Employee Assistance Program Staffing Past, Present and Future

Paul A. Kurzman, PhD
Professor and Chair of the World of Work Program
Hunter College of the City University
New York, New York

Published in *Employee Assistance Quarterly* (1992), volume 8(2), pp. 79-88

Employee Assistance Program Staffing Past, Present and Future

PAST

Employee Assistance Programs (EAPs) emerged almost twenty years ago from Occupational Alcoholism Programs (OAPs). Stimulated by passage of the Hughes Act and its formation of a National Institute on Alcoholism and Alcohol Abuse (NIAAA), with an Occupational Program Branch, the OAP was the forerunner of the modern EAP.

Staffing preferences for EAPs usually reflect program function and performance expectations. Initially, OAPs were designed to permit the work organization to identify its alcoholic employees. Supervisors and foremen were trained in appropriate techniques for placing alcoholic workers in job jeopardy, followed by the offer to comply with a mandatory supervisory referral to the OAP, as an alternative to being fired from their job. Staff of the OAP generally were company employees who usually themselves were recovering alcoholics, had maintained a considerable period of sobriety, and knew the employment setting well. They were responsible for confirming the alcoholism assessment and then confronting these employees with the alternative of losing their job, or, accepting referral to a detoxification program followed by a period of rehabilitation and supervised aftercare.

When the early OAP programs found themselves dealing with a rapidly increasing number of clients with non-alcohol related personal and emotional problems, staff found that their skills were becoming marginal to the work organization's performance expectations. Most OAP staff had no mental health training or formal education at a professional level. Hence, the movement from OAP to EAP made the continuing use of able, but indigenous recovering personnel, somewhat problematical. Since staffing decisions generally mirror the nature of the function to be performed, use of line staff and recovering personnel had to be supplemented with the presence of trained health and mental health experts, initially as part-time staff or as consultants. During the late 1970s and early 1980s, the evolution of these new employee assistance units

toward a "broad-brush" EAP model made professional participation a necessity in both labor and management settings.

More recently, both internal (in-house) and external (contract- for-service) EAPs have come to realize that alcoholism is not the only problem in the workplace. Indeed, statistics today show that it is not even the dominant problem at the worksite. Stress, handicaps, work-family dilemmas, developmental disabilities, child and elder care, mental illness and the addictions (broadly defined) would appear to be the principal issues to which EAPs must respond. Such presenting problems require EAP staff to be able to make complex differential diagnoses and be trained in making sophisticated organizational and clinical assessments. Waiting for workers (and their performance) to deteriorate so badly that they are in job jeopardy has become a costly model of intervention-even with alcoholics-in an era where health and mental health care cost containment has grown to become a serious management issue. As a result, broad-brush EAPs began during the late 1980s to move toward a "comprehensive services" EAP model, with organizational sanction to assume a larger function, embracing all of the presenting problems noted above. A change in staff requirements and expectations has followed from this expansion of function.

As industrial EAPs evolved toward becoming an organizational norm rather than exception, the field became an attractive arena to capture. Hospitals, family service agencies and community mental health centers began to offer their established expertise and settings to employers on a contract-for-service basis. The availability of a range of professionals in nursing, medicine, social work, and drug and alcohol rehabilitation, (and back-up facilities in which in and out-patient services could be provided), created a competitive alternative to the limited internal programs available to management in communities across the country. Private, proprietary EAP consultant firms began to be formed as well to capture the market with comprehensive and cost-effective alternatives to existing internal programs, whose staff often were limited in their range, resources and education. The pressure was on staff of in-house programs to offer an equivalent scope of service and professional expertise when employers chose to start or to expand "broad-brush" programs. If existing program managers could not, their EAP could be displaced by a

contract with an external provider able to offer a more comprehensive and sophisticated EAP package, at no incremental cost.

Finally, the move away from middle-stage alcohol abusers as the principal (indeed often only) focus, to a model that could respond to all clients and a wide range of contemporary personal problems, led to a focus on the need for earlier intervention, and prevention. Employers began to see their health care expenditures rise several times the rate of inflation. (Indeed, health care is costing America over $1 billion a day, more than the cost of national defense.) Primary prevention is much more cost effective than tertiary intervention and treatment. Human resource managers responsible for making EAP design and staffing decisions came to understand that if employers were to avoid the problem of rising health care costs they would have to re-evaluate the "waiting for the troubled worker" approach inherent in the old job jeopardy, supervisory referral model. A proactive, preventive, problem-solving model came to be recognized as the pragmatic answer. Hence, staff today are expected to have the clinical and organizational education requisite to promote and provide this more sophisticated and comprehensive model of service.

PRESENT

The answer, whenever possible, has been to form an interdisciplinary EAP staff team with a licensed health or mental health professional at the helm. While graduate trained, licensed social workers would appear to be emerging as the principal preference for EAP program directors in the country today, other master's level practitioners frequently are considered, including psychiatric nurses, who have graduate mental health training. Staff members usually include credentialed alcoholism counselors, and other experts on drugs and addictions, who are often persons in recovery. Staff with master's degrees in occupational counselling, counselling psychology, substance abuse counselling and vocational rehabilitation also are seen as bringing valuable EAP knowledge and skill.

These interdisciplinary EAP programs generally report to a larger unit of the employing organization that has a human services function. Typically, this will be a company medical

department, personnel department or human services division. While maintaining program and fiscal accountability, EAP managers are expected to be highly self-directed and to operate with the latitude generally accorded a professional function. To outline the background and qualifications of those who typically serve today as members of a comprehensive services EAP team, the following summary is presented:

Physicians = Licensed medical practitioners, usually with a specialization in internal medicine or psychiatry. They more often serve as the head of the unit to which the EAP manager reports than be immediately responsible for the EAP's daily functions. They are always needed as consultants to EAPs when there are questions of possible organic disorders; for short-term hospital admission of clients with serious disorders; and, to make assessments for clients who may need medication. Graduate degree = MD or DO.

Psychologists = Licensed clinical and industrial psychologists are occasionally seen directing EAPs, although less frequently today than when the movement began. They bring clinical and organizational expertise, and generally hold a masters or doctoral degree. Graduate degree = PhD or MA.

Social Workers = Licensed Certified Social Workers most frequently serve today as managers and senior staff of comprehensive programs. They have both clinical and organizational training (for work with individuals, groups and management teams) and hold at least a two-year professional master’s degree. Graduate degree = MSW or DSW.

Psychiatric Nurses = Licensed as Registered Nurses, they also have pursued graduate level psychiatric training. As EAPs have taken on a greater commitment to health education, wellness and prevention, their role is seen as increasingly important in a mature EAP program. Graduate degree = MSN.

Professional Counsellors = Professionally trained but usually not licensed, these counsellors have one or two year graduate degrees and bring specific expertise in areas such as rehabilitation,

stress management, family counselling, AIDS education and the addictions. They not only serve clients individually, but often in group modality programs. Graduate degree = MA or MS.

Business Administrators = Professionally trained in master's degree programs, they bring business and fiscal management skill that often is useful in mapping strategies for health care cost containment and managed care programs. Frequently, a larger EAP will have such expertise available through a part-time or consultant arrangement. Graduate degree = MBA.

Personnel Administrators = Professionally prepared in graduate personnel and public administration programs, they bring expertise in personnel management systems and procedures. Those trained in public administration programs have knowledge that is particularly useful in federal, state, county and municipal EAPs. Graduate degree = MPA or MS.

Public Health Administrators = Concerned particularly with large, organization-wide epidemiological issues, they hold one year master's degrees in public health prevention and program planning. They are skilled at problem analysis on issues such as AIDS outreach, workplace health and safety, and stress management. They often also hold joint degrees in social work or public administration. Graduate degree = MPH.

Credentialed Alcoholism Counsellors = While there generally are no formal university educational standards, CACs usually hold certification from a state alcoholism or substance abuse unit after passing a written and/or oral exam. They have specific experience working in alcohol rehabilitation and treatment settings; and, often the benefit of the experience of their own recovery, and membership in the self-help fellowships that promote abstinence for the client and family.

In 1987, the Association of Labor-Management Administrators and Consultants on Alcoholism (ALMACA)-since renamed the Employee Assistance Professionals Association-in response to a challenge from the Employee Assistance Society of North America (EASNA), set up an Employee Assistance Certification Commission to establish standards for receiving designation as a Certified Employee Assistance Professional (CEAP). While there was a generous grand-

parenting provision for existing EAP practitioners, those new to the field are required to have three years of EAP experience and pass a written examination covering six content areas: human resources development, EAP policy and administration, direct services, work organizations, chemical dependency and addictions, and psychological problems. The goal of the CEAP designation was to assist employers, labor unions, health-care providers, educators, other practitioners and the public in identifying the qualified employee assistance professional, and to protect occupational alcoholism professionals already in the field.

While many felt that it was a helpful designation, and a sign of the further maturation of the field, others felt that use of the term "professional" in the designation might be open to debate. The classic hallmarks of professional status in the Western world-successful completion of a uniform and nationally accredited university course of professional study, and, a minimum standard of education (usually at the graduate level)-are not requirements for the award of the CEAP credential. One need not even be a high school graduate to become a CEAP. There is no nationally accredited curriculum a CEAP must pursue in order to qualify for the award of "professional" status. As in the early days of the professions, where an individual might "read for the law" in a law office, or apprentice to a practicing physician, it is EAPA's wish that EAP practitioners be professionally recognized on the basis of their experience and the test of their trade association. While useful in creating a performance-specific identity for EAP practitioners, and an alternative route for recognition, there is some question as to whether labor and management will recognize a credential not based on uniform standards of training, university education and state licensure.

Statistics show that professional social workers, holding graduate (MSW and/or DSW) degrees and eligibility for state licensure are becoming the predominant EAP providers in this country. Their training in both the clinical and organization dimensions of practice; education in independently accredited, graduate degree programs; and, full qualification (like nurses, pharmacists and physicians) for certification or licensure in all fifty states, has helped to position them to assume this leadership function.

There are two weaknesses in the training of many social work practitioners, however, which are similar to the limits in preparation of other health and mental health practitioners, including psychologists, psychiatric nurses and physicians. First, there often is a paucity of exposure in their graduate education and internship to work issues and settings; second, a lack of curriculum depth in the areas of alcohol, drugs and the addictions. While some graduate schools of social work have taken progressive steps to rectify past limitations in these two arenas, the response has not been uniform among all programs. However, social workers today holding graduate degrees with a specialization in "Industrial/Occupational Social Work" practice will have preparation that includes these two important EAP arenas.

FUTURE

Employee assistance program staffing for the Year 2000 presents a clear trend, already supported by national statistics. EAP programs will increasingly be professionally directed, prevention (as well as assessment- and intervention-centered), and comprehensively focused. Staff will represent a broad spectrum of disciplines. There are practical reasons for these trends.

First, as workers and their families present more complex and more severe problems, use of organizationally savvy but untrained personnel has become less realistic. In addition, licensed health and mental health professionals (MSWs, PhDs, RNs and MDs) offer labor and management advantages that are increasingly evident and hard to ignore: privileged communication (i.e., legally recognized confidentiality for their workers); status acceptance and recognition in the broader community; specific education in taking responsibility for the substantial human and fiscal resources being placed under their command; more extensive education and preparation for practice in a comprehensive services setting; and, greater protection for the work organization from external liability and litigation (in the eyes of insurance companies and the courts) in the event of malpractice litigation.

As data have begun to show convincingly that alcohol is not necessarily the sole or even dominant problem of the modern workplace, the role of recovering alcoholics (who often are Certified Alcoholism Counselors) has changed to become one of EAP team member, rather than team leader. As the presenting problems have become more complex, recovering personnel and

those with a primarily business background often may not be able to make the rather intricate differential assessments required today. They also generally are not qualified to take responsibility for the professionally trained and licensed health and mental health team that is expected to perform triage and gatekeeping diagnostic functions in a modern, comprehensive services employee assistance program.

Employers across the country are reporting that the cost of employee fringe benefits, in general, and the cost of health and mental health care, in specific, is rising rapidly, and often out of control. Surveys, however, are showing that companies with comprehensive EAPs-that include attention to health education, wellness and fitness-are spending about $500 less per employee in the annual cost of health care. Hence, employer motivation to pursue the comprehensive model is often pure dollars and cents pragmatism. Through either in-house or external-contract arrangements, the comprehensive interdisciplinary model is seen as the most cost-effective, organizationally protective and flexible EAP design. This interdisciplinary model, while serving employers' needs and expectations, has the important serendipitous advantage of providing "a place in the sun" for most EAP providers who are past or present participants. As long as chemical dependence is prevalent, there will be a need for CACs (providing they are prepared to provide expertise beyond alcohol alone-to include drugs as well). Primary prevention, with its potential for a real and measurable reduction in future health and mental health fringe benefit expenditure, will call upon nurses and public health education professionals as important participants. Organizational development, human resources linkage and benefit systems management functions will ensure a staff (or consultative) role for MAs, MPAs and MBAs in these programs. The centrality of personal, social, emotional and mental health problems will call for the training that psychiatrists, psychologists and social workers provide. Indeed, some of the combined professional degrees, which several universities now provide (MSW-MPH, MA-MPA, MSN-CAC, MSW-MBA) may provide ideal preparation. The CEAP designation might become a welcome additional identification of staff with program experience, familiarity with chemical dependence, and with workplace settings.

External contract providers who are capable of providing a team with such inter-professional expertise may present the most competitive staff arrangement; and internal in-house programs

that offer a part-time, full-time, and consultation team (with combined knowledge, skills and values) will provide employers with the most attractive program potential. In this spirit, the professionally directed, cost-conscious, systems sensitive, comprehensively focused, prevention oriented, interdisciplinary centered model would appear to be a strong and pragmatic preference for both labor and management EAP settings in the future.

NOTE

1. The term EAP will be used throughout to refer as well to labor sponsored programs, which are generally referred to as Member Assistance Programs (MAPs).