Preparing for the Challenges of the Employee Assistance Research Foundation:
A Reprisal to Carl Tisone's *Call To Action*:

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Much fanfare surrounded the inaugural meeting of the Employee Assistance Research Foundation (EARF) at the 2007 World EAPA Conference in San Diego this past October. The naming of Dr. Paul
Roman, Distinguished Professor of Sociology, University of Athens-Georgia, as Senior Advisor to the EARF Board and a pledge of matching financial support from the Carl Tisone Family Foundation formalized the presence of this organization within the professional world of EAP. The event was a true milestone for the EAP field and Tisone deserves our recognition for organizing this initiative. Now that the standing ovations have quieted and we have all returned to our varied rolls in doing work loosely defined as EAP, the infant EARF is charged with a not-so-simple question, "Now what?"

In September, Carl R. Tisone issued a paper, *Call to Action*, which laid the foundation for the EARF and created the gauntlet that was thrown down by Dr. Roman at the World Conference. The voices of Roman, Tisone, Paul Heck, DuPont's Worldwide Director of EAP, Dale Masi, President of Masi Research Consultants, and a collective who's who of the EAP industry attending the conference resonated with many. While celebration is in order, Tisone's call to action should be viewed as a wake-up call. While we have been busy doing our good work, the world of EAP has moved, without guidance, from under our feet and in the wrong direction.

Is Research a Cure for What Ails Us?

Few will disagree with Tisone's indictment in his paper that there is an absence of significant empirical evidence showing that EAP—in any of its shapes and sizes—offers measurable business-relevant value. To clarify, this is not to suggest that EAP offers no value. Rather, the implication is that we can't prove that it does. The gold standard of research, the randomized controlled study, is non-existent in the contemporary EAP world. We also know from other research in the behavioral sciences that merely publishing and disseminating empirical research may not lead to major changes in practice.

Working with or inside company medical departments, we are surrounded by physicians whose professional existence is more grounded in evidence-based practices. While our colleagues in the field of medicine do not completely dismiss our labors, in their eyes what we bring to the table lacks empirical evidence. If the practice of psychology is a soft science, then the practice of EAP is floating in a sea of watery Jell-O™.

Let us play devil's advocate. Is that level of scrutiny necessary? Does EAP really need to be held to the same standard of proof as medical science? At the San Diego EAPA Conference, Heck commented that to cement EAP's legitimacy—and, as a result, secure the future of internal or highly integrated external programs and break the commodity trap—EAPs need to be viewed as

legitimate business entities in the same manner as Accounting, Human Resources (HR) and Legal departments.

When was the last time attorneys, accountants, or HR professionals were required to run a randomized control trial of their daily activities to justify their existence and command respect as a "field?"
It's not likely that they ever have. The fact is that businesses could not run without these functions—and that is the evidence of their value. EAPs, however, cannot make that claim.

Outsourcing, off-shoring, and extreme budget cutbacks threaten the status quo of these corporate entities just as the EAP has been threatened. These corporate service entities will not disappear; although the integrity of their work continues to be challenged through many of the same pressures EAPs have experienced. Paul Heck's analogy, while instructive, falters because EAPs don't hold that same immediate business impact as an Accounting or Legal department. Unlike Accounting and Legal, EAP is not recognized as a "discipline" and does not have its own unique academic training, license to practice, and highly developed body of knowledge. Therefore, the future of EAP faces a much greater peril.

How EAP is Currently Defined

The truth is EAPs are rooted in medicine, as is the entire field of mental health. The issue of EAP's proper place in the world-of-work versus the world-of-health can be debated. However, from our observation, even the "Thundering Hundred" were trying to help employees recover from an illness. Successful recovery resulted in value that was seen and experienced by smartly using the workplace as "leverage" to motivate, and occasionally coerce, resistant employees into receiving treatment and returning to full productivity.

In his paper, Tisone channels some brilliant corporate jargon in his description of EAP's mission as "the application of our core competencies to the improvement of organizational productivity through the enhancement of individual well-being." He boils this down further by quoting two of the Thundering
Hundred, "focus on job performance and the rest will take care of itself."

If it were only that simple in the climate faced by today's contemporary EAP.

On another day we may pontificate on observations of why the EAP field, which rests on the training, education, and efforts of *mental healthcare professionals*, has worked so hard to separate itself from the world-of-health. But make no mistake; in spite of our often-inflated sense of purpose and importance, most purchasers do not view EAP as an HR consultant or a work performance management tool.

Recent research by Sharar (2007) shows that contemporary EAPs, and their use of Affiliate Networks, have significant overlap with services provided through the employer's outpatient behavioral health benefit. The content of EAP intervention, as practiced by Network Affiliates, has drifted from Roman and Blum's original core technology. There has been significant leakage from routine General Practice Counseling into EAP, or the degree to which EAP clients simply receive

brief treatment in the EAP setting. Some employers, but certainly not all, may be paying two premiums for a similar or identical service. A few savvy purchasers with highly integrated programs have and will connect the dots to see the broad business-relevant value of EAP. However, most purchasers view EAP as a type of employee counseling benefit designed to lessen the burden of employees' mental health, substance abuse, and behavior problems on their ability to operate a business.

Therein lies the good news. We know how to address these personal and medical problems. There is even empirical evidence demonstrating that we know how to treat illnesses such as substance abuse and depression with tools that we are trained and licensed to use. Depression is now one of the leading causes of disability and performance decline worldwide; and employers are seeking solutions.

While the world of EAP has been oversold by the cheapest bidder, and EAP professionals have worked hard not to be viewed as mental health professionals, we may have missed the boat both in terms of developing a research base and demonstrating value that is relevant to EAP stakeholders and purchasers.

To illustrate, we have spent the last few years tackling a couple of important issues that are relevant but seen as ancillary to EAP. Both are highly visible and cost employers very real dollars. The first is the impact of mental health conditions, both primary and co-morbid, on healthcare costs and productivity. The second is the skyrocketing problem of short and long-term disability due to mental health conditions.

We have spent considerable time and effort looking into these issues, including services offered by industries such as Managed Behavioral Healthcare (MBH), Disease Management (DM), health promotion, wellness, and disability management. All of these industries have proposed solutions to address the problem of mental health in the context of the workplace, albeit with varying levels of supporting data. Some industries, such as disease management or "care management" for depression, are investing resources in randomized controlled trials to demonstrate their impact on business-relevant metrics. Here's the irony: companies large and small are spending top dollar for these products, especially when compared to the low capitated price of an EAP.

What does this mean for EAPs? As the EAP profession flounders to find its identity and invests little in developing evidence-based practices, these other industries walked right in and adopted the identity we have been futilely searching for yet are so unwilling to accept.

Now, back to the good news. As we read and reread Tisone's compelling *Call to Action*, we are struck by references to *we* and *what*. The *we* refers to the nebulous EAP industry. The *we* are those who sell EAPs, manage accounts, work in call centers, develop work-life resources, see EAP clients in private practices, hold offices in Union halls, conduct training, and operate internal EAPs. *What* is all of the various things *we* promise to do for the consumers of EAP.

Carl Tisone and the mission of the EARF are spot on. The *we* and *what* of EAP are still too vague and still far too undervalued. Only through the development of a body of empirical research can clear proof be demonstrated of the value of *what we* do. In addition, out of that evidence will come

greater respect for our work, an end to marginalization and commoditization, and a transformation of the world of EAP.

Redefining EAP by Making the Business Case

With a majority of North American employers purchasing EAPs and with growing global enthusiasm, why do EAPs and EAP practice remain misunderstood, marginalized, and under funded? Why are even the most revered and respected internal programs in top Fortune companies being threatened by low-bidding vendors and HR outsourcing?

There is clearly a paucity of empirical research supporting contemporary EAP products and practices.
Research in EAP is dominated by proprietary vendor program evaluations that do not subscribe to high levels of rigor commonly seen in National Institutes of Health funded studies. In spite of the lack of sound empirical outcomes, the EAP field has been able to avoid scrutiny of its lack of evidence. This is true as EAPs, in some form, remain as a fundamental but tiny part of an employer's benefit packages. Yet as an industry we have slowly and quietly been victimized by our own lack of a business case.

While healthcare costs continue to show yearly double-digit increases, EAPs—both internal and external—continue the fight to merely stay solvent. Internal programs are eliminated in favor of capitated affiliate model programs. Even successful EAP vendors operate on thin-to-no profit margins, ration services, and occasionally "spin" utilization reports merely to retain customers and persuade them that EAP activity is robust. Some are even making money by peddling the "free" EAP that is embedded as a "give-away" within an insurance product.

There are many published studies looking at EAP-type services. Most are either fraught with methodological problems or focus narrowly on EAP process evaluations, single case studies, and measures of client satisfaction. Is a high level of exploration and scientific rigor really necessary for EAPs? While the industry is struggling, it is not disappearing. After all, aren't EAPs still being purchased?

We contend that the lack of an evidence base and business-relevant metrics have directly led to the erosion of the business and practice of EAP. As a result, the tradition, integrity and even the true value of EAP weaken under the weight of larger forces, such as EAP's integration into Managed Behavioral Health and Human Resource Outsourcing.

The power of sound science in a health-related industry can be demonstrated in the simple example of diabetes. Diabetes has a huge health-related and financial impact. Research on treatments and chronic disease management is being widely conducted. As a result, health promotion and disease management is quickly emerging as a stand-alone industry and an HMO add-on that is being sold to address many chronic conditions.

Importantly, a relative small body of sound empirical studies published in reputable scientific journals has made the connection between improved diabetes control and business-relevant measures, such as healthcare costs, absenteeism, disability and retention, and thus fueled an entire

industry (Wagner, Sandhu, Newton, McCulloch, Ramsey, & Grothaus, 2001; Testa & Simonson, 1998; CDC Diabetes Cost-effectiveness Group, 2002.).

For example, studies conducted by Health Partners (Gilmer, O'Connor, Manning & Rush, 1997.) have demonstrated that when diabetics with no significant co morbid illnesses reduce their Hba1c by a single point (through treatment compliance and a healthy lifestyle) their total healthcare costs can be reduced by as much as $1205 per year.

It is most noteworthy that these studies demonstrate value for the clinical consumer, potential ROI for the employer-purchaser and help make the business case for products sold by a thriving industry. What if an EAP could demonstrate in an article published in the Journal of Occupational and Environmental Medicine that a select few of its services resulted in a 50% improvement in depression symptoms, reduced absenteeism by 9 days per year per employee-client, and a reduction in total healthcare claims by $800 dollars per year per client? How might such a study influence EAP sales presentations? How many more companies would invest in EAPs? How would capitated rates or EAP vendor profit margins change?

We desperately need to establish a new standard of EAP science. While the academic and financial infrastructure does not yet exist to accomplish this, the EARF provides an excellent first step. The EAP field is in need of scientific rigor that demonstrates evidence-based practices and outcomes that are both clinical and business-relevant. We are not suggesting that EAP vendors should stop conducting studies of process measures that aid in quality management and evaluation. However, the industry needs independent, multi-site randomized control studies that demonstrate the impact of what we do. In traditional EAP terms, we must prove value for both the employee-client and employer-client.

There are several challenges inherent to the mission of the EARF. Securing funding for research is always an obstacle. Another challenge, which is a subtle yet likely major factor related to the dearth of research, is that the field has not traditionally been heavily populated with research professionals. Most often, EAP professionals are clinically minded or entrepreneurial and do not come from training programs that are heavily focused on research methods. As a result, we tend to focus on doing what we do rather than on expanding the knowledge base. We fail to invest in our own profession, then lament the state of EAP.

The EARF seems intent to address these issues. Through matching grants and fundraising, necessary funding streams can be established. In our experience, institutions such as the Substance Abuse and
Mental Health Services Administration (SAMHSA), National Institutes of Health (NIH), and the Centers for
Disease Control and Prevention (CDC) are willing to fund corporate and workplace-focused studies. In addition, when attached to the names of large corporations, academic institutions are often eager to commit resources to partner on corporate research initiatives.

Squarely Facing the Challenges Ahead

Fundamental in developing any research initiative is to (a) define a research question, (b) operationally define the construct to be studied, and (c) determine the methods available to study the question. However, there are two core reasons why these fundamentals are the largest challenges facing the research initiative and could possibly undermine the mission of the EARF.

First, breaking the world of EAP into separate components to study effectiveness fundamentally challenges the validity of products, jobs, and professional work that make up an entire industry. The EAP industry, which is now mostly comprised of large vendor corporations rather than practitioners or internal EAP professionals, will be challenged by the mere discussion of independent research. We imagine there may only be marginal support from large EAP vendor corporations for research potentially demonstrating that pieces of their product show no financial benefit (e.g., return-on-investment) for purchasers. The fear is that the EAP field and industry will be unwilling to face an honest and candid look in the mirror. In addition, the results of such research may even been hidden from purchasers when they reflect unfavorably on product offerings.

Second, in spite of the core technology, there is no consistent and well-defined operational definition of an "EAP." Instead, we have a large array of products and practices that fall under the rubric of EAP. Therefore, rather than immediately setting out on a path to research "the [cost] effectiveness of EAP," we need to step back, break the practice of EAP into its fundamental components, and operationally define the individual activities that make up the EAP practice. There is continued uncertainty regarding the active and specific ingredients that separate EAP as a unique model. Once we can articulate the exact recipe for EAP, we can begin asking research questions of those EAP constructs.

It's expected that some, if not many, of the constructs that make up EAP will not show well under the scrutiny of well-controlled research. This will challenge our profession and our industry. As discussed, this level of rigor will be necessary for EAP to move to a higher level of professional credibility and reap longer-term financial benefits. The long-term results will reveal a list of "active ingredients" that make up an EAP. These active ingredients will be those that clearly show positive outcomes—i.e., evidence-based practices (EBPs).

Again, we must be prepared to challenge what we hold as our unique definition of what is and isn't an
EAP. It is possible that components of what we view as EAP will show no improvements on the measures we view as important, such as clinical improvement, improved absenteeism, reduced accidents, or decreased healthcare costs. We then need to face the decision to change our practice and our products, or not. However, a demonstration of partial or limited benefits does not mean that we must stop doing some of the things fundamental to EAP practice. One glance at a tube of toothpaste shows that only one of the
fifteen ingredients are "active." The remaining fourteen are still relatively important to the overall quality of the product.

A reasonable analogy to conducting EAP research would be for the medical community to study the benefits of hospitalization. The concept of hospitalization is vast, vague, and contains many components. Depending on an individual's vantage point, what encompasses a hospitalization will

vary greatly. Taken as a whole, it would be impossible to make any comments on the benefits of hospitalization primarily because of the many discriminate parts and a lack of an operational definition.

However, broken down, the benefits of all the things that encompass a stay in the hospital can be evaluated. For example, there is the efficacy of the medical care provided. Certainly, the medical community works tirelessly to develop evidence-based medical guidelines for the hundreds of conditions that may warrant an in-patient stay.

What about all the other activities that drive costs and manpower? Does an unlimited supply of ice chips and clear liquids served by a nurse help a patient recover any faster? What about a private room or a television hanging from the wall? Is there evidence in favor of frequent visits by a nurse to the hospital bedside or the value of allocating real estate resources to an in-house gift shop? These questions seem tangential but they reflect the “ingredients” of hospitalization.

In spite of the obvious lack of impact on the ultimate outcome of a hospital stay, hospitalization still involves many non-value added activities. Hospital administrators likely debate and study the cost-benefit of these "nice-to-haves." But there should be only limited, isolated professional debate on the "active ingredients" or the EBPs leading to a patient's improved health as a result of a hospital stay.

In many ways the practice of EAP is no different. EAP involves a multitude of ingredients provided by professionals of many disciplines. Our contention is that, like toothpaste or a stay in the hospital, there are likely many "active" and "other" ingredients that make up EAP services. Can we demonstrate how a client’s personal problem impacts job performance? Perhaps case management and follow-up leads to improved business-relevant measures. Perhaps referrals for childcare, pet sitting, or short-term couples counseling do not. The fact is, we just don't know.

EAPs may chose to engage in work that is a non-value-add to the purchaser, but pleases the employee-client. Or, perhaps the future of EAPs will involve a mere fraction of the services currently offered because we will get better at doing what we know works; and we will stop doing what doesn't.

A Time for Change

History has shown that purchasers will not force the EAP industry to demonstrate value through scientific rigor. No one is going to force us to self-evaluate to the degree suggested in this article. However, if we choose not to, the value of EAP will be out of our control and left to the variability and whim of the economy and the purchaser. It is our responsibility to learn what works and what doesn't and to then, in an unbiased and objective fashion, disseminate this new knowledge to the field and the purchaser.

It will be at that point, and probably only at that point, where the perceived and true financial value of EAP will grow and no longer stagnate. It will be at that point where EAP will be a practice, a product, and a profession that we can provide with unwavering confidence.

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