Cost-Effectiveness and Preventive Implications of EMPLOYEE ASSISTANCE PROGRAMS

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
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Center for Substance Abuse Prevention

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CSAP Mission Statement

The Center for Substance Abuse Prevention (CSAP) supports and promotes the continued development of community, State, national, and international, comprehensive prevention systems. CSAP strives to connect people and resources with effective and innovative ideas, strategies, and programs, aimed at reducing and eliminating alcohol, tobacco, and other drug (ATOD) problems in our society. CSAP's prevention programs and models, tailored to specific cultures and locales, capitalize on broad-based community involvement and enhanced public and professional awareness of prevention.

CONTENTS

1 Overview of Employee Assistance Programs

Many cost-effectiveness studies indicate the value of employee assistance programs (EAPs) in dealing with alcohol and other drug (AOD) problems. This report reviews a wide range of these studies and presents data about EAP use for AOD-related problems.

EAPs are worksite-based programs designed to help identify and facilitate the resolution of behavioral, health, and productivity problems that may adversely affect employees' well-being or job performance. The focus is wide-ranging, covering alcohol and other drug abuse; physical and emotional health; and marital, family, financial, legal, and other personal concerns that may affect employees. The Employee Assistance Professionals Association (EAPA), an organization with a membership of over 6,000, has adopted standards for EAPs that specify a comprehensive set of services. For an EAP to be most effective, it should include expert consultation for employees and managers; training for appropriate persons in identifying and helping to resolve behavioral, health, or job performance problems; confidential, appropriate, and timely problem assessment services; referrals for diagnosis, treatment, and other assistance; establishment of links between workplace and community resources that provide these services; follow-up services; education and information on the prevention of AOD problems; consultation about environmental changes that may reduce the incidence of employee problems; and coordinated policy statements concerning AOD use and sanctions.

The EAP is usually based on a written policy statement and provides a means for supervisors, managers, and union shop stewards to get expert guidance in dealing with subordinates or coworkers who need help. Self-referral is also encouraged. The guidance is provided by an internal EAP coordinator or a staff member at a contract agency, who may be contacted either by telephone or in person. Some contract agency representatives spend some or all of their time at the worksites for which they provide services, and some internal EAP coordinators are located off-site, to maximize confidentiality.

Employers have been highly receptive to adopting and implementing the EAP model; this implies that employers perceive EAPs as appropriate means for addressing significant workplace problems (Milne et al. 1994). In 1991, national sample data indicated that 45 percent of full-time employees had access to an EAP provided by their employer (Blum and Roman 1992, Blum et al. 1992*b*). Virtually all large workplaces and the majority of medium-size workplaces provide some form of EAP. EAP coverage is least likely to be found in small worksites. A survey of full-time employees, conducted at the end of 1993 and the beginning of 1994, indicated (1) that the proportion of employees who work for employers who provide EAPs has plateaued and (2) that EAP use has increased among employees and their dependents (Blum and Roman 1994).

Data from EAP records and reports between 1984 and 1988 indicate that approximately 5 percent of the employees who work in an organization with an EAP use it over a

12-month period (Blum 1989). About one-fourth of these users have relatively minor problems that are resolved quickly, typically without an external referral. Approximately 1.5 percent of the employees in medium-size to large worksites use the EAP for AOD-related problems in a given year (Blum 1989). At first glance these use rates may appear low; however, they are quite high when considered in light of the expected prevalence of the problems they are designed to address. Further, since most employee tenure is lengthy, it is useful to view EAP use as cumulative over a number of years. From this perspective, without adjusting for turnover or reutilization, approximately 25 percent of an organizational workforce would receive EAP services over a 5-year period, and 7.5 percent of the employees would receive AOD-abuse related services. These rates are based on employee use only; they do not include EAP use by dependents or retirees, which in these data accounts for approximately 20 percent of EAP caseloads.

2 EAPs and Prevention

EAPs do not have a clear practical or conceptual place as part of "prevention" or "treatment" of AOD or mental health problems. In some cases, EAPs have been erroneously classified as a component of treatment. During the founding period of the National Institute on Alcohol Abuse and Alcoholism (NIAAA) in 1971, the policy leadership and programmatic funding of EAP support efforts were placed in the Occupational Programs Branch, in the Division of Special Treatment and Rehabilitation Programs. This placement associated EAPs with treatment concerns, an image supported at least until 1981, when the division was disbanded.

The placement may have been appropriate in the early stages of EAP development and the first several years of EAP staff activity, when caseloads were primarily composed of long-term alcohol abusers and chronic alcoholics, for whom tertiary interventions were required. Initially, staffing for both EAPs and EAP support activities was made up largely of recovering alcoholics. Not only did the treatment and recovery experiences of these persons loom large in the direction of their work, but their experiences were generally inconsistent with notions of primary prevention; that is, alcohol abuse or excessive drinking were commonly seen as markers of the forces (the "allergy" of Alcoholics Anonymous) leading to alcoholism, believed to be irreversible without abstinence-directed treatment interventions.

Had there been the opportunity for a choice of a conceptual home for EAPs in both government and the private sector, many EAP workers would have favored EAPs' continuing to be classified as treatment. There are generally more resources and opportunities associated with treatment than with prevention; treatment activities tend to be more prestigious than prevention activities; and the results of treatment are typically more tangible and measurable than the consequences of preventive interventions.

Making a distinction between prevention and treatment, however, misrepresents the reality of EAPs in many respects and sharply limits the development of a truly integrated continuum between community and worksite prevention efforts. AOD and mental health problems require multifaceted solutions, but bifurcated prevention and treatment labels and constituencies have encouraged competition between these two essential components of community and worksite policies and practices. Mature EAPs and those in communities that have other AOD prevention activities deal less often with late-stage problems. Also, as they evolve, EAPs are less likely to be staffed by recovering persons without advanced clinical training, a staffing pattern typical of EAPs in the 1970's. Increased professionalism increases the likelihood of a focus on primary and secondary prevention activities.

EAPs are substantially involved in prevention activities on both the individual and worksite levels. Their basic roles include supervisory consultation, assessment, treatment linkage, and follow-up/aftercare or relapse prevention. The

typical image of EAPs is centered around caseloads of employees with problems, but many preventive activities occur under EAP auspices. The following are examples of cases in which EAPs have played a role in prevention:

- One of the most costly experiences for individuals, families, and communities is job loss by a significant breadwinner. The impact of unemployment on all family members has been well documented. Because they are designed as human resource conservation programs, EAPs help prevent unemployment or gaps in employment. The goal of an EAP is to retain jobs and career continuity for individuals and their families while preventing costly turnover experiences for employers.
- By definition, EAPs deal with clients who are still able to do their jobs. In their attention to alcohol and other drug use, EAPs see substantial numbers of clients who may use AODs to excess but who have not yet passed to stages of impairment characterizing severe dependence or addiction. Confrontations, either formal or informal, that include the contingency of job sanctions or loss may halt the progression to alcoholism or other drug dependence and addiction.
- Services are made available to employees' family members, reducing the occurrence of alcoholism and other drug dependencies among them as well. This kind of assistance clearly affects the work setting, since employees with troubled family members are likely to become performance problems themselves.

- Informing employees' families of EAP availability may encourage early referral of workers with AOD problems. Family members who know about the EAP usually become involved in the referral process at a much earlier stage than would be expected in the ordinary course of events.
- EAP caseloads include many employees with family problems and other dysfunctions that do not appear to involve AOD dependence, but that may be prodromal to dependence. Thus, EAPs engage in primary prevention of AOD abuse by helping people resolve problems that otherwise might lead to excessive or dependent use of alcohol or other drugs as coping devices. EAPs also can mitigate the consequences of AOD problems if AOD abuse is already apparent as part of the family discord.
- EAPs provide an array of services to employees who are parents. By providing services to parents who need them, EAPs also engage in potential AOD abuse prevention for their children.
- As drug-free workplace policies are implemented, EAP personnel can play a vital role in the design and integration of employee testing strategies. When drug-free policies are implemented, it is critically important to minimize contradictions between them and other organizational policies. EAP referral of employees with positive drug screens was not envisioned in the original design of the drug-free workplace. This may not only prevent job loss for the individual and costly turnover for the employer, but such

referral also can translate the positive drug test into a counseling strategy to prevent AOD use or abuse from escalating to dependence or addiction.

- EAPs provide advice and brief assistance to self-referred clients, which may preclude the need for their entry into community-based treatment.
- EAPs provide educational materials to employees about AOD and mental disorders and their prevention, a direct strategy of primary prevention.
- EAPs generate primary prevention by educating supervisors and union representatives about the management of AOD and mental health problems. It is clear from research cited later in this report that supervisors have substantial effects on employees' decisions to deal with personal problems before they reach the stage of job performance decrements that can be documented.
- EAP presence is highly correlated with distinctive rules against the use of alcohol in all work-related functions, and with the presence of no-smoking workplace policies (Blum et al. 1990, Blum and Roman 1994). The philosophy emanating from the EAP offers synergistic support to these policies through its contribution to a workplace culture that emphasizes behavioral health, a contribution that is clearly primary prevention.
- EAPs contribute to transformations of workplace cultures from those that support excessive drinking and stigmatize attempts at recovery into cultures that provide support for defining and dealing with AOD problems and for employees who have elected to do so.

EAPs are worksite mechanisms that help bridge the gap between prevention and treatment. Social settings and relationships are important in the development of and recovery from AOD problems (Bacon 1973). These forces are also central to successful prevention. Next to the family, worksites are the most important contexts for shaping and constraining expectations and behavior concerning alcohol and other drugs (Beattie et al. 1992). EAPs have been adopted across the private and public sectors as integral parts of worksite AOD abuse prevention activities. They are involved in resolving family problems, and they include family members in the prevention or resolution of problems relating to alcohol and other drugs. Access to an EAP is even more important for employees whose families are unable or unwilling to prevent or resolve problems, or those who have no family support structures.

These observations are based on an *open systems* perspective, in which worksite programming occurs in community settings—the community influences the worksite and the worksite influences the larger community. The next section is a review of published and unpublished studies of, first, the cost-effectiveness of EAPs. These studies focus on the treatment impacts of EAPs, which means that the data underestimate the true value of EAPs' impact beyond the individual employee and do not consider traditional conceptualizations of prevention. The second section presents recent data about individual employees/clients of EAPs,

data that reflect preventive processes within the EAP, at the worksite, and in the larger community. The third section reconceptualizes the preventive role of EAPs, describing a variety of processes that are part of prevention but usually unmeasured and describing the synergy between EAPs and worksite wellness programs and other parallel activities.

3 Cost-Effectiveness Studies

Studies of the effectiveness of EAPs are generally limited to before-and-after comparisons of EAP clients. These are typically single-group pre- and post-test designs with outcomes centered on some organizationally relevant or individual AOD use variable. In some instances comparison groups are also included in the studies, usually without indication that the EAP and comparison groups are legitimately comparable. The research designs of EAP evaluations often have deficiencies, but the evaluations still provide information about the importance of EAPs in worksite prevention and intervention for employee and family member problems, including AOD abuse.

Four caveats apply to the following review:

1. Indisputable proof does not exist that all EAPs are cost-effective or that a single EAP model can be assumed to be cost-effective across many settings. Nonetheless, EAPs continue to be adopted and maintained by many companies. EAPs are especially prominent in larger companies that see benefits from their own EAPs which have not been reported in research journals (Blum and Roman 1989, Harris and Heft 1992). Research surveys indicate that 82.3 percent of companies with more than 1,000 employees have an EAP (Hartwell et al. 1995).
2. There are many areas of human resource management in organizations for which there is little if any

evaluation research (Dunnette 1990, Harris and Heft 1992). EAP evaluation is probably at a more advanced stage than evaluation of most other parallel worksite practices.

3. All of the published studies indicate that EAPs are cost-effective. There is no published evidence that EAPs are harmful to corporate economies or to individual employees. Given the tremendous competition that exists in the human services delivery field, competent studies that cast a negative light on the economic or social value of EAPs would be published in professional journals and would quickly draw media attention. If such studies exist, they are not visible.
4. The extent of improvement in outcome measures is limited by the kinds of clients seen, the severity of their problems, and their work performance difficulties. If assistance is provided in the early stages of a problem, dramatic investment-to-cost ratios are less likely, especially if the study is treatment focused rather than prevention focused. In other words, clients with dramatic middle- and late-stage problems who are very costly to the organization will show the greatest cost reductions, and organizations with many such clients will produce the most dramatic time-series changes in costs. Thus it is possible for poorly implemented EAPs to show the most dramatic results, if costs and cost reduction are defined in traditional ways.

Despite the lack of definitive studies of the outcomes of EAPs, there is an impressive accumulation of evidence

across a variety of worksites about EAP effectiveness. Consistent with the perception of EAPs as part of treatment, these studies are limited to individual client outcomes; thus they examine only part of what EAPs can do.

EAP Study Findings

The **Hazelden Foundation** compiled a list of 11 studies, conducted between 1976 and 1981, on the cost impact of EAPs in dealing with employees with alcohol problems (Bureau of National Affairs 1987). These studies indicate substantial improvement among EAP clients in work performance, as well as reductions in accidents, grievances, visits to the medical department, and workers' compensation claims. In one study conducted in a number of plants, EAP clients showed improvement on before-and-after measures in all of the above criteria (Foote et al. 1978). Of the three plants included in a study of absenteeism before and after EAP use, absenteeism increased in one plant and decreased in the other two. In four plants where sickness and accident data were available, three had increased rates in the year after entry into the EAP, probably reflecting the use of sickness and accident benefits for AOD treatment. This study also indicated that changes in measures are not always consistent across different EAPs. Employees whose job performance levels were well below the company norm at EAP intervention showed improvements in performance after intervention, while employees who were not performing below the norm did not show improvement. This finding is consistent with our observation, in caveat number 4, about

improvement artifacts associated with low scores and measures that are viewed over time.

In the before-and-after outcome comparisons of Hazelden clients (Bureau of National Affairs 1987), more than one-third of the clients had improved quality and quantity of work, improved relationships with coworkers and supervisors, at least a threefold decrease in arriving late or leaving early, and a decrease in other absences from an average of 56 absences before EAP use to none. Utilization of health insurance decreased, as did number of sick days, but medical leave days increased. Workers' compensation episodes decreased from eight to zero, with no change in workplace accidents, which are rare but potentially tragic and costly events.

Kurtz et al. (1984) reviewed eight studies that used change in drinking behavior as an indicator of outcome. These studies all indicated improvement in drinking status after EAP use. In the two studies that had comparison groups of employees who refused to use the EAP, more than twice as many in the EAP use group had "socially recovered." This review also examined 16 studies that used work performance as the criterion of success. Absenteeism was the most frequent criterion examined; it decreased in all studies in which it was evaluated. Reductions in accidents, grievances, disciplinary actions, and the use of sick leave were also reported.

Kurtz et al. (1984) also reviewed 11 studies with cost reduction as the criterion of workplace program success. Six of

these studies used no comparison group, four used comparisons with those who refused EAP or treatment, and one study compared EAP clients with employees who had personal problems not involving alcohol and other drugs and also with the norms for the organizational population. Three of the studies did not show any significant cost reductions, one study indicated a negative cost-benefit ratio, and seven studies indicated substantial savings. One study indicated a 5:1 reduction in work hours and wages lost for those who used the EAP compared with those who refused to use the EAP over a 1-year period. This same study indicated a 13:1 change in use of sickness and accident benefits; employees who used the EAP had a reduction of 5 percent in the 12-month period, compared with a 60 percent increase among those who did not. A 1977 study included in the review indicated 2.2 times more saving for rehabilitation than for replacement of employees who used the EAP; a 1980 study indicated a saving of $1,590 per EAP user in sickness and accident benefits over a 5-year period; and a 1972 study indicated a saving of $1,142 per EAP user.

A number of studies have been conducted since the Kurtz et al. review. Like many evaluations of human resource activities, these studies do not always meet the requirements of rigorous evaluation. In some instances they do not appear in peer-reviewed publications because they contain internal company data or proprietary information. Some appear in trade publications with minimal description of the research methodologies. However, the methodologies of these more recent studies show improvements over those

of earlier studies and continue to indicate the cost efficacy of EAPs.

EAP cost-effectiveness data generally indicate savings-to-investment ratios ranging from 1.5:1 to 15:1 (McDonnell Douglas 1989); the results of a 1989 study (Smith and Mahoney) conducted at the **McDonnell Douglas Corporation** estimate a minimum 4:1 savings-to-investment ratio. This study found minimum (conservatively estimated) savings of $5.1 million as the result of use of the company's EAP, which served 100,000 employees and 250,000 dependents. The study compared EAP clients who received AOD dependency or psychiatric treatment with employees who received treatment for the same categories of problems during the same time period but accessed treatment through other routes. Data were compared for the year of program entry, with follow-up points ranging up to 3 years later. EAP clients treated for AOD dependency missed 44 percent fewer days of work, and EAP clients treated for psychiatric conditions missed 34 percent fewer days compared with those who sought treatment on their own. At the end of 4 years, EAP clients treated for AOD dependency had a turnover rate of 7.5 percent, compared with a 40 percent turnover rate for employees who received treatment using other routes. In a similar comparison of EAP clients and others treated for psychiatric conditions, the former had a 60 percent lower turnover rate. The medical claims of spouses and dependents who accessed treatment through EAP referral were 35 percent less than those of spouses and dependents who did not use the EAP. The average per-case cost for EAP clients was $7,370 lower for AOD

dependency and $2,400 lower for psychiatric cases than the costs for employees who did not use the EAP.

The average per-case employee medical claim for EAP clients with alcoholism was $9,898 less than that of employees who entered treatment without using the EAP. The comparable figure for other drug diagnoses was $715 less; for mixed abuse diagnoses, $5,779 less; and for psychiatric conditions, $715 less. The excess costs of treatment among those not using the EAP for alcohol problems for spouses or other dependents was $5,522; for other drug diagnoses, $7,765; for mixed-abuse diagnoses, $739; and for psychiatric conditions, $6,292.

Sample sizes and selection criteria for constructing comparison groups are not always clear in the reports from this study. Also, the study provides no information to demonstrate the similarity of the EAP-using and non-EAP-using samples, particularly with regard to symptom severity. The analysts attribute any differences between the groups to EAP use, assuming that the groups are similar in all important characteristics of a sociodemographic or occupational nature. This may be a reasonable assumption: Other studies (e.g., Beyer and Trice 1978, Milne et al. 1994) reveal that knowing of the EAP's existence and understanding of how it operates are more important factors in EAP use than employees' social characteristics. In any event, the results of this study are dramatic, and it is difficult to conceive of an alternative explanation for the cost savings. Even if the savings were explained by differential problem severity between