Chapter 16

Employee Assistance Programs in the Year 2002

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Introduction

From its beginnings in the late 1970s, the employee assistance (EA) field has evolved into a full-fledged professional service addressing myriad personal and organizational needs in today's economy. Like the business community in which they exist, Employee Assistance Programs (EAPs) now find themselves in a period of significant transition. This chapter presents the current status of EAPs from eight different perspectives: (1) an overview, (2) program models and funding mechanisms, (3) integration of services, (4) professional certification, (5) accreditation, (6) international context, (7) training and professional development, and (8) research. It concludes with a section on future trends.

Overall Picture

EA efforts began as occupational alcoholism programs staffed by workers who had achieved sobriety. These workplace efforts have evolved into

empowering them to negotiate contracts for clinical services can dramatically reduce costs for organizations while providing quality mental health services for workers and their dependants.

EAPs continue to have opportunities to demonstrate their value by helping organizations cope with the increasing stress and complexity of today's workplace. EA personnel will continue to remain the first point of contact for employees and their family members experiencing personal concerns. The current unprecedented demand for EA services is an opportune occasion to firmly position EAPs as an integral part of the new workplace environment and as the entry point for the system of mental health and substance abuse services.

Program Models and Funding Mechanisms

No single example can succinctly describe the various models of EAPs. Instead, descriptive terms have evolved over time that focus on aspects of service design and delivery. Reflecting the wide diversity in types of organizations that sponsor EA efforts, delivery models of EA services are many and varied. However, there appears to be a practical and functional aspect to distinguishing EAPs along a number of discrete dimensions.

Session Limitation

The Assessment and Referral Model typically offers up to three EAP sessions focused on problem identification and linkage to an appropriate outside resource for problem improvement or resolution.

The Short-Term Problem Resolution Model offers additional sessions beyond the assessment process when it is determined that the assessed problem can be improved or resolved using EA services. When the assessed problem cannot be adequately addressed through additional EAP sessions, the EA professional provides appropriate linkage to outside resources. Typical short-term problem-solving models offer four to eight sessions, inclusive of the assessment session(s).

Range of Services

The Basic Model offers the core services of a traditional EAP, including consultation with appropriate persons in the identification and resolution of job performance issues, problem assessment, referral and followup services, organizational consultation, program promotion, and education.

The Add-on Service Model offers a menu of related services in addition to core EAP services. These services might include critical incident response, wellness training, work/life services, legal assistance, financial services, and so on.

Relationship With Behavioral Health Services

The Stand-alone Model is one for which no service relationship exists between the EAP and the behavioral health services available to beneficiaries.

The Integrated Model is one in which the EAP and the behavioral health services available to beneficiaries are purposefully interrelated in a predefined capacity by the sponsoring organization(s). For example, the EAP may serve as the required gateway to behavioral health services.

Service Location

In the *On-Site Model*, EA services are delivered on the property or worksite of the sponsoring organization(s).

In the *Off-Site Model*, EA services are delivered at a location other than the worksite or property of the sponsoring organization(s).

In the *Virtual Model*, EAP services are delivered by telephone or online, eliminating the issue of EAP office location. The virtual site has been used extensively for delivering "add-on" EAP service, such as work/life services, health promotions, employee education, organizational training, and mental health screenings. Online delivery of core EAP services is gaining momentum as the industry develops standards and protocols for optimal efficiencies and client protection.

The *Mixed-Site Model* is a blend of onsite, offsite, and virtual sites made available to beneficiaries.

Service Provider

In the *Internal Model*, staff or members of the sponsoring organization(s) provide services.

therapy services. Internal and external EAPs play various roles in the integration with MBHC, from a simple intake capacity with the MBHC plan providing referrals to models in which the EAP provides assessment, referral, and managed care services as well. In these (less prevalent) models, the EAP contracts with a treatment provider network, and the employer's needs govern the type of EA services provided.

EAPs Integrated With Work/Life Services

A recent phenomenon for EA service provision is its integration with work/life services, such as child care and elder care resources and referral. The early 1980s were a growth period for work/life services as women began to enter the workforce in much larger numbers. Employers became aware of the need for quality child care to support the two-parent workforce. By 1985, several private companies were administering resource and referral services for large multisite employers, primarily assisting employees in finding and managing child care arrangements. As the 1980s progressed, baby boomers began to experience significant issues with their elderly parents. The addition of elder care services to the work/life field was a controversial development. Many EAPs had already been providing services in the elder care area, and the issue was whether work/life programs or EAPs were more appropriate for handling elder care. At this time, no evaluations have been performed to ascertain the better model for service delivery.

The work/life companies moved away from addressing only dependent care issues toward a holistic approach to providing support to the workforce, addressing the broader notion of finding balance between work and family. Additional services were developed—educational, concierge, financial, and legal service, for example—to appeal to a more diverse audience. In the mid- to late 1990s, it became clear that the EAP and work/life fields needed to partner in their support of a productive work environment by offering employers an integrated model of service—one-stop shopping. In the late 1990s, many larger national EAPs merged with work/life companies or developed partnerships to support an integrated model of service delivery.

Web-Based Services

Many EAPs have begun to offer Web-enabled services. The Internet provides client organizations with a platform for inexpensive, yet customized, EA promotional information via intranets and e-mails. Web-based EA products offer a wide range of services, including notification of company benefits and policies; preventative education; multimedia access to early, confidential self-assessment services; resources and tools for managers; multimedia access to coaching and mentoring instruments or literature; access to training modules; and continuing support via chat technology. Common offerings are mental health clinical content, which may include tip sheets, wellness information, assessment and screening tools, and helpful articles on a variety of topics. These services are offered through self-assessment tools and dial-a-counselor programs. Perhaps most compelling is the technology's round-the-clock availability, which accommodates different work schedules and locations while offering privacy and confidentiality and may increase access from those client segments most hesitant about seeking traditional face-to-face counseling. The National Board of Certified Counselors has developed one notable set of practice guidelines for certified counselors for delivering online mental health services (posted on its Web site: http://www.nbcc.org/ethics/webethics.htm).

One of the most common methodologies for Web-based services uses an asynchronous approach, the other a synchronous approach. Asynchronous Web-service communications occur with the EA professional and the client working at different times. E-mail and instant messaging are examples. Asynchronous Web services can also be used to provide psychoeducation or Web-based bibliotherapy. For the former, the EA professional would refer the client to informative Web sites and other electronic sources of information. With the psychoeducation approach, an EA professional must be competent to recognize when to move the client into more traditional face-to-face services, as appropriate. Synchronous Web-service communications occur simultaneously (in real time) using interactive electronic technology, such as video and voice or audio via computer, with no lag between interactions. Chat room technology is an example.

EA professionals understand that the Internet is not appropriate for all clients at every level of service but that it is part of a continuum of options. The eventual promise of Web-based technology to successfully deliver services beyond mere health ed-

Professional Certification

Established in 1986, the Employee Assistance Certification Commission (EACC) administers a professional credential, the Certified Employee Assistance Professional (CEAP©), to identify EA practitioners meeting established standards for competent, client-centered practice and adhering to an enforceable code of professional and ethical conduct. Each candidate must meet experience, professional development, and advisement requirements and pass a qualifying examination. The EACC remains the autonomous credentialing body responsible for all aspects of the CEAP© program, including establishing policies and procedures of the CEAP© credential; developing examinations; and enforcing ethics codes. In January 1987, the EACC commissioners approved the CEAP© designation for those successfully completing certification requirements. As of December 2001, over 5,500 CEAPs© were practicing in the United States and in 16 other countries.

Future Trends in EA Professional Certification

The EACC and the CEAP© credential continue to evolve. A new version of the CEAP© examination debuts in May 2002, reflecting revised job requirements identified by a recent role delineation study. It will include test questions based on different cognitive levels. Application and analysis skills are integral to competency in EA practice, and items to assess these two higher cognitive levels are now incorporated. To make certification, already widely recognized in the United States and Canada, more accessible to those in the international community, the EACC has adopted revised advisement requirements and developed internationally relevant versions of the examination.

In response to the EA profession's increasingly sophisticated professional development needs, the EACC continues to prepare for advanced certification, such as a master's-level CEAP© and the possibility of providing subspecialty credentials, such as a Substance Abuse Professional and CISD certification. The U.S. Army recently adopted the CEAP© credential for its civilian and uniformed employees working as substance abuse specialists.

EAP Accreditation

In 1981, the Standards for Employee Alcoholism and/or Employee Assistance Programs were drafted by a joint committee representing the Association of Labor/Management Administrators and Counselors, the National Council on Alcoholism, the Occupational Program Consultants, and the National Institute on Alcohol Abuse and Alcoholism (NIAAA). From this early effort until today, the need for program standards and practice guidelines has taken on increasing importance in the EAP field. Although both the EAPA and the Employee Assistance Society of North America (EASNA) have actively supported the need for international standards of practice, only two organizations are accrediting EAPs today:

The Council on Accreditation (COA) began accrediting EA service providers as components of child and family service organizations in 1987. Of more than 100 EAP services accredited under this process, most are part of larger multiservice child and family organizations in the United States and Canada. In 2001, COA expanded its accreditation of EAPs by collaborating with EASNA to create a separate book of standards for stand-alone EAPs. In June 2002, COA became the EA accreditation service provider and will own the new revised standards to be published in the latter part of the year.

The Council on Accreditation of Rehabilitation Facilities (CARF) established an EAP accreditation product in 1988. Most of the 21 EAPs receiving CARF accreditation to date are provided through community human service organizations or EAP counseling agencies.

Many different market forces have led to the increasing importance of accreditation in the EA field. The consolidation of EAPs throughout North America has increased the visibility of accreditation and the need to use accreditation as a means of differentiation and quality improvement. Accountability to internal and external stakeholders has also increased, and accreditation is one tool that an EAP can use to demonstrate accountability. The search for a common language for the field and common definitions of what constitutes a case or how utilization is determined has led EA service providers to adopt accreditation as a means of standardization. EAPs have also moved toward accreditation as a way of self-regulating to prevent excessive oversight or regulation at the Federal or State level.

Typically, an EAP undergoing the process of accreditation engages in a period of self-study and evaluation during which the EAP itself determines

from each European country. Although different in nature and mandate than EAPs in North America, the network of occupational social workers provides some functions for European employers similar to those provided by EAP practitioners in North America.

In Australia and New Zealand, a relatively robust EA industry exists, with an estimated 30 percent market penetration (Hopkins, 1999). In Latin America and Asia, the initial appearance of EA was largely initiated by the needs of multinational companies and consortia to provide EA services to expatriate employees, although many of these multinationals have begun to extend program services to in-country workers and other worksites as appropriate to the local market and climate.

World Strategic Partners is an international health industry network whose mandate is to empower and influence health and policy leaders to succeed by providing access to its professional network, international health care initiatives, and a forum for knowledge exchange. World Strategic Partners hosts an annual Global Symposium at the International Labor Organization in Geneva, Switzerland, to reinforce the essential nature of the individual's well-being in relation to the employer's well-being. Key public and private sector leaders and decisionmakers from around the world gather at this symposium to address the global movement toward individual and organizational wellness.

As the movement for information sharing and standardization of practice increases, it is more apparent that external factors, such as the globalization of multinational corporate organizations, the lowering of barriers to the free movement of goods and services, the advent of the information superhighway, and other technological advancements, have created a new, wider lens through which to view the world. This evolution offers the opportunity to experience and understand global cultural differences and, in doing so, to learn about the many similarities that human beings share.

On a more practical scale, people worldwide continue to experience problems in their daily lives that have a negative impact on their ability to perform in the workplace and to contribute to the productivity of the organization. Mental health knows no geographical or socioeconomic boundaries. Although standards and practices may vary from country to country, the response to address employee mental health issues is born out of a commonality that transcends race, culture, language, and gender.

Training and Professional Development

Background

The earliest EA professionals were called occupational program consultants (OPCs). Many were senior employees who combined their business savvy and personal recovery from alcoholism to start industrial alcoholism programs to assist employees.

The Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (often referred to as the Hughes Act after its primary sponsor, Senator Harold Hughes) established the NIAAA. In its groundbreaking *Special Report on Alcohol and Health* (1971), NIAAA estimated that five percent of the workforce suffered from alcoholism and another five percent were serious alcohol abusers. Pegging the annual cost of lost work time due to alcohol abuse and alcoholism at $10 billion, the report endorsed the therapeutic value of industrial alcoholism programs (see also United States Department of Health and Human Services, 1987).

NIAAA subsequently provided funding for 100 occupational program consultants (known as the "Thundering 100") who were instrumental in the rapid growth of many internally staffed corporate and union-based EAPs in the 1970s. OPCs successfully educated employers that proper assessment and opportunities for treatment combined with leveraging the employment contract could be instrumental in returning employees with performance problems to productivity. OPCs also consulted with employers in developing workplace policies and procedures for corrective action based on job performance, rather than alcohol use.

Professional Training

The diversity of backgrounds among EA practitioners has created unique training and professional development challenges for the EA industry. EA professionals have degrees and training in social work, psychology, psychiatric nursing, addictions counseling, and organizational development, to name a few.

To date, opportunities for higher education in EAP services have been limited, notwithstanding some notable exceptions—such as the University of Maryland's School of Social Work. The extent and

(U.S. Department of Labor, Bureau of Labor Statistics, 1988). In 1988, the Bureau of Labor Statistics (BLS) conducted a more extensive survey, its *Survey Employer Anti-drug Programs,* of 7,502 private sector employers of all sizes (U.S. Department of Labor, Bureau of Labor Statistics, 1988). Results of this survey estimated an overall prevalence rate for EAPs of 6.5 percent of worksites of all sizes, but these programs covered approximately 31 percent of U.S. employees. Additionally, about three percent of employers without EAPs were considering establishing one. The survey revealed that the most important factor in EA implementation was establishment size—76 percent of the Nation's largest establishments (1,000 or more employees) had instituted EAPs versus only nine percent of the smallest (fewer than 50 employees). Differences in EAP coverage were less by industry, although notable. The mining, communications, public utilities, and transportation industries were most likely to have EAPs, while the retail trade, service, and construction industries were least likely. This is not surprising considering that small employers dominate the latter industries—76 percent of construction and services establishments had fewer than 10 employees, as did 67 percent of retail trade firms.

In 1990, BLS conducted a followup study with a portion of the 1988 respondents. Results indicated eight percent of employers without an EAP in 1988 had one by 1990. Overall, the percentage of worksites offering access to EA services increased approximately five percent, from 6.5 to nearly 12 percent, with larger businesses starting programs at a much higher rate than smaller businesses (Haygue, 1991).

This trend of sustained EAP growth continued into the 1990s. The 1993 *National Survey of Worksites and Employee Assistance Programs,* a survey of more than 3,000 worksites, confirms EAP market share expansion to an estimated prevalence of one-third of mid- to large-sized U.S. workplaces (more than 50 employees). EAPs were more likely to be found in workplaces where employees were unionized, more educated, and with relatively fewer minority workers. Geography seemed to have no impact on the existence of programs. Additionally, this study reported a marked shift in EA service delivery—away from the historical onsite by internal EAP personnel to a majority (81 percent) of services provided by external vendors offsite (cited in Hartwell et al., 1996).

A special module of questions included in the 1994 and 1997 *National Household Survey on Drug Abuse* collected information on workplace substance abuse interventions, including EAPs (DHHS, 1999). Findings again illustrated a marked disparity in access to EA services relative to establishment size, although continued increases in overall EA coverage were evident. In 1994, 15 percent of workers in small establishments reported access to EA services. By 1997, this number increased to 28 percent, whereas 61 percent of workers in mid-sized establishments and 75 percent of workers in large establishments reported EA coverage.

Open Minds, a behavioral health industry research and consulting firm in Gettysburg, Pennsylvania, began its annual surveys of managed behavioral health and EA providers in 1994, reporting an estimated 27.2 million individuals enrolled in EAPs—20 million in stand-alone EAPs and 7.2 million in integrated EA/MBHC programs. By 2001, Open Minds estimates enrollment figures of 51 million in stand-alone EAPs and 15.5 million in integrated EA/MBHC programs—a 245 percent increase since 1994 and a 13.3 percent increase since 1999 (Open Minds, 2000). The Society for Human Resource Management's 2001 *Annual Benefits Survey* provides further testimony of strong market penetration, with 67 percent of 754 human resource professionals responding that their organization offers an EAP, five percent stating their organization plans to offer one in the coming year, and only 24 percent stating they do not offer one. Industries subject to government regulation and workplaces with more acute occupational safety concerns, such as energy, transportation, and public safety, almost universally provide access to EA services, in contrast to food service, hospitality, retail sales, and temporary or contract labor services.

Costs of EAPs

Fees for externally provided EA services are typically calculated annually on a per capita basis (i.e., number of employees multiplied by cost per year), although occasionally a fee-for-service arrangement is used. Program charges vary by company or worksite and are typically negotiated between provider and employer on an individual contract basis.

Differences in the type, extent, staffing levels, and expected use of services offered to program participants can affect cost proposals. Other cost factors have historically included size of employee population and number of worksites. Using a standardized approach, a Research Triangle Institute case study of seven different EAPs during fiscal

DHHS's evaluation of the Employee Counseling Service (ECS) is a model for the use of a control group with repeated collection of measurable data. This model, developed in the mid-1980s, remains an industry standard of rigorous research design reviewing cost-effectiveness and cost-benefit of the ECS and more than 2,000 EAP clients. The study evaluated the components of context, inputs, process, impact, and outcomes with a client tracking system (CTS). The CTS measures client status, work performance by supervisors, and personnel data at intake, after three months, and after nine months. Results identified the dollar benefits in only six months of $1,274 per employee served; for every dollar spent, a return of $1.29; and an estimated five-year cost-benefit ratio of 13 to 1 (Masi and Maiden, 1985).

Masi Research Consultants conducted a study for the U.S. Postal Service in 1994, capturing data from one year before EAP entry to one year after, and examined health insurance claims, personnel and financial variables, workers' compensation claims, equal employment opportunity (EEO) costs, and employee job performance (Masi et al., 1995). Data from EAP clients were compared with a random sampling of non-EAP clients. On an order-of-magnitude basis, cost-benefit ratios conformed to prior results, with some of the greater returns in the EEO and workers' compensation areas.

A study of Virginia Power's EAP in 1991 used long-term longitudinal data to assess the program's cost-effectiveness. Medical claims data four years prior to and four years after introduction of the EAP were analyzed (Every and Leong, 1994). Results indicated that employee medical costs were 23 percent lower for EAP clients than for those accessing behavioral health care on their own. More surprising, the nonbehavioral-related medical costs showed a larger drop than the behavioral illness costs (32 percent vs. 17 percent).

The Chevron Corporation initiated two cost-benefit analyses in the 1990s: a return on investment (ROI) study and a post-substance abuse treatment analysis of safety records (Collins, 1998). The ROI study calculated the value of retention compared with new hiring and training, improved productivity for mandatory and formal referrals, and improved productivity for self-referrals. Combining the totaled estimates from these three categories resulted in savings of approximately $20.6 million over 5 years and, considering Chevron's EAP annual budget of $1.5 million, yielded a return ratio of 14 to 1.

The 1990 McDonnell-Douglas-Health Strategies study (Stern, 1990) is perhaps the best-known comparative study of the effectiveness of an EAP linked with behavioral health benefits. It compared employees who used the EAP to access treatment for alcohol, tobacco, and drug (ATD) dependency or psychiatric conditions with a control group of employees using services via traditional non-EAP sources. Followup case reviews revealed that ATD EAP clients missed 44 percent and psychiatric EAP clients missed 34 percent fewer workdays compared with the control group. Compared with the control group's 40 percent turnover rate, ATD EAP clients had a turnover rate of only 7.5 percent, and psychiatric EAP clients had a 60 percent lower turnover rate than the control group. Additionally, medical claims averaged $2,400 lower for EAP psychiatric cases than for employees who choose not to use the EAP and 35 percent lower for dependants who accessed treatment through the EAP.

Another type of cost-benefit analysis used monetized ratings for EA clients referred by a supervisor. The assumption employed by this analysis was that higher-rated employees are more productive than lower-rated employees and that productivity can be translated into dollar values. Scores at intake were compared with scores at 3 months and 9 months to obtain a 6-month value and multiplied by salary levels to obtain a dollar benefit value. The results revealed an ROI ratio of 13 to 1.

Future Directions

In spite of rapidly changing economic conditions that continuously create new challenges in today's work organizations, EAPs remain focused on providing quality support services to employers and their workers. Employers and other purchasers will continue to expect cost-efficient, integrated, and responsive EA service delivery. These services must be streamlined, be relatively simple to administer, and, above all, contribute to enhanced employee well-being and increased productivity. There appear to be at least three distinctive trends likely to affect the EA field in program service, coverage, and quality.

The first trend is the drive for greater quality assurance in EA services. This trend is not unique to EAPs but is universal across all health care and human service delivery systems, prompted by shrinking public and private resources and the continuous squeeze on worker benefits packages because of global competition. For both internal and

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