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Supporting Workforce Mental Health During the Pandemic

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Since 2020, more than 1 million lives in the U.S. have been lost due to the COVID 19 pandemic.[1] In addition to the physical harm caused by virus infection, living through the pandemic has exacted an undeniable emotional toll. Americans have experienced new stressors that have increased mental health issues as well as risk of substance use disorders.[2]

Employers in the U.S. have reason to be concerned about the impact of these stressors on the mental health of their workforce.[3] Employee mental health is associated with increased health care costs and sick time.[4,5] Many employers in the U.S. pay for health care[6] and an increasing number of states require employers to provide paid sick leave.[7] Employee mental health has also been linked to reduced at-work productivity.[8]

Employers are uniquely situated to respond to employees' need for mental health supports. Full-time employees spend more of their waking hours at work than any other primary activity.[9] A conceptual framework proposed by Sorensen et al[10] illustrates this central role that work plays in determining health. The framework shows how workplace policies, programs and practices can influence worker outcomes including worker health and wellbeing. An updated version of the framework[11] places these workplace-factors in a broader context, illustrating how higher level influences including the socio-political-economic environment and employment patterns shape the conditions of work, which then influence organizational policies, work conditions and employee health outcomes. Employers can benefit from understanding these key drivers of employee health as it can help them to identify key levers to improving employee wellbeing.

Even prior to the pandemic, many businesses had already developed and deployed programs to support employee mental health within the workplace setting, such as employee assistance programs.[12] Despite an accumulated knowledge base about what works, there is no clear playbook for employers to use as a guide for what to do during this unprecedented time. For example, employee assistance programs and health plans can be effective to link people to services but may not be sufficient to fully support employees, particularly those who do not recognize an issue or who are hesitant or unwilling to seek help. Most program evaluations were designed and tested prior to the pandemic, in in-person settings, which are no longer the norm for all employers. Today, many more employees work from home full-time or come into the workplace only occasionally. Even in industries and companies where in-person settings are still required,

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office space and workplace policies may have been modified to limit virus transmission.

Implementing programs is also more challenging during the pandemic. The pandemic has led to labor shortages and higher than usual levels of turnover. Such labor strains may make new programs and interventions more difficult to implement due to inability to identify external staff, increased work pressures and lack of leadership continuity.

Information on how small employers can support employee mental health during the pandemic is particularly scarce. Small businesses do not have the same access to resources to invest in programs and generous benefits and may not be able to reach efficiencies of scale. Second, small businesses may be particularly strained by pandemic-related increases in staff turnover, given fewer staff to absorb increased work responsibilities and onboarding.

Small businesses do have some advantages when it comes to taking action to support employee mental health. Because of their smaller size, leadership can maintain closer connections to their employees so they may have better understanding about what specifically is needed without costly data collection efforts. Small business leadership may have an easier time communicating and championing new programs because of their more intimate connections with employees.

In contrast to small businesses, larger organizations may have greater access to resources to invest and implement new programs to support employees. However, even well-resourced programs can fail at their goals if employees do not know about them or do not feel able to take advantage of them. Employees have been burdened by increased workload from labor shortages, turnover, and new role responsibilities as a consequence of the virus and, thus, may not feel the program is accessible even if it is available.

In this month's Knowing Well Being Well, we explore how businesses, both large and small, are supporting employee mental health during the pandemic. Zhang and colleagues describe 3 categories of stressors— psychological, organizational, and environmental—and outline strategies employers can use to address each type of stressor along with examples of interventions.[13] Bennett and colleagues provide the results of a survey of organizational stakeholder perceptions related to the burden of mental health problems on their businesses and their economic consequences, specifically contrasting experiences between small and large organizations.[14] Attridge's article defines small businesses and discusses how small employers can take advantage of employee assistance programs that are traditionally targeted toward larger organizations.[15] Mulvaney-Day and colleagues provide real-world evidence about the increase in use of telehealth for behavioral health and discuss the potential importance of employers maintaining reimbursement of telemedicine after the public health emergency ends.[16] Lastly, Daley provides 5 case examples to illustrate a variety of approaches businesses have taken to address the specific needs of their employees.[17] Examples provided include large and small employers, in both virtual and in person settings.

This series of invited contributions makes it clear that supporting employee mental health is not a one-size-fits-all approach. Both large and small employers have options that can be tailored to the needs of their workforce and available resources. There are several areas where more research is needed. First, if work from home arrangements extend to the long term, new or modified interventions need to be designed and tested for effectiveness in employees who work from home. Related, the effectiveness of telehealth for behavioral health services needs to be evaluated to help inform employers of the value of this new modality of care. Second, work-life conflict has emerged

as a long-term stressor given the lasting shift to work from home, thus, new programs may be needed to assist employees with boundary management. Finally, as the pandemic enters its fourth year, pandemic related stressors are changing from acute to chronic. Regrettably, current events are adding to employees' mental load including tragedies related to gun violence, hate crimes, political unrest, international conflict, and climate events. Employers will benefit from creating an environment and programs that recognize these stressors instead of ignoring them and enable employees to seek and receive the supports they need to maintain their health.

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Addressing Workplace Stressors Emerging from the Pandemic

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Introduction

Faced with new and exacerbated stressors on workers due to COVID-19, employers are asking what they can do to support employees' mental health and wellbeing and rebuild a resilient workforce. To serve as a guide, this paper reviews workplace interventions aimed at improving workers' mental health and wellbeing. The review was developed with support from the National Institute for Occupational Safety and Health (NIOSH) Total Worker Health® Centers of Excellence as part of a broader program to design, implement, and evaluate large-scale initiatives focused on mental health in the workplace.[1]

Background

In March 2020, the World Health Organization[2] (WHO) declared COVID-19 a pandemic, the effects of which would create immense and long-lasting damage to societies and their economies. COVID-19 negatively affected employee mental and physical health, and consequently workforce productivity.[3] Specifically, since the COVID-19 pandemic emerged, employees have reported increased stress and anxiety levels precipitated by new circumstances affecting work-life balance, employment status, and financial insecurity.[4] Organizations have endured forced shutdowns, revenue instability, absenteeism, vacancies, and low productivity, all of which have exerted a profound impact on business climate and the global economy.[5-7]

Factors affecting workplace mental health and wellbeing during the pandemic were organized into 3 stressor categories: Psychosocial, Organizational, and Environmental (POE factors).

Psychosocial Stressors

A worker's personal characteristics and psychological state influence their workplace behaviors and interface with psychosocial stress at work, eg, job demand-support and effort-reward imbalance. One of the most prominent psychosocial stressors is work-life conflict, which the pandemic aggravated through increased workload and irregular work schedules.[8,9] Additionally, school and daycare closures blurred home-life boundaries, especially for women who are often expected to take on a larger share of family and childcare responsibilities in addition to their paying jobs.[10,11]

Fear of COVID-19 exposure and infection was another psychosocial stressor. For months, the novel nature of the virus and limited treatment options fostered intense anxiety among workers who were unable to limit contact to infected individuals. Some workers were faced with the dilemma of protecting the health of members of their household or keeping a job that provided needed income. For workers who were able to limit physical contact with others, social isolation took a heavy toll on their sense of connectedness and social engagement.[12,13]

Organizational Stressors

Organizational conditions include the set of programs, policies and environmental supports that foster a healthy and safe workplace. During the pandemic, organizations had to modify processes and policies to address emergent supply chain shortages, requirements for technological adaptation, staffing limitations, and uneven demand for products and services. Unprepared human resource management led to increased anxiety and uncertainty among staff, which intensified workplace conflicts.[14,15]

Wages and salaries did not increase in proportion to workload and work demands, causing increased financial stress on employees. For workers in industries whose earnings included tips from in-person interactions, the pandemic reduced take-home pay. Over half of restaurant workers reported they would not

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Table 1. Psychosocial, organizational, and environmental (POE) stressors, interventions, and expected outcomes.

Dimension	Stressors	Interventions	Expected Outcomes
Psychosocial	• Work-life conflict • Fear of COVID-19 exposure and infection • Social isolation	• Self-care • Employee empowerment • Social connectedness • Mental health services	Decrease in • Psychological stress, distress, and anxiety • Burnout • Stigma and feelings of isolation • Post-traumatic and other stress disorders • Insomnia • Anger and cynicism • Behavioral deviance
Organizational	• Increased workload • Poor human resource management • Economic/job insecurity • Lack of employer-sponsored benefits	• Assistance programs providing concrete support • Improved communication	Decrease in • Employee turnover rates and voluntary resignations • Inability to fill job vacancies • Poor employee performance
Environmental	• Physical environment conducive to virus transmission • Frequent face-to-face interactions • Loosely enforced safety protocols • Limited access to personal protective equipment (PPE) • Unclear regulatory guidance and communication	• Reinforcing infection control measures • Providing PPE and clear instructions on use • Adding safety trainings and workshops • Reaching out directly to employees regarding environmental interventions • Ensuring workspaces are well-ventilated, accommodate social distancing, and installing appropriate physical barriers	Decrease in • Risk of contracting COVID-19 • Risk of sustaining an injury • Substance and alcohol use • All-cause mortality

come back to their jobs unless higher steady wages and consistent schedules were offered.[16] Further, the pandemic intensified known structural issues such as inadequate employer and government-sponsored benefits (eg, health insurance, childcare benefits, and paid sick leave).

Environmental Stressors

Biological (including viral), chemical, mechanical/ergonomic, and physical exposures impact worker illness, injury and mental health outcomes. Front line workers reported feeling unsafe during the early stages of the pandemic because social distancing to reduce viral exposures was not always possible or enforced. Further, access to personal protective equipment (PPE) was limited even for health care workers, and communications regarding safe working conditions were inconsistent.[14,17-21]

Employee Outcomes

As a result of these stressors, employees have reported increased psychological distress, depression, anxiety, burnout, feelings of isolation, insomnia, anger, and cynicism.[17,20-22] Working in unsafe environments heightened the risk of contracting COVID-19 and sustaining injuries.[22,23] Workers also experienced increased drug and alcohol use as mechanisms to cope with stress.[13,23,24] Workers' deteriorated health has been linked to

decreased employee performance, increased job vacancies, and high turnover.[14,16,22,25-28]

Interventions

We conducted a literature review to identify interventions to address the immediate crisis of COVID-19 along with strategies applicable to non-crisis situations (Table 1 and Table 2). In the narrative that follow the tables, we elaborate on the interventions and their value in addressing mental health and wellbeing challenges at work.

Psychosocial Interventions

Employers can implement psychosocial interventions that focus on self-care, employee empowerment, social connectedness, and access to mental health services. We describe examples of each in this section.

Self-care is the first step in resilience building. Employers can communicate the importance of self-care during crises by addressing the health benefits of self-care routines such as: taking breaks, getting enough sleep, and healthy eating and meal preparation; and offer resources such as: mindfulness and relaxation trainings, access to meditation apps, and physical exercise incentives.[3,30,35-38] Employers can also give employees permission to flexibly schedule self-care into their daily routine.[30,37] Finally, employers can train managers to model self-care to build healthy cultural norms.[13,19,38-40]

Table 2. Sample Programs Addressing the POE Factors.

Dimension	Sample Program	Program Elements	Satisfaction	Program Impact
Psychosocial	A "help point" program[29]	After psychological support requests are made by healthcare workers, a multidisciplinary team follow 6 steps: 1. Conduct a demand analysis of the support request 2. Conduct a case assessment 3. Provide psychological support to healthcare workers when needed 4. Collect feedback 5. Compare pre- and post-intervention health status 6. Monitor healthcare workers' health status to ensure improvement sustainability	High	• Improved healthcare workers' productivity • Sickness absence days reduced by 60% • Net profit related to reduced absenteeism in a year was estimated to be EUR 58919.13, yielding a return on investment (ROI) of EUR 2.73 for each euro spent
	A digital psychological wellbeing support package for healthcare workers[30]	Healthcare workers use an interactive e-learning package to locate information and resources on COVID-19-related psychological impacts, psychologically supportive teams, communication, social support, self-care, managing emotionsetc.	High	• High participation. Accessed 17 633 times within 7 days of release, High satisfaction. Recruited healthcare workers and students (n = 55) assessed the package and reported high content quality, intervention practicality, and package usability • Outcomes not yet assessed
	Improving employees' physical and mental behavioral health with the assistance of wearable devices[31]	Employees wear a device that keeps track of behaviors such as physical activity, healthy food choices, and sleep	Not directly measured	• Increased likelihood of engaging in physical activity, healthy eating • Positive changes in employee engagement, job satisfaction, and organizational commitment
	Prioritizing a diversity climate and perceived supervisor support[32]	Supervisors provide informational and emotional support to employees and address cynicism that can foster distrust and harassment in the workplace	Not directly measured	• Increased sense of fairness • Decreased sense of discrimination and social exclusion

Table 2. (continued)

Dimension	Sample Program	Program Elements	Satisfaction	Program Impact
Organizational	Inclusive leadership[8]	Managers exhibit "words and deeds that invite and appreciate others' contributions"	High	• Assessment results showed that inclusive leadership negatively correlated to psychological distress and positively correlated to work engagement • Created an open and engaging environment for healthcare workers, Reduced psychological distress significantly and sustainably
	Managers' supportive behaviors[15]	Managers create a positive psychosocial safety climate in which organizational policies and practices are perceived as protective to employees' physical and psychological health. Showing genuine concerns about employees' welfare and acting quickly to address employee health issues are 2 examples of manager support Managers demonstrate supportive behaviors such as paying attention to employees' health and wellbeing, showing appreciation, and providing guidance	Not directly measured	• A positive psychosocial safety climate accounts for a 13% increase in employees' wellbeing score and a 13% decrease in employees' symptoms of common mental disorders • Managers' supportive behaviors account for a 10% increase in employees' wellbeing score and a 7% decrease in employees' symptoms of common mental disorders
	Paid sick leave[33]	Provide employees in all states with 1 hour of paid sick leave for every 30 hours worked. The formula is retroactively applied to the prior 26 weeks	High	• A 49% expansion of paid sick leave access (employees who were qualified for paid sick leave were expanded from those from 11 states and DC to all employees) reduced presenteeism by approximately 15% • Workers who had 2 or more years of tenure with the company had the largest decrease in presenteeism
	A fun workplace[28]	Plan fun activities, social opportunities, and set expectation that manager encourages employee socializing, and provides clear and meaningful job description at training	Moderate	• Turnover was significantly reduced by coworker socializing and managerial support for fun at workplace
Environmental	Universal masking[34]	Require mask-wearing for all healthcare workers at workplace	Not measured	• PPE can effectively prevent healthcare workers from being infected

Employers can also acknowledge that it is common to feel powerless during a crisis that has a long-lasting, worldwide impact. Employers can empower their employees by encouraging employees to take breaks when needed; encouraging employees to speak up when struggling[9,40-43]; offer employees accommodative work arrangements[44,45]; and grant employees the opportunity and authority to participate in decision-making.[23,40,44,46,47]

For workers who report feeling isolated and disconnected, employers can help build interpersonal support and social connectedness to instill a sense of belonging, support, and social fulfillment in the workplace[46]; be attentive to workers' feelings, feedback, and non-workplace needs[48]; highlight shared goals and promote a team growth mindset[41]; provide platforms to bond employees over shared experiences and mutual concerns[12,40]; implement a buddy system in which employees are paired to provide mutual support[38,41,49]; and use digital communication platforms when in-person check-ins are not feasible.[35]

Supporting access to mental health care is critical and can address employees' stress and anxiety,[50,51] foster healthy relationships in the workplace, and improve productivity.[52] Employers can remove barriers to treatment by having counselors available on site or near workplaces[12,53]; offering virtual mental health resources as an alternative when in-person care is not available[54]; expanding Employee Assistance Programs (EAPs) using online mental health resources[44]; and providing free subscriptions to credible mental health applications and platforms.[44]

For employees experiencing acute psychological symptoms of stress, psychological first aid should be added in the toolkit. A mental health analogue to physical first aid, psychological first aid (PFA) is a form of psychological crisis intervention that has been shown to be effective in reducing acute stress.[55] For example, the Johns Hopkins RAPID psychological first aid model is an evidence-based intervention involving Reflective listening, Assessment, Prioritization, Intervention and Disposition.[56]

Example interventions providing psychosocial support (see Table 2). A "Help Point" program, offered by Bambino Gesù Children's Hospital in Rome, Italy, was led by a multidisciplinary team and followed a six-step process to provide psychological support to healthcare workers.[29] A "demand analysis" was first completed to assess healthcare workers' contextual needs for psychological assistance. Then, psychologists and occupational health physicians examined reported problems and complaints. A series of therapeutic interviews conducted by the psychologist followed. The monitoring phase assessed the sustainability of the program. Evaluation of the program found that 8 meetings were adequate for significant mental health improvement. Participants reported reduced work discomfort, improved mental health, and decreased absenteeism. The intervention also benefited the organization, in that sickness absence days were reduced by 60% and over EUR 58,000 of net profit related to reduced absenteeism in a year was generated for the hospital as workers' productivity improved, yielding a return on investment (ROI) of 2.73 for the program.

A digital psychological wellbeing support package for healthcare workers[30] was developed at the University of Nottingham during the first 3 weeks of the COVID-19 outbreak. The intervention included an interactive e-learning toolkit with links to psychological resources, supportive teams, self-care guides, and other sources relevant for the early stages of the pandemic. The platform was accessed 17 633 times within the first 7 days

of release. Users reported high satisfaction with the content quality, intervention practicality, and package usability.

Organizational Interventions

Organizations can support the wellbeing of employees by offering living wages, competitive benefits, incentives for risky assignments, and flexible work arrangements (eg, condensed work weeks, lower exposure positions for high-risk workers, and cross-training).[16,23,44,45] Examples of organizational interventions include: non-punitive absence policies[45]; paid time off and sick leave[29,57]; provision of explicit career path growth opportunities[58]; expanded benefits (including mental health care, childcare, eldercare)[44,45,50]; free access to EAPs with allowances for additional therapy sessions[44,50]; enhanced job security by offering furloughs (instead of layoffs or terminations) to employees not able to work due to temporary organizational insolvency or personal health reasons[24,44]; provision of perks, such as food delivery, alternative housing/lodging, and childcare[14,41,44]; and use of practical reintegration protocols for returning employees including reassimilation training, career advancement, and widely publicized resources for emotional and physical support.[59-69]

A healthy work environment is beneficial to workers' mental health and wellbeing during crises.[70,71] Building a healthy company culture includes recognizing employees for their hard work; giving positive feedback routinely (not just during performance reviews); communicating opportunities for promotions and raises; and demonstrating social intelligence by listening closely in times of grief or high stress.[8,23,72,73] Other ways to build healthy company cultures include organizing informal fun social events such as light-hearted team challenges.[28] Also shown to be effective in maintaining a healthy company culture is building an inclusive workforce that emphasizes diversity of opinion, race, ethnicity, gender, sexual orientation, and cultural background.[8,32,50,74]

Organizations can heighten stressors if workplace communication lacks consistency, clarity, or empathy.[39] Strengthened communication can reduce unnecessary stress and improve team morale. Examples of activities that improve communications to employees include routine messaging to address fear or uncertainty[18] provided in clear language,[41] eg, updated policies, health behavior recommendations, and required safety protocols[59]; increasing managers' availability to employees, welcoming constructive input, transparency in providing alternative actions, resources, and career growth opportunities[9,57,60]; and communicating positive and hopeful sentiments and stories.[44,61]

Example interventions involving organizational support (see Table 2). Paid sick leave has been shown to be effective in reducing presenteeism and retaining tenured employees.[33] An example is Olive Garden's approach that credits employees with 1 hour of paid sick leave for every 30 hours worked, and this formula is also retroactively applied to the prior 26 weeks.[63] A study found that a 49% expansion of Olive Garden's paid sick leave access reduced presenteeism by approximately 15%, and workers who had 2 or more years of tenure with the company had the most substantial reduction in presenteeism.[33]

Environmental Interventions

The pandemic has required that workplaces consider both infrastructure and administrative controls to guard against exposure to

infectious agents. A healthy work environment, along with training in problem-focused coping strategies, has been shown to reduce post-traumatic stress disorders (PTSD).[64] Organizations can lessen environmental hazards by reinforcing infection control measures through frequent updates of safety protocols, ongoing monitoring of hazards, and investing in environmental air purification systems[14,16,17,45,57,65-68]; providing PPE and clear instructions on its use as part of a normal work routine[34,69]; providing safety trainings and workshops[17,41,42,45,57,65]; ensuring workspaces are well-ventilated, accommodate social distancing, and contain appropriate physical barriers[45,69]; and employee engagement to inform environmental interventions to make them feel safe returning to work.[50]

A healthy work environment can provide comfort, foster a sense of security, encourage social bonding and community support, and help employees cope with stress during crises.[70,71] Investment in workplace built environment (eg, ventilation and air purification systems, physical barriers) and administrative controls (e,g, social distancing, one-way traffic) can reduce exposures to the virus that causes COVID-19 and can improve worker perceptions of safety culture.

Example intervention involving environmental support (see **Table 2***).* Because the virus that causes COVID-19 is so infectious through airborne routes,[2] universal masking – requiring employees to wear masks at workplace – has proven to be an effective environmental intervention. A Massachusetts community healthcare system secured N95 masks for all healthcare workers who directly worked with patients either confirmed or suspected of COVID-19 infection and other approved masks for all clinical and non-clinical staff. As a result, the 7-day average incidence rate between March 17th, 2020 to May 6th, 2020 decreased among the healthcare workers, whereas it increased among Massachusetts residents where universal masking was not mandated. The results showed that mask mandates among healthcare workers can significantly decrease SARS-CoV-2 positivity rate and slow the spread of the virus.[34]

Conclusion

The impact of the COVID-19 pandemic has been significant and reverberating. When employers take initiative to identify psychosocial, organizational, and environmental stressors and intervene strategically in these areas, it will likely mitigate employee stress and further support a healthy, productive, resilient, and thriving workforce.

Acknowledgments

Declaration of Conflicting Interests

Funding

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More Vulnerable, More to Gain? A Pilot Study of Leader's Perceptions of Mental Health Programs and Costs in Small Workplaces

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Introduction

Small businesses have the most to gain from, yet are least likely to offer, health promotion programs, including those focusing employee on mental health.[1,2] Collecting information on leaders' perceptions of mental health burden and related programs can help identify factors that can promote increased awareness of mental health needs in small businesses.[3-5]

Gathering input across networks is critical to building capacity for evidence-based mental health promotion (MHP), including in small businesses. Models including the Strategic Prevention Framework,[6] the Community Health and Economic Prosperity initiative,[7] and Research-to-Practice Methods[8] emphasize the importance of conducting needs assessments, providing feedback to the workforce community, and ensuring relevance of content to stakeholders, including the provision of information about program return on investment.

The current study is part of a multi-agency project of community stakeholders who, working at the interface of economic development, public health, and MHP, seek to increase utilization of evidence-based MHP. Collaborators adapted a MHP called Team Awareness[9,10] to help build stakeholder interest in MHP and forecast positive economic impact on the local workforce. Part of the project included providing actionable feedback to stakeholders to address previously identified concerns including how to estimate return on investment of programs.

We conducted a survey of community stakeholders and business leaders to gather information on how to collect financial data to estimate economic impact of MHP.[11] The survey was designed to address:

(1) To what extent do workplace leaders feel that exposures (eg, burn-out, mental health, poor health, fatigue) cause productivity problems in their workforce?

(2) What are the estimated financial costs associated with mental health related (MHR) exposures?

(3) What types of MHR programs are in place to help mitigate these losses?

(4) To what degree can MHR programs reduce these costs?

[1]Organizational Wellness & Learning Systems
[2]Econometrica
[3]Southern Tier 8 Regional Board (Appalachian Regional Commission)
[4]Leatherstocking Education on Alcoholism/Addictions Foundation (LEAF)
[5]National Council on Alcoholism & Drug Dependence-Rochester Area (NCADD-RA)

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We were particularly interested in exploring MH vulnerability and the degree to which respondents report productivity loss as a function of the number or magnitude of MH exposures. While we hypothesized that greater exposure to MH risk would lead to greater loss or cost, some respondents may report loss even with one exposure while others may have many exposures and lower costs.

We conducted the study focusing on organizations in Central New York. Workplaces in remote rural settings, such as Central New York are rarely included in survey assessments. Further, a recent report on occupational disease points to the need for MH programs in New York state.[12]

Methods

Collaborators recruited stakeholders and employers to participate in initial interviews and focus groups designed to engage stakeholders, assess MHR concerns, and identify potential solutions. The interviews and focused groups informed the development of a survey designed for workplace leaders including the following item sets: demographics, ratings on MHR concerns, estimated productivity impact, current MHR programs, and financial data.

Collaborator Recruitment Efforts

Collaborators contacted participants for this project, including Southern Tier 8—the local development district of the federal Appalachian Regional Commission and the Economic Development Administration (Binghamton); agencies associated with the Collaborative Recovery Empowerment of the Southern Tier (CREST); The National Council on Alcoholism and Drug Dependence — Rochester Area; and Leatherstocking Education on Alcoholism/ Addictions Foundation (Oneonta).

Initial Capacity Building

From July through December 2021, we conducted 18 in-depth 90-minute stakeholder interviews with leaders in diverse communities (including directors of chambers of commerce, executives from for-profit businesses, public health, and county government, and directors of workforce development). We also conducted 90-minute focus groups in 6 organizations whose employees work directly with at-risk populations (staff in workforce development, mental health in higher education, YMCA, community mental health, a youth center, and non-profit social charity).

Focus Group Input on Survey Design

A draft survey was sent to thirteen workplace leaders who were recruited to participate from CREST leadership. Eight participants attended a 90-minute focus group to provide detailed feedback on survey design and wording. Participants held various leadership positions (eg, CEO, President, Senior Directors) and represented diverse industries (eg, Healthcare, Manufacturing, Restaurants, Information Technology, Security).

Survey Design and Implementation

Following input from the interviews and focus groups, we developed a 25-item, anonymous survey to capture organizational stakeholder perceptions of mental health-related productivity loss and perceptions of programs that could help mitigate those impacts. Sampling was based on convenience and snowball methods. Collaborators sent notifications to colleagues and member lists through email and social media. A total of 238 respondents began the survey and roughly 140 completed most sections for results reported here. Sample sizes vary by analysis due to missing data.

Survey Sample

Organizational respondents included nonprofit (61%), for-profit (24%), and government organizations (14%). Industries most represented were health care and social services (35%), public administration (18%), and educational services (16%). Manufacturing, construction, and arts/entertainment each added between 4% and 6%. Other industries provided less than 2% (eg, food services, finance, information, mining, retail). Most prevalent job positions included C-suite (23%), Director/Vice-President (21%), Manager/Supervisor (20%), Senior Manager (11%), and Health and Wellness Professional (6%). Respondents represented an estimated 52,000 workers from twenty-two counties in Central New York. Business sizes are described in Figure 1.

Measures

Eight variables assessed the influence of mental health-related (MHR) programs on administrative and labor costs. These were perceived *impact of exposures* to MHR issues in their workforce, the *percentage of personal lost administrative productivity* dealing with these issues, the *percentage of employee lost productivity* due to these issues, and the number of employee MHR programs in the organization. In addition, respondents reported their personal salary, and estimated total employee labor cost. For all variables, mean imputation based on organization size was used to supplement missing data.

Average Impact of MHR Exposures. Respondents reported "the extent to which financial health and productivity problems in your organization has been caused by each of the following: stress and burn-out; employee mental health concerns; lack of sleep and fatigue; lack of general health; employee alcohol use; and other drug use." Responses options were 1-Not at all, 2-To a small extent, 3-To a moderate extent, 4-To a large extent, 5-To a very great extent, and Don't Know. After removing don't know responses, the average of the 6 items was calculated to assess magnitude of impact across all 6 exposures (Mean = 2.61; Median = 2.5; SD = 1.00, n = 172).

Lost administrative productivity. To assess productivity lost due to these 6 exposures, we asked: "What percentage of your own time at work (in a typical month) have you spent dealing with the above work issues? This includes taking time to put out fires or deal with crises; do extra work you would otherwise not have to do; take extra problem-solving time; talk to employees; coach, counsel, or discipline; conduct performance reviews; meet with human resources; or work with consultants or vendors." Respondents provide a number from '0%' to '90+%'.

Lost employee productivity. One survey item asked: "For the typical employee, what percentage of an employee's workweek is unproductive
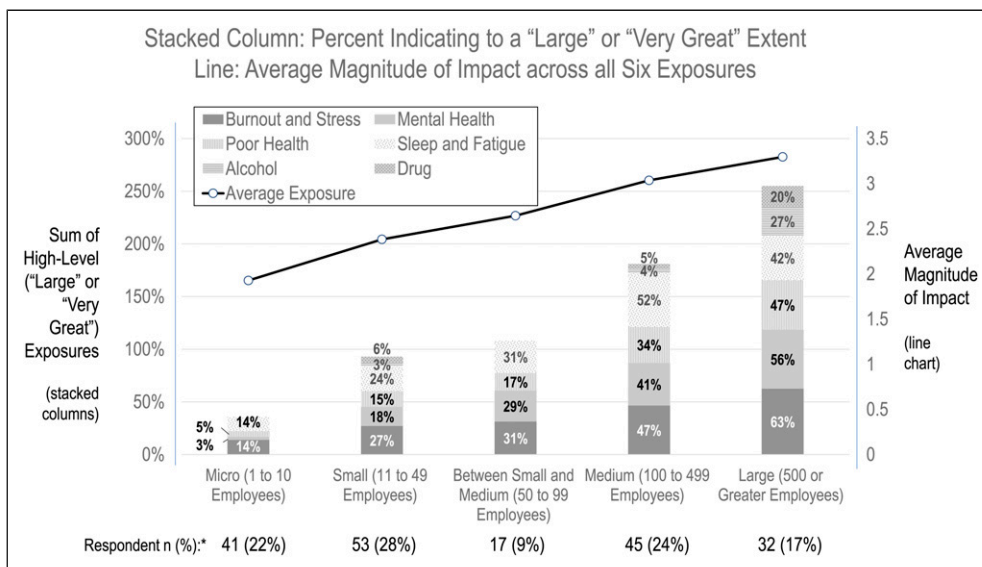
Figure 1. Mental Health-Related Exposures by Workplace Size. Note. Ns Vary Due to Missing Cases. Response Options for Each of 6 Items Were 1-Not at All, 2-To a Small Extent, 3-To a Moderate Extent, 4-To a Large Extent, 5-To a Very Great Extent, and Don't Know.
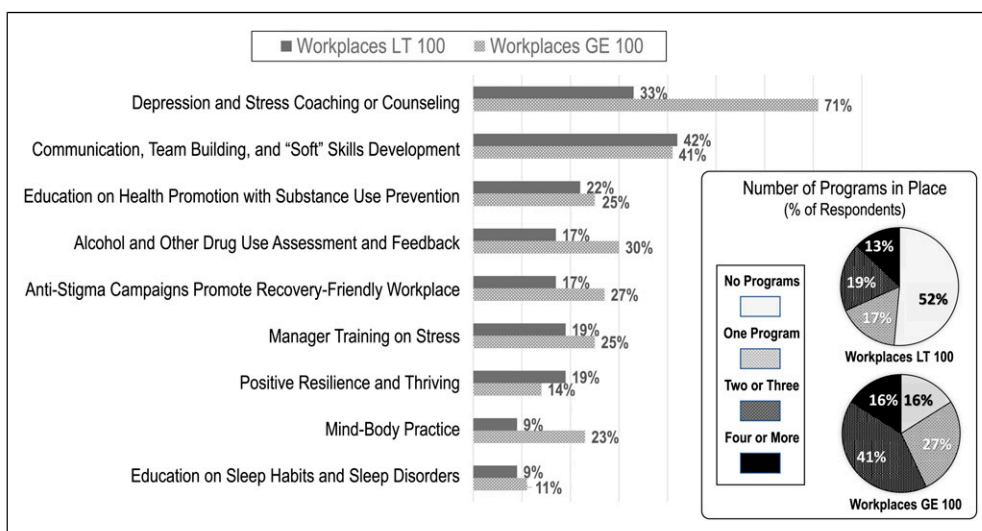

Figure 2. Current Mental Health-Related Programs: Compared by Business Size with Less Than 100 Employees. Note. GLM Model Did Not Converge; Last Iteration Shown. Graph Removes Any Cases Where Cost Equal 0$.

because of their stress, burn-out, mental health, alcohol, or drug misuse issues?" Respondents provide a number from '0%' to '50+%'.

Number of mental health-related programs (MHP). Respondents were provided a list of 9 programs and indicated "whether you know that your organization provides the service or program." See Figure 2 for list of programs. A sum was calculated for all 9 programs with a total score ranging from '0' to '9' (Mean = 1.55; Median = 1.00; SD = 1.77).

Costs associated with lost productivity. Respondents provided typical hours worked per week for themselves and for both full- and part-time employees, the number of these employees, and hourly wages. These variables were used to calculate total annual salaries for each respondent and for employees within their organizations as well as to estimate both the total annual cost of lost administrative time and cost of lost employee productivity.

Analytic Approach

We compared results for workplace sizes of less than 100 to sizes greater than 100. In addition to calculating the distribution of all responses, we used correlational analyses to assess the relationship between self-reported *Average MHR exposures* and cost variables. We reviewed scatterplots to identify and remove outliers. Model fit improved after outlier removal. We estimated generalized linear models (GLM) with quasi-Gamma distribution and log link function to assess the relationships between the 2 lost administrative productivity and lost employee productivity and 3 predictors: *exposures*, *MHP*, and the interaction of *exposure x MHP*. This interaction terms tests whether the presence of programs moderate exposures. Gamma distribution was used to accommodate cost outcomes. Gamma distribution was used for outcomes

Table 1. Estimates of Lost Time and Productivity Costs Associated with Mental Health-related Exposures: Workplaces with Less than 100 or 100 or More Employees.

	Average Cost (SD)	Total cost	Correlation (R^2 with average Exposures)	Average cost (SD)	Total cost	Correlation (R^2 with average Exposures)
	Workplace Size Less than 100			Workplace size 100 or more		
	Estimated Average Annual Costs Due to Lost Administrative Time (Per Workplace)					
Estimates	$25,134 ($22,014)	$2.2 mill	r = .41* R^2 = .17	$41,996 ($29,762)	$2.1 mill	r = .02 R^2 = .00
	Estimated Average Annual Costs Due to Lost Labor Productivity (Per Workplace)					
Estimates	$108,313 ($113,758)	$9.6 mill	r = .55* R^2 = .30	$3.4 mill ($7.5 mill)	$171.2 mill	r = .17 R^2 = .03

*$P < .001$. Ns vary due to missing cases. For workplaces of LT 100: Lost administrative time (Mean Workplace Size = 21; n = 82; 7 outliers removed); Lost labor productivity (Size = 20; n = 85; 4 outliers). For workplaces of GE 100: Lost administrative time (Size = 548; n = 50; no outliers); Lost labor productivity (Size = 477; n = 47; 3 outliers).

with a high number of zeros. For purposes of the current pilot study and using estimates, we modeled a solution that compared having a comprehensive set of (all 9) programs vs having none.

Results

Mental Health-related Exposures

Respondents identified burn-out and stress (35% reporting high or "large" or "very great" levels); sleep and fatigue (31% reporting high-levels); and mental health (27% reporting high levels) as conditions with the greatest impact on productivity and financial loss. The percent of respondents indicating MHR exposures varied by business size. Figure 1 shows these differences for the average magnitude of impact across all 6 exposures (line chart), and the percent of respondents reporting "large" or "very great" (ie, high-level) responses for all 6 exposures (stacked columns). There was a positive relationship between workplace size and each exposure, the accumulation of high-level exposures, and the average MHR related exposures.

Lost Productivity

Respondents reported 39% (M = 39.1; SD = 26.8) of their own lost productivity was due to MHR exposures each month, and 16% (M = 15.5; SD = 11.5) of lost employee productivity each week. Comparing by business size, lost admin time was lower for smaller/LT 100 (M = 34.3; SD = 24.8; n = 93) than larger/GE 100 (M = 47.7; SD = 28.6; n = 53); $t(144) = 2.96, P = .004$. A similar pattern was found for lost employee productivity: smaller (M = 14.1; SD = 11.6; n = 93) and larger (M = 17.9; SD = 11.06; n = 53); $t(180) 1.97, P = .05$.

Costs Associated with Lost Productivity

Table 1 provides respondents assessment of the average cost per workplace for both lost administrative time and lost worker productivity, and the total accumulated costs. The average cost of lost productivity was significantly lower for smaller organizations. Summing all respondents cost data, total annual costs due to lost labor productivity was $9.6 M for smaller and $171M for larger workplaces. Table 1 provides the correlation and r-squared between *average MHR exposure* and these cost estimates. Correlations between exposures and costs were significant at the $P < .05$ level only for smaller workplaces.

The latter suggests that the more MHR exposures experienced by respondents the more likely this has an effect on both their own and their employee's productivity costs. To illustrate, Figure 3 provides the scatterplots for each of the correlational analyses as reported in Table 1. Smaller businesses appeared more vulnerable as they reported more cases with low exposure and higher costs.

Presence of Program

Figure 2 shows MHP in place. There were more programs in larger workplaces (M = 1.98; SD = 1.59) than smaller workplaces (M = 1.27; SD = 1.80), $t(121) = 2.19, P = .03$. For example, 84% of larger workplaces had at least 1 program, compared to 48% of smaller workplaces. Programs that included coaching or counseling for stress or depressions were significantly greater in larger compared to smaller workplaces.

Programs as Moderators

GLM analyses were conducted with workplaces of varying size to estimate the degree that the presence of MHR programs lessened productivity losses and related financial estimates due to those exposures. All analyses showed a significant interaction between exposures and programs ($P < .05$). Figure 4 illustrates these effects.

Based on predicted values from this model, a business would see a cost reduction of roughly $375,738, if a highly-exposed business had all suggested programs in place. This estimate was obtained by using the GLM to predict the cost of 2 new (simulated) cases with an average exposure rating of 3.5, 1 with no programs and 1 with all 9 programs. Considering the small sample and relatively weak predictive power of the model, this estimate will vary across businesses and likely does not reflect the true reduction in cost.

Discussion

Our study found that larger workplaces experience greater financial burden due to mental health concerns in their workforce. However, smaller workplaces appear more vulnerable—having relatively more mental health-related costs despite small exposures. Small businesses appear more likely to become increasingly vulnerable as concerns accumulate. While leaders in larger organizations are likely more removed from direct contact with MH problems and also have more
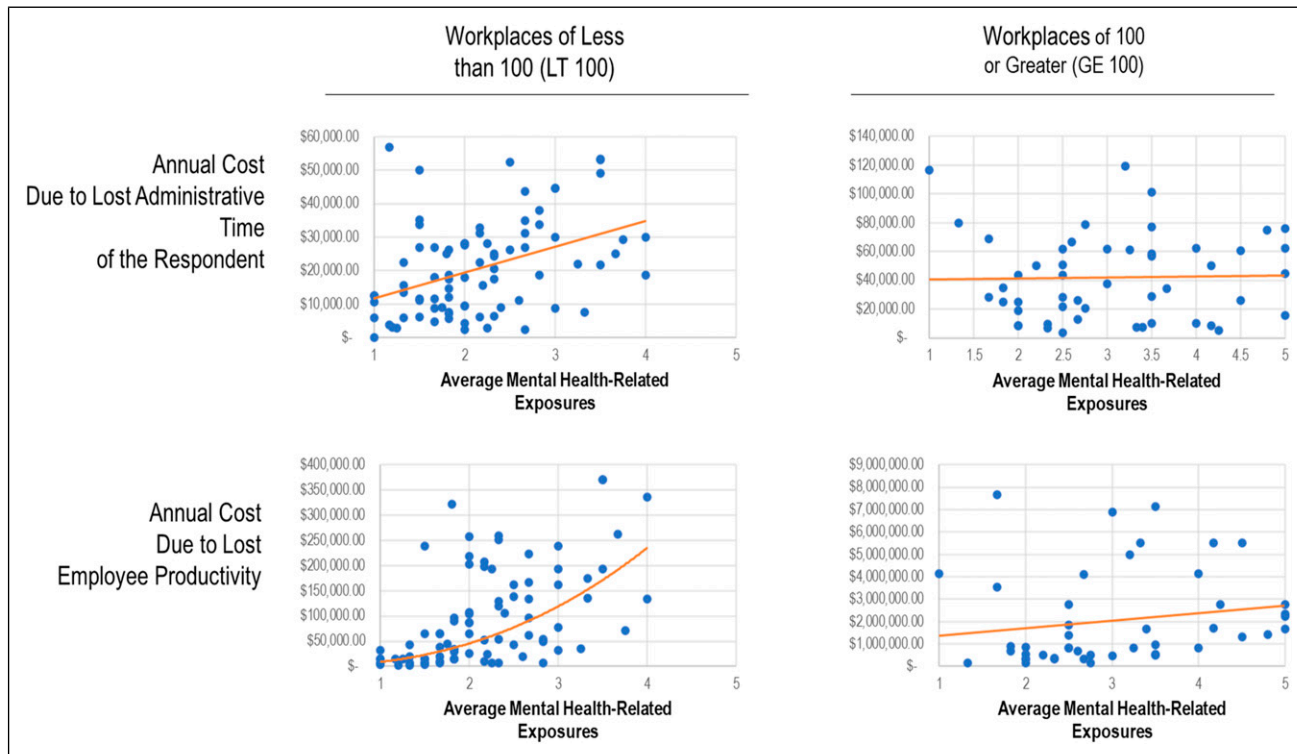
Figure 3. Scatterplots Showing Relationship Between Cost Variables and Average Mental Health-Related Exposures. Note. Outlying Cases Were Removed From Scatterplots.
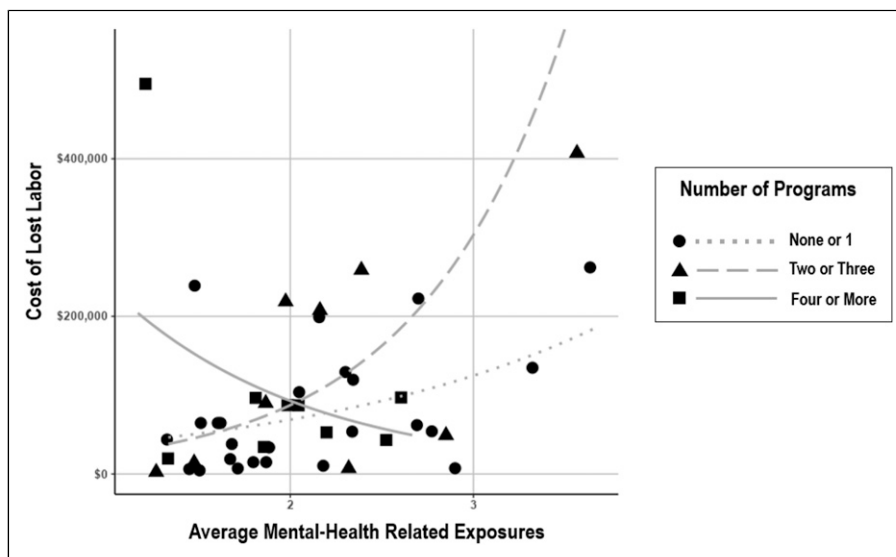
Figure 4. Plot Showing Interaction of MHR Exposures and Number of Programs When Predicting Lost Employee Productivity Costs in Smaller Organizations Discussion.

resources to buffer against greater MH exposures, those in smaller workplace appear more likely to benefit with more added MHR programs. Accordingly, we hope these data encourage others to continue to assess vulnerability, as well as explore ways to improve utilization of MH programs, in smaller workplaces.

The study has several limitations. Results from a Central New York convenience sample is not necessarily generalizable to other locations. This paper may be best considered part of a broader capacity-building effort to report survey results to the stakeholder community that helped to design the survey. Given these limitations and intent, the results make a compelling argument to pursue more rigorous assessments.

Our project offers one step toward communicating organizational stakeholder perceptions across networks (eg, government, community

organizations, healthcare and wellness providers). Networks in local communities may foster interaction and enhance stakeholder valuation of wellness.[13] These networks, in turn, can promote the importance of mental health related programs in the workplace, especially for small businesses.

Acknowledgments

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Profile of Small Employers in the United States and the Importance of Employee Assistance Programs During the COVID-19 Pandemic

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Introduction

Although, they represent the lion's share of the American workforce, few articles specifically address the mental health and wellbeing needs and related resources for small employers.[1-4] In this paper we define small businesses and their share of the U.S. workforce. Next, we review the research on the increasing burden of behavioral health disorders during the COVID-19 pandemic. Finally, we discuss the role of employee assistance programs (EAP) in small businesses to effectively respond to the kinds of worker health and workplace problems exacerbated by the pandemic.

Small employers can be defined in several ways. In the United States, having 1 to 50 employees qualifies a company for access to the federal health care benefits associated with the Affordable Care Act.[5] In contrast, the Small Business Association (SBA) part of the federal government generally defines its audience as employers with less than 500 employees. However, to qualify as a small business for various government loans and other SBA programs involves a complex combination involving the number of employees (ranging from under 100 to over 1000), the industry, and the total annual revenue for the company.[6]

The U.S. Bureau of Labor Statistics (BLS) conducts an annual compensation survey of employers of all sizes, industries, and sectors to assess employee wages and other employer-sponsored benefits.[7] When combined with other national data from the Census Bureau on the number of businesses and organizations at the county level based on size of the establishment,[8] we can create a profile of American business by company size and sector. This profile, for the most recent year available from 2021, is shown in Table 1.

This data indicates that the smallest size employers, those with less than 50 workers, constitute the vast majority of all establishments in the U.S., accounting for 94.5% of the total. These workplaces employ 52.4 million workers, which is almost 40% of the total workers in the private sector. The next size up of companies with between 50 and 99 workers is only 3% of the total employers in the private sector, but they employ another 16.7 million workers (about 1 every 8 workers). All of the establishments with less than 100 employees when combined as 1 group – defined as "small employers" for this paper – account for 97.5% of all establishments and also the majority of all of the workers in the private sector (based on both total count of over 69 million workers and 52% of total workers).

In the public sector in the U.S. (ie, local and state government employers; excluding federal government workers), the story is both similar and different. Although small employers (ie, under 100 workers) represent almost 60% of all establishments, these organizations employ only a small fraction of the total workers at the local and state government level (2.9% of the 1.2 million total count of employees). Thus, when both sectors are considered together, over 99% of all small employers are in the private sector, based on both number of total establishments (private = 7,798,580 vs public = 1950) and the number of total workers (private = 69,096,995 vs public = 26,835).

Workplace Mental Health in the COVID-19 Pandemic Context

Historically, about 1 in every 4 working adults in the United States meet clinical criteria for having a behavioral health condition.[10,11] The consequences of leaving anxiety, depression, alcohol, drugs, and other common behavioral disorders unidentified and untreated[9,12,13] have negative impacts in several areas relevant to employers.[14] These problems include reducing the ability of employees to be at work (absenteeism) and to properly perform their work,[15-18] increased health care treatment costs,[19,20] and greater workplace safety risks that can contribute to employee accidents and disability.[21-23]

Many of these behavioral health conditions have become much more prevalent in the United States,[24,25] and in other countries[26] during the COVID-19 global pandemic. For example, results of the National Health Interview Survey and the U.S. Census Bureau[27] showed that in the first half of 2019 (before the pandemic) about 1 in every 10 Americans reported symptoms of depression or anxiety, but that after the pandemic had taken hold in January of 2021 this rate increased almost 4-fold (from 11% to 41%). The pandemic has made worker mental health a topic of major concern among employers with greater emphasis on the role of employee assistance programs (EAP).[28-32]

Employee Assistance Programs

What are Employee Assistance Programs? Employee assistance programs are an employer-sponsored benefit designed to help employees resolve acute but modifiable behavioral health and personal life issues. A unique goal of these programs is to understand the clinical and work impacts of these kinds of issues and how to provide counseling that can restore both better health and work performance. More specifically, the Employee Assistance Professionals Association (EAPA)[33] defines EAP as:

> "a worksite-based program designed to assist (1) work organizations in addressing productivity issues and (2) employee clients

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Table 1. Number of Establishments and Number of Workers in the United States in Year 2021: By Company Size within Private and Public Sectors.

	Establishments		Workers	
Size of employer	Number	%	Number	%
Private sector - all businesses				
Very small (1-49)	**7,555,381**	**94.5%**	**52,396,317**	**39.5%**
Small (50-99)	**243,199**	**3.0%**	**16,700,678**	**12.6%**
Medium (100-499)	176,338	2.2%	33,575,795	25.3%
Large (500+)	21,963	.3%	30,084,137	22.7%
Total	7,996,881	100.0%	132,756,927	100.0%
Public sector - state and local governments				
Very small (1-49)	**1804**	**54.9%**	**15,876**	**1.1%**
Small (50-99)	**146**	**4.4%**	**10,959**	**.8%**
Medium (100-499)	755	23.0%	182,316	13.0%
Large (500+)	592	18.0%	1,197,271	85.1%
Total	3287	100.0%	1,406,422	100.0%

Sources: Bureau of Labor Statistics[7] and Department of the Census[8], U.S. government. Bold indicates small employers. Not included in table are another 2,181,106 employees of the U.S. government at the federal level (excluding military and certain other non-civilian workers).[9]

in identifying and resolving personal concerns, including, but not limited to, health, marital, family, financial, alcohol, drug, legal, emotional, stress, or other personal issues that may affect job performance."

How is Brief Counseling Provided? EAPs are staffed mostly by masters-level licensed social workers or mental health counselors.[34] The clinical experience usually involves a comprehensive initial assessment of the issue or problem and the available support options (from the EAP, from employee benefits, or from the local community or online resources).[35] Then problem-focused counseling is provided to individuals for usually between 3 to 6 sessions per case over a 1 to 2 month treatment period. Anything discussed with the counselor is confidential and is not shared with the employer sponsor of the EAP - within the professional limits of patient privacy laws that allow for rare exceptions for legally mandated disclosure of self-harm or harm to others. Most EAPs are available to use 24/7 by telephone. However, there is variation how fast a client can be connected with a counselor, depending on the level of clinical severity, the availability of counselors on staff at the EAP or network affiliate counselors who work on contract part-time for EAP vendors, and the client's preference for using in-person, telephonic, online video, or text/email modalities to meet with their counselor.

Why is Employee Assistance Programs Counseling Used? The reasons why employees using such counseling represent a wide range of behavioral health, personal life, and work-related issues. For example, the most recent industry report examined the mix of presenting issues for over 29,000 total cases contributed by 35 different EAPs globally during the years 2010 to 2021.[36] This study found that mental health issues (such as anxiety or depression) accounted for 30% of the total cases. In contrast, alcohol misuse or other addiction issues represented less than 3% of the total cases. The other two-thirds of cases in this study were spread across categories of personal

life and personal stress (29%), marital, family, or personal relationships (19%), or various kinds of occupational issues and work-related stress (19%).

Beyond these counselor care users are employees who use the EAPs for support with many kinds of personal life issues other than mental health. Most EAPs have staff and specialists who can address wellness and wellbeing resources (eg, stress, sleep, nutrition, exercise),[37] work/life issues for child care, elder care, and family members,[38] and personal legal or financial issues.[39] Debt and money problems for families has increased in society[40] and thus has become of the most common reasons for seeking support from EAPs in recent years

Who Uses Employee Assistance Programs? The users of EAP counseling represent a complex mix of working adults of both genders and across all ages and industries.[41] Most EAPs also cover the immediate family members of employees. Many people who use an EAP for counseling are in the normal (pre-clinical) range of behavioral health risks but who experience an acute stressor event of some kind and thus need immediate support and practical direction to return to their typical level of personal functioning and work performance. However, some employees with more severe clinical symptoms also use EAPs are usually referred out of the EAP for further treatment by other employee benefit providers or to relevant community or specialty support services (ie, 5% to 20% of all cases are referred to outpatient mental health, addiction treatment, psychiatric medications).[42]

How Many Employees Use Employee Assistance Programs counseling? Historically, about 5 out every 100 employees with access to the EAP benefit use it for personal counseling in a year.[42] But more recently since the pandemic this clinical use rate has doubled. A clinical case utilization rate was obtained from recent national survey of 96 EAPs – split between external vendors and internal programs (with similar findings for both types).[36] The results found that an average of 7.6 people per every 100 covered employees used the EAP for counseling in year 2019 and this rose to 9.7 during the pandemic in 2021. Other results revealed the average number of sessions of counseling per case rose from 3.9 in 2019 to 5.3 sessions in 2021. Thus, both the number of total cases and the number of sessions of counseling used per case increased during the pandemic. These results represent national data across many EAP vendors and programs and the use rates were not detailed by size of the employer or by the market sector.

How do Employee Assistance Programs Support the Workplace? In addition to supporting individual workers, most full-service EAPs also support the workplace and larger organizational issues. This side of the EAP business model involves providing consulting to managers and leaders,[43] workplace crisis preparedness and incident response,[44] organizational level behavioral health risk management services,[45] and specialists for difficult workplace events (ie, harassment, bullying, sexual inappropriate behavior, customer conflicts, work team dysfunction).[46] Moreover, full-service providers often seek to build strategic alliances with other employee benefits and family support services for a more proactive approach to finding at-risk employees. When EAPs are embraced within the organization by health promotion, wellness, safety, and company leadership, they

can be more effectively integrated into other parts of the larger organization.[47]

What Types of Employee Assistance Programs are Available? There are different types of EAPs based on who they serve and how they are purchased.[48] EAPs vary based on if the services are provided by staff who work for the same company served the program (internal models), the services are provided by an external company (vendor models), or a hybrid model that has some combination of internal staff and external provider services. Most smaller size employers, due to having less funding available per employee than medium and larger size employers, tend to get their EAP services from 1 of 3 kinds of external EAP sellers: a specialty insurance company, a health plan, or an external full-service EAP vendor. Another option for small employers in some locations is to get EAP services from 1 of the hundreds of internal EAP programs that serve a particular hospital or health system that also sells their counseling and workplace support services to other employers in the same local area.

How do Small Businesses use Employee Assistance Programs? Most smaller businesses rely on insurance brokers to select their provider of EAP services (along with other insurance needs). Many insurance carriers also sell very low-cost EAPs or even give away EAP services for free if other higher-revenue insurance products are purchased. Because of this broker-lead sales model, many small employers may be unwitting victims of these imposter EAPs.[49,50] low cost and "Free EAPs" are rarely promoted and lack much (if any) interaction with the workplace and the managers and HR staff who can make referrals, the "Free EAPs" are under-utilized (only 1 to 2 counseling cases per every 100 covered employees[51]) and thus offer little real business value to the employer.

How Many U.S. Workers Have Access to an Employee Assistance Programs in 2021? We know from annual government surveys how many workers have an EAP benefit and also some evidence of how many employers sponsor an EAP. The most recent Bureau of Labor Statistics national survey data from year 2021[7] – shown in Table 2

reveals that although most employers have an EAP benefit, it varies dramatically by market sector and company size.

This data indicates that in the private sector, the percentage of workers with an EAP benefit ranges from about 1 in every 4 workers at the smallest size employers (under 50 workers), to almost half of workers at companies with between 50 and 99 workers, to about two-thirds of workers at medium size companies and better than 8 in every 10 workers at large companies. Results for the public sector reveals the same increasing trend by size of employer but at higher overall rates. The percentage of public sector workers with an EAP benefit ranges from 60% of very small organizations, 68% of workers at companies with between 50 and 99 workers, 69% of workers at medium size organizations, and 89% of workers at large organizations.

In total, there are over 67 million workers in the private sector who have access to an EAP from the 51% of all companies that sponsor this benefit. There are also another 1.1 million workers in the public sector at the local and state level who have an EAP from the 79% of employers in this sector that sponsor the benefit. In addition, all 2.2 million civilian employees working for the federal government also have access to an EAP. In total, over 70.9 million workers in the U.S. have access to an EAP.

Considering just the small employers who have from 1 to 99 workers, about 1 in 3 employees (32%) at these companies have an EAP. This translates into about 21.9 million total employees working for small employers who have access to an EAP. Almost all of these employees are from small companies in the private sector with only 1% coming from the small size state and local government employers.

How Many U.S. Employers (Workplaces) Have an Employee Assistance Programs in 2021? Employers in many countries around the world are also increasingly starting to sponsor EAPs, although at lower levels than in the U.S. (see review in[52]). A global survey conducted in 2016 identified 839 different external providers EAPs, with 70% of these vendors based in the U.S.[53] Yet, an accurate count of the total number of EAPs in the U.S. is unknown as there is no centralized list of all of the vendors and internal/hybrid programs. Thus, for this paper, the BLS data for the total number of establishments and the percentage of workers in such establishments with access to an EAP benefit was analyzed together to yield an actuarial estimate the number of specific employer establishments with an EAP benefit. This was done for the year 2021 for both the private and public sectors.

Table 2. Percentage and Number of Workers in the United States in Year 2021 for Small Employers (1-99 Workers): By Private and Public Sectors and Total.

Size of employer	Private sector (all businesses)		Public sector (Local and State Governments)		Total	
	% Of workers with EAP benefit	Number of workers with EAP benefit	% Of workers with EAP benefit	Number of workers with EAP benefit	% Of workers with EAP benefit	Number of workers with EAP benefit
Very small (1-50)	**27%**	**14,147,006**	**60%**	**9526**	**32%**	**21,853,748**
Small (50-99)	**46%**	**7,689,764**	**68%**	**7452**		
Medium (100-499)	66%	22,160,025	69%	125,798		
Large (500+)	83%	24,969,834	89%	1,065,571		
Total	51%	67,706,033	78%	1,097,009		
			Public sector federal			
			100%	2,181,106		70,984,148

Source: Bureau of Labor Statistics and Department of the Census, US Government.[7,9] **Bold** indicates small employers.

Table 3 shows the results in the estimated number of total establishments or specific workplaces that have an EAP benefit, sorted by size of employer in the private and public sectors in year 2021. The number of small size employers with EAP is estimated to be over 2.1 million, with the vast majority being from the very small size employers with less than 50 workers. There are 111,971 small employers (50-99 workers) with an EAP. Which is about the same as the 116,904 medium size employers with EAP. The number of large size employers with EAP is far less at just 18,756. Combined, that is about 4.1 million different establishments in the U.S. Of this total, very small employers account for 89.2%, small employers 4.9%, medium size employers 5.1%, and large employers only .8%. It is important to note that most of the small size employers likely have the "Free EAP" type of benefit that is embedded in other insurance products, which are quite different in design and effectiveness than the other types of full-service EAPs that are purchased directly from health plans or external specialty vendors by most of the medium and large size employers. Some of the largest size organizations even have internal staff to run their employee assistance program.

Time Trends for Employee Assistance Programs in U.S. 1999 to 2021. A final point of interest was understanding how access to EAPs has changed over time. Figure 1 uses data from the BLS but shows the percentage of workers in the private sector in the U.S. that had access to an EAP for small, medium, and large size employers in years 1999,[54] 2009,[55] 2019,[56] and 2021.[7] This data shows a trend for small size employers that after a big increase from 1999 to 2009 (change from 14% to 24%), the level of EAP access continued to increase over the past decade (2019 = 31%) with a jump up since the pandemic started (37% in 2021). For medium size employers there was also a trend of that a big increase from 1999 to 2009 (change from 42% to 58%), followed by a continued increase over the past decade with only a small rise since the pandemic (2009 = 66%; 2021 = 68%).

Table 3. Number of Establishments in U.S. in Year 2021 with an EAP: By Private and Public Sectors and Total.

| Size of Employer | Establishments with EAP | | | |
	Private sector (all businesses)	Public sector (local and state governments)	Total	Total as %
Very small (1-50)	**2,039,953**	**1082**	**2,041,035**	**89.2**
Small (50-99)	**111,872**	**99**	**111,971**	**4.9**
Medium (100-499)	116,383	521	116,904	5.1
Large (500+)	18,229	527	18,756	0.8
Total	2,286,437	2230	2,288,666	

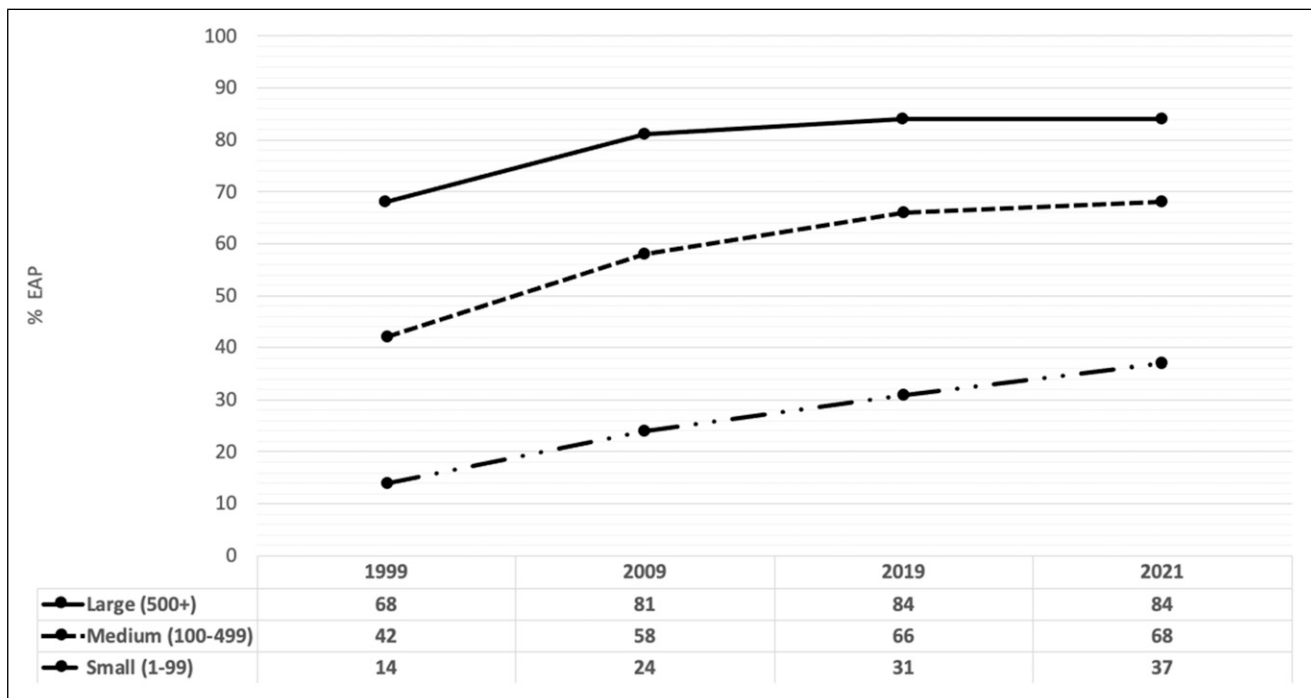Source: Estimated from U.S. government reports.[7,8]

Figure 1. Percentage of workers with access to an EAP in the United States in the private sector: By Employer size in years 1999, 2009, 2019 and 2021 (source: Bureau of Labor Statistics, US government).
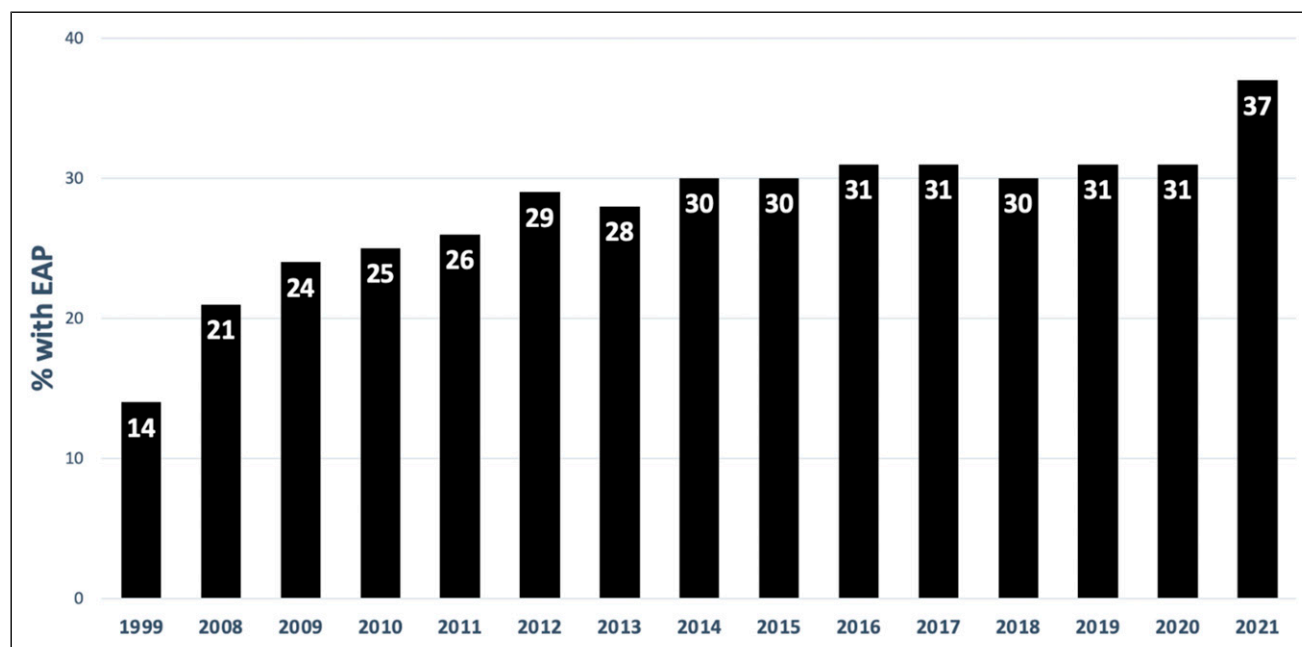
Figure 2. Percentage of workers with access to an EAP in the United States among small employers (1-99 workers) in the private sector: By year 1999 to 2021 (source: Bureau of labor statistics, US government).

The trend for large size employers also shows a large increase between 1999 to 2009 (change from 68% to 81%), which then remained stable over the past decade and into the pandemic period (2019 = 84%; 2021 = 84%).

We know from Table 2 that there is a big difference by the size of employer involving access to EAPs in present day. As in year 2021 there were major differences by company size in the trends over time for EAP. The percentage of workers with access to an EAP at small employers was 2.64 times greater in 1999 than it was in 2021. This same 23-year period had less dramatic growth for adding EAP services among both the medium (1.62 x more) and the large size employers (1.23 x more), largely because of the relatively much higher starting rates these latter groups compared to small employers.

As the most rapid growth in the EAPs occurred with small employers, this was examined in more detail for each year of data available. Figure 2 uses national data from the BLS in year 1999[51] and then annually for each year starting with 2008 through 2021[57-67] just for the small size employers (1-99 workers) in the private sector. This line chart shows the large increase in the percentage of workers at small size employers in the private sector that have access to an EAP over time in the U.S. Of key importance is the jump up in the most recent year of data (from 31% to 37% of workers with access to EAP among these small employers) reflecting the COVID-19 pandemic period. Thus, more small employers had added an EAP in response to the increased need for mental health support associated with the pandemic.

What is the Business Case for Employee Assistance Programs? Research indicates that counseling provided by EAPs is generally effective for most clients, regardless of whether it is provided in-person, over the telephone, or using internet video.[36,42,68-70] The financial return on investment for EAPs is also compelling with cost savings in multiple areas, such as avoided health care claims, avoided lost work productivity and absenteeism, and possibly even avoided employee turnover, accidents, disability claims or other high cost events.[71-74] A recent analysis estimated a $3.25 return for every $1.00 invested in the EAP for the typical small employer in the U.S.[75] This ROI was based on only the outcomes of work productivity and absenteeism at $2034 in savings per counseling case, using a $25 per employee per year rate of the investment in the EAP, and a low level of use at only 5% of all covered employees using the EAP for counseling.

Conclusion

More research is needed to understand the specific mental health burden of small employers and current strategies for addressing this burden. Using EAPs to support employee mental health issues may be relevant for smaller size employers as they have fewer workers, managers, and leaders available to make the business successful, it is all the riskier for a behavioral health breakdown to occur for any 1 of the human parts of the work organization. The relatively low cost and high impact of an EAP may make sense for small employers if they can encourage employee utilization when needed – especially during the increased challenges of the global pandemic.

However, more research is needed to understand the specific mental health burden of small employers and current strategies for addressing these issues. One promising example is the recent initiative by Health Enhancement Research Organization (HERO) in the U.S. to better understand the needs of small and mid-size businesses.77 In early 2022 they conducted a survey and plan to offer a small and mid-size business summit in the fall of 2022 to examine issues of employee mental and emotional health and well-being, how leaders and manager can support employee health and well-being, applying best practices within small and mid-size organizations, and controlling health risks and costs. Similar efforts by other employer groups supportive of small businesses are encouraged.

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Trends in Use of Telehealth for Behavioral Health Care During the COVID-19 Pandemic: Considerations for Payers and Employers

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Purpose

In the early months of the COVID-19 pandemic, telehealth use in the United States increased dramatically as providers shifted their modes of practice to decrease risks of exposure to the virus.[1,2] During this time, telehealth use for behavioral health conditions far exceeded its use for general physical health conditions.[1,2] *Telehealth* includes health services rendered via interactive, synchronous or asynchronous, audio and video telecommunication systems. Overall, rates of telehealth use for all conditions declined later in 2020, as the initial COVID-19 surge abated.[1] However, these declines were primarily driven by visits for physical health conditions, while rates for behavioral health conditions remained consistently high throughout 2021.[2,3]

These early data suggest that the use of telehealth for behavioral health conditions resonates with both patients and providers and may be a vital component to continue to include in benefit packages offered by employers to support the well-being of their employees. These data also suggest that expanded telehealth benefits and reduced cost sharing for telehealth visits among self-insured plans and other commercial insurers in some states[4] incentivized the uptake of telehealth in the early months of the pandemic. Given the increase in the reported prevalence of behavioral health conditions during the pandemic,[5,6] continuing disruptions to the workforce due to resignations[7] and work-from-home policies,[8-10] and evidence of increased burnout overall,[11] the continued expansion of access to behavioral health services via telehealth is an important consideration for employers.

To date, analyses of the use of telehealth during the pandemic have not stratified trends for behavioral health telehealth visits by substance use disorder (SUD) vs mental health conditions. Employers need information about trends across these 2 broad groups to inform benefit design. The purpose of this analysis was to examine trends in (1) the delivery of telehealth by behavioral health care providers compared with general health care providers and (2) the use of telehealth for behavioral health care stratified by mental health conditions and substance use conditions. Our study time frame extends through November 2021 to allow for the observation of trends before and after the surge of the Delta variant of COVID-19.

Methods

Sample

The data used for this analysis, covering January 2020 through November 2021, were from the IBM® MarketScan® Commercial and Medicare Supplemental Databases, combining annual, quarterly, and early view releases. During this period, these claims databases represented the health services of approximately 26 million employees, dependents, and retirees in the United States with primary or Medicare coverage through privately insured fee-for-service, point-of-service, or capitated health plans. More than 70% of the data came from large, self-insured employers. The remaining data came from health plans that serve a variety of employer clients.

Design, Measures, and Analysis

We examined approximately 849 million outpatient service records during this period for use of telehealth services. Telehealth was identified from the outpatient files using a combination of place of service codes (Telehealth, value 02) and the procedure modifier codes listed in Table 1. Using a combination of codes ensured inclusion of both audio and video telehealth modalities. We categorized data using key major behavioral health diagnostic groups and bundled them into mental health or SUD diagnostic groups as well as groups for selected provider types. We conducted a descriptive trend analysis using the World Programming System (WPS) 4.3.[12]

The IBM MarketScan Research Databases contain statistically deidentified data that are fully compliant with U.S. privacy laws and regulations, including the Health Insurance Portability and

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Accountability Act. Such data are exempt from institutional review board approval.

Results

As the COVID-19 pandemic began to affect the U.S. health care system, providers who treat mental health and SUD diagnoses (i.e., counselors, psychiatrists, and psychologists) saw a rapid rise in telehealth claims, from about 1% in February 2020 to about 20% in March and 53-59% in April 2020, with an attenuation to about 40% at the end of 2021 (see Figure 1). Telehealth claims from these providers also showed a slight rise at the end of 2020 into the beginning of 2021. In contrast, general practitioners (i.e., pediatricians and those in general medicine or family practice) saw a much lower rise in telehealth claims at the beginning of the pandemic and a rapid fall to almost prepandemic levels after the April 2020 peak. These categories quickly attenuated to less than 10% of claims by provider type by June 2020 and less than 5% by the end of 2021. Still, overall telehealth claims as a proportion of all health care claims across all provider types were several orders of magnitude larger than prepandemic levels, with the largest, most persistent gains among behavioral health providers.

Looking specifically at mental health and SUD telehealth claims, we observed similar patterns to those identified in the analysis by provider type. As shown in Figure 2, the proportion of behavioral health claims that were telehealth was much higher by April 2020 than in the immediate prior months. In January–February 2020, all telehealth claims for these diagnoses represented a very small proportion of overall behavioral health claims. However, by April 2020, telehealth claims for mental health diagnoses accounted for more than 51% of all mental health claims. Since that time, the proportion of telehealth claims for mental health diagnoses has generally fallen, with a slight rise at the end of 2020 through the beginning of 2021, to roughly 30% of all mental health diagnosis claims. Claims for SUD diagnoses also saw a rapid rise in the first months of the pandemic in the United States, from less than 1% in February 2020 to almost 14% in April. As with mental health diagnoses, there was a drop in the share of telehealth claims for SUD diagnoses through the end of 2021 to about 10%, although that proportion seems to have plateaued.

Discussion

The COVID-19 pandemic introduced a major systemic change in the delivery of behavioral health care in the United States.[3,13,14] This analysis demonstrates that telehealth services continued to be attractive to those covered by commercial insurance and Medicare Supplemental Insurance well into 2021, irrespective of whether COVID-19 transmission was in an acute surge. Furthermore, these data suggest that individuals are continuing to use telehealth, despite the widespread return to in-person activities in health care settings, workplaces, and other public spaces.

This persistence in the use of telehealth for behavioral health conditions indicates that at this point, use of telehealth is likely not simply about safety concerns but also convenience, comfort, and costs. Pre-COVID-19 concerns about acceptability of this modality of health care delivery appear to be somewhat allayed.[15,16] Previous barriers

Table 1. Procedure Modifier Codes in Health Claims Used to Identify Telehealth.

| Code	Definition
95	Synchronous telemedicine service rendered via real-time interactive audio and visual telecommunication system
GO	Telehealth services for diagnosis, evaluation, or treatment of symptoms of acute stroke
GQ	Telehealth service rendered via asynchronous telecommunications system
GT	Telehealth service rendered via interactive audio and video telecommunication systems
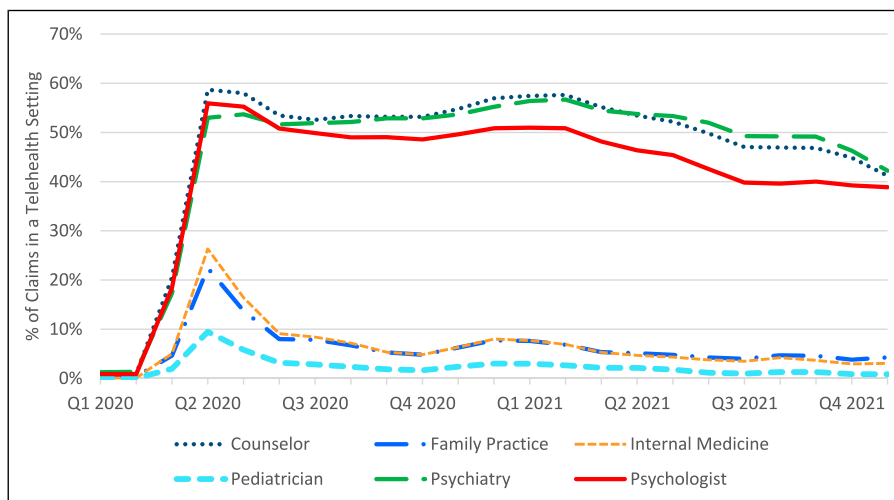
Figure 1. Percentage of claims for services provided by telehealth, January 2020 to November 2021.
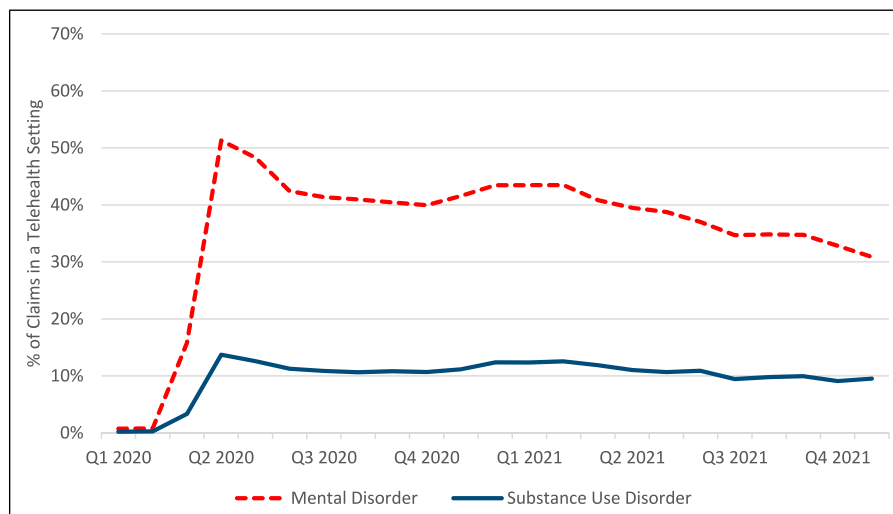
Figure 2. Percentage of claims for services provided by telehealth for mental and substance use disorders, January 2020 to November 2021.

related to the comfort of patients or providers with mental health care delivery through telehealth in particular may have been overcome during this pandemic-initiated system change.[1,14] The ability of telehealth services for mental health conditions to fit flexibly and easily into busy lives may have an impact on staying power. Decreased transportation costs for patients and reduced infrastructure costs for providers who do not need to pay for office space may also be factors. Telehealth also has the potential to facilitate care more easily to those who previously may have been reluctant to attend in-person care due to stigma, mental health symptoms such as social anxiety, or other issues.[2]

However, the findings do suggest somewhat different patterns for adoption of telehealth for SUD-related care compared with telehealth adoption for mental health care. SUD-related telehealth constituted a lower share of behavioral health telemedicine visits throughout the observation period. At the same time, the line seemingly remains flat, whereas the proportion of claims for mental health services continues to drop slowly. These differences suggest that although there may be some continued attenuation of telehealth visits for mental health, the current rate of decline in SUD telehealth visits may have plateaued. A better understanding of patient and provider comfort with telehealth for SUDs is warranted, especially given some indication that SUD group treatment is less easily facilitated by telehealth.[17] Privacy concerns related to telehealth treatment may also be a significant concern for those with SUD.[18]

Key questions remain about the extent to which quality behavioral health care can be effectively delivered via telehealth. Evidence supports that the quality of care for mental health conditions via telehealth is comparable to care provided in person,[17,19] but there is mixed evidence for both uptake and effectiveness of SUD treatment via this modality.[1,20] It is important to consider how the COVID-19 public health emergency (PHE)-related policy flexibilities affected trends in the use of telehealth for initiation of treatment and counseling for opioid use disorder (OUD). In particular, questions remain about the relationship between the continuation or expansion of these PHE flexibilities, telehealth service use trends, and effective treatment for individuals with OUD.[21]

The findings from this analysis make a compelling argument that flexibilities in the workplace should be matched by flexibilities in the delivery of health care via telehealth, although the potential for

subsequently creating new barriers to treatment should be carefully considered. On one hand, as workplaces continue to support hybrid working environments,[22] including a broader geographic range of behavioral health providers in employer-based insurance plans via telehealth may be an important strategy to expand employees' access to behavioral health services, especially given current constraints in the behavioral health provider workforce.[23] To effectively leverage opportunities to expand access presented by this shift to telehealth, and to support robust coverage for employees, employers should consider including telehealth in their benefit packages. However, disparities in access to broadband internet likely need to be considered in rural communities.[24,25] Similarly, understanding the differences between video and telephonic delivery of care is also important, as patterns of engagement vary across these 2 formats by demographic groups.[25,26] In some cases, telehealth services have also led to a shift to self-pay among behavioral health clinicians,[3,15] which could ultimately restrict access.

Our study prompts several considerations for the field. First, this descriptive trend analysis does not provide any information about the quality of the telehealth care provided. We also do not know from this analysis how much patient preferences, such as the potential for decreased stigma, or provider preferences, such as reductions in cost for office space, are driving the shift to telehealth. In addition, the analysis does not consider the adequacy of telehealth in filling pandemic-related gaps in behavioral health care, nor does it address whether there are differences in acceptability of telehealth treatment for initiation vs continuation of treatment. Finally, although the extent of the difference in trends is large from prepandemic to the end of the observation period for this analysis, further research should test the significance of these changes over time and assess the impact of these system changes on behavioral health outcomes.

Despite being in the early phases of research on its effectiveness across behavioral health diagnostic categories, telehealth seems to resonate with employees. Including telehealth in employee benefit packages may be an important strategy that employers can use to bolster their network of behavioral health providers and support employee health. As the evidence base continues to expand, hybrid approaches to behavioral health treatment that include both in-person and telehealth treatment modalities across episodes of care may be a possible outcome of this system change. Employers may consider

coverage of behavioral health treatment for both video and telephonic approaches as well as reimbursement rates that are equivalent across all modes of delivery.[27] Self-insured companies may also consider examining their own data to assess differential uptake of telehealth across specific demographic groups to ensure equitable access to treatment using this modality.

Acknowledgments

Disclaimers

Certain data used in this study were supplied by International Business Machines Corporation as part of one or more IBM MarketScan Research Databases. Any analysis, interpretation, or conclusion based on these data is solely that of the authors and not International Business Machines Corporation. The opinions expressed by the authors are their own and this material should not be interpreted as representing the official viewpoint of the U.S. Department of Health and Human Services, the National Institutes of Health or the National Cancer Institute.

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Supporting Workplace Mental Health in the COVID Era: Exemplary Practices from the Business Sector

Tamara C. Daley, PhD, and Rachel Mosher Henke, PhD

Introduction

Supporting employee mental health has been of growing focus of employers, even before the pandemic. For decades, research and media reports have highlighted the prevalence of untreated mental illness in the workforce and the link between mental health and productivity[1,2] In response, employers have expanded behavioral health coverage and invested in worksite health promotion programs.[3]

When COVID surfaced in the U.S. in early 2020, employers initially focused on the health and safety of their employees. This included preparing workspaces or temporarily closing workspaces to stop the spread and supporting employees and families infected by the virus with additional sick time. At that point, pandemic-related increased risk for depression, anxiety, and stress was a secondary focus for most employers. However, as the months passed and the pandemic lingered even after the introduction of effective vaccines, employers increasingly focused on employee mental health and burnout as a primary health concern.

Findings from across independent surveys of employees[4] report varying approaches to specifically addressing mental health concerns related to the pandemic.[5] Understanding what shifts took place at U.S. businesses and organizations, large and small, allows us to identify best practices for future implementation and evaluation. Describing what has been helpful in different workplace contexts is helpful as employers continue to find solutions that are practical for their business to best meet the needs of employees. This article highlights a diverse set of companies that identified mental health as a concern after the onset of the pandemic and implemented solutions specific to their workforce needs.

Methods

In selecting case studies, we sought 5 businesses to reflect a range of industries, sizes, and locations in the U.S. (see Table 1). We especially wanted to include both a small and large business to be able to illustrate how adaptations occur at different scale, depending on the number of employees. We also wanted to include an example of a business in the hospitality industry, which were among businesses that felt the impact of the COVID pandemic most directly and highlight The Morris in San Francisco to reflect that. Our case studies include an example of a business that was already fully remote before COVID, Goodway Group, and 1 that was very tied to the physical campus, Jackson Healthcare. We include a business, Fors Marsh, that is B Corporation Certified, indicating that they already met high standards on social sustainability and environmental performance. We also include a group operating within a university context, Prevention Insight, to illustrate how a simple low-cost intervention can be as helpful as a top-down solution. For each case study, we give a brief overview and snapshot of pre-COVID support, followed by selected changes in policies and practice that each took.

We note that, due to space limitations, these descriptions do not always reflect the full breadth of support that these businesses undertook. Many businesses, for example, shifted their response with different phases of stay-at-home orders and in response to evolving needs of their employees over time.

Goodway Group: Blending Supportive Policies With Digital Solutions

Since 2006, the digital marketing agency Goodway Group has operated with a remote workforce, now with over 450 employees located in 40 states and 3 countries. Prior to COVID, Goodway Group had already introduced an open PTO policy, known as "My Time",

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and had also created a program to support growth and development called Dedicated Development Day, where non-essential meetings were avoided. Also prior to the pandemic, Goodway Group offered a 2 week-long working and bonding summit for all employees twice each year.

In contrast to many businesses that had to shift to remote work setting, Goodway Group employees were already accustomed to this configuration. Yet feedback from the teams suggested that employees were nonetheless adjusting to an entirely new routine at home as they balanced pressures related to childcare, virtual learning, elder care, and finances. Goodway Group's solution was to combine individualized policies with digital approaches. Goodway Group encouraged teams to create schedules that worked for their individual groups. For example, a team developed a work schedule that accommodated members overseeing remote learning with young children. Teams shared feedback that being provided this sense of autonomy strengthened bonds and trust within the teams, and team members continued to support each other when in need. Goodway Group also recognized that some employees were experiencing significant financial impacts of COVID, though others were not. Goodway Group established a confidential employee emergency fund for team members to work one-on-one with those in need to determine the level of financial support needed, and then provide those funds on the same day. Donations from employees were matched by owners, demonstrating support from leadership while also reinforcing the bonds among employees. Goodway Group implemented additional initiatives, such as Family Friday Fun days via Zoom to highlight family talents and surprise all-company holidays, to make sure employees were taking time off.

As a digital marketing agency, Goodway Group took a unique approach to facilitate their biannual summits in a post-pandemic world. Goodway Group introduced Virbela, a 2D virtual reality (VR) program that allowed employees to use avatars to explore the company's online campus, giving them the feeling of walking around an event, while providing a break from Zoom. Goodway Group instituted a full VR option for all teams to use both at the summit and throughout the year for team building. As the pandemic has waned, Goodway Group provided all employees with an Oculus headset, a dedicated trainer and a full array of social and educational programs to continue virtual connections. Goodway Group is continuing conversations with team members to determine which initiatives will continue in 2022 and beyond, and notes that it is critical for businesses to approach conversations around mental health with compassion and empathy: "[C]onsistent conversations that are focused on well-being, progress and development are key to having happy, engaged employees who power successful business outcomes."

Focus on Finances: The Morris

The Morris is a well-regarded restaurant in San Francisco, in operation since 2016. In line with The Morris's goal of being a true neighborhood restaurant, the owners embraced their diners while also focusing on their staff right from its inception. Both the founder, Paul Einbund, and his chef and partner had been in the restaurant industry long enough to have exposure to

restaurants where the climate was stressful, demoralizing and rife with harassment. Even prior to COVID, the restaurant leadership made an effort to make The Morris a happier place to work. With COVID, The Morris was thrown into the same turmoil as restaurants across the U.S. with questions about whether allowing guests to dine and staff to work could literally be killing people. Morris founder Einbund recalls that everyone was stressed: "We all needed to pay bills, but we all needed to stay safe."

The primary mechanism to support the restaurant's staff was financial. When the restaurant stopped on-site dining at the beginning of the pandemic, the owners asked their investors to donate whatever money they could and wrote checks to every employee to try to offset their loss of income. The management then operated a GoFundMe and wrote another 2 checks to employees. During the entire pandemic, anyone who wanted shifts was given them, and no one on salary received any less pay than they did before the pandemic. In addition, the management emphasized balance, breathing, meditation and safety above all. The Morris received attention from the *San Francisco Chronicle* after closing for a week for a "mental health break," at which time they wrote another check to every employee to offset the loss of income.

While supplemental checks are not a sustainable practice, The Morris continues to support employee mental health by attempting to offer 4 day work weeks for whoever wants them, including the general manager, and by creating more balance overall. One important shift has been to focus on successes, pointing out repeat guests, birthday celebrations, and other important moments customers choose to spend at the restaurant. Maintaining these changes, along with investment in manager training and engaging in explicit conversations with staff about what they need to feel supported are the key ingredients for supporting employee mental health.

A Multifaceted Strategy: Fors Marsh Group

Fors Marsh Group (FMG) is a 400-employee market and consumer research company headquartered in Arlington, VA, and a certified B-Corp company since 2017. As such, Fors Marsh had policies in place to support employee well-being already, including 16 hours of paid time for employees to volunteer for a personal cause they believe in, offering financial advising, and calling the "sick" leave "personal health" leave to encompass mental health. With COVID, FMG began seeing a notable increased in reports of isolation, disconnection, and uncertainty through their quarterly employee survey.

FMG focused on a strategy to reduce the stigma and financial barriers associated with seeking treatment, working with 3 components. First, they provided employees and dependents 6 free virtual therapy sessions per year and reduced copays for additional visits. Second, to address the increase in substance use disorders (SUD) associated with the pandemic, they implemented a Workplace Supported Recovery Program (WSRP). This Program provides employees (and their dependents) with easy access to substance use disorder services and assistance with returning to work. Through the program, the company also supports employees with SUD while they actively seek treatment.

Table 1. Summary of Case Study Sites.

Business Name	Industry	Number of Employees	Location
The Morris	Restaurant	23	San Francisco, CA
Prevention Insight	University-based	35	Bloomington, IN
Fors Marsh group	Research	400	Arlington, VA
Goodway group	Digital marketing	450	40 states, 3 countries
Jackson healthcare	Healthcare staffing	1600	Atlanta, GA

The third component of their approach was to ensure employees have time to take care of their health, enacted through an unlimited leave program. Employees are explicitly *not* required to disclose their reasons for needing days off. At the same time, FMG now encourages senior leaders to share their own use of mental health days to help destigmatize the use of this leave. In preparing for program implementation, FMG researched ways unlimited leave programs succeed – and fail. One of the big takeaways was that, in addition to communicating to employees that they have as much leave as they need, the message to employees is that there is an expectation that they take at least 2 weeks of leave per year, with the goal that they would take closer to three-four weeks per year. Like the WSRP, the Personalized PTO program is a permanent change that FMG believes will allow employees not just the time they need to not just balance work and life, but to stay healthy and happy.

Reconceptualizing Support for a Remote World: Jackson Healthcare

Founded in 2000, Jackson Healthcare is a healthcare staffing company consisting of a group of 15 specialized healthcare staffing, search and technology companies. Most of the 1600 employees work out of the corporate headquarters in Atlanta, and prior to COVID, Jackson Healthcare's approach to employee well-being centered on services located on the physical campus. Employees and their families could access primary healthcare, preventative services, and licensed professional counselors; a fitness center and daily fitness classes; walking trails, and other outdoor recreation. Inside, staff could spend time in a game room or "serenity spaces" to contemplate, meditate or connect spiritually in other ways.

In March 2020, the shift to a fully remote work created an abrupt rupture with these supports. The focus became meeting employee needs in a remote work context, especially for employees with children. Jackson Healthcare instituted personalized, flexible work from home hours to accommodate families trying to balance work with care for children. Although the company's onsite childcare center was closed, teachers from the center led recorded activities and lessons for associates' children. When the childcare center re-opened, it did so with new part-time and drop-in childcare options. For parents with older children, Jackson Healthcare reserved spots at a nearby onsite distance learning facility that oversees student work during the school day and offered space on our campus for parents who wanted to host learning pods.

To maintain a sense of cohesiveness throughout 2020, Jackson Healthcare reconceptualized campus traditions as virtual events. These included activities such as virtual holiday decoration and costume contests, a "pay it forward" Thanksgiving dinner where associates could choose a modified meal or donate the value forward to a local area nonprofit, and Santa photos that could include a socially distant in-person photo or virtual photos over Zoom. The organization shifted in-person professional development courses to a virtual, on-demand system and launched an online leadership development program portal to provide additional virtual development opportunities. The leadership team launched a communications campaign called #PositivelyJH, to share good news and celebrate people, the business and the company culture, as another way to help employees feel connected and supported. Through its internal communications platform, Jackson Healthcare provided daily content focusing on ways associates could support each other and the community, wellbeing and work-from-home tips, and more.

Though associates are now back on the physical campus and using in-person offerings, Jackson Healthcare continues to embrace changes that were implemented during COVID. Each of the Jackson Healthcare companies has its own hybrid work model that includes a defined work-from-home policy. Increased telehealth offerings that were launched in 2020 are now permanent. Jackson Healthcare continues to provide virtual professional development options, as well as a virtual component to company and holiday celebrations. And by leveraging focus groups, surveys and one-on-one conversations, the organization continues to assess how needs have shifted over the last few years and what employees currently value most.

Personal Connections: Prevention Insights, Indiana University

Not all efforts to support employees require a lot of resources, investments, or a top-down approach. Prevention Insights, a group of 35 employees within the School of Public Health at Indiana University, took a simple yet effective approach to supporting their employees during the pandemic. Prevention Insights already had an active wellness committee that focused on employee health through newsletters, learning opportunities, and social initiatives. When their organization went from primarily having employees in the office full time to working from home, they understood employees were facing a large change in how they worked on top of the stress of COVID and new family obligations. Some team members had very independent roles and did not have natural opportunities to interact with one another.

The wellness committee developed a plan to have monthly check-ins with all employees. Members of the wellness team were assigned up to 5 employees to check in with over each month. These interactions could take the form of a phone call, an outdoor walk, or even just emails. Over time, the group also added more social activities, including online lunches, a cooking class, and pickleball.

Importantly, the wellness team also received training that included a better understanding of emotional intelligence to provide better services to their staff. Staff reported that during COVID, even just having the opportunity to talk to other employees beyond work was exceptionally helpful. The online social gatherings helped replace the free talk that would have occurred in hallways or the lunchroom before COVID. Employees reported that the check-ins allowed them to share challenges and struggles as well as all the good in their lives.

Now that some employees have returned to the office, the online games and lunch events have been supplemented by in-person games, and lunch and walks and will be permanent. What this team has learned can be a lesson for many – it is important to talk to each other *not* about work. Having meetings and moments and gatherings that are simply an opportunity to talk to each other, get to know each other better and create a safe space for people to share with each other can be nurturing and supportive of employee wellbeing, particularly during times of ongoing uncertainty and change.

Discussion

While these 5 organizations differ in size and industry, there are several important lessons that emerge from their experiences. In each of these cases, the policies and practices put in place were tied to the specific needs of employees. Several of these organizations found that financial support was a key to mental well-being. For example, The Morris's strategy was to first make sure that staff would have stability while the restaurant was closed, and then secondarily to make sure the work environment was positive and supportive. Goodway Group similarly incorporated a mechanism to secure and provide money to team members who were struggling.

Across these and so many organizations, COVID has brought a shift toward recognizing the importance of accommodating the family system to support employee well-being. Balancing the competing demands of work and family is a well-known challenge for many organizations, but the pandemic required more explicit policies and practices, such as allowing more flexible work hours at Jackson Health and Goodway Group, and a range of ways of incorporating family traditions and activities at Jackson Health. With continuing labor shortages affecting access to child care, these changes may signify an important cultural shift toward more open dialogue about work-family balance.

These organizations varied in the costliness of their COVID-related practices. The social activities and "check ins" that were added by Prevention Insights, and sharing good news at Jackson Health, for example, were no- or extremely low-cost. At the other end of the spectrum, the technology solution of providing VR devices implemented by Goodway Group may not be feasible for many companies. In some cases, it will take time for the cost-benefit analyses to be complete, and even then, the value of certain policies may be hard to quantify. For example, continued support for employees as they take time to attend a rehab program or undergo some other type of substance use treatment may not be cost effective if that specific employee does not come back to work, but simply having the program in place may be considered attractive by other employees and help retention in that respect.

Two organizations approached employee mental health through leave policies. Unlimited leave policies, which are in place at Goodway Group and FMG, are sometimes criticized because employees may not take as much vacation time as when they have set leave, and in unlimited PTO situations, companies are not required to pay out unused time. However, the FMG implementation of this practice was different in that they strongly encourage employees to take multiple weeks off, and if they do not, their managers engage in discussions with them to understand why they have not.

Conclusion

The COVID era has brought unprecedented changes to the way business is conducted across a variety of industries and economic sectors, and each of these changes has brought challenges to employee well-being in its wake. Furthermore, as the acute phase of the pandemic recedes and a "new normal" takes hold, many of the changes to business remain in place. Policies that center employees' physical and mental health and wellness, recognize the precarious nature of financial well-being for many American workers, and acknowledge that employees exist within larger family systems were well-received by workers and perceived as valuable by employers in 2020-2021. More research is needed to quantify the benefits of these policies, but the present sample suggests that those benefits are real, and that they will continue to be so in 2022 and beyond.

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