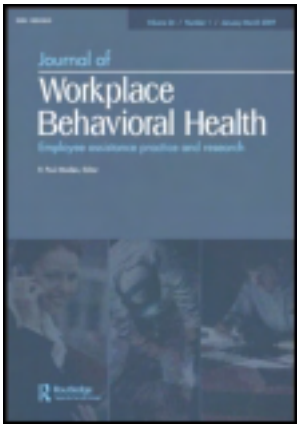

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Bringing EAP to Faith Communities: Genesis of a Canadian Congregational Assistance Plan

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Inspired by employee assistance programming, this article reviews the evolution of a parallel process for a different constituency, members of faith communities, a Congregational Assistance Plan. The relationship between spirituality and counseling in Canada is discussed leading to a review of the process through which two Christian-based counseling agencies developed a network to serve the personal and mental health needs of church parishioners. The goals of the Congregational Assistance Plan are presented along with its structuring, implementation, and utilization data for the churches that piloted the initiative.

KEYWORDS Christian counseling, Congregational Assistance Plan, faith, spirituality

Spirituality has been a component of employee assistance programming since the pioneers of Alcoholics Anonymous (AA) took the 12th step into the workplace in the early 1940s in helping to develop Occupational

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Alcoholism Programs (Csiernik, 2009). Today AA members remain actively involved in providing assistance in some workplaces with spirituality still being a component of their recovery dialogue (Csiernik & Csiernik, 2012). The concept of workplace wellness consists of five components: physical health, social health, psychological health, vocational/intellectual health, as well as spiritual health (Csiernik, 2005b; Sefton et al., 1992). The critical importance of the spiritual dimension of work has been explored by a range of authors (Adams & Csiernik, 2002, Ashmos & Duchon, 2000; Butts, 1999; Driscoll & Wiebe, 2007; Karakas, 2010; Tourish & Tourish, 2010), though this should not be surprising given that the foundation of contemporary counseling, particularly social work, comes from early Christian practices and traditions in North America (Gibelman & Gelman, 2003; Graham, Coholic, & Coates, 2007; Yancey & Atkinson, 2004). Faith communities have historically contributed to broader community well-being through outreach, community service, and through advocating for social justice. Faith communities have also been leaders in providing spiritual, instrumental, and emotional supports not only to their congregational members but also to the broader community through the creation of a range of social services, including counseling agencies, emergency shelters, alcohol and drug recovery programs, and food banks (Cnaan, Boddie, & Wineburg, 1999; Degeneffe, 2003; Lowenberg, 1988).

There has been a long association between spirituality and counseling professions (Ebears, Csiernik, & Bechard, 2006; Este, 2007; Graham, 2007). Counseling professions, in particular social work, were founded upon religious beliefs, particularly, service, humanitarian, and egalitarian values but separated in part to gain legitimacy as professions. However, the two have continued to interact, in partnership and in contest (Graham et al., 2007). Faith-based organizations have continued throughout the 20th and 21st centuries to provide significant social support and assistance in serving those with great needs such as impoverished and homeless individuals (Gibelman & Gelman, 2003; Yancey & Atkinson, 2004). However, for the most part those services have become the domain of social work, and as the profession of social work evolved in the 20th century these forms of assistance were historically placed outside of the formal boundaries of faith communities to serve not only members of the immediate church family but also the broader community. Unfortunately, at the end of the last century a dramatic negative shift in the provision of social services in the broader community had begun, a trend carried into the 21st century, with less public funding being provided. This devolution has had a negative impact upon social welfare programs and how counselors are able and not able to deliver services in the community, with extensive waiting lists becoming the norm and some services no longer being readily available (Gainsborough, 2003; Schneider & Netting, 1999).

This has led to several ideas on how to better serve members of faith communities. One proposed route was to introduce counselors directly into faith communities, to complement the parish nurse concept with that of a parish social worker (Cohen, Weis, Schank, & Matheus, 1999; Ebears et al., 2006, 2008a, 2008b; Schank, Weis, & Matheus, 1996). The other has been to equate a congregation to a work environment and to replicate the Employee Assistance Program (EAP) model within the spiritual community with a focus upon parishioners rather than a workplace counseling service for clergy (Carlson & Cyper Bartlett, 1994; Kelly 1995). This idea was first formally expressed in the 1990s when Carlson and Cyper Bartlett (1994) discussed a variant of the professional EAP model, a voluntary Member Assistance Program as a template for delivering counseling services to members of the church community. They discussed how they had implemented the idea within an Episcopal church in Rochester, New York. In contrast, Kelly (1995) wrote about attempting to develop a Congregational Assistance Program among church parishioners in Illinois in the early 1990s using the traditional professional EAP model as the foundation. However, no further case studies or evaluations have appeared in the EAP literature that focused upon the needs of the church members (Csiernik, 2011) though there was an article examining the value of offering EAP services to clergy (Dickman, 2009).

CREATING AN ORGANIZED RESPONSE

Two long established Christian-orientated services in Ontario, Christian Counselling Services of Toronto and Shalem Mental Health Network of Hamilton, began providing traditional EAP counseling services during the 1990s as a result of requests from organizations who themselves had Christian mission statements. This necessitated the development of a network of Christian counselors from around Ontario and Canada, as well as an infrastructure for delivering EAP services. This network became quite broad but was not being utilized to its full potential or capacity. In 2004 the Board of Directors of Shalem Mental Health Network tasked their executive director with reaching out even further to the community with innovative mental health proposals. Since the EAP initiative had been undertaken, there had been several inquiries from individual churches reflecting a perceived need within faith communities to be able to respond effectively and quickly to the emotional challenges faced by church members rather than church employees. Pastors associated with the counseling services reported feeling overwhelmed at times by these requests whereas those offering lay pastoral care reported feeling that some of the issues they faced were well beyond their expertise. Many of these churches already provided some funding for

parishioners who wanted specialized counseling beyond the scope of the pastor or volunteers but could not afford it. However, a number of pastors had indicated that there was at times also a perception of shame experienced by those in need of formal counseling who had to request the church pay for the service and that this was acting as a significant barrier to people receiving appropriate and timely assistance.

Among the concepts proposed by Shalem and Christian Counselling Services of Toronto was the adaption of the EAP model for churches with the primary focus being upon members of the congregation. EAPs had been developed for clergy in the past for example by CIGNA in the United States and for the United Church clergy in Canada, however a Congregational Assistance Plan (CAP) was envisioned as a method of service delivery for congregations based upon the EAP model of delivering counseling services with only slight modifications needed to fit a congregational context (Table 1). The intent of a CAP would be to

- have a strong diaconal service thrust. A CAP would remove financial barriers that presently prevent individuals in need from obtaining the help they require. As well, pastors and other staff could also access the service themselves as could their family members.
- enhance local communities. A CAP would locate and leave responsibility for mental health services at the local congregational level, namely with church leadership, pastors and individual church members.

TABLE 1 Program Characteristics

Attribute	Employee Assistance Program	Congregational Assistance Plan
Ownership and administration	Joint Labor-Management Committee	Church Council subcommittee
Availability and eligibility	All employees and family members including children at home	All employees and family members including children at home
Range of services	Broad brush	Broad brush
Referrals	Primarily voluntary though can be mandated in some circumstances	Exclusively voluntary
Service fee	Primarily paid by employer though some are cost shared and some are paid for via union dues	Either as part of core budget or through special church collections
Additional fees	No additional user fees	No additional user fees
Service limit	Both capped and uncapped service Those with caps average five sessions with a range of four to ten	Eight session cap Eight additional sessions possible
Service provision	Internal peers and professionals External counselors	External counselors
Awareness	New employee orientation, Web site, company media	Presentation during service Web site, congregation bulletin

Note. Source: Csiernik (2005a).

- focus careful attention to accountability. The program providers would give churches quarterly reports upon service usage and presenting issues without providing identifying information. Church members would access CAP not only confidentially but also in complete anonymity, without anyone in the congregation, including the leadership, knowing who is receiving the service.
- enhance a congregation's ability to minister to the needs of parishioners. If a cluster of presenting issues emerges, the church could tailor its ministry directions in support of emerging needs. Also, if a client provided informed consent, CAP counselors could engage the church in supporting and developing an overall plan of care.
- encourage members to stay in the community. Mental health problems by their very nature cause isolation. CAP would support community for people struggling with isolation.

PROGRAM IMPLEMENTATION

The program began with two Christian Reformed churches, one in an urban setting the second in a rural part of Ontario both with Church Councils who agreed to participate for one year in the pilot project. The urban church was in downtown Hamilton a community of 500,000 whose pastor had a keen interest in psychotherapy and regularly referred parishioners to local Christian counselors whereas the chair of the church council was a registered psychologist. The Church Council voted to pay for the costs of CAP through three special collections that were not viewed as an extraordinary expense in that there was already an allocation in the church budget for requested individual counseling at nearly the same cost of CAP for one year. The second church was in Bowmanville, a more rural region in the central part of the province. The church was in the process of temporarily having a pastoral vacancy and thus had an even greater need for a mechanism through which to provide counseling support to parishioners. This church employed a parish nurse, and thus some members were already supportive of nontraditional resources as part of the mission of the church to the congregation. Even with some monies diverted from the vacant minister position funding CAP remained an issue with a significant minority of the Church Council skeptical of the church's ability to pay for a service not deemed to be a core service. In the end, proponents including the parish nurse prevailed, and the Church Council voted to fund CAP through three extra collections throughout the year, while actively promoting CAP use in the church bulletin on a weekly basis.

At both churches there was considerable discussion about the desirability of a copay structure, where a client could pay a portion of the counseling fee. The counseling agency providing the service argued strongly against this option, used in a few EAP situations, for several reasons. The

provider wished CAP to be as barrier free as possible, arguing that requesting and arranging copayment actually added additional administrative costs that would minimize potential savings to the congregation. As well, in the spirit of Christian philosophy, it was believed that if clients appreciated CAP and had financial means available to them, they could further support CAP by making donations to the program through the special collections which in turn could enhance the availability of CAP to other parishioners.

CAP began at the two churches early in 2006, with signed 12-month contracts modeled after a traditional EAP contract. Each parishioner received a brochure describing the service and how he or she could access it. The information also highlighted the issues of confidentiality and anonymity and that there was no cost to use CAP. A formal announcement launching CAP was made at each church, with the Shalem executive director present as a guest speaker.

The cost formula developed for the pilot was based upon an estimated 5% utilization rate per family in the church using the norm established within the EAP field by external providers, though actual utilization rates do vary quite widely in Canada (Csiernik & Csiernik, 2012). The family was used as the foundation for utilization as the Christian Reformed Church counts members by "families." CAP was set up to accommodate up to eight counseling sessions, with up to an additional eight sessions if there was a compelling clinical case to be made for the extension of service. If a family had more than one issue it wished to pursue, for example, an individual matter and a marital conflict, each issue was granted the session allotment described above.

The CAP process mirrored that of any traditional EAP (Table 2). Parishioners would call a toll-free number and state which church they were from to ensure they were part of the program. The parishioner described

TABLE 2 Process of Service Provision

	External Employee Assistance Program provider	Congregational Assistance Plan
Client location	Workplace or home	Congregation or home
Contact route	Toll-free number	Toll-free number
Initial verification	Employer name	Church name
Intake	Assess risk level Identify problem	Assess risk level Identify problem
Counselor	Provider selects one counselor	Provider selects one counselor
Appointment selection	Provider provides initial appointment time for client	Counselor contacts client to arrange initial appointment time
Consent for service	Confidentiality form completed at first meeting	Confidentiality form provided to client prior to initial meeting
Time between intake call and appointment	1 to 5 days	Within 1 week

their presenting issue and their preference as to the gender of the therapist if they had one. An intake worker then selected a preapproved counselor from the developed roster, contacted the counselor, and sent consents for the client to sign and then had the chosen counselor directly contact the client to arrange the inaugural meeting. The CAP standard of service was that a session would occur within seven days of the initial call. The churches provided complete family member lists to Shalem to allow the intake worker to cross-reference the name of the caller with the provided list prior to authorizing service.

Shalem's executive director developed contracts with six to eight counselors practicing from a Christian standpoint in each area, beginning with local therapists with whom the pastor or church leadership had already developed a relationship through previous EAP work. Christian counseling includes the use of Scripture and prayer as part of the counseling process based upon the needs of each individual client or client system. Each provider needed to have a minimum of a master's degree in a counseling field, belong to a professional association that followed prescribed ethical guidelines, provide evidence of current professional liability insurance, and be able to articulate the integration of their faith with their clinical practice. Each church was provided with a list of Shalem-approved CAP counselors, with descriptions of the areas of specialization for each therapist. Each church also had the ability to reject any proposed counselor (Table 3).

CAP counselors were paid at the high end of EAP rates in Ontario and were expected to keep clinical notes as they normally would in their individual practice. The fee formula was calculated to cover only the fees of the CAP providers as Shalem's intake, and administrative services were provided in-kind during the pilot project as part of the Board of Directors' goals to provide enhanced service to the community. Apart from the providers in-kind contribution CAP was designed to be revenue neutral. At the conclusion of the first year utilization exceeded expectation at more than 16% of the families for both congregations (Table 4). There was some variation in the nature of presenting problems with depression, family issues, and anxiety being more prominent within the urban Hamilton congregation and

TABLE 3 Counselor Attributes

	External Employee Assistance Program Provider	Congregational Assistance Plan
Counselor qualification	Masters level	Masters level
Knowledge of Christian counseling	Needs to be requested by client	Required of all counselors
Membership in professional college	Required	Required
Personal liability insurance	Required	Required

TABLE 4 Program Use by Congregation

	Hamilton	Bowmanville	Scarborough	Newmarket	Willowdale
2006					
Utilization rate	16.7%	17.4%			
# of Sessions	102	112			
Average sessions	5	4			
2007					
Utilization rate	12.5%	15.5%			
# of Sessions	102	123			
Average sessions	4	4			
2008					
Utilization rate	10.7%	11.2%	12.5%	5.0%[a]	6.0%[a]
# of Sessions	59	106	62	71	25
Average sessions	4	4	4	4	3

[a]Household used to calculate utilization rather than family.

marital issues, family issues, and bereavement being more frequently reported within the rural Bowmanville congregation (Figure 1).

At the conclusion of the pilot both churches agreed to continue in the CAP initiative for one additional year. However, because of the unexpectedly greater than anticipated utilization the maximum number of allowed sessions per parishioner per issue was reduced to a maximum of six sessions, with up to an additional six if there was a compelling clinical case to be made. In the second year utilization at the Hamilton church dropped 4% to 12.5%, which was still more than double the initial intended rate whereas at the Bowmanville church utilization remained relatively constant (Table 4). By midway through the second year of the pilot, it was clear to the provider that CAP could be viable. This led to the expansion of the pilot by to an additional three churches in Scarborough, Newmarket, and Willowdale, communities surrounding Ontario's capital city Toronto.

During the second year of the initiative the provider realized that it had made a crucial error in calculating utilization. By using "families" as the foundation of the calculation, Shalem was bypassing "singles" in the congregation, all of whom could access CAP, and some of whom were. Shalem learned that Christian Reformed churches do not include "singles" in their membership calculations, only "families" due to the structure by which individual churches are assessed ministry dues by the denomination. As a result, utilization rates had been skewed high. Further, this formula could not provide a true comparison to EAP utilization rates, which count "households" rather than families, though there remains huge debate within the EAP community of the comparability of utilization rates between organizations (Csiernik, 2002, 2003; Csiernik & Csiernik, 2012). Thus, in mid-2008 a decision was made to use "households" to calculate utilization rates with Newmarket and Willowdale being the first churches to use the new formula. The transition from family to household as the denominator led to utilization rates in the Newmarket and Willowdale

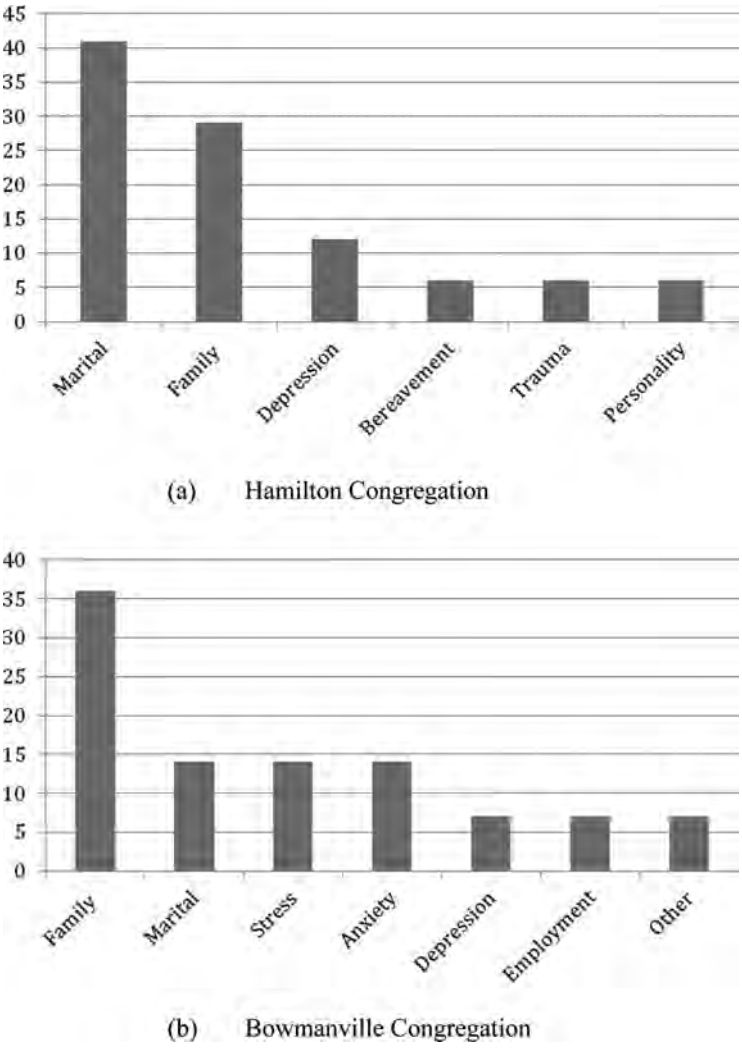

FIGURE 1 Presenting issues. (Color figure available online.)

churches becoming more reflective of conventional EAP utilization rates and more in line that was initially proposed during the pilot project (Table 4).

By the end of 2008 the Shalem Board felt that it had learned enough from the pilot phase to now open up CAP to any interested church. They were confident in the established financing formula and had developed a fee structure that incorporated intake and program management costs that also allowed for the hire of a dedicated program director. Acknowledging the vital importance of the counselors providing direct service Shalem raised the remuneration as part of a new 3-year CAP Strategic Plan. The plan's goal was to have 50 member churches with a CAP by 2013, a number that would make the initiative self-sustaining based upon a utilization rate of 7%. CAP churches presently span southwestern Ontario, from the Chatham area to north of

Belleville in eastern Ontario, and Shalem's list of CAP providers is approximately 80. Table 5 provides a summary of the 2010 program statistics for the 13 churches participating in the CAP at that time.

CONCLUSION

The CAP was literally a leap of faith. It was unknown if in Canada the idea of EAP could translate into a similar idea but with a geographic church congregation as the foundation rather than an employee population. Although some initiatives had been attempted in the United States and though many clergy had long had access to their own EAPs, nothing like this was in existence in the country. Utilization data along with anecdotal comments suggest that CAP is an initiative with potential. To this time every congregation whose Church Council voted to move forward has maintained their program. The attrition rate has been zero with 21 signed contracts through 2012. Although some churches continue to fund CAP through special collections throughout the year, others have made the initiative a regular budget item.

What has been of even greater value to the initiators of the CAP has been the reactions from the pastors. At the Hamilton church that was part of the pilot the minister was surprised by how unconnected he actually was from many of the people in his church accessing CAP. His assumption had been that most CAP users would have engaged him at some level with their issues as this pastor had historically referred many of his parishioners to community-based counseling services as he did not offer counseling himself. He had assumed a greater level of engagement on his part in the emotional struggles of his parishioners than appeared to be the case. The Bowmanville pastor, who had left just prior to CAP beginning, was startled at the high rate

TABLE 5 2010 Congregational Assistance Plan Program Data

Church	Number of user households	Number of files opened	Number of sessions	Utilization rate
Acton	5	5	20	3.6%
Blenheim	4	6	24	5.3%
Bowmanville	15	19	72	7.6%
Cobourg	3	4	17	2.6%
Courtice	17	27	97	11.0%
Frankford	7	9	34	7.7%
Guelph	6	7	34	4.9%
Hamilton	16	25	123	9.0%
Newmarket	3	6	16	3.0%
Oshawa	8	11	66	8.1%
Scarborough	4	6	29	4.4%
Whitby	12	12	67	5.7%
Willowdale	5	7	37	4.6%
Total	105	144	636	

of usage in the church; his belief based upon his insights into his congregation was that CAP would not be utilized adequately and would be a misuse of limited church funds.

An early client at one of the churches told her counselor that she would never have been able to seek out counseling support without CAP. It was specifically the CAP structure that made her involvement possible. She described a highly controlling husband who limited her access to money. As CAP was anonymous and did not require preapproval by the church, she could attend counseling without his knowledge. She was also able to attend because CAP was free and not structured as a copay program. Due to the level of control exercised over her by her husband, even a payment of $5 would have been noted by him, and he would have prohibited her involvement in counseling.

However, as with any good initiative answered questions spawn new unanswered one that require further exploration. To date, all 21 of the CAP churches are from the Christian Reformed denomination. Although there is room for more growth among Christian Reformed churches, if CAP is to reach its goal of becoming self-sustaining, churches from other denominations are required. Concerted promotion efforts are now underway in a variety of denominations. Networking is taking place through the Evangelical Fellowship of Canada and the Canadian Council of Churches. Current plans are to offer small pilots to specific denominations, with a view to have CAP fit the culture and specific realities of particular denominations.

As CAP was premised upon the well-established EAP model including program characteristics, the process of service provision, and counselor attributes, it is not surprising that initial outcomes have looked similar. However, it is Shalem's desire to develop a much more robust evaluation regime for CAP. A research and evaluation Working Group has been formed, and in October 2010, the Working Group jointly presented at the annual conference of the Society for the Scientific Study of Religion in Baltimore, Maryland, about the initial success of CAP but also for the need of more systemic outcome data. Currently the group is formulating research questions to ask about faith communities and mental health services, using CAP as the intervention vehicle.

Finally, a striking finding has been that pastors from CAP churches are not accessing the service themselves, and in fact up until 2012 there is no record of any member of the eligible clergy having used the service. This is despite the fact that a study conducted by the University of Toronto's Centre for Clergy Care of 338 ministers from six Canadian denominations found that the number of pastors diagnosed with clinical depression was twice the national average (Moll & O'Brien, 2009). In 2009, Emerge Ministries Canada approached Shalem with a request to assume its Clergy Care counseling program. Shalem did so at the end of 2009, using specialized therapists from the CAP provider network to provide counseling services targeted to the unique needs of pastors and their families. As this program develops, the

hope is to learn more about the unique mental health needs of pastors and their families while continue to meet the needs of increasing numbers of congregational members from a range of faith groups.

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