CHAPTER II

LITERATURE REVIEW

2.0 Introduction

The main aim of this research was to identify the teachers' perceptions and expectations toward help-seeking through the counseling services provided as part of the occupational stress management method in Malaysian context. Based on the findings, the research aimed to develop a handbook of Employee Assistance Services to be used as the guideline for the teachers in schools. The effectiveness level and teachers' satisfaction toward the suggested services were measured to identify the teachers' pre and post-perceptions toward help-seeking through counseling services.

Numerous studies on the effectiveness of Employee Assistance Services in the Western countries have been conducted. Due to the inadequate number of Malaysian resources on Employee Assistance Services, this chapter mostly discusses the theories and models related to the topic of study and previous studies done by researchers from outside the country. This chapter focused on occupational stress management, counseling services in the Malaysian education system, perceptions toward seeking professional counseling, the evolution of Employee Assistance Services, challenges of Employee Assistance Services as the occupational stress management program, the

model of job stress and health, Employee Assistance Services policy and procedure, the Employee Assistance Services design, the type of services offered, the implementation of Employee Assistance Services, the Employee Assistance Services models, methods of evaluation and the effectiveness as well as the satisfaction toward Employee Assistance Services.

2.1 Counseling in Malaysian Education System

In Malaysia, The Ministry of Education has appointed board of counselors through the Counseling Unit to each states and districts to organize and implement counseling activities specifically for school counselors (counseling teachers), teachers, and students. These counselors sometimes also hold parts as the person in charge for teachers' counseling services. In 1996, a directive from the Ministry of Education clarified the roles and functions of school counselors. It emphasized three main areas; academic-related issues, career guidance and development issues as well as psychosocial and mental-health-related issues (Ng & Stevens, 2001).

Counselors in Malaysian schools are also known as Counseling and Guidance Teachers. They are trained to focus on assisting and organizing counseling programs for students, parents and teachers. However, teachers can also be clients in counseling sessions organized by the counselors in the district, state or senior counselors at the Ministry of Education in Putrajaya on certain basis.

There are also other agencies and units implemented by other ministries in the government such as the Credit Management and Counseling Agency (AKPK), National Population and Family Development Board (LPPKN) as well as the National Anti-Drug Agency (AADK) to serve the counseling and assistance services in different area and problems. However, these agencies and units offer counseling services not specifically to only teachers as they are serving and encounter with issues from the public too.

In 2000, every secondary school had at least one full-time counselor, also known as the guidance and counseling officer. These counselors work by office hours and provide guidance and counseling services to students from both the morning and afternoon sessions (Ng & Stevens, 2001). However, most of the school counselors involved only in the students counseling session and teachers who voluntary involve in counseling session will mostly choose to meet counselors at the District Education Office (*Pejabat Pelajaran Daerah* –PPD) or the State Education Department (*Jabatan Pelajaran Negeri* – JPN). For serious cases, these teachers will be appointed to the Senior Counselors at the Education Ministry in Putrajaya. Certain issues related to serious mental issues, monetary, drug abuse or alcoholism will be referred to the counselors in respective agencies and psychiatrists in government hospitals.

The types of community counseling services currently available in Malaysia are telephone counseling, face-to-face counseling, and support groups. Telephone counseling is managed by lay volunteers and focuses on crisis counseling. Counseling agencies in Malaysia is said to tend to be characterized by language and religion (See & Ng, 2010). Government-linked agencies offer their services mainly in Malay Language while most agencies established by Chinese Malaysian community run their programs and services in Chinese languages.

2.2 Perceptions towards Seeking Professional Counseling

Perception has been one of the important issues in philosophical discussions (Afifeh Hamedi, 2013). There are numerous researches that have been conducted to examine the relationship between one's perceptions towards seeking counseling and the utilization of mental health services. More specifically, researchers sought to comprehend why at least 70% to 80% of individuals with a diagnosable mental health disorder do not seek professional help (McKenzie, Knox, Gekoski, & Maculay, 2004).

Identifying those factors which influence one's attitude towards seeking professional counseling can assist mental health professionals and other service providers in designing interventions aimed at attracting those who are in need of these services (Komiya, Good, & Sherrod, 2000).

Professional counseling is perceived as a difficult, embarrassing and risky process by many. Such perceptions instill fear and avoidance of mental health services in many who need professional counseling services (Kushner & Sher, 1989 in Vogel & Wester, 2003). Many people think counseling as a last resort and even more troubling is the finding that less than one third of people who are in need of counseling never seek out professional help (Andrews, Issakidis, & Carter, 2001; Vogel & Wester, 2003).

According to Afifeh Mehdi (2013), Mulla Sadra believes that the origin of all perceptions is the external objective, which immediately after entering the mind obtains some degree of immateriality. This means, Mulla Sadra stated that all human perceptions are immaterial and do not depend on a specific matter in the brain or the body for their existence but has connection with the outside matters around human such as other people's behavior, time constraint, and monetary. It depends and changes according to how an individual accept it.

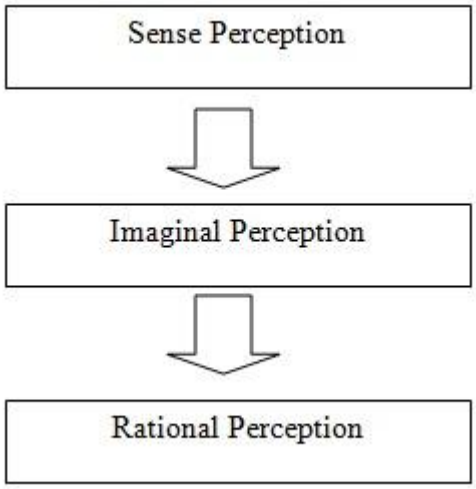

Figure 1: Mulla Sadra Perception Stages
(Source : Afifeh Hamedi, 2013)

Based on the Mulla Sadra Perception Stages (Afifeh Hamedi, 2013), there are three stages of one's perception; sense perception, imaginal perception, and rational perception. Sense perception consists of the reflection of external facts by the five senses. In this stage, the human soul gain knowledge from senses and images. It is mentioned that the important elements which are necessary for sense perception are divided into attention and awareness. According to Mulla Sadra, both attention and awareness are presental knowledge resulting from psychological phenomenon and has nothing to do with the body. Attention is the result of man's attention to things which presence for him while awareness is the very presence of external objects in man's mind (Afifeh Hamedi, 2013).

Imaginal perception means a series of free images which have no share of reality (Afifeh Hamedi, 2013). It is the sort of perception that follows the sense perception however the imaginal perception is not as clear as it is in the case of sense as the sense perception needs to take place in a particular position and direction, conditions that imaginal perception does not need (Muhammad Javad, 1994). In

addition, Muhammad Javad also stated that the sense perception, in contrast to imaginal perception, will disappear at the time of the absence of direct connection between the perceiver and the object. Rational perception also known as the intellectual perception is a universal perception which can only be obtained after sense perception and imaginal perception. According to Afifeh Hamedi (2013), Mulla Sadra defined the intellectual perception as the presence of the universal form of any intelligible before the mind. It means that at this stage of perception, an individual is often react by the universal principles and known facts which are abstracted and inferred from external objects and phenomenon (Khamenei, 2001 in Afifeh Hamedi, 2013).

In this research, perceptions toward help seeking through professional counseling services were observed and studied based on the understanding of the Mulla Sadra Perception Stages as explained earlier. It is very important that through this understanding, the research variables that were used to test the school teachers' perceptions reflected the most common sense, imaginal, and the rational perception toward help seeking through the existing professional counseling services. By following this concept, the variables used to test the school teachers' perceptions were also chosen based on the observation and informal interviews conducted before the preliminary study of this research.

2.2.1 Emotional Openness

One such fear, which still receives only scant attention, is the fear of emotions (Komiya, Good, & Sherrod, 2000). Emotional openness refers to the degree to which a person is comfortable talking to others about personally distressing information (Kahn & Hessling, 2001). A high level of emotional openness indicates a strong ability and level of comfort with disclosing personal information with others, and more specifically with strangers. A low level of emotional openness has been linked to negative attitudes towards professional counseling and consequently avoidance of mental health services.

A low level of emotional openness is also associated with instigating several treatment fears in individuals who need professional counseling services (Komiya, Good, & Sherrod, 2000).

Komiya, Good, and Sherrod (2000) also examined the relationship between emotional openness and college students' attitudes towards seeking professional counseling. They identified the following four factors as negatively influencing one's attitudes towards help-seeking: (1) male gender, (2) greater perception of stigma associated with counseling, (3) lack of openness to emotions and (4) lower psychological symptom severity. They also revealed that greater emotional openness predicts more favorable attitudes towards seeking professional counseling. Women were found to have more open attitudes to emotions, perceive less stigma, and report more severe psychological symptoms than men (Komiya et al., 2000).

2.2.2 Social Stigma

The impact that social stigma has on individuals who need professional counseling is evident in the finding that many prefer to forgo mental health benefits, which are provided by their employers and instead opt to pay for psychological services on their own to prevent the risk of disclosure in the workplace (Greenidge, 2007). Stigma attached to seeking professional counseling has been identified as a major deterrent to seeking counseling. Outram, Murphy, and Cockburn (2004) explored factors associated with accessing professional help for psychological distress in midlife Australian women. The researchers gathered both qualitative and quantitative data to determine barriers to help-seeking. Subjects' perceived barriers included feelings of shame and embarrassment and fears of being judged negatively by others. Some of the participant responses were "They'll think I'm neurotic" and "…people look on you as weak if you need counseling" (Outram et al., 2004). Other perceived barrier included fear of painful self-discovery, belief in coping alone, and belief no one can help. A similar study with Afro-Caribbeans in the U.K. revealed analogous findings with

responses such as “Mental Illness, that’s another word for laziness isn’t it” and “If you are depressed the last thing you are going to do is ask for help because people will think you are mad” (Marwaha & Livingston, 2002).

Many relevant factors existing that play a role in an individual’s decision in seeking help in counseling services. The most frequently cited reason for why people do not seek counseling and other mental health services is the stigma associated with mental illness and seeking treatment (Corrigan, 2004). Stigma has consistently been cited as one of the main factors inhibiting individuals from seeking mental health care and there is a great deal of research suggestive of the strong stigma attached to mental illness and seeking psychological services (Vogel, Wade, & Haake, 2006). According to Vogel et al. (2006), “stigma associated with mental health services is the perception that a person who seeks psychological treatment is undesirable or socially unacceptable”. This means, that social stigma can barricade the need for help seeking through counseling services.

2.2.3 Self Stigma

In contrast to public endorsement of stigma, self stigma is a reduction in an individual’s self-esteem or self-worth as a consequence of that individual’s self-identification as being someone in need of mental health services (Heather, 2008). Self-stigma can be a thought of as “what members of a stigmatized group may do to themselves if they internalize public stigma” (Corrigan, 2004). Research has shown that people do internalize negative perceptions when dealing with mental health concerns (Link & Phelan, 2001). Help seeking is often viewed as a threat to one’s self-esteem because seeking help from another is often internalized by the individuals as being inadequate or inferior and may lead the person to decide not to seek help, even when experiencing psychological distress (Heather, 2008).

Studies have showed that self-stigma is conceptually different from other, potentially related constructs, such as self-esteem and public stigma, suggesting that self-stigma is potentially unique in the conceptualization of help-seeking behavior. Similarly, self-stigma uniquely predicts attitudes toward seeking psychological help and willingness to seek counseling above previously identified factors (Vogel, Wade, & Haake, 2006). Furthermore, research suggests that self-stigma mediates the relationship between perceived public stigma and attitudes toward seeking help as well as willingness to seek help. This mediating relationship makes sense, as public stigma's effect on one's decision to seek help may have as much or more to do with the internalization of societal messages about what it means to be mentally ill (Andrews, Issakidis, & Carter, 2001) or to seek psychological services. The internalization can lead to shame and loss of self-esteem (Andrews et al., 2001) and the attempt to avoid those feelings may have the most direct effect on an individual's attitudes toward and willingness to seek counseling.

2.2.4 Anticipated Risk and Utility

Anticipated risk and utility is defined as "an individual's perception of the consequences associated with self-disclosing to someone" (Vogel & Wester, 2003). These anticipated risks are perceived as even worse than the problem itself thus hindering service utilization. This is particularly true for people from cultures where it is prohibited to disclose information about oneself or the family to strangers (Vogel & Wester, 2003).

Lin (2002) also lends support to the finding that people shy away from counseling to avoid the shame and embarrassment of having to disclose personal information to a stranger. Kelly & Achter (1995) found that the fear of disclosing emotionally painful information directly leads to negative attitudes toward counseling while Komiya et al. (2002) state that one's fear about the consequences of disclosing personal information in counseling is the most influential barrier to seeking counseling.

Outram, Murphy, and Cockburn (2004) measured factors associated with accessing professional help for psychological distress in Australian women. Results indicate that 52% of their sample preferred to speak with a General Practitioner about their personal problems than to seek help from a mental health counselor. Some of the more common perceived barriers to seeking help included a desire for privacy, a belief in coping alone, belief that no one can help, shame and embarrassment, and fear of painful self-discovery.

Through understanding and identifying the perceptions toward help-seeking through counseling services and professional help, there are many developed services and programs as the element of human resource development and management that might be suitable in catering the need of the teachers as the employees of the Ministry of Education Malaysia. Among the earliest introduced was the Employee Assistance Services (EAS) also known as the Employee Assistance Programs (EAPs).

2.3 Employee Assistance Services (EAS)

An Employee Assistance Services (EAS), also known as Employee Assistance Programs (EAPs), traditionally has had the purpose of helping an employee with non-work related problems that had the potential to interfere with performance on the job through consultation and counseling services as its main component. For instance, some of the first EAS focused on alcohol and substance abuse problems, which adversely affected job performance (Norman, 2002; Panks, 2001). Today some of the plans offer legal advice, assistance with aging parents, marital or family counseling, psychological counseling, stress reduction sessions, financial planning assistance, and a number of other programs to assist employees with personal problems.

An EAS is a reactive program designed to mitigate existing negative circumstances by addressing core problems (personal, medical, and emotional) as they affect an employee's productivity (Jeremiah, 2009; John et.al., 2010) . Adding to this

point, Gilliland (2010) has found out that as a result, some employees see an EAS as a mean to only address performance deficiencies and are reluctant to take advantage of other services for fear of being labeled unproductive.

Klingner, Llorens and Nalbandian (2009) suggested that these programs are "designed to diagnose, treat and rehabilitate employees whose personal problems are interfering with work performance. From the employee's viewpoint, the objective is to treat personal problems before they have an irreparable effect on job status. From the employer's view point, the objective is to rehabilitate employees whose personal problems are a threat to productivity".

Employee Assistance Services (EAS), like other human resource services and health care entities, have experienced much change in the past years. All service delivery systems are being modified, merged and integrated and EAS are no exception. Traditionally, EAS were internal programs based inside the host organization and staffed by employees of the organization (Peter, 1998). The EAS field has experienced outsourcing as have many industries.

Majority of EAS in Malaysia are internal programs provided by the employers (Ming et. al. 2009). However, there are evidences that external programs are also provided to the employer organization through outside contracting EAS vendors (Low, 2010). This findings are supported by Gilliland (2010), that these EAS firms have, many cases, also been integrated into other behavioral health delivery systems such as behavioral health Managed Care Organization (MCOs).

The challenge for EAS is to maintain their clarity of vision and purpose, as the models of EAS respond to the market place. Recent human resources issues – such as the Drug-free Workplace Act, Equal Employment Opportunity Committee (EEOC) rulings, child and elder care concern and workplace violence are triggering a closer look at EAS (Wei, 2002).

Wei (2002) added, with the advent of prepaid behavioral health Managed Care Organizations (MCOs), there were some who felt that EAS were merely mental health as defined by the Health Maintenance Organizations (HMOs) and that no distinction in services could be made. MCOs saw EAS as duplicative services to the mental health access numbers and provider panels that they were offering. In the early 1980s, there were many predictions by MCOs of the demise of EAS but MCOs have learned over the intervening years that the contracting employers, the one paying for the services, values highly the work-site-focused services offered by EAS and, in fact, EAS enrollment has increased 45% since 1994 (Freda, 2000; James, 1999).

The stigma associated with EAS has somehow being said as its biggest drawback in making an impact on the organization. Some EAS are strictly designed to identify and assist troubled employees and do not make overtures to current productive employees. The scholarly literature is filled with instances where EAS was studied and the dependent variable was the problematic employee as stated long time ago by Hartwell, Steele, French, Potter, Rodman and Zarkin (1996). Hartwell et. al. (1996) continues the negative stereotype of EAS by conducting a study entitled, "Aiding Troubled Employees: The Prevalence, Cost, and Characteristics of Employee Assistance Programs in the United States." These studies and the general negative characteristics associated with EAS have kept some productive employees from participating in their positive aspects.

In the Western countries, EAS are known as the employee benefit programs offered by many employers (Matrone, 2008; Freda, 2000; Linda, 2000) typically conjunction with a health insurance plan. EAS are intended to help employees deal with personal problems that might adversely impact their work performance, health and well-being. Studies showed that EAS have a significant impact on improving worker productivity (Chan et al., 2004 and Elliot & Shelley, 2005). EAPs have become a very important and popular institutional mechanism in many enterprises for promoting

health and emotional well-being, reducing absenteeism, and improving performance (Ruiz, 2006 and Cooper et al., 2003).

The services in EAS generally include assessment, short-term counseling and referral services for employees and their household members (Carolyn, 1996). Services in the EAS are usually free to the employees as it is having pre-paid by the employers. In many cases, an employer contracts with a third-party company to manage its EAS also called external EAPs provider (Tamara, 1999). These findings are supported by Kirk and Brown (2003) saying that, an EAS is an employer funded resource offered to employees and often including the employees' families. Adding to their point of findings, they've found out that the core service offered by an EAS is generally professional assessment, referral and short-term counseling.

2.4 The Evolution of Employee Assistance Services (EAS)

Employee Assistance Services (EAS) have experienced tremendous growth both in size and interest since their origin in the early 1900s. This expansion has been of great importance to the employee and the employer (Peters, 1997; Buon & Compton, 1990). EAS provides a troubled employee with some measure of counseling assistance in order to diminish the negative impact that such personal problems might inflict on his or her personal life and job performance.

Employee Assistance Services were originally designed as an occupational resource that provided assistance with the alcohol-related issues such as absenteeism, declining performance, and the associated impairment of the labor force (Daniels, Teems & Carroll, 2005). As issues of the workforce changed and new challenges arose, the EAS industry evolved and expanded to offer a wide range of behavioral health and human resources services. The EAS industry is now faced with the challenge of

distinguishing itself, or establishing a role, within the behavioral health-care industry and health care in general.

EAS have a long history of providing crucial services to alcohol-impaired employees in the workplace. EAS were primarily influenced by the growth of Alcoholics Anonymous and eventually shifted away from industrial alcohol programs towards broader employee assistance programs as companies began to extend their alcoholic programs to employees that were experiencing mental health problems (Kirk & Brown, 2003). EAS now provide services ranging from traditional counseling and drug-free workplace training to wellness services and management of behavioral health benefits. Much of the international demand for EAS can be attributed to the development of worldwide corporations. To serve large multinational corporations, EAS providers had to abandon their traditional model of delivery in favor of programs that contractually provided a wide range of services with a large network of affiliates (Arthurs, 2000).

As a reflection of the EAS field's growth, the identity and practice of EAS was captured in the creation of a Service delivery models and services and have continued to expand as business recognized the value of the programs especially in the Western countries. Some EAS now offer compliance programs to help employers monitor and comply with the requirements of the Human Resource Development and Management field; based on various organizations or local agency requirements. In addition, EAS help businesses cope with critical incidents such as natural disasters and violence in the workplace.

2.5 Challenges of EAS as the Occupational Stress Management

There are a number of studies examined specific effects of the EAS as the tool of occupational stress and occupational stress management in the education system abroad. Occupational stress is a term used to define ongoing stress that is related to the workplace (Malcolm, 2009). The stress in occupation may have to do with the responsibilities associated with the work itself, or be caused by conditions that are based in the corporate culture or personality conflicts (Grant & Sally, 2002).

Occupational stress in teaching profession is a much talked of phenomenon, however there is little consensus between different professional groups regarding its etiology (Sandeep, 2010) or how to manage it. Research by Choi and Mardhiah (2015) revealed that there was a significant relationship between occupational stress and job satisfaction among 386 teachers in Malacca, Malaysia. Based on reviews of international and local research, it is concluded that occupational stress is a real phenomenon and are reliably associated with a range of causal factors.

Occupational stress can be defined as the physical and emotional responses that occur when worker perceive an imbalance between their work demands and their capability and resources to meet these demands or in simple words it is the harmful physical and emotional response that can happen when there is conflict between job demands on the employee and the amount of control an employee has over meeting these demands (Sandeep, 2010).

However, there are a few challenges in adhering EAS as part of the occupational stress management services and programs. These challenges are common in efforts of implementing any professional help. Followings are found documented evidences of the challenges in implementing EAS as the method in occupational stress management.

2.5.1 Identifying Individual's Type of Stress and Stressors

According to Oliver and Venter (2003), stress is an unavoidable consequence of modern living. The coping of a situation or extent of a reaction depends on every individual. A situation that is harmful to one may not be the same for the other so the stress is a very complex phenomenon.

Research by Brotheridge and Lee (2005) indicated that occupational stressors have a more severe impact on home life than home-related stressors do on occupational life. Studies have shown that teachers who experience a great deal of occupational stress may have difficulty establishing rapport (Kyriacou, 2001) and maintaining relationships with their students, peers and spouses (Attridge et al., 2000; Golnaz & George, 1997). Therefore, these teachers may have difficulty in home living, also in motivating their students in the classroom and meeting the educational goals.

Stress is prevalent in modern society and can have many consequences in the business world, including job burnout, ill-health, high staff turnover, absenteeism, low morale and reduced efficiency and performance (Hannigan, Edwards & Burnard, 2004). By managing stress and burnout, the attempt to examine organizational intervention on EAS and individual level strategies, such as self-efficacy definitely will support the effectiveness of EAS.

2.5.2 Acculturating Public Awareness

EAS have become a very important and popular institutional mechanism in many enterprises for promoting health and emotional well-being, reducing absenteeism and improving performance (Ruiz, 2006; Strazewski, 2005). The rapid growth of these programs has been partly because of the phenomenon of workplace stress (Coles, 2003).

While EAS are readily available at many workplaces in affluent Western countries, they are still rare in other parts of the world. According to Ming, Chiu-Chuan and San-Yuan (2009), Taiwan's EAS implementation lags significantly behind the Western countries and EAS are only common nowadays in Taiwanese high-tech workplaces. Comparing to Low (2010), EAS in Malaysia is still at its infancy and the growth of EAS importance as well as awareness are still slow especially among the government sectors.

Dynamic change often leads to awkward growth. The EAS industry grew in the United States so quickly if compare to the Asian countries, which it seemed to be a "one-stop shopping center" for all workplace health and human resource issues (Katherine & Hannah, 2008).

Therefore, without continuous research and measures, corporations and organizations may only place value on the price of EAS and not quality. Clearly, EAS must establish themselves as a vital component of behavioral health care. With a rich history of workplace interventions for substance abuse and mental health issues, EAS are positioned to create a clear and unified mission and vision for themselves and develop a set of core principles that will meet the demand for quality, evidence, and performance standards. With these efforts, the acculturation and awareness toward the importance of help-seeking through workplace wellness programs such as the EAS will reach its goal among the employees and the public.

2.5.3 Differences in Individual's Demographic Background & Expectations

The differences in employees' demographic background such as their gender, race and norms, religions and beliefs, educational levels, socio-economic status, workplace culture, and also their unfulfilled expectations toward workplace wellness

programs are among the deterrent factors found in previous researches toward the under utilization of the counseling services.

According to Komiya et al.(2000), based on gender differences, female employees were found to have more open attitudes of getting help through counseling services. They also shown evidences of perceiving less stigma compared to the male employees. This finding supported the previous studies conducted by Tata and Leong (1994) and Mallinckrodt and Leong (1992) which had also proven that women were more likely to find, provide and ready to receive support and help than men when dealing with mental health issues. Obviously, there appears to be gender differences in the activation and satisfaction levels of getting support and men are said to be traditionally more independent while women are interdependent (Weckwerth & Flynn, 2006).

Research by Oliver, Reed, Katz and Haugh (1999) shown that Asian Americans were less likely than European Americans to seek social support in times of distress. Chang (2001) also proved that Asian cultures are less likely to seek help when it comes to emotional issues.

Taylor, Sherman, Kim, Jarcho, Takagi and Dunagan (2004) in their writing also stated that East Asian cultures are less likely to seek support when needed. These findings were supported by the later research done by Mortensen (2006) which found that although respondents from the Asian cultures background recognized and understood the importance of receiving help and support, they were less likely to do so even though they admitted of having personal distress and needed assistance.

Factors such as the location and type of services offered are a few of discussed matters of employees' expectations when deciding to participate in programs provided by their employers. Grossmark (1999) indicated that an EAP program may have ascribed status due to many factors such as location and involvement with wellness initiatives. Location of the offered services or programs in EAS can be conducted

through both off-site and on-site basis (Grossmark, 1999; Anema, 2010). Anema (2010) proved in his study that employees and also supervisors showed better satisfaction level toward in-house EAP. In the focus group, the feeling was expressed that an in-house program was more convenient for both supervisors and employees as it helped consumers with transportation problems and the supervisors thought an internal program was more accessible (Anema, 2010).

Even with these challenges, EAS is still considered as a relevant method in occupational stress management efforts in helping employees dealing with home-life and work-life ordeals (Low, 2010). Therefore, it is very important for the Human Resource Development and Management in any organization to understand the need of EAS and how it works to provide productive and quality as well as happy and emotionally balanced employees.

2.6 Model of Job Stress and Health

Job stressors respect no occupational boundaries, so the potential for the exposure to this class of health risks is limitless (Lawrance, 2006). The United States of America National Institute for Occupational Safety and Health (NIOSH) has listed psychological disorders as one of the top ten leading work-related diseases and injuries, and has formulated a national strategy for the prevention of psychological disorders in the workplace.

Friedman (2000) observed that stress not only come from demands that individual faces, but also from the reaction to those demands and the perception of the ability to deal with them satisfactorily. This finding is supported by Roth and Gold (2007) studies that stress can occurs if teachers were presented with new work demands not well matched to their knowledge, skills or abilities which challenge their ability to

cope or adapt with the new existing job scope. Having too much stress, especially over a long period of time, almost always lead to health disorders such as ulcers, migraine headaches, and muscle pain.

Researches by Valerie (2011) and Viviane et al. (2006) had mentioned that stressors such as disruptive student, heavy workload and lack of support put teachers' mental health in danger. Thus, the study of occupational stress management among teachers is a great significance. Individual's abilities are reflected through the performance and the performance is directly related to the mental state and physique.

Schindelheim (2004) recommended that controlling stress is best achieved by using a wide range of coping skills that address both the demands that individual faces and the reaction to them. According to Austin et al. (2006), when teachers try to cope with overwhelming stress by themselves, they are not always successful. The results showed that avoidance, accepting responsibility, and unrestrained aggression, were some of the negative coping strategies used by the teachers.

The core of the model indicates that job stressors produce acute reactions or strains and these can lead to chronic illness. Although job stressors are listed as a single category, usually they are grouped into several broad categories which has been defined as factors intrinsic to the job, role in the organization, relationship at work, career development and organizational structure and climate (Cooper and Marshall in Lawrance, 2006).

Based on the model of job stress and health relationship by NIOSH (2001) as shown in Figure 2, the moderating factors operate to strengthen or weaken the relationship between job stressors and health outcomes. The model highlights the complexity of the problem of stress, as it cuts across work and non-work domains. These cross-cutting effects suggest that the study of job stress and the design of stress management interventions should be approached from a multidisciplinary perspective,

to produce an accurate picture of the nature of stress and how it should be managed. One important perspective is that of the employee assistance program.

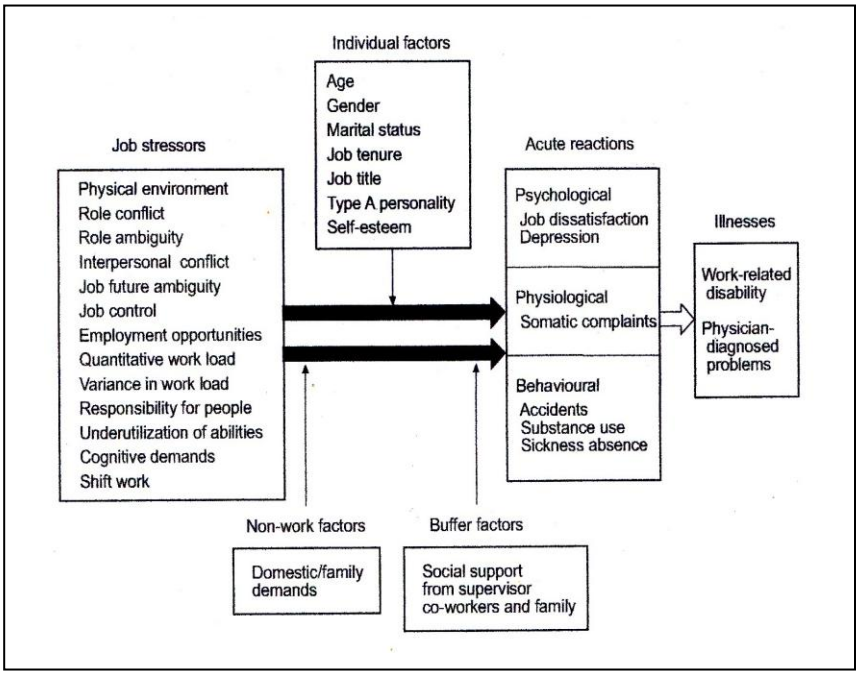

Figure 2: The Model of Job Stress and Health Relationship
(Source: NIOSH, 2001)

EAS see a wide spectrum of stress problems, some of which have their root causes in the work environment. Due to confidentiality matters, EAS provide very limited feedback to management. Usually the feedback is restricted to information about how many employees were seen in EAS and the general types of problems encountered. Historically, EAS has focused on characteristics of the employee, not characteristics of the job or organization, which may be causing employee stress (Tamara, 1999). Therefore, the collaborative approach, by soliciting input from human resource management and EAS group, is more likely to produce comprehensive stress management strategies that target the organization as well as the individual.

2.7 Employee Assistance Programs and Services in Malaysia

Like other countries in Southeast Asia, Malaysia struggles in the arena of mental health program development compared to development in medical fields. The field of EAS in Malaysia has been found evolving since 2004 (Low, 2010). However, EAS development in Malaysia has been described as still not sufficient to cater the well being of the local workforce.

The evolution of various mental health areas in Malaysia may not be familiar with Malaysia in the area of government policies, psychosocial rehabilitation, community mental health services, professional resources and insurance policies. The development in these areas has progressed but is still in a growing stage if compared to development in Western countries. Development in these areas is closely related to the development of EAS due to the nature of interdependency of these fields within Malaysia. Thus, for the EAS field itself, development in the last five years can be described as still in a growing stage with these scenarios (Low, 2010).

According to Low (2010); "the clienteles of the existing EAS in Malaysia has shown that almost all multinational corporations already have EAS in their headquarters or home base countries. Therefore, having EAS for their employees in Malaysia comes naturally. However, the approach and educating local Malaysian companies about the importance of EAS has been very challenging. These local companies acknowledged the importance of EAS after acquiring an understanding about EAS, but remained reluctant to allocate budget to purchase EAS".

Most of these local companies rather willing to engage a trainer to deliver an hour-long on stress talk and do not see the urgent need to allocate budget to have follow ups sessions in a holistic wellness program for employees which is a more comprehensive stress management program or services (Low, 2010). Most of these companies are not aware of the actual expertise of EAS professionals. They usually will

invite psychiatrists, psychologists, and counselors to deliver trainings to their employees because these professionals usually charge a minimal fee, as they are based in government or non-government agencies. Most of these professionals themselves work in clinical and institutional settings and are not very well versed in workplace mental health issues (Ng & Stevens, 2001).

According to Ming et al. (2009), the overall perception of these local companies is that EAS only involves employee counseling or crisis management. It means, they might not understand the preventive component of EAS. Many of these companies are also not aware of the actual impact of stress, absenteeism, medical leaves, workplace injuries and troubling behaviors of employees on the overall productivity of their workforce. This ignorance stems from the unavailability of local research data on EAS return on investment (Ming et. al., 2009). Meanwhile, based from Weng (2011), overcoming the stigma associated with mental health problems is still an uphill task. For EAS to develop further, it is critical to overcome this hurdle with creative approaches in the delivery of EAS. Otherwise, the program may fail because of support lacking from the employees.

In Malaysia, the current healthcare or insurance systems in general still do not cover mental health (Low, 2010). Any company intending to set up EAS will have to allocate a special budget to cover psychiatric treatment, psychological intervention and EAS because the usual medical insurance policies do not cover mental health. Low (2010) added that the growth of occupational health is also considered young in Malaysia, where only huge multinational companies will engage the services of an occupational health doctor. The number of trained occupational health professionals is still small. The collaboration with occupational health doctors is very critical in the management of EAS cases. However, because of a lack of expertise in occupational health, often EAS's struggle efforts to collaborate with medical professionals because of their lack of knowledge and understanding of the workplace implications when employees are ill (Weng, 2011).

Most EAS purchasers placed their EAS under the Benefits or the Employee Relations Department. In comparison with healthcare, EAS might fits better into the Human Resources structure in Malaysia because the field of Human Resources is more mature and established with every company, be it big or small, local or multinational, a Human Resources department is compulsory in every company's structure.

2.8 Services Offered through Employee Assistance Services

The main core of services offered in EAS is based through consultation, coaching and counseling. Through EAS professional assessment, counseling and referral services, employees and their family members can receive assistance with a wide variety of personal problems resulting from alcohol and drug abuse, depression, illness, death, anxiety, stress, family and marital difficulties, job performance problems, child and elder care concerns and other problems affecting their work or personal lives. Although not everyone feels motivated to refer themselves for counseling when they are so deeply involved in their own personal dilemma, Employee Assistance Services provide training and consultation to supervisors and managers so they can effectively respond to troubled employees and refer them for help (Sharar, 2006).

Training seminars and preventive educational workshops are other methods utilized to engage employees in meeting objectives of the EAS – early detection and prevention of emotional and social problems. Norman (2002), in his research findings has stated, of equally great importance to employers, the EAS is the result of a good business decision to protect their valuable investment in human resources and to respond to the need to contain health care costs and improve worker productivity, and thus compress business expenditures associated with employee problems.

According to Micheal et. al.(2009), it is important to delineate what services and components combine to create the unique EAS approach to productivity problems. The pressure from MCO has helped develop more clarity about EAS services and the development of EAS standards of practice. EAS has several core components that are not present in other delivery systems.

EAS are defined by the Employee Assistance Professional Association (EAPA) as work-site-based programs designed to assist work organizations in addressing productivity issues and "employee clients" in identifying and resolving personal concerns (including but not limited to health, marital, family, alcohol, drug, legal, emotional, stress or other personal issues) that may affect performance. Although traditional behavioral health clinical skills are employed to this end, the key focus is on work-site problems as the trigger for case finding. The focus on performance problems, combined with self identification, positions the EAS to intervene early on in the development of many problems (Ruiz, 2006).

The following Employee Assistance Services were as provided by Employee Assistance Programs Association (2010) and Employee & Family Resources (2012);

2.8.1 Counseling Services

Counseling services offer employees and their family members personalized attention to help them identify and respond to the issues affecting their emotional and/or physical well-being; the very issues that may be interfering in an employee's work performance and attendance. All EAS counselors are suggested with the license as counselors and with experience in issues ranging from marital and family conflict to mental health and substance abuse disorders. The member receives a comprehensive assessment of their concerns followed by brief counseling or, when needed, referrals for ongoing or specialized services to help them continue working toward resolution of

their issues. Counseling services are consisted of both face-to-face counseling and also group counseling via suggested Self & Emotional Development Services.

2.8.2 Life Coaching and Consultations

Life coaching and consultations offer an alternative to counseling services for individuals whose concerns and goals may be well suited, or even better suited, for the coaching and consultation process than for counseling services. According to Paterson (2008), through coaching and consultation services, participants seemed to show lesser stigmas when seeking help through professional wellness programs. Examples of issues of Employee & Family Resources or EFR (2012), "life coaches have assisted with include, but are not limited to, improving work habits, wellness issues, spending habits, strengthening parenting skills, time management, improving work or life balance, stress management and multiple personal growth issues". Employees can work with a trained Life Coach via telephone, email and a personal, confidential appointment to set goals and work toward achieving these goals to make the desired changes in their lives. These services may vary such as the Education & Career Development Services, Health & Nutritional Consultation Services, Sexual Related Help Services, Monetary Advisory & Consultancy Services, Substance Abuse & Drugs, Alcoholism, and Gambling Addiction.

2.8.3 Industrial Relations and Financial Consultancy Services

The stress caused by legal concerns as well as the time involved in seeking out legal advice can interfere in an employee's work performance and attendance. (Ruiz, 2006). EFR (2012) helps to address this through the Legal Services offering through the EAP. The EAS provides a no-cost telephone consultation with an attorney on a wide range of personal legal issues. When ongoing legal representation is needed, the employee can choose to continue with a network attorney directly to discuss further.

Financial issues can create great stress in the lives of individual and families. Individuals often do not know of the resources available to them to better understand how they can respond to their financial concerns or questions. EFR's EAS includes a no-cost 30 minute telephone consultation for employees with a qualified financial expert. Matters that the EAS Financial Services offering can respond to include credit counseling, debt and budgeting assistance, retirement planning, and tax planning. If further services are needed, assistance with locating a resource in the member's community is provided.

2.8.4 Family Relationship Consultancy

With the aging of our population, there is increased need to respond to the stress of providing care giving services to an older parent and the worry about the needs of a parent or other family member residing elsewhere. EAS offers an Eldercare Service for members who are experiencing this stage of life. Employee Assistance Services Coordinator will assist members with locating and accessing resources for elderly and dependent adults. These services range from locating Meals on Wheels, Visiting Nurses, and other in-home services to locating residential facilities and other housing options. EFR (2012) offers a Childcare Services option in which the EAP provides assistance locating childcare resources for its members. The EAS provides a list of available childcare resources to including day care centers, family day care, in home care, nursery schools, nannies, and before and after school care. This service also suggesting helps for employees to face any issues related to divorce or burdened of being single parents.

2.8.5 Critical Incident Stress Debriefings (CISD)

EFR (2012) recognizes the importance of planning for, and providing immediate and caring responses to, critical incidents that may impact the workplace. Examples of critical incidents that occur in and/or impact the workplace include the death of an employee or employee's family member; on-the-job accidents; serious injury; natural disasters; violent acts; robbery; and workforce changes.

In the event of a critical incident, Joint Advisory Team can immediately consult with the EAS Critical Incident Stress Management team. The team will help the employer to develop a response plan which will often include Critical Incident Stress Debriefings (CISD). CISD's are on-site meetings, generally held within 72 hours of the incident, with the goal of allowing employees to express their reactions to the event and to receive guidance on how to move toward recovery. CISD's have been demonstrated to accelerate the recovery of employees from traumatic events, helping business operations to get back to normal as quickly as possible.

2.8.6 Telephone and Email Consultation

According to the EFR (2012), the qualified EAS counselors shall be available by telephone 24 hours a day, seven days a week. The counselors spend the time necessary with the member listening to their concerns, offering emotional support, and helping them to develop a plan to respond to their concerns. When the employee is in need of services beyond the telephone consultation, the EAS counselor makes referrals to appropriate resources in the employee's community, including connecting them with the additional no-cost services offered through the EAS. Not just consultation through telephones, employees also have the choice to email the counselors for any matters with the maximum of one working day to be replied.

2.9 Employee Assistance Services Policy & Procedure

The essential ingredients of an effective EAS noted by Andrew (2000) include a clear, written set of policies and procedures outlining its purpose and function, supervisor training in problem identification, education of employees and promotion of EAS services, a continuum of care-referral through follow up of each case, explicit confidentiality policy, maintaining records for evaluation, and commitment and support from the top management. Lee and Gray (1994) identified the key issues involved with the implementation of an employee assistance program as clarification of the basic objectives and policies, the type of model to be implemented and the delivery of services.

EAS exists in different forms depending upon the philosophy and purpose of the program, the context of the environment into which it is implemented and the needs of the population addressed through the program. The scaffolding of all EAS requires a delivery system, clearly communicated policy and procedures, the support of supervisors and a well-defined method of evaluation. The ultimate goal of any EAS is "preventing, identifying and treating personal problems that adversely affect job performance" (Lee and Gray, 1994).

The foundation of an employee assistance program is a detailed policy that reflects the philosophy of the organization and specifies the procedures involved in the utilization of EAS services. Two important aspects of the policy include confidentiality and the relationship between EAS services and work performance (Andrew, 2000). Employees must trust that strict rules governing confidentiality will be adhered to, although limitations must be clearly defined to include times when confidentiality must be broken, say as the issues of safety. Employees need to understand that all conversations with EAS representatives or other health care professionals are private.

While information pertaining to job performance and disciplinary actions are placed in the personnel file, information about treatment for addiction or mental illness is kept separately and only released with the written consent of the employee. Only in situation involving child or elderly abuse and threats of homicide or suicide is information disclosed by the employer to the state. The policy should address such issues as the location of the records, the security of the records, accessibility to the records and the limitations for maintaining confidentiality (Lee and Gray, 1994).

Likewise, procedures must be addressed in the written policy for data collection and record keeping. Lee and Gray (1994) identify three areas of necessary data collection; demographic characteristics, referral and treatment statistics and job performance records. While data collection is an important tool in organizational life, confidentiality must be protected throughout the record-keeping procedures.

The relationship between disciplinary procedures and EAS services must also be clearly communicated in the written policy. Participation in an EAS or other treatment program is voluntary (Hartog, Hickey, Reichman and Gracin, 1993). Refusal to participate should not be used as a reason for dismissal; rather quality of performance should determine such a decision. Other methods of improvement include referral to a list of therapists and health agencies that may be covered under the organization's health care plan. In the industrial approach to employee assistance programs, the first step in the procedure was to officially document a decline in job performance. The supervisor then confronted the employee and made a referral to EAS services. The "constructive confrontation" strategy begins with the supervisor confronting the employee, issuing a warning that work performance was suffering and encouraging the employee to seek assistance or making the referral (Walker, 2003). Supervisors may experience the following phases when dealing with an employee whose quality of performance is deteriorating despite interventions. Initially, the employee may provide excuses to cover poor work performance and the uncertain supervisor initiates a "heart-to-heart" conversation with the employee (Walker, 2003).

As the problem continues, the supervisor may become angry and frustrated, suspecting the employee of covering up. The supervisor then begins to doubt himself for accepting the employee's excuses and for possibly losing his temper when the employee's performance continues to decline. The final phase for the supervisor is recognizing that normal efforts have not resolved the employee's problem and documentation, confrontation and referral to other assistance are necessary steps (Mark et. al., 2005).

According to John & Jack (2010), documenting observations of initial work performance problems and attempted interventions is an important component of the employee assistance program. Specific details to include in the documentation are employee's name, date, time and location of the incident, summary of supervisor's observations, involvement of witnesses, interventions and employee's response. John & Jack (2010) added that, documentation provides evidence, objective facts, a picture over time, patterns of behaviors and support for corrective actions. Following the documentation of the employee's poor work performance, a meeting with the employee should take place. The supervisor should discuss the situation with the human resource representative prior to confronting the employee. This meeting should occur before problems become serious enough to warrant a dismissal. The objective of the meeting is to advise the employee of poor performance and produce an agreement on the method of improvement.

2.10 Employee Assistance Programs Association (EAPA) Standards

EAPA Standards define an EAS as a work site-based program. The individual standards include some items that are properly the responsibility of the host organization. However, others can only be achieved jointly by employee assistance professionals and elements of the host organization. According to Linda et. al.(2004), an external EAP vendor may well provide services to one organization in which the

EAP is fully integrated and operating according to the standards, while at the same time providing services to another organization in which the EAP fails to meet standards.

Jeremiah (2009) stated that, the quality of any EAP and its compliance with EAPA standards is therefore a product of the interaction between the professional staff and the host organization. Ideally, accreditation should apply, and be awarded, to the specific programs arising from the joint responsibility and interaction of the vendor and host organization. As a practical matter, however, this may not be feasible for vendors operating EAPs in multiple host organizations. Therefore, the Committee considered that external vendor organization itself, or the overall internal program would likely be the entity to be accredited (Joseph, 2007).

To achieve such accreditation, vendors should be able to demonstrate their full integration into the workplace at a randomly selected sample of their multiple organizational clients. Multisite internal programs should be able to demonstrate full integration at a randomly selected sample of their sites.

Lawrance (2004) believed that; "EAPA is strongly committed to retaining control of the standards for EAS. The development of the EAPA Standards has been and continues an update on its work in the EAPA Exchange magazine, distributed a "fax-back" memorandum to the EAPA membership to stimulate awareness and discussion, and held a forum at the 1995 Annual Conference to gather additional input and encourage more dialogue".

According to Joseph (2007), the rumors helped to flourish feeding concern of the accreditation process. Some internal programs, both labor and management based are worried that they would not be able to meet the accreditation criteria, and would be replaced by external programs. He added that, some smaller external vendors were concerned that larger vendors would gain an advantage if accreditation existed.

Ironically, the original intent was not to favor a specific EAS and indeed to provide added support for highly integrated internal programs and for smaller vendors. These concerns among others began to raise doubts among certain board members as to whether EAPA should continue to move forward with accreditation.

An accreditation process becomes important when purchasers of professional services are limited in their ability to determine whether the services meet appropriate standards. This opinion is supported by James (1999) that stated "accreditation provides assurance that knowledgeable professionals have reviewed the services and found them meet to the applicable standards. Accreditation is therefore the logical extension of a standards development process. Once standards are agreed upon, the accreditation review determines whether a particular entity has successfully operationalised them in its services".

EAS thus fit the profile for accreditation. An EAS is a set of services for which professional standards have been developed, but most corporate and individual clients of EAS don't have the means to determine whether any individual program meets those standards. According to Jeremiah (2009), at times, the term "EAS" may be used inappropriately to refer to sets of services that clearly do not meet EAPA standards. Since the term is unprotected, there is currently no way to prevent this from happening. Through accreditation, it would help define employee assistance practice and distinguish true EAS from other sets of services that do not meet the standards of the profession (James, 1999). The process of accreditation provides a template to improve EAS services and may help demonstrate to organizational decision makers why a particular activity is important and why staff time, expertise, and resources need to be allocated to it.

On the other hand, at the time there was reason to believe that in the absence of a viable accreditation process, government might take responsibility for defining employee assistance programs and standards.

2.11 Program Design

The EAS is designed to benefit every area in an organization where individual performance plays a part (Megranahan, 1995). The scope is extremely broad and ranges from the single task to complex jobs which all levels of employees undertake. It follows from these principles that within an organization every individual's contribution is important.

The EAS provides the employee, the supervisor and manager, the union representative, the medical or occupational health department, the HR function and ultimately the organization itself with a well-tested package for addressing a wide range of issues. The package balances the need for performance maintenance with the desire to sustain employee wellbeing.

According to Linda (2000), before an EAS is introduced there needs to be a clear analysis of the aims and objectives for the services, the ways in which the EAS should be designed in order to meet the objectives and most vitally, how these objectives will be monitored. Without this exercise, the off-the-shelf package will go unmonitored, may be inappropriate and certainly will not have mechanisms to define, measure and improve the processes used to deliver an EAS.

Program design depends a great deal on the goals of the EAS. Some EAS deliver assessment and referral services only, others add clinical services in the form of short-term problem resolution (Westling et. al.,2006). Micheal et. al. (2009) added, still others are fully integrated with behavioral health benefits and take on a more clinical appearance. Whatever the collateral services offered, and no matter how they are packaged, the core EAS functions must be present. These seven core components combine to create a unique approach to addressing work productivity issues and client concerns that affect job performance.

According to Max (2007), EAS core technology is consultation with training and assistance to work organization leaders (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 EAS services. It must also be confidential and timely problem identification or assessment services for employee clients with personal concerns that may affect job performance. The use of constructive confrontation, motivation, and short-term intervention with employee clients to address problems that affect job performance is very important too.

Referral of employee clients for diagnosis, treatment, and assistance, plus case monitoring and follow-up services as well as consultation with work organizations in establishing and maintaining effective relations with treatment and other services providers, and in managing provider contracts. The consultation with 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. The identification of the effects of EAS on the work organization and individual job performance must be continuously made to ensure the services fulfill its objectives and aims.

Although frequently talked about, the issue of quality is rarely analysed seriously or examined by the organization which is taking on an EAS. What can be achieved is however considerable, simply by applying existing quality management practices. Based from Megranahan (1995), at every phase of a quality review process, it is vital that agreed standards or benchmarks are then set in place. Agreeing on the same opinion, Andrew (1998) has mentioned that benchmarks are measurements used to gauge the actual performance of a business to that of others. According to Megranahan (1995), the benchmarking process of the EAS follows by four stages and it is on the organization itself to set objectives according to its needs.

Table 1: The Benchmarking Process (Megranahan, 1995)

Stage	Activity
Focus	EAS Implementation.
Analyze	How is success measured?
Develop	Establish optimum targets.
Implement	Carry through and evaluate.

Once an organization begins to look at the issues which it believes an EAS can address, it may well find a range of internal problems exposed and such issues need to be examined. A responsible EAS provider will also advise the organization in this type of scenario and introducing an EAS is a very important and responsible task (Andrew, 1998). The EAS will have a privileged and intimate relationship with the organization and its staff. Trust is obviously vital in any relationship but the good review mechanisms strengthen this bond and provide for an open and constructive dialogue to be introduced.

2.12 The Implementation of Employee Assistance Services

According to Mayhew (2012), to start an EAS for a workplace, it shows that the company is among the thousands of employers who recognize the benefit of adding these services to the company's existing group health care plan. EAS offer a variety of services at no cost to the employees however the cost to the employers depends on the types of EAS to be offered and current negotiated costs for group health care benefits.

Adding an EAS may not be as expensive as most people think, depending on the size of the workforce, the types of services wanted to provide to employees and the timing of request. It may be easier to negotiate a better rate if it is near open enrollment

time or if expressed to change group health care plans. Use the negotiation skills to obtain the best possible plan for employees at the most reasonable cost to the company (Mark et. al., 2005).

Review past employee opinion survey responses for information might help to decide which types of EAS services employees are most likely to use (Mayhew,2012). Based on findings from Gilliland's survey (2010), "conducting small (five to seven employees) focus groups to discuss how EAS work and the kinds of EAS employees feel are most valuable. If plans for adding EAS services to existing health benefits are down the road, administer an employee survey that asks specific questions about desired Employee Assistance Services must be implemented. Adding EAS to company's benefits may not be cost-prohibitive; nevertheless, the company wants to ensure that employees are interested in and will use EAS benefits".

Tailoring EAS to address the needs of the workforce conveys an understanding of employee needs (Max, 2007). According to Peter (1998), to observe which EAP services employees use most frequently, one must analyze that information to further refine company's EAP benefits. He added, the key to using this method is communication. Maintaining communication with employees about benefits programs will make it easier to implement new benefits without worrying about what will happen if the company decides later to eliminate EAS benefits. Accepting that the objectives set are realistic, the next stage is to examine how these objectives can be met by an EAS and to recognize certain potentially problematic areas of EAS provision (Peter , 1998).

Table 2: The EAS Stages of Adoption and Installation (Peter, 1998)

Phase	Principal Activity	EAS Aspects to Note
Pre-Implementation	Selection	Is every aspect of EAS examined and compared with other services?
Interim	Monitoring	Is the EAS open and accountable?
Post-Implementation	Review	Is there sufficient data to plan future needs from previous experience?

2.13 Choosing the Right Employee Assistance Services Models

EAS target both on employees whose performance shows a pattern of decline which is not readily explained by supervisory observation of their job circumstances and employees who are aware of personal difficulties that may be affecting or may start to affect their work lives.

According to Tamara (1999), the majority (up to 90%) of the EAS clients are from this second group and access the EAS through self-referral (see Figure 3). These are employees who have some insight into their problems and avail themselves of the easy access offered by the employers' EAS. Employees who self-refer are given assurances that their personal issues will be kept confidential and that the employer's interest is in maintaining a safe and productive workforce. These employees contact the EAS to receive assessment services and referral to qualified local providers or to receive short-term solution focused counseling provided within the EAS system.

Of the employees who access EAS services, up to 80% receive the guidance that they need to clarify their issues, contact appropriate resources, and effect change if necessary (Tamara, 1999). Therefore, these employees do not access their mental health benefit. Early intervention when symptoms are milder results in a considerable savings to the employer and benefits cost containment.

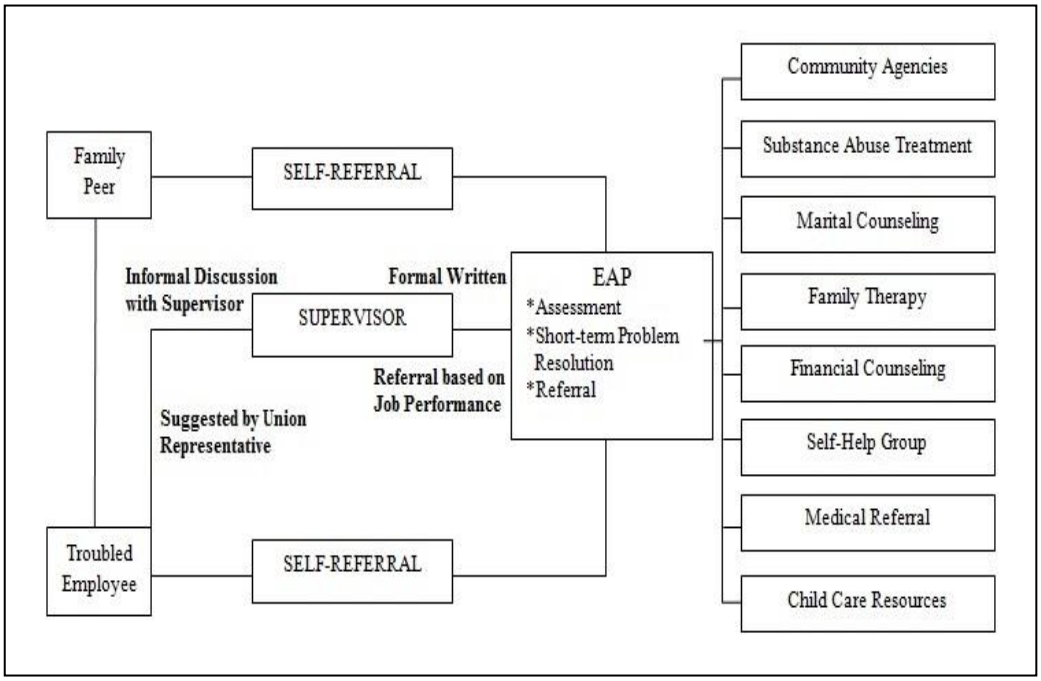

Figure 3: General EAS Structure (Tamara, 1999)

2.13.1 Supervisory Referrals Model

According to Tamara (1999), when an employer has a functional EAS, they do not wait for the employee to contact one of their panel providers, or wait for the problem to escalate to a point where fitness for duty or workers' compensation systems are called into play. Effective management always involves understanding and responding to people as individuals. In the case of behavioral health problems, some of these individual characteristics can become a management issue. Emotional problems at work cause a dilemma for most managers.

There is a tendency to want to leave charged emotional issues alone, but there is also a natural desire to help. Employee problems do need to be recognized before they can be address and recognition can be difficult. Less enmeshed in the personal emotional turmoil of the employee, often workplace colleagues and management recognize problems before the family or the employee has to confront them. Problems at work show up in subtle ways such as decreased productivity, ambition, quality, or interpersonal effectiveness.

EAS offer a tool that allows supervisors to combine their concern with an offer of assistance and progressive disciplinary action. The employee does not have to possess insight into the problem, admit to a problem, or have motivation to seek help. The supervisor is provided with a means to intervene at an early stage of dysfunction and to refer the employee to a professional for assessment and assistance.

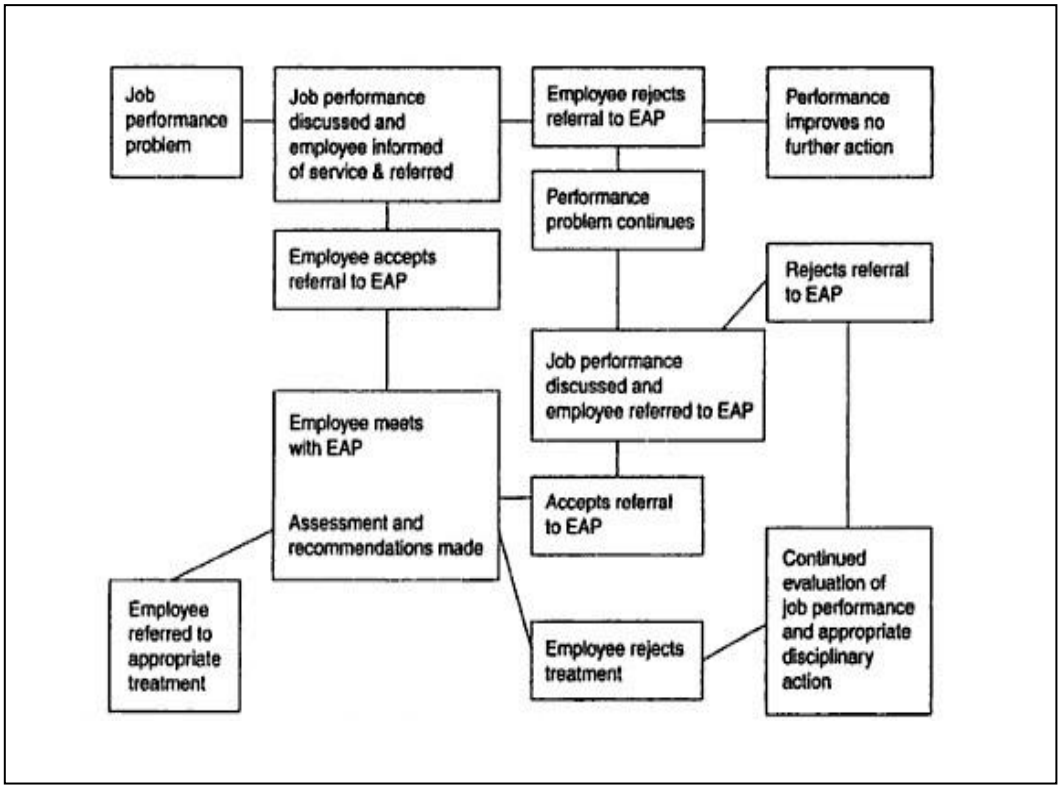

Figure 4: EAS Supervisory Referral (Tamara, 1999)

As part of their specialized services, EAS provide supervisors with training and consultation to determine the appropriateness of the EAS referral and to guide the Internal EAS, while focusing on its core components, is also in a unique position to contribute to other areas in the organization and to identify collaborative tasks between the various human resource areas. The developing areas of human resource consultation fit well with this model.

2.13.2 Internal EAS Model

The Internal EAS model also allows for closer management of EAS professionals. Clinical supervision and quality assurance functions are routinely performed. The EAS is not relying on a far-flung panel of independent affiliates to deliver services.

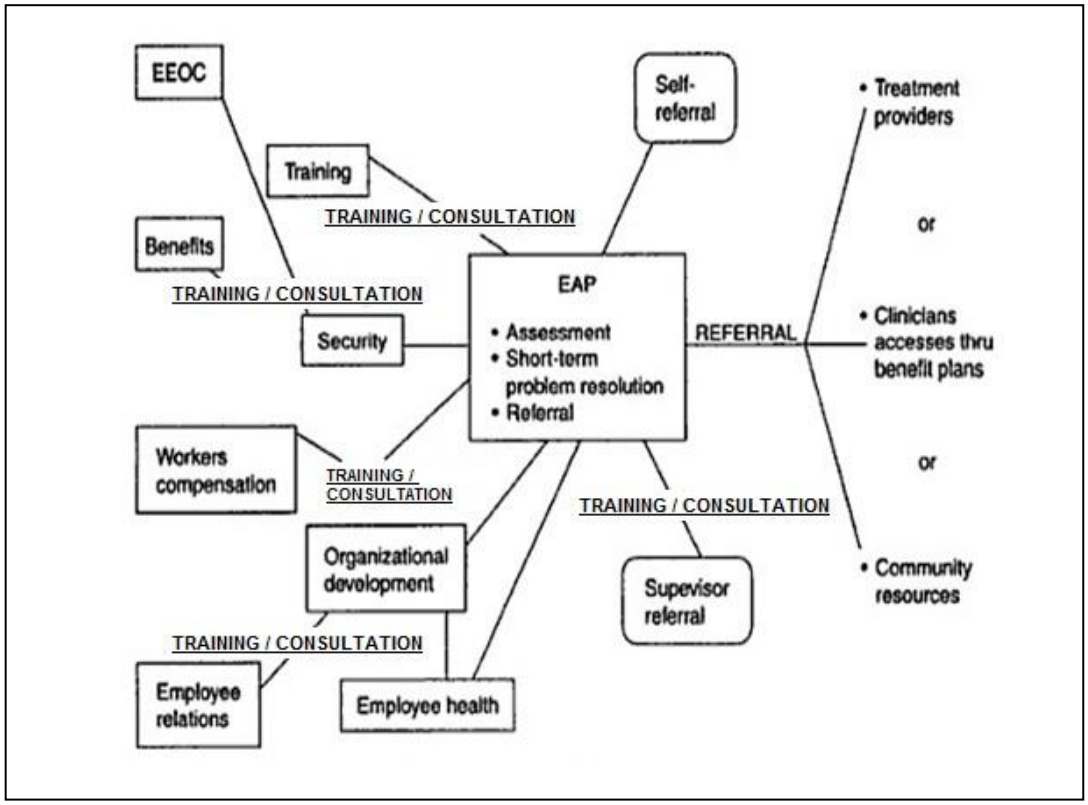

Figure 5: Internal EAS Model (Tamara, 1999)

According to Tamara (1999), "the labor organization corollary of an internal corporate EAS is a member assistance program (MAP). Many labor organizations are strong supporters of internal EAS systems. The unions have in some cases established member assistance programs that are totally union run. These programs deliver EAS services to union members and their families". Through reading, researcher has understood that, MAPs are an efficient arrangement for employees who work out of a

hiring hall or by the job. These workers often are not on one job with consistent supervision for any extended period. Patterns of poor performance can go undetected by short-term supervisors but are more visible to the union. MAPs also offer a consistent source of assistance for mobile employees' groups.

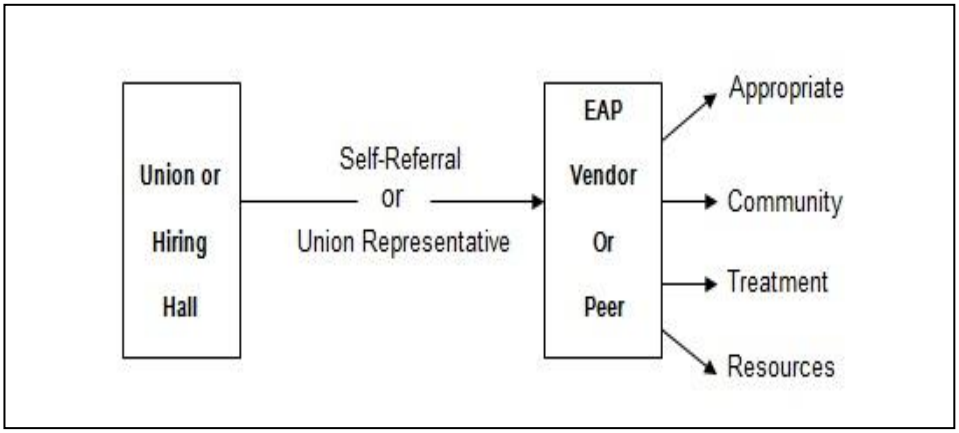

Figure 6: Member Assistance Program (Tamara, 1999)

The decision concerning the source through which to offer employee assistance services ultimately revolves around the company's philosophy of its role in regard to helping troubled employees and the size of the organization. Two basic avenues exist through which to design an EAS; the internal program, which offers services from within the organization's own resources, and the external program, which contracts an outside agency to provide EAS services. Internal services can range from dispensing information to actual treatment services provided by on-site professionals. External services can be provided by a single agency or a consortium of agencies that exist outside the organization (Lee and Gray, 1994). Both programs contain advantages and disadvantages relating to issues of confidentiality, perception of negative impact on career status, convenience, and support of supervisors and co-workers (Collins, 2000).

The Internal EAS services can be more costly to implement due to the additional personnel, paperwork, and maintenance of records necessary to support the program. The strongest argument for offering EAS services internally is that the program can tailor services to the specific needs of the company. EAS personnel can appreciate the politics and culture of the organization may place the employee assistance under medical services (Lee & Gray, 1994), staff development, the personnel department or with social services (Collins, 2000). The placement of the EAS may stretch the resources of a particular department and limit the expertise available to employees (Lee & Gray, 1994; Collins, 2000). A lack of trust in confidentiality and a fear of negative repercussions on career status will result if employee assistance services are perceived to be controlled by the management (Collins, 2000; Harlow, 1998).

2.13.3 External EAS Model

Many small employers began contracting with external vendors to have ready access to behavioral health services that were not covered in their benefit plans. This model also gave small employers access to human resource consultation services that they were lacking but the external vendor model has expanded far beyond just meeting the needs of small employers (Collins, 2000).

As corporations sought to outsource any services not related to their primary product and needed to provide access to EAS in multiple sites, external vendors became the norm rather than the exception (Tamara, 1999). The external vendor model is now the most prevalent regardless of type of industry or work-site size. The external model allows vendors to take advantage of the economies of scale and centralized administrative services that lower the contract cost for the employer. The advantages of using EAS outside the employer organization lie largely in the availability of a greater

breadth of expertise and in diminished concern about confidentiality and potential conflicts of interest.

The models of delivering external EAS services are as varied as the organizations that contract for the services. A traditional external model has a centrally located employer contracting with a local external vendor. The external EAS has offices near the employers and operates on a staff model or may form alliances with other EAS firms and individuals clinicians who deliver care in outlying areas.

Another example of an external EAS model is one in which the employer contracts with an outside vendor who has a management system in place that verifies eligibility and screens the employee to determine the major complaint. The employee is then channeled to the appropriate affiliate clinician for assessment, short-term problem resolution, or referral for more intensive treatment. Any ongoing treatment is accessed through the employee benefit plan or community resources. In another variation, the employer contracts with one external vendor that offers both EAS and managed care services.

The employee can access the EAS or can directly access treatment providers who are part of the network. Some MCOs separate these two functions. The EAS affiliates refer those employees needing a higher level of care to the MCO. It is generally recommended that EAS affiliate clinicians not be the clinicians who would take over ongoing care. This blurring of roles is confusing to the employer and the employee. Separating these functions allows the EAS affiliate to deal with supervisory referrals through case management and to have the clinical care delivered by a therapist (Tamara, 1999).

An external program may not provide a location for services as convenient to the employees as with an internal program, however, the trade off would be that the perception of enforced confidentiality would provide a lesser degree of threat to job security (Collins, 2000). An external EAS services can be more quickly implemented, offer a wider range of services and provide ready expertise to a troubled employee (Collins, 2000; Lee and Gray, 1994). However, an external program will not be as responsive to the culture and climate of an organization as would be the internal program (Collins, 2000).

To address this weakness some organizations have coordinated support services within the community, creating a network of community resources that help decrease the cost of an internal program. Another option is the consortium that can provide greater control over the service provider but requires special expertise to set up and maintain the program.

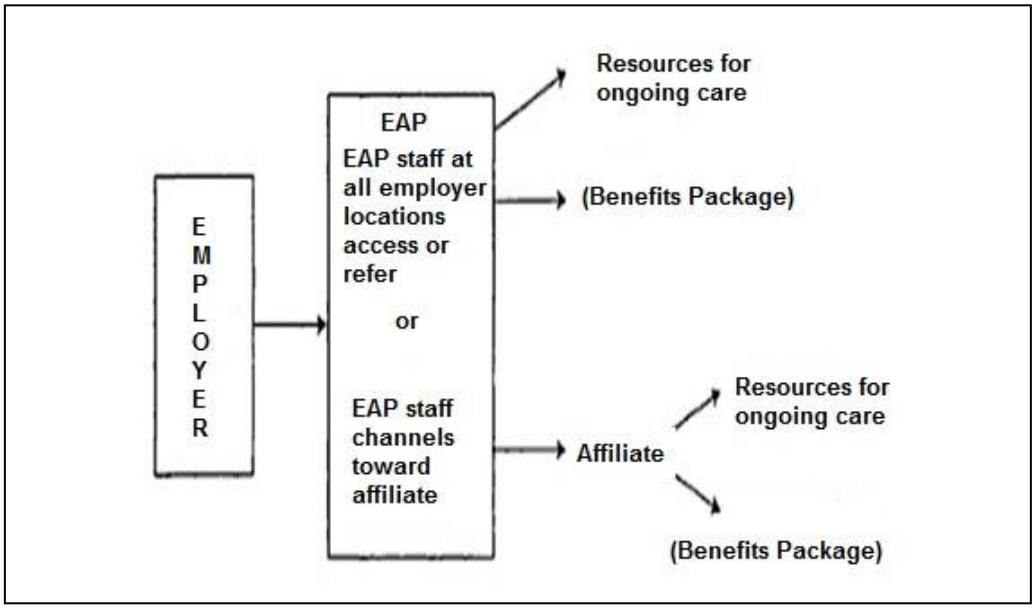

Figure 7: External EAS Staff Model with Affiliates (Tamara, 1999)

2.13.4 EAS Affiliates

If affiliates are used, specialized training in EAS is a must. A routine psychological assessment performed by clinicians without an EAS focus may not address the workplace issues. Although the clinical skills processed by EAS professionals mirror those of MCO clinical providers, an EAS professional must also be well versed in the structural functions of work organizations, human resource management issues, labor law, and legislative and regulatory mandates that impact the workplace. It is also essential that affiliates know the difference between an EAS service that includes the interests of the company and a private treatment relationship.

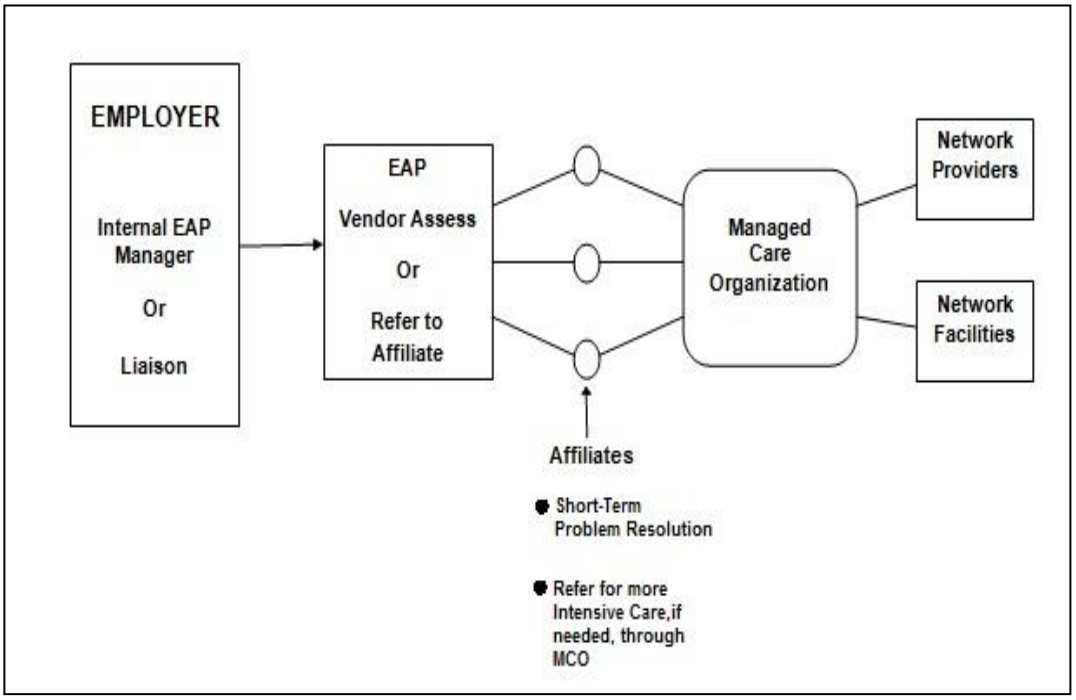

Figure 8: External EAS with Affiliates and Managed Care Organization (Tamara, 1999)

An EAS professional's role varies from a clinical provider in shortened terms of engagement, the limits of confidentiality, the need to respond to various constituencies, and the focus on job performance. Clinicians are traditionally trained to regard the relationship of the therapist and the client as sacrosanct. As an EAS affiliate, they are working with an "employee client". The focus of their work together is to identify problem areas, explore possible solutions and engage in short-term problem resolution.

The EAS professional has multiple constituencies including the supervisor, the employer organization, the EAS vendor, and at times, even public safety. All the EAS constituencies have legitimate interests in the outcome of the case. This complex relationship has to be understood by both the affiliate and the client and managed by the EAS vendor.

2.13.5 Integrated EAS Model

The advent of managed care has brought changes in program design. Many employers who contract for EAS services also contract for managed care services. These services can be delivered by two different entities but the preferred model for large self-insured employers and union groups is an integrated model. Collins (2000) stated, "A single vendor reduces the possibility of the programs working at cross-purposes and increases administrative efficiencies because the managed care firms focus on channeling clients to the most appropriate level of care and functioning as an access, the MCO may at times appear to work at cross-purposes with the EAS". The EAS focuses on early intervention and increased case finding and utilization. Well-designed integrated systems have proven to work well. By integrating both EAS and managed behavioral health care, the focus is on behavioral health benefit management, with an integrated *gatekeeping* function for access to both employee assistance and behavioral health benefits. The MCO benefits from the early intervention activities of the EAS.

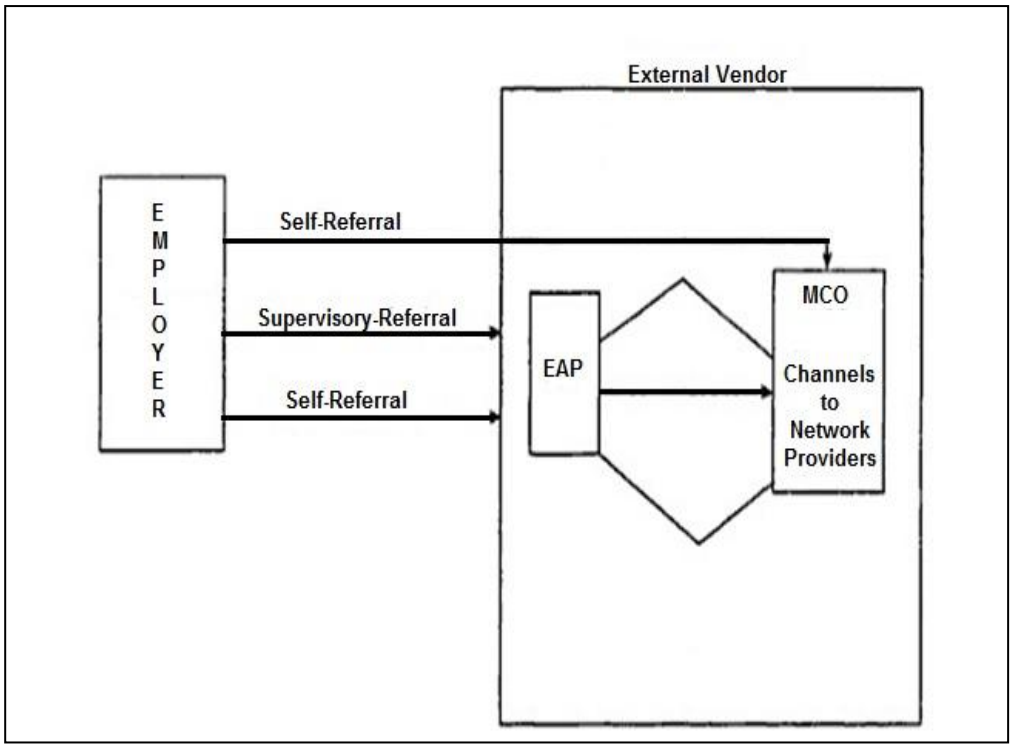

Figure 9: Integrated EAS (Tamara, 1999)

An increasing number of employees are enrolled in EAS. This has created renewed interest among managed care organizations and hospital systems in acquiring EAS. According to Tamara (1999), "As a result, EAS market share is experiencing rapid consolidation. A recent study done by Open Minds industry survey, EAS enrollment has increased 45% since 1994. The largest percentage increased in enrollment has occurred in the integrated EAS/MCO model. It is estimated that the total national EAS enrollment of 49 million represents 42% of the potential market of employees in businesses with 50 or more employees. It is reasonable to assume that by the year 2000, penetration could rise to 65%, with a potential for 20 million new EAS enrollees."

A dozen national players each have enrollment of over 80,000 lives. But these large vendor organizations are having difficulties managing their far-flung acquisitions and assuring consistency of services. These drawbacks are opening the market to small local and regional EAS. Smaller vendors have the flexibility to customize services and can establish direct relationships with the purchasers.

According to Lee & Gray (1994), these are just a few of the designs in use to deliver EAS services. EAS design is tailored to suit the workforce and the variations are infinite. What is definite is the increasing pressure on employers to respond to employees' personal problems and to minimize the impact that these personal problems have on the workplace. The concerns of organized labor, public opinion, employee morale, federal regulations, and cost/benefit considerations are making it increasingly difficult for employers to simply deal with these issues by terminating the employee. Additional pressure is being added by drug and alcohol testing in the workplace and the desire to provide employees with an opportunity for rehabilitation while safeguarding the public. Employee assistance programs can be designed and implemented in such a way that they strike a balance and satisfy both individual employee and organizational needs.

2.14 Methods of Evaluation

Evaluation is an essential component of the employee assistance program. In the same manner that the policy is written to reflect the philosophy of the organization, the method of evaluation must match the philosophy of the program. The evaluation of a program should be determined at the inception of the program. The purpose of the evaluation is to verify that the needs of the program's clients are met successfully and to insure the quality of the program (Megranahan, 1995).

The program's evaluation should follow the process from its initial inception through the process to its final outcomes. Walker (2003) denotes several principles involved in such an evaluation. Evaluation should be an integral part of any program, ideally designed as the program begins, that guides its maturation, highlighting strengths and accomplishments as well as areas that need improvement. Evaluation is not research in the sense that researchers seek to prove hypotheses; rather evaluation looks at program effectiveness. Evaluation can offer valid proof of policy and program results and should be undertaken for this reason as well as for quality assurance purposes (Megranahan, 1995).

Questions to consider during the evaluation component of an employee assistance policy are to what degree the following benchmarks are being met. Research done by Masi (1994) concluded that it includes providing employees with assistance and help with which they are satisfied, providing supervisors with appropriate training and support, reaching all levels and types of employees with education and policy information, appropriately assessing the kinds of problems presented by employees and family members, making appropriate referrals, maintaining confidentiality, operating efficiently and meeting legal requirements.

Benchmarking the client contract is an important method of evaluation because it assesses the standards of the program. What credentials do the counselors hold? What is the minimum and maximum number of sessions? What are the criteria for client eligibility are questions to be explored during the writing of the contract and revisited at designated times throughout the span of the contract? Next, the overall process of access and referral should be examined periodically. According to Peter (1998), monitoring the client referral line for a clear process involves technical as well as personnel considerations. For example, how long does it take for a client to speak with professional personnel? How clear is the overall procedure for making initial contact? What is the procedure for emergency situations? Most importantly, how smoothly and quickly is assistance accessed by the client?

Evaluation of the physical facilities also is an important component to quality assurance. The location and atmosphere of the facilities are important factors to encourage initial clients to seek support through the EAS. The accessibility is again an issue as related to the hours of available services. The maintenance and destruction of case records are important factors in the security of documents. Confidentiality should be assessed at this point as well as throughout the entire process (HMA, 2011).

Empirical data is essential for an accurate evaluation of the program. Penetration rates revealing the degree to which subpopulations within the organizations are served should be reviewed periodically (John et. al.,2010). The utilization rate of the programs (determined by the number of employees seen divided by the total number of employees in the organization) should also be reviewed periodically and a system to track the success rate should be developed and monitored over the life of the program (John et. al.,2010). The numerical data is well complemented by employee feedback in the form of a client participation survey. These surveys should be completed voluntarily, anonymously and confidentially (Peter,1998; Anema, 2010).

According to Stephen (1994), the program should be evaluated in consideration of both its cost effectiveness and its cost benefits. In cost-effectiveness, the focus is on the degree to which the goals have been achieved, how well the employee has been rehabilitated or ‘healed’ in relation to the cost of the program. Studies involving cost effective analysis have often been accused of bias due to promotional issues. The cost benefit analysis is a more feasible and in-depth study of the program. This evaluation method examines the operational costs of the program in relation to the savings generated by the program. Cost benefit can be measured through outcomes such as absences, medical expenses and supervisory time spent with discipline issues. Indirect outcomes such as morale, accidents, and replacement costs of employees are helpful but more difficult to measure (Panks, 2001).

Many challenges exist in the evaluation of an EAS. Most organizations lack the funding and resources to adequately implement evaluative measures throughout the program. Data acquisition is difficult to maintain due to the issue of confidentiality, producing a baseline from which to operate and the involvement sometimes of several different departments. The mere cost of defining, storing, analyzing and reporting data can be expensive as well as cumbersome to implement. Finally, EAS find it difficult to separate the influence of a program on the outcome variables from other influences that may affect outcome variables. Chalmers (2002) views an employee assistance program as a system of interlocking components that should be evaluated separately and compared as to which groups of employees benefit most, which services are most effective and what is the result of the interaction of the components with one another.

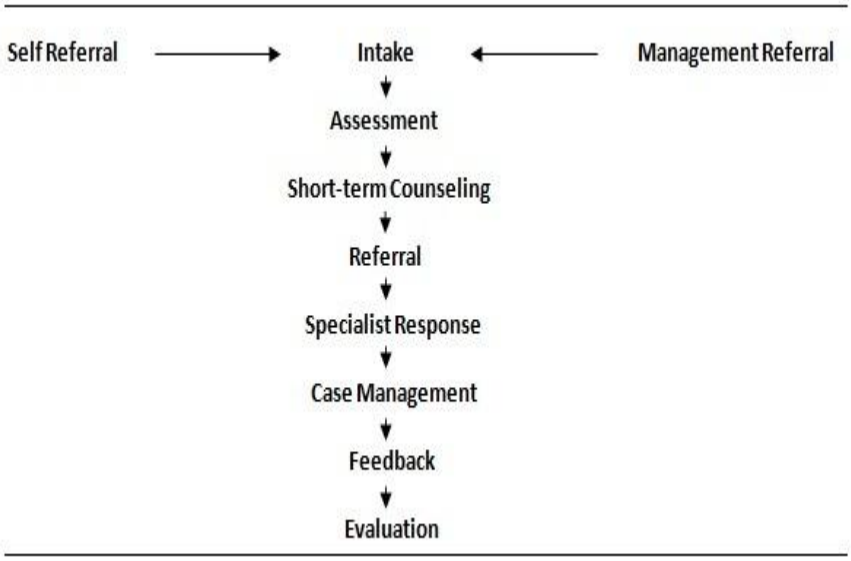

Figure 10: The EAS Sequence of Process (Megranahan, 1995)

2.15 The Effectiveness and Satisfaction of EAS

In a national survey in the United States, teachers were asked about their perceptions of the professional school counselor role as defined by the American School Counselor Association (ASCA, 2005). Teachers believed that school counselors should engage in and were engaged in a variety of tasks endorsed as appropriate or inappropriate by ASCA.

Clark and Amatea (2004) indicated that teacher expectations and knowledge of counselor performance impacted the counseling program, as teachers influence the perceptions of principals, students, and parents. They found that participants believed that communication and collaboration between school counselors and teachers were the most important tasks for school counselors, followed by large group counseling. Fewer than half of teachers believed that individual or small-group counseling was important.

According to Fischer & Farina (1995), intriguing factors such as time constraint, location of the counseling services and the trust to the counselors were said to be agreed as the reason to feel unmotivated to participate in the stress management programs. The readiness to participate is also among the factors of this issue. Research by Dawn et al. (2007) indicated that family involvement in the counseling program does matter. The support from the family members will help the client to be more comfortable and it helped the process better.

Researchers have explored the effectiveness of stress management services and programs using questionnaires and face-to-face interviews. Schiraldi & Brown (2001) performed an exploratory study in which college students completed nine questionnaires pre- and post-intervention, including measures of anger and hostility (the Cook-Medley Hostility scale of the MMPI, the William's Hostility Short Scale, and the Rosenberg Misanthropy Scale). They noted significant decreases in depression and trait anxiety following their stress management intervention.

Deffenbacher, Huff, Lynch, Oetting, & Salvatore (2000) also explored state and trait anger levels following a stress management intervention, however were unable to demonstrate significant reductions in anger levels following the intervention. Although Deffenbacher et al. improved upon the Schiraldi & Brown study by using a no-treatment control group to compare intervention effects, they were studied a group of individuals with a history of problem anger instead of a less pathological group.

Numerous researchers have identified the necessary components of an ideal EAP evaluation but as Csiernik (1995) notes; the literature contains considerably more articles on how to conduct such research than has actually been carried out. Nevertheless, it is generally recognized that the criteria for a satisfactory study should include; the collection of standardized data that would allow comparison with other studies, a true experimental research design, the inclusion of employees who use other kinds of mental health services, linking the mental health status of individuals with their counseling utilization rates, the use of adequate control groups, collection of data at least 3 years prior to and 3 years following the EAP intervention, random assignment of employees to different treatment and non-treatment conditions, the employment of work-performance indicators and a cost-benefit or economic analysis (Blaze-Temple & Howat, 1997).

A study in the UK postal service's internal EAS counseling service found improvements in mental health and absence, but less improvement in job satisfaction and organizational commitment (Cooper & Sadri, 1994). This study used a control group to measure effectiveness before and after counseling and employed standardized measures of mental health, absence, work satisfaction and self-esteem.

EAS and stress management techniques in general claim to relieve the symptoms of stress, improve mental health, increase productivity and produce cost savings to organizations. The studies reviewed suggest most of the evidence for these claims comes from American studies of alcohol and drug based EAPs. However,

according to Andrew (2000), little research has been conducted into the long-term effects of broadly based EAS and stress management programs and these have affected the evidence of the effectiveness level of the EAS conducts.

Nevertheless, the research reviewed, even though methodologically inconsistent, suggests that employees who use broadly based EAS have significant mental health problems, experience symptom reduction and are satisfied with the counseling-type interventions they received. The employees appreciate the provision of the service by their employer and have fewer absences as a result (Andrew, 2000; Sharar, 2008).

Study done by Anema (2011) has indicated that EAP utilization and users' satisfaction sustained favorable attitudes toward the offered EAP. According to 41 responses of the research survey, over 90% of supervisors and non-supervisors rated the EAP highly in helpfulness, promptness of service, professionalism, understanding of the situation, and satisfied with the results. Similar findings in ratings were found when the EAP was compared to a larger, traditional EAP program. His study also proved that the location of the program is important and stated that the hallmarks of a successful EAP is how well it is integrated into the workplace.

2.16 Summary

The concepts of EAS are vary and significantly within the reviewed material. Definitions as well as suggestions are differing within the literature. Numerous issues on stress and occupational stress management which require specific circumstances, processes and structures were defined through this literature review. Furthermore, the advantages and disadvantages vary within the topic depending on the philosophical approach. Advantages of occupational stress management are well understood but less

proved by evidences by local researches. The assumption about the importance of EAS is generally shared within the reviewed literature mostly from abroad.

Therefore, the aspects of EAS by different frameworks were highlighted. In a further part, opinions and findings from the previous research were reviewed and evaluated. Additionally, the EAS models as the framework were discussed specifically to widen the understanding of each implementation as well as to suit the best criteria of Employee Assistance Services handbook for the school teachers in this research.

From this chapter, the researcher has highlighted the variables that were taken as the items in the questionnaire in the first phase; emotional openness, social stigma, self-stigma as well as anticipated risk and utility. Together with this, the researcher also considered the items to measure the school teachers' expectations by discussing the models and results from the existing EAS implemented locally and abroad. By having these discussions, the researcher hoped to get better understanding of the most suitable criteria that later have been used to guide the second phase of the research.

Most of the EAS has shown positive feedbacks in inculcating higher motivation in employees and shown evident of increased productivity of these employees. Therefore, the need to conduct this research based on elements of occupational stress management programs through Employee Assistance Services might provide the findings that can be used to assist teachers in District G.