Standards for the EAP Profession:

Isn’t It Time We All Start Speaking the Same Language?

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**Abstract**

Employee Assistance Programs (EAPs) are expected to provide efficient and effective services to their customers. Practice standards, including evidence-based interventions and standardized outcomes, have not been established. This article reports findings from an online survey focused on EAP outcomes from 23 EAP owners, who cover 1,500 work organizations and more than 900,000 employees. Results suggest work-related stress and cost of health care are of paramount concern to EAPs and their customers, and standardized outcomes and reporting formulas would be welcomed. Implications for future research to advance the EAP field and better demonstrate value are discussed.

*Keywords:* Employee Assistance Program (EAP), outcome measures, standardized reporting

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Employers are beginning to understand and accept the impact of employee health and well-being has on worker performance and productivity (Burton et al., 2005; Goetzel, Hawkins, Ozminkowski, & Wang, 2003; Goetzel et al., 2007; Loeppke et al., 2007; Pelletier, Boles, & Lynch, 2004). Recent research supports a correlation between increasing levels of workplace stress among less healthy employees and subsequent negative outcomes such as depression and increased substance misuse (Hilton et al., 2008; Kessler et al., 2008). In light of adverse effects of workplace functioning, including, but not limited to, absenteeism, sick time, presenteeism, health care costs, and disability claims (Wang, Simon, & Kessler, 2008), employers have no choice but to acknowledge the impact behavioral health problems, such as depression and substance abuse, have on their bottom line.

Many mental health problems such as depression and substance abuse are considered preventable or at a minimum modifiable (Rothermel, Slavit, Finch, Marlo, & Dan, 2008; Watson Wyatt, 2007). These potentially preventable problems have led employers to pay increased attention to outcomes related to targeted interventions such as workplace health promotion and wellness. The goal of such programs is to not only prevent or minimize negative effects from modifiable mental health and behavioral problems, but to do so in a manner that will contribute to reduced health care costs, while simultaneously encouraging a healthier and more productive workforce.

Historically, Employee Assistance Programs (EAPs) have provided behavioral health services to employees and their covered dependents, designed to offer early intervention, assessment and referral, and short-term counseling for personal problems that have the potential to negatively affect work performance and/or productivity. With increased attention to the costs of depression and substance misuse among employees, employers are increasing their focus on how EAPs provide or could potentially provide services that can be empirically evaluated to demonstrate effectiveness and return on investment (ROI). This increased attention and oversight has affected internal and external EAP providers, forcing them to develop strategies that clearly demonstrate that their EAP services represent best- practice interventions that have observable and measurable effects and can be provided in a cost-effective manner. The EAP field has responded in the past with the creation of professional work groups and task forces to discuss and develop standardized definitions and outcome measures.

**EAP Definitions and Standardization**

Roman and Blum (1988) studied EAPs and identified key components that define and should make up any EAP. These components, referred to as the EAP core technology, include:

1. Consultation with, training of, and assistance to work organization leadership (managers, supervisors, and union stewards) seeking to manage the troubled employee, enhance the work environment, and improve employee job performance; and outreach/education of employees/dependents about availability of EA services
2. Confidential and timely problem identification/assessment services for employee clients with personal concerns that may affect job performance;
3. Use of constructive confrontation, motivation, and short-term intervention with employee clients to address problems that affect job performance;
4. Referral of employee clients for diagnosis, treatment, and assistance, plus case monitoring and follow-up services;
5. Assistance to work organizations in managing provider contracts, and in forming and auditing relations with service providers, managed care organizations, insurers, and other third party payers;
6. Assistance to work organizations to support employee health benefits covering medical/behavioral problems, including but not limited to: alcoholism, drug abuse, and mental/emotional disorders; and
7. Identification of the effects of EA services on the work organization and individual job performance. (Employee Assistance Professionals Association [EAPA], 2009, p. 6)

Aside from agreeing on these core elements to define an EAP, there is little else that the EAP field has agreed on with regard to standardized definitions, best practices, and evaluation methods. EAP leaders are currently engaged in debate regarding the relevance of the EAP core technology for today’s EAPs. For example, many EAP leaders point out that *prevention* should be added as a core technology element for all EAPs (Bennett & Attridge, 2008; Williams, 2009).

In 2003, EAPA defined *employee assistance* as “the work organization’s resource that utilizes specific core technologies to enhance employee and workplace effectiveness through prevention, identification, and resolution of personal and productivity issues” (EAPA, 2009, p. 6). They further defined an EAP as

“a worksite-based program designed to assist 1) work organizations in addressing productivity issues and 2) “employee clients” 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.” (p. 6)

These definitions emerged from the work conducted by EAP task groups to update the *EAPA Standards and Professional Guidelines for Employee Assistance Programs* (2009).

Due in part to their expansion of services provided to employers and employees, definitions and reporting standards within the EAP field became necessary as the ways in which different EAPs defined an EAP case and reported utilization varied significantly from EAP to EAP. EAPA took on this challenge and created the EAPA Measurements Subcommittee that was charged with developing standardized definitions and formulas for calculating and reporting EAP utilization. After much debate, the subcommittee declared, “utilization cannot be summarized into one number” (EAPA, 2009, p. A2). Instead, they recommended a collaborative process in which employers and EAPs worked together at the start of a new contract to define what constitutes an EAP case and utilization. Prior to calculating utilization, the Subcommittee suggested identifying the types of services provided by the EAP.

The first broad category of utilization to report was called “direct service to individuals and families” and included: information-only contacts, EAP life management contacts (i.e., work/life services), and an EAP case that was defined as “a documented record of contact between an EAP counselor and an eligible user that includes a comprehensive assessment according to EAPA Standards, a plan of action, …and a follow-up plan” (EAPA, 2009, p. A3). The second category of services, “direct service to the organization,” included: workplace consultation, policy consultation, training, information and education activities, critical incident management, special situation response, and program implementation and management.

Once services were clearly identified and defined, the Subcommittee identified six potential utilization formulas that could be applied to two potential EAP population groups: number of eligible employees or number of “covered lives” that includes eligible employees and their covered dependents. The types of utilization included EAP information-only contacts, EAP life management contacts, and active EAP cases. While defining an EAP case and developing standards for reporting utilization were critical first steps for the field, the lack of regulation and oversight allowed many EAPs to continue using different and sometimes-conflicting definitions and formulas for reporting utilization. This continues to be a practice today and contributes to increased confusion within the field due to an inability to compare utilization across EAPs.

**EAP Accreditation**

The Employee Assistance Society of North America (EASNA) partnered with the Council on Accreditation Standards (COA) to develop accreditation standards for EAP practices and services. EAP accreditation was not a new concept as it has been in existence for many years in Canada; however, it was relatively new for the United States, and the majority of U.S. providers today are still not yet accredited. The accreditation standards represented an initial attempt to further define EAPs with attention to service quality and acceptable methods for measuring outcomes.

Another organization that provides EAP accreditation is the Commission on Accreditation of Rehabilitation Facilities (CARF; www.carf.org). CARF established standards for accreditation independently from COA, EAPA, and EASNA. CARF’s accreditation criteria were first made available to EAPs in 1998, and as of today, CARF has accredited at least 20 programs (Haaz, Maynard, Petrica, & Williams, 2003). COA and CARF accreditation are voluntary and provide “external objective benchmarks for consumers and stakeholders of recognized standards of practice and quality of service provision” (Hartley & Jorgensen, 2003, p. 91). Because accreditation never became a mainstream practice in the United States, most companies and other work organizations who are seeking EAP services, do not require accreditation when reviewing proposals for services.

**Recent Steps Toward Standardization**

In 2004, The National Business Group on Health (NBGH) was tasked with developing strategic recommendations to improve the design and implementation of EAP services. To better integrate EAPs into the broader spectrum of employer-sponsored health benefits and develop evaluative processes which could demonstrate EAP efficacy, the NGBH established the EAP Workgroup. The Workgroup initially reviewed the recommendations of *An Employer’s Guide to Behavioral Health Services* (Finch & Phillips, 2005) and assessed other EAPs to determine which practices could be considered best-practice and/or evidence-based. Results of their research were published in a report titled *An Employer’s Guide to Employee Assistance Programs* (Rothermel et al., 2008). The report included eight overarching recommendations or “challenges” posed for the EAP field.

The first two challenges proposed by the NBGH included a recommendation for the field to establish a well-recognized definition of EAPs in an evolving market where definitions have been blurred between EAPs and employee benefits programs (Rothermel et al., 2008). The NBGH further encouraged the field to establish professional standards criteria and credentialing parameters for EAP practitioners. The third challenge included a recommendation for the field to define a recognized EAP “scope of service” (Rothermel et al.). In the recent past, EAPs began to offer services based on competitive market pressures, at times leading to speculative service provision and cost undercutting. Instead, the NBGH suggested that EAP services be driven by a thorough review of industry-wide needs, the development of core services, and staying with this core. The NBGH suggested developing this scope of service by defining strategic operation tasks systematically, including organizational consultation tasks, assessment, counseling and referral services for employees, and development of a healthy workplace and other proactive programs in concert with human resources departments. The fourth challenge posed by the NBGH involves their view of the EAP as having a legitimate place at the table to provide workplace consultation regarding contract management, specifically with third-party payers such as insurers and managed health care organizations (Rothermel et al.). Developing a standardized scope of service will also help to eliminate duplication of services with human resources departments (Challenge 5). This could be accomplished by consulting with organizations around productivity, absenteeism, disability, job satisfaction, and employee morale, as well as the planning and administration of employee health and welfare benefits.

The NBGH’s final three challenges are directed at methods to systematically plan, direct, and evaluate EAP services (Rothermel et al., 2008). First, they assert the need to “quantify” service provision, using standardized measures to validate the efficacy of EAP services. They recommend that these measures incorporate the EAP core technology and other activities involving the provision of short-term counseling. One of the challenges for EAPs in the development of such measures will be the decision of how to best obtain and use data from employers in a legal and ethical manner. Next, the NBGH recommended EAPs to engage in peer-reviewed research to further establish the relevancy of EAP services and their contribution to workplace productivity and performance (Rothermel et al.).

The final challenge posed by the NBGH was to use standardized metrics that can be compared to quantitative benchmarks for the field (Rothermel et al., 2008). They suggest the creation of a national database where EAP industry standards can be developed and housed. Metrics should include employee utilization, assessment of the impact of EAP services, and outcomes regarding the financial return on investment (ROI) to employers. The final challenge further defined suggested methods for measuring and reporting utilization, impact assessment, and financial return. For utilization, the NBGH recommended reporting utilization rates for EAP supportive services such as information-only contacts, referrals, work/life resources, and any other type of EAP service not already captured (Rothermel et al.). In addition to utilization, the NBGH recommends that the use of the EAP by supervisors and/or managers be tracked separately due to its perceived importance to the workplace. A final type of utilization metric the NBGH recommended was for EAPs to report effectiveness or impact of services on workforce health and productivity (Rothermel et al.). This is more difficult for EAPs to calculate, but represents an important step for EAPs to begin demonstrating value. Effectiveness can be calculated through the use of pre- and post-test measures (i.e., self-report) and using employer-reported job performance data such as absenteeism, retention, performance evaluations, and disability to link to EAP services.

Given the recent publication of the NBGH’s recommendations for the EAP field, research has not yet been conducted to determine how EAP leaders will respond and/or integrate the recommendations into their EAP practices (Rothermel et al., 2008). To begin assessing the EAP field’s perception of issues and recommendations raised by the NBGH and other researchers and experts, the current study surveyed EAP owners and executives to determine how they perceive EAP reporting, standardizing, and research, in addition to how they perceived their customers would also view the same questions.

**Method**

**Procedures**

In fall 2008, an international provider of EAP software services collaborated with a large university to conduct research related to EAP standards and outcomes. Specifically, the software company’s owner was interested in surveying his EAP customers to determine the best way to support their emerging needs as they respond to increasing pressure from the businesses they serve to demonstrate outcomes and ROI. Additionally, the software owner was interested in determining whether or not his EAP customers would be interested in participating in a benchmarking service and sharing data in the aggregate with an external university researcher.

To begin addressing these questions, researchers from the university developed an online, anonymous survey that could be distributed to EAP owners who were currently engaged in utilizing the software services (*N*=45) (i.e., the software company’s current book of business). EAP software customers that had not had any contact with the software provider for five or more years were excluded from the study, and EAPs that did not have access to the online software were also excluded (*n*=10). Upon receipt of exemption status from the University Institutional Review Board (IRB), an e-mail was sent to the EAP companies introducing the study and encouraging participation. E-mails were sent directly to the software company’s primary contact who was either the EAP owner or a designated executive.

**Sample**

Of the 45 companies invited to participate, 23 responded and returned a completed online survey, a 51% response rate. The average number of work organizations receiving services from the EAPs in the sample was 83.67 (*SD*=80.88). The 23 respondents represented EAPs that provide services to more than 1,500 different work organizations and cover more than 900,000 employees (*M*=41,533, *SD*=47,867.47). Of the 23 respondents, 4 (17.4%) defined their EAP as “internal,” 6 (26.1%) defined their EAP as “external,” and 9 (39.1%) defined their EAP as “combination – internal EAP with external component” (*n*=4, 17.4% did not respond). The majority of respondents, regardless of EAP model, reported their service area as “local” (*n*=11, 47.8%) followed by “regional” (*n*=7, 30.4%). The sample included one national and one international EAP.

**Survey**

The survey consisted of 13 questions focused on EAP outcome measures, reporting standards, and demographic questions. Questions were developed by the researchers in collaboration with the EAP software company and members of an advisory board of four people who were either EAP owners or had significant EAP work experience. The survey included questions about the types of metrics suggested by the NBGH (Rothermel et al., 2008), EAPA’s definition of employee assistance and utilization (EAPA, 2009), and the EAP Core Technology (Roman & Blum, 1988).

**Results**

Respondents were asked to perceive and report how much of a problem or concern various workplace or organizational problems were for their customers. The most problematic or concerning issue was work-related stress (*M*=4.14, *SD*=.77) followed closely by cost of health care (*M*=4.13, *SD*=1.01), absenteeism or lost work time (*M*=3.56, *SD*=.94), and customer service (*M*=3.52, *SD*=1.20). Alcohol and/or drug use/abuse (*M*=3.48, *SD*=.79) was rated almost identically to presenteeism (*M*=3.48, *SD*=.84). See Table 1 for a complete list of work-related problems or issues included in the survey.

Table 1

*Work-Related Problems or Concerns of Employee Assistance Program Customers as Perceived by Respondents*

|  |  |  |
| --- | --- | --- |
| Work-related problem or concern | *M* | *SD* |
| Work-related stress | 4.17 | .77 |
| Cost of health care | 4.13 | 1.01 |
| Absenteeism or lost work time | 3.56 | .94 |
| Customer service | 3.52 | 1.20 |
| Presenteeism | 3.48 | .79 |
| Alcohol and/or drug use/abuse | 3.48 | .84 |
| Employee morale | 3.39 | 1.08 |
| Retention & other problems associated with turnover | 3.39 | 1.20 |
| Safety violations and/or workplace accidents | 3.35 | .98 |
| Workplace critical incidents or other traumatic events | 3.30 | 1.10 |
| Workplace violence | 3.30 | 1.10 |
| Disability claims | 3.18 | 1.01 |
| Recruitment | 2.95 | .79 |
| Worker’s compensation | 2.91 | 1.06 |
| Lawsuits and/or other legal problems | 2.87 | .81 |
| Theft (by employees) | 2.26 | .75 |

Respondents were then asked to rate how important the various types of utilization reports were, initially for their own EAP and then as thought to be perceived by their customers. For their own EAP companies, the most important utilization report was employees reached through EAP clinical services, (*M*=4.50, *SD*=.67) followed by employees identified with alcohol and/or drug abuse problems (*M*=4.20, *SD*=.77), number or percent of employees reached through organizational EAP services, that is via training, coaching, critical incident response, and so forth (*M*=4.14, *SD*=.85), supervisor or management consultations (*M*=4.09, *SD*=1.09), employees identified with depression (*M*=3.86, *SD*=.85), and mandatory referrals to EAP (*M*=3.77, *SD*=1.15). For their customers the EAPs perceived employees reached through EAP

clinical services (*M*=4.57, *SD*=.60) as most important, followed closely by employees reached through EAP organizational services (*M*=4.55, *SD*=.51), employees identified with alcohol and/or drug abuse problems (*M*=4.33, *SD*=.58), employees identified with depression (*M*=4.19, *SD*=.68) ranked similarly to mandatory referrals to EAP (*M*=4.19, *SD*=1.17), and last, supervisor or management consultations (*M*=4.14, *SD*=1.59). As the number of customers served by the EAPs increased, the importance of reporting mandatory referrals to the EAP (*r*=.636) and identifying employees with alcohol and/ or drug problems (*r*=.519) also increased (*p*<.05).

The third set of questions asked respondents to rate how important reporting information other than the primary utilization figures already asked were for their EAP and then as perceived to be by their customers. With regard to importance for their EAP, respondents reported impact of EAP services related to work problems as the most important (*M*=4.55, *SD*=.60), followed by impact of EAP services related to improving employee personal problems (*M*=4.42, *SD*=.69), return on investment for EAP services related to worker productivity and performance (*M*=4.30, *SD*=.80), impact of EAP services related to problems identified during management consultations (*M*=4.21, *SD*=.92), presenting and assessed problems for EAP clients (*M*=4.05, *S*D=1.08), and return on investment for EAP services related to health care costs (*M*=4.05, *SD*=.94). The remaining types of information deemed important to the EAPs can be found in Table 2.

Table 2

*Importance of Information Reported by the Employee Assistance Program (EAP) for the Respondents*

|  |  |  |
| --- | --- | --- |
| Information reported by EAPs | *M* | *SD* |
| Impact of EAP on improving work-related problems | 4.55 | .60 |
| Impact of EAP on improving personal problems | 4.42 | .69 |
| Return on investment on employee work performance | 4.30 | .80 |
| Impact of EAP on improving problems identified during management consultations | 4.21 | .92 |
| Presenting and assessing problems for EAP clients | 4.05 | 1.08 |
| ROI related to health care costs | 4.05 | .94 |
| Average number of EAP face-to-face sessions | 3.95 | .89 |
| EAP impact on attendance | 3.85 | .81 |
| EAP impact on retention | 3.78 | 1.16 |
| Case disposition at closing | 3.75 | .97 |
| Average scores or ratings from client satisfaction surveys | 3.60 | 1.23 |
| Number or percentage or EAP clients who go on STD or LTD | 3.30 | 1.34 |
| Average scores or ratings for organizational services | 3.30 | 1.69 |
| Demographics for EAP clients | 3.15 | 1.22 |
| Note. STD=short-term disability; LTD=long-term disability. |

A significant relationship was found in the positive direction between number of work organizations served by the EAP and importance of reporting the impact of EAP services related to problems identified during management consultations (*r*=.498, *p*=.042).

For their customers, respondents reported return on investment for EAP services related to worker productivity and performance (*M*=4.45, *SD*=.76) as most important followed by presenting and assessed problems for EAP clients (*M*=4.37, *SD*=.89). Third was return on investment for EAP services related to health care costs (*M*=4.35, *SD*=.93) followed by impact of EAP services related to work problems (*M*=4.09, *SD*=1.68), EAP effectiveness regarding work attendance (*M*=4.00, *SD*=.79), and impact of EAP services related to problems identified during management consultations (*M*=3.95, *SD*=1.70). The remaining response categories are listed in Table 3.

Table 3

*Importance of Information Reported by the Employee Assistance Program (EAP) for the EAP Customers (as Perceived by the EAP Respondents)*

|  |  |  |
| --- | --- | --- |
| Information reported by EAPs | *M* | *SD* |
| Return on investment (ROI) on employee work performance | 4.45 | .76 |
| Presenting and assessing problems for EAP clients | 4.37 | .89 |
| ROI related to health care costs | 4.35 | .93 |
| Impact of EAP on improving work-related problems | 4.09 | 1.68 |
| EAP impact on attendance | 4.00 | .79 |
| Impact of EAP on improving problems identified during management consultations | 3.95 | 1.70 |
| Impact of EAP on improving personal problems | 3.91 | 1.74 |
| Average number of EAP face-to-face sessions | 3.87 | 1.69 |
| EAP impact on retention | 3.83 | .86 |
| Average scores or ratings from client satisfaction surveys | 3.73 | 1.86 |
| Case disposition at closing | 3.61 | 1.64 |
| Demographics for EAP clients | 3.22 | 1.56 |
| Average scores or ratings for organizational services | 3.13 | 1.98 |
| Number or percentage or EAP clients who go on STD or LTD | 2.78 | 1.73 |
| Note. STD=short-term disability; LTD=long-term disability. |

With regard to standardized screening, respondents were asked if they were currently using validated measures as part of their standard EAP screening procedures to identify substance use or abuse, depression, and work-related problems. A slight majority of respondents reported using standardized measures to screen for substance use and/or abuse (*n*=13, 56.5%). When asked which scales or standardized measures they were using, respondents provided similar answers. Six respondents (46.2%) reported using the Cut, Annoyed, Guilty, and Eye Opener (CAGE; Ewing, 1984), six (46.2%) used the Substance Abuse Subtle Screening Inventory (SASSI; Miller 1985, 1999), two (15.4%) used the Michigan Alcohol Screening Test (MAST; Selzer, 1971), two (15.4%) used the Alcohol Use Disorders Identification Test (AUDIT; Saunders, Aasland, Babor, de la Fuente, & Grant, 1993), two (15.4%) used the Drug Abuse Screening Tool (DAST; Gavin, Ross, & Skinner, 1989), and four (30.8%) reported using another scale such as the Addiction Severity Inventory (ASI; McLellan, Lubrosky, Woody, & O’Brien, 1980) or did not report which scale they were using.

The majority of respondents reported using standardized measures for depression screening within their EAP (*n*=15, 65.2%). Specifically, ten (66.7%) reported using the Beck Depression Inventory (BDI; Beck, Ward, & Mendelson, 1961), six (40.0%) used the Global Assessment of Functioning (GAF; Luborsky, 1962), and four (26.7%) reported using a different scale such as the Patient Health Questionnaire (PHQ-9; Kroenke & Spitzer, 2002).

Only a small percentage (*n*=3, 13.0%) of respondents reported using a standardized measure to screen for work-related problems. Of those who indicated they used a standardized measure or screening tool, only one reported the name of the measure which was the Stanford Presenteeism Scale (SPS; Koopman et al., 2002). The SPS is a popular measure of presenteeism, which is defined as “work time loss” due to decreased or below-normal work productivity.

With regard to demonstrating ROI for EAP services, only a small percentage of respondents indicated that they were currently providing ROI figures to their customers (*n*=4, 17.3%). Commonly reported reasons for not providing ROI figures included “lack of time to mail or email letters or surveys,” “not being asked to provide data,” “lack of time to enter data from completed surveys,” and “lack of time to analyze data.”

When asked to indicate on a scale from 1 to 5, how much they agreed or disagreed with the statement, “Collecting data to be used to measure outcomes would improve the services I currently offer,” the majority (*n*=17, 85%) reported yes, they either “agreed” or “strongly agreed” (*M*=4.20, *SD*=1.00). The same number of respondents reported they either “agreed” or “strongly agreed” that comparing data collected from other EAPs for purposes of benchmarking would be useful. Finally, 15 respondents (65.2%) “agreed” or “strongly agreed” that they would feel comfortable sharing deidentified EAP data with an external university researcher for purposes of research (*M*=4.00, *SD*=1.12).

**Strengths and Limitations**

With any research study, there are strengths and limitations. One limitation regarding the sample involves its size. Although results are based on only 23 respondents, it is important to consider who these 23 respondents represent as they are EAP owners, who are not typically studied within research. Moreover, these 23 owners provide EAP services to more than 1,500 businesses, covering almost 1,000,000 employees. Many of the EAPs represented were internal and/or smaller providers that may report different answers than owners of large national and international EAP companies. Due to these limitations, the researchers advise using caution when interpreting results. Although not representative of the entire field, the current study does provide a contribution to EAP research and knowledge base as it represents a first step in ascertaining EAP leaders’ opinions about the potential integration and use of standardized outcome measures and formulas for reporting utilization and ROI as well as which areas of measurement are perceived as most important.

In addition to the importance of who was surveyed, another strength of the current study is its timeliness. As mentioned earlier, in December 2008, the NBGH released its final report of recommendations for EAP outcomes and standards (Rothermel et al., 2008). How EAP professionals will respond to this report and its suggestions remains to be seen; however, the current study provides baseline data that can be used to further assess how EAP owners and executives view and respond to the new recommendations for EAP standardized outcome measures.

**Future Research**

As an initial step toward “taking the pulse” of today’s EAPs with regard to opinions about the adoption of standardized measures, this survey supports some commonly held beliefs, while also shedding new light on areas that will hopefully advance the field. Although the majority of respondents reported health care costs, work-related stress, and absenteeism or other lost work time as the most important concerns for their customers, only three EAPs surveyed actually reported using standardized measures to assess these problems. Further, only four (20%) respondents reported using or providing their customers with ROI figures at the time of the survey. Although respondents recognize the need to more accurately measure the impact of EAP services on workplace problems, few are actually providing such data. The NBGH recommends using data related to attendance, retention, and performance to calculate comprehensive cost/benefit analysis (Rothermel et al., 2008). This challenge posed by the NBGH is likely to be an area that will need significant work by the EAP field.

Regarding clinical and direct EAP services, alcohol and depression continue to be two problems requiring early identification and intervention as perceived by the EAP and their customers. These two problems account for some of the most common and costly behavioral health problems experienced by U.S. businesses. The American Psychological Association’s Practice Organization published information from a Congressional Budget Office report indicating that substance abuse cost American businesses $246 billion in direct and indirect costs, while depression cost tallied $83.1 billion (American Psychological Association, 2008). Given the current state of the economy, depression and substance abuse expected to increase among working adults. Companies will be looking to their EAPs for solutions that result in early identification and support for troubled employees to prevent further decline and achieve and sustain acceptable or optimal levels of work performance and productivity.

When asked what standardized measures respondents were using to assess depression, several respondents reported using the Global Assessment of Functioning (GAF; American Psychiatric Association, 2000). Although the GAF is a well-known and popular scale for assessing overall mental health and well-being, it was not developed to be used as a screening tool for depression. Rather, it was developed to gauge social, psychological, and occupational functioning as they relate to mental illness. As an outcome measure and commonly used sole indicator of mental well-being, research suggests mixed results regarding the GAF’s validity and reliability (Bacon, Collins, & Plake, 2002; Endicott, Spitzer, Fleiss, & Cohen, 1976; Jones, Thornicroft, Dunn, & Coffey, 1995; Startup, Jackson, & Bendix, 2002; Vatnaland, Vatnaland, Friis, & Opjordsmoen, 2007).

One EAP reported using the PHQ-9, a valid and reliable measure of depression, which is freely available to EAPs. The PHQ-9 was originally developed from the Primary Care Evaluation of Mental Disorders (PRIME-MD) diagnostic instrument to detect symptoms of depression and more recently was used to develop the PHQ-2, an even briefer screening instrument (Kroenke, Spitzer, & Williams, 2003). Both measures have been found to be valid and reliable for depression (Kroenke, Spitzer, & Williams, 2001, 2003). Considering the potential debilitating impact depression has on the health and well-being of working adults (researchers estimate between 5% to 13% of the total U.S. population suffer from major depression; Williams & Schouten, 2008), it is critical that as the “behavioral health experts” of the work place, EAPs lead the way in accurately identifying employees troubled by depression. Statistics suggest that up to 6.7% of the general population may be clinically depressed within any 12-month time period; however only about

30% of this population actually receive treatment (Kessler, Chiu, Demler,

Merikangas, & Walters, 2005). EAPs can play an important role in the early identification, assessment and referral of vulnerable or at-risk working adults who are in need of mental health support services.

Considering the potentially severe negative consequences of alcohol and drug abuse and their impact on worker productivity and performance, it was encouraging to find that the majority of respondents surveyed reported using some type of standardized measure to assess alcohol and/or drug use. The majority reported using the CAGE, and though the CAGE is a good initial screen for alcohol, it does not assess illicit drug use and/or abuse. Some EAPs reported using the CAGE-AID, an adaptation of the original CAGE to include questions specific to drug use and abuse (Brown & Rounds, 1995). The AUDIT, considered by some to be the “gold standard” for alcohol screening, was being utilized by two EAPs in the current study. Unfortunately, the use of the AUDIT does not screen for illicit drug abuse.

With alcohol as one of the problems primary to the establishment of EAPs, it is vital that EAPs take the lead in identifying and responding to alcoholism within the workplace as many alcohol problems among employees continue to go undetected, even within EAP client populations (Chan-Oscilla, Neighbors, & Marlatt, 2004; Osilla, Zelmer, Larimer, Neighbors, & Marlatt, 2008). Researchers suggest that between 15% to 31% of the U.S. workforce at any time experiences problems with alcohol abuse, even when they don’t meet the Diagnostic and Statistical Manual of Mental Health Disorders (American Psychiatric Association, 2000) criteria for alcohol abuse or dependence. However, when we look at current rates of alcohol use or abuse documented by EAPs, it is common to see only between 1% to 10% of the EAP client population presenting with addictive behavior problems (Blum, 1989; Reichman, Young, & Gracin, 1988). This is low when compared to national epidemiological data that estimate 70% of illicit drug using adults are employed and 78% of adults who have alcohol problems are employed (Substance Abuse and Mental Health Services Administration [SAMHSA], 2008). The low rate of alcohol and drug abuse identified by today’s EAPs is concerning. Potential reasons for low reported rates may include problems with EAPs minimizing the seriousness of drinking and/or drug use reported by employees who seek EAP services or the EAPs may not even be asking appropriate screening questions that would uncover stigmatized problems. The absence of valid and standardized questions further contributes to problems with EAPs who only address the client’s presenting problem and may fail to uncover a hidden underlying addiction problem (Masi, Jacobson, & Cooper, 2000).

With regard to screening for work-related problems, such as absenteeism and presenteeism, productivity, turnover, accidents, and theft or violence, only one EAP reported using a standardized measure; the Stanford Presenteeism Scale (SPS). Although the SPS is a valid and popular measure, it is limited in scope as it focuses solely on measuring presenteeism, defined as “loss work time.” Presenteeism is often calculated based on self-report estimates of productivity or lack of productivity while at work. Although this EAP’s attempt to measure presenteeism as an outcome related to EAP services is to be commended, EAPs also need to address how personal problems may affect a broader array of work-related problems such as workplace safety, disability, retention, morale and more recently, traumatic events such as layoffs resulting from the current economic downturn.

A standardized measure that would accurately screen for various

work-related problems, comparable to how the AUDIT screens for alcohol use and the PHQ-9 screens for depression, has yet to be developed. The authors suggest the development of such a screening measure as one area EAP researchers and professionals can collaborate to support the field in leading the development of a standardized measure. Such a screening tool could be used to quickly identify the most common work-related problems addressed within EAPs. Given the fact that the majority of face-to-face EAP services are provided by affiliates who often lack workplace experience and therefore may neglect to ask about work-related problems, a standardized measure could minimize this problem by ensuring that EAP affiliates were asking questions about how personal problems affect workplace behaviors and performance (Sharar, 2008). In addition to accurately screening for work-related problems, incorporating a standardize workplace problem screen within EAP paperwork could then be used to measure outcomes if the screen was applied at the beginning and conclusion of EAP services.

Problems such as depression and substance abuse, in conjunction with the ever-increasing cost of health care, make it no surprise that employers are paying serious attention to the utilization of evidence-based interventions that will not only improve worker health and well-being, but are expected to contribute to overall cost savings for the workplace (Myette, 2008; Rost, Smith, & Dickinson, 2004; Wang et al., 2008). The fast-growing field of health and productivity management (HPM) embraces this critical relationship between employee health and well-being as they relate to productivity. Researchers within the HPM field of study are actively pursuing empirical study to assess the impact and effectiveness of workplace-based interventions, including, but not limited to EAPs. Unfortunately, few EAP professionals are active in the HPM field and therefore are not in positions to inform leading researchers about the potential unique attributes of EAP services.

In addition to HPM, EAP professionals are also not currently working in strategic policy-level positions that would allow them opportunities to educate decision makers about how EAP outcomes should be defined and measured. Without empirical evidence to demonstrate how EAP services contribute to the overall strategic goals of the workplaces they risk extinction by replacement with programs such as work/life, wellness, health promotion, and coaching. The myth that EAPs are too competitive to collaborate with each other or with external researchers has been challenged, and results from this study support the fact that EAPs have recognized a need to put competition aside and share data in the aggregate to be used for purposes of conducting empirical research that will further define services and standardize methods for measuring outcomes. In this time of economic downturn, when needs are great but resources sparse, employers are desperate for ways to cut costs and focus on providing those services which are critical and cost-effective. EAPs have an opportunity to position themselves within the workplace so that they are seen as critical and essential to any work organization, which would solidify their future existence.

References

American Psychiatric Association. (2000). Diagnostic and statistical manual of mental health disorders (4th ed., text rev.). Washington, DC: Author.

American Psychological Association. (2008). *Congress should enact a mental health parity bill this year*. Retrieved January 11, 2010, from http://www. apapracticecentral.org/update/2008/03-27/parity-milestone.pdf

Bacon, S., Collins, M., & Plake, E. (2002). Does the Global Assessment of Functioning assess functioning? *Journal of Mental Health Counseling, 24(3)*, 202–212.

Beck, A., Ward, C., & Mendelson, M. (1961). Beck Depression Inventory (BDI). *Archives of General Psychiatry, 4*, 561–571.

Bennett, J., & Attridge, M. (2008). Adding prevention to the EAP core technology. *Journal of Employee Assistance, 39*, 4–6.

Blum, T. (1989). The presence and integration of drug abuse intervention in human resource management. *National Institute on Drug Abuse Research Monograph, 91*, 245–269.

Brown, R., & Rounds, L. (1995). The CAGE questions adapted to include drugs (CAGE-AID). *Wisconsin Medical Journal, 94*, 135–140.

Burton, W., Chen, C., Conti, D., Schultz, A., Pransky, G., & Edington, D. (2005). The association of health risks with on-the-job productivity. *Journal of Occupational & Environmental Medicine, 47(8)*, 769–777.

Chan-Oscilla, K., Neighbors, C., & Marlatt, G. (2004). Treating addictive behaviors in the employee assistance program: Implications for brief interventions. *Addictive Behaviors, 29*, 1883–1887.

Employee Assistance Professionals Association. (2009). EAPA standards and professional guidelines for employee assistance programs. Arlington, VA: Author. Retrieved January 11, 2010, from [http://www.eapassn.org/files/](http://www.eapassn.org/files/public/)public/ EAPASTANDARDS09.pdf

Endicott, J., Spitzer, R., Fleiss, J., & Cohen, J. (1976). The Global Assessment Scale: A procedure for measuring overall severity of psychiatric disturbance. *Archives of General Psychiatry, 33*, 766–771.

Ewing, J. (1984). Detecting alcoholism: The CAGE questionnaire. *Journal of the American Medical Association*, 252, 1905–1907.

Finch, R. A., & Phillips, K. (2005). Center for Prevention and Health Services. *An employer’s guide to behavioral health services: A roadmap and recommendations for evaluating, designing and implementing behavior health services*. Washington, DC: National Business Group on Health.

Gavin, D., Ross, H., & Skinner, H. (1989). Diagnostic validity of the drug abuse screening test in the assessment of DMS-III drug disorders. *British Journal of Addiction, 84(3)*, 301–307.

Goetzel, R. Z., Hawkins, K. O., Ozminkowski, R. J., & Wang, S. (2003). The health and productivity cost burden of the “top 10” physical and mental health conditions affecting six large U.S. employers in 1999. *Journal of Occupational & Environmental Medicine, 45(1),* 5–14.

Goetzel, R. Z., Shechter, D., Ozminkowski, R., Marmet, P., Tabrizi, M., & Roener, E. (2007). Promising practices in employer health and productivity management efforts: Findings from a benchmarking study. *Journal of Occupational and Environmental Medicine, 49(2)*, 111–130.

Haaz, E., Maynard, J., Petrica, S., & Williams, C. (2003). Employee assistance program accreditation: History and outlook. In R. P. Maiden (Ed.), *Accreditation of employee assistance programs* (pp. 1–26). New York: Hawthorne Press.

Hartley, L., & Jorgensen, D. (2003). The future of credentialing and accreditation in employee assistance programs. In R. P. Maiden (Ed.), *Accreditation of employee assistance programs* (pp. 87–92). New York: Hawthorne Press.

Hilton, M. F., Whiteford, H. A., Sheridan, J. S., Cleary, C. M., Chant, D. C., Wang, P.S., et al. (2008). The prevalence of psychological distress in employees and associated occupational risk factors. *Journal of Occupational & Environmental Medicine, 50(7)*, 746–757.

Jones, S., Thornicroft, G., Dunn, G., & Coffey, M. (1995). A brief mental health outcome scale: Reliability and validity of the global assessment of functioning. *British Journal of Psychiatry, 166(5)*, 654–659.

Kessler, R., Chiu, W., Demler, O., Merikangas, K., & Walters, E. (2005). Prevalence, severity and comorbidity of 12-month DSM-IV disorders in the national comorbidity survey replication. *Archives of General Psychiatry, 62(6)*, 617–627.

Kessler, R., White, L. A., Birnbaum, H., Qiu, Y., Kidolezi, Y., Mallett, D., et al. (2008). Comparative and interactive effects of depression relative to other health problems on work performance in the workforce of a large employer. *Journal of Occupational & Environmental Medicine, 50(7)*, 809–816.

Koopman, C., Pelletier, K., Murray, J., Sharda, C., Berger, M., Turpin, R., et al. (2002). Stanford Presenteeism Scale: Health status and employee productivity. *Journal of Occupational and Environmental Medicine, 44*, 14–20.

Kroenke, K., & Spitzer, R. (2002). The PHQ-9: A new depression and diagnostic severity measure. *Psychiatric Annals, 32*, 509–521.

Kroenke, K., Spitzer, R., & Williams, J. (2001). The PHQ-9: Validity of a brief depression severity measure. *Journal of Internal Medicine, 16(9)*, 606–613.

Kroneke, K., Spitzer, R., & Williams, J. (2003). The Patient Health Questionnaire-2: Validity of a two-item depression screener. *Medical Care, 41*, 1284–1292.

Loeppke, R., Taitel, M., Richling, D., Parry, T., Kessler, R. C., Hymel, P., et al. (2007). Health and productivity as a business strategy. *Journal of Occupational and Environmental Medicine, 49(7)*, 712–721.

Luborsky, L. (1962). Clinicians’ judgments of mental health. *Archives of General Psychiatry, 7*, 407–417.

Masi, D., Jacobson, J., & Cooper, A. (2000). Quantifying quality: Findings from clinical reviews. *Employee Assistance Quarterly, 15(4)*, 1–17.

McLellan, T., Lubrosky, L., Woody, G., & O’Brien, C. (1980). An improved diagnostic evaluation instrument for substance abuse patients: The Addiction Severity Index. *Journal of Nervous and Mental Disease, 168(1)*, 26–33.

Miller, G. (1985). *The Substance Abuse Subtle Screening Inventory (SASSI) manual*. Springville, IN: SASSI Institute.

Miller, F. G., & Lazowski, L. E. (1999). *The Substance Abuse Subtle Screening Inventory-3 (SASSI-3) manual*. Springville, IN: SASSI Institute.

Myette, T. (2008). Research on depression in the workplace: Where do we go from here? *Journal of Occupational & Environmental Medicine, 50(4)*, 492–500.

Osilla, K., Zellmer, S., Larimer, M., Neighbors, C., & Marlatt, G. (2008). A brief intervention for at risk drinking in an employee assistance program. *Journal of Studies on Alcohol and Drugs, 69(1)*, 14–20.

Pelletier, B., Boles, M., & Lynch, W. (2004). Change in health risks and work productivity over time. *Journal of Occupational & Environmental Medicine, 46(7)*, 746–754.

Reichman, W., Young, D., & Gracin, L. (1988). Identification of alcoholics in the workplace. *Recent Developments in Alcoholism, 6*, 171–179.

Roman, P., & Blum, T. (1988). The core technology of employee assistance programs: A reaffirmation. *The Almacan,19(8)*, 17–22.

Rost, K., Smith, J. L., & Dickinson, M. (2004). The effect of improving primary care depression management on employee absenteeism and productivity. *Medical Care, 42(12)*, 1202–1210.

Rothermel, S., Slavit, W., Finch, R. A., Marlo, K., & Dan, D. (2008). *An employer’s guide to employee assistance programs*. Washington, DC: National Business Group on Health.

Saunders, J., Aasland, O., Babor, T., de la Fuente, J., & Grant, M. (1993). Development of the Alcohol Use Disorders Identification Test (AUDIT): WHO collaborative project on early detection of persons with harmful alcohol consumption. *Addiction, 88*, 349–362.

Selzer, M. (1971). The Michigan Alcoholism Screening Test (MAST): The quest for a new diagnostic instrument. *American Journal of Psychiatry, 127*, 1653–1658.

Sharar, D. (2008). General mental health practitioners as EAP affiliates: Do they make referrals beyond the EAP? *Journal of Workplace Behavioral Health, 23*, 337–358.

Startup, M., Jackson, M., & Bendix, S. (2002). The concurrent validity of the Global Assessment of Functioning (GAF). *British Journal of Clinical Psychology, 41*, 417–422.

Substance Abuse and Mental Health Services Administration. (2008). *Issue brief #5: Save money by addressing employee alcohol problems*. Rockville, MD: Author.

Vatnaland, T., Vatnaland, J., Friis, S., & Opjordsmoen, S. (2007). Are GAF scores reliable in routine use? *Acta Psychiatrica Scandinavica, 115(4)*, 326–330.

Wang, P. S., Simon, G. E., & Kessler, R. C. (2008). Making the business case for enhanced depression care: The National Institute of Mental Health-Harvard work outcomes research and cost-effectiveness study. *Journal of Occupational & Environmental Medicine, 50(4)*, 468–475.

Watson Wyatt. (2007). *2007/2008 staying @ work report, building an effective health and productivity framework*. Washington, DC: Watson Wyatt Worldwide.

Williams, C. (2009). Prevention needs to be clearly defined in EAPs. *Journal of Employee Assistance, 39(2)*, 4–5.

Williams, C., & Schouten, R. (2008). Assessment of occupational impairment and disability from depression. *Journal of Occupational and Environmental Medicine, 50(4)*, 441–450.