Article

Oncology Healthcare Professionals' Awareness and Uptake of the Employee Assistance Programme in Three Public Healthcare Facilities in KwaZulu-Natal, South Africa

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Abstract

Institutional psychosocial support services have gained traction, globally, more so within the context of healthcare facilities. This is mainly due to the recognition that institutional psychosocial support services are beneficial to both employees and employers, alike. However, while these institutional psychosocial support services are important, their uptake remains relatively low. With the focus being on the employee assistance programme (EAP), this study aimed to explore the awareness and uptake of institutional psychosocial support services among oncology healthcare professionals (OHPs) in public healthcare facilities in KwaZulu-Natal (KZN), South Africa. Using the interpretative phenomenological approach, the qualitative study was conducted in three public healthcare facilities that offer oncology services in KZN. Semi-structured in-depth interviews were conducted among 31 participants who were OHPs in the three public healthcare facilities. Thematic data analysis produced two main themes and six respective sub-themes. The main themes were awareness of institutional psychosocial support services and low uptake of institutional psychosocial support services, mainly owing to adequate personal support systems, privacy and confidentiality concerns, and stigma. The study findings point to the need for stronger EAPs that are needs-based, promoted regularly, and evaluated, in public healthcare facilities. To encourage service uptake and address privacy, confidentiality and stigma concerns, innovative and non-stigmatising ways of promoting these services are required, including hybrid

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approaches to the provision of EAP services. The study findings can provide a valuable contribution to the continued development and strengthening of institutional psychosocial support services in public healthcare facilities.

Keywords: employee assistance programme; oncology healthcare professionals; psychosocial support services; awareness; uptake; workplace wellbeing

Introduction

Institutional psychosocial support services, such as the employee assistance programme (EAP), have gradually gained traction, globally, a phenomenon that was brought back into the spotlight by the workplace disruptions caused by the Covid-19 pandemic, especially in the healthcare sector (Long and Cooke 2022). The EAP is an organisation-based programme that is designed to assist employees with work, personal, family and health-related problems (Attridge 2014; Long and Cooke 2022). The Employee Assistance Professionals Association of South Africa (EAPA-SA 2024) describes the EAP as a voluntary intervention programme that is work-based and is offered by employers as an employee benefit. The EAP encompasses a wide range of psychosocial support services aimed at holistically promoting the wellbeing of individuals in the workplace by alleviating existing employee difficulties and mitigating future problems (Long and Cooke 2022). EAPs have proven effective, as they benefit both employees and organisations, alike (Bardoel et al. 2014).

With an EAP coverage of over 97% in large organisations in the United Stares (US), high income countries seem set to optimise the full benefits of this phenomenon (Long and Cooke 2022). EAPs continue to develop in many parts of Europe, Asia and South America with culturally relevant versions of EAP services being developed in over 50 countries, globally (Attridge 2014). The EAP had its origin in the US, where it was first established in 1917 (Long and Cooke 2022). Since then, this concept has evolved from being a compulsory service for the rehabilitation of problematic employees to a more voluntary and holistic private service that forms part of employment benefits (Long and Cooke 2022). EAPs in the South African context are relatively new; however, emerging in the 1980s and developing in the mining sector, they continue to evolve and provide insights to EAP practitioners, social workers and related professionals regarding workplace challenges faced by their South African colleagues (Govender and Vandayar 2018; Maiden 1992). Many industries in South Africa currently have some form of EAP and in 2001, the South African Department of Public Service and Administration mandated all government departments to establish EAPs making them compulsory in the public sector (Govender and Vandayar 2018).

Programmes, such as the EAP, are vital in the healthcare profession, more so in the field of oncology, where conditions such as compassion fatigue, burnout and trauma are pervasive (Hamilton, Tran and Jamieson 2016; Hlubocky, Rose and Epstein 2017; Medland, Howard-Ruben and Whitaker 2004). EAPs provide supportive platforms for addressing the psychosocial wellbeing of healthcare professionals through enabling

them to communicate their feelings freely in safe spaces (Granek et al. 2012; Lyckholm 2001). In a study conducted by Granek et al. (2012) among oncology healthcare professionals (OHPs) in Canada, oncologists recognised the value institutional psychosocial support had in their lives. The current study is testament to the value that institutional psychosocial support services, such as the EAP, have on the wellbeing of healthcare professionals.

Although the provision of professional psychosocial support services in the workplace has a special place among healthcare professionals, these services are largely underutilised, globally (Granek et al. 2012; 2013). Accordingly, many healthcare professionals consider it unprofessional and a sign of weakness to grieve over patient loss and thus, they rarely seek psychosocial support to deal with this grief in their professional settings (Granek et al. 2012; 2013). Other factors likely to deter healthcare professionals from the service uptake may include the stigma attached to seeking professional help in the workplace, and a general fear of privacy and confidentiality being breached (Granek et al. 2012; Kerasidou and Horn 2016; Medland, Howard-Ruben and Whitaker 2004; Sefotho and Seema 2020; Wallace 2012).

Therefore, the current study aimed to explore the OHPs' awareness and uptake of the EAP to elicit context-specific insight of the psychosocial support services in public healthcare facilities in KwaZulu-Natal (KZN), South Africa. The following section presents a detailed description of the methods followed in conducting the study. The subsequent sections present the main findings of the study, and a critical discussion thereof which embed recommendations for the strengthening of EAPs, study limitations and recommendations for future research relative to the study topic. The last section is a conclusion highlighting the main findings, discussion, and implications of the study within the context of public healthcare facilities in KZN, South Africa.

Methodology

Study Design

This was a qualitative study rooted in the interpretive phenomenology research design which explored OHPs' awareness and uptake of EAP services (Thanh and Thanh 2015; Tracy 2019; Tuohy et al. 2012). The interpretivist paradigm was appropriate due to its ability to allow for the exploration and interpretation of the subjective perspectives of OHPs regarding their awareness and uptake of EAP services (Thanh and Thanh 2015).

Study Setting

The study was conducted in the three major public healthcare facilities that offer full oncology services in KZN. The three healthcare facilities will be referred to as Facility 1, Facility 2 and Facility 3. These healthcare facilities are located in Durban (Facility 1 and Facility 2) and Pietermaritzburg (Facility 3), respectively, which are the two largest cities in KZN. The three healthcare facilities are operated by the KZN Department of Health and they offer a variety of specialist services including full oncology services in

the province (KZN 2024a; 2024b; 2024c). Table 1 shows the approximate staff complement in each healthcare facility at the time of the study:

Table 1: Approximate staff complement in each healthcare

Facility	Number of staff members
Facility 1	2 200 staff members
Facility 2	2 500 staff members
Facility 3	2 100 staff members

All three public healthcare facilities have EAP services with inhouse employee assistance practitioners.

Study Population, Sampling Approach and Sample Size

The study population consisted of healthcare professionals from different cadres of healthcare that care for patients with cancer, otherwise referred to as OHPs in the context of the study. These OHPs included oncologists, oncology nurses, radiographers, radiation therapists, medical officers and other healthcare professionals who regularly work with patients living with cancer. The participants were purposively sampled based on the set eligibility criteria and objective of the current study (Etikan, Musa and Alkassim 2016). The set eligibility criteria included the provision of oncology services to cancer patients in the participating public healthcare facilities for more than a year at the time of data collection. Thirty-one in-depth interviews were conducted at which point data saturation was reached bringing the total sample size to 31 participants.

Data Collection

Upon obtaining ethical approval for the study from the relevant ethics bodies and site permission from the three healthcare facilities, data collection began with assistance from the oncology heads of department in each healthcare facility. The heads of department played a vital role in assisting with access to all potential study participants.

Access to potential participants was sought through consultation with the heads of the oncology departments in the three healthcare facilities. The lead researcher was invited to the pre-shift meetings in the oncology departments where a summary of the study was orally presented to the potential participants and an opportunity for questions was provided. At the end of each meeting and after questions and clarities were provided, interested OHPs shared their contact details with the lead researcher and were contacted to schedule a suitable interview date. Interviews were conducted both physically (in-person in a private room at the respective healthcare facilities) and virtually (telephonically and via the zoom platform). The physical and virtual combination of data collection was due to the participants' demanding schedules. While some OHPs could commit to physical interviews during work hours, others opted to be interviewed after work, thereby necessitating virtual interviews.

A semi-structured interview guide was used in each interview with further probing based on participant responses (Jamshed 2014). The lead researcher, being bilingual, prepared the interview guide in both the English and IsiZulu languages, which are the two dominant languages spoken in KZN. The interview questions centred around the awareness and uptake of psychosocial support services offered at the participating healthcare facilities, with a specific reference to the EAP. The interviews were audio recorded (with the participants' permission), and only one participant requested to have an unrecorded interview, thereby necessitating hand-written field interview notes. The respondents were labelled R1 to R31.

Data Analysis

All the recorded interviews were transcribed verbatim by an experienced transcriber and the interviews that were conducted in IsiZulu were translated into English and quality checked by the lead researcher. The transcripts were then uploaded to the NVIVO 12 software (Phillips and Lu 2018). The data was coded and organised into deductive themes based on the interview guide (Fereday and Muir-Cochrane 2006). The full analysis was conducted by the lead researcher under the supervision of the senior co-authors, who are experienced in qualitative research. Constant consultation with the co-authors and research peers was an essential part of researcher reflexivity which was maintained throughout the research process.

Ethical Considerations

The study obtained ethics approval (BREC/00002515/2021) and gatekeeper permission (KZ_202103_028) from the University of KwaZulu-Natal Biomedical Research Ethics Committee and the KZN Department of Health, respectively. All participants provided signed informed consent forms prior to participating in the study. The names of the participating healthcare facilities were omitted to strengthen participant anonymity. This is due to the smaller number of participants from two healthcare facilities which may lead to easy participant identification by facility through demographic characteristics.

Findings

Table 2: Oncology healthcare professionals' demographic characteristics

Respondent no.	Gender	Age range	Occupation	Experience (Years)	Facility
R1	F	30–39	Medical Officer	1–5	Facility 2
R2	F	40–49	Nurse	16–20	Facility 2
R3	F	50–59	Nurse	11–15	Facility 2
R4	F	40–49	Oncologist	11–15	Facility 1 and Facility 2

R5	F	50–59	Nurse	6–10	Facility 2
R6	F	40–49	Nurse	16–20	Facility 2
R7	F	30–39	Oncologist	1–5	Facility 2
R8	F	40–49	Radiographer	21–25	Facility 3
R9	M	30–39	Radiographer	11–15	Facility 3
R10	F	30–39	Radiographer	16–20	Facility 3
R11	M	Under 30	Radiotherapist	6–10	Facility 3
R12	F	Under 30	Radiographer	6–10	Facility 3
R13	F	Over 60	Nurse	Over 30	Facility 1
R14	F	40–49	Nurse	11–15	Facility 1
R15	F	50–59	Nurse	21–25	Facility 1
R16	M	40–49	Nurse	11–15	Facility 3
R17	F	Under 30	Nurse	1–5	Facility 3
R18	F	30–39	Radiotherapist	16–20	Facility 1
R19	F	30–39	Radiotherapist	11–15	Facility 1 and Facility 2
R20	M	30–39	Radiotherapist	6–10	Facility 1 and Facility 2
R21	F	50–59	Medical Officer	6–10	Facility 3
R22	F	30–39	Speech Therapist	11–15	Facility 3
R23	M	40–49	Oncologist	11–15	Facility 3
R24	F	30–39	Physiotherapist	11–15	Facility 3
R25	F	30–39	Nurse	1–5	Facility 1
R26	M	40–49	Medical Officer	1–5	Facility 3
R27	F	30–39	Registrar	6–10	Facility 3
R28	F	30–39	Medical Officer	6–10	Facility 1 and Facility 2
R29	F	50–59	Oncologist	21–25	Facility 2
R30	M	30–39	Medical Officer	1–5	Facility 3
R31	F	40–49	Medical Officer	6–10	Facility 3

There was 31 participants (24 females and 7 males) in total, consisting of medical officers (*n* = 6), nurses (*n* = 10), oncologists (*n* = 4), radiographers (*n* = 4), radiotherapists (*n* = 4), a speech therapist (*n* = 1), a physiotherapist (*n* = 1), and a registrar (*n* = 1), with ages ranging from 26 to 60 years (see table 1). The participants' years of experience in occupation ranged from two to 33 years with the majority spread between the 6–10 (*n* = 8) and 11–15 (*n* = 9) years of experience categories. Four participants worked at both Facility 1 and Facility 2, while the majority (*n* = 15) of the participants were from Facility 3.

Themes

Two main themes and six sub-themes were deductively produced by data analysis. These themes were: (a) awareness of institutional psychosocial support services (*general psychosocial services*; and *employee assistance programme*); and (b) low uptake of institutional psychosocial support services (*personal support system and coping*; *fear of confidentiality breach, judgement and stigma*; *time constraints*; and *perceived importance and benefits of EAP services*).

Awareness of Institutional Psychosocial Support Services

General Psychosocial Services

The participants were asked about their knowledge of any psychosocial services that are offered to healthcare professionals at their institutions. The majority (*n* = 19) of the participants were aware of at least one psychosocial service offered in their workplace, with mention of the wellness programme or specific elements of it such as leisure time and the EAP:

> Yes, it's [psychosocial services] part of the wellness programme, so they [Wellness programme personnel] conduct programmes, like they have Zumba classes once a week or they give you permission to go run like in school grounds, we have a small-time gym in physiotherapy you can go and exercise there if you want. (R16)

> So, there is leisure time where we are given like an hour or so, we just get out of the department and just de-stress in terms of maybe exercise or just taking a walk outside for fresh air, things like that, and there is a person as well that we are allowed to use for . . . I can't get his name right now, but there is a specific term they use for him. (R17)

> Okay, so [Facility 3] has the Employee Assistance Programme, which has become . . . which was always there, but it's become very prominent due to the COVID 19 pandemic that has a whole lot of services available. (R30)

Of the 19 participants aware of the available psychosocial services in their institutions, eight were uncertain about what these services were called or how they worked. Many participants had heard of the services but had never utilised them and thus, were unsure of specific details:

> I'm not too familiar and I'm not going to lie to you, I'm not too familiar with the policy regarding it, but I know of it, and I have heard of it, I have not been partaking in it. (R17)

> Yeah, no, I believe there is [psychosocial support]. There is an avenue I've forgotten what it's called. But I think you can go and speak to someone; you can see a psychologist. (R24)

> There is the EAP – actually I'm embarrassed to say I don't know a lot about it because I haven't ever really used it. (R22)

Employee Assistance Programme

The EAP was the most mentioned psychosocial service, but about half (16 out of 31) of the participants were not sure of the EAP details, despite having heard about it:

> There is the EAP and it is stated that if you are feeling overwhelmed and there are things that have not sat well with you, and you can see that you are not coping you should go to EAP. (R3)

> We have the EAP, yes, they are practitioners that if you are not coping, they take you there. (R20)

> The EAP is there for everyone at the hospital and not just for oncology. So that's why I think I'm not familiar with how it works. (R2)

Although the majority of the participants were aware of the psychosocial services available to them at their institutions, 12 had no knowledge of any psychosocial services available to them at their workplace. They were not aware of any general psychosocial services, nor did they know about the existence of the EAP specific to their institutions. The participants who had no knowledge about the existence of psychosocial services spread across varying years of experience and professional training (1–25 years):

> Nothing that I'm aware of, no, no there's nothing for healthcare workers no. (R1)

> No ways, no, I have never heard of any [psychosocial services for staff]. (R12)

> No. I've actually asked my Medical Officers, I said to them, if you are stressed, is there anything provided at the hospital? And they've said to me no, which was one of the reasons that I wanted to start some sort of debriefing programme. (R29)

Some of the participants knew of psychosocial services such as EAPs through avenues outside of their workplaces:

> No. Here [current workplace] no, but in the previous place there was [psychosocial services], even then I only heard of it [psychosocial services] because my colleague had an issue that was threatening his or her employment because of not coping at work. (R10)

> I know about the Employee Assistance Programme from the diploma that I did for Occupational Health, but when it comes to healthcare workers, I haven't heard of Employee Assistant Programme, No. EAP, no. Not for healthcare providers. Specially not here, if there is, I haven't heard about it. (R26)

Low Uptake of Institutional Psychosocial Support Services

Personal Support System and Coping

In exploration of the uptake of the available psychosocial services in the three healthcare facilities and specifically the EAP, the participants were asked about their use of EAP services in their respective institutions. Those who were not aware of the available EAP services in their institutions were asked if they would utilise the services had they known about them. Twenty-one participants reported to have not and/or would not utilise the EAP services offered in their workplaces. The following statements arose: "Uhm, I don't think so" (R1); "I would not utilise them" (R10); "I never used it in all the years of my work" (R13); "personally I don't see a need of going to the EAP" (R15); "I don't use it" (R20); and "Probably not, no" (R24).

Reported own support systems and coping mechanisms were the overarching reasons for non-use of workplace EAP services:

> I think for me personally because I have quite a well-structured support system. I don't think I would need to use it. (R29)

> I seem to have my own ways of coping. I feel it's sufficient. Unless I feel that is not working for me maybe I would then consider it, but for now I'm good. (R17)

> Like I said before that, I now know how to block it [work related emotional stress], I have come to that point in these so many years, it doesn't affect me emotionally and mentally anymore. (R18)

> I think so far, I've been able to manage my stress levels and emotional and mental challenges adequately on my own. So far, I haven't had a need to [utilise EAP services]. (R4)

> No. Now I am old, I can cope without those services [EAP services]. (R3)

Fear of Confidentiality Breach, Judgement and Stigma

Other main reasons for not utilising the EAP were confidentiality and privacy concerns, while others had a fear of judgement in the workplace:

> Because of fear of confidentiality being breached, fear of being judged, and having my private things become public knowledge. There are things that are very personal that you do not want your employer to know. I have not seen it here, but I have seen somewhere else where a person's private things that were said in confidentiality became public knowledge. So, I can say they don't give you the confidence to confide in them.

> I am not sure if I would use the services but rather would use someone private who is outside the hospital. (R10)

> You know the branding [stigma] of going to a psychologist and all that can mean something is going on with my mind, you know that kind of a thing. (R14)

> I don't use it because I avoid that it might be viewed as if I am not coping with work, and you get that look that this one is not doing well because they will be like now, he is going to the psychologist, he is not well [Stigma]. (R20)

> I haven't felt I've had to rely on those [EAP services] and I think I'd like to sort of keep my emotions private from work. I don't like other people knowing what I'm thinking or whatever. (R22)

Time Constraints

There was a lone voice reporting time constraints as a factor for non-utilisation of EAP services. The participant reported that the demanding work environment makes it difficult to take some time to utilise such services. The participant also expressed that they would not fully focus on the service at hand due to the worry about the patients and the work that awaits them:

> I don't have the time. By the time you think of utilising all these good, good services, but then you go back and you think of the patients that are waiting for you, the work that you need to do, you just don't have the time. Because taking that maybe half an hour or 45 minutes or an hour just to debrief, my mind will not focus on that session, my mind will still think that shucks, I've got 15 patients or 10 patients waiting for me, maybe my colleague is not there, or maybe we are short staffed. So, my mind definitely, I will not focus at all and then it won't be beneficial. So, it strictly has to do with time, it's just not enough time. (R28)

Perceived Importance and Benefits of EAP Services

Only 10 participants reported to be utilising or would utilise the EAP services if they knew about them. The following statements arose: "I do utilise them" (R16); "I think I would utilise them" (R11); "Yes, I would" (R7); "Yeah. Who doesn't want that?" (R31); and "Definitely, I would use them if I knew about them" (R27).

Other participants expressed the importance and usefulness of such services in the workplace:

> Sometimes when you become overwhelmed or over stressed with your daily managerial duties, I do utilise them. I have visited them on numerous occasions because I was faced with different challenges. (R16)

> I used to [utilise EAP services], before when I was still new to the oncology department because it was a struggle. To me, though it was personal because I had had many

> miscarriages, I had gone to work in the neonatal ICU, seeing babies sick and die. I couldn't sleep at night; I would see these babies when I would try and sleep. So, I went to EAP, and they recommended that I be taken out of that department. (R3)

Two participants acknowledged the need for and importance of these services for the benefit of others, and not for themselves:

> For myself personally at this time I don't think so, if it's for another staff member or junior staff member that I know they are struggling or an incident happened, I would definitely refer them. (R18)

> I don't think I would need to use it, but I'm aware of some doctors who would benefit from that. (R29)

Discussion

The study findings have shown limited awareness and appreciation of institutional psychosocial services. This then translates to poor utilisation of institutional psychosocial support services as the main study findings also highlighted a low uptake of these services, despite the participants' knowledge of their existence in the healthcare facilities (Granek et al. 2012; 2013). Sixteen OHPs were specifically aware of the EAP, but admitted to not having utilised its services, while some also acknowledged the need for and benefits of the EAP (Berry, Mirabito and Baun 2020; Hlubocky, Rose and Epstein 2017; Medland, Howard-Ruben and Whitaker 2004). This indicates that EAPs may improve by adopting a needs-based approach to contextualise the provision of EAP services based on employee and employer needs (Wu et al. 2021). Thus, regular needs assessments, such as wellbeing questionnaires and EAP services evaluations, may provide useful insights into strengthening EAPs (Csiernik, Cavell and Csiernik 2021; Wu et al. 2021). Wu et al. (2021) state that a strong EAP is one that encourages utilisation, one that employees are aware of and can access its services (Wu et al. 2021). As seen in the current study, some OHPs were not aware of the institutional support services available to them, and those who were aware of them, lacked operational understanding of the services. This highlights the need for stronger institutional engagement with employee wellness policies and services to improve their awareness.

The study also found through the participants' self-reporting that adequate personal support systems and coping mechanisms were key positive factors contributing to the low uptake of EAP services. These ranged from having well-structured support systems, such as family and personal coping mechanisms, including good stress management abilities. These findings are congruent with those of Granek et al. (2013) who found that oncologists deal with grief over patient loss by using personal and private coping mechanisms. The study findings revealed that there were negative factors that also contributed to the low uptake of EAP services, and these included fears of confidentiality breach, judgement and stigma, as well as time constraints. These

negative factors have been found in other studies on the utilisation of workplace support (Guille et al. 2010; Kerasidou and Horn 2016).

Barriers to the utilisation of institutional psychosocial services have mainly been due to the stigma attached to seeking professional help in the workplace and confidentiality concerns (Sefotho and Seema 2020; Wallace 2012). These barriers could potentially be overcome through the adoption of hybrid EAP models, for example, collaboration with external service providers that offer wellness services, and regular promotion of services with an emphasis on confidentiality policy statements (SAACI 2023). Collaboration with external enterprises in the provision of institutional psychosocial support services would serve as a facilitator to their uptake, owing to their independent, private and flexible operations (ICAS 2023; SAACI 2023).

The oncology profession generally operates within a high-pressured work environment with heavy workloads (Medisauskaite and Kamau 2017). As such, the study found that another barrier to the utilisation of workplace support was the lack of time, resulting in OHPs being unable to prioritise themselves. This factor was, however, raised by only one participant whose occupational demand may have already been exacerbated by concurrently working at two healthcare facilities. It is a considerable factor that speaks to high workloads and time constraints as a barrier to the utilisation of institutional psychosocial support services which can be remedied through flexible access hours and provision of virtual services (ICAS 2023). Despite the time factor being raised by only one participant in the current study, this factor is well documented in other studies, especially those conducted by Guille et al. (2010) and Hu et al. (2012).

EAP services were generally well perceived by OHPs in the study, but this positive perception did not translate into usage, since fewer OHPs reported to have used these services. While the helpfulness of the EAP services was never in question, some participants saw these services as good for others, as they believed that they had adequate personal support systems (Granek et al. 2013). This may be attributed to their levels of resilience as the participants who reported adequate personal support systems and coping were older OHPs with longer work experience in oncology. Furthermore, a study by Bozdağ and Ergün (2021) found higher levels of psychological resilience among older healthcare professionals. This suggests that resilience levels increase with age and experience; therefore, as healthcare professionals gain more experience in the workplace, they become more skilled at dealing with the negative aspects of their work environment (Bozdağ and Ergün 2021). With resilience well associated with indicators of psychological wellbeing and attributed to physical and mental health, OHPs may benefit from EAP services that focus on improving these factors to ultimately develop and strengthen resilience among workers of all ages and levels of experience in the profession (Eicher et al. 2015).

While the personal support systems were not interrogated in the study, the participants' lack of desire to utilise the institutional psychosocial support services while seeing them

as best for others, can be best understood through the theory of othering (Roberts and Schiavenato 2017). As part of the helping profession, OHPs may not be accustomed to receiving help, but in contrast, see themselves as providers of help, hence they view EAP services as good for others. In this context, the concept of benevolent othering can particularly be used to understand this notion as it places emphasis on reinforced feelings of superiority and viewing others as vulnerable and in need of support (Akbulut and Razum 2022; Carroll 2016; Grey 2016; Johnson et al. 2004).

Healthcare professionals being in the superior position to provide that support then translates to benevolent othering, being the giver of support in the form of healthcare, and not the recipients of psychosocial support in this context (Akbulut and Razum 2022; Carroll 2016). This form of othering further reinforces the existing stigma attached to seeking psychosocial support among healthcare professionals as it perpetuates the notion of psychosocial support being for the weak and vulnerable (Akbulut and Razum 2022; Granek et al. 2012; 2013; Grey 2016. This then acts as another barrier to the utilisation of institutional psychosocial support services which may be used in understanding the low uptake of EAP services found in the study.

Greater investment is required to advocate for, promote and destigmatise EAP services, especially for caring professions and particularly OHPs (Naidoo and Jano 2003). While the study provides important insights that can be used in the design of responsive interventions to help promote the uptake of EAP services, there is a need for a larger study that draws from both qualitative and quantitative methodologies. Thus, the study may have further contributed additional insights to the body of knowledge by exploring the general utilisation rate of EAP services in public healthcare facilities and by further exploring participants' perspectives on the barriers and facilitators to EAP service uptake, phenomena that may be explored in future research. Furthermore, research that focuses on the perspectives of the employee assistance practitioners may also provide deeper insights regarding this subject matter.

Conclusion

The current study has highlighted the limited awareness of institutional psychosocial services among OHPs. The uptake of these services, specifically those of the EAP, was found to be low with the participants' limited awareness being a contributing factor. The low uptake of EAP services was mainly due to positive factors such as adequate personal support systems and coping abilities, and negative factors such as privacy and confidentiality concerns. Thus, the study makes a case for the strengthening of EAP services in public healthcare facilities through innovative and consistent promotion, needs assessments, and evaluation of EAP services. A hybrid approach to EAPs may potentially aid in addressing perceived privacy and confidentiality risks, and the provision of needs-based EAP services may encourage utilisation.

While the study found a low uptake of EAP services among OHPs in public healthcare facilities, the study is also testament to the necessity of EAPs and, more importantly,

the need for strengthened EAP services in public healthcare facilities. Strong and effective EAPs may not only benefit the healthcare professionals and healthcare institutions, but they may also benefit the patients through improved patient care in public healthcare facilities. Evidence from the study findings can contribute greatly to efforts pertaining to the continued development of institutional psychosocial support services and more so, efforts to strengthen EAPs in public healthcare facilities.

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