution's available EAP treatments (*cf.* 6.3.1.6).

6.3.3.2 *Emphasis should be placed on the general well-being of employees to ensure their productivity in the workplace*

The introductory statement of the EAP must emphasise the aim of providing assistance to employees with both their personal and work-related problems in order for them to be productive within the workplace. The general well-being of employees will increase with an effective EAP, but the productivity of employees may depend on more than simply having a successful EAP as previously discussed (*cf.* 2.1).

6.3.3.3 *The importance of the work-based programme in assisting employees with personal problems*

An EAP, as a work-based programme, must clearly define services that assist health care workers with their personal problems since these problems impact directly on their performance and productivity. The ultimate aim of an EAP is to empower employees by providing them with tools and general assistance in order to solve their own problems rather than creating co-dependent victims of a system. However, it is important to consider having a broader focus rather than adopting a micro-employee perspective, as well as the fact that too much emphasis on a personal level could lead to stigmatisation of the programme.

6.3.3.4 *An explanation of the roles of the employer within the EAP*

The roles of the employer within the EAP must be specified in broad terms. Details of these roles do not need to be included in the introductory statement. Instead, these can be provided by means of a policy and procedure or in the format of a guideline.

6.3.3.5 *Emphasis should be placed on the fact that employees ultimately remain responsible for their own conduct and health*

It must be emphasised that the health care workers' responsibility and accountability for their own life cannot be transferred to the employer, the workplace or the EAP. An EAP can only assist health care workers in dealing with certain problems and cannot take responsibility for the conduct of the health care workers in the institutions.

6.3.3.6 *Neither should the EAP nor the process of entering the programme be seen as punitive or threatening, nor should the programme be regarded as a replacement for disciplinary procedures*

The purpose of including such an element in the introductory statement is to ensure that the health care worker entering the EAP is neither a punitive measure nor is it

part of the disciplinary procedure. The EAP should not be used as a tool to replace any of the disciplinary procedures of the health care institution as recognised internationally (*cf.* 2.2). Additional details regarding disciplinary procedures and the EAP must be formalised in a policy and procedures format.

6.4 INTRODUCTION: THE STRUCTURES AND PROCESS FOR A BEST-PRACTICE EAP

It is conceptualised that structure follows strategy in the development of a programme such as an EAP (Chandler 1962 in Venohr 2007:4; Irwin 1995:41). All these strategies, structures and processes need to be clarified during a proper planning process. This will ensure that the implementation of the programme is conducted in an organised manner. The most important structures and processes of an EAP in a health care institution are: (a) a set of appropriate policies and procedures; (b) development and implementation of applicable business processes; (c) appointment of the appropriate service providers to provide pre-determined services; (d) the appointment of an EAP coordinator; and (e) the establishment of an in-house EAP committee. Each of these five aspects will be discussed in more detail.

6.5 THE POLICIES AND PROCEDURES

Policies and procedures are required to formalise any system or programme and they should provide the necessary guidance for people to ensure orderly activities. It is not the purpose of this study to evaluate and describe the mechanisms or the format for the policy and procedure documentation; however, a few critical requirements were identified during the research process. Before any policy or procedure can be developed, the requirements as illustrated in Figure 6.6 must be considered.

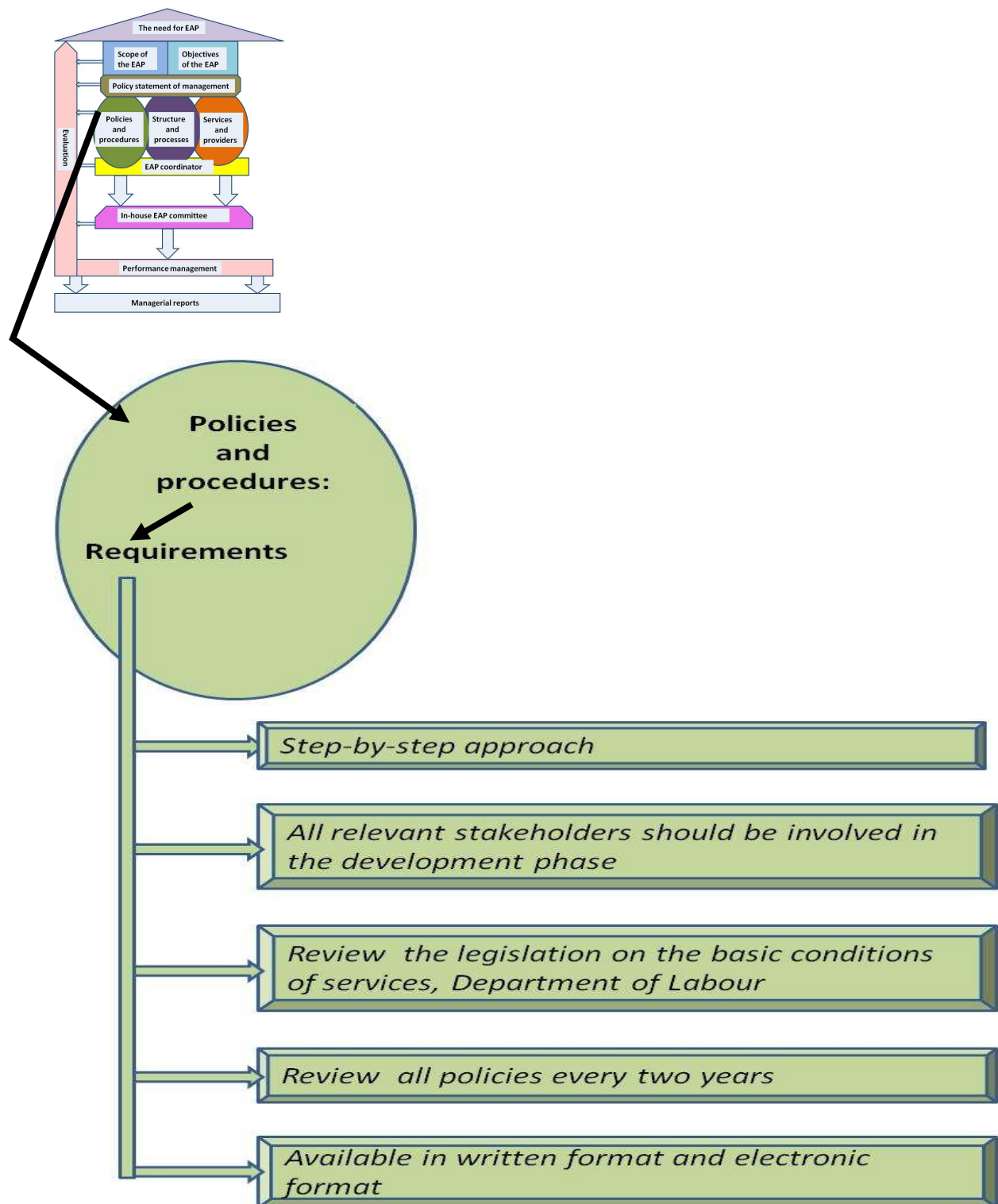


Figure 6.6: The requirements for EAP policies and procedures

A critical requirement for a policy and procedures document is to provide a step-by-step guideline of what is required. The 'who, what, where, how and when' details of the procedures must be addressed and each of these components clearly defined in these documents. Care should be taken not to include too much detail in each step as this might lead to confusion. The relevant stakeholders must be involved in the development of these documents to foster buy-in. A review should be conducted of the Department of Labour's legislation pertaining to the basic conditions of services in order to ensure that the EAP policies and procedures adhere to the requirements stipulated in the labour relations legislation. Furthermore, the policies and procedures must be subjected to a formal review every two years. It is essential to review and adapt the policies and procedures according to the changing needs of health care workers as well as changes within the health care institution. Lastly, the policies and procedures must be available in a written format and, if possible, in electronic format as well. The availability of the policies and procedures in electronic format is the standard for some quality assurance programmes (Commission for Environmental Cooperation 2007:20) and it might promote transparency and good governance within the EAP.

6.5.1 Types of policies and procedures

Several types of policies and procedures are needed to formalise an EAP. Figure 6.7 summaries the five categories of policies and procedures that are required.

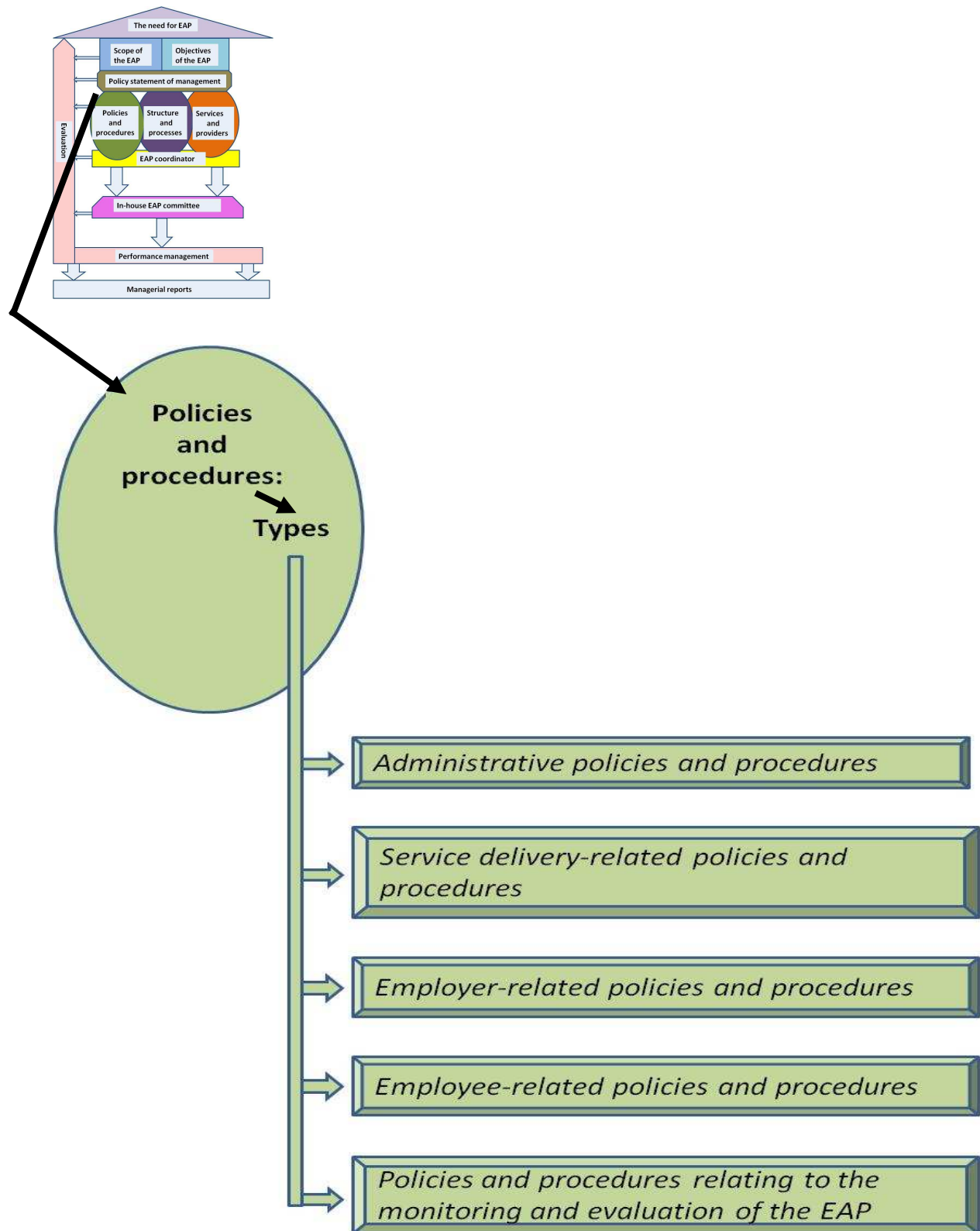


Figure 6.7: The types of EAP policies and procedures

Tables 6.1 - 6.5 provide a list of the types of policies and procedures identified in each category which are considered to be critical for an effective EAP. These tables do not provide a comprehensive list, but these policies and procedures were identified as being crucial by the research participants. Comments on these policies and procedures are provided after each table.

Table 6.1: Critical administrative policies and procedures for the EAP

1. <u>Administrative policies and procedures</u>
1.1 The administrative requirements for the referral of an employee to the EAP
1.2 The description of the method of self-referral of an employee to the EAP
1.3 The description of the method of referral of an employee to the EAP by the employer
1.4 The communication channels to be followed in order to obtain assistance
1.5 The formal communication lines between the EAP provider and supervisors regarding employees entered into the EAP
1.6 The management of possible manipulation/misuse of the EAP by the employee
1.7 The principles regarding confidentiality of the information generated
1.8 Whether employees are to attend EAP activities/services during their official working hours
1.9 The funding structure for services rendered within the EAP

There are several mechanisms through which a health care worker can enter an EAP. These mechanisms should be stipulated in a policy and procedure format. Once health care workers are referred to the EAP, they must know exactly how EAP-related issues will be communicated; not only within the EAP, but also within the health care institution. There should be regular feedback from the EAP provider/s to the

supervisor of the health care workers involved. These types of communication between the role-players should be formalised in order to ensure consistency in safeguarding confidently. The communication procedures should also ensure that trustworthy information reaches the supervisor and that the health care workers' right to privacy is protected.

A policy and procedures document should stipulate that health care workers are allowed to participate in the activities of the EAP during office hours. If they are not allowed to do so it can result in poor attendance. Another reason for stipulating when health care workers can take part in EAP activities is to ensure that supervisors remain informed as to the whereabouts of the health care workers. Remaining informed will make it possible for them to redeploy other staff to perform the functions for the period that the health care workers are participating in the EAP activities.

There are several models available to fund an EAP. The funding structure for services rendered within the EAP should be clarified to prevent unrealistic expectations. It may not be possible for the employer to carry all the expenses (*cf.* 2.11), especially if an external EAP service provider model is adopted. An EAP should provide certain essential services free of charge to the health care worker, but the decision must be aligned with the budgeting strategies of the institution.

Table 6.2: Critical service delivery-related policies and procedures for the EAP

2. <u>Service delivery policies and procedures</u>
2.1 Clear guidelines on who may access/use the services of the EAP
2.2 The treatment options to be followed with regard to the specific reason for entering the EAP
2.3 The total timeframe allowed for participating in EAP activities, including follow-up activities
2.4 The actions to be taken in the case of relapse of an employee in the EAP or after discharge
2.5 The steps to be followed regarding the non-compliance of a health care worker in an EAP

Clear guidelines on who may access/use the services of the EAP are vital as the health care institution may receive requests from people other than eligible employees. Internationally, it is acceptable for employers to allow employees' wives or husbands, partners, children as well as the organisations' retirees to access the services of the EAP (*cf.* 2.6.5). Institutions need to take available resources into account and define access criteria to the programme accordingly.

It must be stipulated that certain treatment options or guidelines for pre-defined problems should be followed to ensure good clinical practice. The benefit of having standard treatment guidelines is that it provides consistency and makes it possible to monitor EAP outcomes. The treatment guidelines may also simplify the EAP processes for supervisors. This will ensure that they know what is expected of them and what they can expect of the programme. However, there often are exceptions and the EAP practitioner may identify a need to change the pre-defined treatment plan. The policy and procedures document should make provision for these scenarios.

All the services or activities of an EAP should be linked to a timeframe, where possible. Exceptions, such as group sessions for ongoing support and motivation, should be considered within reasonable limits where timeframes are decided upon.

Health care workers can relapse/lapse while in or after being discharged from the EAP. It is critical to define the concept of 'relapse' in the policy and procedures. Once relapse has been defined, specific indications of the seriousness of the default should be drafted as well as how these relapses will be managed. It must be remembered that a health care worker cannot stay in the EAP indefinitely or re-enter the EAP every other month.

Policies and procedures on non-compliance by a health care worker participating in the EAP should provide fundamental guidance on how to manage such a situation, especially if the health care worker was referred by the employer to address specific unproductive behaviour. A health care institution should take care as to not view the EAP as punitive but rather as a programme that should provide care and support. The procedures need to indicate how this situation will be managed.

Table 6.3: Critical employer-related policies and procedures for the EAP

3. <u>Employer-related policies and procedures</u>
3.1 The principles regarding the governance of the EAP
3.2 The EAP should not been seen as a mandate by management
3.3 The resources to be put in place in order to render EAP services in the health care institution
3.4 The role and responsibilities of the supervisor regarding all the activities of the EAP
3.5 An open-door approach by supervisors to ensure availability of the supervisors to discuss problems with their employees

As part of good governance, an EAP policy should stipulate that the programme is a tool to assist employees and not a mere directive from management. However, management's support for the programme must be highlighted as this is critical for the success of the programme. The principles regarding the governance of the EAP should be transparent in order to create a trustworthy programme.

There should be an indication of the resources needed to implement and render EAP services in the health care institution. The functioning of the EAP as a service delivery entity and the resource allocation should be specified in the policy and procedures document as definite aspects. The resources available in the nearby community should be identified and included in the policy and procedures document. Furthermore, provision should be made for regular evaluations and follow-up needs assessments that may identify the need for additional services.

The responsibilities of the supervisor should be formalised and should address issues, such as early identification of the problem/unproductive behaviour of the health care worker as well as early intervention and referral, until the health care worker is once again fully functional and productive. Such guidelines will prevent supervisors from being under the impression that, once the troubled health care worker has entered into the EAP, their responsibility stops until the health care worker is discharged from the EAP. Supervisors should play an active role in the entire process as required and directed by the EAP practitioners.

Lastly, an open-door approach by supervisors will encourage health care workers to initiate necessary discussions in order to prevent a case from becoming complicated.

Table 6.4: Critical employee-related policies and procedures for the EAP

4. <u>Employee-related policies and procedures</u>
4.1 The responsibilities of the employee entering the EAP
4.2 The commitment needed from employees throughout the EAP
4.3 The principle of voluntary entry by the employee into the EAP
4.4 The requirement of signed consent from an employee before he/she enters the EAP

Entering a programme such as an EAP entails the acceptance of generic as well as employee-specific responsibilities. Examples of generic responsibilities include: (a) acknowledgment by the health care workers that they have a problem and that there is a need for some kind of assistance; (b) an agreement for entering into the programme followed by full cooperation from the health care workers; (c) taking care of themselves; (d) demonstrating commitment to the programme; and (e) showing loyalty towards the health care institution that appointed them.

In terms of the commitment of the employee towards the EAP, a contractual agreement can be considered. If the health care worker does not commit to the EAP, entering the programme will not provide a solution for the person's problem and it would be a waste of valuable resources. A contractual agreement brings the concept of a signed informed consent document into play with the risk of the EAP being viewed a part of a disciplinary process. However, it is required for good governance purposes as well as good clinical practice. The intent, as well as the content, of such an informed consent procedure and information document can be negotiated and adapted for a specific health care institution. The information on the consent form should contain information about the EAP as well as about what can be expected of the EAP. Some of the reasons for obtaining informed consent from health care workers before allowing them to enter the EAP are to inform the health care workers and to ensure that they understand what the EAP entails. As a health care institution invests resources into providing EAP services, it is appropriate to inform the health

care workers beforehand of their responsibilities. The consent may also contain a disqualification clause if the health care workers are not committed to the programme for whatever reason.

A person entering the EAP is still subject to the disciplinary processes stipulated in the institution's human resource procedures. For example, the fact that health care workers have entered the EAP does not preclude the supervisor from addressing their poor work performance. The two issues should be kept separate to prevent a breach of the health care workers' rights as well as of confidentiality.

The question might be asked as to what should happen if the counterproductive behaviour for which the health care workers entered the EAP continues. Can the health care workers be disciplined for unproductive behaviour or must this be tolerated due to the fact that they are undergoing treatment in the EAP? This scenario is contentious and procedures which are in line with current labour relations legislation should be put in place in order to avoid any confusion as to how the matter should be managed. These procedures are critical in avoiding labour relations disputes.

The EAP should not be perceived or utilised as the 'dumping ground' for problematic health care workers or as a scapegoat shortly before the initiation of disciplinary procedures. These types of actions can discredit the EAP and result in a loss of confidence in the EAP (*cf.* 2.7.2). Health care workers must therefore be referred only after careful consideration and planning with a specific goal in mind. Lastly, procedures should also indicate the steps to be taken if services are recommended for troubled health care workers and they do not utilise the EAP.

The principle of voluntary entry by a health care worker into the EAP should also be explained in the policies and procedures. Voluntary entry into the EAP may not have all the implications of other methods of referral. With voluntary entry, health care workers may be provided with opportunities to withdraw whenever they wish to, but they should be discouraged from abusing the programme.

Table 6.5: Critical policies and procedures relating to the monitoring and evaluation of the EAP

5. Monitoring policies and procedures
5.1 The monitoring and evaluation of the EAP
5.2 The formal feedback system between all stakeholders involved with employees in the EAP
5.3 The formal written reports to be provided by EAP providers regarding the progress made by an employee in the EAP

The maintenance of confidentiality throughout the monitoring and evaluation processes is vital, especially with regard to communication and formal feedback to the different stakeholders involved in the EAP. Appropriate preventative measures should be put into place to ensure that confidentiality is maintained.

In some instances, there is a need for formal written reports by the EAP providers regarding the progress made by employees in the programme. The content of these reports, as well as the recipients thereof, need to be specified. Sending such a report to the relevant supervisor would be beneficial for the comprehensive monitoring of the health care workers as well as the monitoring of the effectiveness of the EAP. It might even be stipulated in the policy and procedures that the supervisor needs to report back to the EAP service providers regarding the progress made by the health care workers in the work situation. These reports need not be very detailed, but should provide sufficient information for supervisors and EAP service providers to manage the health care workers and their situation. In order to ensure confidentiality, the content, as well as the requirements for the release of the formal written reports, must be specified.

6.6 EAP STRUCTURE AND PROCESSES

EAPs are complex programmes consisting of preventative and curative measures. This fact makes it difficult to determine what the most appropriate processes are that need to be in place for providing the services. One reason for the complexity and difficulty could be the ambivalence caused by the need for confidentiality, on the one hand, and the need for good organisational processes, on the other hand. A formalised programme would prevent any confusion and address uncertainty through clear guidelines.

Researchers recommend that the structures and processes for an EAP be designed in such a way that the programme can adapt to the ever-changing world of health care (*cf.* 2.3.2). Figure 6.8 illustrates the critical EAP processes to be included in a best-practice EAP, followed by a more detailed discussion.

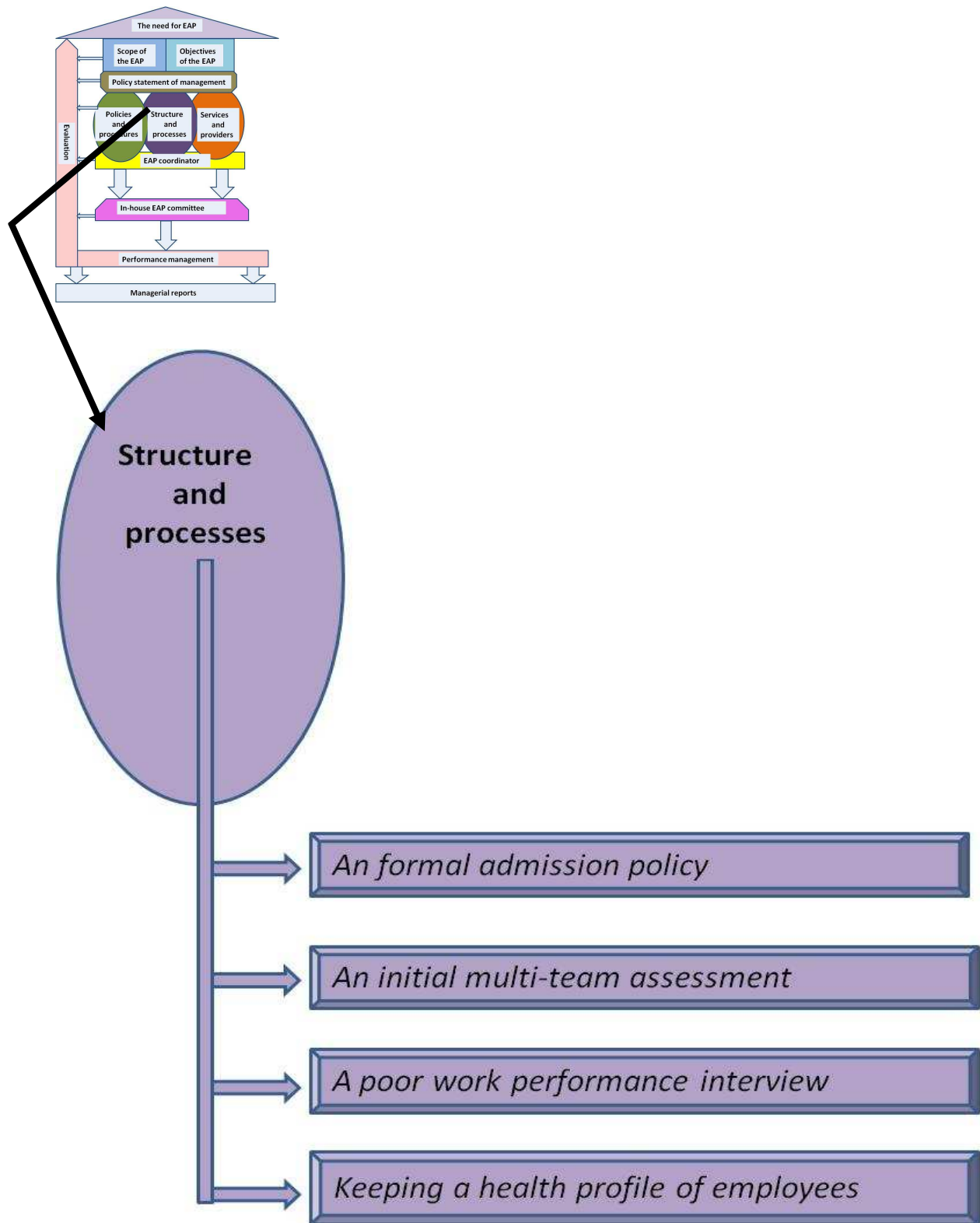


Figure 6.8: The processes for a best-practice EAP

6.6.1 A formal admission policy

A formal admission policy and procedures document must be compiled in which all the procedures are described for officially entering a health care worker into the programme. Formalising the admission process will ensure proper access, utilisation, monitoring and control of the EAP. Admission into the EAP cannot be done in an informal manner since this might result in a misused, or even an abused, programme. The admission procedure is a continuation of the referral policies and procedures (*cf.* Table 6.1). The starting point of the admission procedures should confirm that one of the formal referral systems, including self-referral, was utilised. The next step would be to formally confirm that the person entering the EAP qualifies for these services. If the services are made available to family members, this confirmation process should also include the validity of such a request. Once again, the admission procedure should be formalised with the required confidentiality clauses in place.

6.6.2 An initial multi-team assessment

Upon entering the EAP, a multi-disciplinary initial assessment of the health care workers and their problem/situation must be performed. The aim of the initial assessment is to obtain a comprehensive overview of the situation for appropriate planning with regard to the seriousness of the situation and the interventions needed. This type of assessment further ensures that all the baseline information on the health care workers is collected. Lastly, the initial assessment will also ensure that cases which are not relevant to the EAP are eliminated. Accurate assessment is also essential in determining the seriousness of the case, and skilled EAP practitioners are required to fulfil this function. During the initial assessment, it should also be established whether the health care workers present with a new or recurring problem.

6.6.3 Poor work performance interview

The modern EAP is structured to allow for assistance with the poor work performances of employees. An interview between the health care workers and their supervisor should be considered if the poor performance of the health care workers is the reason for referral to the EAP. Such an interview could also be deemed to be part of the work performance management interview if the health care institution's performance management system allows for it. As stated previously, an institution must guard against these interviews being viewed as punitive by health care workers and supervisors. Instead, these interviews should be promoted as a mechanism for providing vital collateral information to the EAP team. This interview can also be conducted by the human resource department as long as it does not undermine the responsibilities of the supervisor. A routine interview (pre-entry interview) by the supervisor with each and every health care worker before they enter into the EAP is not recommended as some of the problems could be of a sensitive nature. Institutions should be careful when allowing interviews between the health care workers and supervisors before entering the EAP. One Delphi expert commented: '[Conduct the interview] [o]nly if you don't want your EAP to make it past the first year.' However, an initial interview conducted by the supervisor with the health care workers cannot be considered unnecessary without evaluating its advantages and disadvantages. Additional assessments to determine the reasons for poor work performance should be conducted as deemed necessary and the health care workers must be informed as to the reason/s for their entering the EAP.

6.6.4 Keeping a health profile of employees

A health profile of a health care worker can be kept as part of the workplace record, but it is not considered to be crucial. Should these types of records be kept, it is advisable that they include the health care workers' physical health records as well as profiles on their mental and emotional well-being. Details of the EAP activities and the behaviour of the health care workers should also be kept by the supervisor. These records could be useful in the evaluation and monitoring processes of the EAP.

6.7 THE SERVICES TO BE PROVIDED BY AN EAP

A wide spectrum of services can be offered by an EAP (*cf.* 2.3). The compilation of these services should be determined by the needs assessment, available resources, the history of the health care institution and inputs from the health care workers. It should also take into account existing programmes that address the wellness of health care workers (*cf.* 2.1; Fogarty 2008:14; Kirk and Brown 2005:355). The core technologies of an EAP must be considered during the planning phase (*cf.* 2.3) as should the EAP strategy (*cf.* 6.3) and the kind of service providers (*cf.* 6.4.3.2) available.

Institutions must guard against viewing EAP services in separate silos. Services should be linked and complement each other to ensure that the health care worker's problem is addressed in a holistic manner. A best-practice EAP should deliver the following five categories of services as illustrated in Figures 6.9a and 6.9b. The next section will discuss the five categories of services for a best-practice EAP in more detail.

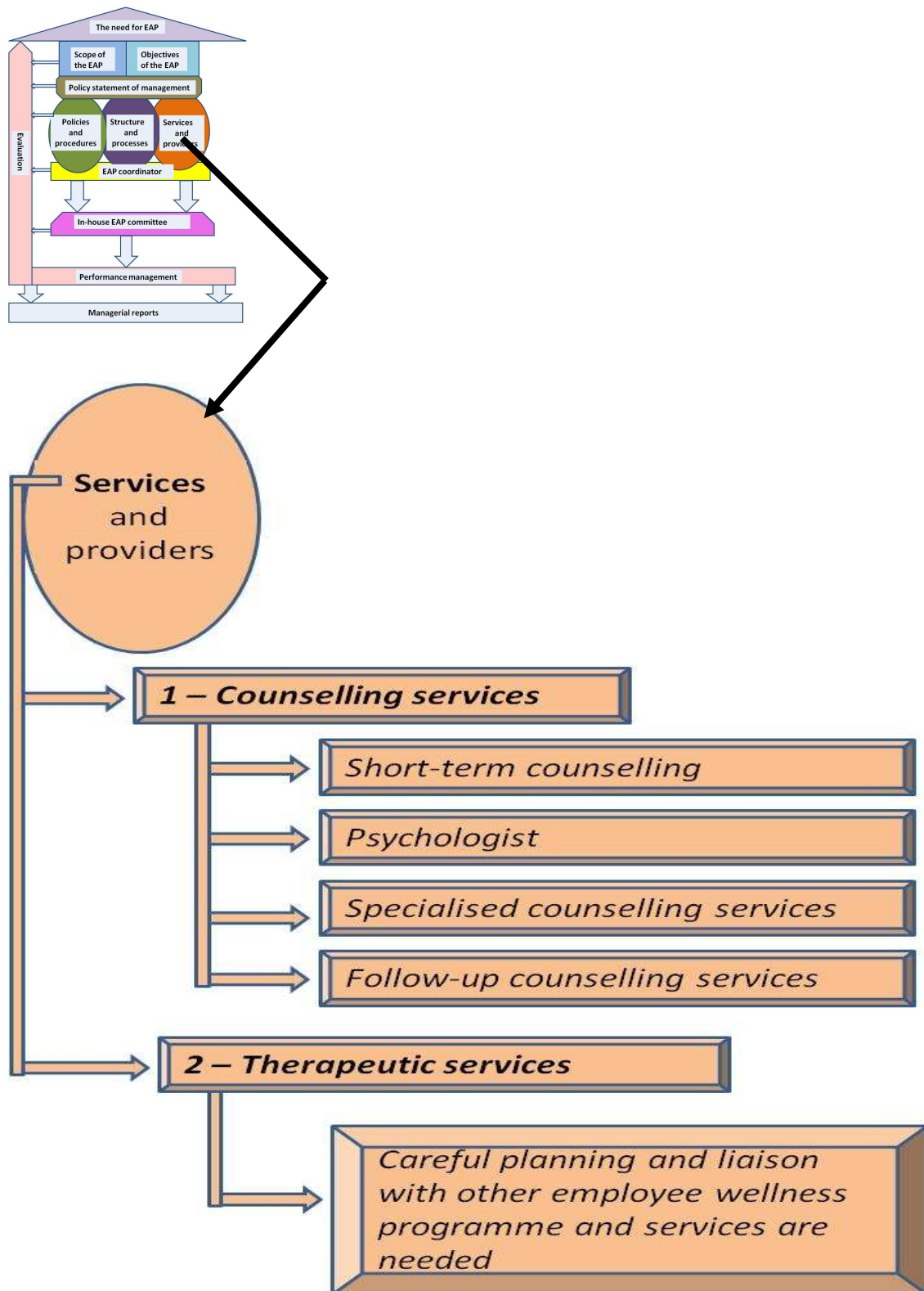


Figure 6.9a: The categories of services to be provided in a best-practice EAP – counselling

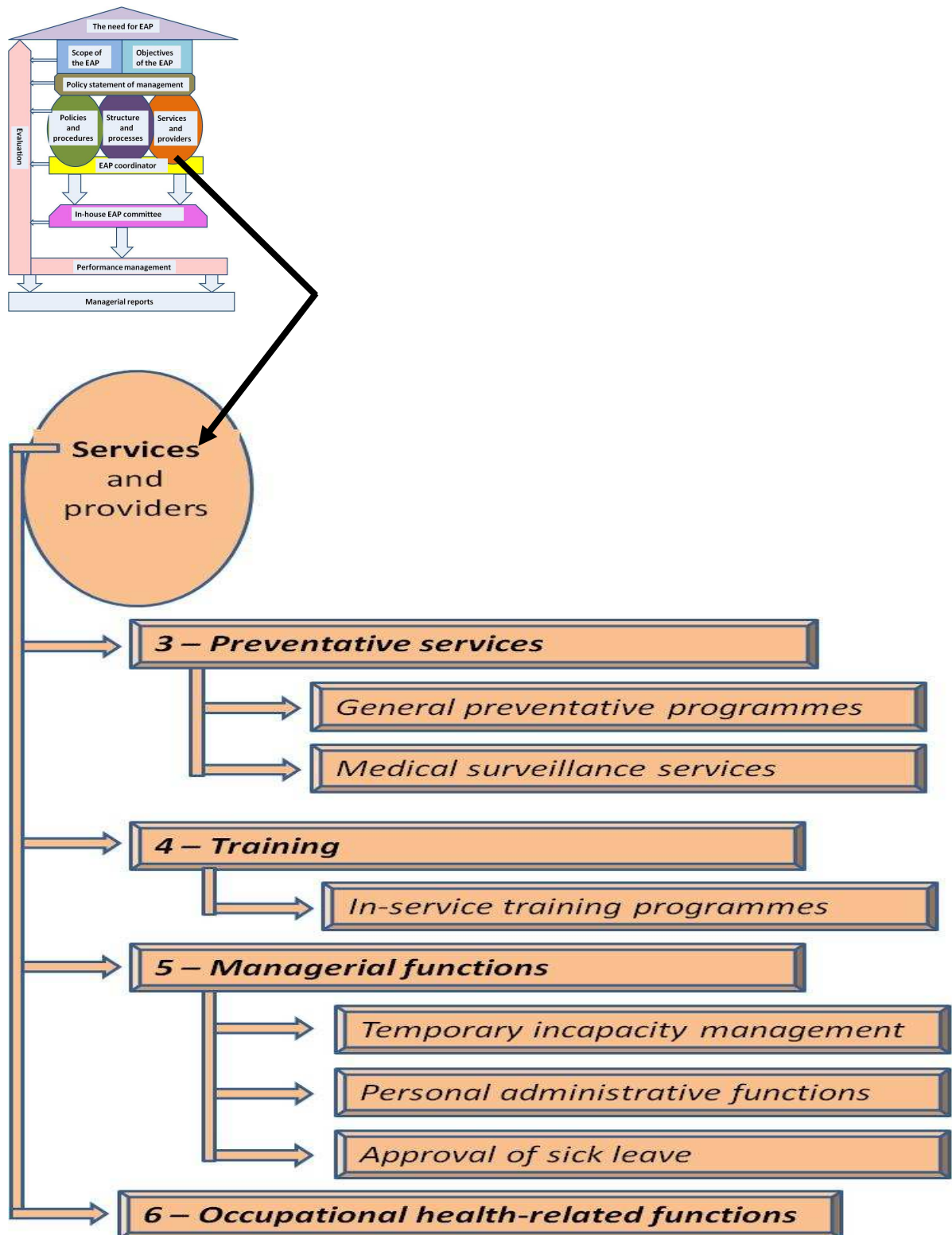


Figure 6.9b: The categories of services to be provided in a best-practice EAP – continued

6.7.1 Category 1 – Counselling services

Counselling services are, in essence, the cornerstone of EAPs (*cf.* 2.3). Counselling services for a best-practice EAP can be divided into four sub-categories:

6.7.1.1 *Sub-category 1 – Short-term counselling*

Short-term counselling consists of general counselling and the purpose can be summarised as having either a short-term therapeutic function or a gate-keeping function, consisting of an evaluative and referral component (*cf.* 3.8.3). Short-term counselling has proved to be effective in cases dealing with alcohol- or drug-related problems (*cf.* 2.3.2, Greenwood *et al.* 2005:9). It is also a therapeutic option in cases where the health care workers' only needs are emotional support to enable them to address their problems.

Furthermore, the short-term counselling service serves as the initial counselling session, limited by the experience, training, skills and resources available to the EAP counsellors. If deemed necessary, the counsellor can refer the health care worker for further counselling or treatment (*cf.* 2.6.8, Sharar 2008:339).

6.7.1.2 *Subcategory 2 – Recommended specialised counselling services*

The initial assessment or the short-term counselling session should provide an indication of the seriousness of the problem. If the indication is that the problem is too complex, the EAP's referral function must be used to acquire additional resources/services. This type of service is categorised as specialised counselling services and must be described as such in the EAP. This referral function should be a streamlined process in order to provide the appropriate services to the health care worker in good time. Utilisation of specialised services elevates a health care worker to the next level of care within an EAP. These specialised counselling services are listed in Table 6.6 with a more detailed discussion following the table.

Table 6.6: The recommended essential specialised counselling services to be provided in a best-practice EAP

<u>No</u>	<u>Types of specialised counselling services (essential)</u>
1.	Services to address relationship problems in the workplace
2.	Assistance with burnout syndrome
3.	Financial advisory services
4.	Trauma and violence debriefing counselling
5.	Stress and post-traumatic stress syndrome management
6.	Crisis management services; critical event management

Health care workers are unique individuals working within a team context. It is therefore not unusual to have differences in work ethos and opinions within a team. These interactions can create problematic relationships, hampering the productivity of some team members. It is possible that these relationships may become so complex that specialised counselling services are needed. The starting point for this type of counselling services should be the creation of general awareness through preventative sessions in a health promotion programme across the health care institution. In the next phase, as part of the treatment component, group intervention sessions must be conducted to assist health care workers in finding their own solutions.

In today's world of work, burnout can undoubtedly be diagnosed in the majority of employees. Several researchers confirm this observation amongst health care workers, while warning that the condition can easily be misdiagnosed (Engelbrecht, Bester, Van den Berg and Van Rensburg 2008:s24; Kendall *et al.* 2006/2007:113; Lee *et al.* 2008:235). Health care workers might also be more prone to this problem as they often try to improve their income by working overtime or taking jobs which result in increased levels of stress.

A considerable number of EAPs provided services to assist employees with anxiety-related to financial problems (cf. 2.1). It is therefore recommended that advisory financial services are available as part of an EAP. Health care workers must explicitly be informed that this type of service does not include financial assistance in the form of cash loans, but rather includes advice on managing personal finances.

Health care workers can be exposed to different kinds of violence such as personal/domestic violence, workplace violence and harassment. In their line of work, they also have to deal with patients who were exposed to violence, which can cause emotional stress to the health care worker. The provision of initial assistance to the health care worker exposed to violence is critical. The EAP cannot control the source of violence, but it can be instrumental in controlling the environment in which the employee recovers from the traumatic event. Health care institutions should monitor their EAP's ability to deal with health care workers with these types of problems by including them in their assessment form. One of the participants in the Delphi survey went as far as suggesting that, if the counsellors do not provide initial assistance and counselling for these types of problems, '*... you should fire them*'. As trauma and violence debriefing counselling is specialised in nature it is recommended that health care workers are referred to the appropriate resource, should the in-house EAP provider not have the appropriate training to deal with these cases.

6.7.1.3 Sub-category 3 – Optional specialised counselling services

Some specialised counselling services can be considered as being optional. These services are listed in Table 6.7.

Table 6.7: Optional specialised counselling services that can be offered in a best-practice EAP

No	<u>Types of specialised counselling services (optional)</u>
1.	Provide marriage counselling within the family context
2.	Conflict management

Organisations are faced with modern-day family situations such as both parents being career professionals; single parents who are career professionals; a lack of traditional community support such as grandparents assisting with children; and changes in the education curriculum with increased demands on parents. EAPs need to accommodate modern lifestyles and thus also render services in terms of the provision of basic information and support. In some parts of the world, EAPs are called EFAP where the additional 'F' stands for 'family'. The current trend in EAPs is to address the employee in a holistic manner; therefore, the EAP's services are often extended to include closely related family (*cf.* 2.6.5). In developed countries, the sentiment expressed by one of the Delphi participants, namely that '*... not doing this should be considered as neglectful practice ...*' is the norm. Some organisations might, however, consider providing extended services to include closely related family members as being too ambitious given their available resources.

The provision of conflict management counselling services is important as conflict could have a negative impact on general output and productivity. Care must be taken not to confuse this issue with conflict between the employer and the employee as this is addressed through the labour relations channels. Conflict management services could be a key aspect in the delivery of an integrated EAP where a programme also addresses multi-dimensional conflicts that are a result of the ever-changing workplace. A coaching programme aimed at handling conflict will form part of preventative EAP measures. This entails assisting individual health care workers to identify their 'triggers' and to develop skills to change their responses to those triggers in order to prevent possible conflict situations.

6.7.1.4 Sub-category 4 – Follow-up counselling services

Upon conclusion of counselling sessions, follow-up of the health care worker is probably essential in most instances. Follow-up sessions need to be conducted by EAP practitioners as well as by the supervisor of the health care worker, who needs to provide additional feedback to the EAP practitioner. These follow-up sessions can be in the form of group or individual sessions, depending on the nature of the problem

as well as the format of the initial counselling sessions. Follow-up counselling sessions are of value in that they can prevent relapses from occurring. Criteria for these sessions need to be specified within the EAP as it is crucial to reach closure and not to withhold resources from new cases due to non-closure.

6.7.2 Category 2 – Therapeutic services

The second main category of services within the EAP is therapeutic services, consisting of seven sub-categories. Careful planning and liaison with other employee wellness programmes and services are needed to ensure that the health care worker receives the appropriate services. The next section will provide more detail on each of the seven types of services in this category.

6.7.2.1 Chronic disease management

The management of chronic diseases is not generally included in the scope of the EAP. However, health care workers with certain chronic diseases such as acquired immune deficiency syndrome (Aids) and tuberculosis (TB) could benefit from counselling services provided by an EAP. If a person is diagnosed with a chronic disease while in the EAP, that person should be referred to the appropriate clinical services for proper management of the condition.

6.7.2.2 The treatment of substance abuse and addictions

The early EAPs were developed for employees with alcohol-related problems (*cf.* 2.1) and it would be appropriate for a best-practice EAP in the health care sector to continue providing such assistance for the health care workers. Further assistance can be provided by means of direct observational services to ensure that health care workers take their medication or attend the appropriate short-term counselling services (*cf.* 6.7.1.1, Buon and Taylor 2008:435). However, the medical treatment of substance abuse/addictions should be performed under the required medical supervision.

6.7.2.3 *General therapeutic services*

The provision of general therapeutic services, such as the treatment of minor ailments, is within the scope of primary health care. The movement towards the delivery of holistic services raised the question as to whether the programme should include general therapeutic services. General therapeutic services can probably be more effectively provided within the setting of an occupational health clinic. Therefore, organisations and staff should be advised to use proper referral channels to appropriate services if therapeutic services are required, rather than trying to provide such services within the EAP.

6.7.2.4 *Supervision of rehabilitation services such as Antabuse[®] treatment*

The same principles apply as is the case in delivering general therapeutic services. If there is a need for medical supervision within the rehabilitation service for example administering Antabuse[®] treatment, occupational health services should be contacted for assistance. The establishment of formal linkages between the EAP providing the necessary counselling and other services providing the medical support for rehabilitation services is important.

6.7.2.5 *Management of Injury on Duty (IOD) cases*

Injury on Duty cases are more appropriately managed by an occupational health service provider. The administrative process of these cases can be managed by the staff responsible for disability management. This recommendation is made on the assumption that there is a dedicated occupational health services provider with whom to collaborate. EAP providers might be able to assist during the post-trauma period.

6.7.2.6 *General rehabilitation services*

General rehabilitation services are vague and should not be considered to be a function of an EAP. EAPs might provide some support to employees in this regard, but this should not be classified as a service. Rehabilitation services should only be provided by the appropriate specialists such as occupational therapists.

6.7.2.7 *Psychiatric services*

Psychiatric services are highly specialised and an EAP should only be the referral point for health care workers requiring this type of therapeutic services.

6.7.3 Preventative services

The third category of services provided by EAPs can be classified as preventative services. These services are not discussed in detail as the category is very broad and some of these services overlap with other types of programmes. Only the major issues are highlighted in the next section.

6.7.3.1 *General preventative programmes*

The current trend within the field of EAPs is to focus on primary prevention activities with health promotion seminars acting as a vehicle for this (*cf.* 2.1). The aim is to assist health care workers before a problem manifests into unproductive employee behaviour. Such services should provide health care workers with the coping skills needed to manage the situations with which they are faced. It is not compulsory for the EAP to provide these types of programmes exclusively, but can simply be included in the health promotion strategies of the institution.

6.7.3.2 *Assistance with medical surveillance services of employees*

Health and safety legislation in South Africa (*cf.* 2.6.5) requires the medical surveillance of employees who have been exposed to certain occupational risks such as hazardous chemical substances. The details of such medical surveillance programmes are stipulated in the regulations of the legislation and it would require specialised services to run the medical surveillance programmes. Medical surveillance programmes, based on a formal risk assessment, are conducted by the medical staff employed by the occupational health services to intervene as necessary. The occupational health services of a health care institution are usually equipped with regard to strategy, resources and specialised occupational health staff to render medical surveillance programmes as required. EAPs can, however, assist with other work-related problems identified in the medical surveillance programme such as psychological problems. EAPs need to have a referral function according to which health care workers can be referred for medical surveillance, if necessary.

6.7.4 Training

The fourth category of services in the EAP is the provision of training to employees. The most suitable place for these training sessions are within the in-service training programme of the institution. More detail is provided in the next section.

The EAP should be able to address the training needs of health care workers on several levels, from basic life skills to more sophisticated managerial training. In order to achieve the best possible attendance and outcome, such training should be conducted as part of the in-service training strategy of the health care institution. The training provided by the human resource department is included in the mentioned in-service training strategy. The training provided by the EAP should supplement the training provided by the human resource department. Teaching basic life skills might aid health care workers in coping with certain personal problems. Alternatively, this can form part of preventative therapy. The role of EAPs in supervisory training to recognise employee problems is contentious and careful consideration is required

with regard to the inclusion of the EAP practitioners in the training programme of supervisors (cf. 2.3.2).

6.7.5 Managerial functions

The fifth category of services that can be provided by an EAP is a group of activities that can be categorised as having managerial functions. Three types of services were identified during the focus group discussions and the institution should be careful not to undermine the roles of the responsible managers when such services are provided by EAP providers.

6.7.5.1 Temporary incapacity management

Temporary incapacity means that an employee is unable to work for a certain period of time due to a medical condition or any other problem which renders the employee unable to perform his or her duties. Ideally, occupational health services staff should manage employees with temporary incapacities. These employees could, however, be referred to the EAP by the human resource department or occupational health services for assistance with work-related issues or coping with the serious debilitating condition.

6.7.5.2 General supportive services in order to conduct personal administrative functions on behalf of the employee

Health care workers need to perform crucial administrative functions of a personal nature such as visiting the Department of Home Affairs for identification documents, birth registrations, passports and/or the Department of Traffic Control for their motor car registration. Offering to conduct these types of personal administrative functions on behalf of the employee can be very unproductive for an EAP and should not be embarked upon without very careful consideration as this will drain valuable resources away from employees who need critical EAP services.

6.7.5.3 *The approval of sick leave*

The approval of sick leave falls outside the ambit of an EAP and is primarily a function of supervisors or line managers. If such a function is delegated to the EAP, it might seriously affect the trustworthiness of the programme. On the other hand, an EAP may be of assistance where absenteeism in a workplace is recognised as a chronic problem and the programme can assist with the monitoring thereof. It can be used as a criterion for measurement, if the absenteeism rates are monitored over a period of time.

6.7.6 **Occupational health-related functions**

The last category of services in relation to EAPs is occupational health-related services. Some of the functions already mentioned, as well as other related functions, might be performed in liaison with the occupational health services of the health care institution (*cf.* 6.7.2.5; 6.7.3.2). It is thus clear that an EAP cannot function in isolation and integration with other institutional programmes, such as the employee wellness programme, is vital in order to deliver a holistic service to employees.

6.8 **THE SERVICE PROVIDERS**

Several health care workers will be employed within the EAP to render the services as determined by the needs assessment. Figure 6.10 summarises the essential characteristics of the EAP service providers. The next section discusses these characteristics in more detail.

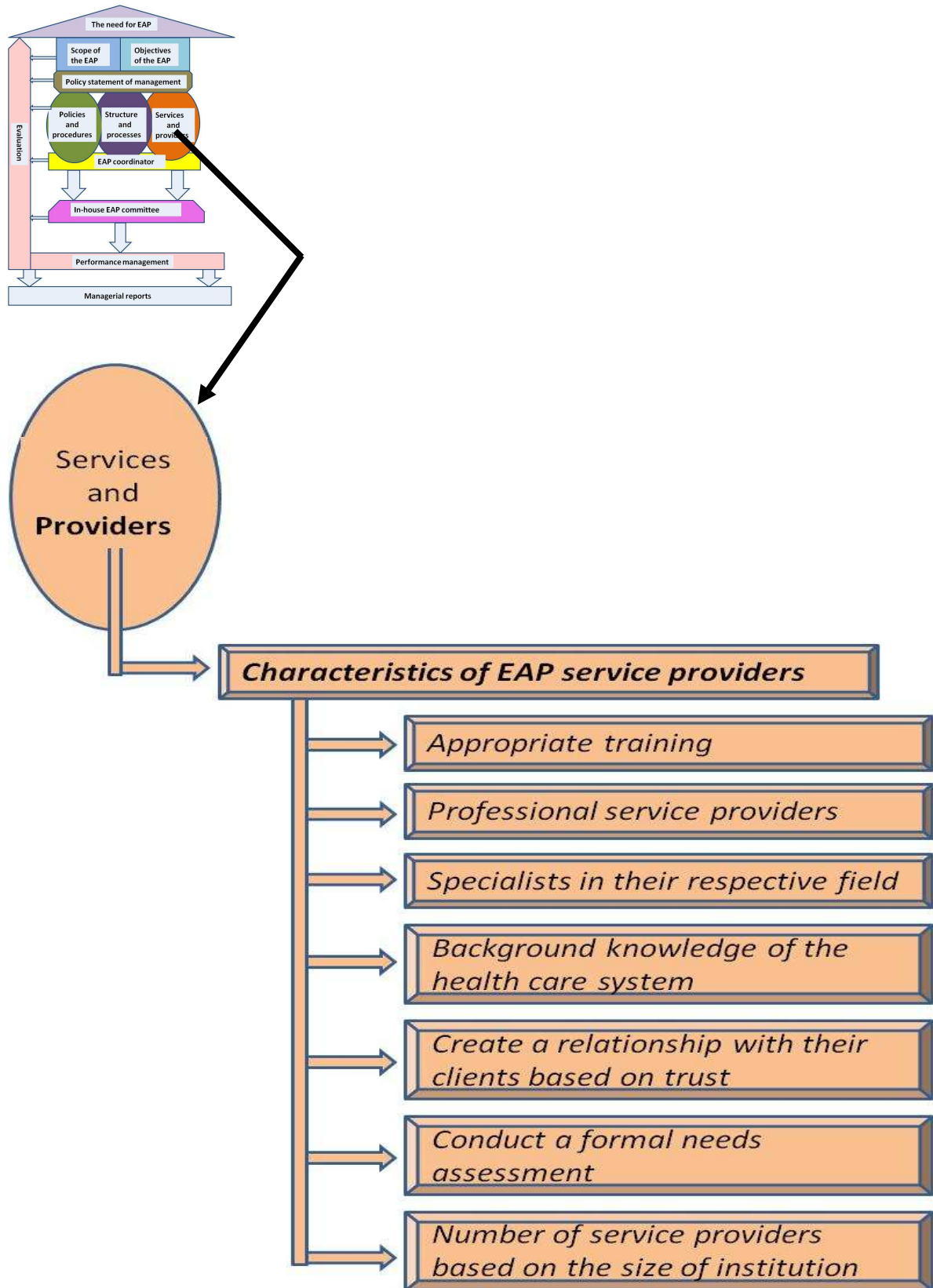


Figure 6.10: The essential characteristics of EAP providers

6.8.1 Characteristics of EAP service providers

Training is indicated as one of the prerequisites for providing quality health care and the success of the EAP depends on the competency of the staff working in the EAP (*cf.* 2.9; Casparie 1998:204; Highley 1996:6). The staff providing the services in an EAP must have the appropriate training in order to render a particular service within an EAP. Staff with experience in, for instance, human resource or labour relations problems can also assist with the EAP. Peers, if trained appropriately, have a role to play in the broader spectrum of an EAP counselling processes. They should clearly understand that, if they are not trained in providing counselling services, they cannot embark on this. In this case, they should provide an information or support service instead.

The staff providing services within the EAP must be professional service providers licensed and registered with their respective professional boards (*cf.* 2.9). Staff working in the EAP must be able to determine when the needs of health care workers fall outside their field of expertise and use the appropriate referral channels to assist them. The needs experienced by some health care workers may require specialised services. If possible, the majority of the staff providing such specialised counselling services in an EAP must be specialists in their respective fields and have the available resources. It is also acceptable to have a generalist who has experience with the full scope of problems ranging from crisis management to addiction to family counselling. In general, the needs and available resources in an institution will determine the type of experience and skills of the service providers who are appointed.

The EAP service providers must have the necessary background knowledge of the health care institution in which they provide the services. This characteristic is more appropriate for the internal model of service provision, but it would also be beneficial for external service providers to have some background information of the health care institution they are serving.

EAP practitioners should be able to create a relationship with their clients based on trust. Trust implies that the health care workers feel comfortable with sharing and discussing their intimate personal information with the practitioners. Trust also includes the sense of feeling confident that they will have access to the required expertise to resolve their problems. The service providers are privy to confidential matters and must not become intermediaries between employees and management. Trust could also be used to counteract the stigma associated with the EAP (*cf.* 2.7.2; Johnson 2008:272).

EAP service providers should conduct a formal needs assessment to establish which types of EAP services are appropriate for the particular health care institution (*cf.* 6.7). Some managers consider a needs assessment to be a luxury as they commented in the Delphi survey that health care institutions at the same level will have similar, generic needs. However, it is crucial to keep in mind that the needs assessment for an institution also serves as the mandate for the EAP of the specific institution.

The number of EAP service providers should be based on the size of the health care institution. Determining the size of the health care institution is not solely based on the number of employees. Instead, factors such as the level of care provided to patients, the geographical location of the institution and available resources need to be considered. Another factor that will determine the effectiveness of an EAP is the fact that certain categories of EAP staff are required. The initial and follow-up needs assessments (*cf.* 6.2.3) should also serve as a guide with regard to the categories and number of EAP providers needed.

A characteristic that is not considered to be crucial is the seniority level of EAP service providers as skills and experience are not limited to senior providers only. Characteristics that are deemed more important than seniority include, *inter alia*, the sincerity to help others, willingness to learn, communication skills and aptitude. It is also worthwhile to offer student internship positions as part of the service programme.

6.8.2 Types of service providers

The various types of EAP providers are illustrated in Figure 6.11.

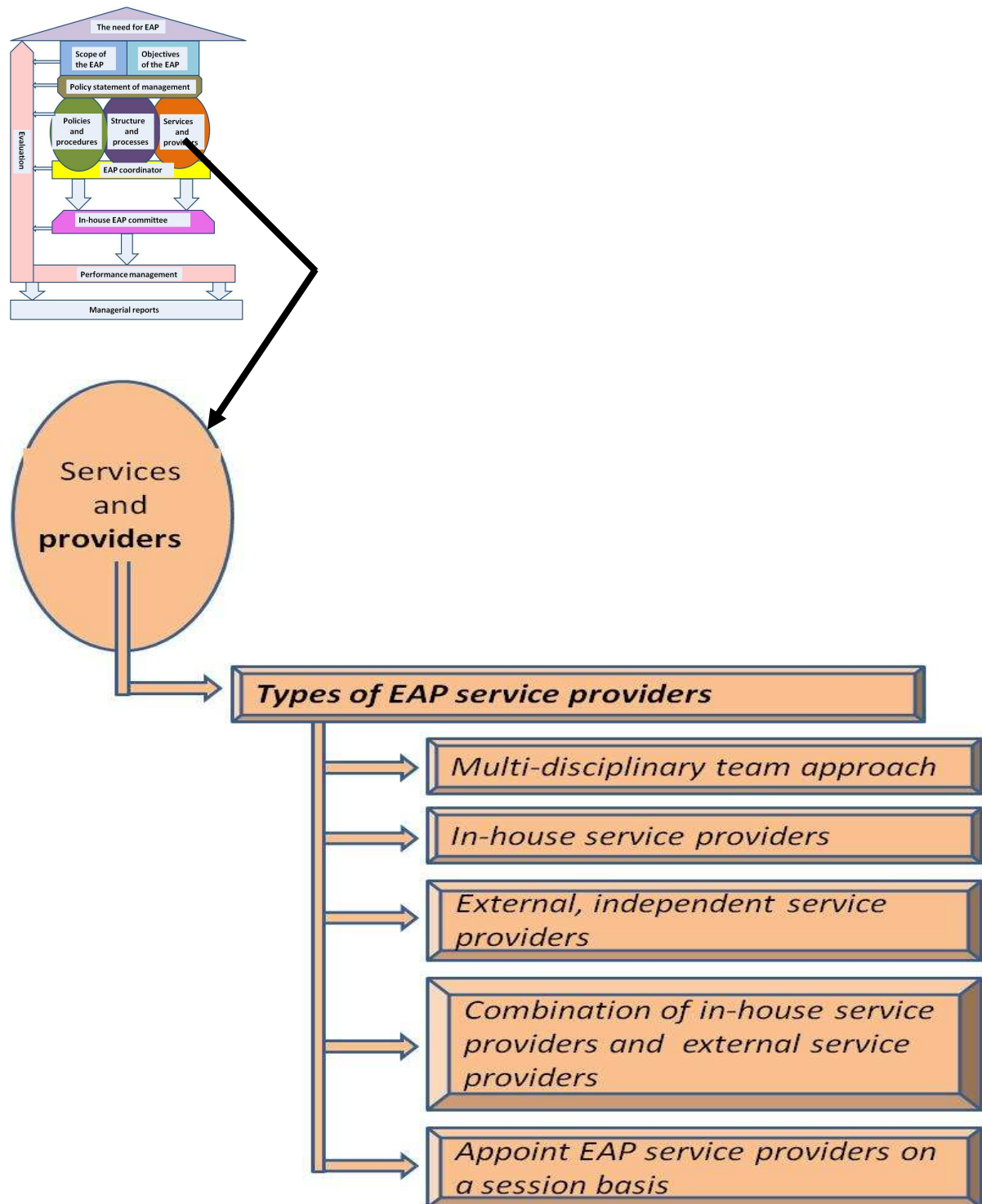


Figure 6.11: The types of EAP providers

A multi-disciplinary team approach is essential because of the broad scope of an EAP, the variation in employee problems and the uniqueness of the individual health care institution. Each member of the multi-disciplinary team needs to play a specific role to ensure that a health care worker is managed in a holistic manner.

Various options for service delivery are available to institutions, namely (a) in-house service providers; (b) outsourcing the service to external providers; (c) a combination of the previous two options; and (d) appointing service providers on a sessional basis.

Although the literature indicates that internal service provision is preferred by many health care institutions and is regarded to be superior, it is not necessary to run a programme in this manner (*cf.* 2.8.1). The size of the health care institution and its capability to provide a comprehensive service are more important in determining whether the service should be completely in-house or not.

The second option for service delivery is by means of outsourcing the services to external independent service providers. The negative aspect of this approach is that external service providers are not always fully informed about the day-to-day working conditions within the institution which could have an impact on the assessment and rehabilitation of employees. Health care institutions using external providers need to ensure that these providers have an in-depth understanding of the specific client needs and requirements. On the other hand, the utilisation rate of an EAP provided by outside providers might increase as this type of programme might be perceived as having a greater degree of confidentiality. There is also the issue of dual loyalty amongst internal EAP staff, meaning that the internal staff demonstrates loyalty to the employees as their clients, as well as to the health care institution as their employer (London 2005:324).

The third option of service delivery consists of a strategy according to which basic EAP services are provided by a core in-house team, followed by the outsourcing of more specialised services. Making use of a combination of internal and external service providers is not uncommon (*cf.* 2.8.3), but the executive management might

argue that such an approach is not the most cost effective. However, it has been proven that a combined programme could not only be cost effective, but could also be the strongest model (*cf.* 2.8.3). One of the Delphi participants referred to this model as the luxury model of EAP service provision as an institution could have the best of two worlds. A balance between in-house and outsourced service providers could also be the best option for an institution with limited EAP skills and resources. If such a programme is adopted, a coordinator employed within the health care institution is vital (*cf.* 6.8.5).

The final option according to which service can be delivered is to appoint EAP service providers on a sessional basis. This approach might sometimes be the only option available to an institution, but is not optimal as services would not be available to health care workers twenty four hours of the day to ensure the continuity of services.

6.8.3 Categories of staff needed within the EAP

An EAP consists of an in-house team of professionals to render the services offered by an EAP (*cf.* 2.9). The appointment of staff within the EAP will depend on the type of EAP providers needed. Table 6.8 lists the various categories of providers that can be considered for the core team of an EAP, with an illustration in Figure 6.12.

Table 6.8: Categories of staff members needed for a best-practice EAP

<u>Critical staff</u>	<u>Staff that could be considered</u>
Human resource officer	Legal advisor
Psychologist	Registered nurse
Social worker	Religious/spiritual leader
Occupational health nurse	Psychiatrist

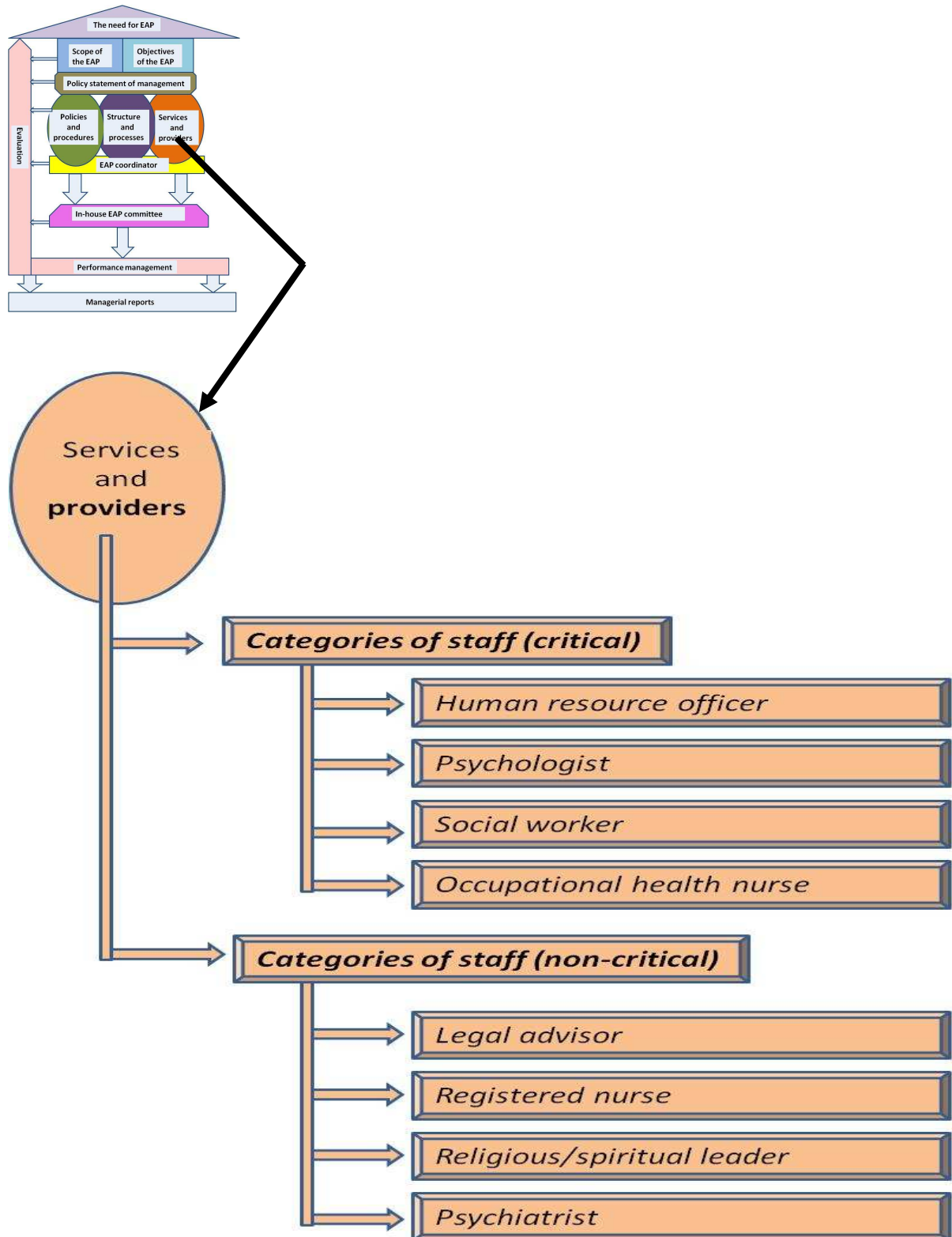


Figure 6.12: The categories of health care workers needed in a best-practice EAP

The following categories of staff could be considered for the core team, but were not regarded as crucial by the participants in the Delphi survey:

- Occupational therapist – occupational therapy has a wide sphere of practice and occupational therapists are at the forefront of rehabilitation teams (Beer, Green, Armitt, Van Bruggen, Daniels, Ghyselen, Sandqvist and Sixsmith 2002:136). However, occupational therapists are not routinely trained to provide EAP counselling services. The experts in the Delphi survey considered occupational therapy to be too specialised for EAPs and one of the international Delphi experts commented: ‘I have never worked on any committee that needed an OT (occupational therapist)’. However, their service will be crucial when there is a need to determine the health care workers’ capacity to continue with their service, for example, performing a work assessment evaluation or in the rehabilitation of a health care worker.
- Financial advisor – a substantial number of employee problems are perceived to be financial. To provide a service to these employees using the EAP, an external service provider, including a debt counsellor, could be appointed to assist them. This will be in line with the combined internal-external EAP model.
- Medical practitioner – with the appointment of medical practitioners care should be taken that the emphasis is placed on general assistance services and not services associated with an ailment clinic. The emphasis should be on holistic care rather than on individualised medical care.
- Administrative staff member – it is recommended that an administrative officer be appointed to perform the administrative functions of the EAP (Bailey and Troxler 2009:358). This function can be performed by the human resource staff member who is part of the core team, but it would depend on the size of the institution and the workload. Young *et al.* (2010:187) confirmed that the role of the human resource officer is moving away from performing purely administrative duties towards that of an educational and developmental role.

Some categories of staff would be better placed on the EAP committee:

- A member of senior management – this category of staff can play a more meaningful role in the in-house EAP committee in the planning, proposals for, budgeting for, and implementation of EAP processes. Buy-in from management into the EAP can be achieved by having such a member on the committee.
- Union members – labour union representation as observers on the in-house EAP committee would ensure transparency and would allow for involvement in developments such as preventative programmes.

6.8.4 EAP coordinator

Modern-day human dynamics and needs require dedicated EAP service providers in order to be successful. To support a best-practice EAP, the appointment of a full-time EAP coordinator in a health care institution is non-negotiable. Various categories of health care workers can be appointed as EAP coordinators. Figure 6.13 highlights the most important aspects regarding the EAP coordinator. Options to consider and reasons are summarised in Table 6.9.

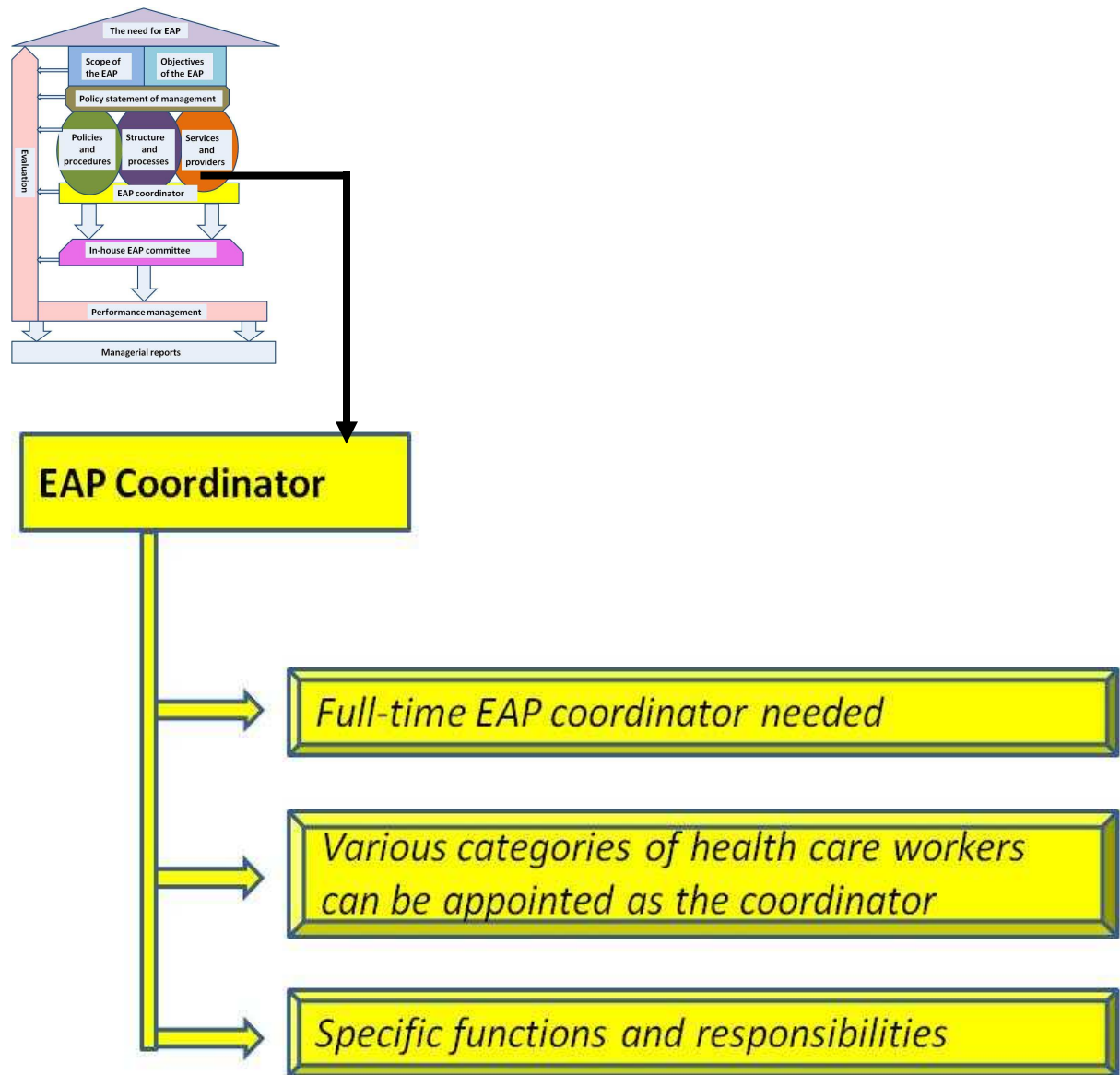


Figure 6.13: The EAP coordinator

Table 6.9: The categories of staff to be considered as EAP coordinator

No	Category	Reasons/discussion
1.	Social worker	In the professions associated with aiding people, social workers are probably the best equipped with regard to assessment and counselling skills.
2.	Clinical psychologist	Clinical psychologists are also suitably trained in order to provide the crucial counselling services.
3.	Occupational health or professional nurse	A qualified nurse might be an option if there is a need for the coordinator to render additional services in a holistic approach such as clinical services.
4.	Medical doctor	Same reasons as those stated for professional nurses.
5.	Human resource graduate	If the staff member has the required experience and skill set.

The categories of health care workers appointed as the EAP coordinator will depend on the strategy and objectives of the institution's EAP. The appointment will also be determined by the duties and responsibilities of the said EAP coordinator. The functions and responsibilities of the coordinator are summarised in Table 6.10.

Table 6.10: Functions and responsibilities of the EAP coordinator

1.	To ensure that an initial assessment is performed on each employee who is referred to the EAP
2.	To ensure that the appropriate treatment plans are developed for each employee entered into the EAP
3.	To ensure that the appropriate communication channels are established and maintained with the relevant stakeholders
4.	To ensure that feedback is compiled and provided on particular cases as stipulated in various policies and procedures
5.	To represent all the EAP providers in the in-house EAP committee
6.	To ensure that the EAP of the health care institution remains adaptable in order to address the ever-changing needs of the employees and the employer
7.	To ensure that all the essential administrative functions of the EAP are performed as stipulated in the various policies and procedures
8.	To ensure that a comprehensive quality assurance programme is in place for internal as well as external service providers

6.8.5 The in-house EAP committee

The formal establishment of an in-house EAP committee is not an absolute necessity but, if constituted, plays a vital role in the governance of the EAP. The advantages and disadvantages of an in-house EAP committee are discussed extensively in the literature (*cf.* 2.7.1). Figure 6.14 illustrates the most important aspects of the in-house EAP committee.

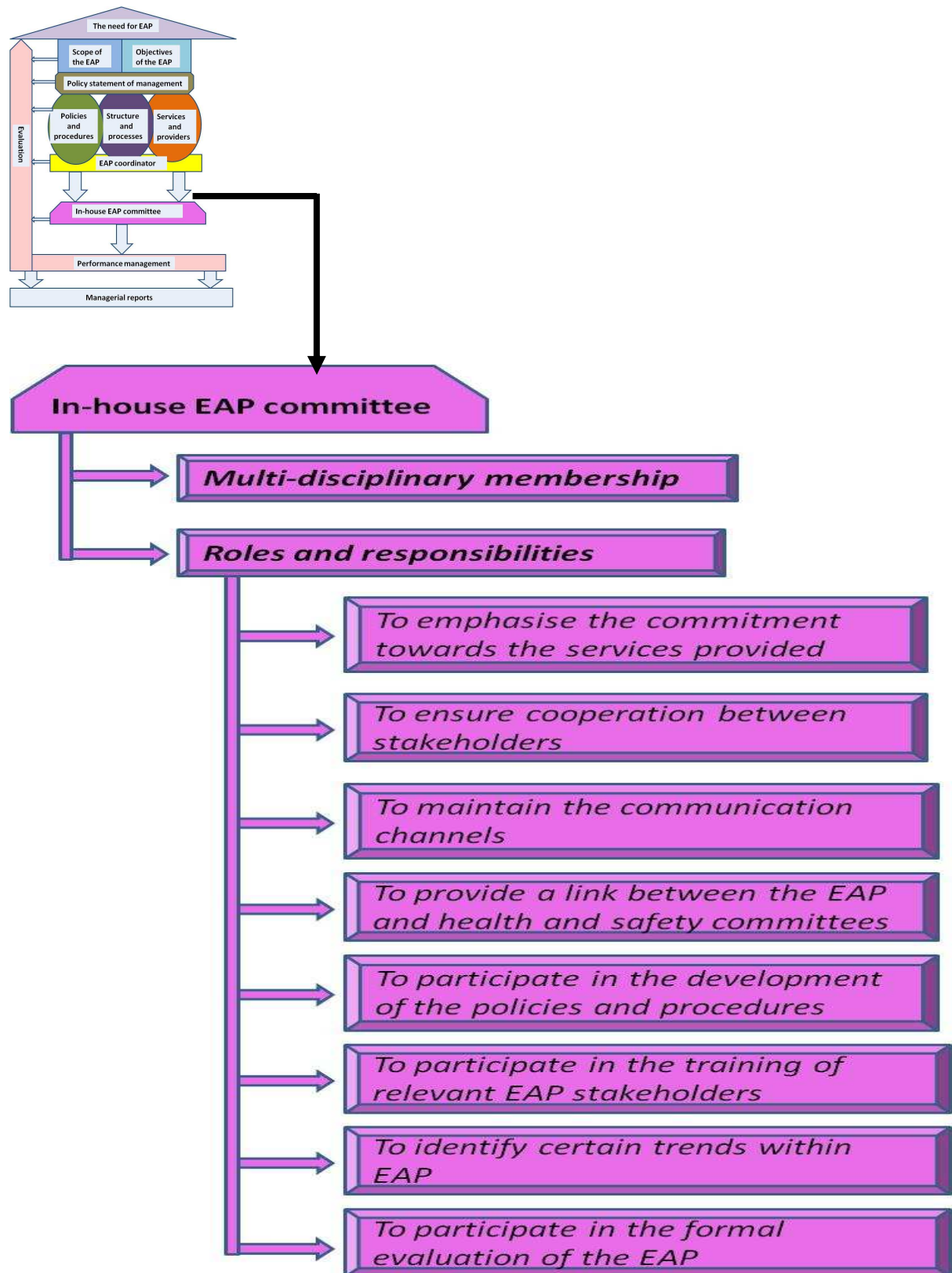


Figure 6.14: The in-house EAP committee

An explicit institutional EAP policy with the supportive procedures serves as the constitution of an EAP. These documents will also serve as the vehicle for establishing an in-house EAP committee. The issue of confidentiality could be used by health care institutions as an argument against the establishment of an in-house EAP committee. Note must thus be taken to address this concern, as highlighted in previous sections of this study.

A clear mandate of the committee should be formulated to ensure that the programme and the in-house EAP committee operate within set parameters. This will also ensure that committee members do not interfere in the actual activities of an EAP. Once the mandate has been formulated, the operation of the committee within the institution should be stipulated to clarify its role and responsibilities. In turn, these roles and responsibilities will determine the in-house membership of the committee. The membership of the in-house EAP committee will be determined by the individual institution's needs and representivity. For an in-house EAP committee, health care institutions should consider representation from the following groups:

- Senior management
- Health and safety officers
- Labour unions
- Human resource department
- Occupational health staff
- EAP coordinator and service providers.

An in-house EAP committee might waste a health care institution's valuable resources if these members are not experts in the field of EAP. They might lack the necessary competencies to drive and maintain the EAP. With the required strategy and structure in place, the formal role clarification and decision-making processes will ensure meaningful contributions and effectiveness of the EAP committee. The role of the in-house EAP committee could include the following:

- To emphasise the commitment of the EAP committee towards the services provided by the EAP. Such commitment will filter through to the health care workers and demonstrate that all the stakeholders are promoting the EAP to be a trustworthy programme with good intentions.
- To ensure that there is the necessary cooperation between stakeholders and, where possible, avoid the duplication of services. It is recommended that the function of an EAP committee should shift from a management to an advisory function (*cf.* 2.7.1). A further suggestion is that there should be an equal representation of labour and management with various collective agreements to ensure cooperation amongst all the role-players. However, the degree of intervention to ensure cooperation will depend on the spectrum of services provided by the programme.
- To assist with the maintenance of communication channels within the EAP and amongst the stakeholders. This will ensure that much-needed information continues to flow through to the relevant stakeholder, with the required protection of confidentiality. Communication back to the committee will ensure that there are channels to review the appropriateness of the programme in terms of its original objectives and prevent unnecessary conflict between the stakeholders.
- To maintain a link between the EAP and the health and safety committee, especially with regard to possible health risks in the workplace. Several work-related problems can be identified by the EAP through health care workers entering into the EAP. The communication around health and safety issues in the workplace should include representation from senior management as they are ultimately responsible for health and safety in the workplace. Confidentiality should be addressed accordingly to protect vulnerable health care workers being victimised or exploited.

- To participate in the development of the policies and procedures of the EAP. The diversity within the committee will ensure that all the required components will be addressed.
- To be involved in identifying the additional training needs of the relevant EAP stakeholders. It must be emphasised that the content of the training should be in line with the scope of the committee.
- To assist with the identification of trends with regard to the referrals to the EAP as well as the types of problems managed by the programme. This function could be linked to the evaluation of the EAP. Management should resolve workplace problems that cause these undesirable trends.
- To participate in the formal evaluation of the EAP in order to determine the effectiveness and efficiency of the programme. The ideal mechanism for evaluation is to utilise an external independent agency, such as an external accreditation organisation, for possible accreditation of the EAP (*cf.* 6.5.3.5).

A health care institution might also consider involving the in-house EAP committee with the discussions centring on problematic cases/health care workers that cannot be solved within the EAP. Such a function is, however, controversial and sensitive. Some of the concerns are as follows:

- The in-house EAP committee is an administrative group and serves to advise the institution and EAP providers on policy and promotional issues.
- The discussion of complicated cases should be the responsibility of qualified practitioners who have the necessary skills to deal with them.
- An ethical dilemma for health care professionals who share case information. Confidentiality will be breached by discussing sensitive information about individual health care workers in an open meeting with a diverse membership. Case information is confidential and only an EAP review team would be able to discuss the case internally.

- The assignment of a case manager(s) to assist problematic cases within the EAP is outside the scope of an in-house EAP committee.

If these concerns are taken into consideration, the conclusion can be drawn that the committee should not be involved in the discussion of individual complicated cases. The committee should not become involved on an operational level as this might stimulate the stigmatisation of the programme. Instead, it should provide principle guidance at a strategic level. In constituting an in-house EAP committee, the health care institution should take note of additional risks associated with this type of committee (*cf.* 2.7.1) and ensure that measures are put in place to address these risks. It is also critical that committee members sign a confidentiality declaration even though their functions do not entail direct case contact.

In conclusion, the in-house EAP committee is an administrative structure which does not have clinical or therapeutic responsibilities. This advisory capacity of the committee should be directed towards generic or strategic issues relating to the programme rather than to individual EAP cases *per se*.

6.9 THE EVALUATION OF AN EAP

The need for formal evaluation and a quality assurance system for an EAP must be a priority for the management of a health care institution since these functions are their responsibility (*cf.* 3.1). The fact that EAP practices and quality measurements are not standardised (*cf.* 3.4) puts further pressure on health care institutions to have effective systems in place for the evaluation of their EAPs. The demands and needs of the employees will also play a role in forcing the institution to adapt an EAP that is able to address these needs and demands. These adaptations should be evaluated by the institution against the suggested EAP core technology (*cf.* 2.3) to prevent unnecessary deviation from internationally accepted guidelines.

It would be difficult to evaluate the performance of the EAP without acceptable standardised performance measurement systems. Courtois *et al.* 2004b (*cf.* 3.4) highlighted several factors that need to be taken into consideration when designing a standardised performance management system for an EAP. These factors include the characteristics of the programme being measured, the purpose of the measurements and the way in which the system will be used. The outcome of this study not only elaborates on these factors, but also addresses other factors to be considered during the design of a performance management system.

The characteristics of an EAP are essentially focused on providing behavioural health care. It is important to acknowledge the significance of clinical and non-clinical factors when evaluating behavioural health care. In order to address these factors, it is recommended that the purpose of the performance management system should focus on the evaluation of the structure, processes and outcome of the EAP (*cf.* 3.3.3) as well as the interaction between these components (Muller *et al.* 2006:480). Such an approach will ensure that the entire programme, with all its systems, processes and functions, are evaluated to serve as a basis for measuring and enhancing the overall quality of the EAP. The evaluation should start with the planning and implementation of the EAP, continue with the nomination of an employee to enter the EAP and follow through to the point where an outcome has been reached to illustrate a possible approach. In order to measure all these different aspects, a variety of methods should be used for evaluation purposes. Basic descriptive data will be generated as part of the evaluation process, but this type of data will not give a health care institution a comprehensive overview of its EAP. Thus, it is important to analyse various relationships between and amongst components such as structure, processes and outcomes as is suggested by Aday *et al.* 1999 (*cf.* 3.3.3). The evaluation of an EAP should be used to provide managers with information, not only with regard to the quality of the services and the need for the introduction of quality improvement cycles, but also as a means of verifying the justification for having an EAP and corroborating whether the EAP actually addresses the needs of the health care institution in its current form (*cf.* 3.4).

The evaluation must be a continuous process covering all the steps and processes, unless otherwise stipulated. The timeframes for the various evaluations must be defined and the person(s) who will be responsible for the evaluation processes must be identified. All activities related to the quality assurance of an EAP should preferably be coordinated by an EAP coordinator. The evaluation must be able to determine whether or not the key objectives were met. It should also indicate whether the programme has assisted in strengthening the other strategic initiatives of the company, for example, attraction of new talent and retention of existing talent. All the evaluation processes must adhere to the confidentiality principles. As a concluding remark, the EAP performance management system should be used in line with the overall quality assurance strategy of the health care institution.

The rest of this chapter will provide detailed information on the actual evaluation of an EAP in a health care institution. The following four areas will be addressed, namely (a) the approach and strategies for ensuring quality; (b) the areas that should be evaluated; (c) the methods that must be utilised; and (d) the tools needed.

6.9.1 Performance management – an approach and strategy

It becomes increasingly important to demonstrate the effectiveness and efficacy of an EAP, using a multi-method design (*cf.* 3.5). Unless a health care institution has internal staff who can conduct evaluations in a confidential manner, the possibility exists that the majority of health care institutions will not want to spend money on anything more than the most elementary evaluation processes. While such an approach might be acceptable, the health care institution must ensure that the key aspects of its EAP are evaluated in order to obtain meaningful reports on the performance and value of the EAP. Figure 6.15 illustrates the approach and strategy to be followed for the quality assurance of a best-practice EAP.

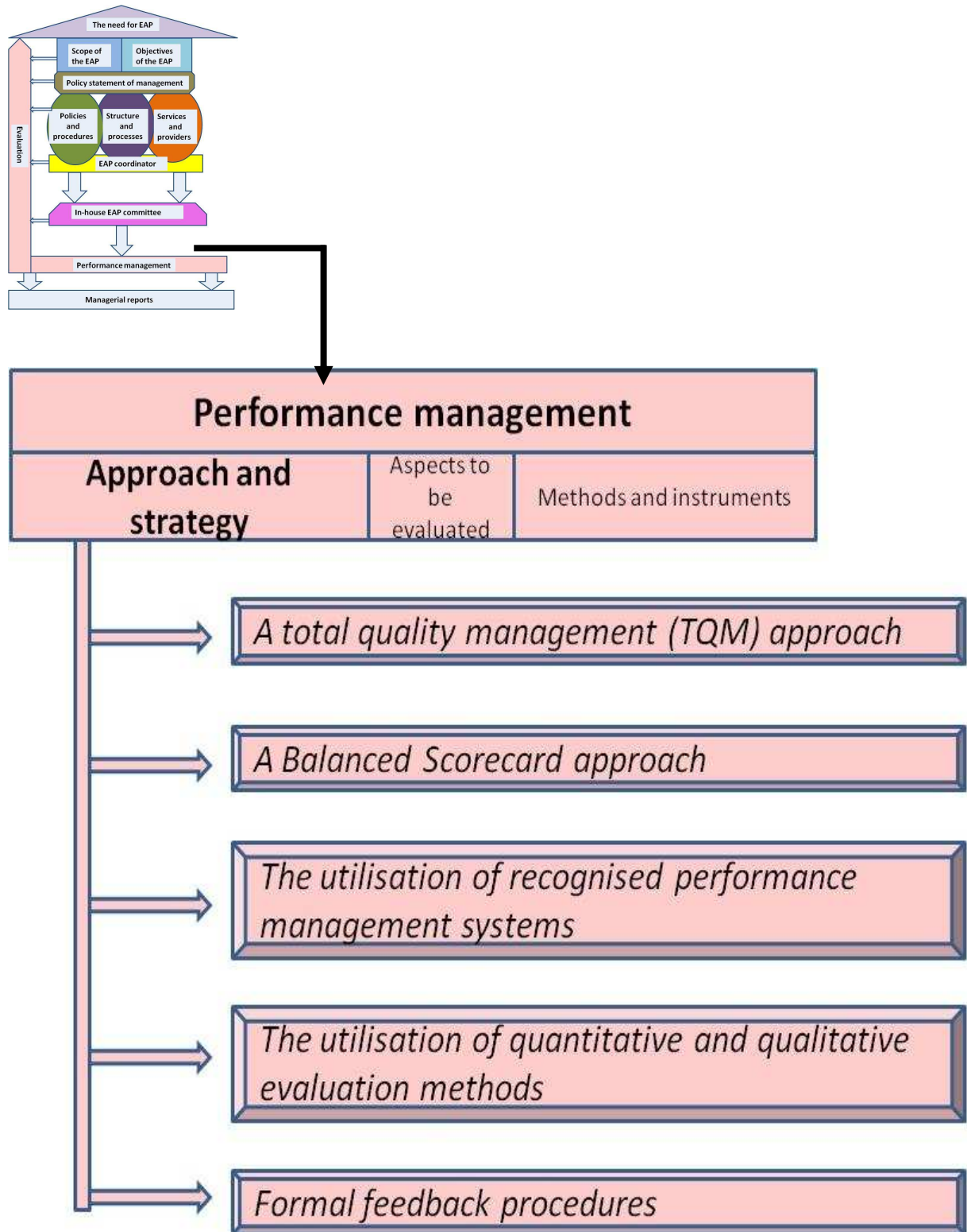


Figure 6.15: The approach and strategy for the performance management of the best-practice EAP

6.9.1.1 *A total quality management (TQM) approach*

The TQM approach might be the answer to evaluating many elements of an EAP as this approach has its foundation in the inclusion of several systems, methods and tools on a vertical, as well as a horizontal, level (*cf.* 3.1). The horizontal level includes various components and aspects that are broader than the core EAP components. On a vertical level, it includes all the key role-players in an EAP. One of the cornerstones of the TQM approach is client satisfaction. Thus, it is advisable that a third party evaluator be included when it comes to the evaluation of client satisfaction to ensure unbiased results.

6.9.1.2 *A Balanced Scorecard approach*

The Balanced Scorecard approach can be considered as an alternative to the TQM approach (*cf.* 3.5). The measures chosen to represent each of the perspectives within the Balanced Scorecard approach need to reflect the performance within the perspective as well as a combination of these perspectives. Within this approach, each of the measurements is given equal weight to provide a comprehensive analysis of the quality of the EAP (*cf.* 3.5). Examples of possible measures within the four perspectives include:

- An input measure, such as the allocated budget for the EAP, which will thus cover the financial perspective
- A cyclic assessment of employee needs to determine the range of services that should be provided to ensure that the customer perspective is considered
- A process measurement, such as the provision of the various types of services within the EAP, will address the internal processes perspective

- Output measures, such as the absenteeism rate, utilisation of the EAP (utilisation rate) and patient satisfactory surveys will provide information on the learning and growth perspective of the scorecard.

This combined approach will ensure that a correlation is established and maintained between the required input, leading and lagging indicators. Institutions must review possible indicators for inclusion in the combined approach to ensure that the quality of the EAP is measured adequately, while it is possible to identify the aspects that need to be addressed in order to improve the quality of the EAP.

The development of a balanced scorecard system for an EAP that includes 'soft services', such as counselling, is complicated, but is probably the most feasible of all the performance management approaches. The four perspectives in the Balanced Scorecard approach can be used as stipulated in Table 6.11. It must be noted that the table only serves as an example and that more detail can be added as deemed vital by a specific health care institution.

Table 6.11: A summarised example of the Balanced Scorecard approach for an EAP (adapted from Gurd and Gao 2008:14)

Perspective	Method to be used
1. Financial	Allocated EAP budget and expenses Cost-benefit analysis Return on investment (ROI)
2. Customer	Needs assessment Employee involvement Employee satisfaction
3. Internal business	Types of services provided Policies and procedures Patient satisfaction
4. Learning and growth	Productivity Human capital value Employee turnover or retention Employees trained Results of quality assurance projects Information capital

It is not the purpose of this study to discuss the Balanced Scorecard approach in detail, but rather to point out its practical value and relevance. Note must be taken of the fact that all the elements of an EAP can influence the quality of the programme and that a single element cannot be a stand-alone indicator for the overall quality. For example, the utilisation rate of the EAP is a reflection on the outcome of the programme, but the utilisation rate can be influenced by inputs such as insufficient funding for running the programme. The funding of the EAP can also influence the

structure and process measures, such as the category of EAP practitioners that are appointed, and therefore the level of services being provided within the programme. Another vital aspect that can further influence the utilisation rate is the level of confidentiality associated with the EAP. This is classified as an outcome measure, but it cannot be used as a single or stand-alone outcome as it does not reflect on the actual quality of the EAP. Thus, there might be a need for additional outcome measures to determine the quality of the programme to allow for a comprehensive picture to emerge of the actual quality of the EAP.

As a concluding remark, health care institutions should take note of the fact that the implementation of the Balanced Scorecard approach will not be effective without the necessary buy-in from, and communication between, all relevant role-players in the EAP.

6.9.1.3 The utilisation of recognised performance management systems for EAPs with formal evaluation instruments

Several recognised performance management systems for EAPs exist and research demonstrates that they can be effectively applied to the health care sector (*cf.* 3.5). A best-practice performance management system for EAPs has not yet been defined. Nevertheless, it is crucial for health care institutions to take note of the holistic nature of an EAP when developing their performance management systems. Using acceptable evaluation instruments that are compatible with the selected performance management system will ensure that acknowledged instruments are used appropriately.

6.9.1.4 The utilisation of quantitative and qualitative evaluation methods

The inclusion of quantitative evaluation methods is the norm for quality management strategies (*cf.* 3.5) and evaluations of EAPs. Qualitative methods, although not foreign to the field of quality management, are not often utilised (*cf.* 3.4.1). Qualitative information gathered during the evaluation process is considered to be appropriate

and less cumbersome to manage. Using a combination of quantitative and qualitative evaluation methods might provide more clarity on issues where doubtful results appear. The qualitative component can, for instance, provide more in-depth information with regard to certain aspects of the EAP and can be used to identify the need to use additional measures or to implement quality assurance cycles (*cf.* 3.4.1).

6.9.1.5 *Formal feedback procedures*

The evaluation of the EAP would be worthless if the results of the evaluations are not communicated to the relevant stakeholders. The evaluation strategy must specify the type of information that should be communicated to each of the stakeholders. This will make the evaluation of EAPs, as well as the dissemination of information, a highly professional task and health care institutions should seriously consider appointing external agencies to perform the evaluation of their EAPs.

6.9.2 Performance management – aspects to be evaluated

The performance management of an EAP consists of a planning process for the identified improvement, implementation of action plans to address the issue, and a subsequent evaluation of the effectiveness of the action in improving the situation (*cf.* 3.3.1). There are certain key aspects of an EAP that have a major influence on the quality of the programme itself (*cf.* 3.4). Figure 6.16 illustrates these aspects of the EAP that need to be considered for inclusion in the performance management system, followed by a more detailed discussion on each aspect.

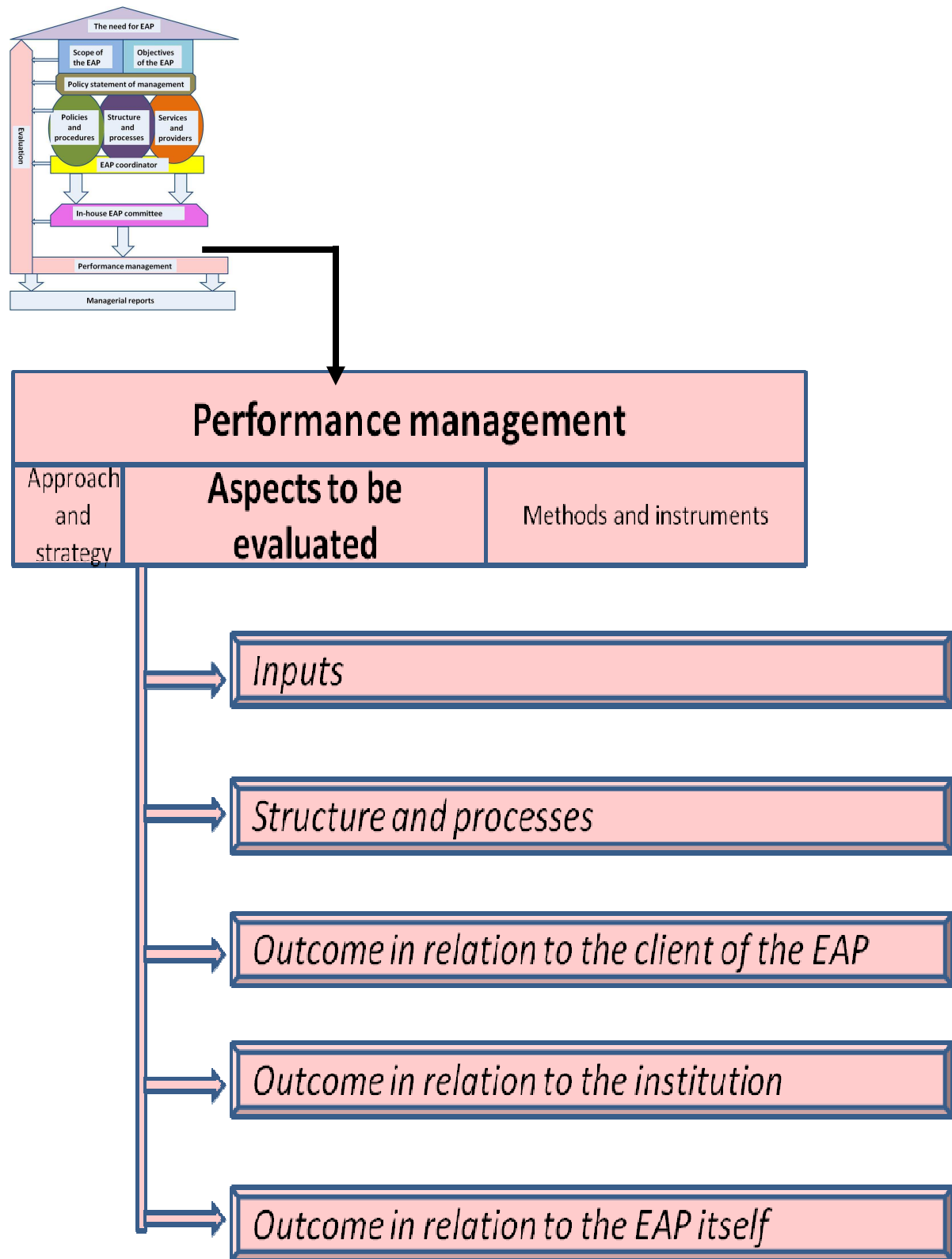


Figure 6.16: Aspects of the EAP to be evaluated

6.9.2.1 *Inputs*

Specific inputs are needed and used within the EAP to produce a required outcome. Some of the inputs that are needed can be classified as EAP resources such as finances, EAP practitioners, the physical infrastructure and technology. Another type of input needed is information regarding the demographic details of the employees as well as their needs and the needs of their families. Institutions must not ignore the possible needs expressed by their supervisors to assist them in managing the employee entered into the EAP. The methods used for monitoring these inputs must be aimed at providing meaningful information on the types of problems experienced, the type of employees utilising the EAP, the significance of the problems as well as the resources needed to address these. It is recommended that these inputs can be measured by using statistics or monetary terms (*cf.* 3.4).

An EAP would be of no value if the health care workers and their supervisors are unaware of the services offered by the programme. Highlighting the EAP as a specific benefit for employees in the awareness campaign can contribute towards optimal utilisation of the programme. It is also important to note that, apart from measuring the level of awareness, the attitude of employees towards the EAP must also be measured as this contains crucial information that will contribute towards the success of the EAP.

The different types of referrals received by the EAP, such as supervisory and spontaneous use, should be separated and evaluated on a continuous basis. The separate classification of referrals is significant as there might be different reasons for high or low referral rates. For example, supervisors may not always be keen on referring employees to the EAP (*cf.* 2.6.6.1). Apart from statistical methods used to determine the referral rates, qualitative evaluations should be conducted in order to determine possible reasons for the resistance of supervisors in referring employees to the EAP. The results of the qualitative evaluations can be used to address the identified EAP shortcomings or to promote the EAP amongst employees.

The burden of problems experienced within an institution can be determined by using a simple descriptive method such as counting the number of problems (*cf.* 3.5). This data should then be transformed into performance indicators which should enable the health care institution to initiate the essential quality improvement cycles (*cf.* 3.5). As the EAP develops and grows, enough data would become available to start evaluating the types of problems employees present with in detail. These problems can then be analysed to identify specific trends or needs, allowing the health care institution to develop and implement preventative strategies to reduce the occurrence of the specific problems amongst its employees.

One of the major inputs for the running of an EAP is financial resources. Finance-related questions, such as the costs of running an EAP, the costs of not having an EAP and possible savings generated by an effective EAP need to be answered. It is beneficial for an institution to determine the value added for the amount of money that was spent on the EAP. This kind of value can be determined by linking the amount of money spent on the EAP with the productivity of the health care workers. Productivity could, for instance, be measured in terms of absenteeism. Another method would be to link the financial inputs of the EAP with the overall budget of the institution as well as with the bed-occupancy rate. This creates a direct link with the overall budget of the institution and possibly provides a better reflection of the financial impact of having an effective EAP.

Health care institutions can also consider establishing a link between the evaluations of the EAP with an environment impact assessment such as a health risk assessment in the workplace. The health risk assessment in the workplace identifies the health hazards and determines the risk for health care workers associated with the identified hazard. It is possible that health care workers experience behavioural problems due to the exposure to, and risk posed by, certain workplace hazards. Such a link could identify any workplace-related factors and the utilisation of the EAP.

6.9.2.2 *Structure and processes*

The inputs of an EAP are translated into outcomes, including health outcomes, through certain structures and processes. Therefore, the process measures are viewed as leading indicators in the evaluation of these structures and processes. This evaluation will provide additional information to gain a better understanding of the actual outcomes of the EAP (*cf.* 3.5). Care should be taken with the interpretation of the inputs, structure and processes evaluations as these measurements may not always be able to predict the outcome. During the review of the outcome measurements, the structure and process factors are not always considered (*cf.* 3.3.3), making a balanced approach between these measurements even more significant. The evaluation of the processes used in EAPs can be conducted by means of several measurements. The measurements that are considered to be crucial will be discussed in more detail in the next paragraphs.

An evaluation of the EAP structures must consist of an evaluation of the degree of accessibility and availability of the EAP services. The convenient location of the EAP office could be used as an indicator to determine the physical accessibility of the EAP. Evaluating the appointment system (timely appointments), as well as the punctuality of the appointment system, are two examples of the evaluation of availability. Furthermore, timely problem identification and intervention is one of the key functions of the EAP. Therefore, one of the process measurements must be the response time of services rendered. A suitable way of measuring the response time is by evaluating the decision lag time, i.e. how long it takes for a problem to be notified and for an adjudication to be reached. Other services availability measurements have to do with the number of staff members who are available during normal working hours, as well as after hours, the kinds of services that are available after hours, and the kinds of services that are available for shift workers (Canadian Centre for Occupational Health and Safety 2009:sp).

Specific criteria in an EAP are formulated to control the relevant activities and therefore the accessibility of the EAP. Among these are the criteria which specify who has access to the services of the EAP (inclusion criteria) as well as the referral criteria. The evaluation must include measurements used to determine whether these criteria are applied consistently. The categories and the number of health care workers with medical aid, using the EAP, must also be evaluated as it can be used to redefine the future referral system and services provided by the EAP. Then there is also a need to evaluate the reasons for the deferral of employees who wanted to access the EAP. This information will help in determining whether or not the pre-determined inclusion criteria are still valid. The formal communication channels used for the EAP activities must be evaluated. Comments or recommendations from the participants in the evaluation process should be regarded as qualitative data and be used to provide more in-depth information with regard to certain aspects of the evaluation and quality improvement processes.

The effectiveness of an EAP can be measured by evaluating whether the different treatment protocols for the various problems are utilised appropriately. According to the definition of effectiveness, services should be based on scientific knowledge and be provided to all who could benefit from these (*cf.* 3.3.2). This approach for measuring the effectiveness of an EAP is not unique as Harlow (1998:sp; *cf.* 3.3.2) studied the authorisation of EAP treatments as an indication of the effectiveness of an EAP with great success. Another measurement that can be used to determine the effectiveness of an EAP is by the evaluation of the appropriateness of the guidelines that were followed. These measurements should be linked to the outcome measurements of an EAP since it evaluates whether or not the guidelines determined for the EAP and/or the employees achieve their purpose.

Confidentiality within the EAP is non-negotiable (*cf.* 2.6.5) and every effort must be made to ensure that confidentiality is maintained. Confidentiality is thus a key EAP process that must be measured. The evaluation of the level of confidentiality is difficult, but qualitative evaluations can be used successfully such as measuring the perceptions of confidentiality amongst key role-players. When measuring the

perceptions amongst key role-players, the same principle of maintaining confidentiality throughout the evaluation process is crucial. One way of ensuring confidentiality throughout the process is by aggregating all the relevant data rather than using the individual and personal data of health care workers during the compilation of a report.

The success of an EAP is determined by the commitment of all the role-players. The extent of compliance of the health care workers currently using the services of the EAP should be used to provide information on commitment. The emphasis of this evaluation is on establishing the reasons as to why employees do not comply with the pre-determined EAP requirements and activities.

The progress made by the health care workers using the EAP is also a measure that can be used for process evaluation. This measurement does not measure the actual clinical progress or outcome of the health care worker, but instead determines the time spent within the EAP and links with the measure of the compliance from the specific health care worker.

The next section will discuss the actual outcome of the EAP which can be considered to be the end result of the health care provided. Outcome measures can thus be viewed as lagging indicators (*cf.* 3.3.3). The evaluation can be categorised as follows: (a) outcomes related to the client of the EAP; (b) outcomes related to the health care institution; and (c) outcomes related to the EAP itself (Figure 6.16). The outcome of a programme very often depends on a variety of factors. Therefore, the outcome evaluation should be based on the consolidated results of all three categories mentioned above.

6.9.2.3 Outcome in relation to the client of the EAP

The main aim of this type of evaluation is to show whether the EAP has changed the unproductive behaviour of health care workers into productive behaviour. An elementary way of evaluating the impact of the programme on a health care worker's performance is simply to compare it with the previously identified unproductive behaviour. Before such elementary evaluations can be done, the measurements in terms of productivity need to be quite explicit. This is particularly true in the health care industry where there is a huge scope of jobs which are not equivalent in terms of the evaluation of this criterion. Productivity can be measured subjectively through a self-assessment questionnaire that may include several aspects as illustrated in Table 6.12.

Table 6.12: Aspects to be included for self-evaluation of productivity (adapted from Moxley 1990:219)

<u>Aspects to be included</u>
Energy levels throughout the day
The ability to cope with stress in the workplace
The perceived overall physical fitness of the health care worker
The perceived quality of the work
The interaction with fellow health care workers
The perceived ability to get work done in a 40-hour work week

Standardised self-assessment instruments such as the BASIS-32[®] was designed to assess the employees' perception of the level of difficulty they experience with their symptoms and functioning (Greenwood *et al.* 2005:3). Feedback, whether positive or negative, from health care workers must not be ignored since it could provide useful information with regard to quality improvement cycles. Another method that can be used is to correlate the self-assessment done by the discharged employees with

assessments done by the people working with them. As these types of evaluations are based on perceptions and constitute a qualitative component of the evaluation, they should be included in a more comprehensive evaluation (*cf.* 3.4.1). Such a comprehensive evaluation must include an objective component, which could be the formal performance management system for employees. Apart from the self-assessment by health care workers, supervisors and EAP practitioners must provide additional information through formal evaluation processes regarding the insight of the referred health care workers into their problem.

Formal evaluations on the progress made by the health care worker in the EAP must be conducted regularly while the health care worker is still entered into the EAP. The interval of such evaluations will depend on the health care worker and the type of problem, but can be done monthly, bi-annually, semi-annually or annually. These evaluations have a tendency to be very subjective and in order to produce meaningful results it must thus be performed using a variety of staff. Health care workers entered into the EAP should provide information on their perceptions of the progress made throughout the EAP. Questions in this evaluation should focus on the health care workers' concentration in relation to the work environment as well as the employees' perception of their job performance rather than their personal problems.

The next evaluation is the formal employee performance appraisal system of the institution. The outcome of these two evaluations must be linked to provide information regarding the insight and understanding of the health care workers into their problem. Conducting evaluations with colleagues of the health care workers can provide another dimension to the progress made by them. It can provide valuable information with regard to the perceived changes in the relationship between the health care workers and their colleagues as teamwork is crucial in providing health care.

The above-mentioned progress evaluations are concluded with an overall outcome evaluation of the health care workers once they have been discharged from the EAP. Such an evaluation must be focused on the health care workers' subsequent performance and functionality in the workplace. To ensure that the appropriate

information is collected in relation to the outcomes, the types of problems managed within the specific institution's EAP must be taken into account. Additional aspects that can be measured are (a) whether the health care workers benefited from the referral and the counselling; (b) the overall benefit of the programme as a whole; and (c) whether there are additional recommendations received from the health care workers. The overall outcome is critical as evaluations on the various other components of the programme might be good and statistically acceptable, while the actual outcome pertaining to the health care workers who used the programme is substandard.

The evaluation of the overall outcome must be pursued as a priority with a structured process for following up these health care workers who completed an EAP intervention (*cf.* 2.6.6.1). Supervisors of the referred health care workers must be responsible for such an evaluation with a focus on the improvements as indicated by the institutional staff performance management system, the health care workers' capability to cope in their work environment, and on the health care workers' ability to utilise the tools provided by the EAP. It is possible that health care workers cannot cope in the workplace after being discharged from the EAP. The monitoring of the relapse rate of health care workers can provide some indication as to the quality of the services provided by the EAP, although it is not recognised as a good measurement standard (*cf.* 3.5).

The measurement of the satisfaction level of customers is a cornerstone in the general quality management systems of the health care industry (*cf.* 3.3.3). EAPs are no different. Apart from the issues already discussed, approachability and compassion of the EAP providers must also be included in the evaluation conducted by the health care workers. Lastly, it must also be determined whether the users of the programme would recommend it to their fellow health care workers.

6.9.2.4 *Outcome in relation to the institution*

Any programme with financial implications must add value to a health care institution. There are also several cost analysis systems available and the conventional cost-benefit analysis and return on investment (ROI) are the methods most widely used to assess the outcome in relation to the value added by the EAP to an institution (*cf.* 3.4). It is beyond the scope of this study to discuss the details of each system, but health care institutions must choose the appropriate method(s) to be aligned with the overall quality assurance system of the institution. The evaluation of the programme in this manner must coincide with the launch of the programme to ensure that the true baseline situation is recorded.

The impact on the absenteeism profile of a health care institution is another method that can be used to determine the value of an EAP. Regular evaluation of absenteeism profiles of the health care workers is relatively easy to perform. The outcome of the absenteeism information can also be applied to calculate the monetary value of days lost as a result of absenteeism (*cf.* 2.4.3). This will then allow for establishing a monetary value of the cost to the institution and provide a measure against which the impact of an EAP can be determined. It is usually the responsibility of the human resource department to monitor absenteeism, but valuable additional information can be provided by the EAP to ensure that a comprehensive absenteeism profile is compiled.

EAPs might also impact on personnel turnover in the health care institution. It is therefore of great significance to have a formal method of evaluating the personnel turnover. It must be noted that staff turnover could be attributable to many other working conditions as well as to external pull or push factors. For these reasons, personnel turnover cannot be measured and interpreted in isolation.

6.9.2.5 *Outcome in relation to the EAP itself*

Criteria to determine the effectiveness of an EAP must be defined beforehand and measured in natural units, for example, the percentage of health care workers relapsing or re-entering the EAP for the same problems. Additional means of determining the effectiveness is through the utilisation of health care workers' performance management systems, their EAP attendance records/report and the health care workers' self-evaluation reports.

Self-evaluations performed by the EAP practitioners could further provide valuable information that can be applied in association with other evaluation methods within the broad spectrum of the programme performance measurement of the EAP (*cf.* 2.4.3). Included in these self-evaluations must be an assessment in terms of their output to ensure a 360-degree evaluation of the programme. This type of the evaluation must be conducted against specific sub-criteria and should not be conducted and interpreted in isolation. The self-evaluation should also include the perceived quality of services rendered by the EAP practitioners. The effectiveness of an EAP can also be evaluated by harnessing the perspective of external EAP practitioners, if such service providers are used, managers and the patients of the health care institutions.

Measurement tools for the utilisation of an EAP must be aimed at health care workers who qualify for services offered by the EAP and who have actually used these services. One such tool is to calculate the utilisation rate of the EAP. The recommended utilisation rate is the number of employees using the services as numerator divided by the number of employees who are eligible to make use of the EAP as denominator (*cf.* 3.4). Other types of utilisation rates can be calculated as defined in the strategy, but it should only be used where appropriate and in a consistent manner. Those people who do not qualify, but who may still have benefited from the programme's services, should not be excluded from the evaluation process, but should be evaluated on another level instead. Another meaningful method to measure utilisation is the average length of stay of employees in the EAP. Care must

be taken with this measurement since it could be counterproductive and hinder the promotion of the programme.

One of the major objectives of an EAP is to promote itself and avoid stigmatisation (*cf.* 2.1) through an increased general awareness amongst health care workers in the institution. The actions to publicise and make people aware of an EAP must be evaluated on a regular basis.

6.9.3 Performance management – available methods and instruments to be used

A range of methodologies must be used in the evaluation process as no single method is suitable to evaluate all the aspects of an EAP (*cf.* 3.4). Specific instruments need to be developed to suit the methodology being applied and to measure the predetermined aspects as defined by the strategic approach. The development of these methodologies and instruments must include procedures for ensuring strict confidentiality. However, the concept of confidentiality should not be confused with anonymity as it could have major implications for the type of methods identified to monitor the performance management system of the EAP. Figure 6.17 illustrates the methods and instruments available that were considered to be critical for a best-practice EAP.

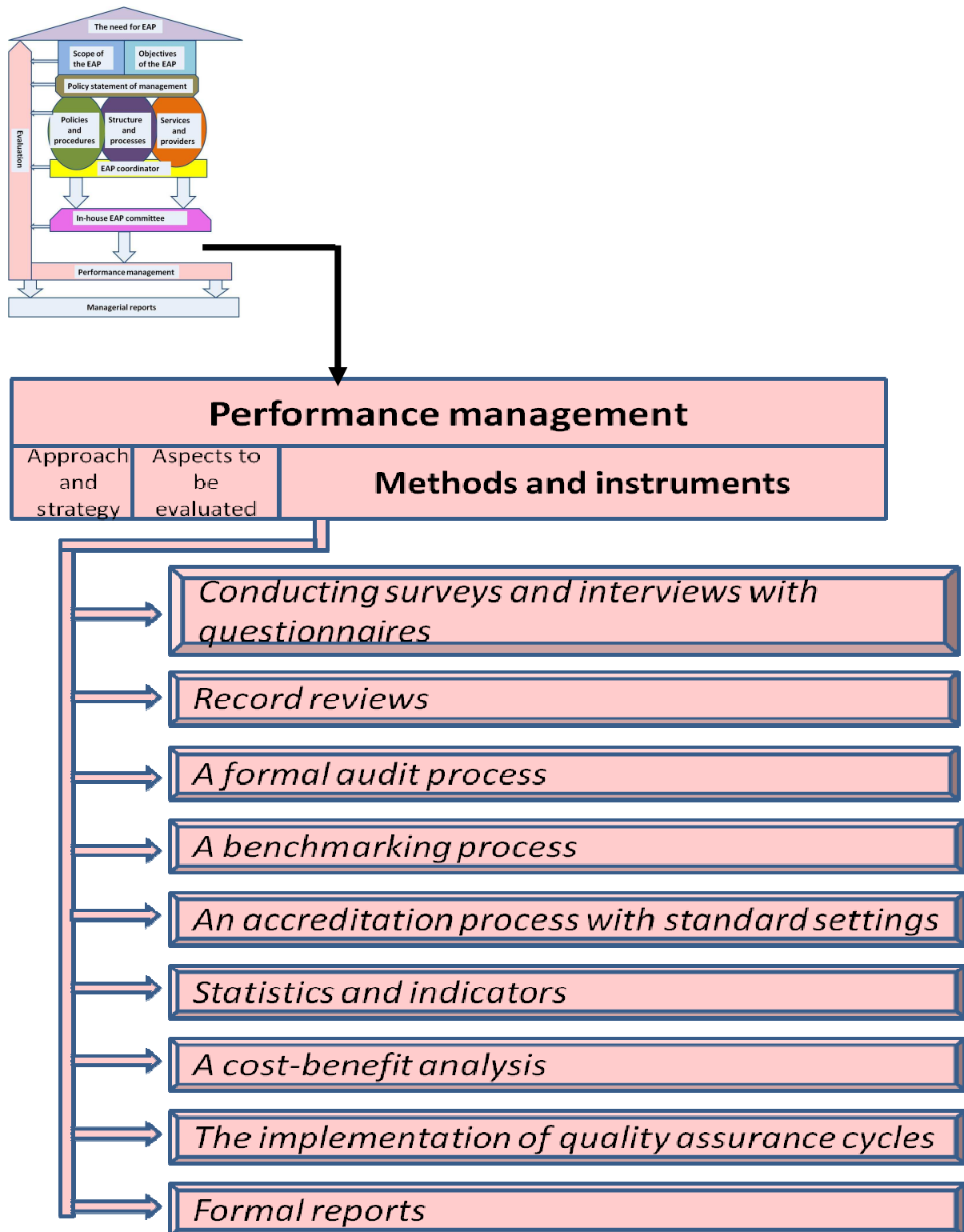


Figure 6.17: Available methods and instruments to be used in the evaluation of the EAP

The next sections provide more information with regard to the available evaluation methods and instruments as well as an indication as to which of these are essential.

6.9.3.1 *Conducting surveys and interviews with questionnaires*

The utilisation of questionnaires in a quality assurance environment is one of the most basic data collection methods and can be used to great effect in the evaluation of the EAP (*cf.* 3.2; 3.5). This form of data collection must be part of the EAP evaluation process as it provides valuable quantitative and qualitative information (*cf.* 6.9.1.4). Employees are usually not comfortable with providing their names when completing sensitive questionnaires. It is therefore recommended that the questionnaires be developed in such a manner as to ensure complete anonymity.

The purpose of using surveys in the evaluation of EAPs is to determine the level of awareness amongst employees of services being provided. This is done in order to determine whether supervisors and employees know how to utilise the EAP, and to gather departmental opinions about the EAP and, more specifically, about the usefulness of the services provided within the EAP. Careful planning is necessary in developing survey tools as participating in the survey should not be a cumbersome process.

Interviews must be conducted at various stages with health care workers participating in EAP activities. These interviews can be conducted at the time of enrolment, in between their sessions or as an exit interview after they have been discharged from the programme. The most value would be gained if interviews are conducted at regular intervals with a focus on gathering qualitative data to evaluate the performance of the system (*cf.* 6.9.1.4). Reliable information regarding the EAP will come from the health care workers who had a problem and who actually used the service (*cf.* 3.5). However, in order to ensure objectivity, the supervisor(s) of the health care workers who had a problem must also be interviewed as they can give an opinion as to whether the employees are coping with the problem for which they entered into the EAP.

6.9.3.2 *Record reviews*

Another method that can produce useful information is a review of various types of records kept within the EAP (*cf.* 2.6.6.2). Evaluating the entire record and filing system can be a daunting task; therefore, selected and well-aimed record reviews would be easier to conduct. The value of the information obtained from the records would depend on the level of aggregation of the data (*cf.* 3.5). As with any other type of employee records, the matter of confidentiality is non-negotiable, making the EAP coordinator the obvious choice as the responsible person for the record review.

6.9.3.3 *A formal audit process*

The aim of an EAP audit, as part of the quality strategy, is to determine whether the EAP in the health care institution is rendering services according to the predetermined policies, procedures and standardised processes (*cf.* 3.4.1). Audits of the EAP will provide information on the quality and consistency of care provided by the EAP. It is important to draft specific audit forms with the required set of standards that must be used for the evaluation of the pre-determined processes. The audit process could be the starting point of a formal quality assurance system and must not be regarded as the only performance measurement method of an EAP.

6.9.3.4 *A benchmarking process*

Two benchmarking approaches are described in the literature, namely the competitive or the process benchmarking approach (*cf.* 3.4.2) of which a health care institution should select one. Within both approaches, a health care institution must identify those aspects they would like to benchmark. The next step would be to identify best-practices from industry leaders and allow the chosen approach to guide the processes to be followed next. The findings of the benchmarking process should then be incorporated into a strategic action plan which could include continuous quality improvement cycles.

6.9.3.5 *An accreditation process with standard settings*

The accreditation process will determine whether an EAP adheres to recognised, industry-specific criteria and standards. It must be noted that if a health care institution only makes use of an accreditation process as a performance management system, there would be a negligible link between the actual outcome of the EAP and the accreditation itself. There are various reasons for using the accreditation of an EAP as a performance management method, such as using it as guarantee for the clients of the programme that it has met recognised standards, and using it in relationship with the benchmarking processes. Patient-centred aspects are often incorporated into accreditation programmes (*cf.* 3.4.3).

6.9.3.6 *Statistics and indicators*

Statistical methods can be used on routine data and can be presented as ordinary descriptive information in the form of indicators. A single performance indicator will not provide enough information on the overall performance of the EAP. It is recommended that inputs, structures, processes and outcomes-related indicators be developed to provide a comprehensive picture of the actual inputs, structures, processes and outcomes of an EAP (*cf.* 3.3.3). These indicators must be based on sound statistical principles with a continuous monitoring process to establish trends and patterns. The indicators of performance do not measure quality itself. Rather, it is the human interpretation of indicators that measures quality (*cf.* 3.5). Indicators must be categorised into leading and lagging indicators to add value to the evaluation process (*cf.* 3.3.3). Both of these types of indicators are needed to provide a comprehensive picture with regard to the quality of an EAP. At a practical level, management might decide that, for their monthly review of the EAP, they will use only a few of these indicators. A combination of a broader range, but a more limited number of indicators in a 'dashboard' format, could be used to monitor the quality of the EAP. The dashboard would consist of a core set of key performance indicators that would give managers an indication of possible problems that might need a more

detailed evaluation. These core indicators should at least cover the important dimensions of the EAP performance as presented in Table 6.13.

Table 6.13: Critical dimensions of the EAP performance to be displayed by a dashboard of indicators

No.	<u>Dimensions to be displayed</u>
1	The responsive governance of the health care institution's needs
2	The responsive governance of the employees' needs
3	Optimal utilisation of allocated resources
4	The outcome of the EAP
5.	The value added to the health care institution

Each health care institution's EAP will be unique and it would be inappropriate to finalise a generic dashboard of core performance indicators. Each health care institution must develop its own dashboard to address its own specific needs. The dashboard indicators can also be used in the benchmarking process (*cf.* 3.4.2).

Formal feedback procedures should be in place in order to receive inputs from all the relevant stakeholders regarding the statistical information distributed. These feedback procedures will promote the accuracy of the data and the usefulness of the information.

6.9.3.7 *A cost-benefit analysis*

A health care institution would expect a reasonable return on the resources invested in an EAP. A cost-benefit analysis would provide such an answer. A cost-benefit analysis entails measuring the total cost of the EAP and comparing this to the benefits accrued by the health care institution through the implementation of the EAP (*cf.* 3.4). Programme benefits can be calculated, using various parameters such as sick leave usage, absenteeism, health benefits paid out, disciplinary actions against

employees and the number of grievances. However, the cost-benefit analysis requires the use of a control group of employees. The cost-benefit analysis, as with the previous processes, cannot be used as a stand-alone method, but must be integrated into a comprehensive quality assurance strategy.

6.9.3.8 *The implementation of quality assurance cycles*

All evaluations must continue in quality assurance cycles as deemed necessary to ensure continuity of the quality assurance process (*cf.* 3.3.2).

6.9.3.9 *Formal reports*

Formal reports can be drafted, using all available relevant information, with the purpose of compiling such reports being clearly indicated. These reports could provide significant information regarding the EAP itself and, by presenting these reports to the in-house EAP committee, the members of this committee become actively involved in the performance management process of the EAP. The involvement of in-house EAP committee members will ensure that the reports are attended to with its value being identified and acknowledged. Maintaining confidentiality within the report by removing any identifiable data is of the utmost importance.

6.9.4.10 *Employees' health surveillance programmes*

The maintenance of a health surveillance programme is not considered to be a critical element of the EAP because of the clinical element involved in the programme. The personnel working in the occupational health services of an institution are more appropriately trained to establish and maintain such a programme (*cf.* 2.9; 6.5.2.1). A health care institution might consider keeping a health surveillance programme as part of the EAP because of the changing needs in this type of institution (*cf.* 2.3.2).

6.9.5 Performance management – Managerial report

An EAP must demonstrate the value added to a health care institution on an ongoing basis (*cf.* 2.4.3). Several of the evaluation processes discussed earlier in this chapter can be combined to provide the necessary information with regard to the value added. Such information must be presented to the executive management in a managerial report format. It should be the responsibility of the EAP coordinator to compile and submit such a report to the management of the health care institution, preferably on a quarterly basis. An annual report that reflects on the activities and outcomes of the previous year as well as the goals and objectives for the following year could be drafted.

6.10 CONCLUSION

Health care workers are one of the most valuable assets in a health care institution and deserve to be looked after in the best possible manner. Providing the required assistance through pre-determined services in a formal programme to solve personal and work-related problems could be viewed as evidence from management that health care workers are regarded as a valuable resource. The services provided in the EAP are classified as behavioural health care and ten rules are proposed for the delivery of quality health care (Table 6.14). These rules are incorporated into the framework for a best-practice EAP as well as its quality management. It is crucial to have a written programme to formalise all the strategies, structures, processes and evaluation of an EAP. All these components of an EAP should be in line with the human resource strategy of the specific health care institution.

Table 6.14: Ten rules for delivering quality health care (adapted from Daniels *et al.* 2005:31)

1	Care is based on continuous healing relationships
2	The patient is the source of control
3	Customisation is based on patient needs and values
4	Shared knowledge and the free flow of information are essential
5	Decision making is evidence based
6	Safety is a system priority
7	There is a need for transparency in all aspects of health care delivery
8	Needs are anticipated
9	The reduction of waste is ongoing
10	Cooperation amongst health care workers is a priority

The challenges of the evaluation of an EAP are well documented (*cf.* 3.4) and some of these are listed in Table 6.15. All these challenges should be addressed within the EAP strategy before any evaluation processes for the programme can be implemented.

Table 6.15: Challenges in the evaluation of an EAP

1	The financial resources needed to perform proper evaluations
2	The lack of data collection efforts within the EAP
3	The preservation of confidentiality of cases may present methodological, policy and practical obstacles
4	The assessment of the impact of the EAP itself might produce methodological difficulties
5	The fragmentation of the evaluation and reports into 'silos'
6	The development of an integrated approach for the EA

A single, generic EAP is not available for health care institutions. The purpose of this study was to develop a framework for a best-practice EAP for health care institutions that can be adapted to address the specific needs of individual health care institutions. Utilising this framework will allow health care institutions to remain within the boundaries of a best-practice EAP as it has developed over the last century, but it will also offer some leeway to ensure that the appropriate value is added to a specific health care institution. It would further assist with the standardisation of the performance management systems for the EAP as well as with the benchmarking processes.

The framework will further enable the executive management of a health care institution to develop the appropriate rationale for establishing an EAP in their institution. An effective EAP must be regarded as a valuable asset in a health care institution.

CHAPTER 7

CONCLUSION, RECOMMENDATIONS AND FINAL REMARKS

7.1 INTRODUCTION

The purpose of scientific research is to provide a systematic way of knowing and explaining natural phenomena (*cf.* 4.3; Walonick 1993:*sp*). It is used to obtain an objective, true picture of reality by minimising the subjective, imagery component, resulting in a clear distinction between falseness and truth in nature. This study represents an attempt to gain a picture of reality and an in-depth exploration into employee assistance and the quality thereof in the health care sector, with the researcher as an observer rather than an active participant in the study. The researcher's expertise was previously applied during his involvement in the development of an EAP for a tertiary health care institution.

A few years after the establishment of the above-mentioned EAP, the researcher was confronted with the question as to how the most valuable resource in the health care sector (namely the health care workers) can be assisted in dealing with personal and work-related problems in the ever-changing world of health care provision. The need was to identify the most effective manner in which behavioural health care can be rendered to health care workers within the internationally recognised principles of employee assistance. It is the responsibility of supervisors within health care institutions to ensure that employees under their supervision function to the best of their ability and maximise their potential. The formal performance management system of the health care institution is the tool applied to measure the performance of the health care workers. However, these performance management systems do not always identify and address all the reasons for poor performance. Therefore, the perspectives and experiences of the supervisors are crucial to identifying the

components of a formal programme required to assist health care workers with addressing personal and work-related problems that affect their work performance. It was not the aim of this study to investigate the details of counselling, treatment or assistance, but rather to concentrate on the formulation of a formal programme in order to ensure that health care workers are functioning optimally in the unique environment of health care provision. Once the formal EAP is implemented, health care institutions should be able to evaluate the value added by the programme.

A qualitative research approach was followed, but the study did not adhere to one specific qualitative research method; rather it contained elements of more than one approach which supported the aims of the study to good effect. The research approach and methods applied in this study were found to be appropriate, and meaningful results were obtained from the data collected by means of three methods, namely a literature review on current EAP practices worldwide, focus group discussions with supervisors from various health care institutions and a Delphi survey with a panel of experts. The literature review, as part of the theoretical orientation, provided the required baseline information for the first part of the empirical phase, which consisted of five focus group discussions conducted with supervisors in various health care institutions. The outcome of the supervisory perspectives confirmed the need for a structured EAP for health care workers. Furthermore, the supervisors shared valuable information with regard to the practical implications of an EAP in their work environment. All of the information gathered was used to establish the criteria needed for the framework for a best-practice EAP. However, the perspectives of health care workers at ground level were not considered in this study as it was not the objective of this study to develop the programme based on employees' perspectives. These criteria were submitted to a panel of experts in the form of a Delphi survey to finalise, through a process of consensus, the most crucial criteria needed for a best-practice EAP. The experts clearly indicated that there are certain elements that are deemed crucial for inclusion in a framework for a best-practice EAP.

The aim of the study was successfully achieved with the identification of the need and the criteria to be included in a framework for a best-practice EAP as well as the quality management thereof. The unique framework for a best-practice EAP in a health care institution was constructed based on the perspectives, experiences and needs of supervisors and executive managers, but with the core technologies of the EAP incorporated into the framework in such a manner that an adapted, institution-unique EAP does not lose its universally accepted characteristics. The framework consists of four components, each of which is structured to such an extent that adaptation would be possible. The four basic components include:

- The need for an EAP in a health care institution
- The strategic approach for the development of such a programme
- The structure and processes of an EAP
- The evaluation of an EAP in terms of its effectiveness.

In Chapter 6, the various elements pertaining to these four components were discussed in great detail and in context.

Additional outcomes of this study were manifested through the interactions of the participants during the data collection process. One such outcome was the constant arguing between participants and the lack of consensus with regard to certain aspects of the EAP. Such indecisions were also evident in the literature, highlighting some of the controversial issues of employee assistance and formal EAPs. These controversial issues were discussed throughout the chapters of this thesis and must be taken into consideration as they could have major implications for the adaption of the proposed framework.

7.2 CONCLUDING REMARKS ON THE VALUE OF UTILISING THE FRAMEWORK

The proposed framework is evidence based and unique since it was developed through a process of triangulation, using information pertaining to current employee assistance practices internationally, the experiences and needs expressed by supervisors and, finally, putting the criteria through a process of consensus achievement in a Delphi survey. The framework is unique in that it addresses the needs of supervisors rather than EAP practitioners and was developed in such a way that a health care institution could adopt it as a planning tool and guiding instrument to develop a formal and acceptable EAP. Furthermore, it could improve and standardise the evaluation of individualised EAPs in institutions.

Adapting the elements of the framework will provide a health care institution with the essential consistency for their EAP development. The best approach for the implementation of a programme of this nature is to do so in incremental steps and escalate the extent of the programme over time. It would be detrimental if the health care institution promises certain services and then cannot deliver. A formalised EAP gives a clear indication as to what to expect from the programme and it also ensures consistency, which results in confidence in the programme.

Health care workers will perceive the adaptation of the EAP as a sign of preparedness on the part of the health care institution in offering assistance with regard to potential problems. The mere fact that the health care institution demonstrates the intention to assist their employees can create a mindset that the institution is prepared to invest in them as valuable workers. The positive attitude created will influence a broader spectrum of employee issues, such as loyalty and production which, in turn, impacts on the quality of care provided to the patients. An effective EAP will be able to grow trust in the programme and remove possible stigmatisation associated with these types of programmes. Employees will see that fellow health care workers are helped with problems that they themselves might experience or which they have been too afraid to disclose or seek assistance for.

Using employees who were successfully assisted by the institution's EAP to promote the programme can be an effective promotional strategy for an EAP.

EAPs need to deliver a comprehensive service. It is thus important that, from its planning phase, the EAP of a health care institution is integrated into other associated human resource and employee wellness strategies. Supervisors and managers will also experience the impact of an effective programme in a direct manner as this will reduce their workload in the sense that they will not need to assist employees with their problems. It is their responsibility to identify employees with problems and to refer them to the EAP while assisting with the monitoring of the employees' progress. It is important to set realistic goals for the EAP and to realise that some users of the programme might never reach a point where they will be able to resolve their problems, regardless of how much assistance they receive from the programme.

7.3 LIMITATIONS OF THIS STUDY

Despite the fact that the researcher put to use several research methods in this study, this study was not without limitations as will be discussed in this section. The researcher considered the following limitations, but realised that they did not have any major implications for the outcome of the study. The possible implications of these limitations are discussed after each limitation mentioned below. Future research on this phenomenon should address the limitations in more detail. These limitations are neither weighted nor presented in any order of priority.

- The specific aim was to develop a framework for a best-practice EAP for health care institutions rather than for service industries in general. The aim was achieved through the development of a framework, consisting of four basic components, each with its own elements. It might be possible that other service delivery industries could benefit from this framework, but the focus was on the unique working environment of health care provision.

- The proposed framework for a best-practice EAP was not implemented in an actual health care institution and therefore cannot be classified as a model. The development of a model would require a separate research project.
- The researcher asked two staff members in his department to review the agenda for the focus group discussions and to make recommendations. The researcher also conducted an interview with the facilitator (an experienced qualitative researcher) as he would have done in a focus group discussion. These methods are not desirable but the researcher felt confident that the focus group discussions would produce meaningful information with regard to the supervisors' experience and opinions about EAPs. The analysis of the data obtained during the five focus group discussions proved this assumption to be correct.
- Representation by different types of health care institutions was included in the focus group discussions, namely, academic, regional, private and psychiatric hospitals, as well as hospitals with a student-training component. District hospitals were not included in this study due to logistical reasons. It might have had an impact on the depth of information gathered, but the researcher considered the possible diluting effect on the outcome of the focus group discussions by having too many sessions (*cf.* 4.4).
- Several private health care institutions from various private companies, as well as an independent hospital, participated in this study. However, not all private health care companies were included in the study as one health care institution from a private company did not respond to the invitation to participate (*cf.* 4.5). Health care institutions from only two provinces were used in the focus group discussion, namely the Free State and the Western Cape. Since saturation was achieved after five focus group discussions, the researcher did not deem it necessary to extend the focus group discussions to other provinces. This study could be extended to include health care institutions in other provinces.

- The framework for a best-practice EAP was developed for health care institutions by including supervisors at institution, as well as Head Office, level in the focus group discussions and the Delphi survey. Health care workers at ground level were not included in the empirical part of this study. Ultimately, it is the supervisors and managers who are responsible for taking care of their employees and, in so doing, ensuring that the health care institutions provide quality patient care. The aim was thus to develop a framework for a best-practice EAP from a managerial point of view. In order to obtain employees' perspectives on ground level, future research should be conducted in this regard.
- Only five focus group discussions were held with supervisors of different categories and levels of health care provision. This can be considered to be a low number for a phenomenon with such a wide scope. Saturation was, however, reached after the fifth session with almost no new information emerging from the fifth focus group discussion.
- Twelve experts in the field of EAPs, health care management and quality assurance participated in the Delphi survey. A bigger sample size has the potential of increasing the trustworthiness of the method, but the number of participants was in line with the recommendations found in the literature (*cf.* 4.7). However, consensus and stability were achieved with regard to all the criteria, which added credibility to the results. No open-ended questions were included in the questionnaire during the first round of the Delphi survey as the content of this questionnaire was identified through the literature review and focus group discussions. There were opportunities to provide comments on each of the questions and at the end of each section. The level of comments received from participants was of a high standard and eighteen new questions were developed from the comments for inclusion in round two of the Delphi survey.

- An extended Delphi survey might have influenced the outcome of the survey in that some of the participants might have felt pressurised into agreeing with statements just to reach consensus. There is also the risk of them becoming bored with the process and, consequently, agreeing with statements just to complete the process. The stability parameter indicated that the participants did not change their rating just to achieve consensus, but that they maintained their original rating. A positive aspect of the extended Delphi survey was that a 100% response rate was achieved during each round thus contradicting the concept of boredom.
- The framework for a best-practice EAP was developed from inputs provided by health care supervisors and managers based on their current experience. Health care, however, is a dynamic field which implies that the framework should also be adaptable. It must be re-evaluated regularly to ensure that it remains relevant to the ever-changing needs and environment of health care workers and the health care industry.
- This study never aimed to develop a specific, tailor-made EAP for the health care industry, but rather to gain an in-depth insight into the field of employee assistance in the health care sector that would result in the development of a framework for a best-practice EAP which can be adapted by health care institutions. Therefore, the results of this study cannot be generalised to the health care industry. The framework was specifically developed for adaptation within a specific health care institution and could be very useful in assisting the institution with the implementation of its own EAP.

7.4 RECOMMENDATIONS

A number of recommendations regarding the utilisation of the proposed framework are made in order to achieve the goal of the study, namely to make a meaningful contribution to the field of EAPs in the health care industry.

- The framework should be presented to all the health care institutions that participated in this research project as the collection of the data might have raised this expectation from supervisors, managers and/or executive managers.
- This framework should be presented to interested health care institutions for adaptation and implementation, especially in provincial hospitals, with the assistance of the researcher.
- For easier conceptualising of the framework by institutions, a summarised version in diagram format, as presented in Appendix S, will be included to facilitate the process and adaptation by institutions.
- The researcher is of the opinion that it may be imperative to first consider piloting such a theoretical framework for a best-practice EAP in a number of health care institutions in order to establish the practical aspects of the adaption of the framework and to refine it as scientific theory.
- The lack of agreement amongst role-players in the field of employee assistance found in this study is an indication that further research is needed and that ample opportunities exist for future studies. Such research should concentrate on the inputs from health care workers as employees themselves and the practical implications of such a best-practice framework and quality management system.

7.5 FINAL REMARKS

The study involved an extensive qualitative research process and was an enriching exercise for the researcher. A study on the topic of behavioural health care and its evaluation was challenging in the sense that different supervisors and managers had different opinions about employee assistance. The research addressed employee assistance, not from the usual EAP practitioners or employee perspective, but from a unique angle by providing a managerial perspective on employee assistance. This approach resulted in addressing the gap of knowledge that exists with regard to the approach used by supervisors in employee assistance. There cannot be a generic EAP for health care institutions, but the components and elements identified by supervisors were compiled into a framework for a best-practice EAP and the quality management thereof. The researcher is of the opinion that the outcome will prove to be useful in and beneficial to employee assistance in the health care industry since it will contribute to the existing, yet limited, information available on EAPs in the service delivery industry.

The researcher cannot claim that this is an all-inclusive or conclusive study, but the above-mentioned challenges resulted in a study that was a profound exercise, which involved viewing the EAP from a variety of angles, seeking to exploit existing knowledge, experience and opinions, while incorporating the perspectives of those who are closely involved with employee assistance into a product of value for health care institutions. The value of the framework could be measured in the way that it represents new perspectives and newly organised insights, in the existing body of knowledge on the EAP as employed worldwide in each and every industry.

Managers in the health care sector must realise that the EAP and the services it offers is a priority for any health care institution. If an EAP is not implemented in a health care institution, managers will experience difficulty in managing troubled, unproductive health care workers until such time that the vital paradigm shift is made. Health care workers are usually committed and dedicated staff members and are seldom reward-driven. They want to provide health care to their community in the

best way possible. Providing them with the much-needed assistance to manage their personal and work-related problems is the least that any health care institution can do for its most valuable resource. Health care institutions can now adopt the framework of a best-practice EAP developed in this study and adapt it to suit their unique purposes.

Having an effective EAP in a health care institution can be summarised in the words of one of the focus group participants: 'I think a happy worker is a healthy worker in a happy environment ... and the more you can look after the people, the better the worker's situation is.'

An effective EAP means everybody wins!

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SUMMARY

Keyword and terms

Employee assistance; employee assistance programme; employee performance; behavioural health care; best-practice; quality management; health care sector; health care workers; qualitative research; case study design; focus group discussion; Delphi survey.

Employee assistance was initiated early in the 19th century in the United States of America to assist employees with alcohol abuse in the workplace. During the 1970s, the concept of an employee assistance programme (EAP) was adapted to assist employees not only with alcohol-related problems, but also with personal and other work-related problems resulting in poor work performance. It is evident from the literature that no EAP is the same and that researchers have developed the seven EAP core technologies to promote uniformity within the field of employee assistance.

The aim of this study was to establish a framework for a best-practice EAP for the health care sector and the quality management thereof. As background to the study, the researcher conducted an extensive literature review to investigate the current situation on the utilisation of EAPs in various industries worldwide. The literature review was used as a guide during the empirical phase of the study in order to gain more in-depth knowledge with regard to employee assistance in the health care sector. A case study design as a qualitative research approach was applied. Five focus group discussions were held with supervisors from various levels in several health care institutions as a data-gathering method. Several criteria for the best-practice EAP were identified during the data gathering and a six-round Delphi survey was conducted to achieve consensus with regard to the criteria to be included in the best-practice EAP. Accordingly, a framework for a best-practice EAP and the quality management thereof was developed.

The management of health care institutions should realise that their health care workers are their most valuable resource and that there is a need to assist them with personal and work-related problems. The framework was developed specifically for a health care institution with the option to adapt it in order to suit the unique requirements of each individual health care institution. This proposed framework could be used to develop an institution-unique EAP. The establishment of a workplace-unique EAP will show employees that they are regarded as the most valuable resource in the health care institution.

The overall goal and objectives, as set out for the research study, were addressed and realised, and meaningful recommendations in the field of employee assistance have been made. The framework for a best-practice EAP is in line with the core technologies of EAPs, the needs of supervisors in health care institutions and the EAPs used internationally. The proposed framework includes the following main aspects, namely the need for an EAP in a health care institution, the strategic approach for the development of such a programme, the structure and processes of an EAP, and the evaluation of an EAP in terms of its effectiveness.

The framework will contribute significantly to the management of human resources in the health care industry and provide a supportive work environment for health care workers to ensure healthy and productive employees.

OPSOMMING

Sleutelwoorde en terme

Werknemerondersteuning; werknemerondersteuningsprogram; werknemerprestasië; beste praktyk; gehaltebestuur; gesondheidsorgsektor; gesondheidsorgwerker; kwalitatiewe navorsing; gevallestudie-ontwerp; fokusgroepbespreking; Delphi-ondersoek.

Werknemerondersteuning het sy oorsprong in die 19de eeu in die Verenigde State van Amerika gehad deur werknemers, wat alkohol misbruik, in die werksplek te ondersteun. In die 1970's is die konsep van 'n werknemerondersteuningsprogram (WOP) aangepas om werknemers te ondersteun wat nie net alkoholverwante probleme het nie, maar ook persoonlike en ander werksverwante probleme wat swak werksprestasië tot gevolg het. Dit is duidelik uit die literatuurstudie dat geen werknemerprogram dieselfde is nie; daarom het navorsers die sewe kerntegnologieë geïdentifiseer om eenvormigheid in die veld van werknemerondersteuning te bevorder.

Die doel van hierdie studie is om 'n raamwerk vir 'n bestepraktyk-WOP vir die gesondheidsorgsektor, asook die gehaltebestuur daarvan, te skep. As agtergrond vir die studie het die navorser 'n uitgebreide literatuurstudie uitgevoer om die huidige situasie aangaande die gebruik van WOP's in verskillende industrieë wêreldwyd te ondersoek. Die uitkoms van die literatuurstudie is gebruik as 'n riglyn tydens die empiriese fase van die studie om meer diepgaande kennis van werknemerondersteuning in die gesondheidsektor in te win. 'n Gevallestudie-ontwerp is as kwalitatiewe navorsingsbenadering gebruik. Vyf fokusgroep-besprekingsessies met toesighouers van verskillende vlakke in verskeie gesondheidsorginstansies is as data-insamelingsmetode gehou. Verskillende kriteria vir die bestepraktyk-WOP is gedurende die data-insamelingsproses geïdentifiseer en 'n Delphi-ondersoek van ses rondtes is uitgevoer om konsensus te bereik aangaande die kriteria wat in hierdie

program ingesluit moet word. Na aanleiding hiervan is 'n raamwerk vir hierdie program en die gehaltebestuur daarvan ontwikkel.

Die bestuur van gesondheidsorginstansies moet beseft dat gesondheidsorgwerkers hulle mees waardevolle hulpbron is en dat daar 'n behoefte is om hulle te ondersteun ten opsigte van persoonlike en werksverwante probleme. Die raamwerk is spesifiek vir 'n gesondheidsorginstansie ontwikkel met die opsie om dit aan te pas by die unieke behoeftes van individuele gesondheidsorginstansies. Hierdie voorgestelde raamwerk kan aangewend word om 'n WOP uniek tot die instansie te ontwikkel. Die daarstelling van 'n WOP uniek tot die werksplek sal aan werknemers toon dat hulle as die mees waardevolle hulpbron in die gesondheidsorginstansie beskou word.

Die oorhoofse doelwit en oogmerke, soos vir die navorsingstudie uiteengesit, is aangespreek en bereik, terwyl betekenisvolle aanbevelings in die veld van werknemerondersteuning gemaak is. Die raamwerk vir die bestepraktyk-WOP is in lyn met die kerntechnologieë van WOP's, die behoeftes van toesighouers in gesondheidsorginstansies en die gebruik van WOP's op internasionale vlak. Die voorgestelde raamwerk sluit die volgende hoofaspekte in naamlik die behoefte vir 'n WOP in 'n gesondheidsorginstansie, die strategiese benadering vir die ontwikkeling van so 'n program, die struktuur en prosesse van 'n WOP en die evaluasie van 'n WOP in terme van die doeltreffendheid daarvan.

Die raamwerk sal 'n betekenisvolle bydrae tot die bestuur van menslike hulpbronne in die gesondheidsorgbedryf lewer en sal 'n ondersteunende werksomgewing vir gesondheidsorgwerkers voorsien om sodoende gesonde en produktiewe werknemers te verseker.

Appendix A

Focus group discussions: Information leaflet



THE UNIVERSITY OF THE FREE STATE

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Dear Participant,

**Request to participate in a focus group discussion for PhD study titled:
Employee Assistance Program for health care sector: a framework for best-practice and quality management.**

A request to participate in focus group discussion as part of a research project refers.

You are hereby invited to participate in a focus group discussion with your fellow employees regarding an Employee Assistance Program (EAP) for the health care sector. In summary, I want you to share your experiences and/or opinion regarding an EAP in your institution.

The details necessary for you to make a decision are as follows:

1. **My current position:** I am currently occupying the position of Head: Department of Community Health in the School of Medicine in the Faculty of Health Sciences at the University of the Free State.
One of the main subjects in the field of Community Health is Occupational

Health and therefore my interesting in the field of EAPs.

2. **Background information:** I am in the process of writing a thesis to obtain a PhD degree in Community Health in the Faculty of Health Sciences at the University of the Free State. The title of my research is *Employee Assistance Program for health care sector: a framework for best-practice and quality management*.

My supervisors are:

Prof. GJ van Zyl

Head: School of Medicine, Faculty of Health Sciences University of the Free State Bloemfontein, South Africa

Prof. A Venter

Head: Department of Pediatrics, School of Medicine, Faculty of Health Sciences University of the Free State Bloemfontein, South Africa

3. The **purpose of my research study** is to establish a frame-work for a best-practice EAP for the health care sector and then to develop a framework for the quality management thereof. The choice of subject was a natural outflow from the fact that there are several models of EAPs worldwide and I want to identify what should be included in a best-practice EAP and how we can manage the quality of that best-practice EAP.
4. The **objectives of this research study** are:
 - 4.1 To gain deeper insight into the current EAPs practices, challenges, constraints and needs that could be of value for the health care sector.
 - 4.2 To develop and consolidate a framework for a best-practice EAP for the health care sector based on information, experiences and insight gathered. This will be done based on information obtained from literature and focus group discussions.

- 4.3 To determine the need for a quality management framework for a best-practice EAP in order to monitor the program and produce meaningful managerial reports. This will be done by conducting a literature survey, getting the necessary information from the focus group discussion and performing a Delphi study technique.
- 4.4 To finalise an appropriate quality management framework for a best-practice EAP for employees employed in health care by conducting a Delphi study technique.
5. The **ultimate goal** of this study is to propose an acceptable quality management framework for a best-practice EAP in the health care sector that can be adapted by any health care institution according to individual needs. In order to develop the quality management frame-work, I need to establish what people think should be a best-practice EAP.
6. In order for you to make an informed decision to participate in this discussion, the following **words** need some explanation:
 - 6.1 EAP:
 - An EAP is a work located program consisting of counselling, support and advice services to assist employees to resolve personal anxieties which may be affecting their performance at work.
 - 6.2 Frame work & Best-practice
 - There are generic issues to be addressed within an EAP. A combination of the most important issues should be grouped into a program and presented as a best-practice EAP.
 - Any health care organisation should be able to adapt the principles presented in the best-practice EAP for their organisation.

6.3 Quality management:

- If a health care service cannot be measured, it cannot be managed. Quality in health care is a widely discussed concept with various methods available to measure it.
- An EAP should be evaluated after its implementation and the necessary indicators and measurement tools should be adapted for this purpose. Without an appropriate measurement framework, no meaningful managerial reports can be produced.

7. **The focus group discussion:**

- The focus group discussion research method is a form of group interview in which interviewees are selected because they are known to have been involved in a particular situation or they can make a meaningful contribution towards it.
- It involves a group discussion consisting of about 8 – 12 people for about 90-120 minutes on a number of topics that is the focus of the conversation under the facilitation of a moderator.
- The main purpose is to stimulate an in-depth exploration of a topic of which little is known and also to study the ways in which people organise knowledge about health issues.

8. **The value** of this research and your inputs will be that it will lay the foundation for the development of a best-practice EAP for the health care sector and the frame work for quality management thereof.

9. **Your participation:**

- You have been selected, according to predetermined criteria, to participate and contribute towards this very important component of Human Resource management. I would, therefore, respectfully request your cooperation in completing this project.
- Approval to conduct this study in your institutions as well as your participation was obtained from your management team. Tea and refreshments will be served and a gift as a token of my appreciation will be handed to you.
- The duration of the discussion will take approximately 90-120 minutes.
- This study was approved by the Ethics Committee of the Faculty of Health Science, UFS.

10. Should you have **any specific questions**, my contact details are as follows:

Telephone number: 051-4053136

Cellular phone: 083 444 0269

Email address: gngmwhk.md@ufs.ac.za

Postal address: PO Box 339(G52)

Department of Community Health, Faculty of Health Sciences

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South Africa

11. **Details of focus group discussion**

- You will be informed about the time and the venue of the focus group discussion shortly. Should you be willing to participate, please fill in the

accompanying consent form and hand it to me just before the discussion session.

Thank you for taking the time to read this communication and I sincerely hope that you are willing to contribute to this project.

Sincerely yours,

Prof. Willem Kruger

Faculty of Health Sciences University of the Free State Bloemfontein
(ETOVSNo. 34/08) Registered Project

Appendix B

Focus group discussions: Informed consent document

CONSENT FORM FOR FOCUS GROUP DISCUSSION

Title: Employee Assistance Program for health care sector: a framework for best-practice and quality management (ETOVS no 34/08.)

Hereby I, the undersigned, give consent to participate in the focus group discussion, which is scheduled to take place on _____

My full particulars are as follows:

Title: _____ Surname: _____

Full _____ names:

Email address (for feedback to be sent):

Contact telephone no: _____

Signature

Date: _____

Please hand this completed form back to me just before the start of the Focus Group Discussion session.

I wish to assure you that the information will be treated in a highly confidential manner and that there will be no references to any names. A specific number will be allocated to all your inputs and only I will have access to the numbers and names. Your name will not appear on the outcome of the study and all inputs will be treated with strict confidentiality.

You may withdraw from the study at any time without any penalization.

Thank you in advance for your kind cooperation. Please take note that the results coming from this doctoral study will be published but all inputs will be anonymous and be assured that your name will never be used/revealed. Thank you for your kind cooperation.

Kind regards

Prof Willem H Kruger

This document will be available in Afrikaans if requested

Appendix C

Focus group discussion:

Agenda for discussion session

AGENDA FOR FOCUS GROUP DISCUSSIONS:

I. Main research question:

To establish the elements of a Best-practice Employee Assistance Program for the health care sector including elements for quality management.

II. Questions for participants:

A. Introductory questions:

<u>Nr</u>	<u>Question</u>	<u>Priority</u>	<u>Time frame</u>
A1	<i>Introduction and explanation of the focus group discussions & process</i>	—	5 min
1	Why do we need an EAP for workers in health care sector?	4	5 min
2	What should be included in the management statement of an EAP policy?	2	10 min
3	What kind of procedures should be included in the formal EAP policy?	2	10 min
4	What is the role of a joint (Labour-management-personnel) EAP committee in a health care institution?	4	5 min
			<u>35 min</u>

B. EAP specific questions

5	How/by who should an EAP be provided?	2	10 min
6	What should the scope of the EAP be and what is the role of the HR department in the EAP?	1	15 min
7	What types of services should be rendered by the EAP? (e.g Therapeutic, Preventative, Monitoring and Follow-up)	1	15 min
			<u>40 min</u>
B1	<i>Tea and refreshments</i>	—	<i>15min</i>
8	What category of staff members and training should be appointed for providing the services in the EAP?	2	10 min
9	What pre-entry processes should be in place?	3	5 min
			<u>30 min</u>

C. Evaluation of EAP question

10	Which areas of the EAP should be evaluated?	1	15 min
11	What methods of evaluations could be used in the evaluation process?	1	15 min
12	What impact do you expect from an EAP on the organisation?	1	15 min
C1	<i>Conclusion and closure</i>	—	<i>5min</i>
			<u>50 min</u>

Total time needed for focus groups discussions:

150 min (2 hours 30minutes)

Appendix D

Focus group discussion: Complete master coding system

Themes and code: Five focus group discussions

Criteria for Delphi survey:

1. Three (3) references or more irrespective on the number of sources.
2. Two (2) references but from two different sources.
3. Significant outliers

(Total number of Delphi questions generated): **162**

<u>No</u>	<u>Category and theme</u>	<u>Number of FDG</u>	<u>Number of times discussed</u>	<u>Used in Delphi</u>
<u>A 1</u>	<u>Rationale for EAP:</u>			
1.1	Unique environment with risks and problems	4	17	Yes
1.2	Healthy & Satisfied worker	5	12	Yes
1.3	Ensure productivity of employees	4	9	Yes
1.4	Employees are a valuable resource	3	6	Yes
1.5	Support needed by employee	2	4	Yes
1.6	Expectation from employee	1	1	No
<u>A 2.</u>	<u>Objectives of EAP:</u>			
2.1	Look after employees	5	15	Yes
2.2	Absenteeism control	3	6	Yes
2.3	Someone to listen	4	6	Yes
2.4	Retention of personnel	2	2	Yes
<u>A 3.</u>	<u>Scope of the EAP:</u>			
3.1	Employees and their families	4	14	Yes
3.2	Wide scope	4	11	Yes
3.3	Assist with appointments	2	10	Yes
3.4	Accessibility	1	8	Yes
3.5	Best can do	3	7	Yes
3.6	Holistic manner	2	6	Yes
3.7	Involvement of Management	2	4	Yes
3.8	Sick leave management	1	4	Yes
3.9	Cultural difference	3	3	Yes
3.1	Work-related and personal problems	2	3	Yes
3.11	Know your employees	2	2	Yes
3.12	Purpose of program	1	2	No
3.13	Relationships	1	1	No
3.14	Resources	1	1	No
3.15	Students	1	1	No

<u>No</u>	<u>Category and theme</u>	<u>Number of FDG</u>	<u>Number of times discussed</u>	<u>Used in Delphi</u>
<u>A 4.</u>	<u>Management introductory statement:</u>			
4.1	Place of disciplinary actions	3	14	Yes
4.2	Management support of program	3	11	Yes
4.3	Non-threatening & non-punitive	3	9	Yes
4.4	Employee's wellbeing & productivity	3	8	Yes
4.5	Assist	3	5	Yes
4.6	Employer's responsibilities	2	2	Yes
4.7	What is offered	2	2	Yes
4.8	Invitation	1	1	No
<u>A 5.</u>	<u>Marketing of EAP (not used in the Delphi):</u>			
5.1	Marketing the EAP	3	5	No
5.2	Correct management	1	3	No
<u>B 1.1</u>	<u>Requirements for Joint EAP Committee:</u>			
1.1.1	Members	4	6	Yes
1.1.2	Practical arrangements to be effective	1	4	Yes
1.1.3	Mandate	3	3	Yes
<u>B 1.2</u>	<u>Role of Joint EAP committee:</u>			
1.2.1	Evaluation function	1	8	Yes
1.2.2	Maintain balance in program	2	8	Yes
1.2.3	Policies and procedure	4	8	Yes
1.2.4	Information sharing	3	7	Yes
1.2.5	Problematic cases	3	5	Yes
1.2.6	Commitment and support	2	4	Yes
1.2.7	Trends	3	4	Yes
1.2.8	Health and safety	1	3	Yes
1.2.9	Training	2	3	Yes
1.2.10	Labour relations	1	2	No
1.2.11	Relationship between employee and Management	1	1	No

<u>No</u>	<u>Category and theme</u>	<u>Number of FDG</u>	<u>Number of times discussed</u>	<u>Used in Delphi</u>
<u>B 2.1</u>	<u>Type of EAP providers:</u>			
2.1.1	External	5	26	Yes
2.1.2	Internal	3	12	Yes
2.1.3	Multi-disciplinary	4	12	Yes
2.1.4	Combined	4	11	Yes
2.1.5	Coordinator	3	9	Yes
2.1.6	Sessional appointment	2	2	Yes
<u>B 2.2</u>	<u>Characteristics of EAP providers:</u>			
2.2.1	Trust	3	16	Yes
2.2.2	Trained	3	11	Yes
2.2.3	Knowledge of organisation	3	5	Yes
2.2.4	Junior vs. senior staff	3	4	Yes
2.2.5	Needs assessment	1	4	Yes
2.2.6	Specialists	2	4	Yes
2.2.7	Knowledgeable	3	3	Yes
2.2.8	Professional	2	3	Yes
2.2.9	Size of team	2	3	Yes
2.2.10	Registered with Council	1	2	No
2.2.11	Communication	1	1	No
2.2.12	Emotionally involved	1	1	No
2.2.13	Experienced	1	1	No
2.2.14	Experimenting	1	1	No
2.2.15	Language	1	1	No
2.2.16	Methods	1	1	No
2.2.17	Qualifications	1	1	No
2.2.18	Responsibility	1	1	No
<u>B 2.3</u>	<u>Categories of staff needed:</u>			
2.3.1	Human resource	5	29	Yes
2.3.2	Psychologist	5	10	Yes
2.3.3	Social worker	5	10	Yes
2.3.4	Occupational therapy	2	5	Yes
2.3.5	Financial advisor	3	4	Yes
2.3.6	Legal advisor	2	4	Yes
2.3.7	Medical doctor	3	4	Yes
2.3.8	Nurse	3	4	Yes

<u>No</u>	<u>Category and theme</u>	<u>Number of FDG</u>	<u>Number of times discussed</u>	<u>Used in Delphi</u>
2.3.9	Pastor	2	4	Yes
2.3.10	Administrative staff	1	3	Yes
2.3.11	Occupational Health	2	3	Yes
2.3.12	Psychiatrist	3	3	Yes
2.3.13	Academic staff	1	1	No
2.3.14	Anybody	1	1	No
2.3.15	Bio kinetics	1	1	No
2.3.16	Dietician	1	1	No
2.3.17	Labour	1	1	No
2.3.18	Physiotherapist	1	1	No
<u>C 1.</u>	<u>Policy requirements:</u>			
1.1	Step by step guidelines	3	11	Yes
1.2	Basic conditions of services	1	3	Yes
1.3	Written policies	2	2	Yes
<u>C 2.</u>	<u>Types of policy needed:</u>			
2.1	Supervisors' responsibilities	5	38	Yes
2.2	Confidentiality	5	16	Yes
2.3	Referral procedures	4	16	Yes
2.4	Employee responsibilities	4	15	Yes
2.5	Funding	5	15	Yes
2.6	Employee commitment	3	12	Yes
2.7	Individual pathways	3	12	Yes
2.8	Manipulation and misuse of EAP	3	12	Yes
2.9	Channels to be followed	2	11	Yes
2.10	Referral procedures - self	2	10	Yes
2.11	Feedback	3	9	Yes
2.12	Resources available	4	9	Yes
2.13	Communication between EAP & supervisors	2	8	Yes
2.14	Relapse	3	8	Yes
2.15	Reports from EAP providers	2	8	Yes
2.16	Non-compliance	2	7	Yes
2.17	Open door	1	7	Yes
2.18	Voluntary entry	2	7	Yes
2.19	Who may access service	4	6	Yes
2.20	Program provided during working times	2	5	Yes

<u>No</u>	<u>Category and theme</u>	<u>Number of FDG</u>	<u>Number of times discussed</u>	<u>Used in Delphi</u>
2.21	Time frame	2	5	Yes
2.22	Consent	1	4	Yes
2.23	Referral procedures - supervisor	2	4	Yes
2.24	Management of program	2	2	Yes
2.25	Evaluation of program	1	2	No
2.26	Booking system	1	1	No
2.27	Goals	1	1	No
2.28	Leave	1	1	No
<u>D 1.</u>	<u>EAP entry processes:</u>			
1.1	Initial assessment	4	8	Yes
1.2	Admission policy	3	8	Yes
1.3	Performance indicators	2	7	Yes
1.4	Formal referral	2	5	Yes
1.5	Pre-entry interview with supervisor	3	5	Yes
1.6	Health profile (Included in work place records)	3	4	Yes
1.7	Employee	3	3	Yes
1.8	First or repeat problem	2	3	Yes
1.9	Seriousness of problem	3	3	Yes
1.10	Contract (included in Admission policy)	1	2	No
1.11	Staff development	1	2	No
1.12	Work place records	1	1	No
1.13	Disciplinary procedures	1	1	No
1.14	Open communication	1	1	No
<u>D 2.</u>	<u>Types of services:</u>			
2.1	Financial	4	17	Yes
2.2	Preventative	4	15	Yes
2.3	Part of in-service training	2	13	Yes
2.4	Chronic disease management	4	10	Yes
2.5	Counselling	4	10	Yes
2.6	Referral function	3	10	Yes
2.7	Follow up program	3	7	Yes
2.8	Promotion	2	5	Yes
2.9	Substance abuse	2	5	Yes
2.10	Burnout	2	4	Yes
2.11	Debriefing	2	4	Yes

<u>No</u>	<u>Category and theme</u>	<u>Number of FDG</u>	<u>Number of times discussed</u>	<u>Used in Delphi</u>
2.12	Therapeutic	3	4	Yes
2.13	Life skills	3	3	Yes
2.14	Marriage problems	3	3	Yes
2.15	Monitoring	1	3	Yes
2.16	Stress management	2	3	Yes
2.17	Absenteeism	2	2	Yes
2.18	Conflict	2	2	Yes
2.19	Rehabilitation	2	2	Yes
2.20	Surveillance	2	2	Yes
2.21	Incapacity management	1	2	No
2.22	Psychiatric	1	2	No
<u>D 2. Types of services (continued):</u>				
2.23	Relationship problems	1	2	No
2.24	Violence	1	2	No
2.25	Anger Management	1	1	No
2.26	Crisis	1	1	No
2.27	Exercises	1	1	No
2.28	Injury on duty cases	1	1	No
2.29	Retirement planning	1	1	No
2.30	Self defence	1	1	No
2.31	Sexual harassment	1	1	No
<u>E 1. E 1. Program evaluation – general:</u>				
1.1	Evaluation period	5	12	Yes
1.2	All aspects to be evaluated	3	7	Yes
1.3	Anonymous ensure	1	6	Yes
1.4	Continuous process	3	4	Yes
1.5	Evaluator	2	3	Yes
1.6	Several methods	2	3	Yes
1.7	No evaluation needed	1	1	No
<u>E 2. Program evaluation - aspects to be evaluated:</u>				
2.1	Outcome	5	13	Yes
2.2	Financial implications	2	12	Yes
2.3	Absenteeism	3	11	Yes
2.4	Types of problems seen	4	11	Yes

<u>No</u>	<u>Category and theme</u>	<u>Number of FDG</u>	<u>Number of times discussed</u>	<u>Used in Delphi</u>
2.5	Self evaluation	5	9	Yes
2.6	Staff working on the EAP	5	8	Yes
2.7	Treatment protocols	4	8	Yes
2.8	Productivity	3	6	Yes
2.9	Trends	2	5	Yes
2.10	Value added	2	5	Yes
2.11	Availability	2	4	Yes
2.12	Confidentiality	2	4	Yes
2.13	Guidelines	3	4	Yes
2.14	Accessibility	2	3	Yes
2.15	Awareness	2	3	Yes
2.16	Correct channels followed	2	3	Yes
2.17	Customer's satisfaction	2	3	Yes
2.18	Effectiveness	2	3	Yes
<u>E 2.</u>	<u>Program evaluation - aspects to be evaluated (continued):</u>			
2.19	Follow up in the workplace	2	3	Yes
2.20	Personnel turnover	1	3	Yes
2.21	Utilisation	2	3	Yes
2.22	Client's performance	2	2	Yes
2.23	Various criteria of program	2	2	Yes
2.24	Response time	1	2	No
2.25	Referrals	1	1	No
2.26	Area of organisation - from which area	1	1	No
2.27	Attitude	1	1	No
2.28	Compliance	1	1	No
2.29	Employee behaviour	1	1	No
2.30	Impact on organisation	1	1	No
2.31	Language of choice	1	1	No
2.32	Length of stay	1	1	No
2.33	Progress in program	1	1	No
2.34	Relapse rate	1	1	No
2.35	Support in the workplace	1	1	No

<u>No</u>	<u>Category and theme</u>	<u>Number of FDG</u>	<u>Number of times discussed</u>	<u>Used in Delphi</u>
<u>E 3.</u>	<u>Program evaluation - methods of evaluations:</u>			
3.1	Questionnaire	4	15	Yes
3.2	Statistics	5	10	Yes
3.3	Feedback	3	8	Yes
3.4	Survey	4	8	Yes
3.5	Interview with employee	3	5	Yes
3.6	Performance	2	4	Yes
3.7	Evaluation instrument	2	3	Yes
3.8	Quality assurance cycle	2	3	Yes
3.9	Reports	2	3	Yes
3.10	Client self assessment	2	2	Yes
3.11	Record review	2	2	Yes
3.12	Interview with supervisor	1	2	No
3.13	Lead indicators	1	2	No
3.14	Tick sheet	1	1	No
3.15	Audit	1	1	No
3.16	Qualitative	1	1	No
3.17	Quantitative	1	1	No

<u>No</u>	<u>Category and theme</u>	<u>Number of FDG</u>	<u>Number of times discussed</u>	<u>Used in Delphi</u>
<u>E</u>	<u>Impact of EAP on organisation (not used in Delphi):</u>			
1.1	Retention of employees	5	11	
1.2	Improved productivity	5	9	
1.3	Positive impact	1	8	
1.4	Improved morale	4	5	
1.5	Attract people	4	4	
1.6	Healthy people make healthy companies	2	4	
1.7	Improve relationships	2	4	
1.8	Loyalty	2	4	
1.9	Team work	2	4	
1.10	Wellness	2	4	
1.11	Better service delivery	3	3	
1.12	Misconduct	2	3	
1.13	Positive patients	2	3	
1.14	Prevention	1	3	
1.15	Cope better	2	2	
1.16	Financial advantage	1	2	
1.17	Management	2	2	
1.18	Work as a team	1	2	
1.19	Absenteeism improved	1	1	
1.20	Burden relieve	1	1	
1.21	Competitive edge	1	1	
1.22	Expectations created	1	1	
1.23	Improved relationships	1	1	
1.24	Learning	1	1	
1.25	Paradigm shift	1	1	
1.26	Remove stigmata	1	1	
1.27	Risk reduction	1	1	
1.28	Stress relieve	1	1	
1.29	Take care of themselves	1	1	

Appendix E

The Delphi survey participants

Participant number:	Participant: Details of position and type of organisation	Working knowledge and experience in Quality assurance					
		Qualification & Working knowledge and experience of occupational health	Experience in human resource management/labour relations	Expertise in strategy development and evaluation strategies	More than 5 years experience in health care administration / management	International expert on EAP	Practical experience in the field of EAP management and service provision
A.	Academia & EAP developer: University					X	X
B	Director: EAP provider		X		X		
C	CEO: EAP provider				X		
D	Executive HR manager: National Head Office		X	X	X		
E	Occupational Health Practitioner: A private OH group	X					X
F	Regional HR manager: A private health care organisation		X				
G	Regional HR manager: A major bank group		X				
H	Executive Manager: A public hospital			X	X		
I	Executive Manager: A private hospital			X	X		
J	Executive manager: Provincial Department of Health		X	X	X		
K	Executive manager: Administration of medical schemes			X	X		
L	Quality surveyor: Not for profit organisation			X			X
Total			6	1	7	6	5

Criteria:

1. **Practical experience in the field of EAP management and service provision**
2. **International expert on EAP**
3. **More than 5 years experience in health care administration / management**
4. **Expertise in strategy development and evaluation strategies**
5. **Experience in human resource management/labour relations**
6. **Qualification & working knowledge and experience of occupational health**
7. **Working knowledge and experience in Quality assurance**

Appendix F

Information document: Delphi survey



THE UNIVERSITY OF THE FREE STATE

Department of Community Health Faculty of Health **Sciences**

Prof. WH Kruger MBChB MMed MBA
PO Box 339 (G52),
Bloemfontein 9300, South Africa

Chief Specialist/Head of Department
Telephone: (+27) 51 – 405 3136
Fax: (+27) 51 – 444 5971
e-mail: gngmwhk.MD@ufs.ac.za

Dear participant

A request to participate in a Delphi survey as apart of a research project refers.

You are hereby invited to participate in a Delphi survey technique with other experts regarding an Employee Assistance Program (EAP) for the health care sector. In summary, I want your experiences and/or opinion about a framework for a best-practice EAP and how to manage the quality thereof.

The details necessary for you to make a decision are as follows:

1. **My current position:** I am currently occupying the position of Head: Department of Community Health in the School of Medicine in the Faculty of Health Sciences at the University of the Free State. One of the main subjects of Community Health is Occupational Health and therefore my interesting in the field of EAPs.
2. **Background information:** I am in the process of writing a thesis to obtain the PhD. degree in Community Health in the Faculty of Health Sciences at the

University of the Free State. The title of my research is *Employee Assistance Program for health care sector: a framework for best-practice and quality management*.

My supervisors are:

Prof. GJ van Zyl

Head: School of Medicine, Faculty of Health Sciences University of the Free State Bloemfontein, South Africa

Prof. A Venter

Head: Department of Pediatrics, School of Medicine, Faculty of Health Sciences University of the Free State Bloemfontein, South Africa

3. The **purpose of my research study** to establish a framework for a best-practice EAP for the health care sector and then to develop a framework for quality management thereof. The choice of subject was a natural outflow from the fact that there are several models of EAPs worldwide and currently being implemented in the Free State province. I want to know what should be included in a best-practice EAP and the quality management framework.
4. The **objectives of this research study** are:
 - 4.1 To gain deeper insight into the current EAPs practices, challenges, constraints and needs that could be of value for the health care sector.
 - 4.2 To develop and consolidate a framework for a best-practice EAP for the health care sector based on information, experiences and insight gathered. This will be done based on information obtained from literature and this Delphi survey.
 - 4.3 To determine the need for a quality management framework for a best-practice EAP in order to monitor the program and produce meaningful managerial reports. This will be done by conducting a literature survey, getting the

necessary information from the focus group discussions and performing a Delphi study technique.

- 4.4 To finalise an appropriate quality management framework for a best-practice EAP for employees employed in health care consisting of relevant indicators by conducting a Delphi study technique.
5. The **ultimate goal** of this study is to propose an acceptable quality management framework for a best-practice EAP in the health care sector that can be adapted by any health care institution according to individual needs:
6. In order for you to make an informed decision to participate in this discussion, the following **concepts** need some explanation:
 - 6.1 EAP:
 - An EAP is a work located program consisting of counselling, support and advice services to assist employees to resolve personal anxieties which may be affecting their performance at work
 - 6.2 Frame work & Best-practice
 - There are generic issues to be addressed within an EAP. A combination of the most important issues should be grouped into a program and presented as a best-practice EAP.
 - Any health care organisation would be able to adapt the principles presented in the best-practice EAP for their organisation.
 - 6.3 Quality management:
 - If a health care service cannot be measured, it cannot be managed. Quality in health care is a widely discussed concept with various methods available to measure it. An EAP should be evaluated after its implementation and the necessary indicators and measurement tools should be adapted for this purpose. Without an appropriate measurement framework, no meaningful managerial reports can be produced.

7. **The Delphi survey technique:**

- The Delphi technique is defined as a method for the collection of opinions on a particular topic in this case a quality management frame work for a best-practice EAP. It is seen as a group facilitation technique that should stimulate an in-dept exploration of a topic.
- It seeks to obtain consensus on the opinion of experts through a series of structured questionnaires referred to as rounds. It may be important to use the Delphi technique more than one round to get sufficient consensus in this group of experts.
- For the development of a quality management framework the conventional Delphi technique will be used because it is the classic technique for the prioritisation of facts.
- A final quality management framework will be developed according to the outcome of these inputs.

8. **The value** of this research and your inputs will be that it will lay the foundation for the development of a frame work for quality management for best-practice EAP for the health care sector.

9. **Your participation:**

- You have been selected, according to predetermined criteria, to participate and contribute towards this very important component of Human Resource management. I would, therefore, respectfully request your cooperation in completing this project.
- This study was approved by the Ethics Committee of the Faculty of Health Science, UFS.

10. Should you have **any specific questions**, my contact details are as follows:

Telephone number: 051-4053136
 Cellular phone: 083 444 0296
 Email address: gngmwhk.md@ufs.ac.za
 Postal address: PO Box 339(G52)
 Department of Community Health, Faculty of Health
 Sciences, University of the Free State
 Bloemfontein 9300, South Africa

11. **Details of Delphi survey technique**

- If you do agree to participate in the Delphi technique, please complete the accompanying consent form and return it to me by fax or email before.....
 After receiving the signed consent form, you will receive more information on the implementation of the Delphi technique shortly.

Thank you for taking the time to read this communication and I sincerely hope that you are willing to contribute to this project.

Sincerely yours,

Prof. Willem Kruger

Faculty of Health Sciences University of the Free State Bloemfontein
 (ETOVSNo.34/08) Registered Project

CONSENT FORM FOR DELPHI SURVEY TECHNIQUE

Title: Employee Assistance Program for health care sector: a framework for best-practice and quality management. (ETOVS no. 154/08)

Hereby I, the undersigned, consent to participate in the Delphi survey technique. My full particulars are as follows:

Title:

Surname:

Full names:.....;

Email address:.....

Telephone no.:..... Cellular number:

.....

Fax no.:

.. ..

Signature

.....

Date

Please return this form on or before _____ by fax, email or post.

My full contact details are as follows:

Telephone number: 051-4053136
 Fax: 051 - 4445279
 Cellular phone: 083 444 0296
 Email address: gngmwhk.md@ufs.ac.za
 Postal address: PO Box 339(G52)
 Department of Community Health, Faculty of Health
 Sciences
 University of the Free State
 Bloemfontein 9300
 South Africa

I wish to assure you that the information will be treated in a highly confidential manner and that there will be no references to any of the participants' names. A specific number will be allocated to all your inputs and only I will have access to the numbers and names. Only I will know what each individual participant inputs were. The other members of the Delphi group won't know who the rest of members are or what each member specifically has said. Your name will not appear on the outcome of the study and all inputs will be treated with the strict confidentiality. You may withdraw from the study at any time without any penalization.

Thank you in advance for your kind cooperation. Please take note that the results coming from this study will be published but all inputs will be autonomous. Thank you for your kind cooperation.

Kind regards

Prof Willem H Kruger

This document will be available in Afrikaans if requested.

Appendix G

Delphi survey questionnaire: Round 1

**HEAD: DEPARTMENT OF COMMUNITY HEALTH
SCHOOL OF MEDICINE
FACULTY OF HEALTH SCIENCES
UNIVERSITY OF FREE STATE**

ROUND 1

January 12, 2010

Dear Delphi Participant,

Thank you very much for agreeing to participate in the Delphi survey of this study and completing the consent form for the process, which I have received. This is the first part of the Delphi survey. Thank you also for taking the effort to complete this first round of documentation.

PURPOSE OF THE QUESTIONNAIRE

This questionnaire is structured to obtain your opinion regarding the importance of the criteria that is envisaged to be part of a best-practice EAP. This questionnaire contains numbered statements, which can be regarded as indicators for the best-practice EAP, but also provides opportunities for additional comments and suggestions. The questions are divided into five main categories and subdivided into subcategories. Each and every section (A-E) and sub-section (e.g. A 1) will have a heading to indicate the exact theme of the section.

All the questions under each section must be answered. The purpose is to obtain the opinion of each participant on the importance of each criterion for such a best-practice EAP. All information will be treated confidentially. Please note that your response is anonymous to the other participants and will be known only to the researcher, and you should therefore feel comfortable and free to answer the questions as honestly as possible. As part of the Delphi process, feedback will be given to you. As part of the feedback, I will indicate the results for each statement in the follow-up rounds. The subsequent rounds to this first round will also be anonymous to the other respondents.

Instructions for the completion of the questionnaire

Please evaluate each numbered statement, which can be regarded as criteria for the best-practice EAP and then indicate the importance thereof on the three-point scale. The specific points of the scale are defined as follows:

- 1 – Consider to be critical (this criterion must definitely be included in the best-practice framework).
- 2 – Could be considered (it does not matter if this criterion is included or left out from the best-practice framework).
- 3 – Not to be considered (this criterion must definitely be left out of the best-practice framework).

If you complete the questionnaire in the electronic format, please type in a cross (X) underneath the point on the scale that represents your opinion on the specific indicator. If you complete the questionnaire in hard copy format (printed out), please write a cross (X) underneath the specific position of the scale.

As part of the design of the questionnaire, I have also included space for comments which can be utilised for each item. There will also be open-ended questions asked on specific criteria to which you may answer in your own words in the space provided. It is very important for me to establish the criteria for a best-practice framework for an EAP in the health care sector. Please keep this in mind when completing the questionnaire. The questionnaire should take you $\pm$ 45 minutes to complete. Thank you for your efforts and helping me to complete this part of my study. As stipulated in the informed consent document, the questionnaire will be available in English only.

Please return the completed questionnaire by no later than 12 February 2010.

Yours sincerely,

Willem Kruger

Student no.: 1981280579



FACULTY OF HEALTH SCIENCES

DELPHI PROCESS FOR PH.D. ON A FRAMEWORK FOR BEST-PRACTICE EAP AND QUALITY ASSURANCE FOR THE HEALTH CARE SECTOR

Delphi Process:

Round 1

The questionnaire will be anonymous to other participants. Only the researcher will know your identity and he will do everything possible to protect your identity.

There will be **five** sections to be completed. Instructions will be supplied with each group of questions.

Example: Please indicate how important each of the following criteria is to be included in the framework for a best-practice EAP according to the following scale: 1= Considered to be critical 2= Could be considered 3= Not to be considered Please mark the appropriate box with an X. Mark only one box.				
1.1 An EAP is needed for health care sector.	1	2 X	3	Comments: Please use this column to any write comments on this statement or use the last bullet for any other additional comments on this section.

Please score each statement as indicated

Section A:**INTRODUCTION OF AN EAP:**

This section deals with issues related to introductory statements to be included in an EAP.

A 1. The rationale for an EAP.

Please indicate how important each of the following criteria according to the following scale to be included in the rationale statement to have an EAP in a health care institution:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

1. The rationale section of an EAP for the health care sector needs to address / should include the following aspects:					Comments
1.1	To acknowledge the unique risky working environment for employees working in the health care sector.	1	2	3	
1.2	To keep employees in an organisation healthy.	1	2	3	
1.3	To ensure optimal productivity of employees.	1	2	3	
1.4	To emphasise that employees are one of the most valuable resources of an organisation.	1	2	3	
1.5	To recognise the need to support employees in the work place with specific problems/issues.	1	2	3	
1.6	Any other comments on the rationale to have an EAP in a health care institution?				

A 2. The objectives of an EAP.

Please indicate how important each of the following statements is according to the following scale with reference to the objectives of an EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

2. The objectives of an EAP for the health care sector needs to include / address the following aspects:					<u>COMMENTS</u>
2.1	To provide a good support network for employees at work.	1	2	3	
2.2	To improve the absenteeism profile of an organisation.	1	2	3	
2.3	To provide a service where an employee feels free to speak to somebody who will listen to their problems.	1	2	3	
2.4	To be used to retain employees in the organisation.	1	2	3	
2.5	Any other comments on the objectives for an EAP?				

A.3 THE SCOPE OF THE EAP.

Please indicate how important each of the following criteria is according to the following scale with reference to the scope of the EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

3. The scope of the EAP must take into account / should address the following issues:					Comments
3.1	A clear explanation as to the services to be provided to employees with their extended families.	1	2	3	
3.2	Should be very broad with a variety of services provided.	1	2	3	
3.3	Should be used to assist with appointment of employees.	1	2	3	
3.4	Should ensure that the services of the EAP are accessible to all those that are stipulated in the policy.	1	2	3	
3.5	Should ensure that the EAP must provide the best type of services available.	1	2	3	
3.6	Should view employees in a holistic manner.	1	2	3	
3.7	Should include the supportive involvement by top management in the programme.	1	2	3	
3.8	Should include the management of sick leave usage.	1	2	3	
3.9	Should consider the different cultures of employees when services within the EAP are provided.	1	2	3	
3.10	Should concentrate on employees' personal problems.	1	2	3	
3.11	Should concentrate on employees' work related problems.	1	2	3	
3.12	Should highlight the importance of getting to know the employees working in the institution through the EAP.	1	2	3	
3.13	Any other comments on the scope of the EAP?				

A.4 THE INTRODUCTORY STATEMENT FROM THE EXECUTIVE MANAGEMENT IN THE EAP.

Please indicate how important each of the following criteria is according to the following scale with reference to the introductory statement from Executive Management of the institution in the EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

4. The introductory statement of Executive Management of the institution should include / address the following aspects:				Comments	
4.1	The EAP does not replace the disciplinary procedures.	1	2	3	
4.2	The critical supportive role of Executive Management of the health care institution in the programme.	1	2	3	
4.3	The process of entering the programme should not be seen as punitive or threatening.	1	2	3	
4.4	There should be an emphasis on the general well-being of employees in order for them to be productive in the workplace.	1	2	3	
4.5	The importance of a work-based programme to assist employees with personal problems in the work place.	1	2	3	
4.6	An explanation of the roles of the employer within the EAP.	1	2	3	
4.7	Clarification on the services that are offered within the EAP.	1	2	3	
4.8	Other comments on the introductory statement of the Executive Management in the EAP?				

Section B:**Structure and requirements for an EAP.**

This section deals with issues related to the structures and requirements of an EAP.

B.1 Requirements of an in-house EAP committee.

Please indicate how important each of the following statements is according to the following scale with reference to an in-house EAP committee for a health care institution:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

5. The requirements for an in-house EAP committee must take into account / needs to include the following aspects:					Comments
5.1	The formal establishment of a multi-disciplinary membership of the committee.	1	2	3	
5.2	Clear explanations of the practical functioning of the committee within the institution.	1	2	3	
5.3	A clearly formulated mandate of the committee.	1	2	3	
5.4	Any other comments on the requirements for an in-house EAP committee within an institution?				

B.2 The role of an in-house EAP committee.					
Please indicate how important each of the following statements is according to the following scale with reference to an in-house EAP committee for a health care institution: 1= Considered to be critical 2= Could be considered 3= Not to be considered Please mark the appropriate box with an X. Mark only one option.					
6.	The role of an in-house EAP committee must include / address the following issues:				Comments
6.1	To participate in the development of the policies and procedures documents for the EAP.	1	2	3	
6.2	To ensure that there is the necessary cooperation for the EAP to remain balanced.	1	2	3	
6.3	To be part of the formal evaluation of the EAP.	1	2	3	
6.4	To assist with the maintenance of communication lines within the EAP.	1	2	3	
6.5	To be involved in the discussion of problematic cases/employees within the EAP.	1	2	3	
6.6	To play a role in the identification of certain trends regarding referrals to the EAP.	1	2	3	
6.7	To emphasise the commitment from the EAP committee regarding the support services provided by the EAP to employees.	1	2	3	
6.8	To maintain a link between the EAP and the health and safety committee especially regarding health risk assessments.	1	2	3	
6.9	To be involved in the training of relevant EAP stakeholders.	1	2	3	
6.10	Any other comments on the role of the in-house EAP committee within a health care institution? 				

B.3 The service providers in an EAP.

Please indicate how important each of the following statements is according to the following scale with reference to the service providers of an EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

7. The manner in which services are provided in an EAP in a health care institution must take into account / needs to address the following aspects:					Comments
7.1	The services could be outsourced to a service provider independent of the health care institution.	1	2	3	
7.2	The services should be provided by an in-house service provider.	1	2	3	
7.3	The services should be provided within a multi-disciplinary team.	1	2	3	
7.4	The services could be a combination between an in-house service provider and an outside (outsourced) service provider.	1	2	3	
7.5	The appointment of a fulltime EAP facilitator in the health care institution to coordinate the activities of the EAP.	1	2	3	
7.6	The EAP service providers can be appointed on a session basis.	1	2	3	
7.7	Any other comments on the types of the EAP providers?				

B.3 The characteristics of the service providers in an EAP.

Please indicate how important each of the following statements is according to the following scale with reference to the characteristics of the service providers in an EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

8. The following characteristics of the EAP providers need to be considered / should be addressed:					Comments
8.1	The EAP service providers should be able to create a relationship with clients based on trust.	1	2	3	
8.2	The staff providing the services in an EAP must have the appropriate training to render a particular service within an EAP.	1	2	3	
8.3	The EAP providers must have the necessary background knowledge of the health care institution in which they provide the services.	1	2	3	
8.4	Only senior level staff members should provide the necessary services in the EAP.	1	2	3	
8.5	A formal needs assessment should be conducted to determine the type of EAP services for the health care institution.	1	2	3	
8.6	The staff working in an EAP must be specialists in their respective fields.	1	2	3	
8.7	All service providers in the EAP must be knowledgeable in their field.	1	2	3	
8.8	All service providers in the EAP must be a professional service provider.	1	2	3	
8.9	The number of EAP providers should be based on the size of the health care institution.	1	2	3	
8.10	Any other comments on the characteristics of the EAP providers?				

B.3 The category of service providers in an EAP.

Please indicate how important each of the following statements is according to the following scale with reference to the category of service providers in an EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

9. The following category of staff members needs to be considered / included in an EAP team to render a service in a health care institution:				Comments
9.1 Human resource officer.	1	2	3	
9.2 Psychologist.	1	2	3	
9.3 Social worker.	1	2	3	
9.4 Occupational therapist.	1	2	3	
9.5 Financial advisor.	1	2	3	
9.6 Legal advisor.	1	2	3	
9.7 Medical practitioner.	1	2	3	
9.8 Registered nurse.	1	2	3	
9.9 Religious/spiritual leader.	1	2	3	
9.10 Administrative staff member.	1	2	3	
9.11 Occupational health nurse.	1	2	3	
9.12 Psychiatrist.	1	2	3	

9.13 Any other comments on categories of staff members to be included in the EAP team to provide services in a health care institution?

Section C:

Policies and procedures for an EAP.

This section deals with issues related to policies and procedures for an EAP.

C.1 Requirements for policies and procedures.

Please indicate how important each of the following statements is according to the following scale with reference to the requirements for the policies and procedures for an EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

10. The following requirements must be considered / needs to be addressed when policies and procedures are developed for an EAP:					Comments
10.1	A step-by-step approach is needed in the development of guidelines.	1	2	3	
10.2	A review of the basic conditions of services from the Department of Labour before drafting policies.	1	2	3	
10.3	Policies should be available in a written format.	1	2	3	
10.4	Any comments on the requirements for policies and procedures to be developed for an EAP?				

C.2 Types of policies and procedures.

Please indicate how important each of the following statements is according to the following scale with reference to the types of policies and procedures needed for an EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

11. The following type of policies and procedures for an EAP must be considered / needs to be developed:					COMMENTS
11.1	The role/responsibilities of the supervisor regarding all the activities of the EAP.	1	2	3	
11.2	The principles regarding confidentiality of the information generated.	1	2	3	
11.3	The administrative aspects regarding the referral of an employee to the EAP.	1	2	3	
11.4	The responsibilities of the employee when entering the EAP.	1	2	3	
11.5	The funding structure for services rendered within the EAP.	1	2	3	
11.6	The commitment needed from employees throughout the EAP.	1	2	3	
11.7	The individual treatment pathways to be followed for each employee entering the EAP.	1	2	3	
11.8	The management of possible manipulation/misuse of the EAP by the employee to his/her advantage.	1	2	3	
11.9	The communication channels to be followed by everybody in order to get assisted.	1	2	3	
11.10	The description of the method of self-referral of an employee to the EAP.	1	2	3	
11.11	The formal feedback system between all stakeholders involved with employees in the EAP.	1	2	3	
11.12	The resources to be put in place in order to render EAP services in the health care institution.	1	2	3	

C.2 Types of policies and procedures (continues).

Please indicate how important each of the following statements is according to the following scale with reference to the types of policies and procedures needed for an EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

11.13	The formal communication lines between EAP provider and supervisors regarding employees in the EAP.	1	2	3	
11.14	The actions to be taken in the case of a relapse of an employee while in the EAP or after discharge.	1	2	3	
11.15	The formal written reports to be provided by EAP providers regarding the progress made by an employee in an EAP.	1	2	3	
11.16	The steps to be followed regarding any type of non-compliance by an employee while being in an EAP.	1	2	3	
11.17	An open door approach by supervisors to ensure availability of the supervisors to discuss problems with their employees.	1	2	3	
11.18	The principle of voluntary entry by the employee into the EAP.	1	2	3	
11.19	Clear guidelines on who may access/use the services of the EAP.	1	2	3	
11.20	Whether employees are to attend EAP activities/services during their official work time.	1	2	3	
11.21	The time frame for how long the employee can continue with the EAP activities including the follow-up afterwards.	1	2	3	
11.22	The description of the method of referrals of an employee to the EAP by the employer.	1	2	3	
11.23	The requirement of signed consent from an employee before he/she enters the EAP.	1	2	3	
11.24	The principles regarding the governance of the EAP.	1	2	3	
11.25	Any other comments on the type of policies and procedures needed for an EAP?				

Section D:**EAP processes and activities.**

This section deals with EAP processes and activities.

D.1 EAP ENTRY PROCESSES

Please indicate how important each of the following statements is according to the following scale with reference the entry processes for an EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

12. Processes regarding the entry of an employee into the EAP must address / needs to include the following:				Comments	
12.1	An initial assessment of the employee and his/her problem/situation is performed.	1	2	3	
12.2	Poor work performance of the employee is identified.	1	2	3	
12.3	There must a formal admission policy and procedures document.	1	2	3	
12.4	Confirmation that a formal referral system was followed.	1	2	3	
12.5	A pre-entry interview with the employee should be performed by the supervisor.	1	2	3	
12.6	Confirmation that the person to be entered into the EAP is currently employed in the health care institution.	1	2	3	
12.7	There should be a differentiation between a new and a repeat problem as presented by the employee.	1	2	3	
12.8	The seriousness of the problem/case must be determined.	1	2	3	
12.9	A health profile of an employee is kept as part of the work place record.	1	2	3	
12.10 Any other comments on the entry processes for an EAP?					

D.2 Types of services to be rendered in an EAP.					
Please indicate how important each of the following statements is according to the following scale with reference to the types of services to be rendered in an EAP: 1= Considered to be critical 2= Could be considered 3= Not to be considered Please mark the appropriate box with an X. Mark only one option.					
13. The following type of services for an EAP must be considered / needs to be included in the programme:				<u>COMMENTS</u>	
13.1	Financial advisory services.	1	2	3	
13.2	General pro-active preventative programmes.	1	2	3	
13.3	Participation in in-service training programmes of the health care institution for all the employees.	1	2	3	
13.4	Chronic disease management.	1	2	3	
13.5	General counselling services.	1	2	3	
13.6	A referral function to additional resources/services.	1	2	3	
13.7	A follow-up service for a certain period of time after the initial sessions.	1	2	3	
13.8	Health promotion programmes.	1	2	3	
13.9	The treatment of substance abuse/addictions.	1	2	3	

D.2 Types of services to be rendered in an EAP (continues).

Please indicate how important each of the following statements is according to the following scale with reference to the types of services to be rendered in an EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

13.10 Assistance with burnout syndrome.	1	2	3	
13.11 Trauma debriefing counselling.	1	2	3	
13.12 Provide general therapeutic services.	1	2	3	
13.13 Teach basic life skills.	1	2	3	
13.14 Provide marriage therapy within the family context.	1	2	3	
13.15 Supervision of rehabilitation services such as Antabuse® dosage.	1	2	3	
13.16 Stress management.	1	2	3	
13.17 The approval of sick leave.	1	2	3	
13.18 Conflict management.	1	2	3	
13.19 Provide general rehabilitation services.	1	2	3	
13.20 Assistance with medical surveillance services of employees.	1	2	3	

Additional criteria

The following six statements deal with additional concepts for possible inclusion in the best-practice EAP, but didn't meet the criteria or were not identified during the focus group discussion. However, these concepts were identified for possible inclusion through the literature review process.

D.2 Types of services to be rendered in an EAP (continues).

Please indicate how important each of the following statements is according to the following scale with reference to the types of services to be rendered in an EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

13.21	Temporary incapacity management.	1	2	3	
13.22	Psychiatric services.	1	2	3	
13.23	Services to address relationship problems in the workplace.	1	2	3	
13.24	Support services to people who were involved in violence.	1	2	3	
13.25	Crisis management services.	1	2	3	
13.26	Management of Injury on Duty (IOD) cases.	1	2	3	
13.27	Any other comments on the type of services to be rendered in an EAP?				

Section E:**The evaluation of the EAP.**

This section deals with the evaluation of the EAP.

E.1 General requirement for the evaluation of an EAP.

Please indicate how important each of the following statements is according to the following scale with reference to the general requirements for the evaluation of an EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

14. The following general requirements must be considered / need to be included during the EAP evaluation process:				<u>COMMENTS</u>	
14.1	The time frames for the various evaluations must be defined.	1	2	3	
14.2	The entire programme should be evaluated.	1	2	3	
14.3	All evaluation processes must adhere to the confidentiality principles.	1	2	3	
14.4	The evaluation must be a continuous process.	1	2	3	
14.5	The person who will be responsible for the evaluation processes must be identified.	1	2	3	
14.6	A variety of methods of evaluation should be used.	1	2	3	
14.7	Any other comments on the general requirements for the evaluation of an EAP?				

E.2 The components of an EAP to be evaluated					
Please indicate how important each of the following statements is according to the following scale with reference to the specific components of the EAP to be evaluated: 1= Considered to be critical 2= Could be considered 3= Not to be considered Please mark the appropriate box with an X. Mark only one option.					
15. The following components of an EAP must be considered / need to be included in the evaluation of an EAP:				<u>COMMENTS</u>	
15.1	The general outcome of employees entered into the EAP.	1	2	3	
15.2	The financial implications of the EAP on the health care institution.	1	2	3	
15.3	The absenteeism profiles of employees in the health care institution.	1	2	3	
15.4	The various types of problems presented by employees for entering the EAP.	1	2	3	
15.5	Self evaluation of employees entered into the EAP.	1	2	3	
15.6	Self evaluation of the staff working for the EAP.	1	2	3	
15.7	The treatment protocols used for the various problems managed in the EAP.	1	2	3	
15.8	The productivity of the employee after entering the EAP.	1	2	3	
15.9	The identification of trends of certain problems in the health care institution.	1	2	3	
15.10	The value that is added to the health care institution by the program.	1	2	3	
15.11	The availability of an EAP.	1	2	3	
15.12	The level of confidentiality kept within the EAP.	1	2	3	
15.13	The appropriateness of the guidelines that were followed.	1	2	3	

E.2 The components of an EAP to be evaluated (continues).				
Please indicate how important each of the following statements is according to the following scale with reference to the specific components of the EAP to be evaluated: 1= Considered to be critical 2= Could be considered 3= Not to be considered Please mark the appropriate box with an X. Mark only one option.				
15.14	The degree of accessibility of the services of the EAP.	1	2	3
15.15	The general awareness amongst employees in the institution regarding the EAP with the services available.	1	2	3
15.16	The types of communication channels followed during the EAP activities.	1	2	3
15.17	The level of satisfaction of the customers of the EAP.	1	2	3
15.18	The effectiveness of the EAP.	1	2	3
15.19	An official follow-up of the employee being discharged from the EAP.	1	2	3
15.20	The utilisation of the EAP by those authorised to use the services of the EAP.	1	2	3
15.21	The personnel turnover in the health care institution.	1	2	3
15.22	The performance of the employee leaving the EAP over a specific period of time.	1	2	3
15.23	The application of certain criteria in the EAP such as inclusion and referral criteria.	1	2	3

Additional criteria

The following seven statements deal with additional concepts for possible inclusion in the best-practice EAP, but didn't meet the criteria or were not identified during the focus group. However, these concepts were identified for possible inclusion through the literature review process.

E.2 The components of an EAP to be evaluated (continues)

Please indicate how important each of the following statements is according to the following scale with reference to the specific components of the EAP to be evaluated:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

15.24	Response time of services rendered.	1	2	3	
15.25	The referrals to the EAP.	1	2	3	
15.26	The attitude of employees towards the EAP.	1	2	3	
15.27	The degree of compliance of employees within the EAP.	1	2	3	
15.28	The length of stay of an employee in the EAP.	1	2	3	
15.29	The progress made by the employee in the EAP.	1	2	3	
15.30	The relapse of employees previously treated in the EAP back into the EAP.	1	2	3	
15.31	Any other comments on the specific components of the EAP to be evaluated?				

E.3 The methods to be used for the evaluation of an EAP.

Please indicate how important each of the following statements is according to the following scale with reference to the specific methods to be used in the evaluation process of the EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

16. The following methods for the evaluation of an EAP must be taken into consideration / should be used in the process:					COMMENTS
16.1	The completion of questionnaires.	1	2	3	
16.2	Keeping of statistics.	1	2	3	
16.3	Formal feedback procedures.	1	2	3	
16.4	Surveys.	1	2	3	
16.5	Conducting interviews with the employee entered into the EAP.	1	2	3	
16.6	The utilisation of recognised performance management systems.	1	2	3	
16.7	The utilisation of formal evaluation instruments.	1	2	3	
16.8	The implementation of quality assurance cycles.	1	2	3	
16.9	The issuing of formal reports.	1	2	3	
16.10	Self-assessment methods for employees to assess how they are coping after entering the EAP.	1	2	3	
16.11	Formal record reviews.	1	2	3	

Additional criteria

The following 11 statements deal with additional concepts for possible inclusion in the best-practice EAP, but didn't meet the criteria or were not identified during the focus group. However, these concepts were identified for possible inclusion through the literature review process.

E.3 The methods to be used for the evaluation of an EAP (continues).

Please indicate how important each of the following statements is according to the following scale with reference to the specific methods to be used in the evaluation process of the EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

16.12 Interview with supervisors.	1	2	3	
16.13 Utilisation of lead indicators.	1	2	3	
16.14 Utilisation of lagging indicators.	1	2	3	
16.15 A formal audit process.	1	2	3	
16.16 Utilisation of qualitative evaluation methods.	1	2	3	
16.17 A cost-benefit analysis.	1	2	3	
16.18 Employees' health surveillance programmes.	1	2	3	
16.19 A benchmarking process.	1	2	3	
16.20 An accreditation process with standard settings.	1	2	3	
16.21 A total quality management (TQM) approach.	1	2	3	
16.22 A balance score card approach.	1	2	3	

16.23 Any other comments on the specific methods to be used in the evaluation of an EAP?

Thank you for completing this questionnaire.

Willem Kruger

Appendix H

Delphi survey questionnaire: Round 2
(individualised)

Head: Department of Community health

SCHOOL OF MEDICINE
FACULTY OF HEALTH SCIENCES
UNIVERSITY OF FREE STATE

ROUND 2

MARCH 16, 2010

Dear Delphi Participant,

Thank you very much for participating in the Delphi survey of this study and completing the first round questionnaire, which I have received. This is the survey for the 2nd round. Consensus was not achieved during the 1st round of the Delphi survey on the following questions and you need to re-assess your original rating.

Instructions for the completion of the questionnaire for Round 2

Each statement will have a score just below the rating scale. That is the number of experts rating that statement. Your score for that statement is indicated by a red colour. See the following examples as an illustration:

<u>Example:</u> Please indicate how important each of the following criteria is to be included in the framework for a best-practice EAP according to the following scale: 1= Considered to be critical 2= Could be considered 3= Not to be considered Please mark the appropriate box with an X. Mark only one option.				
1.1 An EAP is needed for health care sector.				
	$\frac{1}{6}$	$\frac{2}{4}$	$\frac{3}{2}$	<u>Comments:</u>

Six of the twelve experts rated this statement:
 “Considered to be critical” (giving it a rating of “1”)

Four of the twelve experts decided this statement “Could be considered” (giving it a rating of “2”). Because the overall score is highlighted in red, it means you are one of the four experts rated it as “2”.

Please re-assess your rating of each numbered statement, which can be regarded as criteria for the best-practice EAP and then indicate the importance thereof on the three-point scale. The specific points of the scale are defined as follows:

- 1 – Consider to be critical (this criterion must definitely be included in the best-practice framework).
- 2 – Could be considered (it does not matter if this criterion is included or left out from the best-practice framework).
- 3 – Not to be considered (this criterion must definitely be left out of the best-practice framework).

There are a few new questions in the questionnaire. Please make sure you rate all the new questions in the questionnaire as well.

If you complete the questionnaire in the electronic format, please type in a cross (X) underneath the point on the scale/overall score that represents your opinion on the specific indicator. If you complete the questionnaire in hard copy format (printed out), please write a cross (X) underneath the specific position of the scale.

As part of the design of the questionnaire, I have also included space for comments which can be utilised for each item. There will still be Comment column for specific criteria as well as Comment space at the end of each section to which you may comment in your own words in the space provided.

Please return the completed questionnaire by no later than 6 April 2010.

Yours sincerely,

Willem Kruger

Student no.: 1981280579

Section A:**INTRODUCTION OF AN EAP:**

This section deals with issues related to introductory statements to be included in an EAP.

A 1. The rationale for an EAP.

Please indicate how important each of the following criteria according to the following scale to be included in the rationale statement to have an EAP in a health care institution:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

1. The rationale section of an EAP for the health care sector needs to address / should include the following aspects:				Comments
1.1	To acknowledge the unique risky working environment for employees working in the health care sector.	<u>1</u> 9	<u>2</u> 3	<u>3</u> 0
1.2	To keep employees in an organisation healthy.	<u>1</u> 9	<u>2</u> 2	<u>3</u> 1
1.3				Consensus
1.4				Consensus
1.5				Consensus
1.6	Any other comments on the rationale to have an EAP in a health care institution?			

A 2. The objectives of an EAP.

Please indicate how important each of the following statements is according to the following scale with reference to the objectives of an EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

2. The objectives of an EAP for the health care sector needs to include / address the following aspects:				COMMENTS
2.1				Consensus
2.2	To improve the absenteeism profile of an organisation.	<u>1</u> 8	<u>2</u> 4	<u>3</u> 1
2.3				Consensus

A 2. The objectives of an EAP.

Please indicate how important each of the following statements is according to the following scale with reference to the objectives of an EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

2.4	To be used to retain employees in the organisation.	<u>1</u> 6	<u>2</u> 5	<u>3</u> 1	
2.5	(New) To provide a comprehensive assistance service that gives employees meaningful support.	<u>1</u>	<u>2</u>	<u>3</u>	
2.6	(New) To provide a service that is in line with the institution's core values including providing quality care to its patients.	<u>1</u>	<u>2</u>	<u>3</u>	
2.7	Any other comments on the objectives for an EAP?				

A.3 THE SCOPE OF THE EAP.

Please indicate how important each of the following criteria is according to the following scale with reference to the scope of the EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

3. The scope of the EAP must take into account / should address the following issues:				Comments
3.1				Consensus
3.2	Should be very broad with a variety of services provided.	<u>1</u> 5	<u>2</u> 5	<u>3</u> 2
3.3	Should be used to assist with appointment of employees.	<u>1</u> 3	<u>2</u> 4	<u>3</u> 5
3.4				Consensus
3.5				Consensus
3.6				Consensus
3.7	Should include the supportive involvement by top management in the programme.	<u>1</u> 8	<u>2</u> 8	<u>3</u> 2
3.8	Should include the management of sick leave usage.	<u>1</u> 7	<u>2</u> 4	<u>3</u> 1
3.9	Should consider the different cultures of employees when services within the EAP are provided.	<u>1</u> 9	<u>2</u> 1	<u>3</u> 2

A.3 THE SCOPE OF THE EAP.

Please indicate how important each of the following criteria is according to the following scale with reference to the scope of the EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

3.10	Should concentrate on employees' personal problems.	<u>1</u> 6	<u>2</u> 4	<u>3</u> 2	
3.11					Consensus
3.12	Should highlight the importance of getting to know the employees working in the institution through the EAP.	<u>1</u> 3	<u>2</u> 5	<u>3</u> 4	
3.13	(New) A clear explanation stating that the EAP is not an extended management tool but a neutral, independent program.	<u>1</u>	<u>2</u>	<u>3</u>	
3.14	(New) The scope of the EAP should be adjusted according to changing needs of the institution.	<u>1</u>	<u>2</u>	<u>3</u>	
3.15	Any other comments on the scope of the EAP?				

A.4 THE INTRODUCTORY STATEMENT FROM THE EXECUTIVE MANAGEMENT IN THE EAP.

Please indicate how important each of the following criteria is according to the following scale with reference to the introductory statement from Executive Management of the institution in the EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

4.	The introductory statement of Executive Management of the institution should include / address the following aspects:				Comments
4.1	The EAP does not replace the disciplinary procedures.	<u>1</u> 8	<u>2</u> 3	<u>3</u> 1	
4.2					Consensus
4.3	The process of entering the programme should not be seen as punitive or threatening.	<u>1</u> 9	<u>2</u> 2	<u>3</u> 1	
4.4					Consensus

A.4 THE INTRODUCTORY STATEMENT FROM THE EXECUTIVE MANAGEMENT IN THE EAP.

Please indicate how important each of the following criteria is according to the following scale with reference to the introductory statement from Executive Management of the institution in the EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

4.5	The importance of a work-based programme to assist employees with personal problems in the work place.	<u>1</u> 9	<u>2</u> 2	<u>3</u> 1	
4.6					Consensus
4.7					Consensus
4.8	(New) Emphasis should be placed on the fact that employees stay ultimately responsible for their own conduct	<u>1</u>	<u>2</u>	<u>3</u>	
4.9	Other comments on the introductory statement of the Executive Management in the EAP?				

Section B:

Structure and requirements for an EAP.

This section deals with issues related to the structures and requirements of an EAP.

B.1 Requirements of an in-house EAP committee.

Please indicate how important each of the following statements is according to the following scale with reference to an in-house EAP committee for a health care institution:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

5.	The requirements for an in-house EAP committee must take into account / needs to include the following aspects:	Comments			
5.1					Consensus
5.2					Consensus
5.3					Consensus
5.4	Any other comments on the requirements for an in-house EAP committee within an institution?				

B.2 The role of an in-house EAP committee.					
Please indicate how important each of the following statements is according to the following scale with reference to an in-house EAP committee for a health care institution: 1= Considered to be critical 2= Could be considered 3= Not to be considered Please mark the appropriate box with an X. Mark only one option.					
6 The role of an in-house EAP committee must include / address the following issues:				Comments	
6.1				Consensus	
6.2	To ensure that there is the necessary cooperation for the EAP to remain balanced.	<u>1</u> 8	<u>2</u> 3	<u>3</u> 1	
6.3	To be part of the formal evaluation of the EAP.	<u>1</u> 8	<u>2</u> 4	<u>3</u> 0	
6.4					Consensus
6.5	To be involved in the discussion of problematic cases/employees within the EAP.	<u>1</u> 5	<u>2</u> 2	<u>3</u> 5	
6.6					Consensus
6.7					Consensus
6.8	To maintain a link between the EAP and the health and safety committee especially regarding health risk assessments.	<u>1</u> 8	<u>2</u> 2	<u>3</u> 2	
6.9	To be involved in the training of relevant EAP stakeholders.	<u>1</u> 8	<u>2</u> 2	<u>3</u> 2	
6.10	Any other comments on the role of the in-house EAP committee within a health care institution?				

B.3 The service providers in an EAP.

Please indicate how important each of the following statements is according to the following scale with reference to the service providers of an EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

7 The manner in which services are provided in an EAP in a health care institution must take into account / needs to address the following aspects:					Comments
7.1	The services could be outsourced to a service provider independent of the health care institution.	<u>1</u> 5	<u>2</u> 5	<u>3</u> 2	
7.2	The services should be provided by an in-house service provider.	<u>1</u> 4	<u>2</u> 4	<u>3</u> 4	
7.3	The services should be provided within a multi-disciplinary team.	<u>1</u> 9	<u>2</u> 2	<u>3</u> 1	
7.4	The services could be a combination between an in-house service provider and an outside (outsourced) service provider.	<u>1</u> 4	<u>2</u> 5	<u>3</u> 3	
7.5	The appointment of a fulltime EAP facilitator in the health care institution to coordinate the activities of the EAP.	<u>1</u> 7	<u>2</u> 3	<u>3</u> 2	
7.5.1 (New)	The full time facilitator should be a social worker	<u>1</u>	<u>2</u>	<u>3</u>	
7.6	The EAP service providers can be appointed on a session basis.	<u>1</u> 2	<u>2</u> 6	<u>3</u> 4	
7.7	Any other comments on the types of the EAP providers?				

B.3 The characteristics of the service providers in an EAP.

Please indicate how important each of the following statements is according to the following scale with reference to the characteristics of the service providers in an EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

8 The following characteristics of the EAP providers need to be considered / should be addressed:					Comments
8.1					Consensus
8.2					Consensus
8.3					Consensus
8.4	Only senior level staff members should provide the necessary services in the EAP.	<u>1</u> 2	<u>2</u> 6	<u>3</u> 4	
8.5	A formal needs assessment should be conducted to determine the type of EAP services for the health care institution.	<u>1</u> 9	<u>2</u> 3	<u>3</u> 0	
8.6	The staff working in an EAP must be specialists in their respective fields.	<u>1</u> 6	<u>2</u> 4	<u>3</u> 2	
8.7					Consensus
8.8	All service providers in the EAP must be a professional service provider.	<u>1</u> 8	<u>2</u> 3	<u>3</u> 0	One expert didn't score the questions
8.9	The number of EAP providers should be based on the size of the health care institution.	<u>1</u> 6	<u>2</u> 4	<u>3</u> 1	One expert didn't score the questions
8.10	Any other comments on the characteristics of the EAP providers?				

B.3 The category of service providers in an EAP.					
Please indicate how important each of the following statements is according to the following scale with reference to the category of service providers in an EAP: 1= Considered to be critical 2= Could be considered 3= Not to be considered Please mark the appropriate box with an X. Mark only one option.					
9 The following category of staff members needs to be considered / included in an EAP team to render a service in a health care institution:				Comments	
9.1	Human resource officer.	<u>1</u> 5	<u>2</u> 4	<u>3</u> 3	
9.2	Psychologist.	<u>1</u> 9	<u>2</u> 2	<u>3</u> 1	
9.3					Consensus
9.4	Occupational therapist.	<u>1</u> 5	<u>2</u> 6	<u>3</u> 1	
9.5	Financial advisor.	<u>1</u> 7	<u>2</u> 4	<u>3</u> 1	
9.6	Legal advisor.	<u>1</u> 4	<u>2</u> 6	<u>3</u> 2	
9.7	Medical practitioner.	<u>1</u> 6	<u>2</u> 4	<u>3</u> 2	
9.8	Registered nurse.	<u>1</u> 3	<u>2</u> 7	<u>3</u> 2	
9.9	Religious/spiritual leader.	<u>1</u> 3	<u>2</u> 6	<u>3</u> 3	
9.10	Administrative staff member.	<u>1</u> 4	<u>2</u> 2	<u>3</u> 6	
9.11	Occupational health nurse.	<u>1</u> 7	<u>2</u> 5	<u>3</u> 0	
9.12	Psychiatrist.	<u>1</u> 2	<u>2</u> 5	<u>3</u> 5	
9.13	(New) A senior member of management	<u>1</u>	<u>2</u>	<u>3</u>	

B.3 The category of service providers in an EAP.

Please indicate how important each of the following statements is according to the following scale with reference to the category of service providers in an EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

9.14 (New) Union members	<u>1</u>	<u>2</u>	<u>3</u>	
9.15 (New) External service providers can be appointed on an as needed basis	<u>1</u>	<u>2</u>	<u>3</u>	
9.16 Any other comments on categories of staff members to be included in the EAP team to provide services in a health care institution?				

Section C:**Policies and procedures for an EAP.**

This section deals with issues related to policies and procedures for an EAP.

C.1 Requirements for policies and procedures.

Please indicate how important each of the following statements is according to the following scale with reference to the requirements for the policies and procedures for an EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

The following requirements must be considered / needs to be addressed when policies and procedures are developed for an EAP:				Comments
10.1				Consensus
10.2	A review of the basic conditions of services from the Department of Labour before drafting policies.	<u>1</u> 7	<u>2</u> 3	<u>3</u> 2
10.3	P			Consensus
10.4 (New)	Policies and procedures should be subjected to review every two years.	<u>1</u>	<u>2</u>	<u>3</u>
10.5 (New)	Policies and procedures should be accessible in an electronic format.	<u>1</u>	<u>2</u>	<u>3</u>
10.6 Any comments on the requirements for policies and procedures to be developed for an EAP?				

C.2 Types of policies and procedures.

Please indicate how important each of the following statements is according to the following scale with reference to the types of policies and procedures needed for an EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

11 The following type of policies and procedures for an EAP must be considered / needs to be developed:				COMMENTS	
11.1				Consensus	
11.2				Consensus	
11.3				Consensus	
11.4				Consensus	
11.5	The funding structure for services rendered within the EAP.	<u>1</u> 9	<u>2</u> 2	<u>3</u> 1	
11.6	The commitment needed from employees throughout the EAP.	<u>1</u> 9	<u>2</u> 2	<u>3</u> 1	
11.7	The individual treatment pathways to be followed for each employee entering the EAP.	<u>1</u> 5	<u>2</u> 6	<u>3</u> 1	
11.7.1	(New) The treatment options to be followed according to the specific reason for entering the EAP	<u>1</u>	<u>2</u>	<u>3</u>	
11.8	The management of possible manipulation/misuse of the EAP by the employee to his/her advantage.	<u>1</u> 9	<u>2</u> 2	<u>3</u> 1	
11.9					Consensus
11.10					Consensus
11.11					Consensus
11.12					Consensus
11.13					Consensus
11.14	The actions to be taken in the case of a relapse of an employee while in the EAP or after discharge.	<u>1</u> 9	<u>2</u> 2	<u>3</u> 1	
11.15	The formal written reports to be provided by EAP providers regarding the progress made by an employee in an EAP.	<u>1</u> 9	<u>2</u> 2	<u>3</u> 1	
11.15.1	(New) The circumstance as to the release of the formal written reports must be specified.	<u>1</u>	<u>2</u>	<u>3</u>	
11.16					Consensus

C.2 Types of policies and procedures.

Please indicate how important each of the following statements is according to the following scale with reference to the types of policies and procedures needed for an EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

11.16.1 (New) The EAP should not been seen as a mandate by management.	<u>1</u>	<u>2</u>	<u>3</u>	
11.17 An open door approach by supervisors to ensure availability of the supervisors to discuss problems with their employees.	<u>1</u> 7	<u>2</u> 3	<u>3</u> 2	
11.18				Consensus
11.19				Consensus
11.20				Consensus
11.21				Consensus
11.22				Consensus
11.23				Consensus
11.24 P				Consensus
11.25 (New) The monitoring and evaluation of the EAP.	<u>1</u>	<u>2</u>	<u>3</u>	
11.26 Any other comments on the type of policies and procedures needed for an EAP?				

Section D:**EAP processes and activities.**

This section deals with EAP processes and activities.

D.1 EAP ENTRY PROCESSES

Please indicate how important each of the following statements is according to the following scale with reference the entry processes for an EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

12 Processes regarding the entry of an employee into the EAP must address / needs to include the following:				Comments	
12.1				Consensus	
12.2	Poor work performance of the employee is identified.	<u>1</u> 9	<u>2</u> 2	<u>3</u> 1	
12.3	There must a formal admission policy and procedures document.	<u>1</u> 8	<u>2</u> 4	<u>3</u> 0	
12.4	Confirmation that a formal referral system was followed.	<u>1</u> 9	<u>2</u> 3	<u>3</u> 0	
12.5	A pre-entry interview with the employee should be performed by the supervisor.	<u>1</u> 3	<u>2</u> 2	<u>3</u> 7	
12.6	Confirmation that the person to be entered into the EAP is currently employed in the health care institution.	<u>1</u> 8	<u>2</u> 2	<u>3</u> 2	
12.7					Consensus
12.8					Consensus
12.9	A health profile of an employee is kept as part of the work place record.	<u>1</u> 9	<u>2</u> 0	<u>3</u> 3	
12.10	Any other comments on the entry processes for an EAP?				

D.2 Types of services to be rendered in an EAP.

Please indicate how important each of the following statements is according to the following scale with reference to the types of services to be rendered in an EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

13 The following type of services for an EAP must be considered / needs to be included in the programme:				<u>COMMENTS</u>
13.1 Financial advisory services.	<u>1</u> 6	<u>2</u> 5	<u>3</u> 1	
13.2				Consensus
13.3 Participation in in-service training programmes of the health care institution for all the employees.	<u>1</u> 9	<u>2</u> 2	<u>3</u> 1	
13.4 Chronic disease management.	<u>1</u> 6	<u>2</u> 5	<u>3</u> 1	
13.5				Consensus
13.6				Consensus
13.7 A follow-up service for a certain period of time after the initial sessions.	<u>1</u> 7	<u>2</u> 4	<u>3</u> 1	
13.8				Consensus
13.9				Consensus
13.10 Assistance with burnout syndrome.	<u>1</u> 9	<u>2</u> 2	<u>3</u> 1	
13.11				Consensus
13.12 Provide general therapeutic services.	<u>1</u> 5	<u>2</u> 5	<u>3</u> 2	
13.13 Teach basic life skills.	<u>1</u> 7	<u>2</u> 4	<u>3</u> 1	
13.14 Provide marriage therapy within the family context.	<u>1</u> 5	<u>2</u> 7	<u>3</u> 0	
13.15 Supervision of rehabilitation services such as Antabuse® dosage.	<u>1</u> 7	<u>2</u> 2	<u>3</u> 3	
13.16				Consensus
13.17 The approval of sick leave.	<u>1</u> 1	<u>2</u> 2	<u>3</u> 9	

D.2 Types of services to be rendered in an EAP.

Please indicate how important each of the following statements is according to the following scale with reference to the types of services to be rendered in an EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

13.18	Conflict management.	<u>1</u> 5	<u>2</u> 6	<u>3</u> 1	
13.19	Provide general rehabilitation services.	<u>1</u> 2	<u>2</u> 3	<u>3</u> 6	You didn't score the question (uncertainty)—general rehabilitation means rehabilitation services for employees who develop a disability in the work place.
13.20	Assistance with medical surveillance services of employees.	<u>1</u> 2	<u>2</u> 8	<u>3</u> 2	

Additional criteria

The following six statements deal with additional concepts for possible inclusion in the best-practice EAP, but didn't meet the criteria or were not identified during the focus group discussion. However, these concepts were identified for possible inclusion through the literature review process.

D.2 Types of services to be rendered in an EAP (continues).

Please indicate how important each of the following statements is according to the following scale with reference to the types of services to be rendered in an EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

13.21	Temporary incapacity management.	<u>1</u> 4	<u>2</u> 7	<u>3</u> 1	
13.22	Psychiatric services.	<u>1</u> 1	<u>2</u> 8	<u>3</u> 3	
13.23	Services to address relationship problems in the workplace.	<u>1</u> 6	<u>2</u> 4	<u>3</u> 2	
13.24	Support services to people who were involved in violence.	<u>1</u> 7	<u>2</u> 4	<u>3</u> 1	
13.25	Crisis management services.	<u>1</u> 9	<u>2</u> 2	<u>3</u> 1	

D.2 Types of services to be rendered in an EAP (continues).

Please indicate how important each of the following statements is according to the following scale with reference to the types of services to be rendered in an EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

13.26	Management of Injury on Duty (IOD) cases.	<u>1</u> 1	<u>2</u> 8	<u>3</u> 3	
13.27	(New) Provide general supportive services such as visiting Department of Home Affairs for Identification documents, birth registrations, passport and motor car registration.	<u>1</u>	<u>2</u>	<u>3</u>	
13.28	(New) Initial individual session should be viewed as a referral tool to appropriate resources.	<u>1</u>	<u>2</u>	<u>3</u>	
13.29	Any other comments on the type of services to be rendered in an EAP?				

Section E:**The evaluation of the EAP.**

This section deals with the evaluation of the EAP.

E.1 General requirement for the evaluation of an EAP.

Please indicate how important each of the following statements is according to the following scale with reference to the general requirements for the evaluation of an EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

14	The following general requirements must be considered / need to be included during the EAP evaluation process:	COMMENTS		
14.1				Consensus
14.2				Consensus
14.3				Consensus
14.4				Consensus
14.5				Consensus
14.6				Consensus
14.7	Any other comments on the general requirements for the evaluation of an EAP?			

E.2 The components of an EAP to be evaluated

Please indicate how important each of the following statements is according to the following scale with reference to the specific components of the EAP to be evaluated:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

15 The following components of an EAP must be considered / need to be included in the evaluation of an EAP:				<u>COMMENTS</u>	
15.1				Consensus	
15.2				Consensus	
15.3	The absenteeism profiles of employees in the health care institution.	<u>1</u> 7	<u>2</u> 4	<u>3</u> 1	
15.4				Consensus	
15.5	Self evaluation of employees entered into the EAP.	<u>1</u> 8	<u>2</u> 4	<u>3</u> 0	
15.6	Self evaluation of the staff working for the EAP.	<u>1</u> 7	<u>2</u> 4	<u>3</u> 1	
15.7	The treatment protocols used for the various problems managed in the EAP.	<u>1</u> 9	<u>2</u> 3	<u>3</u> 0	
15.8				Consensus	
15.9				Consensus	
15.10				Consensus	
15.11				Consensus	
15.12				Consensus	
15.13				Consensus	
15.14				Consensus	
15.15	The general awareness amongst employees in the institution regarding the EAP with the services available.	<u>1</u> 9	<u>2</u> 3	<u>3</u> 0	
15.16	The types of communication channels followed during the EAP activities.	<u>1</u> 9	<u>2</u> 2	<u>3</u> 1	
15.17				Consensus	
15.18				Consensus	
15.19				Consensus	
15.20	The utilisation of the EAP by those authorised to use the services of the EAP.	<u>1</u> 7	<u>2</u> 5	<u>3</u> 0	

E.2 The components of an EAP to be evaluated

Please indicate how important each of the following statements is according to the following scale with reference to the specific components of the EAP to be evaluated:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

15.21	The personnel turnover in the health care institution.	<u>1</u> 9	<u>2</u> 3	<u>3</u> 0	
15.22					Consensus
15.23	The application of certain criteria in the EAP such as inclusion and referral criteria.	<u>1</u> 9	<u>2</u> 3	<u>3</u> 0	

Additional criteria

The following seven statements deal with additional concepts for possible inclusion in the best-practice EAP, but didn't meet the criteria or were not identified during the focus group. However, these concepts were identified for possible inclusion through the literature review process.

E.2 The components of an EAP to be evaluated (continues)

Please indicate how important each of the following statements is according to the following scale with reference to the specific components of the EAP to be evaluated:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

15.24					Consensus
15.25					Consensus
15.26	The attitude of employees towards the EAP.	<u>1</u> 8	<u>2</u> 4	<u>3</u> 0	
15.27	The degree of compliance of employees within the EAP.	<u>1</u> 8	<u>2</u> 4	<u>3</u> 0	
15.28	The length of stay of an employee in the EAP.	<u>1</u> 9	<u>2</u> 3	<u>3</u> 0	
15.29	The progress made by the employee in the EAP.	<u>1</u> 9	<u>2</u> 2	<u>3</u> 1	
15.30	The relapse of employees previously treated in the EAP back into the EAP.	<u>1</u> 9	<u>2</u> 2	<u>3</u> 1	

15.31 Any other comments on the specific components of the EAP to be evaluated?

E.3 The methods to be used for the evaluation of an EAP.

Please indicate how important each of the following statements is according to the following scale with reference to the specific methods to be used in the evaluation process of the EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

16 The following methods for the evaluation of an EAP must be taken into consideration / should be used in the process:				<u>COMMENTS</u>
16.1 The completion of questionnaires.	<u>1</u> 5	<u>2</u> 7	<u>3</u> 0	
16.2				Consensus
16.3				Consensus
16.4 Surveys.	<u>1</u> 6	<u>2</u> 4	<u>3</u> 2	
16.5 Conducting interviews with the employee entered into the EAP.	<u>1</u> 5	<u>2</u> 5	<u>3</u> 2	
16.6 The utilisation of recognised performance management systems.	<u>1</u> 5	<u>2</u> 4	<u>3</u> 3	
16.7 The utilisation of formal evaluation instruments.	<u>1</u> 8	<u>2</u> 3	<u>3</u> 1	
16.8 The implementation of quality assurance cycles.	<u>1</u> 8	<u>2</u> 4	<u>3</u> 0	
16.9 The issuing of formal reports.	<u>1</u> 9	<u>2</u> 3	<u>3</u> 0	
16.10 Self-assessment methods for employees to assess how they are coping after entering the EAP.	<u>1</u> 7	<u>2</u> 5	<u>3</u> 0	
16.11 Formal record reviews.	<u>1</u> 8	<u>2</u> 4	<u>3</u> 0	

Additional criteria

The following 11 statements deal with additional concepts for possible inclusion in the best-practice EAP, but didn't meet the criteria or were not identified during the focus group. However, these concepts were identified for possible inclusion through the literature review process.

E.3 The methods to be used for the evaluation of an EAP (continues).

Please indicate how important each of the following statements is according to the following scale with reference to the specific methods to be used in the evaluation process of the EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

16.12	Interview with supervisors.	<u>1</u> 5	<u>2</u> 5	<u>3</u> 2	
16.13	Utilisation of lead indicators.	<u>1</u> 8	<u>2</u> 4	<u>3</u> 0	
16.14	Utilisation of lagging indicators.	<u>1</u> 8	<u>2</u> 4	<u>3</u> 0	
16.15	A formal audit process.	<u>1</u> 9	<u>2</u> 2	<u>3</u> 1	
16.16	Utilisation of qualitative evaluation methods.	<u>1</u> 9	<u>2</u> 2	<u>3</u> 1	
16.17	A cost-benefit analysis.	<u>1</u> 7	<u>2</u> 5	<u>3</u> 0	
16.18	Employees' health surveillance programmes.	<u>1</u> 5	<u>2</u> 5	<u>3</u> 2	
16.19	A benchmarking process.	<u>1</u> 8	<u>2</u> 4	<u>3</u> 0	
16.20	An accreditation process with standard settings.	<u>1</u> 5	<u>2</u> 5	<u>3</u> 2	
16.21	A total quality management (TQM) approach.	<u>1</u> 6	<u>2</u> 6	<u>3</u> 0	

E.3 The methods to be used for the evaluation of an EAP (continues).

Please indicate how important each of the following statements is according to the following scale with reference to the specific methods to be used in the evaluation process of the EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

16.22 A balance score card approach.	<u>1</u> 5	<u>2</u> 7	<u>3</u> 0	
16.23 (New) The utilisation of only a few indicators to monitor the impact of the EAP on a monthly basis.	<u>1</u>	<u>2</u>	<u>3</u>	
16.24 Any other comments on the specific methods to be used in the evaluation of an EAP?				

Thank you for completing this questionnaire: Round 2.

Willem Kruger

Appendix I

Delphi survey individualised report on consensus/stability: Round 1 for Expert #1

**HEAD: DEPARTMENT OF COMMUNITY HEALTH
SCHOOL OF MEDICINE
FACULTY OF HEALTH SCIENCES
UNIVERSITY OF FREE STATE**

ROUND 2

MARCH 30, 2010

Dear Delphi Participant,

Thank you very much for participating in the Delphi survey of this study and completing the first round questionnaire, which I have received. This is the outcome of the 1st round of the Delphi survey and we achieved consensus on the following statements/questions.

The overall score for each statement/question is given just below the rating number. The colour code (red) is an indication of which rating you gave to that particular statement/question. You will see some numbers in the table without statements. Those are the statements which were sent to earlier to re-assess your rating because consensus was not achieved. You don't need to be concerned.

Just to remind you – this is just the outcome of the first round on the statements/questions where consensus was achieved. **You don't need to rate the statements/questions again.**

Yours sincerely,

Willem Kruger

Student no.: 1981280579



FACULTY OF HEALTH SCIENCES

DELPHI PROCESS FOR PH.D. ON A FRAMEWORK FOR BEST-PRACTICE EAP AND QUALITY ASSURANCE FOR THE HEALTH CARE SECTOR

Delphi Process:

Round 2

The questionnaire will be anonymous to other participants. Only the researcher will know your identity and he will do everything possible to protect your identity.

There will be **five** sections to be completed. Instructions will be supplied with each group of questions.

<u>Example:</u> Please indicate how important each of the following criteria is to be included in the framework for a best-practice EAP according to the following scale: 1= Considered to be critical 2= Could be considered 3= Not to be considered Please mark the appropriate box with an X. Mark only one option.				<u>Comments:</u>
1.1 An EAP is needed for health care sector.	1 10	2 1	3 1	

The colour red indicates you are one of 10 experts rating the question as “1”

Section A:**INTRODUCTION OF AN EAP:**

This section deals with issues related to introductory statements to be included in an EAP.

A 1. The rationale for an EAP.

Please indicate how important each of the following criteria according to the following scale to be included in the rationale statement to have an EAP in a health care institution:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

1. The rationale section of an EAP for the health care sector needs to address / should include the following aspects:					Comments
1.1					
1.2					
1.3	To ensure optimal productivity of employees.	1 10	2 2	3 0	
1.4	To emphasise that employees are one of the most valuable resources of an organisation.	1 10	2 1	3 1	
1.5	To recognise the need to support employees in the work place with specific problems/issues.	1 11	2 1	3 0	
1.6	Any other comments on the rationale to have an EAP in a health care institution?				

A 2. The objectives of an EAP.

Please indicate how important each of the following statements is according to the following scale with reference to the objectives of an EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

2. The objectives of an EAP for the health care sector needs to include / address the following aspects:					COMMENTS
2.1	To provide a good support network for employees at work.	1 11	2 0	3 1	
2.2					
2.3	To provide a service where an employee feels free to speak to somebody who will listen to their problems.	1 10	2 1	3 1	
2.4					
2.5	Any other comments on the objectives for an EAP?				

A.3 THE SCOPE OF THE EAP.

Please indicate how important each of the following criteria is according to the following scale with reference to the scope of the EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

3. The scope of the EAP must take into account / should address the following issues:				Comments	
3.1	A clear explanation as to the services to be provided to employees with their extended families.	1 11	2 0	3 1	
3.2					
3.3					
3.4	Should ensure that the services of the EAP are accessible to all those that are stipulated in the policy.	1 11	2 1	3 0	
3.5	Should ensure that the EAP must provide the best type of services available.	1 10	2 2	3 0	
3.6	Should view employees in a holistic manner.	1 11	2 1	3 1	
3.7					
3.8					
3.9					
3.10					
3.11	Should concentrate on employees' work related problems.	1 10	2 2	3 0	
3.12					
3.13	Any other comments on the scope of the EAP?				

A.4 THE INTRODUCTORY STATEMENT FROM THE EXECUTIVE MANAGEMENT IN THE EAP.

Please indicate how important each of the following criteria is according to the following scale with reference to the introductory statement from Executive Management of the institution in the EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

4. The introductory statement of Executive Management of the institution should include / address the following aspects:					Comments
4.1					
4.2	The critical supportive role of Executive Management of the health care institution in the programme.	1 11	2 1	3 0	
4.3					
4.4	There should be an emphasis on the general well-being of employees in order for them to be productive in the workplace.	1 11	2 1	3 0	
4.5					
4.6	An explanation of the roles of the employer within the EAP.	1 10	2 2	3 0	
4.7	Clarification on the services that are offered within the EAP.	1 11	2 1	3 0	
4.8	Other comments on the introductory statement of the Executive Management in the EAP?				

Section B:**Structure and requirements for an EAP.**

This section deals with issues related to the structures and requirements of an EAP.

B.1 Requirements of an in-house EAP committee.

Please indicate how important each of the following statements is according to the following scale with reference to an in-house EAP committee for a health care institution:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

5. The requirements for an in-house EAP committee must take into account / needs to include the following aspects:				Comments
5.1 The formal establishment of a multi-disciplinary membership of the committee.	1 10	2 2	3 0	
5.2 Clear explanations of the practical functioning of the committee within the institution.	1 11	2 1	3 0	
5.3 A clearly formulated mandate of the committee.	1 12	2 0	3 0	
5.4 Any other comments on the requirements for an in-house EAP committee within an institution?				

B.2 The role of an in-house EAP committee.

Please indicate how important each of the following statements is according to the following scale with reference to an in-house EAP committee for a health care institution:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

6. The role of an in-house EAP committee must include / address the following issues:					Comments
6.1	To participate in the development of the policies and procedures documents for the EAP.	1 10	2 2	3 0	
6.2					
6.3					
6.4	To assist with the maintenance of communication lines within the EAP.	1 11	2 1	3 0	
6.5					
6.6	To play a role in the identification of certain trends regarding referrals to the EAP.	1 10	2 2	3 0	
6.7	To emphasise the commitment from the EAP committee regarding the support services provided by the EAP to employees.	1 10	2 1	3 1	
6.8					
6.9					
6.10	Any other comments on the role of the in-house EAP committee within a health care institution?				

B.3 The service providers in an EAP.

Please indicate how important each of the following statements is according to the following scale with reference to the service providers of an EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

7. The manner in which services are provided in an EAP in a health care institution must take into account / needs to address the following aspects:					Comments
7.1					
7.2					
7.3					
7.4					
7.5					
7.6					
7.7	Any other comments on the types of the EAP providers?				

B.3 The characteristics of the service providers in an EAP.

Please indicate how important each of the following statements is according to the following scale with reference to the characteristics of the service providers in an EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

8. The following characteristics of the EAP providers need to be considered / should be addressed:					Comments
8.1	The EAP service providers should be able to create a relationship with clients based on trust.	1 12	2 0	3 0	
8.2	The staff providing the services in an EAP must have the appropriate training to render a particular service within an EAP.	1 12	2 0	3 0	
8.3	The EAP providers must have the necessary background knowledge of the health care institution in which they provide the services.	1 11	2 1	3 0	
8.4					
8.5					
8.6					
8.7	All service providers in the EAP must be knowledgeable in their field.	1 11	2 0	3 1	
8.8					
8.9					
8.10	Any other comments on the characteristics of the EAP providers?				

B.3 The category of service providers in an EAP.

Please indicate how important each of the following statements is according to the following scale with reference to the category of service providers in an EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

9. The following category of staff members needs to be considered / included in an EAP team to render a service in a health care institution:					Comments
9.1					
9.2					
9.3	Social worker.	1 12	2 0	3 0	
9.4					
9.5					
9.6					

B.3 The category of service providers in an EAP.

Please indicate how important each of the following statements is according to the following scale with reference to the category of service providers in an EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

9.7				
9.8				
9.9				
9.10				
9.11				
9.12				
9.13	Any other comments on categories of staff members to be included in the EAP team to provide services in a health care institution?			

Section C:**Policies and procedures for an EAP.**

This section deals with issues related to policies and procedures for an EAP.

C.1 Requirements for policies and procedures.

Please indicate how important each of the following statements is according to the following scale with reference to the requirements for the policies and procedures for an EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

10. The following requirements must be considered / needs to be addressed when policies and procedures are developed for an EAP:					Comments
10.1	A step-by-step approach is needed in the development of guidelines.	1 12	2 0	3 0	
10.2					
10.3	Policies should be available in a written format.	1 11	2 1	3 0	
10.4	Any comments on the requirements for policies and procedures to be developed for an EAP?				

C.2 Types of policies and procedures.

Please indicate how important each of the following statements is according to the following scale with reference to the types of policies and procedures needed for an EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

11. The following type of policies and procedures for an EAP must be considered / needs to be developed:					<u>COMMENTS</u>
11.1	The role/responsibilities of the supervisor regarding all the activities of the EAP.	1 10	2 2	3 0	
11.2	The principles regarding confidentiality of the information generated.	1 12	2 0	3 0	
11.3	The administrative aspects regarding the referral of an employee to the EAP.	1 10	2 2	3 0	
11.4	The responsibilities of the employee when entering the EAP.	1 10	2 2	3 0	
11.5					
11.6					
11.7					
11.8					
11.9	The communication channels to be followed by everybody in order to get assisted.	1 12	2 0	3 0	
11.10	The description of the method of self-referral of an employee to the EAP.	1 12	2 0	3 0	
11.11	The formal feedback system between all stakeholders involved with employees in the EAP.	1 12	2 0	3 0	
11.12	The resources to be put in place in order to render EAP services in the health care institution.	1 10	2 2	3 0	
11.13	The formal communication lines between EAP provider and supervisors regarding employees in the EAP.	1 11	2 1	3 0	
11.14					
11.15					
11.16	The steps to be followed regarding any type of non-compliance by an employee while being in an EAP.	1 10	2 0	3 2	
11.17					
11.18	The principle of voluntary entry by the employee into the EAP.	1 10	2 2	3 0	
11.19	Clear guidelines on who may access/use the services of the EAP.	1 11	2 1	3 0	
11.20	Whether employees are to attend EAP activities/services during their official work time.	1 11	2 1	3 0	

C.2 Types of policies and procedures.

Please indicate how important each of the following statements is according to the following scale with reference to the types of policies and procedures needed for an EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

11.21	The time frame for how long the employee can continue with the EAP activities including the follow-up afterwards.	1 12	2 0	3 0	
11.22	The description of the method of referrals of an employee to the EAP by the employer.	1 11	2 1	3 0	
11.23	The requirement of signed consent from an employee before he/she enters the EAP.	1 11	2 0	3 1	
11.24	The principles regarding the governance of the EAP.	1 10	2 2	3 0	
11.25	Any other comments on the type of policies and procedures needed for an EAP?				

Section D:**EAP processes and activities.**

This section deals with EAP processes and activities.

D.1 EAP ENTRY PROCESSES

Please indicate how important each of the following statements is according to the following scale with reference the entry processes for an EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

12. Processes regarding the entry of an employee into the EAP must address / needs to include the following:				Comments	
12.1	An initial assessment of the employee and his/her problem/situation is performed.	1 12	2 0	3 0	
12.2					
12.3					
12.4					
12.5					
12.6					
12.7	There should be a differentiation between a new and a repeat problem as presented by the employee.	1 10	2 2	3 0	
12.8	The seriousness of the problem/case must be determined.	1 12	2 0	3 0	
12.9					
12.10	Any other comments on the entry processes for an EAP?				

D.2 Types of services to be rendered in an EAP.

Please indicate how important each of the following statements is according to the following scale with reference to the types of services to be rendered in an EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

13. The following type of services for an EAP must be considered / needs to be included in the programme:				<u>COMMENTS</u>
13.1				
13.2 General pro-active preventative programmes.	1 11	2 0	3 1	
13.3				
13.4				
13.5 General counselling services.	1 11	2 0	3 1	
13.6 A referral function to additional resources/services.	1 11	2 0	3 1	
13.7				
13.8 Health promotion programmes.	1 11	2 0	3 1	
13.9 The treatment of substance abuse/addictions.	1 10	2 1	3 1	
13.10				
13.11 Trauma debriefing counselling.	1 10	2 2	3 0	
13.12				
13.13				
13.14				
13.15				
13.16 Stress management.	1 10	2 2	3 0	
13.17				
13.18				
13.19				
13.20				

Additional criteria

The following six statements deal with additional concepts for possible inclusion in the best-practice EAP, but didn't meet the criteria or were not identified during the focus group discussion. However, these concepts were identified for possible inclusion through the literature review process.

D.2 Types of services to be rendered in an EAP (continues).

Please indicate how important each of the following statements is according to the following scale with reference to the types of services to be rendered in an EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

13.21				
13.22				
13.23				
13.24				
13.25				
13.26				
13.27	Any other comments on the type of services to be rendered in an EAP?			

Section E:**The evaluation of the EAP.**

This section deals with the evaluation of the EAP.

E.1 General requirement for the evaluation of an EAP.

Please indicate how important each of the following statements is according to the following scale with reference to the general requirements for the evaluation of an EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

14. The following general requirements must be considered / need to be included during the EAP evaluation process:					<u>COMMENTS</u>
14.1	The time frames for the various evaluations must be defined.	1 10	2 2	3 0	
14.2	The entire programme should be evaluated.	1 11	2 1	3 0	
14.3	All evaluation processes must adhere to the confidentiality principles.	1 12	2 0	3 0	
14.4	The evaluation must be a continuous process.	1 10	2 2	3 0	
14.5	The person who will be responsible for the evaluation processes must be identified.	1 10	2 1	3 1	
14.6	A variety of methods of evaluation should be used.	1 10	2 1	3 1	
14.7	Any other comments on the general requirements for the evaluation of an EAP?				

E.2 The components of an EAP to be evaluated					
Please indicate how important each of the following statements is according to the following scale with reference to the specific components of the EAP to be evaluated: 1= Considered to be critical 2= Could be considered 3= Not to be considered Please mark the appropriate box with an X. Mark only one option.					
15. The following components of an EAP must be considered / need to be included in the evaluation of an EAP:					<u>COMMENTS</u>
15.1	The general outcome of employees entered into the EAP.	1 12	2 0	3 0	
15.2	The financial implications of the EAP on the health care institution.	1 10	2 1	3 0	
15.3					
15.4	The various types of problems presented by employees for entering the EAP.	1 10	2 2	3 0	
15.5					
15.6					
15.7					
15.8	The productivity of the employee after entering the EAP.	1 10	2 1	3 1	
15.9	The identification of trends of certain problems in the health care institution.	1 12	2 0	3 0	
15.10	The value that is added to the health care institution by the program.	1 12	2 0	3 0	
15.11	The availability of an EAP.	1 11	2 1	3 0	
15.12	The level of confidentiality kept within the EAP.	1 12	2 0	3 0	
15.13	The appropriateness of the guidelines that were followed.	1 10	2 2	3 0	
15.14	The degree of accessibility of the services of the EAP.	1 12	2 0	3 0	
15.15					
15.16					
15.17	The level of satisfaction of the customers of the EAP.	1 10	2 2	3 0	
15.18	The effectiveness of the EAP.	1 12	2 0	3 0	
15.19	An official follow-up of the employee being discharged from the EAP.	1 10	2 1	3 1	

E.2 The components of an EAP to be evaluated

Please indicate how important each of the following statements is according to the following scale with reference to the specific components of the EAP to be evaluated:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

15.20				
15.21				
15.22 The performance of the employee leaving the EAP over a specific period of time.	1 10	2 1	3 1	
15.23				

Additional criteria

The following seven statements deal with additional concepts for possible inclusion in the best-practice EAP, but didn't meet the criteria or were not identified during the focus group. However, these concepts were identified for possible inclusion through the literature review process.

E.2 The components of an EAP to be evaluated (continues)

Please indicate how important each of the following statements is according to the following scale with reference to the specific components of the EAP to be evaluated:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

15.24 Response time of services rendered.	1 12	2 0	3 0	
15.25 The referrals to the EAP.	1 10	2 2	3 0	
15.26				
15.27				
15.28				
15.29				
15.30				
15.31 Any other comments on the specific components of the EAP to be evaluated?				

E.3 The methods to be used for the evaluation of an EAP.

Please indicate how important each of the following statements is according to the following scale with reference to the specific methods to be used in the evaluation process of the EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

16. The following methods for the evaluation of an EAP must be taken into consideration / should be used in the process:				<u>COMMENTS</u>
16.1				
16.2 Keeping of statistics.	1 12	2 0	3 0	
16.3 Formal feedback procedures.	1 10	2 1	3 1	
16.4				
16.5				
16.6				
16.7				
16.8				
16.9				
16.10				
16.11				

Additional criteria

The following 11 statements deal with additional concepts for possible inclusion in the best-practice EAP, but didn't meet the criteria or were not identified during the focus group. However, these concepts were identified for possible inclusion through the literature review process.

E.3 The methods to be used for the evaluation of an EAP (continues).

Please indicate how important each of the following statements is according to the following scale with reference to the specific methods to be used in the evaluation process of the EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

16.12				
16.13				
16.14				
16.15				
16.16				
16.17				
16.18				
16.19				
16.20				
16.21				
16.22				

16.23 Any other comments on the specific methods to be used in the evaluation of an EAP?

Appendix J

Delphi survey: Final Report

**EAD: DEPARTMENT OF COMMUNITY HEALTH
SCHOOL OF MEDICINE
FACULTY OF HEALTH SCIENCES
UNIVERSITY OF FREE STATE**

Delphi Process:

Final report

Section A:

INTRODUCTION OF AN EAP:

This section deals with issues related to introductory statements to be included in an EAP.

A 1. The rationale for an EAP.

Please indicate how important each of the following criteria according to the following scale to be included in the rationale statement to have an EAP in a health care institution:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

1. The rationale section of an EAP for the health care sector needs to address / should include the following aspects:					Comments
1.1	To acknowledge the unique risky working environment for employees working in the health care sector.	1 11	2 1	3 0	Consensus Round 2
1.2	To keep employees in an organisation healthy.	1 10	2 1	3 1	Consensus Round 2
1.3	To ensure optimal productivity of employees.	1 10	2 2	3 0	Consensus Round 1
1.4	To emphasise that employees are one of the most valuable resources of an organisation.	1 10	2 1	3 1	Consensus Round 1
1.5	To recognise the need to support employees in the work place with specific problems/issues.	1 11	2 1	3 0	Consensus Round 1
1.6	Any other comments on the rationale to have an EAP in a health care institution?				

A 2. The objectives of an EAP.					
2. The objectives of an EAP for the health care sector needs to include / address the following aspects:					COMMENTS
2.1	To provide a good support network for employees at work.	1 11	2 0	3 1	Consensus Round 1
2.2	To improve the absenteeism profile of an organisation.	1 10	2 2	3 0	Consensus Round 2
2.3	To provide a service where an employee feels free to speak to somebody who will listen to their problems.	1 10	2 1	3 1	Consensus Round 1
2.4	To be used to retain employees in the organisation.	1 11	2 0	3 1	Consensus Round 3
2.5	(New Round 2) To provide a comprehensive assistance service that gives employees meaningful support.	1 11	2 1	3 0	Consensus Round 2
2.6	(New Round 2) To provide a service that is in line with the institution's core values including providing quality care to its patients.	1 11	2 1	3 0	Consensus Round 4
2.7	Any other comments on the objectives for an EAP?				

A.3 THE SCOPE OF THE EAP.

Please indicate how important each of the following criteria is according to the following scale with reference to the scope of the EAP:
1= Considered to be critical
2= Could be considered
3= Not to be considered
Please mark the appropriate box with an X. Mark only one option.

3.	The scope of the EAP must take into account / should address the following issues:				Comments
3.1	A clear explanation as to the services to be provided to employees with their extended families.	1 11	2 0	3 1	Consensus Round 1
3.2	Should be very broad with a variety of services provided.	1 9	2 2	3 1	Stability Round 5
3.3	Should be used to assist with appointment of employees.	1 0	2 2	3 10	Consensus Round 6
3.4	Should ensure that the services of the EAP are accessible to all those that are stipulated in the policy.	1 11	2 1	3 0	Consensus Round 1
3.5	Should ensure that the EAP must provide the best type of services available.	1 10	2 2	3 0	Consensus Round 1
3.6	Should view employees in a holistic manner.	1 11	2 1	3 0	Consensus Round 1
3.7	Should include the supportive involvement by top management in the programme.	1 10	2 1	3 1	Consensus Round 2

A.3 THE SCOPE OF THE EAP.

Please indicate how important each of the following criteria is according to the following scale with reference to the scope of the EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

3.8	Should include the management of sick leave usage.	<u>1</u> 10	<u>2</u> 2	<u>3</u> 0	Consensus Round 2
3.9	Should consider the different cultures of employees when services within the EAP are provided.	<u>1</u> 11	<u>2</u> 0	<u>3</u> 1	Consensus Round 3
3.10	Should concentrate on employees' personal problems.	<u>1</u> 11	<u>2</u> 0	<u>3</u> 1	Consensus Round 4
3.11	Should concentrate on employees' work related problems.	<u>1</u> 10	<u>2</u> 2	<u>3</u> 1	Consensus Round 1
3.12	Should highlight the importance of getting to know the employees working in the institution through the EAP.	<u>1</u> 0	<u>2</u> 10	<u>3</u> 2	Consensus Round 3
3.13	(New Round 2) A clear explanation stating that the EAP is not an extended management tool but a neutral, independent program.	<u>1</u> 10	<u>2</u> 1	<u>3</u> 1	Consensus Round 2
3.14	(New Round 2) The scope of the EAP should be adjusted according to changing needs of the institution.	<u>1</u> 10	<u>2</u> 2	<u>3</u> 0	Consensus Round 3
3.15	Any other comments on the scope of the EAP?				

A.4 THE INTRODUCTORY STATEMENT FROM THE EXECUTIVE MANAGEMENT IN THE EAP.

Please indicate how important each of the following criteria is according to the following scale with reference to the introductory statement from Executive Management of the institution in the EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

4.	The introductory statement of Executive Management of the institution should include / address the following aspects:					Comments
4.1	The EAP does not replace the disciplinary procedures.	<u>1</u> 11	<u>2</u> 0	<u>3</u> 1		Consensus Round 3
4.2	The critical supportive role of Executive Management of the health care institution in the programme.	<u>1</u> 11	<u>2</u> 1	<u>3</u> 0		Consensus Round 1
4.3	The process of entering the programme should not be seen as punitive or threatening.	<u>1</u> 10	<u>2</u> 1	<u>3</u> 1		Consensus Round 2

A.4 THE INTRODUCTORY STATEMENT FROM THE EXECUTIVE MANAGEMENT IN THE EAP.

Please indicate how important each of the following criteria is according to the following scale with reference to the introductory statement from Executive Management of the institution in the EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

4.4	There should be an emphasis on the general well-being of employees in order for them to be productive in the workplace.	1 11	2 1	3 0	Consensus Round 1
4.5	The importance of a work-based programme to assist employees with personal problems in the work place.	1 11	2 1	3 0	Consensus Round 4
4.6	An explanation of the roles of the employer within the EAP.	1 10	2 2	3 0	Consensus Round 1
4.7	Clarification on the services that are offered within the EAP.	1 11	2 1	3 0	Consensus Round 1
4.8	(New Round 2) Emphasis should be placed on the fact that employees stay ultimately responsible for their own conduct	1 11	2 0	3 1	Consensus Round 2
4.9	Other comments on the introductory statement of the Executive Management in the EAP?				

Section B:

Structure and requirements for an EAP.

This section deals with issues related to the structures and requirements of an EAP.

B.1 Requirements of an in-house EAP committee.

Please indicate how important each of the following statements is according to the following scale with reference to an in-house EAP committee for a health care institution:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

5.	The requirements for an in-house EAP committee must take into account / needs to include the following aspects:				Comments
5.1	The formal establishment of a multi-disciplinary membership of the committee.	1 10	2 2	3 0	Consensus Round 1
5.2	Clear explanations of the practical functioning of the committee within the institution.	1 11	2 1	3 0	Consensus Round 1
5.3	A clearly formulated mandate of the committee.	1 12	2 0	3 0	Consensus Round 1
5.4	Any other comments on the requirements for an in-house EAP committee within an institution?				

B.2 The role of an in-house EAP committee.					
Please indicate how important each of the following statements is according to the following scale with reference to an in-house EAP committee for a health care institution: 1= Considered to be critical 2= Could be considered 3= Not to be considered Please mark the appropriate box with an X. Mark only one option.					
6.	The role of an in-house EAP committee must include / address the following issues:				Comments
6.1	To participate in the development of the policies and procedures documents for the EAP.	1 10	2 2	3 0	Consensus Round 1
6.2	To ensure that there is the necessary cooperation for the EAP to remain balanced.	1 11	2 1	3 0	Consensus Round 2
6.3	To be part of the formal evaluation of the EAP.	1 11	2 1	3 0	Consensus Round 2
6.4	To assist with the maintenance of communication lines within the EAP.	1 11	2 1	3 0	Consensus Round 1
6.5	To be involved in the discussion of problematic cases/employees within the EAP.	1 8	2 0	3 4	Stability Round 6
6.6	To play a role in the identification of certain trends regarding referrals to the EAP.	1 10	2 2	3 0	Consensus Round 1
6.7	To emphasise the commitment from the EAP committee regarding the support services provided by the EAP to employees.	1 10	2 1	3 1	Consensus Round 1
6.8	To maintain a link between the EAP and the health and safety committee especially regarding health risk assessments.	1 11	2 1	3 0	Consensus Round 2
6.9	To be involved in the training of relevant EAP stakeholders.	1 10	2 2	3 0	Consensus Round 2
6.10	Any other comments on the role of the in-house EAP committee within a health care institution?				

B.3 The service providers in an EAP.					
Please indicate how important each of the following statements is according to the following scale with reference to the service providers of an EAP: 1= Considered to be critical 2= Could be considered 3= Not to be considered Please mark the appropriate box with an X. Mark only one option.					
7.	The manner in which services are provided in an EAP in a health care institution must take into account / needs to address the following aspects:				Comments
7.1	The services could be outsourced to a service provider independent of the health care institution.	1 2	2 10	3 0	Consensus Round 4
7.2	The services should be provided by an in-house service provider.	1 1	2 10	3 1	Consensus Round 3
7.3	The services should be provided within a multi-disciplinary team.	1 11	2 0	3 1	Consensus Round 2
7.4	The services could be a combination between an in-house service provider and an outside (outsourced) service provider.	1 2	2 9	3 1	Stability Round 5
7.5	The appointment of a fulltime EAP facilitator in the health care institution to coordinate the activities of the EAP.	1 10	2 1	3 1	Consensus Round 2
7.5.1	(New Round 2) The full time facilitator should be a social worker	1 0	2 11	3 1	Consensus Round 4
7.6	The EAP service providers can be appointed on a session basis.	1 0	2 11	3 1	Consensus Round 4
7.7	Any other comments on the types of the EAP providers?				

B.3 The characteristics of the service providers in an EAP.					
Please indicate how important each of the following statements is according to the following scale with reference to the characteristics of the service providers in an EAP: 1= Considered to be critical 2= Could be considered 3= Not to be considered Please mark the appropriate box with an X. Mark only one option.					
8.	The following characteristics of the EAP providers need to be considered / should be addressed:				Comments
8.1	The EAP service providers should be able to create a relationship with clients based on trust.	1 12	2 0	3 0	Consensus Round 1
8.2	The staff providing the services in an EAP must have the appropriate training to render a particular service within an EAP.	1 12	2 0	3 0	Consensus Round 1
8.3	The EAP providers must have the necessary background knowledge of the health care institution in which they provide the services.	1 11	2 1	3 0	Consensus Round 1

B.3 The characteristics of the service providers in an EAP.					
Please indicate how important each of the following statements is according to the following scale with reference to the characteristics of the service providers in an EAP: 1= Considered to be critical 2= Could be considered 3= Not to be considered Please mark the appropriate box with an X. Mark only one option.					
8.4	Only senior level staff members should provide the necessary services in the EAP.	1 1	2 10	3 1	Consensus Round 3
8.5	A formal needs assessment should be conducted to determine the type of EAP services for the health care institution.	1 11	2 1	3 0	Consensus Round 2
8.6	The staff working in an EAP must be specialists in their respective fields.	1 11	2 1	3 0	Consensus Round 4
8.7	All service providers in the EAP must be knowledgeable in their field.	1 11	2 0	3 1	Consensus Round 1
8.8	All service providers in the EAP must be a professional service provider.	1 10	2 2	3 0	Consensus Round 4
8.9	The number of EAP providers should be based on the size of the health care institution.	1 11	2 1	3 0	Consensus Round 2
8.10	Any other comments on the characteristics of the EAP providers?				
B.3 The category of service providers in an EAP.					
Please indicate how important each of the following statements is according to the following scale with reference to the category of service providers in an EAP: 1= Considered to be critical 2= Could be considered 3= Not to be considered Please mark the appropriate box with an X. Mark only one option.					
9. The following category of staff members needs to be considered / included in an EAP team to render a service in a health care institution:					Comments
9.1	Human resource officer.	1 10	2 2	3 0	Consensus Round 3
9.2	Psychologist.	1 10	2 1	3 1	Consensus Round 2
9.3	Social worker.	1 12	2 0	3 0	Consensus Round 1
9.4	Occupational therapist.	1 9	2 3	3 1	Stability Round 5
9.5	Financial advisor.	1 9	2 3	3 1	Stability Round 4
9.6	Legal advisor.	1 1	2 10	3 1	Consensus Round 4
9.7	Medical practitioner.	1 8	2 2	3 2	Stability Round 3

B.3 The category of service providers in an EAP.

Please indicate how important each of the following statements is according to the following scale with reference to the category of service providers in an EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

9.8	Registered nurse.	1 1	2 10	3 1	Consensus Round 2
9.9	Religious/spiritual leader.	1 0	2 11	3 1	Consensus Round 3
9.10	Administrative staff member.	1 2	2 1	3 9	Stability Round 6
9.11	Occupational health nurse.	1 10	2 2	3 0	Consensus Round 2
9.12	Psychiatrist.	1 1	2 11	3 0	Consensus Round 4
9.13	(New Round 2) A senior member of management	1 6	2 1	3 5	Stability Round 3
9.14	(New Round 2) Union members	1 6	2 2	3 4	Stability Round 4
9.15	(New Round 2) External service providers can be appointed on an as needed basis	1 10	2 2	3 0	Consensus Round 2
9.16	Any other comments on categories of staff members to be included in the EAP team to provide services in a health care institution?				

Section C:**Policies and procedures for an EAP.**

This section deals with issues related to policies and procedures for an EAP.

C.1 Requirements for policies and procedures.

Please indicate how important each of the following statements is according to the following scale with reference to the requirements for the policies and procedures for an EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

10. The following requirements must be considered / needs to be addressed when policies and procedures are developed for an EAP:					Comments
10.1	A step-by-step approach is needed in the development of guidelines.	<u>1</u> 12	<u>2</u> 0	<u>3</u> 0	Consensus Round 1
10.2	A review of the basic conditions of services from the Department of Labour before drafting policies.	<u>1</u> 11	<u>2</u> 1	<u>3</u> 0	Consensus Round 2
10.3	Policies should be available in a written format.	<u>1</u> 11	<u>2</u> 1	<u>3</u> 0	Consensus Round 1
10.4	(New Round 2) Policies and procedures should be subjected to review every two years.	<u>1</u> 11	<u>2</u> 1	<u>3</u> 0	Consensus Round 3
10.5	(New Round 2) Policies and procedures should be accessible in an electronic format.	<u>1</u> 11	<u>2</u> 1	<u>3</u> 0	Consensus Round 2
10.6	Any comments on the requirements for policies and procedures to be developed for an EAP?				

C.2 Types of policies and procedures.

Please indicate how important each of the following statements is according to the following scale with reference to the types of policies and procedures needed for an EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

11. The following type of policies and procedures for an EAP must be considered / needs to be developed:					<u>COMMENTS</u>
11.1	The role/responsibilities of the supervisor regarding all the activities of the EAP.	1 10	2 2	3 0	Consensus Round 1
11.2	The principles regarding confidentiality of the information generated.	1 12	2 0	3 0	Consensus Round 1
11.3	The administrative aspects regarding the referral of an employee to the EAP.	1 10	2 2	3 0	Consensus Round 1
11.4	The responsibilities of the employee when entering the EAP.	1 10	2 2	3 0	Consensus Round 1
11.5	The funding structure for services rendered within the EAP.	1 11	2 1	3 0	Consensus Round 2
11.6	The commitment needed from employees throughout the EAP.	1 10	2 1	3 1	Consensus Round 2
11.7	The individual treatment pathways to be followed for each employee entering the EAP.	1 1	2 11	3 0	Consensus Round 4
11.7.1	(New Round 2) The treatment options to be followed according to the specific reason for entering the EAP	1 11	2 1	3 0	Consensus Round 3
11.8	The management of possible manipulation/misuse of the EAP by the employee to his/her advantage.	1 10	2 0	3 2	Consensus Round 2
11.9	The communication channels to be followed by everybody in order to get assisted.	1 12	2 0	3 0	Consensus Round 1
11.10	The description of the method of self-referral of an employee to the EAP.	1 12	2 0	3 0	Consensus Round 1
11.11	The formal feedback system between all stakeholders involved with employees in the EAP.	1 12	2 0	3 0	Consensus Round 1
11.12	The resources to be put in place in order to render EAP services in the health care institution.	1 10	2 2	3 0	Consensus Round 1
11.13	The formal communication lines between EAP provider and supervisors regarding employees in the EAP.	1 11	2 1	3 0	Consensus Round 1
11.14	The actions to be taken in the case of a relapse of an employee while in the EAP or after discharge.	1 11	2 0	3 1	Consensus Round 2
11.15	The formal written reports to be provided by EAP providers regarding the progress made by an employee in an EAP.	1 11	2 0	3 1	Consensus Round 2

C.2 Types of policies and procedures.				
Please indicate how important each of the following statements is according to the following scale with reference to the types of policies and procedures needed for an EAP: 1= Considered to be critical 2= Could be considered 3= Not to be considered Please mark the appropriate box with an X. Mark only one option.				
11.15.1 (New Round 2) The circumstance as to the release of the formal written reports must be specified.	<u>1</u> 10	<u>2</u> 1	<u>3</u> 1	Consensus Round 2
11.16 The steps to be followed regarding any type of non-compliance by an employee while being in an EAP.	<u>1</u> 10	<u>2</u> 0	<u>3</u> 2	Consensus Round 1
11.16.1 (New Round 2) The EAP should not been seen as a mandate by management.	<u>1</u> 11	<u>2</u> 0	<u>3</u> 1	Consensus Round 3
11.17 An open door approach by supervisors to ensure availability of the supervisors to discuss problems with their employees.	<u>1</u> 11	<u>2</u> 0	<u>3</u> 1	Consensus Round 3
11.18 The principle of voluntary entry by the employee into the EAP.	<u>1</u> 10	<u>2</u> 2	<u>3</u> 0	Consensus Round 1
11.19 Clear guidelines on who may access/use the services of the EAP.	<u>1</u> 11	<u>2</u> 1	<u>3</u> 0	Consensus Round 1
11.20 Whether employees are to attend EAP activities/services during their official work time.	<u>1</u> 11	<u>2</u> 1	<u>3</u> 0	Consensus Round 1
11.21 The time frame for how long the employee can continue with the EAP activities including the follow-up afterwards.	<u>1</u> 12	<u>2</u> 0	<u>3</u> 0	Consensus Round 1
11.22 The description of the method of referrals of an employee to the EAP by the employer.	<u>1</u> 11	<u>2</u> 1	<u>3</u> 0	Consensus Round 1
11.23 The requirement of signed consent from an employee before he/she enters the EAP.	<u>1</u> 11	<u>2</u> 0	<u>3</u> 1	Consensus Round 1
11.24 The principles regarding the governance of the EAP.	<u>1</u> 10	<u>2</u> 2	<u>3</u> 0	Consensus Round 1
11.25 (New Round 2) The monitoring and evaluation of the EAP.	<u>1</u> 12	<u>2</u> 0	<u>3</u> 0	Consensus Round 2
11.26 Any other comments on the type of policies and procedures needed for an EAP?				

Section D: EAP processes and activities.

This section deals with EAP processes and activities.

D.1 EAP ENTRY PROCESSES

Please indicate how important each of the following statements is according to the following scale with reference the entry processes for an EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

12. Processes regarding the entry of an employee into the EAP must address / needs to include the following:					Comments
12.1	An initial assessment of the employee and his/her problem/situation is performed.	1 12	2 0	3 0	Consensus Round 1
12.2	Poor work performance of the employee is identified.	1 12	2 0	3 0	Consensus Round 2
12.3	There must a formal admission policy and procedures document.	1 12	2 0	3 0	Consensus Round 2
12.4	Confirmation that a formal referral system was followed.	1 12	2 0	3 0	Consensus Round 2
12.5	A pre-entry interview with the employee should be performed by the supervisor.	1 0	2 0	3 12	Consensus Round 4
12.6	Confirmation that the person to be entered into the EAP is currently employed in the health care institution.	1 10	2 0	3 2	Consensus Round 2
12.7	There should be a differentiation between a new and a repeat problem as presented by the employee.	1 10	2 2	3 0	Consensus Round 1
12.8	The seriousness of the problem/case must be determined.	1 12	2 0	3 0	Consensus Round 1
12.9	A health profile of an employee is kept as part of the work place record.	1 10	2 0	3 2	Consensus Round 2
12.10	Any other comments on the entry processes for an EAP?				

D.2 Types of services to be rendered in an EAP.					
Please indicate how important each of the following statements is according to the following scale with reference to the types of services to be rendered in an EAP: 1= Considered to be critical 2= Could be considered 3= Not to be considered Please mark the appropriate box with an X. Mark only one option.					
13. The following type of services for an EAP must be considered / needs to be included in the programme:					<u>COMMENTS</u>
13.1	Financial advisory services.	1 10	2 2	3 1	Consensus Round 3
13.2	General pro-active preventative programmes.	1 11	2 0	3 1	Consensus Round 1
13.3	Participation in in-service training programmes of the health care institution for all the employees.	1 11	2 0	3 1	Consensus Round 2
13.4	Chronic disease management.	1 11	2 1	3 0	Consensus Round 3
13.5	General counselling services.	1 11	2 0	3 1	Consensus Round 1
13.6	A referral function to additional resources/services.	1 11	2 0	3 1	Consensus Round 1
13.7	A follow-up service for a certain period of time after the initial sessions.	1 11	2 1	3 0	Consensus Round 2
13.8	Health promotion programmes.	1 11	2 0	3 1	Consensus Round 1
13.9	The treatment of substance abuse/addictions.	1 10	2 1	3 1	Consensus Round 1
13.10	Assistance with burnout syndrome.	1 10	2 2	3 0	Consensus Round 2
13.11	Trauma debriefing counselling.	1 10	2 2	3 0	Consensus Round 1
13.12	Provide general therapeutic services.	1 10	2 2	3 0	Consensus Round 4
13.13	Teach basic life skills.	1 10	2 1	3 1	Consensus Round 2
13.14	Provide marriage therapy within the family context.	1 1	2 11	3 0	Consensus Round 4
13.15	Supervision of rehabilitation services such as Antabuse® dosage.	1 10	2 0	3 2	Consensus Round 3
13.16	Stress management.	1 10	2 2	3 0	Consensus Round 1
13.17	The approval of sick leave.	1 2	2 0	3 10	Consensus Round 2

13.18	Conflict management.	1 2	2 10	3 0	Consensus Round 4
13.19	Provide general rehabilitation services.	1 0	2 2	3 10	Consensus Round 4
13.20	Assistance with medical surveillance services of employees.	1 2	2 10	3 0	Consensus Round 2

Additional criteria

The following six statements deal with additional concepts for possible inclusion in the best-practice EAP, but didn't meet the criteria or were not identified during the focus group discussion. However, these concepts were identified for possible inclusion through the literature review process.

D.2 Types of services to be rendered in an EAP (continues).

Please indicate how important each of the following statements is according to the following scale with reference to the types of services to be rendered in an EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

13.21	Temporary incapacity management.	1 2	2 10	3 0	Consensus Round 2
13.22	Psychiatric services.	1 1	2 8	3 3	Stability Round 3
13.23	Services to address relationship problems in the workplace.	1 10	2 2	3 0	Consensus Round 3
13.24	Support services to people who were involved in violence.	1 10	2 2	3 0	Consensus Round 3
13.25	Crisis management services.	1 11	2 1	3 0	Consensus Round 2
13.26	Management of Injury on Duty (IOD) cases.	1 1	2 11	3 0	Consensus Round 2
13.27	(New Round 2) Provide general supportive services such as visiting Department of Home Affairs for Identification documents, birth registrations, passport and motor car registration.	1 0	2 11	3 1	Consensus Round 6
13.28	(New Round 2) Initial individual session should be viewed as a referral tool to appropriate resources.	1 10	2 2	3 0	Consensus Round 3
13.29	Any other comments on the type of services to be rendered in an EAP?				

Section E: The evaluation of the EAP.

This section deals with the evaluation of the EAP.

E.1 General requirement for the evaluation of an EAP.

Please indicate how important each of the following statements is according to the following scale with reference to the general requirements for the evaluation of an EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

14. The following general requirements must be considered / need to be included during the EAP evaluation process:					<u>COMMENTS</u>
14.1	The time frames for the various evaluations must be defined.	1 10	2 2	3 0	Consensus Round 1
14.2	The entire programme should be evaluated.	1 11	2 1	3 0	Consensus Round 1
14.3	All evaluation processes must adhere to the confidentiality principles.	1 12	2 0	3 0	Consensus Round 1
14.4	The evaluation must be a continuous process.	1 10	2 2	3 2	Consensus Round 1
14.5	The person who will be responsible for the evaluation processes must be identified.	1 10	2 1	3 1	Consensus Round 1
14.6	A variety of methods of evaluation should be used.	1 10	2 1	3 1	Consensus Round 1
14.7	Any other comments on the general requirements for the evaluation of an EAP?				

E.2 The components of an EAP to be evaluated

Please indicate how important each of the following statements is according to the following scale with reference to the specific components of the EAP to be evaluated:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

15. The following components of an EAP must be considered / need to be included in the evaluation of an EAP:					<u>COMMENTS</u>
15.1	The general outcome of employees entered into the EAP.	1 12	2 0	3 0	Consensus Round 1
15.2	The financial implications of the EAP on the health care institution.	1 10	2 1	3 1	Consensus Round 1
15.3	The absenteeism profiles of employees in the health care institution.	1 11	2 1	3 0	Consensus Round 2
15.4	The various types of problems presented by employees for entering the EAP.	1 10	2 2	3 0	Consensus Round 1

15.5	Self evaluation of employees entered into the EAP.	1 10	2 2	3 0	Consensus Round 2
15.6	Self evaluation of the staff working for the EAP.	1 10	2 2	3 0	Consensus Round 2
15.7	The treatment protocols used for the various problems managed in the EAP.	1 11	2 1	3 0	Consensus Round 2
15.8	The productivity of the employee after entering the EAP.	1 10	2 1	3 1	Consensus Round 1
15.9	The identification of trends of certain problems in the health care institution.	1 12	2 0	3 0	Consensus Round 1
15.10	The value that is added to the health care institution by the program.	1 12	2 0	3 0	Consensus Round 1
15.11	The availability of an EAP.	1 11	2 1	3 0	Consensus Round 1
15.12	The level of confidentiality kept within the EAP.	1 12	2 0	3 0	Consensus Round 1
15.13	The appropriateness of the guidelines that were followed.	1 10	2 2	3 0	Consensus Round 1
15.14	The degree of accessibility of the services of the EAP.	1 12	2 0	3 0	Consensus Round 1
15.15	The general awareness amongst employees in the institution regarding the EAP with the services available.	1 11	2 1	3 0	Consensus Round 2
15.16	The types of communication channels followed during the EAP activities.	1 11	2 0	3 1	Consensus Round 2
15.17	The level of satisfaction of the customers of the EAP.	1 10	2 2	3 0	Consensus Round 1
15.18	The effectiveness of the EAP.	1 12	2 0	3 0	Consensus Round 1

E.2 The components of an EAP to be evaluated					
Please indicate how important each of the following statements is according to the following scale with reference to the specific components of the EAP to be evaluated: 1= Considered to be critical 2= Could be considered 3= Not to be considered Please mark the appropriate box with an X. Mark only one option.					
15.19	An official follow-up of the employee being discharged from the EAP.	1 10	2 1	3 1	Consensus Round 1
15.20	The utilisation of the EAP by those authorised to use the services of the EAP.	1 10	2 2	3 0	Consensus Round 2
15.21	The personnel turnover in the health care institution.	1 11	2 1	3 0	Consensus Round 2
15.22	The performance of the employee leaving the EAP over a specific period of time.	1 10	2 1	3 1	Consensus Round 1
15.23	The application of certain criteria in the EAP such as inclusion and referral criteria.	1 12	2 0	3 0	Consensus Round 2
Additional criteria The following seven statements deal with additional concepts for possible inclusion in the best-practice EAP, but didn't meet the criteria or were not identified during the focus group. However, these concepts were identified for possible inclusion through the literature review process.					
E.2 The components of an EAP to be evaluated (continues)					
Please indicate how important each of the following statements is according to the following scale with reference to the specific components of the EAP to be evaluated: 1= Considered to be critical 2= Could be considered 3= Not to be considered Please mark the appropriate box with an X. Mark only one option.					
15.24	Response time of services rendered.	1 12	2 0	3 0	Consensus Round 1
15.25	The referrals to the EAP.	1 10	2 2	3 0	Consensus Round 1
15.26	The attitude of employees towards the EAP.	1 12	2 0	3 0	Consensus Round 2
15.27	The degree of compliance of employees within the EAP.	1 12	2 0	3 0	Consensus Round 2
15.28	The length of stay of an employee in the EAP.	1 12	2 0	3 0	Consensus Round 2
15.29	The progress made by the employee in the EAP.	1 11	2 0	3 1	Consensus Round 2
15.30	The relapse of employees previously treated in the EAP back into the EAP.	1 11	2 0	3 1	Consensus Round 2

15.31 Any other comments on the specific components of the EAP to be evaluated?

E.3 The methods to be used for the evaluation of an EAP.

Please indicate how important each of the following statements is according to the following scale with reference to the specific methods to be used in the evaluation process of the EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

16. The following methods for the evaluation of an EAP must be taken into consideration / should be used in the process:					<u>COMMENTS</u>
16.1	The completion of questionnaires.	1 1	2 11	3 0	Consensus Round 4
16.2	Keeping of statistics.	1 12	2 0	3 0	Consensus Round 1
16.3	Formal feedback procedures.	1 10	2 1	3 1	Consensus Round 1
16.4	Surveys.	1 11	2 0	3 1	Consensus Round 2
16.5	Conducting interviews with the employee entered into the EAP.	1 10	2 1	3 1	Consensus Round 3
16.6	The utilisation of recognised performance management systems.	1 10	2 0	3 2	Consensus Round 3
16.7	The utilisation of formal evaluation instruments.	1 11	2 0	3 1	Consensus Round 2
16.8	The implementation of quality assurance cycles.	1 12	2 0	3 0	Consensus Round 2
16.9	The issuing of formal reports.	1 12	2 0	3 0	Consensus Round 2
16.10	Self-assessment methods for employees to assess how they are coping after entering the EAP.	1 11	2 1	3 0	Consensus Round 2
16.11	Formal record reviews.	1 12	2 0	3 0	Consensus Round 2

Additional criteria

The following 11 statements deal with additional concepts for possible inclusion in the best-practice EAP, but didn't meet the criteria or were not identified during the focus group. However, these concepts were identified for possible inclusion through the literature review process.

E.3 The methods to be used for the evaluation of an EAP (continues).

Please indicate how important each of the following statements is according to the following scale with reference to the specific methods to be used in the evaluation process of the EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

16.12	Interview with supervisors.	1 10	2 1	3 1	Consensus Round 3
16.13	Utilisation of lead indicators.	1 11	2 1	3 0	Consensus Round 2
16.14	Utilisation of lagging indicators.	1 11	2 1	3 0	Consensus Round 2
16.15	A formal audit process.	1 11	2 0	3 1	Consensus Round 2
16.16	Utilisation of qualitative evaluation methods.	1 10	2 1	3 1	Consensus Round 2
16.17	A cost-benefit analysis.	1 12	2 0	3 0	Consensus Round 2
16.18	Employees' health surveillance programmes.	1 10	2 2	3 0	Consensus Round 3
16.19	A benchmarking process.	1 11	2 1	3 0	Consensus Round 2
16.20	An accreditation process with standard settings.	1 10	2 2	3	Consensus Round 4
16.21	A total quality management (TQM) approach.	1 10	2 2	3	Consensus Round 4
16.22	A balance score card approach.	1 4	2 8	3 0	Stability Round 4
16.23	(New Round 2) The utilisation of only a few indicators to monitor the impact of the EAP on a monthly basis.	1 10	2 2	3 0	Consensus Round 3
16.24	Any other comments on the specific methods to be used in the evaluation of an EAP?				

Appendix K

**An example of the Excel spreadsheet used to record the
outcomes of Delphi survey (Round 1)**

E14.6	1		1	1	1	1	1	1	1	1	1	1	1	1	1	1	10	1	1
E14.7																			
E15.1	1		1	1	1	1	1	1	1	1		1	1	1	1	1	12	0	0
E15.2	1		1	1	1	1	1	1	1			1	1	1	1	1	10	1	0
E15.3		1	1	1	1	1	1	1	1	1		1	1	1	1	1	7	4	1
E15.4	1		1	1	1	1	1	1	1	1		1	1	1	1	1	10	2	0
E15.5	1		1	1	1	1	1	1	1	1		1	1	1	1	1	8	4	0
E15.6	1		1	1	1	1	1	1	1	1		1	1	1		1	7	4	1
E15.7	1		1	1	1	1	1	1	1	1		1	1	1	1	1	9	3	0
E15.8	1		1	1	1	1		1	1	1		1	1	1	1	1	10	1	1
E15.9	1		1	1	1	1	1	1	1	1		1	1	1	1	1	12	0	0
E15.10	1		1	1	1	1	1	1	1	1		1	1	1	1	1	12	0	0
E15.11	1		1	1	1	1	1	1	1	1		1	1	1	1	1	11	1	0
E15.12	1		1	1	1	1	1	1	1	1		1	1	1	1	1	12	0	0
E15.13	1		1	1	1	1	1	1	1	1		1	1	1	1	1	10	2	0
E15.14	1		1	1	1	1	1	1	1	1		1	1	1	1	1	12	0	0
E15.15	1		1	1	1	1	1	1	1	1		1	1	1	1	1	9	3	0
E15.16	1		1	1	1	1	1	1	1	1		1	1	1	1	1	9	2	1
E15.17	1		1	1	1	1	1	1	1	1		1	1	1	1	1	10	2	0
E15.18	1		1	1	1	1	1	1	1	1		1	1	1	1	1	12	0	0
E15.19	1		1	1	1	1		1	1	1		1	1	1	1	1	10	1	1
E15.20	1		1	1	1	1	1	1	1	1		1	1	1	1	1	7	5	0
E15.21	1		1	1	1	1	1	1	1	1		1	1	1	1	1	9	3	0
E15.22	1		1	1	1	1		1	1	1		1	1	1	1	1	10	1	1
E15.23	1		1	1	1	1	1	1	1	1		1	1	1	1	1	9	3	0
E15.24	1		1	1	1	1	1	1	1	1		1	1	1	1	1	12	0	0
E15.25	1		1	1	1	1	1	1	1	1		1	1	1	1	1	10	2	0
E15.26	1		1	1	1	1	1	1	1	1		1	1	1	1	1	8	4	0
E15.27	1		1	1	1	1	1	1	1	1		1	1	1	1	1	8	4	0
E15.28	1		1	1	1	1	1	1	1	1		1	1	1	1	1	9	3	0
E15.29	1		1	1	1	1		1	1	1		1	1	1	1	1	9	2	1

Appendix L

A transcribed focus group discussion:

Focus group discussion session 1

Prescribed Focus group discussion – Provincial Department of Health

(This is the transcription of the first focus group discussion that was held. All the typed focus group discussion was about 20-30 pages long –this appendix is an example of a transcribed focus group discussion.

For explanation purposes:

Column 1: A number allocated to each discussion/response by participant. This was a very convenient system to make it easy to identify the section in the transcribed set of data.

Column 2: An indication who provided the response. All the participants had a number from 1-12 placed in front of them on the table. During the discussion, participants were referred to as the number and not the name to ensure confidentiality. In order to make each participant unique, a letter was put in front of their number:
 U = the first focus group discussion
 M = the second focus group discussion
 R = the third focus group discussion
 P = the fourth focus group discussion
 B = the fifth focus group discussion

Column 3: The detail of the actual discussions/response from everybody

Column 4: The column added after the typed data was read to reflect the field notes captured by the observer during the group discussions

Conducted November 03, 2008 from 10H45 to 12H45 in the Committee Room 1, Pelonomi Hospital, Bloemfontein

<u>1</u> No	<u>2</u> Participant	<u>3</u> Response	<u>4</u> Comments (field notes)
	Facilitator	I do have a guideline that is provided because I know which questions have more weight than others and which ones we can dwell on that little bit more than others. So I am going to limit you. Would you like me to give you an indication that when we start, how much time we got for each question? Okay, will that help you? And then the other thing is I would like to as many people as possible to participant in each question. So if you can just consider it to give everybody a	Just the introduction made by the facilitator. Didn't include the initial introduction – recorder was not on Everybody agrees to that

		turn to respond, so and then not to repeat too much what was already said. If you agree, you can just said I agree with so and just let me know. Hmm just to get a little bit of consensus and not to repeat everything and to save some time. So for the first part, we do have about 70 minutes before we break for tea but we can see how we cope. If you feel that you need to faint now , just indicate so that it can give you some refreshments or just time to take a breath, especially you not feeling well. Ok, then I think we can start.	
	Observer	Yes, it is fine.	
	Facilitator	We just need to get the sounds ready.	
	Observer	I am ready now and please talked loudly, don't whisper	
	Facilitator	I am told that you are all experts on the topic so you will find very question very easy. OK, the first question and here we need about five minutes, not so much time. Hmm, why do we need an EAP for workers in health care sector? Why do we need an EAP for the health care sector? Anybody?	
1	U7	I think a happy worker is a healthy worker in a happy environment and in a good environment and the more you can look after the people the better the well worker situation is.	An immediate response without hesitation
2	U2	I would say that an EAP helps quality control regarding absenteeism from HR point of view. Our presentism is of, of hmm great concern and absenteeism and EAP can go hand in hand.	
3	U3	It is important for the employee to know that the employer cares about him and that is why we need the program.	
4	U4	I do agree with participant the number seven. Our employees are our most valuable asset and we need to keep them healthy so that they can be productive.	
5	U5	I think we need that because some of the employees don't actually know where to go when they have certain problems. So, in a way the EAP helps them to direct towards the, the places where they want to go for help	
6	U6	I think the obvious problems that workers experience do effect them and they spent U8 hours at work, so naturally must be some help for them	

		during those U8 hours if they experience problems.	
7	U1	I think that we always said that a therapist needs a therapist and I think in the health sector the people are, they do see a lot of things that it's hard not only at home but at work that might affect them and you need to somewhere to go and some way to work through that.	Silence after almost all participants gave inputs
	Facilitator	Anybody else like to comment, anything that you remember now having listened to your other participants?	Everybody looks around them
8	U2	I would like to add please, health care is very disciplined environment where patient care comes first and in a disciplined environment we need disciplined people and we need committed people and usually a person participating in an EAP is not 100% competent to the profession or to the patient.	
9	U7	And can I just add one thing that I think it is important that we don't just look at the results of the problem. Often in a work situation we look at absenteeism. We look at all the results of the problem and not the cause of the problem and I think that is where EAP comes in where they go back and look at the roots of the problem and address the roots of the problem or the reasons for the problem and the results	U5 agrees by nodding and everybody laughs
10	U5	But to add on that we, EAP that we should be more on the preventative side. We should not wait for that time until there is a problem and call on an employee. Try and see things and prevent them before they actually happen	Several participants agreed using body languages
	Facilitator	And from the nods round the table I see that almost everybody is in agreement with the statement. OK, shall we proceed to the next question? Ok, and it sound like this: What should be included in a management statement of the EAP policy? What should be included in a management statement of the EAP policy? And here we can elaborate a little bit longer because we do have 10 minutes for this question	All agree – they look eager to continue with session
11	U6	Is this statement by management in the policy? Or management policy?	Uncertainty of what is expected from

			participants
	Facilitator	In policy there is a management statement - what should that statement include?	
12	U2	I would like to see in such a statement from the employer's side, hmm, there should be a health profile of every employee. It is a starting point when you enter. You've got to have a health profile	Immediate response – participant wants to make a definite statement
13	U7	I think maybe some emphasis on something important about the social, emotional, and physical well being of every employee and how important that is to management. Hmm	Supported by two and three. Meaningful pause add the end of that statement
14	U5	I think we can also add that like I said before an EAP should be more proactive rather than reactive	Supported by one
15	U4	Maybe it should also have a statement there that it is not punitive. It is to help workers and it should not be mixed with discipline.	Silence after input
	Facilitator	OK, anymore comment on this question? Do you want to think a bit more? What should be included in a management statement of the EAP policy?	
16	U4	Maybe again, that hmm, it should add that the role of the supervisors or managers so that they can know their role when to identify challenges early so that the person can be assessed	Not sure how to say it
17	U2	If you will allow me and if time regards it and if it is not necessary but I really think that an EAP in the management system should always be described as a system that should not be misused or abused because from you know there should be an end, a beginning and an end. Hmm, I am talking about relapses and all those you know. You cannot stay in this programme forever and ever for only one thing	Started the statement very apologetic but trying to convince other members with the statement. Achieved it as some of the participants agreed
	Facilitator	That was participant number two and if I hear you correctly you say there should be limits or boundaries if that is correctly	No U2 nodded in agreement
18	U3	I think things that we might think is is know should say that to No UU1 it is work-base program. That should be stated in the policy and it should assist employees with personal and work-related problems. Because personal problems could have	Hesitation Observer replace participant number with

		an effect on people and work-related problems can have an effect on people. And then I want to add again what number two said that you need to look at a person in a holistic.	name mentioned by no U3
19	U5	So to add on what number three had said. Employees should know that health and safety is everybody's business. So that they should even made aware that it is still their responsibility to come forward when they are having problems and they should not wait for the employer or the supervisor to recall them, so they must come on their own and report to the programme so that they can be identified early enough so that they can benefit at such.	
	Facilitator	Thank you number five and at this stage we are joined by an extra participant which we will referring to participant number eight. We are just on managing the question: what should be included in a management statement of an EAP policy? In an EAP policy, what should the EAP statement include? Would you like to join in on that question?	The participant is introduced to the rest of the group by observer
	Facilitator	Would you like to response to that question?	Question asked after the introduction
20	U8	Can you say that question again?	
	Facilitator	OK, we said: what should be included in a management statement of the EAP policy?	
21	U8	Statement? Is it like objectives?	Pause after 2nd question by participant while she is thinking
22	U8	I think it should be clarified what EAP covers. Basically the areas that should be covered by the EAP. For instance the different categories of EAP if maybe it could include HIV should be there and all that the areas that it will touch on. That's all, yes.	
	Facilitator	OK, any other comments on the specific question? Can we move on to the next question? The third question reads like this: What kind of procedures should be included in the formal EAP policy? What kind of procedures should be included in a formal EAP policy? We have about UU10 minutes to explore this question	
23	U3	Well, the referral procedures should be discussed	Confirmed by

		there.	number one and several nods
24	U7	Eksuus, ek het nie gehoor nie.	
25	U3	Referral procedure, referral procedure	
26	U8	Whom may access the service?. Access the service. Who may access the service?	Participant ensure that she is heard
	Facilitator	Access	Just confirmation by Facilitator
27	U6	I think the referral is not only from the supervisor. Well, obviously firstly there are hmm different referrals. It is firstly from the supervisor to the EAP, and then from the EAP to whoever else like occupational therapy, psychiatry, or HR or....hmm	Hesitation
28	U1	I would also like to add that hmm, that may be that you would describe the road that the patient/worker will follow. This is the problem so I am going either this road or this road or this road. I am going to see these two people the pathway that should be followed....	Explain with gestures Interrupted by no U7
29	U7	Pathway	
30	U1	Yes, pathway, which pathway would be followed in the management of the patient and how is he going to be re-assessed for the success of the programme	
31	U7	How he will be assessed eventually.	
	Facilitator	Right	
32	U2	I would like to see feedback to the supervisors	Silence
33	U8	I don't know if this is an obvious thing but the principles governing the EAP service providers and practitioners	Silence of the statement
34	U5	So going back to referrals, I think it must be clearly indicated the levels of referral like most of the time we talk about a supervisor referring the person. An employer referring the person and most of the time especially when it comes to employer most of the time is when the worker's job is at the rock. So they should, we should also instill on the workers they should, there is smoothing called self-referral. They must be able to refer themselves when there is still time	
	Facilitator	Thank you participant no U5	
35	U7	Also the consent to be given and the fact that he will actually allow him to go through the	Supported by three

		whole...you know, that he sort of sign consent to go through all the different steps that he needs to go through	
36	U2	I would like to see feedback and the HR role very permanent regarding the leave that this person is taking because it is special leave so that the person itself can not be negatively affected by being in the programme and being referred.	
37	U4	Maybe with the principles we must stress the importance of like confidentiality	
38	U8	That is what I want to go back and say - specifically confidentiality and ethical conduct concerning the information that is used during the process	Supported by four
39	U6	Another important procedure would be if a supervisor suspect that somebody is under the influence - exactly the steps that you should follow, hmm you know how we should report it, record it, observe it. You know, I mean there is a whole procedure that should be followed and then referred to the EAP and then obviously when he is sober, back referral and the reply from the EAP to the supervisor what is going to be done. I think that is as far as intoxication is concerned. Absenteeism obviously the same. It is no use, I know they often use to send somebody and you don't know the background and how long he had seen or the absenteeism pattern or causes or so. So those things should be specified how that referral should take place	Supported by two
40	U1	I would also like to add on what number seven on the consent that the participant will have to sign. Also some form of commitment because we do see that they don't always go through the whole programme and that also have to be included	Participant no U7 nodding in agreement
41	U3	I want to add there that in a policy there actually needs to be a written also that there needs to be commitment from the supervisor because sometimes you do get the idea that they refer and then they think now it is your baby. Then there is no cooperation. So if that is part of the policy, then it is there. It works both ways	Nods from several participants
42	U7	The whole evaluation of the client by the multidisciplinary team to look at the different components and how each one can play a role hmm later on. So in the planning, the whole planning process of how this patient will be dealt	Supported by three

		with.	
43	U6	Another procedure is that in case of misconduct. You know EAP shouldn't..., the procedures should be clear that it is not in the place of disciplinary actions. It, they must still follow disciplinary procedure but it should be spelled out to the employer, supervisor how to... the procedure, that they should follow disciplinary and then refer to the EAP. And not instead of the disciplinary actions if there was misconduct	
44	U7	Also if there is noncompliance, to see then what we going to in case of non-compliance or when do we see something as noncompliance	
	Facilitator	Number four I saw that you wanting to make a contribution	Facilitator interrupting No U2
45	U4	I just wanted to say that it should be clear in the case of non-compliance what steps are going to be taken if one doesn't comply. That must be included in the policy as well	Not very convincing, even shy comment
46	U2	I would like to see in the consent form a disqualifying clause where you can disqualify yourself by not being committed to the process and then I would definitely like to see that the next step would be the disciplinary procedure	Want to make a certain point, lean forward
	Facilitator	Any other comments on this question? I think we basically reached our time limit. Are you happy if we proceed? OK, The last question in this set of questions reads like this: "What is the role of joint EAP committee and by joint we mean labour, management, personnel in a health care institution? "What is the role of joint EAP committee in a health care institution and by joint we mean labour, management, personnel? and for this we can use about five minutes – not so much time	Silence and uncertainty follows
47	U2	I would like to see the role of the committee is to keep management informed of the trends hmm, ja.... and all the role players like labour taking note of everything so that a person in the committee can be.... in the programme can be sort of hmmm beskerm, kom gou, gou, protected. Protection of the person.	Participant hesitated after "trends" silence after her comments
48	U7	I think it is also for setting certain guidelines and certain procedures. I mean if the whole committee is together it is much easier if people can each give their inputs in specifically institutionalise certain	

		guidelines and procedures, pitfalls and....	
49	U3	It should also be the responsibility of the EAP committee to draw up the policy because it is not that one person drawing up the policy. It is a team and it should be consensus. this is how we want the program to run in the institution. So therefore there are more people needed to do that	Look around for support from others
50	U5	I think also it could be important for these special components to give inputs to the committee relating to the relevant issues of the EAP. For instance labour will give inputs on how the guidelines will be affected by information from their section, management from their section, practitioners from their section, the personnel. Each one to give inputs so that they make informed maybe policy decisions and something like that.	Supported by three
51	U6	I think it is what number U7 said as well that those procedures we spoke about earlier should be drawn up by this group because it's now health care workers, labour and management and personnel must all sit together and draw up those procedures. And I think the other thing is I think is where they can play a role with problematic cases. To discuss problematic cases that couldn't be solved by other components or...	
52	U7	I think I just got a problem with that and we need to be careful if we do that with problematic cases that we still keep confidentiality and that we don't like through things in the open in an open meeting where people's names will be discussed and that we keep it to the case and not maybe to the personal particulars.	No U7 very quick to respond Supported by two and three
	Facilitator	Participant number three, do you want to add something?	
53	U3	I just wanted to say clearly that I don't think the aim of the committee is not to discuss .I think one must stay away from this.	Several participants agreed and whisper to each other
	Facilitator	OK, are you happy with this question? Can we move on? You are doing very well. I am so impressed with your time management. We are now going to enter a second section of questions where there will be five questions. No sorry three and here we can elaborate a little bit more. I'll give you UU10 to UU1U5 minutes on each different	A few uncertain laughs after the question was asked

		question. OK, so these are specific questions and the first one here reads as follows: "How or by whom should an EAP be provided?" "How or by whom should an EAP be provided?"	
54	U7	Sorry do you mean specifically think like an in-hospital or outside the institution or more by different role players? Both?	
	Facilitator	Yes both and we need your opinion. So what is your opinion?	
55	U2	Well, the employer should provide an EAP	
56	U3	Preferably at each institution from the institution	
	Facilitator	So you mean internally?	
57	U3	Yes	
	Facilitator	From the institution?	
58	U5	So, it should be provided by the employer and then if we say how with the involvement of each and every stakeholder, in the hospital or in the institution or where ever, So each and every part should be represented	
59	U7	I do agree with number five in a sense that can't be done by just one person because people got such a vast like a... wide range of problems that it must be done by a multi-professional team because each person can play a different role in the thing	Supported by U3 and U4
60	U1	I think also like I want to support number seven. It is important that we have a multidisciplinary team in the management of the patients. But the other flip side of the coin is that we do need enough people to help. It is like always the case. In the ideal world it would be very good if we can get a very nice big team.	Number U7 nodded in agreement
61	U2	I would apparently be the only one who would like the multi-disciplinary team to be outsourced. As a HR person you know our employees, hmm are, if we do the EAP internally we are utilising employees and the post has been created for patient care. So personally from Universitas point of view, we've seen that our health workers are really overworked, burned out themselves like she said herself a therapist needs a therapist. I would much rather go like the private sector and outsourcing the whole thing and I do believe that our clients, our employees, would much rather be more freely enter the programme like that because they, they tend not to trust the inside	Sit back and look around

	Facilitator	That was participant the number U2 supporting external based	
62	U6	I think there is merit for that because we've all encountered the problem of dual loyalty. You know you've got your client but you are employed by the employer, paid by him and he actually appoints you to do this but then he expects you to defend his case while you also have an ethical loyalty to the client, the patient so, hmm, it seems like outsourcing will solve that problem but on the other hand we work with the cases, with the staff themselves in the clinic work with the cases, and they get...buildup a relationship and they know they eventually and then they deal with their problems as well. They gained their trust so there is this conflict which I don't know what the best answer would be.	Well supported by several other participants
63	U7	I think it doesn't need to be a conflict because I think this people that work with the people could also just be a link towards the outside people that you don't need to be totally out of this situation but then you could be the link the whole time between employer and the employee that is in the EAP.	
64	U2	The idea of outsourcing is that there should be a manager who sort of overseen the quality of the outsourced firm and I would also like to add to this earlier I said that there should be a health profile for every person and hmm in the hospital in the employment and a firm like this can sort of update management on the whole health profile which might include age analysis and trends and all these things. So just to add on that.	
65	U3	I would say....I don't agree with participant number two because I think we are working in a sector where there are no money to outsource everything and it could be the ideal situation. Therefore people who got medical aids they go out to other professions. You don't even know that they had a problem. You just hear when they come back from leave that they were admitted to Bloemcare or something like that. But it depends on how you run your programme, you will win or lose the confidence of the people. They will be confident to come, utilise the service depending on how you treat them. So you will sell yourself and hmmm you need to understand the dynamics of personalities, relationships. People take sometimes a long time	Participant wasn't sure how to start her sentence. Start with soft words, then harder

		before...., they look and see what is going on in the programme and slowly they come out of there own. So I, I really want to say it depends on the people that are running it. One mistake that we should not make is to allow junior workers to work in the programme hmmm because there is something about people that have got an attitude and say I don't want to be helped by somebody who has just finished hmm their studies and sometimes we as employers make the mistake by advertising these posts on a junior level and that is where you make the mistake so that people don't want to utilise the programme later	Now she is very positive about her view point
66	U8	I think this question links up with how will the service be funded. Who should pay for the service? Because when she mentioned people with medical aid sometimes it is necessary to get a particular level of care which is not in the policy of the EAP and the patient will definitely use their own medical aid. Or maybe it should be in the policy how should it be done with people who have medical aid. It should be specific.	
67	U2	I would like to see the tender being drawn up for the outsource that we should have multidisciplinary people there and if age should be root out should it be. I also see that the department of health will hmmm pay for this service in the outsource. I also believe that a person has got the right to choose his own hmm private person but going through the EAP it would be feedback to the multi-professional skilled EAP firm so that if I want to go to the psychiatrist, and he is not on that list like we do with SOMA at this moment, we can get that person in. For those who got medical aid, be it so. For those who haven't got medical aid, then is what we are paying the firm for.	Silence after the statement
	Facilitator	Can we move on to the next question?	
68	U6	Just one thing, rehabilitation services for example drying out and so on obviously will all outsourced because none of the facilities can provide that.	
	Facilitator	Right, can we move now? OK, next ...	Facilitator interrupted by participant number eight
69	U8	Sorry, this...., there are options about outsourcing and in-sourcing. You can have half of each in one	She is no sure

		programme. That is also possible. So there are options that can be worked out in a particular institution. There is a way of having both in one programme	how to put it in words, or is she unsure about herself?
70	U5	I agree with her because most of the time, sometime it happens that the problem is work-related meaning that this person needs support at the working area. So sometimes when it is outsourced, totally outsource, it is not going to be easy for somebody out of the institution to come and say "You in this department, need to do one, two, three". Unless maybe we work on like we said earlier that there should be a focal person who was going to see to it that he is going to receive the report and going back to those people. But as long as we just send them to the outsource areas and there is no feedback or the feedback goes just up to this person and they don't go back to department where the actual and real problem is, then it becomes a problem. So I support that maybe we should weigh the opps and cons then use both outsource and in-source services.	Statement supported all around the table
71	U3	I just want to support the speaker.	
	Facilitator	Right, shall we move on? What should the scope of the EAP be? So these are two questions in one. The first is: "What should the scope of the EAP be?" And: "what is the role of the HR department in the EAP?" What should the scope of the EAP be? First of all and then what is the role of the HR department in the EAP? We can spend about UU1U5 minutes on this	Silence after the question was asked
72	U2	I would like to start with the second. Should or iss there aaa? Thank you. The HR Department/person is very much, we see people as an investment. So surely we want to see that our investments are fine and hmmm happy in order to give a good service. Another role of the HR Department in an EAP is there is a financial thing and that its leave, sick leave, there are patterns of absenteeism that is not known to the multidisciplinary team hmmmUU1. Yes, and your HR Department, in Universitas I don't know in Pelonomi but we got a very good relationship with all our clients. So in, it is very much to the advantage of the person in the EAP if HR is involved and of course the HR Department has also got to be very strictly information and personal information. We got to have those legal	Participant not sure how to start UU1 very unsure what to say

		documents in place	
73	U6	Can I add there? Maybe where you'll also..., an important role is to assist with what you mentioned the whole leave management and allocation. You know, this incapacity, short-term and long-term the whole process for those people who need that.	
74	U2	And I forgot and number two has forgotten to say that re-deployment. If a person is forever unhappy and in certain circumstances it is the HR role to re-deploy to a better situation.	
75	U6	And re-skilling.	Just trough in the words, not further comment from participant
76	U1	I think that if I do understand the question of the scope correctly. I think a person or people are very individual like number one, number seven said on the previous question. At the EAP we look at the person as a whole. So, to determine the scope we will also have to look at the person as a whole and I think the scope would be very wide because each individual have very unique problems. It can be financial problems and then occupational therapy would not really play a big role because we are not equipped to handle that than and so it would be the social worker or even a financial adviser. So I think the scope could be quite big and I think the whole multidisciplinary team, occupational therapy, social work, I think even physiotherapy with stress handling, psychiatry with a bit more psychiatric or psychology. I think there are quite an involvement.	Supported by number seven
77	U3	Do you want use to mean them all?	Asking question to U1, not sure what U1 meant.
78	U7	The different aspects or do you need the detail?	
	Facilitator	Let's hear, start listing.	
79	U3	I will just start listing and the others can add. Things that were mentioned before like absenteeism, substance abuse, and stress. Marriage problems hmm	A few laughs round the table
80	U6	Work conflict	
81	U2	Burnout	A bit of hesitation from the participants
82	U1	Burnout	
83	U3	Domestic violence, problems with children	

84	U6	Psychiatric problems I mean apart from stress	
85	U2	Sexual harassment	
86	U1	Psychiatric illness	
87	U8	Chronic illness and the management of disease in general	
88	U7	Lack of life skills	
89	U3	Relationship problems	
90	U1	And not coping with what they see at work. Maybe I am working with the patient/EAP that couldn't cope with seeing children what they see at work and not coping with the patient and the...	Participant not sure how to continue
91	U8	Workplace violence - not only physical but emotionally as well. It is all under one umbrella when they have abuse in a work situation.	
92	U4	Things like debriefing maybe when being exposed to a situation like in casualty where you saw patients are dying or something like that.	
93	U6	I think not only substance abuse and addictions but also other addictions like gambling. Assisting with the management of their money and so on.	Few participants agreed
94	U8	Personal financial management	Pause after this comment
	Facilitator	Right	
95	U3	Anger management	
96	U8	And stress	Supported by U8U4U5 followed by silence
	Facilitator	Right so now we do have an idea of the scope. I didn't keep up with whom see what. I think it was just for listing. OK, what types of services should be rendered, I think we already looked at that in this but should there be therapeutic, preventative, monitoring, follow up?	
97	U1	Especially the follow up. I was lodging about that because if they come for the programme especially in occupational therapy. We do have a five week programme and I never know what happens when they are back. We don't get the feedback from the supervisors. Did it work? Could they cope? Is their stress handling better? So ja, the input is important but also the follow up. It's very important.	Supported by U3U4U5 and eight Laughs round the table as everyone was in agreement
98	U3	And, and the follow up programme is different. Let say for somebody that has been on suspension. Then you got to have a follow up programme for certain period of time and there is reports from	Support from others

		EAP to the supervisor, from the supervisor back to the EAP and then somebody who comes back from rehab. There is a certain period of time where there is an after-care service that is rendered. That is also restricted, you cannot go on for ever with everybody. When there is reports again because you do the therapy and you see the person on an individual basis but the person is working in the setup and he needs to be monitored there. So there is monitoring on both sides. Very important. Otherwise the programme is not working and that is a concern.	
99	U2	I just want to know one thing on the table. In the scope - the EAP are going to provide a number of services but where does it end? Is it only to the employer and his or her spouse and children? Or you know would it be for her family or whatever. There should be a limit, you know only to children, spouse, mother.	
100	U3	I think it is known that EAPs render a service that include the family if they are part of the problem. So you can call in anybody. You can call in a child, spouse.	
101	U2	Direct family or so I gather it is direct family.	
102	U3	I said, if the person is part of the problem. It can be the sister in law, and it's really a big problem. It is a big issue and you cannot solve with the person alone.	Participant is very persistent to state her point – even raised her voice
103	U6	Can I go back a little bit to what number one said that you know I think that is an important part of those procedures that must be written. The follow-up procedure that should also be somehow specified or structured so that it is procedurised. If I can say that.	
	Facilitator	Some of the others are being quiet. All quiet. OK? Are we still nodding?	
104	U7	I am still concerned about what number two was saying because I think I heard what number three said but I think somehow we can't, there must be some limit that we can say hmm, you know you can't follow people that is in Cape Town or or hmm that is getting problems. Somehow you must limited to exactly what are you going to do about the problem if it is far away if it's hmmm without boundaries of help.	Very adamant, but this went interrupts the facilitator to make a statement
105	U3	I didn't say, I didn't talk about distance. I said that if	Very defensive

		it is a big problem because many of the people are staying together. The extended families are staying together. So it is literally like close family. I did not refer to somebody in the Cape.	
106	U7	I am just....	No U7 interrupted by no U3
107	U3	Then obviously you will refer or you will get guidance for the person to handle in a different way. No, I think immediate family....	No U3 interrupted by no U7
108	U7	Yes, I understand but I just want to have it specified the boundaries	
109	U2	There got to be specifics.	
	Facilitator	OK, are you happy with this question? Can we move on?	
110	U6	Can I mention one thing else which practically happened, I mean it is like supervising Antabuse for addicted people. I mean, you think the EAP would be ideal there.	
111	U7	Or DOT or....	
112	U6	Or DOT or HIV treatment but I mean specifically now the Antabuse because I think it is part of the EAP, has been the referred, put on this and now someone must supervise the treatment	
	Facilitator	Are you ready for a tea break?	
113	U6	Yes please I am very hungry.	Everybody laughs
	Facilitator	All right let's continue then after our break. There are five questions left on which we will spent a reasonable amount of time and in this section there will be two that are linked. The first one says: "What category of staff members and training should be appointed for providing the services in the EAP?" I know we touch on that but maybe we can elaborate a bit more for about UU10 minutes. "What category of staff members and training should be appointed for providing the services in the EAP?"	Unusual long silence followed after the question was asked
114	U2	Psychiatrist, psychologist, social worker, nursing person, occupational therapist.	
115	U7	A medical doctor	
116	U2	A medical doctor!	Laughs from around the table
117	U7	Admin staff	
118	U2	Certainly admin staff as well	
119	U1	I even think physiotherapy has a role to play	

120	U3	Oh yes	
121	U5	Occupational therapist	
122	U7	Got it	
123	U5	A pastor	
124	U3	Pastor	
125	U4	Is the occupational therapist also in? And the hmm psychologist? Should it be in? Clinical psychologist or industrial psychologist? Maybe an industrial psychologist.	Silence
126	U2	I think the industrial psychologist is more to the training. That would be	Participant unsure what to say next
127	U4	Personnel with psychological problems, psychosocial. We need to a social worker and psychologist	
128	U1	Clinical psychologist	
129	U3	It is debatable. I think we are not used to using industrial psychologist. But that is what is happening in private sector. The big companies are employing industrial psychologists. It is debatable and it depends on what kind of problems	
	Facilitator	What level of intervention are we talking about? Preventative, therapeutic?	
130	U3	You can't employ a person just to do therapy.	Supported by four. Silence after that statement
131	U1	How can we see the role of some other form of financial adviser? Outsource but??	
132	U7	A legal team also, some legal form, even if it is part time, just hmm. Lawyer or hmm	Supported by U2
133	U2	Legal adviser stroke financial adviser	
134	U3	I just want to go back. We are talking about a very big team here. And they always say you need to be smart. Many of these can be sessional workers. Hmm, there must be somebody in the office who is receiving the let's call it then the complaints or whatever. And then you refer to the different people in the multidisciplinary team because hmm I agrees specifically with the legal team. You must have a resource because it is one of the big problems and I think we left it out previously in the scope. We left it out, people with financial problems. My goodness.	Embarrassed
	Facilitator	I think financial was mentioned but not the legal. Alright, so we will record it now. OK	
135	U5	So, I am sure it means that all these people that	

		we have mentioned need to be incorporated into a committee but not particularly been employed by the organisation. And then there after like number seven said we would need to do across referral based on the problem but the initial assessment and problem finding need to be done by a local person who will be an EAP facilitator. And then based on the problem found we are going to refer to the resources.	
136	U7	What number five said is it I think there needs to be a core team that can sort of deal with the basic needs and then from there need to be a extended team of a way of referral or send a patient to more care	Supported by number one and two
137	U6	I think there is hmm it needs to be tapered according to the size of the place as well. Obviously these people cannot be established obviously these peoples cannot be established in every place. But there might be just the nurse in a small hospital and then in a bigger hospital may be a bit more and so until you get to a big complex like this. But I think even here it is unlikely that they will have all these people but they'll need to have access maybe to them.	
138	U3	There is one other one that I want to add because it is also a trend in private sector is to get and I don't know if I pronounce it correctly bio-kinetics. The trend is to have a little gym at the workplace but you can not just have the facility and there is nobody giving guidance. Then there is going to be a fruitless exercise.	Supported by eight and one
	Facilitator	Right, can we move on? What pre-entry processes should be in place? Pre-entry processes. What pre-entry processes should be in place?	Silence after the question was asked
139	U8	For appointment as.... Pre-entry for what?	
140	U2	Entering the EAP.	
141	U8	The programme	
142	U6	The employees	
143	U8	Okay	
144	U7	Initially there should be a good policy	
145	U6	And I think those procedures that we mentioned before should be in place and that will hmmm I mean hmmm will deal with this. The process needs to be followed before someone is enters.	
146	U2	Hmm, I just want to make it clear that if you enter the EAP you don't enter it for wellness. You enter it for.... you've got to have a problem. So the	Participant didn't complete her sentence but

		wellness programme is another leg. I just want to....	the silence follow her statement
	Facilitator	So we said policy and procedures.	Silence after that
147	U2	Consent.	
148	U1	Again I think commitment is very important from the employer, employee also. Hmm, commitment	
149	U4	Maybe hmm the entry into the programme. The, the, a contract with the employee should be there so that, that comes back to commitment. The person must know exactly that I am going to adhere to this programme after the explanation on everything and that person can sign the contract.	
150	U7	I think it is important in a contract it must say what's going to happen if a person does not comply and what's going to happen if he is complying. He must know exactly what is waiting for him, what is the cost entailed, what is everything as he enters. He must know the consequences.	Participant five and two in agreement
151	U6	I think if, if they self refer themselves obviously there won't be any process before they come. They just pitch up there. But... maybe, I don't know if part of the process would be a booking system. I don't know if you were thinking that could be, it could be dealt with here. It is probably obvious.	Several agreed Participant didn't want to finish his sentence, not sure about himself
152	U8	Since it involves seeing the practitioner during working hours. Even if it is separate there has to be some guidance on how to make the employer aware that...	
153	U6	O, the supervisor	Interrupted
154	U8	You are aware, the supervisor, that you are using official time sometimes if you to see. There has to be a way of informing the supervisor even if it is in a separate way.	Supported by U3, U6 and seven
	Facilitator	OK	
155	U8	So, it needs to go into the referral system.	
	Facilitator	OK, Let's move on then to the next set of questions which then has three on which we can each spent UU10 to UU1U5 minutes. The first one reads like this: "Which areas of the EAP should be evaluated?" "Which areas of the EAP should be evaluated"?	Silence after the question was asked
156	U1	Of the current programme or the people who are participating? Current program?	Uncertainty

	Facilitator	The programme	Silence while participants are thinking
157	U7	I think the different types of problems. Hmm, maybe keeping statistics hmm, to see that trends hmm in the different kinds of problems in the institution. Hmm.	Participant not sure what to say
158	U2	The success rate and the relapses.	Supported by three
159	U8	It should also see the availability. Is it accessible? And personnel - is personnel available?	Supported by one
160	U7	I think also measuring the outcome. Maybe looking at the people of compliance, people that really help people that hmm sort of how did they end of also looking at maybe the reasons why people did not comply or the reasons why people didn't hmm to see at it will almost be like quality assurance hmm circle to get back to see if some of the problems can be solved.	
161	U2	I want to add on that hmm the person's performance and his functionality of the leaving the programmes should be monitored for a prescribed time.	Supported well around the table. Silence of the statement
162	U6	One can also evaluate is the users of the service. You know that they score the service. Hmm satisfaction score or customer care. Hmm scoring	
	Facilitator	OK, I think that actually add to the next question. So should we move on or should we...	Facilitator interrupted by participants
163	U5	Did we say anything about support in the department? Supporting the workplace? Are these people well supported by supervisors and co-workers sometimes?	
	Facilitator	So that is another area that must be evaluated. So that was participant number five and will support the round table.	
164	U2	The challenge of keeping confidentiality and meeting confidentiality while supporting.	Supported by three and eight
165	U7	I think also in the whole record system and a filing system of these hmm could be quite a challenge.	Silence after the statement
	Facilitator	Anymore areas that you want to suggest?	
166	U5	I've, I've just said the follow up into the ward but another thing that I want to say is that there should be a constant and continuous communication between the supervisor and the EAP officer. The person who is referred and report back should be	Silence after the statement

		an ongoing so that supervisor mustn't just say that I've posted this employee to the EAP officer. And then even if the employee doesn't make a follow-up, just left like that and they'll only identify and notice that when there is another problem. So I think there should be an ongoing and constant communication so that there should be a wake-up call that I am still expecting your report. Where is the report for this person? In that fashion it is going to keep the programme really sustainable until the expected period sort of.	
	Facilitator	OK, we can move onto the next question which actually flows from this and that is: "What methods of evaluation could be used in this evaluation process?" One has been already been suggested.	
167	U1	One that I'm thinking about right at the time and now I am specifically talking about what we do in occupational therapy hmm is that hmm I already thought about evaluating also when the patient is referred in the beginning or the employee is referred having some or other the kind of hmm interview with the supervisor to ask how is the employee coping at this moment. How is the work relationship and then going to the programme and then maybe look after the six weeks and then after another six weeks maybe when the patient I always want to say patient the employee is back in reality for six weeks. Good work. The supervisor even if it is an objective person would also be able to tell was the effect like we wanted it to be. Even from the employee himself also.	
168	U7	Ja, I think, sorry, I think self-assessment will also be good because then they can see how do they self feel they are coping with stress. How they are coping with conflict. How, it would be interesting to see this the self-evaluation hmm correlates with the evaluation of the people around the sort of hmm the observers or whatever	Supported by two and three
169	U6	I think another method is what number seven mentioned. I mean to keep the stats, trends and outcomes on a sheet and I think maybe this new Canada system will probably hmm facilitate that or make that possible.	Extended silence and uncertainty after the statement
	Facilitator	Participant number four, you are very quiet. Very quiet. Are you in support of your colleagues?	Some laughs around the table silence follows
	Facilitator	OK, and then the last question, can you believe?	Several

	ator		participants are not impressed
170	U6	For the day?	
171	U2	Ons raak nou eers opgewarm	
172	U6	Dit raak nou eers lekker	
	Facilitator	"What impact do you expect from an EAP on the organisation?" What do you expect?	
173	U5	There should be an improved productivity.	Silence after the statement
174	U1	I think if it is implemented correctly and everybody and that they are, they entered the right people then you will have happy like happy workforce, happy people and happy patients and it will also go out further than in the person. Happy investment.	Supported by U2, U3 and four
175	U7	I think also...	Participant interrupted by other participants to support previous statement made by number one
176	U7	If it works successful I think the whole thing just treating and treating will change in keeping wellness and more preventative and keeping it more sustainable. You know that it runs more smoothly.	
177	U2	And it is also hmm a big financial hmm advantage. I am talking investments or money but happiness is also presentism. So the financial losses that we are suffered at the moment because often unwell hmm workforce is tremendous. It is tremendous if you take it into account. Hmm so I think financially it, we would, could gain a lot as well.	
178	U4	Care absenteeism and hmm saving as you said.	More than one participant want to talk
	Facilitator	Please talk some more,	Everybody wants to make a comment
179	U4	Can I talk some more?	
	Facilitator	You were so quiet	
180	U4	The relationship, the employer and employee relationship we enhance and they trust the employee more. This employer is caring for us as employees.	

181	U5	We received ...	Participant number three wanted to interrupt
182	U4	We will attract people from outside to apply to the organisation to come and work here.	
	Facilitator	You see, now that you have the floor, you do have everybody's support	Everybody is laughing in support
183	U3	And at the end you will have better service delivery because that is what every employer deserves.	
184	U7	If we got good life skills and you will cope better even if your circumstances are difficult there is nobody is known that the way you cope is better, the way you communicate better, the way you handle conflict is better. So that it's not that the problems will be less but the way of coping will be much easier.	Supported by all
185	U3	I think EAP is also we are not just talking around the bush on one aspect. Their health status can, ... in the end, ... if the programme..... is running smoothly we will have healthier employees because they will learn how to take care off themselves. It will be things happening to us that will have an influence on our health and emotional status but hmm health care workers got a tendency, they take care of somebody else. They don't take care of themselves. So it is a learning curve and I hope in the end the programme is running properly and we teach them to take care off themselves. So it is a long process	Supported by five and one
186	U2	I just want to add that this can be a retention tool as well you know. If hmm if an employee are being looked after with a salary and holistically this can make a change to go out or to stay in.	Supported by eight, three and four. Silence after the statement
187	U8	Sorry, it will have an impact of less turnover - employee turned over. Following from what we said.	Supported by two Silence after the statement
188	U6	I think...	Interrupted by participant number two
189	U2	Kan die girl nie net so vir ons 'n ander vragie ingooi nie?	
190	U6	I think if the EAP has hmm has a good impact on the workplace it will, it should naturally move more	

		over into wellness you know more other programmes, preventative programmes if it is really doing, I mean function optimally. Ideally I think that should develop from a proper EAP programme.	
191	U1	I also think there would be a lot value in a more preventative programme if we had, could have the resources because I think everybody, high functioning people, all of them has sometime difficulty in handling conflict. It is normal, human. So I think the more preventative we can start working on that, the better	Supported by eight and three
192	U5	I also think it's going to improve the spirit of wellness and morale because like right now we are having the problem, the pandemic of HIV. Its an effect on other employees and we are still at that stage where the colleagues and co-workers are not supporting each other but if it is functioning well we will get to that stage where everybody will realise that this is a problem of infected people and it's going to affect most of us and we need to support each other and work together as one.	
193	U7	I think if the EAP works well it can also take the stigma out of a lot of things. If people see that HIV people are helped there or people with stress or people with depression or whatever they won't be scared to expose themselves to tell that I've got this problem because they feel we going to be helped there and it makes a difference. You know it is not hmm ...	Statement was well supported
194	U2	O, definitely	
195	U4	And hmm if hmm an EAP is hmm comprehensive and it is not a stand-alone and then people will come for the service. And if it is a good programme, people talk, employees talk. People from other organisations will come and benchmark and then it can spread all over.	
196	U8	I think it will highlight to management the importance of having a holistic approach to employee health by including all other hmm components. Not only the EAP and move towards one's wellness because it will... because if the EAP works well it will highlight the gaps you know towards wellness – comprehensive wellness. Which includes even just, even occupational health and safety. It includes wellness. It is comprehensive.	Supported by two and three

	Facilitator	Anymore responses to do this question - what impact?	Silence after the question was asked
	Facilitator	OK, so well done. You are a very good cooperative focus group.	
197	U3	We are just worried that we haven't said enough.	
198	U2	Dit voel ook vir my so	
199	U3	Because you cannot really remember what was said and what was not said. There is the evidence but maybe we haven't said enough.	
200	U6	What I am missing from here, if, can we say that? Is hmm the role of management in this whole, you know this whole framework for the best-practice because I think management critical I think. What we experience trying to do something is that management was always (laugh) critical or hmm they were expecting us to fight their case and not so much the EAP case. So I don't know if that is To me that is a critical issue in this whole thing. If management doesn't support and if they don't stand and honor those people who do the work, then it's always a hassle and conflict and hmm and that will...	Interrupted by participant number two
201	U2	Maybe one could say that EAP hmm success is based on the support of the management. They've got to be, you know, the management. This is got to be their wish. This is not the wish of us. It should be their wish.	
202	U4	Support and commitment of management.	Supported by two
203	U6	Like we....	Interrupted by the facilitator
	Facilitator	Sorry this was a statement made by six and well supported by two and four.	
204	U6	What I, a practical example is hmm I mean when we had this conflicts. They said that no, the best to take the EAP away from the clinic. Without consulting us and not without speaking or consulting those who were directly involved with this and I think that type of management will hamper the whole system and it is very dependent that they hmm it is important that they support it and that they hmm. They must drive it also. They mustn't just sit back and expect others hmm...	
205	U7	I think also being actively involved sounds terrible but I mean we are talking about managers that put sense on their PDMS but never attend one	Interrupted by number seven

		meeting. Never had one... never ever once talked to anybody in the EAP team. Yet they are the one that got it on as part of their core function. I feel that's not right you know it is...(very adamant).	But this and feel very strongly about it even stuttered to get the words out Strongly supported by two
206	U2	There is should also be a very clear mandate to the EAP committee and their. This mandate should be excluding interference by a management member.	
207	U6	Exactly	
208	U3	One must be very clever who should be on the EAP committee because they should be somebody from management there and even other hmm not middle managers but senior managers should be there. And that is what we've tried to do last week. We've been asking for a long time that the wellness programme, that that we want to do, gone on training for that and at the end we succeeded to get managers in the end. Because they don't really know what is EAP. So now you made them involved and they actually participated in the whole process. And now that is a good starting point. Now they are informed. It is not just inform them - the model is there. Worldwide that is used on how an EAP should be run but sometimes they don't know it - the managers and as you say it is part of their functions but they don't really know what is their role.	Supported by four in five participant number three feels very adamant about this statement even raised her voice in the middle part silence after her statement
209	U5	If I can just make a follow-up on that. We are still at that stage where each and every person feels for a person to go to EAP a supervisor needs to take you there but we wish to be really on that stage where I feel that I am having a problem and it should be going on my own. Meaning that it is actually a triangle. It should be an employee who is troubled. There should be a supervisor and a manager or a management. So people should be encouraged to do that self referral because they are the people who knows their problems like for example if a person is having HIV, sorry we are keep on bringing an example of that and they've been diagnosed somewhere we will find out that the family members doesn't know, the colleagues	Supported by four

		doesn't know, my friends, my manager and I am always having the problems at work but other people can't support me because they don't know that I am having this problem. So we must really encouraged that even employees should go and seek the, the, the help from the EAP officer. And even the colleagues sometimes even if they don't go deep or go deep into problem but they should be able to come and say I see that there is a problem here. Maybe discuss it with a supervisor. Can you please go deeper into this because I can see that this person was like this but what I've seen some changes. Today she is like that. It should be colleagues referring, self referral and then it goes to the level of the supervisor but it shouldn't be supervisors, supervisors, supervisor all the time.	
210	U8	Sometimes the supervisor if I can just emphasise the point of involving the supervisor all the time. Not necessarily telling him the problem but making him aware that you are self referring yourself. I think that it is an important issue as far as Administration is concerned because then people would hide behind EAP sessions. We shall try that and not known by supervisors. I went to EAP sessions because I am self referred and I don't have to tell you anything. The supervisor is got to know. You just inform your supervisor what is happening or in the policy there is a guideline about self referred patients on what then to do as far as the official time is concerned. So as to care absenteeism.	Several "yes" from the other participants
211	U2	Can I just add hmm? The whole marketing and rollout of the EAP is a bit difficult because what you need actually your happy people who went through the programme to advertise yourself. So hmm, maybe we should also start support groups of members who has left the EAP. Just to be a referral system. Hmm currently there is still a stigma on the EAP and we haven't got happy customers to say: "You know I've been there and it has helped me, please go there." So a support group if you exit this programme there should be something nice. Something sort of leading to a wellness programme.	
212	U3	Support by saying it is happening in reality. Hmm there was one person that I've worked with and I think she referred about four people to me. So it	Verbally supported by number two

		makes a difference.	Supported by four and five
	Observer	Thank you. Now I can say something. Right, thank you people for this session. In the second session I was sitting here smiling because I thought I need to keep notes but I see Beryl here was keeping notes and Elize was keeping notes. So hopefully it was also very helpful for you. Right because please it is also as session to share information with each other but I am also going to use the this information now to compile the best-practice EAP and quality management thereof. So after the session I am going to listen to this tape and I'm going to type it word for word what you've said and I will send you to Deirdre and I'll also send it to you to make sure that this is what I've said. So please change it so you are also part of the validation process. Please make sure everything that was said is true and then afterwards I will analyse it by making use of certain software. So just once again thank you very much. Thanks for your time and I hope you've enjoyed it.	

Appendix M

Themes, categories and subcategories from focus group discussions

THEMES, CATEGORIES AND SUBCATEGORIES: FIVE FOCUS GROUP DISCUSSION SESSIONS (FGD)

Also used to draft questions for Delphi survey

Criteria used to select aspect in Delphi questionnaire:

1. Three (3) number of quotations or more irrespective on the number of focus group discussions (FGD).
2. Two (2) number of quotations but from two different focus group discussions (FGD).

Total number of questions for Delphi survey
Round 1: **187**

Type	Details	Number of FGD	Number of quotations	Used in Delphi
THEME 1:	<u>THE NEED FOR AN EAP</u>			
Category 1.1:	<u>The rationale for an EAP</u>			
Sub-category:				
1.1.1	Unique environment in health care with risks and problems	4	17	Yes
1.1.2	Healthy and satisfied worker	5	12	Yes
1.1.3	Ensure productivity of employees	4	9	Yes
1.1.4	Employees are a valuable resource	3	6	Yes
1.1.5	Support needed by employee	2	4	Yes
1.1.6	Expectation from employee	1	1	No
Category 1.2:	<u>The objectives of EAP</u>			
Sub-category:				
1.2.1	To act as support system for employees	5	15	Yes
1.2.2	To assist with absenteeism control	3	6	Yes
1.2.3	To provide someone to listen	4	6	Yes
1.2.4	To assist with retention of personnel	2	2	Yes
Category 1.3	<u>The scope of the EAP</u>			

Type	Details	Number of FGD	Number of quotations	Used in Delphi
Sub-category:				
1.3.1	Employees and their families	4	14	Yes
1.3.2	Wide scope	4	11	Yes
1.3.3	Assist with appointments	2	10	Yes
1.3.4	Accessibility	1	8	Yes
1.3.5	Best can do	3	7	Yes
1.3.6	Holistic manner	2	6	Yes
1.3.7	Involvement of Management	2	4	Yes
1.3.8	Sick leave management	1	4	Yes
1.3.9	Cultural difference	3	3	Yes
1.3.10	Work-related and personal problems	2	3	Yes
1.3.11	Know your employees	2	2	Yes
1.3.12	Purpose of program	1	2	No
1.3.13	Relationships	1	1	No
1.3.14	Resources	1	1	No
1.3.15	Students	1	1	No

THEME 2: THE REQUIREMENTS FOR AN EAP				
Category 2.1	An introductory statement from Management			
Sub-category:				
2.1.1	Place of disciplinary actions	3	14	Yes
2.1.2	Management support of program	3	11	Yes
2.1.3	Non-threatening & non-punitive	3	9	Yes
2.1.4	Employee's wellbeing & productivity	3	8	Yes
2.1.5	Assist	3	5	Yes
2.1.6	Employer's responsibilities	2	2	Yes
2.1.7	What is offered	2	2	Yes
2.1.8	Invitation	1	1	No
Category 2.2	A joint EAP Committee			
Sub-category:				
2.2.1	Members	4	6	Yes
2.2.2	Practical arrangements to be effective	1	4	Yes
2.2.3	Mandate	3	3	Yes

Type	Details	Number of FGD	Number of quotations	Used in Delphi
Category 2.3	<u>Role of a Joint EAP committee</u>			
<u>Sub-category:</u>				
2.3.1	Evaluation function	1	8	Yes
2.3.2	Maintain balance in program	2	8	Yes
2.3.3	Policies and procedure	4	8	Yes
2.3.4	Information sharing	3	7	Yes
2.3.5	Problematic cases	3	5	Yes
2.3.6	Commitment and support	2	4	Yes
2.3.7	Trends	3	4	Yes
2.3.8	Health and safety	1	3	Yes
2.3.9	Training	2	3	Yes
2.3.10	Labour relations	1	2	No
2.3.11	Relationship between employee and Management	1	1	No
Category 2.4	<u>Requirements for EAP policies</u>			
<u>Sub-category:</u>				
2.4.1	Step by step guidelines	3	11	Yes
2.4.2	Basic conditions of services	1	3	Yes
2.4.3	Written policies	2	2	Yes
Category 2.5	<u>Types of EAP policies needed</u>			
<u>Sub-category:</u>				
2.5.1	Supervisors' responsibilities	5	38	Yes
2.5.2	Confidentiality	5	16	Yes
2.5.3	Referral procedures	4	16	Yes
2.5.4	Employee responsibilities	4	15	Yes
2.5.5	Funding	5	15	Yes
2.5.6	Employee commitment	3	12	Yes
2.5.7	Individual pathways	3	12	Yes
2.5.8	Manipulation and misuse of EAP	3	12	Yes
2.5.9	Channels to be followed	2	11	Yes
2.5.10	Referral procedures - self	2	10	Yes
2.5.11	Feedback	3	9	Yes
2.5.12	Resources available	4	9	Yes
2.5.13	Communication between EAP & supervisors	2	8	Yes
2.5.14	Relapse	3	8	Yes

Type	Details	Number of FGD	Number of quotations	Used in Delphi
2.5.15	Reports from EAP providers	2	8	Yes
2.5.16	Non-compliance	2	7	Yes
2.5.17	Open door	1	7	Yes
2.5.18	Voluntary entry	2	7	Yes
2.5.19	Who may access service	4	6	Yes
2.5.20	Program provided during working times	2	5	Yes
2.5.21	Time frame	2	5	Yes
2.5.22	Consent	1	4	Yes
2.5.23	Referral procedures - supervisor	2	4	Yes
2.5.24	Management of program	2	2	Yes
2.5.25	Evaluation of program	1	2	No
2.5.26	Booking system	1	1	No
2.5.27	Goals	1	1	No
2.5.28	Leave	1	1	No
Category 2.6	Possible EAP entry processes			
Sub-category:				
2.6.1	Initial assessment	4	8	Yes
2.6.2	Admission policy	3	8	Yes
2.6.3	Performance indicators	2	7	Yes
2.6.4	Formal referral	2	5	Yes
2.6.5	Pre-entry interview with supervisor	3	5	Yes
2.6.6	Health profile (Included in work place records)	3	4	Yes
2.6.7	Employee	3	3	Yes
2.6.8	First or repeat problem	2	3	Yes
2.6.9	Seriousness of problem	3	3	Yes
2.6.10	Contract (included in Admission policy)	1	2	No
2.6.11	Staff development	1	2	No
2.6.12	Work place records (Combined with health profiles)	1	1	No
2.6.13	Disciplinary procedures (included in Admission policy)	1	1	No
2.6.14	Open communication	1	1	No

Type	Details	Number of FGD	Number of quotations	Used in Delphi
Category 2.7	Marketing of an EAP		Not used in Delphi	
Sub-category:				
2.7.1	Marketing the EAP	3	5	
2.7.2	Correct management	1	3	
Category 3.1	Type of EAP providers			
Sub-category:				
3.1.1	External	5	26	Yes
3.1.2	Internal	3	12	Yes
3.1.3	Multi-disciplinary	4	12	Yes
3.1.4	Combined	4	11	Yes
3.1.5	Coordinator	3	9	Yes
3.1.6	Sessional appointment	2	2	Yes
Category 3.2	Characteristics of EAP providers			
Sub-category:				
3.2.1	Trust	3	16	Yes
3.2.2	Trained	3	11	Yes
3.2.3	Knowledge of organisation	3	5	Yes
3.2.4	Junior vs. Senior staff	3	4	Yes
3.2.5	Needs assessment	1	4	Yes
3.2.6	Specialists	2	4	Yes
3.2.7	Knowledgeable	3	3	Yes
3.2.8	Professional	2	3	Yes
3.2.9	Size of team	2	3	Yes
3.2.10	Registered with Council	1	2	No
3.2.11	Communication	1	1	No
3.2.12	Emotionally involved	1	1	No
3.2.13	Experienced	1	1	No
3.2.14	Experimenting	1	1	No
3.2.15	Language	1	1	No
3.2.16	Methods	1	1	No
3.2.17	Qualifications	1	1	No
3.2.18	Responsibility	1	1	No

Type	Details	Number of FGD	Number of quotations	Used in Delphi
Category 3.3	<u>Categories of staff needed</u>			
<u>Sub-category:</u>				
3.3.1	Human resource	5	29	Yes
3.3.2	Psychologist	5	10	Yes
3.3.3	Social worker	5	10	Yes
3.3.4	Occupational therapy	2	5	Yes
3.3.5	Financial advisor	3	4	Yes
3.3.6	Legal advisor	2	4	Yes
3.3.7	Medical doctor	3	4	Yes
3.3.8	Nurse	3	4	Yes
3.3.9	Pastor	2	4	Yes
3.3.10	Administrative staff	1	3	Yes
3.3.11	Occupational Health	2	3	Yes
3.3.12	Psychiatrist	3	3	Yes
3.3.13	Academic staff	1	1	No
3.3.14	Anybody	1	1	No
3.3.15	Biokinetics	1	1	No
3.3.16	Dietician	1	1	No
3.3.17	Labour	1	1	No
3.3.18	Physiotherapist	1	1	No
Category 3.4	<u>The types of services to be provided by an EAP</u>			
<u>Sub-category:</u>				
3.4.1	Financial	4	17	Yes
3.4.2	Preventative	4	15	Yes
3.4.3	Part of in-service training	2	13	Yes
3.4.4	Chronic disease management	4	10	Yes
3.4.5	Counseling	4	10	Yes
3.4.6	Referral function	3	10	Yes
3.4.7	Follow up program	3	7	Yes
3.4.8	Promotion	2	5	Yes
3.4.9	Sub stance abuse	2	5	Yes
3.4.10	Burnout	2	4	Yes
3.4.11	Debriefing	2	4	Yes
3.4.12	Therapeutic	3	4	Yes
3.4.13	Life skills	3	3	Yes
3.4.14	Marriage problems	3	3	Yes
3.4.15	Monitoring	1	3	Yes

Type	Details	Number of FGD	Number of quotations	Used in Delphi
3.4.16	Stress management	2	3	Yes
3.4.17	Absenteeism	2	2	Yes
3.4.18	Conflict	2	2	Yes
3.4.19	Rehabilitation	2	2	Yes
3.4.20	Surveillance	2	2	Yes
3.4.21	Incapacity management	1	2	No
3.4.22	Psychiatric	1	2	No
3.4.23	Relationship problems	1	2	No
3.4.24	Violence	1	2	No
3.4.25	Anger Management	1	1	No
3.4.26	Crisis	1	1	No
3.4.27	Exercises	1	1	No
3.4.28	Injury on duty cases	1	1	No
3.4.29	Retirement planning	1	1	No
3.4.30	Self defense	1	1	No
3.4.31	Sexual harassment	1	1	No

THEME 4: THE EVALUATION OF THE EAP				
Category 4.1	Program evaluation - general aspects			
Sub-category:				
4.1.1	Evaluation period	5	12	Yes
4.1.2	All aspects to be evaluated	3	7	Yes
4.1.3	Anonymous ensure	1	6	Yes
4.1.4	Continuous process	3	4	Yes
4.1.5	Evaluator	2	3	Yes
4.1.6	Several methods	2	3	Yes
4.1.7	No evaluation needed	1	1	No
Category 4.2	Program evaluation - aspects to be evaluated			
Sub-category:				
4.2.1	Outcome	5	13	Yes
4.2.2	Financial implications	2	12	Yes
4.2.3	Absenteeism	3	11	Yes
4.2.4	Types of problems seen	4	11	Yes
4.2.5	Self evaluation	5	9	Yes
4.2.6	Staff working on the EAP	5	8	Yes
4.2.7	Treatment protocols	4	8	Yes
4.2.8	Productivity	3	6	Yes

Type	Details	Number of FGD	Number of quotations	Used in Delphi
4.2.9	Trends	2	5	Yes
4.2.10	Value added	2	5	Yes
4.2.11	Availability	2	4	Yes
4.2.12	Confidentiality	2	4	Yes
4.2.13	Guidelines	3	4	Yes
4.2.14	Accessibility	2	3	Yes
4.2.15	Awareness	2	3	Yes
4.2.16	Correct channels followed	2	3	Yes
4.2.17	Customer's satisfaction	2	3	Yes
4.2.18	Effectiveness	2	3	Yes
4.2.19	Follow up in the workplace	2	3	Yes
4.2.20	Personnel turnover	1	3	Yes
4.2.21	Utilisation	2	3	Yes
4.2.22	Client's performance	2	2	Yes
4.2.23	Various criteria of program	2	2	Yes
4.2.24	Response time	1	2	No
4.2.25	Referrals	1	1	No
4.2.26	Area of organisation - from which area	1	1	No
4.2.27	Attitude	1	1	No
4.2.28	Compliance	1	1	No
4.2.29	Employee behaviour	1	1	No
4.2.30	Impact on organisation	1	1	No
4.2.31	Language of choice	1	1	No
4.2.32	Length of stay	1	1	No
4.2.33	Progress in program	1	1	No
4.2.34	Relapse rate	1	1	No
4.2.35	Support in the workplace	1	1	No
Category 4.3	Program evaluation - methods of evaluations			
Sub-category:				
4.3.1	Questionnaire	4	15	Yes
4.3.2	Statistics	5	10	Yes
4.3.3	Feedback	3	8	Yes
4.3.4	Survey	4	8	Yes
4.3.5	Interview with employee	3	5	Yes
4.3.6	Performance	2	4	Yes
4.3.7	Evaluation instrument	2	3	Yes
4.3.8	Quality assurance cycle	2	3	Yes
4.3.9	Reports	2	3	Yes

Type	Details	Number of FGD	Number of quotations	Used in Delphi
4.3.10	Client self assessment	2	2	Yes
4.3.11	Record review	2	2	Yes
4.3.12	Interview with supervisor	1	2	No
4.3.13	Lead indicators	1	2	No
4.3.14	Tick sheet	1	1	No
4.3.15	Audit	1	1	No
4.3.16	Qualitative	1	1	No
4.3.17	Quantitative	1	1	No

THEME 5:	<u>The impact of EAP (not used in Delphi survey)</u>			
Category 5.1	<u>Impact on employees</u>			
Sub-category:				
5.1.1	Retention of employees	5	11	
5.1.2	Improved morale	4	5	
5.1.3	Loyalty	2	4	
5.1.4	Wellness	2	4	
5.1.5	Misconduct	2	3	
5.1.6	Absenteeism improved	1	1	
5.1.7	Take care of themselves	1	1	
5.1.8	Expectations created	1	1	
5.1.9	Stress relieve	1	1	
Category 5.2	<u>Impact on the organisation</u>			
Sub-category:				
5.2.1	Improved productivity	5	9	
5.2.2	Positive impact	1	8	
5.2.3	Attract people	4	4	
5.2.4	Healthy people make healthy companies	2	4	
5.2.5	Improve relationships	2	4	
5.2.6	Team work	2	4	
5.2.7	Better service delivery	3	3	
5.2.8	Positive patients	2	3	
5.2.9	Prevention	1	3	
5.2.10	Cope better	2	2	
5.2.11	Financial advantage	1	2	
5.2.12	Management	2	2	
5.2.13	Work as a team	1	2	

Type	Details	Number of FGD	Number of quotations	Used in Delphi
5.2.14	Burden relieve	1	1	
5.2.15	Competitive edge	1	1	
5.2.16	Improved relationships	1	1	
5.2.17	Learning	1	1	
5.2.18	Paradigm shift	1	1	
5.2.19	Remove stigmata	1	1	
5.2.20	Risk reduction	1	1	

Appendix N

Delphi survey questionnaire: Round 2

HEAD: DEPARTMENT OF COMMUNITY HEALTH

SCHOOL OF MEDICINE

FACULTY OF HEALTH SCIENCES

UNIVERSITY OF FREE STATE

ROUND 2

MARCH 30, 2010

Dear Delphi Participant,

Thank you very much for participating in the Delphi survey of this study and completing the first round questionnaire, which I have received. This is the survey for the 2nd round. Consensus was not achieved during the 1st round of the Delphi survey on the following questions and you need to re-assess your original rating.

Instructions for the completion of the questionnaire for Round 2

Each statement will have a score just below the rating scale. That is the number of experts rating that statement. Your score for that statement is indicated by a red colour. See the following examples as an illustration:

<u>Example:</u> Please indicate how important each of the following criteria is to be included in the framework for a best-practice EAP according to the following scale: 1= Considered to be critical 2= Could be considered 3= Not to be considered Please mark the appropriate box with an X. Mark only one option.				
1.1 An EAP is needed for health care sector.	$\frac{1}{6}$	$\frac{2}{4}$	$\frac{3}{2}$	<u>Comments:</u>

Six of the twelve experts rated this statement:
 “Considered to be critical” (giving it a rating of “1”)

Four of the twelve experts decided this statement “Could be considered” (giving it a rating of “2”). Because the overall score is highlighted in red, it means you are one of the four experts rated it as “2”.

Please re-assess your rating of each numbered statement, which can be regarded as criteria for the best-practice EAP and then indicate the importance thereof on the three-point scale. The specific points of the scale are defined as follows:

- 1 – Consider to be critical (this criterion must definitely be included in the best-practice framework).
- 2 – Could be considered (it does not matter if this criterion is included or left out from the best-practice framework).
- 3 – Not to be considered (this criterion must definitely be left out of the best-practice framework).

If you complete the questionnaire in the electronic format, please type in a cross (X) underneath the point on the scale/overall score that represents your opinion on the specific indicator. If you complete the questionnaire in hard copy format (printed out), please write a cross (X) underneath the specific position of the scale.

As part of the design of the questionnaire, I have also included space for comments which can be utilised for each item. There will still be Comment column for specific criteria as well as Comment space at the end of each section to which you may comment in your own words in the space provided.

Please return the completed questionnaire by no later than 6 April 2010.

Yours sincerely,

Willem Kruger

Student no.: 1981280579

Section A:**INTRODUCTION OF AN EAP:**

This section deals with issues related to introductory statements to be included in an EAP.

A 1. The rationale for an EAP.

Please indicate how important each of the following criteria according to the following scale to be included in the rationale statement to have an EAP in a health care institution:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

1. The rationale section of an EAP for the health care sector needs to address / should include the following aspects:				Comments
1.1	To acknowledge the unique risky working environment for employees working in the health care sector.	<u>1</u> 9	<u>2</u> 3	<u>3</u> 0
1.2	To keep employees in an organisation healthy.	<u>1</u> 9	<u>2</u> 2	<u>3</u> 1
1.3				Consensus
1.4				Consensus
1.5				Consensus
1.6	Any other comments on the rationale to have an EAP in a health care institution?			

A 2. The objectives of an EAP.

Please indicate how important each of the following statements is according to the following scale with reference to the objectives of an EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

2. The objectives of an EAP for the health care sector needs to include / address the following aspects:				COMMENTS
2.1				Consensus
2.2	To improve the absenteeism profile of an organisation.	<u>1</u> 8	<u>2</u> 4	<u>3</u> 1
2.3				Consensus

A 2. The objectives of an EAP.

Please indicate how important each of the following statements is according to the following scale with reference to the objectives of an EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

2.4	To be used to retain employees in the organisation.	<u>1</u> 6	<u>2</u> 5	<u>3</u> 1	
2.5	(New) To provide a comprehensive assistance service that gives employees meaningful support.	<u>1</u>	<u>2</u>	<u>3</u>	
2.6	(New) To provide a service that is in line with the institution's core values including providing quality care to its patients.	<u>1</u>	<u>2</u>	<u>3</u>	
2.7	Any other comments on the objectives for an EAP?				

A.3 THE SCOPE OF THE EAP.

Please indicate how important each of the following criteria is according to the following scale with reference to the scope of the EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

3. The scope of the EAP must take into account / should address the following issues:					Comments
3.1					Consensus
3.2	Should be very broad with a variety of services provided.	<u>1</u> 5	<u>2</u> 5	<u>3</u> 2	
3.3	Should be used to assist with appointment of employees.	<u>1</u> 3	<u>2</u> 4	<u>3</u> 5	
3.4					Consensus
3.5					Consensus
3.6					Consensus
3.7	Should include the supportive involvement by top management in the programme.	<u>1</u> 8	<u>2</u> 8	<u>3</u> 2	
3.8	Should include the management of sick leave usage.	<u>1</u> 7	<u>2</u> 4	<u>3</u> 1	
3.9	Should consider the different cultures of employees when services within the EAP are provided.	<u>1</u> 9	<u>2</u> 1	<u>3</u> 2	

A.3 THE SCOPE OF THE EAP.

Please indicate how important each of the following criteria is according to the following scale with reference to the scope of the EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

3.10	Should concentrate on employees' personal problems.	<u>1</u> 6	<u>2</u> 4	<u>3</u> 2	
3.11					Consensus
3.12	Should highlight the importance of getting to know the employees working in the institution through the EAP.	<u>1</u> 3	<u>2</u> 5	<u>3</u> 4	
3.13	(New) A clear explanation stating that the EAP is not an extended management tool but a neutral, independent program.	<u>1</u>	<u>2</u>	<u>3</u>	
3.14	(New) The scope of the EAP should be adjusted according to changing needs of the institution.	<u>1</u>	<u>2</u>	<u>3</u>	
3.15	Any other comments on the scope of the EAP?				

A.4 THE INTRODUCTORY STATEMENT FROM THE EXECUTIVE MANAGEMENT IN THE EAP.

Please indicate how important each of the following criteria is according to the following scale with reference to the introductory statement from Executive Management of the institution in the EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

4.	The introductory statement of Executive Management of the institution should include / address the following aspects:				Comments
4.1	The EAP does not replace the disciplinary procedures.	<u>1</u> 8	<u>2</u> 3	<u>3</u> 1	
4.2					Consensus
4.3	The process of entering the programme should not be seen as punitive or threatening.	<u>1</u> 9	<u>2</u> 2	<u>3</u> 1	
4.4					Consensus

A.4 THE INTRODUCTORY STATEMENT FROM THE EXECUTIVE MANAGEMENT IN THE EAP.

Please indicate how important each of the following criteria is according to the following scale with reference to the introductory statement from Executive Management of the institution in the EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

4.5	The importance of a work-based programme to assist employees with personal problems in the work place.	<u>1</u> 9	<u>2</u> 2	<u>3</u> 1	
4.6					Consensus
4.7					Consensus
4.8	(New) Emphasis should be placed on the fact that employees stay ultimately responsible for their own conduct	<u>1</u>	<u>2</u>	<u>3</u>	
4.9	Other comments on the introductory statement of the Executive Management in the EAP?				

Section B:

Structure and requirements for an EAP.

This section deals with issues related to the structures and requirements of an EAP.

B.1 Requirements of an in-house EAP committee.

Please indicate how important each of the following statements is according to the following scale with reference to an in-house EAP committee for a health care institution:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

5.	The requirements for an in-house EAP committee must take into account / needs to include the following aspects:	Comments			
5.1					Consensus
5.2					Consensus
5.3					Consensus
5.4	Any other comments on the requirements for an in-house EAP committee within an institution?				

B.2 The role of an in-house EAP committee.					
Please indicate how important each of the following statements is according to the following scale with reference to an in-house EAP committee for a health care institution: 1= Considered to be critical 2= Could be considered 3= Not to be considered Please mark the appropriate box with an X. Mark only one option.					
6	The role of an in-house EAP committee must include / address the following issues:				Comments
6.1					Consensus
6.2	To ensure that there is the necessary cooperation for the EAP to remain balanced.	<u>1</u> 8	<u>2</u> 3	<u>3</u> 1	
6.3	To be part of the formal evaluation of the EAP.	<u>1</u> 8	<u>2</u> 4	<u>3</u> 0	
6.4					Consensus
6.5	To be involved in the discussion of problematic cases/employees within the EAP.	<u>1</u> 5	<u>2</u> 2	<u>3</u> 5	
6.6					Consensus
6.7					Consensus
6.8	To maintain a link between the EAP and the health and safety committee especially regarding health risk assessments.	<u>1</u> 8	<u>2</u> 2	<u>3</u> 2	
6.9	To be involved in the training of relevant EAP stakeholders.	<u>1</u> 8	<u>2</u> 2	<u>3</u> 2	
6.10 Any other comments on the role of the in-house EAP committee within a health care institution?					

B.3 The service providers in an EAP.					
Please indicate how important each of the following statements is according to the following scale with reference to the service providers of an EAP: 1= Considered to be critical 2= Could be considered 3= Not to be considered Please mark the appropriate box with an X. Mark only one option.					
7	The manner in which services are provided in an EAP in a health care institution must take into account / needs to address the following aspects:				Comments
7.1	The services could be outsourced to a service provider independent of the health care institution.	<u>1</u> 5	<u>2</u> 5	<u>3</u> 2	
7.2	The services should be provided by an in-house service provider.	<u>1</u> 4	<u>2</u> 4	<u>3</u> 4	
7.3	The services should be provided within a multi-disciplinary team.	<u>1</u> 9	<u>2</u> 2	<u>3</u> 1	
7.4	The services could be a combination between an in-house service provider and an outside (outsourced) service provider.	<u>1</u> 4	<u>2</u> 5	<u>3</u> 3	
7.5	The appointment of a fulltime EAP facilitator in the health care institution to coordinate the activities of the EAP.	<u>1</u> 7	<u>2</u> 3	<u>3</u> 2	
7.5.1	(New) The full time facilitator should be a social worker	<u>1</u>	<u>2</u>	<u>3</u>	
7.6	The EAP service providers can be appointed on a session basis.	<u>1</u> 2	<u>2</u> 6	<u>3</u> 4	
7.7	Any other comments on the types of the EAP providers?				

B.3 The characteristics of the service providers in an EAP.					
Please indicate how important each of the following statements is according to the following scale with reference to the characteristics of the service providers in an EAP: 1= Considered to be critical 2= Could be considered 3= Not to be considered Please mark the appropriate box with an X. Mark only one option.					
8 The following characteristics of the EAP providers need to be considered / should be addressed:				Comments	
8.1				Consensus	
8.2				Consensus	
8.3				Consensus	
8.4	Only senior level staff members should provide the necessary services in the EAP.	<u>1</u> 2	<u>2</u> 6	<u>3</u> 4	
8.5	A formal needs assessment should be conducted to determine the type of EAP services for the health care institution.	<u>1</u> 9	<u>2</u> 3	<u>3</u> 0	
8.6	The staff working in an EAP must be specialists in their respective fields.	<u>1</u> 6	<u>2</u> 4	<u>3</u> 2	
8.7					Consensus
8.8	All service providers in the EAP must be a professional service provider.	<u>1</u> 8	<u>2</u> 3	<u>3</u> 0	One expert didn't score the questions
8.9	The number of EAP providers should be based on the size of the health care institution.	<u>1</u> 6	<u>2</u> 4	<u>3</u> 1	One expert didn't score the questions
8.10	Any other comments on the characteristics of the EAP providers?				

B.3 The category of service providers in an EAP.

Please indicate how important each of the following statements is according to the following scale with reference to the category of service providers in an EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

9 The following category of staff members needs to be considered / included in an EAP team to render a service in a health care institution:				Comments
9.1 Human resource officer.	<u>1</u> 5	<u>2</u> 4	<u>3</u> 3	
9.2 Psychologist.	<u>1</u> 9	<u>2</u> 2	<u>3</u> 1	
9.3				Consensus
9.4 Occupational therapist.	<u>1</u> 5	<u>2</u> 6	<u>3</u> 1	
9.5 Financial advisor.	<u>1</u> 7	<u>2</u> 4	<u>3</u> 1	
9.6 Legal advisor.	<u>1</u> 4	<u>2</u> 6	<u>3</u> 2	
9.7 Medical practitioner.	<u>1</u> 6	<u>2</u> 4	<u>3</u> 2	
9.8 Registered nurse.	<u>1</u> 3	<u>2</u> 7	<u>3</u> 2	
9.9 Religious/spiritual leader.	<u>1</u> 3	<u>2</u> 6	<u>3</u> 3	
9.10 Administrative staff member.	<u>1</u> 4	<u>2</u> 2	<u>3</u> 6	
9.11 Occupational health nurse.	<u>1</u> 7	<u>2</u> 5	<u>3</u> 0	
9.12 Psychiatrist.	<u>1</u> 2	<u>2</u> 5	<u>3</u> 5	
9.13 (New) A senior member of management	<u>1</u>	<u>2</u>	<u>3</u>	

B.3 The category of service providers in an EAP.

Please indicate how important each of the following statements is according to the following scale with reference to the category of service providers in an EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

9.14 (New) Union members	<u>1</u>	<u>2</u>	<u>3</u>	
9.15 (New) External service providers can be appointed on an as needed basis	<u>1</u>	<u>2</u>	<u>3</u>	
9.16 Any other comments on categories of staff members to be included in the EAP team to provide services in a health care institution?				

Section C:**Policies and procedures for an EAP.**

This section deals with issues related to policies and procedures for an EAP.

C.1 Requirements for policies and procedures.

Please indicate how important each of the following statements is according to the following scale with reference to the requirements for the policies and procedures for an EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

10 The following requirements must be considered / needs to be addressed when policies and procedures are developed for an EAP:				Comments
10.1				Consensus
10.2 A review of the basic conditions of services from the Department of Labour before drafting policies.	<u>1</u> 7	<u>2</u> 3	<u>3</u> 2	
10.3				Consensus
10.4 (New) Policies and procedures should be subjected to review every two years.	<u>1</u>	<u>2</u>	<u>3</u>	
10.5 (New) Policies and procedures should be accessible in an electronic format.	<u>1</u>	<u>2</u>	<u>3</u>	

10.6 Any comments on the requirements for policies and procedures to be developed for an EAP?

C.2 Types of policies and procedures.

Please indicate how important each of the following statements is according to the following scale with reference to the types of policies and procedures needed for an EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

11 The following type of policies and procedures for an EAP must be considered / needs to be developed:				<u>COMMENTS</u>
11.1				Consensus
11.2				Consensus
11.3				Consensus
11.4				Consensus
11.5 The funding structure for services rendered within the EAP.	<u>1</u> 9	<u>2</u> 2	<u>3</u> 1	
11.6 The commitment needed from employees throughout the EAP.	<u>1</u> 9	<u>2</u> 2	<u>3</u> 1	
11.7 The individual treatment pathways to be followed for each employee entering the EAP.	<u>1</u> 5	<u>2</u> 6	<u>3</u> 1	
11.7.1 (New) The treatment options to be followed according to the specific reason for entering the EAP	<u>1</u>	<u>2</u>	<u>3</u>	
11.8 The management of possible manipulation/misuse of the EAP by the employee to his/her advantage.	<u>1</u> 9	<u>2</u> 2	<u>3</u> 1	
11.9				Consensus
11.10				Consensus
11.11				Consensus
11.12				Consensus
11.13				Consensus
11.14 The actions to be taken in the case of a relapse of an employee while in the EAP or after discharge.	<u>1</u> 9	<u>2</u> 2	<u>3</u> 1	
11.15 The formal written reports to be provided by EAP providers regarding the progress made by an employee in an EAP.	<u>1</u> 9	<u>2</u> 2	<u>3</u> 1	
11.15.1 (New) The circumstance as to the release of the formal written reports must be specified.	<u>1</u>	<u>2</u>	<u>3</u>	

C.2 Types of policies and procedures.

Please indicate how important each of the following statements is according to the following scale with reference to the types of policies and procedures needed for an EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

11.16				Consensus
11.16.1 (New) The EAP should not been seen as a mandate by management.	<u>1</u>	<u>2</u>	<u>3</u>	
11.17 An open door approach by supervisors to ensure availability of the supervisors to discuss problems with their employees.	<u>1</u> 7	<u>2</u> 3	<u>3</u> 2	
11.18				Consensus
11.19				Consensus
11.20				Consensus
11.21				Consensus
11.22				Consensus
11.23				Consensus
11.24 P				Consensus
11.25 (New) The monitoring and evaluation of the EAP.	<u>1</u>	<u>2</u>	<u>3</u>	
11.26 Any other comments on the type of policies and procedures needed for an EAP?				

Section D:**EAP processes and activities.**

This section deals with EAP processes and activities.

D.1 EAP ENTRY PROCESSES

Please indicate how important each of the following statements is according to the following scale with reference the entry processes for an EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

12 Processes regarding the entry of an employee into the EAP must address / needs to include the following:				Comments	
12.1				Consensus	
12.2	Poor work performance of the employee is identified.	<u>1</u> 9	<u>2</u> 2	<u>3</u> 1	
12.3	There must a formal admission policy and procedures document.	<u>1</u> 8	<u>2</u> 4	<u>3</u> 0	
12.4	Confirmation that a formal referral system was followed.	<u>1</u> 9	<u>2</u> 3	<u>3</u> 0	
12.5	A pre-entry interview with the employee should be performed by the supervisor.	<u>1</u> 3	<u>2</u> 2	<u>3</u> 7	
12.6	Confirmation that the person to be entered into the EAP is currently employed in the health care institution.	<u>1</u> 8	<u>2</u> 2	<u>3</u> 2	
12.7					Consensus
12.8					Consensus
12.9	A health profile of an employee is kept as part of the work place record.	<u>1</u> 9	<u>2</u> 0	<u>3</u> 3	
12.10	Any other comments on the entry processes for an EAP?				

D.2 Types of services to be rendered in an EAP.

Please indicate how important each of the following statements is according to the following scale with reference to the types of services to be rendered in an EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

13 The following type of services for an EAP must be considered / needs to be included in the programme:

COMMENTS

13.1 Financial advisory services.	<u>1</u> 6	<u>2</u> 5	<u>3</u> 1	
13.2				Consensus
13.3 Participation in in-service training programmes of the health care institution for all the employees.	<u>1</u> 9	<u>2</u> 2	<u>3</u> 1	
13.4 Chronic disease management.	<u>1</u> 6	<u>2</u> 5	<u>3</u> 1	
13.5				Consensus
13.6				Consensus
13.7 A follow-up service for a certain period of time after the initial sessions.	<u>1</u> 7	<u>2</u> 4	<u>3</u> 1	
13.8				Consensus
13.9				Consensus
13.10 Assistance with burnout syndrome.	<u>1</u> 9	<u>2</u> 2	<u>3</u> 1	
13.11				Consensus
13.12 Provide general therapeutic services.	<u>1</u> 5	<u>2</u> 5	<u>3</u> 2	
13.13 Teach basic life skills.	<u>1</u> 7	<u>2</u> 4	<u>3</u> 1	
13.14 Provide marriage therapy within the family context.	<u>1</u> 5	<u>2</u> 7	<u>3</u> 0	
13.15 Supervision of rehabilitation services such as Antabuse® dosage.	<u>1</u> 7	<u>2</u> 2	<u>3</u> 3	
13.16				Consensus
13.17 The approval of sick leave.	<u>1</u> 1	<u>2</u> 2	<u>3</u> 9	

D.2 Types of services to be rendered in an EAP.

Please indicate how important each of the following statements is according to the following scale with reference to the types of services to be rendered in an EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

13.18	Conflict management.	<u>1</u> 5	<u>2</u> 6	<u>3</u> 1	
13.19	Provide general rehabilitation services.	<u>1</u> 2	<u>2</u> 3	<u>3</u> 6	One expert didn't score the question
13.20	Assistance with medical surveillance services of employees.	<u>1</u> 2	<u>2</u> 8	<u>3</u> 2	

Additional criteria

The following six statements deal with additional concepts for possible inclusion in the best-practice EAP, but didn't meet the criteria or were not identified during the focus group discussion. However, these concepts were identified for possible inclusion through the literature review process.

D.2 Types of services to be rendered in an EAP (continues).

Please indicate how important each of the following statements is according to the following scale with reference to the types of services to be rendered in an EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

13.21	Temporary incapacity management.	<u>1</u> 4	<u>2</u> 7	<u>3</u> 1	
13.22	Psychiatric services.	<u>1</u> 1	<u>2</u> 8	<u>3</u> 3	
13.23	Services to address relationship problems in the workplace.	<u>1</u> 6	<u>2</u> 4	<u>3</u> 2	
13.24	Support services to people who were involved in violence.	<u>1</u> 7	<u>2</u> 4	<u>3</u> 1	
13.25	Crisis management services.	<u>1</u> 9	<u>2</u> 2	<u>3</u> 1	

D.2 Types of services to be rendered in an EAP.

Please indicate how important each of the following statements is according to the following scale with reference to the types of services to be rendered in an EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

13.26	Management of Injury on Duty (IOD) cases.	<u>1</u> 1	<u>2</u> 8	<u>3</u> 3	
13.27	(New) Provide general supportive services such as visiting Department of Home Affairs for Identification documents, birth registrations, passport and motor car registration.	<u>1</u>	<u>2</u>	<u>3</u>	
13.28	(New) Initial individual session should be viewed as a referral tool to appropriate resources.	<u>1</u>	<u>2</u>	<u>3</u>	
13.29	Any other comments on the type of services to be rendered in an EAP?				

Section E:**The evaluation of the EAP.**

This section deals with the evaluation of the EAP.

E.1 General requirement for the evaluation of an EAP.

Please indicate how important each of the following statements is according to the following scale with reference to the general requirements for the evaluation of an EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

14 The following general requirements must be considered / need to be included during the EAP evaluation process:				<u>COMMENTS</u>
14.1				Consensus
14.2				Consensus
14.3				Consensus
14.4				Consensus
14.5				Consensus
14.6				Consensus
14.7	Any other comments on the general requirements for the evaluation of an EAP?			

E.2 The components of an EAP to be evaluated

Please indicate how important each of the following statements is according to the following scale with reference to the specific components of the EAP to be evaluated:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

15 The following components of an EAP must be considered / need to be included in the evaluation of an EAP:				<u>COMMENTS</u>
15.1				Consensus
15.2				Consensus
15.3 The absenteeism profiles of employees in the health care institution.	<u>1</u> 7	<u>2</u> 4	<u>3</u> 1	
15.4				Consensus
15.5 Self evaluation of employees entered into the EAP.	<u>1</u> 8	<u>2</u> 4	<u>3</u> 0	
15.6 Self evaluation of the staff working for the EAP.	<u>1</u> 7	<u>2</u> 4	<u>3</u> 1	
15.7 The treatment protocols used for the various problems managed in the EAP.	<u>1</u> 9	<u>2</u> 3	<u>3</u> 0	
15.8				Consensus
15.9				Consensus
15.10				Consensus
15.11				Consensus
15.12				Consensus
15.13				Consensus
15.14				Consensus
15.15 The general awareness amongst employees in the institution regarding the EAP with the services available.	<u>1</u> 9	<u>2</u> 3	<u>3</u> 0	
15.16 The types of communication channels followed during the EAP activities.	<u>1</u> 9	<u>2</u> 2	<u>3</u> 1	
15.17				Consensus
15.18				Consensus
15.19				Consensus
15.20 The utilisation of the EAP by those authorised to use the services of the EAP.	<u>1</u> 7	<u>2</u> 5	<u>3</u> 0	

E.2 The components of an EAP to be evaluated (continues).

Please indicate how important each of the following statements is according to the following scale with reference to the specific components of the EAP to be evaluated:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

15.21	The personnel turnover in the health care institution.	<u>1</u> 9	<u>2</u> 3	<u>3</u> 0	
15.22					Consensus
15.23	The application of certain criteria in the EAP such as inclusion and referral criteria.	<u>1</u> 9	<u>2</u> 3	<u>3</u> 0	

Additional criteria

The following seven statements deal with additional concepts for possible inclusion in the best-practice EAP, but didn't meet the criteria or were not identified during the focus group. However, these concepts were identified for possible inclusion through the literature review process.

E.2 The components of an EAP to be evaluated (continues)

Please indicate how important each of the following statements is according to the following scale with reference to the specific components of the EAP to be evaluated:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

15.24					Consensus
15.25					Consensus
15.26	The attitude of employees towards the EAP.	<u>1</u> 8	<u>2</u> 4	<u>3</u> 0	
15.27	The degree of compliance of employees within the EAP.	<u>1</u> 8	<u>2</u> 4	<u>3</u> 0	
15.28	The length of stay of an employee in the EAP.	<u>1</u> 9	<u>2</u> 3	<u>3</u> 0	

E.2 The components of an EAP to be evaluated (continues)

Please indicate how important each of the following statements is according to the following scale with reference to the specific components of the EAP to be evaluated:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

15.29	The progress made by the employee in the EAP.	<u>1</u> 9	<u>2</u> 2	<u>3</u> 1	
15.30	The relapse of employees previously treated in the EAP back into the EAP.	<u>1</u> 9	<u>2</u> 2	<u>3</u> 1	
15.31	Any other comments on the specific components of the EAP to be evaluated?				

E.3 The methods to be used for the evaluation of an EAP.

Please indicate how important each of the following statements is according to the following scale with reference to the specific methods to be used in the evaluation process of the EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

16 The following methods for the evaluation of an EAP must be taken into consideration / should be used in the process:					<u>COMMENTS</u>
16.1	The completion of questionnaires.	<u>1</u> 5	<u>2</u> 7	<u>3</u> 0	
16.2					Consensus
16.3					Consensus
16.4	Surveys.	<u>1</u> 6	<u>2</u> 4	<u>3</u> 2	
16.5	Conducting interviews with the employee entered into the EAP.	<u>1</u> 5	<u>2</u> 5	<u>3</u> 2	
16.6	The utilisation of recognised performance management systems.	<u>1</u> 5	<u>2</u> 4	<u>3</u> 3	
16.7	The utilisation of formal evaluation instruments.	<u>1</u> 8	<u>2</u> 3	<u>3</u> 1	

E.3 The methods to be used for the evaluation of an EAP.

Please indicate how important each of the following statements is according to the following scale with reference to the specific methods to be used in the evaluation process of the EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

16.8	The implementation of quality assurance cycles.	<u>1</u> 8	<u>2</u> 4	<u>3</u> 0	
16.9	The issuing of formal reports.	<u>1</u> 9	<u>2</u> 3	<u>3</u> 0	
16.10	Self-assessment methods for employees to assess how they are coping after entering the EAP.	<u>1</u> 7	<u>2</u> 5	<u>3</u> 0	
16.11	Formal record reviews.	<u>1</u> 8	<u>2</u> 4	<u>3</u> 0	

Additional criteria

The following 11 statements deal with additional concepts for possible inclusion in the best-practice EAP, but didn't meet the criteria or were not identified during the focus group. However, these concepts were identified for possible inclusion through the literature review process.

E.3 The methods to be used for the evaluation of an EAP (continues).

Please indicate how important each of the following statements is according to the following scale with reference to the specific methods to be used in the evaluation process of the EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

16.12	Interview with supervisors.	<u>1</u> 5	<u>2</u> 5	<u>3</u> 2	
16.13	Utilisation of lead indicators.	<u>1</u> 8	<u>2</u> 4	<u>3</u> 0	

E.3 The methods to be used for the evaluation of an EAP (continues).

Please indicate how important each of the following statements is according to the following scale with reference to the specific methods to be used in the evaluation process of the EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

16.14	Utilisation of lagging indicators.	<u>1</u> 8	<u>2</u> 4	<u>3</u> 0	
16.15	A formal audit process.	<u>1</u> 9	<u>2</u> 2	<u>3</u> 1	
16.16	Utilisation of qualitative evaluation methods.	<u>1</u> 9	<u>2</u> 2	<u>3</u> 1	
16.17	A cost-benefit analysis.	<u>1</u> 7	<u>2</u> 5	<u>3</u> 0	
16.18	Employees' health surveillance programmes.	<u>1</u> 5	<u>2</u> 5	<u>3</u> 2	
16.19	A benchmarking process.	<u>1</u> 8	<u>2</u> 4	<u>3</u> 0	
16.20	An accreditation process with standard settings.	<u>1</u> 5	<u>2</u> 5	<u>3</u> 2	
16.21	A total quality management (TQM) approach.	<u>1</u> 6	<u>2</u> 6	<u>3</u> 0	
16.22	A balance score card approach.	<u>1</u> 5	<u>2</u> 7	<u>3</u> 0	
16.23	(New) The utilisation of only a few indicators to monitor the impact of the EAP on a monthly basis.	<u>1</u>	<u>2</u>	<u>3</u>	
16.24	Any other comments on the specific methods to be used in the evaluation of an EAP?				

Thank you for completing this questionnaire: Round 2.

Willem Kruger

Appendix O

Delphi survey questionnaire: Round 3

**HEAD: DEPARTMENT OF COMMUNITY HEALTH
SCHOOL OF MEDICINE
FACULTY OF HEALTH SCIENCES
UNIVERSITY OF FREE STATE**

ROUND 3

APRIL 19, 2010

Dear Delphi Participant,

Thank you very much for participating in the Delphi survey of this study and completing the second round questionnaire, which I have received. This is the survey for the 3rd round. Consensus was not achieved during the 1st and 2nd round of the Delphi survey on the following questions and you need to re-assess your original rating. You can change or stay with your original rating.

Instructions for the completion of the questionnaire for Round 3

Each statement will have a score just below the rating scale. That is the number of experts rating that statement. Your score for that statement is indicated by a red colour. See the following examples as an illustration:

Example:

Please indicate how important each of the following criteria is to be included in the framework for a best-practice EAP according to the following scale:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

1.1 An EAP is needed for health care sector.

1

2

3

Comments:

6

4

2

Six of the twelve experts rated this statement:

“Considered to be critical” (giving it a rating of “1”)

Four of the twelve experts decided this statement “Could be considered” (giving it a rating of “2”). Because the overall score is highlighted in red, it means you are one of the four experts rated it as “2”.

Please re-assess your rating of each numbered statement, which can be regarded as criteria for the best-practice EAP and then indicate the importance thereof on the three-point scale. The specific points of the scale are defined as follows:

- 1 – Consider to be critical (this criterion must definitely be included in the best-practice framework).
- 2 – Could be considered (it does not matter if this criterion is included or left out from the best-practice framework).
- 3 – Not to be considered (this criterion must definitely be left out of the best-practice framework).

If you complete the questionnaire in the electronic format, please type in a cross (X) underneath the point on the scale/overall score that represents your opinion on the specific indicator. If you complete the questionnaire in hard copy format (printed out), please write a cross (X) underneath the specific position of the scale.

As part of the design of the questionnaire, I have also included space for comments which can be utilised for each item. There will still be Comment column for specific criteria as well as Comment space at the end of each section to which you may comment in your own words in the space provided.

Please return the completed questionnaire by no later than 3 May 2010.

Yours sincerely,

Willem Kruger

Student no.: 1981280579

Section A:**INTRODUCTION OF AN EAP:**

This section deals with issues related to introductory statements to be included in an EAP.

A 1. The rationale for an EAP.

Please indicate how important each of the following criteria according to the following scale to be included in the rationale statement to have an EAP in a health care institution:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

1. The rationale section of an EAP for the health care sector needs to address / should include the following aspects:				Comments
1.1				Consensus Round 2
1.2				Consensus Round 2
1.3				Consensus Round 1
1.4				Consensus Round 1
1.5				Consensus Round 1
1.6	Any other comments on the rationale to have an EAP in a health care institution?			

A 2. The objectives of an EAP.

Please indicate how important each of the following statements is according to the following scale with reference to the objectives of an EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

2. The objectives of an EAP for the health care sector needs to include / address the following aspects:				<u>COMMENTS</u>
2.1				Consensus Round 1
2.2				Consensus Round 2
2.3				Consensus Round 1
2.4	To be used to retain employees in the organisation.	<u>1</u> 9	<u>2</u> 3	<u>3</u> 0

A 2. The objectives of an EAP.

Please indicate how important each of the following statements is according to the following scale with reference to the objectives of an EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

2.5				Consensus Round 2
2.6	To provide a service that is in line with the institution's core values including providing quality care to its patients.	<u>1</u> 8	<u>2</u> 4	<u>3</u> 0
2.7	Any other comments on the objectives for an EAP?			

A.3 THE SCOPE OF THE EAP.

Please indicate how important each of the following criteria is according to the following scale with reference to the scope of the EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

3.	The scope of the EAP must take into account / should address the following issues:	Comments		
3.1				Consensus Round 1
3.2	Should be very broad with a variety of services provided.	<u>1</u> 8	<u>2</u> 8	<u>3</u> 2
3.3	Should be used to assist with appointment of employees.	<u>1</u> 3	<u>2</u> 4	<u>3</u> 5
3.4				Consensus Round 1
3.5				Consensus Round 1
3.6				Consensus Round 1
3.7				Consensus Round 2
3.8				Consensus Round 2
3.9	Should consider the different cultures of employees when services within the EAP are provided.	<u>1</u> 9	<u>2</u> 1	<u>3</u> 2

A.3 THE SCOPE OF THE EAP.

Please indicate how important each of the following criteria is according to the following scale with reference to the scope of the EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

3.10	Should concentrate on employees' personal problems.	<u>1</u> 8	<u>2</u> 2	<u>3</u> 2	
3.11					Consensus Round 1
3.12	Should highlight the importance of getting to know the employees working in the institution through the EAP.	<u>1</u> 1	<u>2</u> 8	<u>3</u> 3	
3.13					Consensus Round 2
3.14	The scope of the EAP should be adjusted according to changing needs of the institution.	<u>1</u> 9	<u>2</u> 3	<u>3</u> 0	
3.15	Any other comments on the scope of the EAP?				

A.4 THE INTRODUCTORY STATEMENT FROM THE EXECUTIVE MANAGEMENT IN THE EAP.

Please indicate how important each of the following criteria is according to the following scale with reference to the introductory statement from Executive Management of the institution in the EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

4.	The introductory statement of Executive Management of the institution should include / address the following aspects:				Comments
4.1	The EAP does not replace the disciplinary procedures.	<u>1</u> 9	<u>2</u> 1	<u>3</u> 2	
4.2					Consensus Round 1
4.3					Consensus Round 2
4.4					Consensus Round 1
4.5	The importance of a work-based programme to assist employees with personal problems in the work place.	<u>1</u> 9	<u>2</u> 2	<u>3</u> 1	
4.6					Consensus Round 1

A.4 THE INTRODUCTORY STATEMENT FROM THE EXECUTIVE MANAGEMENT IN THE EAP.

Please indicate how important each of the following criteria is according to the following scale with reference to the introductory statement from Executive Management of the institution in the EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

4.7				Consensus Round 1

4.8				Consensus Round 2

4.9	Other comments on the introductory statement of the Executive Management in the EAP?			

Section B:

Structure and requirements for an EAP.

This section deals with issues related to the structures and requirements of an EAP.

B.1 Requirements of an in-house EAP committee.

Please indicate how important each of the following statements is according to the following scale with reference to an in-house EAP committee for a health care institution:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

5.	The requirements for an in-house EAP committee must take into account / needs to include the following aspects:	Comments		

5.1				Consensus Round 1

5.2				Consensus Round 1

5.3				Consensus Round 1

5.4	Any other comments on the requirements for an in-house EAP committee within an institution?			

B.2 The role of an in-house EAP committee.

Please indicate how important each of the following statements is according to the following scale with reference to an in-house EAP committee for a health care institution:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

6 The role of an in-house EAP committee must include / address the following issues:				Comments
6.1				Consensus Round 1
6.2				Consensus Round 2
6.3				Consensus Round 2
6.4				Consensus Round 1
6.5	To be involved in the discussion of problematic cases/employees within the EAP.	<u>1</u> 6	<u>2</u> 1	<u>3</u> 5
6.6				Consensus Round 1
6.7				Consensus Round 1
6.8				Consensus Round 2
6.9				Consensus Round 2
6.10	Any other comments on the role of the in-house EAP committee within a health care institution?			

B.3 The service providers in an EAP.					
Please indicate how important each of the following statements is according to the following scale with reference to the service providers of an EAP: 1= Considered to be critical 2= Could be considered 3= Not to be considered Please mark the appropriate box with an X. Mark only one option.					
7	The manner in which services are provided in an EAP in a health care institution must take into account / needs to address the following aspects:				Comments
7.1	The services could be outsourced to a service provider independent of the health care institution.	<u>1</u> 5	<u>2</u> 6	<u>3</u> 1	
7.2	The services should be provided by an in-house service provider.	<u>1</u> 3	<u>2</u> 6	<u>3</u> 3	
7.3					Consensus Round 2
7.4	The services could be a combination between an in-house service provider and an outside (outsourced) service provider.	<u>1</u> 4	<u>2</u> 6	<u>3</u> 2	
7.5					Consensus Round 2
7.5.1	The full time facilitator should be a social worker	<u>1</u> 4	<u>2</u> 6	<u>3</u> 2	
7.6	The EAP service providers can be appointed on a session basis.	<u>1</u> 1	<u>2</u> 8	<u>3</u> 3	
7.7	Any other comments on the types of the EAP providers?				

B.3 The characteristics of the service providers in an EAP.					
Please indicate how important each of the following statements is according to the following scale with reference to the characteristics of the service providers in an EAP: 1= Considered to be critical 2= Could be considered 3= Not to be considered Please mark the appropriate box with an X. Mark only one option.					
8	The following characteristics of the EAP providers need to be considered / should be addressed:				Comments
8.1					Consensus Round 1
8.2					Consensus Round 1
8.3					Consensus Round 1

B.3 The characteristics of the service providers in an EAP.				
Please indicate how important each of the following statements is according to the following scale with reference to the characteristics of the service providers in an EAP: 1= Considered to be critical 2= Could be considered 3= Not to be considered Please mark the appropriate box with an X. Mark only one option.				
8.4	Only senior level staff members should provide the necessary services in the EAP.	<u>1</u> 1	<u>2</u> 9	<u>3</u> 2
8.5				Consensus Round 2
8.6	The staff working in an EAP must be specialists in their respective fields.	<u>1</u> 9	<u>2</u> 1	<u>3</u> 2
8.7				Consensus Round 1
8.8	All service providers in the EAP must be a professional service provider.	<u>1</u> 8	<u>2</u> 4	<u>3</u> 0
8.9				Consensus Round 2
8.10	Any other comments on the characteristics of the EAP providers?			

B.3 The category of service providers in an EAP.				
Please indicate how important each of the following statements is according to the following scale with reference to the category of service providers in an EAP: 1= Considered to be critical 2= Could be considered 3= Not to be considered Please mark the appropriate box with an X. Mark only one option.				
9 The following category of staff members needs to be considered / included in an EAP team to render a service in a health care institution:				Comments
9.1	Human resource officer.	<u>1</u> 9	<u>2</u> 2	<u>3</u> 1
9.2				Consensus Round 2
9.3				Consensus Round 1
9.4	Occupational therapist.	<u>1</u> 7	<u>2</u> 4	<u>3</u> 1

B.3 The category of service providers in an EAP.				
Please indicate how important each of the following statements is according to the following scale with reference to the category of service providers in an EAP: 1= Considered to be critical 2= Could be considered 3= Not to be considered Please mark the appropriate box with an X. Mark only one option.				
9.5	Financial advisor.	<u>1</u> 8	<u>2</u> 3	<u>3</u> 1
9.6	Legal advisor.	<u>1</u> 3	<u>2</u> 8	<u>3</u> 1
9.7	Medical practitioner.	<u>1</u> 8	<u>2</u> 2	<u>3</u> 2
9.8				Consensus Round 2
9.9	Religious/spiritual leader.	<u>1</u> 1	<u>2</u> 9	<u>3</u> 2
9.10	Administrative staff member.	<u>1</u> 4	<u>2</u> 3	<u>3</u> 5
9.11				Consensus Round 2
9.12	Psychiatrist.	<u>1</u> 1	<u>2</u> 6	<u>3</u> 5
9.13	A senior member of management	<u>1</u> 6	<u>2</u> 1	<u>3</u> 5
9.14	Union members	<u>1</u> 5	<u>2</u> 3	<u>3</u> 4
9.15				Consensus Round 2
9.16	Any other comments on categories of staff members to be included in the EAP team to provide services in a health care institution?			

Section C:**Policies and procedures for an EAP.**

This section deals with issues related to policies and procedures for an EAP.

C.1 Requirements for policies and procedures.

Please indicate how important each of the following statements is according to the following scale with reference to the requirements for the policies and procedures for an EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

10 The following requirements must be considered / needs to be addressed when policies and procedures are developed for an EAP:				Comments
10.1				Consensus Round 1
10.2				Consensus Round 2
10.3				Consensus Round 1
10.4	Policies and procedures should be subjected to review every two years.	1 9	2 3	3 1
10.5				Consensus Round 2
10.6	Any comments on the requirements for policies and procedures to be developed for an EAP?			

C.2 Types of policies and procedures.

Please indicate how important each of the following statements is according to the following scale with reference to the types of policies and procedures needed for an EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

11 The following type of policies and procedures for an EAP must be considered / needs to be developed:				COMMENTS
11.1				Consensus Round 1
11.2				Consensus Round 1
11.3				Consensus Round 1
11.4				Consensus Round 1

C.2 Types of policies and procedures.

Please indicate how important each of the following statements is according to the following scale with reference to the types of policies and procedures needed for an EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

11.5				Consensus Round 2
11.6				Consensus Round 2
11.7 The individual treatment pathways to be followed for each employee entering the EAP.	<u>1</u> 4	<u>2</u> 7	<u>3</u> 1	
11.7.1 The treatment options to be followed according to the specific reason for entering the EAP	<u>1</u> 8	<u>2</u> 3	<u>3</u> 0	One participant didn't score the statement
11.8				Consensus Round 2
11.9				Consensus Round 1
11.10				Consensus Round 1
11.11				Consensus Round 1
11.12				Consensus Round 1
11.13				Consensus Round 1
11.14				Consensus Round 2
11.15				Consensus Round 2
11.15.1				Consensus Round 2
11.16				Consensus Round 1
11.16.1 The EAP should not been seen as a mandate by management.	<u>1</u> 9	<u>2</u> 1	<u>3</u> 2	
11.17 An open door approach by supervisors to ensure availability of the supervisors to discuss problems with their employees.	<u>1</u> 9	<u>2</u> 1	<u>3</u> 2	
11.18				Consensus Round 1
11.19				Consensus Round 1
11.20				Consensus Round 1
11.21				Consensus Round 1
11.22				Consensus Round 1
11.23				Consensus Round 1
11.24 P				Consensus Round 1
11.25				Consensus Round 2
11.26 Any other comments on the type of policies and procedures needed for an EAP?				

Section D:**EAP processes and activities.**

This section deals with EAP processes and activities.

D.1 EAP ENTRY PROCESSES

Please indicate how important each of the following statements is according to the following scale with reference the entry processes for an EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

12 Processes regarding the entry of an employee into the EAP must address / needs to include the following:				Comments
12.1				Consensus Round 1
12.2				Consensus Round 2
12.3				Consensus Round 2
12.4				Consensus Round 2
12.5	A pre-entry interview with the employee should be performed by the supervisor.	<u>1</u> 3	<u>2</u> 2	<u>3</u> 7
12.6				Consensus Round 2
12.7				Consensus Round 1
12.8				Consensus Round 1
12.9				Consensus Round 2
12.10	Any other comments on the entry processes for an EAP?			

D.2 Types of services to be rendered in an EAP.

Please indicate how important each of the following statements is according to the following scale with reference to the types of services to be rendered in an EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

13 The following type of services for an EAP must be considered / needs to be included in the programme:				<u>COMMENTS</u>
13.1 Financial advisory services.	<u>1</u> 9	<u>2</u> 2	<u>3</u> 1	
13.2				Consensus Round 1
13.3				Consensus Round 2
13.4 Chronic disease management.	<u>1</u> 9	<u>2</u> 3	<u>3</u> 0	
13.5				Consensus Round 1
13.6				Consensus Round 1
13.7				Consensus Round 2
13.8				Consensus Round 1
13.9				Consensus Round 1
13.10 Assistance with burnout syndrome.	<u>1</u> 9	<u>2</u> 2	<u>3</u> 1	Consensus Round 2
13.11				Consensus Round 1
13.12 Provide general therapeutic services.	<u>1</u> 6	<u>2</u> 4	<u>3</u> 2	
13.13				Consensus Round 2
13.14 Provide marriage therapy within the family context.	<u>1</u> 5	<u>2</u> 7	<u>3</u> 0	
13.15 Supervision of rehabilitation services such as Antabuse® dosage.	<u>1</u> 9	<u>2</u> 0	<u>3</u> 3	
13.16				Consensus Round 1
13.17				Consensus Round 2
13.18 Conflict management.	<u>1</u> 5	<u>2</u> 6	<u>3</u> 1	
13.19 Provide general rehabilitation services.	<u>1</u> 0	<u>2</u> 4	<u>3</u> 8	
13.20				Consensus Round 2

Additional criteria

The following six statements deal with additional concepts for possible inclusion in the best-practice EAP, but didn't meet the criteria or were not identified during the focus group discussion. However, these concepts were identified for possible inclusion through the literature review process.

D.2 Types of services to be rendered in an EAP (continues).

Please indicate how important each of the following statements is according to the following scale with reference to the types of services to be rendered in an EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

Please mark the appropriate box with an X! Mark only one option!				
13.21				Consensus Round 2
13.22	Psychiatric services.	<u>1</u> 1	<u>2</u> 8	<u>3</u> 3
13.23	Services to address relationship problems in the workplace.	<u>1</u> 8	<u>2</u> 2	<u>3</u> 2
13.24	Support services to people who were involved in violence.	<u>1</u> 9	<u>2</u> 2	<u>3</u> 1
13.25				Consensus Round 2
13.26				Consensus Round 2
13.27	Provide general supportive services such as visiting Department of Home Affairs for Identification documents, birth registrations, passport and motor car registration.	<u>1</u> 3	<u>2</u> 5	<u>3</u> 4
13.28	Initial individual session should be viewed as a referral tool to appropriate resources.	<u>1</u> 8	<u>2</u> 4	<u>3</u> 0
13.29	Any other comments on the type of services to be rendered in an EAP?			

Section E:**The evaluation of the EAP.**

This section deals with the evaluation of the EAP.

E.1 General requirement for the evaluation of an EAP.

Please indicate how important each of the following statements is according to the following scale with reference to the general requirements for the evaluation of an EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

14 The following general requirements must be considered / need to be included during the EAP evaluation process:				<u>COMMENTS</u>
14.1				Consensus Round 1
14.2				Consensus Round 1
14.3				Consensus Round 1
14.4				Consensus Round 1
14.5				Consensus Round 1
14.6				Consensus Round 1
14.7 Any other comments on the general requirements for the evaluation of an EAP?				

E.2 The components of an EAP to be evaluated

Please indicate how important each of the following statements is according to the following scale with reference to the specific components of the EAP to be evaluated:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

15 The following components of an EAP must be considered / need to be included in the evaluation of an EAP:				<u>COMMENTS</u>
15.1				Consensus Round 1
15.2				Consensus Round 1
15.3				Consensus Round 2
15.4				Consensus Round 1
15.5				Consensus Round 2

E.2 The components of an EAP to be evaluated

Please indicate how important each of the following statements is according to the following scale with reference to the specific components of the EAP to be evaluated:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

15.6				Consensus Round 2
15.7				Consensus Round 2
15.8				Consensus Round 1
15.9				Consensus Round 1
15.10				Consensus Round 1
15.11				Consensus Round 1
15.12				Consensus Round 1
15.13				Consensus Round 1
15.14				Consensus Round 1
15.15				Consensus Round 2
15.16				Consensus Round 2
15.17				Consensus Round 1
15.18				Consensus Round 1
15.19				Consensus Round 1
15.20				Consensus Round 2
15.21				Consensus Round 2
15.22				Consensus Round 1
15.23				Consensus Round 2

Additional criteria

The following seven statements deal with additional concepts for possible inclusion in the best-practice EAP, but didn't meet the criteria or were not identified during the focus group. However, these concepts were identified for possible inclusion through the literature review process.

E.2 The components of an EAP to be evaluated (continues)

Please indicate how important each of the following statements is according to the following scale with reference to the specific components of the EAP to be evaluated:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

15.24				Consensus Round 1
15.25				Consensus Round 1
15.26				Consensus Round 2
15.27				Consensus Round 2
15.28				Consensus Round 2
15.29				Consensus Round 2
15.30				Consensus Round 2

15.31 Any other comments on the specific components of the EAP to be evaluated?

E.3 The methods to be used for the evaluation of an EAP.

Please indicate how important each of the following statements is according to the following scale with reference to the specific methods to be used in the evaluation process of the EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

16 The following methods for the evaluation of an EAP must be taken into consideration / should be used in the process:					COMMENTS
16.1	The completion of questionnaires.	<u>1</u> 5	<u>2</u> 7	<u>3</u> 0	
16.2					Consensus Round 1
16.3					Consensus Round 1
16.4					Consensus Round 2
16.5	Conducting interviews with the employee entered into the EAP.	<u>1</u> 8	<u>2</u> 2	<u>3</u> 2	
16.6	The utilisation of recognised performance management systems.	<u>1</u> 9	<u>2</u> 1	<u>3</u> 2	
16.7					Consensus Round 2
16.8					Consensus Round 2
16.9					Consensus Round 2
16.10					Consensus Round 2
16.11					Consensus Round 2

Additional criteria

The following 11 statements deal with additional concepts for possible inclusion in the best-practice EAP, but didn't meet the criteria or were not identified during the focus group. However, these concepts were identified for possible inclusion through the literature review process.

E.3 The methods to be used for the evaluation of an EAP (continues).

Please indicate how important each of the following statements is according to the following scale with reference to the specific methods to be used in the evaluation process of the EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

16.12	Interview with supervisors.	<u>1</u> 8	<u>2</u> 2	<u>3</u> 2	Consensus Round 2
16.13					Consensus Round 2
16.14					Consensus Round 2
16.15					Consensus Round 2
16.16					Consensus Round 2
16.17					Consensus Round 2
16.18	Employees' health surveillance programmes.	<u>1</u> 8	<u>2</u> 3	<u>3</u> 1	
16.19					Consensus Round 2
16.20	An accreditation process with standard settings.	<u>1</u> 8	<u>2</u> 3	<u>3</u> 1	
16.21	A total quality management (TQM) approach.	<u>1</u> 8	<u>2</u> 4	<u>3</u> 0	
16.22	A balance score card approach.	<u>1</u> 5	<u>2</u> 7	<u>3</u> 0	
16.23	The utilisation of only a few indicators to monitor the impact of the EAP on a monthly basis.	<u>1</u> 7	<u>2</u> 4	<u>3</u> 0	
16.24	Any other comments on the specific methods to be used in the evaluation of an EAP?				

Thank you for completing this questionnaire: Round 3.

Willem Kruger

Appendix P

Delphi survey questionnaire: Round 4

**HEAD: DEPARTMENT OF COMMUNITY HEALTH
SCHOOL OF MEDICINE
FACULTY OF HEALTH SCIENCES
UNIVERSITY OF FREE STATE**

ROUND 4

MAY 05, 2010

Dear Delphi Participant,

Thank you very much for participating in the Delphi survey of this study and completing the 3rd round questionnaire, which I have received. This is the survey for the 4th round. Consensus / stability was not achieved during the 1st, 2nd and 3rd round of the Delphi survey on the following 29 statements and you need to re-assess your current rating on the statements as indicated. You can change your rating or keep your current rating as it is.

Instructions for the completion of the questionnaire for Round 4

Each statement will have a score just below the rating scale. That is the number of experts rating that statement. Your score for that statement is indicated by a red colour. See the following examples as an illustration:

Example:

Please indicate how important each of the following criteria is to be included in the framework for a best-practice EAP according to the following scale:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

1.1 An EAP is needed for health care sector.

1

2

3

Comments:

6

4

2

Six of the twelve experts rated this statement:

“Considered to be critical” (giving it a rating of “1”)

Four of the twelve experts decided this statement “Could be considered” (giving it a rating of “2”). Because the overall score is highlighted in red, it means you are one of the four experts rated it as “2”.

Please re-assess your rating of each numbered statement, which can be regarded as criteria for the best-practice EAP and then indicate the importance thereof on the three-point scale. The specific points of the scale are defined as follows:

- 1 – Consider to be critical (this criterion must definitely be included in the best-practice framework).
- 2 – Could be considered (it does not matter if this criterion is included or left out from the best-practice framework).
- 3 – Not to be considered (this criterion must definitely be left out of the best-practice framework).

If you complete the questionnaire in the electronic format, please type in a cross (X) underneath the point on the scale/overall score that represents your opinion on the specific indicator. If you complete the questionnaire in hard copy format (printed out), please write a cross (X) underneath the specific position of the scale.

As part of the design of the questionnaire, I have also included space for comments which can be utilised for each item. There will still be Comment column for specific criteria as well as Comment space at the end of each section to which you may comment in your own words in the space provided.

Please return the completed questionnaire by no later than 17 May 2010.

Yours sincerely,

Willem Kruger

Student no.: 1981280579

Section A:**INTRODUCTION OF AN EAP:**

This section deals with issues related to introductory statements to be included in an EAP.

A 1. The rationale for an EAP.

Please indicate how important each of the following criteria according to the following scale to be included in the rationale statement to have an EAP in a health care institution:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

1. The rationale section of an EAP for the health care sector needs to address / should include the following aspects:				Comments
1.1				Consensus Round 2
1.2				Consensus Round 2
1.3				Consensus Round 1
1.4				Consensus Round 1
1.5				Consensus Round 1
1.6	Any other comments on the rationale to have an EAP in a health care institution?			

A 2. The objectives of an EAP.

Please indicate how important each of the following statements is according to the following scale with reference to the objectives of an EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

2. The objectives of an EAP for the health care sector needs to include / address the following aspects:				<u>COMMENTS</u>
2.1				Consensus Round 1
2.2				Consensus Round 2
2.3				Consensus Round 1
2.4				Consensus Round 3
2.5				Consensus Round 2
2.6	To provide a service that is in line with the institution's core values including providing quality care to its patients.	<u>1</u> 9	<u>2</u> 3	<u>3</u> 0
2.7	Any other comments on the objectives for an EAP?			

A.3 THE SCOPE OF THE EAP.

Please indicate how important each of the following criteria is according to the following scale with reference to the scope of the EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

3. The scope of the EAP must take into account / should address the following issues:				Comments	
3.1				Consensus Round 1	
3.2	Should be very broad with a variety of services provided.	<u>1</u> 8	<u>2</u> 2	<u>3</u> 2	
3.3	Should be used to assist with appointment of employees.	<u>1</u> 0	<u>2</u> 5	<u>3</u> 7	
3.4					Consensus Round 1
3.5					Consensus Round 1
3.6					Consensus Round 1
3.7					Consensus Round 2
3.8					Consensus Round 2
3.9					Consensus Round 3
3.10	Should concentrate on employees' personal problems.	<u>1</u> 9	<u>2</u> 1	<u>3</u> 2	
3.11					Consensus Round 1
3.12					Consensus Round 3
3.13					Consensus Round 2
3.14					Consensus Round 3
3.15	Any other comments on the scope of the EAP?				

A.4 THE INTRODUCTORY STATEMENT FROM THE EXECUTIVE MANAGEMENT IN THE EAP.

Please indicate how important each of the following criteria is according to the following scale with reference to the introductory statement from Executive Management of the institution in the EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

4. The introductory statement of Executive Management of the institution should include / address the following aspects:				Comments
4.1				Consensus Round 3
4.2				Consensus Round 1
4.3				Consensus Round 2
4.4				Consensus Round 1
4.5	The importance of a work-based programme to assist employees with personal problems in the work place.	<u>1</u> 9	<u>2</u> 3	<u>3</u> 0
4.6				Consensus Round 1
4.7				Consensus Round 1
4.8				Consensus Round 2
4.9	Other comments on the introductory statement of the Executive Management in the EAP?			

Section B:**Structure and requirements for an EAP.**

This section deals with issues related to the structures and requirements of an EAP.

B.1 Requirements of an in-house EAP committee.

Please indicate how important each of the following statements is according to the following scale with reference to an in-house EAP committee for a health care institution:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

5. The requirements for an in-house EAP committee must take into account / needs to include the following aspects:				Comments
5.1				Consensus Round 1
5.2				Consensus Round 1
5.3				Consensus Round 1
5.4	Any other comments on the requirements for an in-house EAP committee within an institution?			

B.2 The role of an in-house EAP committee.

Please indicate how important each of the following statements is according to the following scale with reference to an in-house EAP committee for a health care institution:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

6 The role of an in-house EAP committee must include / address the following issues:				Comments
6.1				Consensus Round 1
6.2				Consensus Round 2
6.3				Consensus Round 2
6.4				Consensus Round 1
6.5	To be involved in the discussion of problematic cases/employees within the EAP.	<u>1</u> 5	<u>2</u> 1	<u>3</u> 6
6.6				Consensus Round 1
6.7				Consensus Round 1
6.8				Consensus Round 2
6.9				Consensus Round 2
6.10	Any other comments on the role of the in-house EAP committee within a health care institution?			

B.3 The service providers in an EAP.

Please indicate how important each of the following statements is according to the following scale with reference to the service providers of an EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

7 The manner in which services are provided in an EAP in a health care institution must take into account / needs to address the following aspects:				Comments
7.4	The services could be outsourced to a service provider independent of the health care institution.	<u>1</u> 2	<u>2</u> 9	<u>3</u> 1
7.5				Consensus Round 3
7.6				Consensus Round 2
7.7	The services could be a combination between an in-house service provider and an outside (outsourced) service provider.	<u>1</u> 3	<u>2</u> 8	<u>3</u> 1
7.8				Consensus Round 2
7.8.1	The full time facilitator should be a social worker	<u>1</u> 2	<u>2</u> 9	<u>3</u> 1
7.9	The EAP service providers can be appointed on a session basis.	<u>1</u> 0	<u>2</u> 9	<u>3</u> 3
7.10	Any other comments on the types of the EAP providers?			

B.3 The characteristics of the service providers in an EAP.

Please indicate how important each of the following statements is according to the following scale with reference to the characteristics of the service providers in an EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

8 The following characteristics of the EAP providers need to be considered / should be addressed:				Comments
8.4				Consensus Round 1
8.5				Consensus Round 1
8.6				Consensus Round 1
8.7				Consensus Round 3
8.8				Consensus Round 2
8.9	The staff working in an EAP must be specialists in their respective fields.	<u>1</u> 9	<u>2</u> 2	<u>3</u> 1
8.10				Consensus Round 1

B.3 The characteristics of the service providers in an EAP.

Please indicate how important each of the following statements is according to the following scale with reference to the characteristics of the service providers in an EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

8.11	All service providers in the EAP must be a professional service provider.	<u>1</u> 8	<u>2</u> 4	<u>3</u> 0	
8.12					Consensus Round 2
8.13	Any other comments on the characteristics of the EAP providers?				

B.3 The category of service providers in an EAP.

Please indicate how important each of the following statements is according to the following scale with reference to the category of service providers in an EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

9 The following category of staff members needs to be considered / included in an EAP team to render a service in a health care institution:					Comments
9.4					Consensus Round 3
9.5					Consensus Round 2
9.6					Consensus Round 1
9.7	Occupational therapist.	<u>1</u> 9	<u>2</u> 2	<u>3</u> 1	
9.8	Financial advisor.	<u>1</u> 9	<u>2</u> 3	<u>3</u> 0	
9.9	Legal advisor.	<u>1</u> 2	<u>2</u> 9	<u>3</u> 1	
9.10					Stability Round 3
9.11					Consensus Round 2
9.12					Consensus Round 3

B.3 The category of service providers in an EAP.

Please indicate how important each of the following statements is according to the following scale with reference to the category of service providers in an EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

9.13	Administrative staff member.	<u>1</u> 3	<u>2</u> 3	<u>3</u> 6	
9.14					Consensus Round 2
9.15	Psychiatrist.	<u>1</u> 1	<u>2</u> 8	<u>3</u> 3	
9.16					Stability Round 3
9.17	Union members	<u>1</u> 6	<u>2</u> 2	<u>3</u> 4	
9.18					Consensus Round 2
9.19	Any other comments on categories of staff members to be included in the EAP team to provide services in a health care institution?				

Section C:**Policies and procedures for an EAP.**

This section deals with issues related to policies and procedures for an EAP.

C.1 Requirements for policies and procedures.

Please indicate how important each of the following statements is according to the following scale with reference to the requirements for the policies and procedures for an EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

10	The following requirements must be considered / needs to be addressed when policies and procedures are developed for an EAP:				Comments
10.1					Consensus Round 1
10.2					Consensus Round 2
10.3					Consensus Round 1
10.4					Consensus Round 3
10.5					Consensus Round 2
10.6	Any comments on the requirements for policies and procedures to be developed for an EAP?				

C.2 Types of policies and procedures.

Please indicate how important each of the following statements is according to the following scale with reference to the types of policies and procedures needed for an EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

11 The following type of policies and procedures for an EAP must be considered / needs to be developed:				COMMENTS
11.1				Consensus Round 1
11.2				Consensus Round 1
11.3				Consensus Round 1
11.4				Consensus Round 1
11.5				Consensus Round 2
11.6				Consensus Round 2
11.7 The individual treatment pathways to be followed for each employee entering the EAP.	<u>1</u> 3	<u>2</u> 9	<u>3</u> 0	
11.7.1				Consensus Round 3
11.8				Consensus Round 2
11.9				Consensus Round 1
11.10				Consensus Round 1
11.11				Consensus Round 1
11.12				Consensus Round 1
11.13				Consensus Round 1
11.14				Consensus Round 2
11.15				Consensus Round 2
11.15.1				Consensus Round 2
11.16				Consensus Round 1
11.16.1				Consensus Round 3
11.17				Consensus Round 3
11.18				Consensus Round 1
11.19				Consensus Round 1
11.20				Consensus Round 1
11.21				Consensus Round 1
11.22				Consensus Round 1
11.23				Consensus Round 1
11.24 P				Consensus Round 1
11.25				Consensus Round 2
11.26	Any other comments on the type of policies and procedures needed for an EAP?			

Section D: EAP processes and activities.

This section deals with EAP processes and activities.

D.1 EAP ENTRY PROCESSES

Please indicate how important each of the following statements is according to the following scale with reference the entry processes for an EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

12 Processes regarding the entry of an employee into the EAP must address / needs to include the following:				Comments
12.1				Consensus Round 1
12.2				Consensus Round 2
12.3				Consensus Round 2
12.4				Consensus Round 2
12.5 A pre-entry interview with the employee should be performed by the supervisor.	<u>1</u> 2	<u>2</u> 1	<u>3</u> 9	
12.6				Consensus Round 2
12.7				Consensus Round 1
12.8				Consensus Round 1
12.9				Consensus Round 2
12.10 Any other comments on the entry processes for an EAP?				

D.2 Types of services to be rendered in an EAP.

Please indicate how important each of the following statements is according to the following scale with reference to the types of services to be rendered in an EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

13 The following type of services for an EAP must be considered / needs to be included in the programme:				<u>COMMENTS</u>
13.1				Consensus Round 3
13.2				Consensus Round 1
13.3				Consensus Round 2
13.4				Consensus Round 3
13.5				Consensus Round 1
13.6				Consensus Round 1
13.7				Consensus Round 2
13.8				Consensus Round 1
13.9				Consensus Round 1
13.10				Consensus Round 2
13.11				Consensus Round 1

13.12	Provide general therapeutic services.	<u>1</u> 7	<u>2</u> 4	<u>3</u> 1	
13.13					Consensus Round 2
13.14	Provide marriage therapy within the family context.	<u>1</u> 3	<u>2</u> 9	<u>3</u> 0	
13.15					Consensus Round 3
13.16					Consensus Round 1
13.17					Consensus Round 2
13.18	Conflict management.	<u>1</u> 3	<u>2</u> 9	<u>3</u> 0	
13.19	Provide general rehabilitation services.	<u>1</u> 0	<u>2</u> 3	<u>3</u> 9	
13.20					Consensus Round 2
13.21					Consensus Round 2
13.22					Stability Round 3
13.23					Consensus Round 3
13.24					Consensus Round 3
13.25					Consensus Round 2
13.26					Consensus Round 2
13.27	Provide general supportive services such as visiting Department of Home Affairs for Identification documents, birth registrations, passport and motor car registration.	<u>1</u> 2	<u>2</u> 6	<u>3</u> 4	
13.28					Consensus Round 3
13.29	Any other comments on the type of services to be rendered in an EAP?				

Section E:

The evaluation of the EAP.

This section deals with the evaluation of the EAP.

E.1 General requirement for the evaluation of an EAP.

Please indicate how important each of the following statements is according to the following scale with reference to the general requirements for the evaluation of an EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

14 The following general requirements must be considered / need to be included during the EAP evaluation process:				<u>COMMENTS</u>
14.1				Consensus Round 1
14.2				Consensus Round 1
14.3				Consensus Round 1
14.4				Consensus Round 1
14.5				Consensus Round 1
14.6				Consensus Round 1
14.7 Any other comments on the general requirements for the evaluation of an EAP?				

E.2 The components of an EAP to be evaluated

Please indicate how important each of the following statements is according to the following scale with reference to the specific components of the EAP to be evaluated:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

15 The following components of an EAP must be considered / need to be included in the evaluation of an EAP:				<u>COMMENTS</u>
15.1				Consensus Round 1
15.2				Consensus Round 1
15.3				Consensus Round 2
15.4				Consensus Round 1
15.5				Consensus Round 2
15.6				Consensus Round 2
15.7				Consensus Round 2
15.8				Consensus Round 1
15.9				Consensus Round 1
15.10				Consensus Round 1
15.11				Consensus Round 1

15.12				Consensus Round 1
15.13				Consensus Round 1
15.14				Consensus Round 1
15.15				Consensus Round 2
15.16				Consensus Round 2
15.17				Consensus Round 1
15.18				Consensus Round 1
15.19				Consensus Round 1
15.20				Consensus Round 2
15.21				Consensus Round 2
15.22				Consensus Round 1
15.23				Consensus Round 2

Additional criteria

The following seven statements deal with additional concepts for possible inclusion in the best-practice EAP, but didn't meet the criteria or were not identified during the focus group. However, these concepts were identified for possible inclusion through the literature review process.

E.2 The components of an EAP to be evaluated (continues)

Please indicate how important each of the following statements is according to the following scale with reference to the specific components of the EAP to be evaluated:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

15.24				Consensus Round 1
15.25				Consensus Round 1
15.26				Consensus Round 2
15.27				Consensus Round 2
15.28				Consensus Round 2
15.29				Consensus Round 2
15.30				Consensus Round 2
15.31 Any other comments on the specific components of the EAP to be evaluated?				

E.3 The methods to be used for the evaluation of an EAP.

Please indicate how important each of the following statements is according to the following scale with reference to the specific methods to be used in the evaluation process of the EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

16 The following methods for the evaluation of an EAP must be taken into consideration / should be used in the process:				COMMENTS
16.1 The completion of questionnaires.	<u>1</u> 3	<u>2</u> 9	<u>3</u> 0	
16.2				Consensus Round 1
16.3				Consensus Round 1
16.4				Consensus Round 2
16.5				Consensus Round 3
16.6				Consensus Round 3
16.7				Consensus Round 2
16.8				Consensus Round 2
16.9				Consensus Round 2
16.10				Consensus Round 2
16.11				Consensus Round 2
16.12				Consensus Round 3
16.13				Consensus Round 2
16.14				Consensus Round 2
16.15				Consensus Round 2
16.16				Consensus Round 2
16.17				Consensus Round 2
16.18				Consensus Round 3
16.19				Consensus Round 2
16.20 An accreditation process with standard settings.	<u>1</u> 9	<u>2</u> 3	<u>3</u> 0	
16.21 A total quality management (TQM) approach.	<u>1</u> 9	<u>2</u> 3	<u>3</u> 0	
16.22 A balance score card approach.	<u>1</u> 4	<u>2</u> 8	<u>3</u> 0	
16.23				Consensus Round 3
16.24 Any other comments on the specific methods to be used in the evaluation of an EAP?				
Thank you for completing this questionnaire: Round 4.				
Willem Kruger				

Appendix Q

Delphi survey questionnaire: Round 5

**HEAD: DEPARTMENT OF COMMUNITY HEALTH
SCHOOL OF MEDICINE
FACULTY OF HEALTH SCIENCES
UNIVERSITY OF FREE STATE**

ROUND 5

JUNE 05, 2010

Dear Delphi Participant,

Thank you very much for participating in the Delphi survey of this study and completing the 4th round questionnaire, which I have received. This is the survey for the 5th round. Consensus / stability was not achieved during the 1st, 2nd, 3rd and 4th round of the Delphi survey on the following 7 statements and you need to re-assess your current rating on the statements as indicated. You can change your rating or keep your current rating as it is.

Instructions for the completion of the questionnaire for Round 5

Each statement will have a score just below the rating scale. That is the number of experts rating that statement. Your score for that statement is indicated by a red colour. See the following examples as an illustration:

Example:

Please indicate how important each of the following criteria is to be included in the framework for a best-practice EAP according to the following scale:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

1.1 An EAP is needed for health care sector.

1

2

3

Comments:

6

4

2

Six of the twelve experts rated this statement:

“Considered to be critical” (giving it a rating of “1”)

Four of the twelve experts decided this statement “Could be considered” (giving it a rating of “2”). Because the overall score is highlighted in red, it means you are one of the four experts rated it as “2”.

Please re-assess your rating of each numbered statement, which can be regarded as criteria for the best-practice EAP and then indicate the importance thereof on the three-point scale. The specific points of the scale are defined as follows:

- 1 – Consider to be critical (this criterion must definitely be included in the best-practice framework).
- 2 – Could be considered (it does not matter if this criterion is included or left out from the best-practice framework).
- 3 – Not to be considered (this criterion must definitely be left out of the best-practice framework).

If you complete the questionnaire in the electronic format, please type in a cross (X) underneath the point on the scale/overall score that represents your opinion on the specific indicator. If you complete the questionnaire in hard copy format (printed out), please write a cross (X) underneath the specific position of the scale.

As part of the design of the questionnaire, I have also included space for comments which can be utilised for each item. There will still be Comment column for specific criteria as well as Comment space at the end of each section to which you may comment in your own words in the space provided.

Please return the completed questionnaire by no later than 17 June 2010.

Yours sincerely,

Willem Kruger

Student no.: 1981280579

Section A:**INTRODUCTION OF AN EAP:**

This section deals with issues related to introductory statements to be included in an EAP.

A 1. The rationale for an EAP.

Please indicate how important each of the following criteria according to the following scale to be included in the rationale statement to have an EAP in a health care institution:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

1. The rationale section of an EAP for the health care sector needs to address / should include the following aspects:				Comments
1.1				Consensus Round 2
1.2				Consensus Round 2
1.3				Consensus Round 1
1.4				Consensus Round 1
1.5				Consensus Round 1
1.6	Any other comments on the rationale to have an EAP in a health care institution?			

A 2. The objectives of an EAP.

Please indicate how important each of the following statements is according to the following scale with reference to the objectives of an EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

2. The objectives of an EAP for the health care sector needs to include / address the following aspects:				<u>COMMENTS</u>
2.1				Consensus Round 1
2.2				Consensus Round 2
2.3				Consensus Round 1
2.4				Consensus Round 3
2.5				Consensus Round 2
2.6				Consensus Round 4
2.7	Any other comments on the objectives for an EAP?			

A.3 THE SCOPE OF THE EAP.

Please indicate how important each of the following criteria is according to the following scale with reference to the scope of the EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

3. The scope of the EAP must take into account / should address the following issues:				Comments
3.1				Consensus Round 1
3.2	Should be very broad with a variety of services provided.	<u>1</u> 8	<u>2</u> 2	<u>3</u> 2
3.3	Should be used to assist with appointment of employees.	<u>1</u> 0	<u>2</u> 5	<u>3</u> 7
3.4				Consensus Round 1
3.5				Consensus Round 1
3.6				Consensus Round 1
3.7				Consensus Round 2
3.8				Consensus Round 2
3.9				Consensus Round 3
3.10				Consensus Round 4
3.11				Consensus Round 1
3.12				Consensus Round 3
3.13				Consensus Round 2
3.14				Consensus Round 3
3.15	Any other comments on the scope of the EAP?			

A.4 THE INTRODUCTORY STATEMENT FROM THE EXECUTIVE MANAGEMENT IN THE EAP.

Please indicate how important each of the following criteria is according to the following scale with reference to the introductory statement from Executive Management of the institution in the EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

4. The introductory statement of Executive Management of the institution should include / address the following aspects:				Comments
4.1				Consensus Round 3
4.2				Consensus Round 1
4.3				Consensus Round 2
4.4				Consensus Round 1
4.5				Consensus Round 4
4.6				Consensus Round 1
4.7				Consensus Round 1
4.8				Consensus Round 2
4.9	Other comments on the introductory statement of the Executive Management in the EAP?			

Section B:**Structure and requirements for an EAP.**

This section deals with issues related to the structures and requirements of an EAP.

B.1 Requirements of an in-house EAP committee.

Please indicate how important each of the following statements is according to the following scale with reference to an in-house EAP committee for a health care institution:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

5. The requirements for an in-house EAP committee must take into account / needs to include the following aspects:				Comments
5.1				Consensus Round 1
5.2				Consensus Round 1
5.3				Consensus Round 1
5.4	Any other comments on the requirements for an in-house EAP committee within an institution?			

B.2 The role of an in-house EAP committee.

Please indicate how important each of the following statements is according to the following scale with reference to an in-house EAP committee for a health care institution:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

6 The role of an in-house EAP committee must include / address the following issues:				Comments
6.1				Consensus Round 1
6.2				Consensus Round 2
6.3				Consensus Round 2
6.4				Consensus Round 1
6.5	To be involved in the discussion of problematic cases/employees within the EAP.	<u>1</u> 5	<u>2</u> 1	<u>3</u> 6
6.6				Consensus Round 1
6.7				Consensus Round 1
6.8				Consensus Round 2
6.9				Consensus Round 2
6.10	Any other comments on the role of the in-house EAP committee within a health care institution?			

B.3 The service providers in an EAP.

Please indicate how important each of the following statements is according to the following scale with reference to the service providers of an EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

7 The manner in which services are provided in an EAP in a health care institution must take into account / needs to address the following aspects:				Comments
7.1				Consensus Round 4
7.2				Consensus Round 3
7.3				Consensus Round 2
7.4	The services could be a combination between an in-house service provider and an outside (outsourced) service provider.	<u>1</u> 3	<u>2</u> 8	<u>3</u> 1
7.5				Consensus Round 2
7.5.1				Consensus Round 4
7.6				Consensus Round 4
7.7	Any other comments on the types of the EAP providers?			

B.3 The characteristics of the service providers in an EAP.				
Please indicate how important each of the following statements is according to the following scale with reference to the characteristics of the service providers in an EAP: 1= Considered to be critical 2= Could be considered 3= Not to be considered Please mark the appropriate box with an X. Mark only one option.				
8 The following characteristics of the EAP providers need to be considered / should be addressed:				Comments
8.1				Consensus Round 1
8.2				Consensus Round 1
8.3				Consensus Round 1
8.4				Consensus Round 3
8.5				Consensus Round 2
8.6				Consensus Round 4
8.7				Consensus Round 1
8.8				Consensus Round 4
8.9				Consensus Round 2
8.10 Any other comments on the characteristics of the EAP providers?				

B.3 The category of service providers in an EAP.				
Please indicate how important each of the following statements is according to the following scale with reference to the category of service providers in an EAP: 1= Considered to be critical 2= Could be considered 3= Not to be considered Please mark the appropriate box with an X. Mark only one option.				
9 The following category of staff members needs to be considered / included in an EAP team to render a service in a health care institution:				Comments
9.1				Consensus Round 3
9.2				Consensus Round 2
9.3				Consensus Round 1
9.4 Occupational therapist.	<u>1</u> 9	<u>2</u> 2	<u>3</u> 1	
9.5				Stability Round 4
9.6				Consensus Round 4
9.7				Stability Round 3
9.8				Consensus Round 2
9.9				Consensus Round 3
9.10 Administrative staff member.	<u>1</u> 3	<u>2</u> 3	<u>3</u> 6	
9.11				Consensus Round 2

B.3 The category of service providers in an EAP.

Please indicate how important each of the following statements is according to the following scale with reference to the category of service providers in an EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

9.12	Psychiatrist.	<u>1</u> 1	<u>2</u> 8	<u>3</u> 3	
9.13					Stability Round 3
9.14					Stability Round 4
9.15					Consensus Round 2
9.16	Any other comments on categories of staff members to be included in the EAP team to provide services in a health care institution?				

Section C:**Policies and procedures for an EAP.**

This section deals with issues related to policies and procedures for an EAP.

C.1 Requirements for policies and procedures.

Please indicate how important each of the following statements is according to the following scale with reference to the requirements for the policies and procedures for an EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

10	The following requirements must be considered / needs to be addressed when policies and procedures are developed for an EAP:	Comments			
10.1					Consensus Round 1
10.2					Consensus Round 2
10.3					Consensus Round 1
10.4					Consensus Round 3
10.5					Consensus Round 2
10.6	Any comments on the requirements for policies and procedures to be developed for an EAP?				

C.2 Types of policies and procedures.

Please indicate how important each of the following statements is according to the following scale with reference to the types of policies and procedures needed for an EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

11 The following type of policies and procedures for an EAP must be considered / needs to be developed:				COMMENTS
11.1				Consensus Round 1
11.2				Consensus Round 1
11.3				Consensus Round 1
11.4				Consensus Round 1
11.5				Consensus Round 2
11.6				Consensus Round 2
11.7				Consensus Round 4
11.7.1				Consensus Round 3
11.8				Consensus Round 2
11.9				Consensus Round 1
11.10				Consensus Round 1
11.11				Consensus Round 1
11.12				Consensus Round 1
11.13				Consensus Round 1
11.14				Consensus Round 2
11.15				Consensus Round 2
11.15.1				Consensus Round 2
11.16				Consensus Round 1
11.16.1				Consensus Round 3
11.17				Consensus Round 3
11.18				Consensus Round 1
11.19				Consensus Round 1
11.20				Consensus Round 1
11.21				Consensus Round 1
11.22				Consensus Round 1
11.23				Consensus Round 1
11.24 P				Consensus Round 1
11.25				Consensus Round 2
11.26 Any other comments on the type of policies and procedures needed for an EAP?				

Section D: EAP processes and activities.

This section deals with EAP processes and activities.

D.1 EAP ENTRY PROCESSES

Please indicate how important each of the following statements is according to the following scale with reference the entry processes for an EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

12 Processes regarding the entry of an employee into the EAP must address / needs to include the following:				Comments
12.1				Consensus Round 1
12.2				Consensus Round 2
12.3				Consensus Round 2
12.4				Consensus Round 2
12.5				Consensus Round 4
12.6				Consensus Round 2
12.7				Consensus Round 1
12.8				Consensus Round 1
12.9				Consensus Round 2
12.10 Any other comments on the entry processes for an EAP?				

D.2 Types of services to be rendered in an EAP.

Please indicate how important each of the following statements is according to the following scale with reference to the types of services to be rendered in an EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

13 The following type of services for an EAP must be considered / needs to be included in the programme:				<u>COMMENTS</u>
13.1				Consensus Round 3
13.2				Consensus Round 1
13.3				Consensus Round 2
13.4				Consensus Round 3
13.5				Consensus Round 1
13.6				Consensus Round 1
13.7				Consensus Round 2
13.8				Consensus Round 1
13.9				Consensus Round 1

D.2 Types of services to be rendered in an EAP.

Please indicate how important each of the following statements is according to the following scale with reference to the types of services to be rendered in an EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

13.10				Consensus Round 2
13.11				Consensus Round 1
13.12				Consensus Round 4
13.13				Consensus Round 2
13.14				Consensus Round 4
13.15				Consensus Round 3
13.16				Consensus Round 1
13.17				Consensus Round 2
13.18				Consensus Round 4
13.19				Consensus Round 4
13.20				Consensus Round 2
13.21				Consensus Round 2
13.22				Stability Round 3
13.23				Consensus Round 3
13.24				Consensus Round 3
13.25				Consensus Round 2
13.26				Consensus Round 2
13.27	Provide general supportive services such as visiting Department of Home Affairs for Identification documents, birth registrations, passport and motor car registration.	<u>1</u> 2	<u>2</u> 6	<u>3</u> 4
13.28				Consensus Round 3
13.29	Any other comments on the type of services to be rendered in an EAP?			

Section E:**The evaluation of the EAP.**

This section deals with the evaluation of the EAP.

E.1 General requirement for the evaluation of an EAP.

Please indicate how important each of the following statements is according to the following scale with reference to the general requirements for the evaluation of an EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

14 The following general requirements must be considered / need to be included during the EAP evaluation process:				<u>COMMENTS</u>
14.1				Consensus Round 1
14.2				Consensus Round 1
14.3				Consensus Round 1
14.4				Consensus Round 1
14.5				Consensus Round 1
14.6				Consensus Round 1
14.7 Any other comments on the general requirements for the evaluation of an EAP?				

E.2 The components of an EAP to be evaluated

Please indicate how important each of the following statements is according to the following scale with reference to the specific components of the EAP to be evaluated:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

15 The following components of an EAP must be considered / need to be included in the evaluation of an EAP:				<u>COMMENTS</u>
15.1				Consensus Round 1
15.2				Consensus Round 1
15.3				Consensus Round 2
15.4				Consensus Round 1
15.5				Consensus Round 2
15.6				Consensus Round 2
15.7				Consensus Round 2
15.8				Consensus Round 1
15.9				Consensus Round 1
15.10				Consensus Round 1
15.11				Consensus Round 1
15.12				Consensus Round 1
15.13				Consensus Round 1
15.14				Consensus Round 1
15.15				Consensus Round 2
15.16				Consensus Round 2
15.17				Consensus Round 1
15.18				Consensus Round 1
15.19				Consensus Round 1
15.20				Consensus Round 2
15.21				Consensus Round 2
15.22				Consensus Round 1
15.23				Consensus Round 2

Additional criteria

The following seven statements deal with additional concepts for possible inclusion in the best-practice EAP, but didn't meet the criteria or were not identified during the focus group. However, these concepts were identified for possible inclusion through the literature review process.

E.2 The components of an EAP to be evaluated (continues)

Please indicate how important each of the following statements is according to the following scale with reference to the specific components of the EAP to be evaluated:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

15.24				Consensus Round 1
15.25				Consensus Round 1
15.26				Consensus Round 2
15.27				Consensus Round 2
15.28				Consensus Round 2
15.29				Consensus Round 2
15.30				Consensus Round 2

15.31 Any other comments on the specific components of the EAP to be evaluated?

E.3 The methods to be used for the evaluation of an EAP.

Please indicate how important each of the following statements is according to the following scale with reference to the specific methods to be used in the evaluation process of the EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

16	The following methods for the evaluation of an EAP must be taken into consideration / should be used in the process:			COMMENTS
16.1				Consensus Round 4
16.2				Consensus Round 1
16.3				Consensus Round 1
16.4				Consensus Round 2
16.5				Consensus Round 3
16.6				Consensus Round 3

E.3 The methods to be used for the evaluation of an EAP.

Please indicate how important each of the following statements is according to the following scale with reference to the specific methods to be used in the evaluation process of the EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

16.7				Consensus Round 2
16.8				Consensus Round 2
16.9				Consensus Round 2
16.10				Consensus Round 2
16.11				Consensus Round 2
16.12				Consensus Round 3
16.13				Consensus Round 2
16.14				Consensus Round 2
16.15				Consensus Round 2
16.16				Consensus Round 2
16.17				Consensus Round 2
16.18				Consensus Round 3
16.19				Consensus Round 2
16.20				Consensus Round 4
16.21				Consensus Round 4
16.22				Stability Round 4
16.23				Consensus Round 3

16.24 Any other comments on the specific methods to be used in the evaluation of an EAP?

Thank you for completing this questionnaire: Round 5.

Willem Kruger

Appendix R

Delphi survey questionnaire: Round 6

**HEAD: DEPARTMENT OF COMMUNITY HEALTH
SCHOOL OF MEDICINE
FACULTY OF HEALTH SCIENCES
UNIVERSITY OF FREE STATE**

ROUND 6

JUNE 14, 2010

Dear Delphi Participant,

Thank you very much for participating in the Delphi survey of this study and completing the 5th round questionnaire, which I have received. This is the survey for the 6th round. Consensus / stability was not achieved during the 1st, 2nd, 3rd, 4th and 5th round of the Delphi survey on the following 4 statements and you need to re-assess your current rating on the statements as indicated. You can change your rating or keep your current rating as it is.

Instructions for the completion of the questionnaire for Round 6

Each statement will have a score just below the rating scale. That is the number of experts rating that statement. Your score for that statement is indicated by a red colour. See the following examples as an illustration:

Example:

Please indicate how important each of the following criteria is to be included in the framework for a best-practice EAP according to the following scale:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

1.1 An EAP is needed for health care sector.

1

2

3

Comments:

6

4

2

X

Six of the twelve experts rated this statement:

“Considered to be critical” (giving it a rating of “1”)

Four of the twelve experts decided this statement “Could be considered” (giving it a rating of “2”). Because the overall score is highlighted in red, it means you are one of the four experts rated it as “2”.

Please re-assess your rating of each numbered statement, which can be regarded as criteria for the best-practice EAP and then indicate the importance thereof on the three-point scale. The specific points of the scale are defined as follows:

- 1 – Consider to be critical (this criterion must definitely be included in the best-practice framework).
- 2 – Could be considered (it does not matter if this criterion is included or left out from the best-practice framework).
- 3 – Not to be considered (this criterion must definitely be left out of the best-practice framework).

If you complete the questionnaire in the electronic format, please type in a cross (X) underneath the point on the scale/overall score that represents your opinion on the specific indicator. If you complete the questionnaire in hard copy format (printed out), please write a cross (X) underneath the specific position of the scale.

As part of the design of the questionnaire, I have also included space for comments which can be utilised for each item. There will still be Comment column for specific criteria as well as Comment space at the end of each section to which you may comment in your own words in the space provided.

Please return the completed questionnaire by no later than 21 June 2010.

Yours sincerely,

Willem Kruger

Student no.: 1981280579

Section A:**INTRODUCTION OF AN EAP:**

This section deals with issues related to introductory statements to be included in an EAP.

A.3 THE SCOPE OF THE EAP.

Please indicate how important each of the following criteria is according to the following scale with reference to the scope of the EAP:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

3. The scope of the EAP must take into account / should address the following issues:	Comments			
3.3 Should be used to assist with appointment of employees.	<u>1</u> 0	<u>2</u> 3	<u>3</u> 9	

Section B:**Structure and requirements for an EAP.**

This section deals with issues related to the structures and requirements of an EAP.

B.2 The role of an in-house EAP committee.

Please indicate how important each of the following statements is according to the following scale with reference to an in-house EAP committee for a health care institution:

1= Considered to be critical

2= Could be considered

3= Not to be considered

Please mark the appropriate box with an X. Mark only one option.

6. The role of an in-house EAP committee must include / address the following issues:	Comments			
6.5 To be involved in the discussion of problematic cases/employees within the EAP.	<u>1</u> 7	<u>2</u> 0	<u>3</u> 5	

B.3 The category of service providers in an EAP.				
Please indicate how important each of the following statements is according to the following scale with reference to the category of service providers in an EAP: 1= Considered to be critical 2= Could be considered 3= Not to be considered Please mark the appropriate box with an X. Mark only one option.				
9. The following category of staff members needs to be considered / included in an EAP team to render a service in a health care institution:				Comments
9.10 Administrative staff member.	<u>1</u> 3	<u>2</u> 1	<u>3</u> 8	
Section D: EAP processes and activities.				
This section deals with EAP processes and activities.				
D.2 Types of services to be rendered in an EAP.				
Please indicate how important each of the following statements is according to the following scale with reference to the types of services to be rendered in an EAP: 1= Considered to be critical 2= Could be considered 3= Not to be considered Please mark the appropriate box with an X. Mark only one option.				
13. The following type of services for an EAP must be considered / needs to be included in the programme:				<u>COMMENTS</u>
13.27 Provide general supportive services such as visiting Department of Home Affairs for Identification documents, birth registrations, passport and motor car registration.	<u>1</u> 0	<u>2</u> 9	<u>3</u> 3	

Thank you for completing this questionnaire: Round 6.

Willem Kruger

Appendix S

Summary of the framework for a best-practice EAP

