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Employee Assistance Program Services for Alcohol and Other Drug Problems: Implications for Increased Identification and Engagement in Treatment

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Abstract: This study examined Employee Assistance Program (EAP) services use among a national probability sample of adults who have sought help for alcohol and other drug (AOD) problems during their lifetime. Data came from the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC, 2001-2002). Among adults who sought any services for alcohol and/or drug-related problems (n=2272), 7.45% (n=166) reported using EAP services for these problems at some point during their lives. Major Depressive Disorder (lifetime), a drug use disorder (lifetime), and *Black* race/ethnicity were associated with a greater likelihood that someone would seek EAP services for help with their AOD problem. Results provide a foundation from which researchers can understand who uses EAP services for AOD problems. Additionally, health and mental health professionals should increase their knowledge of EAP services to improve collaboration and continuity of care for employees with AOD problems. EAPs are in a unique position to reach out to vulnerable employees in the workplace through alcohol and other mental health screening and work to engage troubled employees in treatment.

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Risky drinking, in addition to alcohol and other drug (AOD) abuse and dependence among working-age adults represent a global public health problem. The U.S. Substance Abuse and Mental Health Services Administration (SAMHSA, 2008) recently reported that 10.2% of all full-time employed adults and 11% of part-time employed adults meet the diagnostic criteria for substance dependence. This equates to over 14 million workers within the U.S.; of these workers, 15% abuse drugs and 85% are addicted to alcohol or a combination of alcohol and drugs. Rates of alcohol and drug use among U.S. employed adults have remained relatively stable between the years 2000 and 2010.

The direct and hidden costs to individuals, families, and employers from AOD problems are considerable. Substance abusing employees cost employers millions in lost productivity, measured by increased absenteeism, workplace accidents, and healthcare costs. Coworkers also suffer from employee AOD problems; one in three workers report being directly affected by another employee's drinking or drug use. Without treatment, AOD abusing employees negatively affect workforce morale, customer satisfaction, and public image.

AOD Problems and Employee Assistance Programs

Employee Assistance Programs (EAPs) have a long history of consulting with and supporting managers and supervisors in their interactions with troubled employees. Employers rely on their EAPs to assist in the identification of employees with AOD problems through brief screening and confidential assessment. Furthermore, employees look to EAPs as a source of support in the workplace as they complete rehabilitative services while maintaining their jobs and staying productive. For non-managerial employees concerned about their own or a

coworker's AOD problems, EAPs provide education, confidential screening and assessment, short-term counseling, and referral with follow-up. Today, over 75% of U.S. employers provide EAP services to their employees and often their family members. This includes 66% of small companies employing between 1 and 99 workers, 75% of medium-sized companies employing between 100 and 499 employees, and 88% of large companies employing 500 or more employees.

Despite their prevalence, employee AOD problems often go undetected. When identified, AOD problems are often left untreated. There are many reasons why AOD problems go untreated, including reluctance and ambivalence on behalf of the employee to seek treatment for a variety of reasons. Specific to the workplace, barriers to using EAPs include a lack of awareness about EAP services, stigma about substance abuse, perceived or real cost of substance abuse treatment, increased use of zero-tolerance programs in the workplace that may further increase barriers to help-seeking behavior, employees and coworkers minimizing the seriousness of drinking and drug use, and an overall decline in the use of employee drug testing. Due in part to the barriers mentioned above, employees who finally seek services through the EAP are often reluctant to disclose AOD problems and instead, present to the EAP with less serious personal and work-related problems. It therefore becomes the responsibility of the EAP professional to conduct a comprehensive assessment that can uncover an underlying or undisclosed AOD problem that may be contributing or causing the employee's presenting problem.

Prior research suggests that when clients follow through with the EAP recommendations, participation in AOD treatment programs is greatly increased, as well as the likelihood that an employee will enter and sustain recovery, while maintaining their employment status. Satisfaction with EAP services is generally high and EAP outcome studies suggest overall

improvement for AOD and other behavioral health problems. Additionally, research suggests that work-related outcomes, such as absenteeism, turnover, productivity, and reduced incidence of disability claims are reported following completion of recommended EAP intervention or services.

Lacking a national database or standardized reporting system within the field, EAP service utilization for AOD problems is difficult, if not impossible, to measure. Average EAP utilization rates within the U.S. for face-to-face counseling ranges from 3.5% to 5% per year. Employees seeking help from the EAP with AOD presenting problems represent approximately 1.5% to 2.5% of all EAP clients. Research suggests that when standardized, brief screening measures for alcohol use are integrated into the EAP intake and assessment procedures, the rate of identifying risky employee drinking behaviors significantly increases. Several EAPs have recently implemented routine AOD problem screening for all EAP callers, regardless of their presenting problem.

This study begins to fill a gap within the AOD services field by specifically identifying rates of EAP service use for AOD problems. In this study, we estimate the prevalence of adults who report using EAP services over the course of their lifetime for help with AOD problems and compare them to adults with AOD problems who report using services other than EAP. Demographic and work-related characteristics, as well as co-occurring mental health and AOD problems among EAP service users, are compared to adults with AOD problems who reported utilizing services other than EAP over the course of their lifetime.

Method

Sample

We analyzed a subset of participants from the National Epidemiologic Survey of Alcohol and Related Conditions (NESARC) who reported seeking services for AOD problems during their lifetime. The NESARC is a large population-based survey designed to estimate the prevalence of AOD use disorders and co-occurring mental health conditions (National Institutes of Health, 2006). Completed between 2001 and 2002, the NESARC survey includes data on 43,093 adults, age 18 and older, living in residences and non-institutional settings such as dormitories. Through a collaboration between the National Institute of Alcoholism and Alcohol Abuse and the U.S. Census Bureau, census workers conducted computer-assisted personal interviews using the Alcohol Use Disorder and Associated Disabilities Interview, Schedule-IV (AUDADIS-IV). The survey included participants from all 50 states; African-Americans, Hispanics, and young adults (18 to 24 years old) were oversampled to derive precise prevalence estimates in these populations. The NESARC research team utilized a multistage sample design and applied survey weights to adjust for survey non-response, oversampling, and to derive estimates reflective of the U.S. Census in 2000.

Measures

In the NESARC survey, participants who endorsed prior use of alcohol and/or a specific drug were asked whether they had received help for an AOD problem. Participants who reported service use were then asked a series of questions about formal and informal services, including whether they received services or help in various settings ranging from inpatient treatment to Alcoholics Anonymous. As part of the services explored, each lifetime help seeker in the NESARC survey was asked whether they had used EAP services in the past year, and whether they had used the services before the past year. Using these two questions, we created a dichotomous (yes/no) variable of *lifetime EAP services use*.

Sociodemographic variables included age, race/ethnicity, marital status, gender, education level, and household income. Age was measured in years and race/ethnicity was derived using a series of questions to create a variable with five categories: *White*, *Black*, *Hispanic (any race), Asian,* and *American Indian*. Three dummy-coded variables were used to measure marital status. Individuals were categorized as *currently married* (married or living as married), *formerly married* (divorced, widowed or separated), and *never married*. We created a three level variable for education and dummy-coded variables for those who had *less than a high school education*, those with a *high school education only*, and those whose *education extended beyond high school*.

We sought to explore differences in mental health and substance abuse morbidity and co-morbidity of EAP services users versus non-EAP services users. Therefore, DSM-IV diagnoses including lifetime Major Depressive Disorder (MDD), Dysthymia, Generalized Anxiety Disorder, Social Phobia, Panic Disorder with Agoraphobia, Specific Phobia, Alcohol Abuse, Alcohol Dependence (with or without abuse), and Pathological Gambling were included in statistical models. These dichotomous variables were created using the AUDADIS-IV survey instrument by the NESARC study team. An additional dichotomous variable indicated any drug abuse or dependence, with all major drug classes included (cannabis, opioids, heroin, hallucinogens, stimulants, cocaine, and inhalants). To explore potential differences in disability, we compared Medical Outcomes Study Short Form-12 (MOS SF-12) Mental Health and Physical Health subscales.

Procedure

Using the *lifetime EAP services use* variable, we derived rates of services use among lifetime help seekers for AOD problems. Separate rates of EAP services use for AOD problems,

as well as composite EAP services use for both alcohol and drugs are reported. Bivariate models tested for differences in sociodemographic variables, lifetime mental health and substance abuse disorders, and health disability between EAP services users as compared to users of other types of services, not including the EAP. Logistic regression models were used to calculate odds ratios for different mental health disorders, adjusting for sociodemographic covariates. We utilized the SUDAAN statistical package to adjust for the multistage design of the NESARC sample.

Results

Among those reporting lifetime help seeking behavior for AOD problems, 7.58% reported using EAP services (See Table 1). A total of 2304 persons endorsed help-seeking from one or more of the treatment options; however, 32 respondents were excluded from the final analysis due to missing data on the EAP-related questions in the NESARC survey. Among lifetime EAP service users only, 81% of these individuals sought help for alcohol-related problems and 40% of these individuals sought help for drug-related problems; EAP services use for both alcohol and drugs was common among 26% of EAP service users reporting lifetime EAP services use for both drug and alcohol problems. Fewer than 2% of help seekers utilized EAP services in the past year for AOD problems.

Overall, EAP services users looked similar to non-EAP services users; however, there were some differences in sociodemographic and clinical covariates (Table 2). EAP services users reported higher household income levels and although only marginally significant, EAP services users were slightly older (44.1 years old) than non-EAP services users (41.7 years old). Racial differences were present on the bivariate level as well. A higher percentage of persons identifying as *Black* reported using EAP services as compared to other, non-EAP service users. EAP services users were also less likely to report being *never married* as compared to their non-

EAP services user counterparts. From the standpoint of DSM-IV Disorders, lifetime MDD and drug use disorders were significantly higher among help seekers who used EAP services as compared to help seekers who did not use EAP services.

In univariate logistic models, unadjusted odds ratios suggested that older age was associated with an increased likelihood of having used EAP services versus non-EAP treatment services (Table 3). *Black* service users were almost twice as likely to report using EAP services as compared to *White* service users. Consistent with chi-square tests, both currently (OR=1.61) and formerly married (OR=1.70) help seekers for AOD problems were more likely to utilize EAP services than never married services users were. EAP services use was associated with nearly twice the odds of a lifetime MDD (OR=1.93) and an increased odds of lifetime Alcohol Dependence (OR=2.11) and lifetime drug use disorder (OR=1.77).

Multivariate models, which controlled for gender, age, marital status, education, race/ethnicity, and income, found that *Black* services users were more than twice (OR_{adj}=2.13) as likely to use EAP services as *White* services users. Lifetime MDD (OR_{adj}=2.42) and lifetime drug use disorder (OR_{adj}=2.08) remained significant in multivariate models; having a lifetime history of a MDD and lifetime drug use disorder were associated with more than twice the likelihood of using EAP services, after controlling for sociodemographic factors.

Discussion

This study found that among U.S. working age adults seeking help for AOD problems, 7.58% reported using EAP services at some point during their lifetime. This is similar to the range that individual EAPs report for annual service use at a singular worksite (ranges between 3% to 15%). Additionally, adults who self-identified their race or ethnicity as *Black* were significantly more likely to report using EAP services for AOD problems at some point during

their lifetime. While research is limited on the relationship between race/ethnicity and EAP use for AOD problems, Delaney, Grube, and Ames reported increased EAP services use among *Black* employees and hourly workers when social support by coworkers and supervisory encouragement were emphasized.

The workplace represents a unique, yet seemingly underutilized environment where EAP and occupational health professionals have an opportunity to educate employees about risky drinking, drug use, and other mental health problems. EAPs are also in a strategic position within the work organization to reach out to working adults, and often their family members, and engage them in assessment and treatment, if necessary, through education, confidential screening, brief counseling, and referral with follow-up services. With growing concerns about the rising cost of healthcare, employers are looking to their EAPs and other occupational health professionals to provide early intervention service, such as brief screening for alcohol, employee education, and confidential assessment, in addition to helping to create innovative solutions that will prevent or mitigate the negative effects of chronic employee health conditions.

With regard to co-occurring mental health problems, EAP services users were more likely to report experiencing a lifetime MDD, after adjusting for sociodemographic characteristics. Depression is one of the most frequently reported presenting problems reported by EAP services users and co-occurring AOD problems that complicate assessment and treatment are common. Substance abuse and depression are two of the most costly behavioral health conditions affecting the workplace; however, they are also two of the most preventable or modifiable. Given the high prevalence of co-occurring depression and AOD problems in working age adults, it is critical that EAP professionals receive additional training to improve screening methods for AOD problems among clients presenting with depressive symptoms.

Future research should examine the temporal relationships between depression, AOD problems, and EAP services use. Such studies should be integrated with intervention research focused on identifying and supporting adults with co-occurring problems.

For complex problems, such as MDD, alcohol dependence, and drug disorders, EAPs should use valid and reliable screening measures, in conjunction with evidence-based brief treatment interventions, to identify and engage employees with AOD problems. Researchers are currently evaluating the feasibility and effectiveness of integrating brief screening measures for AOD problems and mental health, specifically, depression, within EAPs and the broader workplace. McPherson and Goplerud demonstrated that the Alcohol Use Disorders Identification Test for alcohol consumption can be effectively integrated into an EAP's intake procedures to screen for risky drinking and to increase identification rates of alcohol use and abuse among employees.

Results from this study suggest that EAPs are beginning to reach employees from vulnerable groups, including, but not limited to, employees from minority racial and ethnic groups. This may be at least partially a result of recent efforts by EAPs to increase outreach efforts to engage employees from diverse racial groups in EAP services. Employees suffering from AOD problems, regardless or race/ethnicity, represent a vulnerable population in the workplace and EAPs have been working to combat negative stigma at the workplace regarding mental illness and substance abuse. Fear of work-related retaliation and other repercussions for admitting to having a problem are often greater among employees suffering from AOD problems as compared to employees with depression or other mental health problems. When employees are aware of services available to them, and the workforce is supportive of using such services,

vulnerable employees, including but not limited to those with AOD problems, are more likely to seek help through the EAP.

With regular outreach and employee education, EAPs are in a prime position to reach out to working adults and engage them in treatment for AOD problems earlier than traditional community-based substance abuse treatment programs. Additionally, the use of supervisory referrals to the EAP for performance problems that may result from employee AOD use can greatly increase the likelihood that an employee will follow through with an EAP appointment and treatment recommendations.

Limitations and Strengths of the Present Study

There are several limitations to this study. First, EAP services use data was based on retrospective self-report. Therefore, the researchers were not able to determine from the survey data the sequence of problem identification and services use. For example, adults who sought EAP services for AOD problems were more likely to also report suffering from MDD; however, it is not clear that adults seeking EAP services met the criteria for both at the time of seeking services through the EAP. Second, the use of the DSM-IV diagnostic categories for identifying major mental health disorders provided a valid and reliable measure of mental illness; however, the majority of employees seek EAP services for less severe mental health and personal problems related to work stress, marital and other relationships, work-life balance, career choices, finances, and other personal problems with the potential to impact one's performance at work. Third, given the lack of a severity measure for AOD problems and MDD, the researchers could not determine if persons with the greatest need sought services from the EAP. Finally, the use of lifetime EAP services use as an outcome variable or measure prevented the researchers from knowing if and within what industry the person was employed at the time of seeking EAP

services for AOD problems. This is also true for persons who reported using EAP services that may have used them as a spouse or dependent of the person employed with the EAP benefit.

In addition to this study's limitations, there are several strengths. Very few national surveys have estimated EAP services use among individuals with AOD problems. One of the major critiques of research within the EAP field is that samples are often based on individual employers, are not representative, lack adequate statistical power, or are otherwise flawed in methodology. The present study utilized a population-based survey, including EAP services use for AOD problems and contributes to our understanding of EAP services use within the U.S. among adults seeking help for AOD and co-occurring mental health problems. In particular, findings about the treatment for AOD and co-occurring mental health problems may illustrate common patterns of help seeking behavior and allow EAPs to meet the needs of vulnerable or at-risk working aged adults in the future.

Conclusion

Future research should examine individual and organizational variables that predict EAP services use for AOD problems and integrate such research with empirical studies evaluating workplace-based interventions offered by the EAP for AOD and co-occurring mental health problems. Additionally, researchers should continue examining adults who use EAP services for depression for the existence of underlying or hidden co-occurring AOD problems. The potential outcome from workplace screening for alcohol and drug use, and depression or anxiety, needs to be studied empirically, in addition to the impact of large-scale screening followed by brief intervention and referral for treatment. Longitudinal studies examining the process of how the EAP professional engages employees in EAP services and outcomes from coordinated care for

referrals and treatment within the community are warranted so that the field may fully understand the potential benefit of EAP services for employees with AOD problems.

EAPs, especially when incorporated into a broader workplace wellness program, may be perceived by employees as less stigmatizing than traditional outpatient mental health or community-based substance abuse programs. Additionally, employees are more likely to use EAP services when referred formally or informally by a peer or an authority figure, such as a supervisor or manager. The use of an EAP as a way to identify risky drinking or drug use, or other related mental health problems, and engage them in assessment and treatment should increase identification of AOD problems and referrals to treatment. Outcomes of successful screening and intervention programs will have positive effects for troubled employees, their family members and coworkers, and for their employer.

Professionals within the community who work with adults seeking help for AOD problems (i.e. primary care physicians, emergency room department staff, nurses, community mental health centers, substance abuse treatment professionals, and chaplains) and self-help groups should increase their knowledge about EAP services and build relationships with EAP professionals. When employees seek treatment for their AOD problems within their communities, they may benefit from having an advocate or mental health professional that they can speak with confidentially at their place of employment. EAPs can provide support to employees who are trying to access medical benefits or leave time, in addition to supporting their return-to-work process following an extended absence for AOD treatment. In conclusion, EAPs have the potential to play an even more important role in the identification and referral to treatment of employees with AOD problems.

Table 1: Employment Assistance Program Use among lifetime service users (n=2272; 54.45%)

	n	wt. %
Lifetime - EAP (alcohol and/or drug)	166	7.58
Lifetime - Alcohol EAP	139	6.16
Lifetime - Drug EAP	66	2.96
Past year - EAP	22	1.25
Past year - Alcohol EAP	14	.64
Past year - Drug EAP	10	.67

Table 2: Correlates of EAP Services Use (n=2272)

Variable	EAP Users (n=166)		Non-EAP Users (n=2106)			
	n	% or m	n	% or m	t or χ^2	*p*
Age (in years)		44.1 yr		41.7 yr	-1.96	.056
Household income		35,175		26,155	-3.17	.002
Gender - Female	48	22.8%	707	30.1%	2.95	.09
Central City	73	36.5%	778	30.9%	1.07	.31
Race						
White	101	71.5%	1340	75.6%	.83	.36
Black	38	16.4%	319	8.8%	4.43	.039
Asian	2	1.8%	32	1.8%	0	.98
NA/AI	7	3.9%	67	4.0%	0	.94
Hispanic	18	6.5%	348	9.9%	1.45	.232
Marital Status						
Currently married	72	55.4%	886	50.8%	1.00	.32
Formerly married	59	27.5%	656	23.9%	.78	.38
Never Married	35	17.1%	564	25.2%	5.39	.02
Education						
<HS	25	17.3%	435	18.0%	.03	.85
High School	42	28.3%	708	31.8%	.66	.42
>High School	99	54.4%	1129	50.2%	.73	.40
Lifetime Axis I Dx						
MDD	83	53.5%	805	37.3%	10.63	.002
Dysthymia	31	22.2%	348	15.3%	1.02	.316
GAD	17	12.9%	277	10.5%	.41	.52
Social Phobia	13	8.1%	200	9.64%	.33	.57
PD -Agoraphobia	6	3.9%	85	3.83%	.00	.95
Specific phobia	17	10.3%	323	15.78%	3.33	.07
Alcohol Abuse	39	23.6%	637	28.9%	1.36	.25
Alcohol Dep.	118	71.5%	1250	62.0%	3.78	.06
Drug Use Disorder	105	67.0%	1084	53.4%	6.65	.01
Gambling Disorder	3	1.76%	46	1.76%	0	1.0
Lifetime Axis II Dx						
ASPD	36	22.6%	370	18.9%	1.02	.32
Avoidant PD	8	5.1%	167	7.9%	1.95	.17
Dependent PD	2	1.9%	46	2.2%	.07	.78
OCPD	25	16.3%	325	15.9%	.01	.91
Paranoid	14	9.6%	287	13.3%	1.72	.19
Schizoid	17	8.8%	185	9.3%	.04	.85
Histrionic	10	6.0%	134	6.8%	.14	.71
Disability						
SF-12 Physical	49.12		48.43		-.63	.53
SF-12 Mental	46.71		48.46		1.36	.17

Table 3: Logistic Regression models of EAP services use

	OR (95% CI)	OR_{adj} † (95% CI)
Age (in years)	1.01* (1.00, 1.03)	1.01 (.99, 1.02)
Gender (Ref=Female)	1.45 (.92. 2.29)	1.49 (.92, 2.41)
Household Income (in US Dollars)	1.00 (1.00, 1.00)	1.00 (1.00, 1.00)
Race (ref.=White)		
Black	1.96* (1.16, 3.31)	2.13** (1.23, 3.70)
Hispanic	.69 (.28, 1.70)	.74 (.32, 1.73)
Asian	1.07 (.24, 4.79)	1.19 (.25, 5.54)
American Indian	1.03 (.41, 2.56)	1.15 (.46, 2.90)
Marital Status (ref.=never married)		
Currently Married	1.61* (1.01, 2.59)	1.53 (.90, 2.60)
Formerly Married	1.70* (1.01, 2.86)	1.70 (.91, 3.18)
Education (ref.=did not complete high school)		
High School	.92 (.48, 1.79)	.93 (.49, 1.76)
>High School	1.14 (.61, 2.13)	1.14 (.62, 2.09)
Lifetime Major Depressive Disorder	1.93** (1.32, 2.82)	2.42*** (1.61, 3.64)
Lifetime Alcohol Use Disorder		
Alcohol Abuse	1.50 (.66, 3.38)	1.39 (.59, 3.26)
Alcohol Dependence (with or without abuse)	2.11* (1.00, 4.45)	2.09 (.97, 4.53)
Lifetime Drug Use Disorder	1.77* (1.12, 2.81)	2.08** (1.22, 3.55)

*p<.05; **p<.01;*** p<.001; †adjusted for age, gender, race, marital status, education and income

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