

A RESEARCH NOTE ON EAP PREVALENCE, COMPONENTS AND UTILIZATION

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Descriptive data from recent survey data collections focused on EAPs are presented. A national survey of full-time employed persons describes the growing prevalence of EAPs, their reported use and workers' general satisfaction with them. More than 45 percent of the full-time workforce reported coverage by EAPs in 1991. A longitudinal study of a sample of internal EAPs reveals them to be remarkably stable. There is clear interdependence in the structural elements comprising EAPs. A study of initial referrals to EAP services at 84 worksites describes the characteristics of EAP caseloads, and allows some general comparisons with the nation sample of employees. Data indicate that EAPs are dealing extensively with employees with serious personal problems, confirming their utility to both employees and organizations.

Employee assistance programs (EAPs) have diffused broadly in terms of their adoption in U. S. work sites. EAPs have reached all types, sizes and varieties of workplaces, and are continuing to diffuse through a broad array of work sites. Virtually all large workplaces provide some form of EAP, with the majority of medium size work-sites also providing EAPs. EAP coverage is least likely in small work sites, where the majority of people are employed. However, rates of EAP growth are greatest in the smaller work sites.

This research note offers several pieces of information about EAP prevalence; changes in and adequacy of some EAP components; EAP utilization; and EAP

caseload characteristics. A description of the research methodology used to collect data from three different research projects is presented in the next section. Following description of the data sets and methods, four sets of research findings are presented.

The first set is on the prevalence and distribution of EAPs, based on data collected from a national sample of full time employees.

The second set focuses on changes in program components in a panel of internal EAPs studied in 1984 and again in 1988, with particular focus on supervisory roles.

The third set includes data about EAP utilization. The EAP utilization data

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comes from two different sources: aggregate data collected from a panel of internal EAP professionals studied in 1984 and 1988; and a national survey of full time employees conducted in 1991.

The fourth set includes data on EAP client problems and characteristics, collected from 6400 EAP clients and professionals from over 80 different worksites, generally new EAP referrals made between 1990 and 1992.

METHODOLOGY

National Employment Survey

The National Employment Survey (NES) was conducted in 1991. The sample is a national probability cross-section obtained by means of a single stage random digit dialing sample procedure used to select households and a most recent birthday method used to assure random selection within the household. Interviews were completed with 3,001 respondents (63% response rate). Eligible respondents were restricted to household members 18 years of age or older who worked for pay at least 35 hours per week.

In addition to standard socio-demographic items, 142 items relevant to the employees, work environment, experiences, attitudes and health were administered from a structured interview schedule. Relevant to this research note are items about EAP coverage, utilization and satisfaction.

EAP Panel Study

During 1984-1985, a research team conducted on-site interviews at 439 operating units of organizations. In two-thirds of these worksites, interviews were conducted with the internal EAP administrator/coordinator. The remaining one-third were externally contracted EAPs, for which interviews were conducted with

the individual internal to the contracting organization who was responsible for maintaining and/or monitoring the linkage with the external provider. The data set is based on a carefully selected sample from which data were collected from over 95% of the eligible respondents, and is representative of EAPs in 1984-1985, both internal and external, in private sector (for profit) worksites with 500 or more employees in California, Michigan, Minnesota, New York, North Carolina and Texas.

The data for this research note is based on a 1988 follow-up through mail questionnaires of the internal EAPs that formed the 1984-1985 data set. More than 70% of the internal programs studied in 1984-1985 were accounted for in the 1988 panel.

Referral Study

From 1990 through 1992, data have been collected on 6,400 employees who have utilized the services of 84 worksites' EAPs. The worksites vary in terms of industry type, number of employees, region of the U.S. and rural versus urban locations. These utilization data differ from other studies in that data were collected from a large number of EAP clients and administrators for research purposes, while other studies of utilization often rely on aggregate data based on EAP-generated records.

Two instruments were used to collect data from this sample of EAP clients making initial contact with their organization's EAP. EAP clients who are dependents of employees are not included in the data set. One instrument is filled out by the EAP administrator, and includes demographic information about each EAP client, EAP administrator defined referral category, client treatment history and clinical assessment, suggested treatment regimen and prognosis. A second instrument was filled out by the EAP client,

and includes information about job functions and performance, satisfaction with relationships, the roles of individuals who were influential in EAP referral or utilization, an alcohol problem index, and a depression inventory.

We now turn to a description of EAP prevalence, EAP components and EAP utilization.

EAP PREVALENCE

The most recent source of EAP prevalence is the NES conducted in 1991, which indicates that 45% of employees who worked for employers full time worked for employers that provided an EAP. Forty-seven percent of the respondents indicated that they did not work for an employer that provided an EAP and almost 8% responded that they did not know whether their employer provided an EAP (Blum and Roman, 1992). Fifty-two percent of the employees who were covered by EAPs were employed in organizations whose EAPs were more than 5 years old. Twenty-one percent of these employees were covered by EAPs that were adopted within the past two years.

Figure 1 indicates the distribution of employees covered by EAPs by the size of their worksites. Figure 1 also indicates the percentage of full time employees who work for employers of different size categories whether or not they are employed by organizations with EAPs. The data indicate that employees who are employed at larger worksites are more likely to be covered by an EAP. While 26% of full time employees work in places with more than 500 employees, 80% of them are covered by EAPs. While the majority of workers who are employed in worksites with more than 100 employees are covered by EAPs, almost half of the full time workers are employed at worksites with fewer than 100 employees. Despite the difficulties with provid-

ing EAP services to smaller sites, 39% of the employees who work in places with between 50 and 99 employees are covered by EAPs, 34% of those who work in places with between 26 and 49 employees are covered by EAPs, 25% of those who work in places with between 15 and 25 employees are covered by EAPs, and 18% of those who work in places with fewer than 15 employees are covered by an EAP. EAPs in the smaller worksites tend to be newer, on average, than those in larger worksites. In some instances they are also locations of larger organizations.

Despite conventional wisdom that EAPs are an urban and suburban phenomenon, Figure 2 indicates that while 36% of full time employees live in small town/rural locations, 42% of them work for employers that provide EAPs. It is true, however, that those who live in rural and small city locations are less likely to be covered by EAPs than their urban and suburban counterparts.

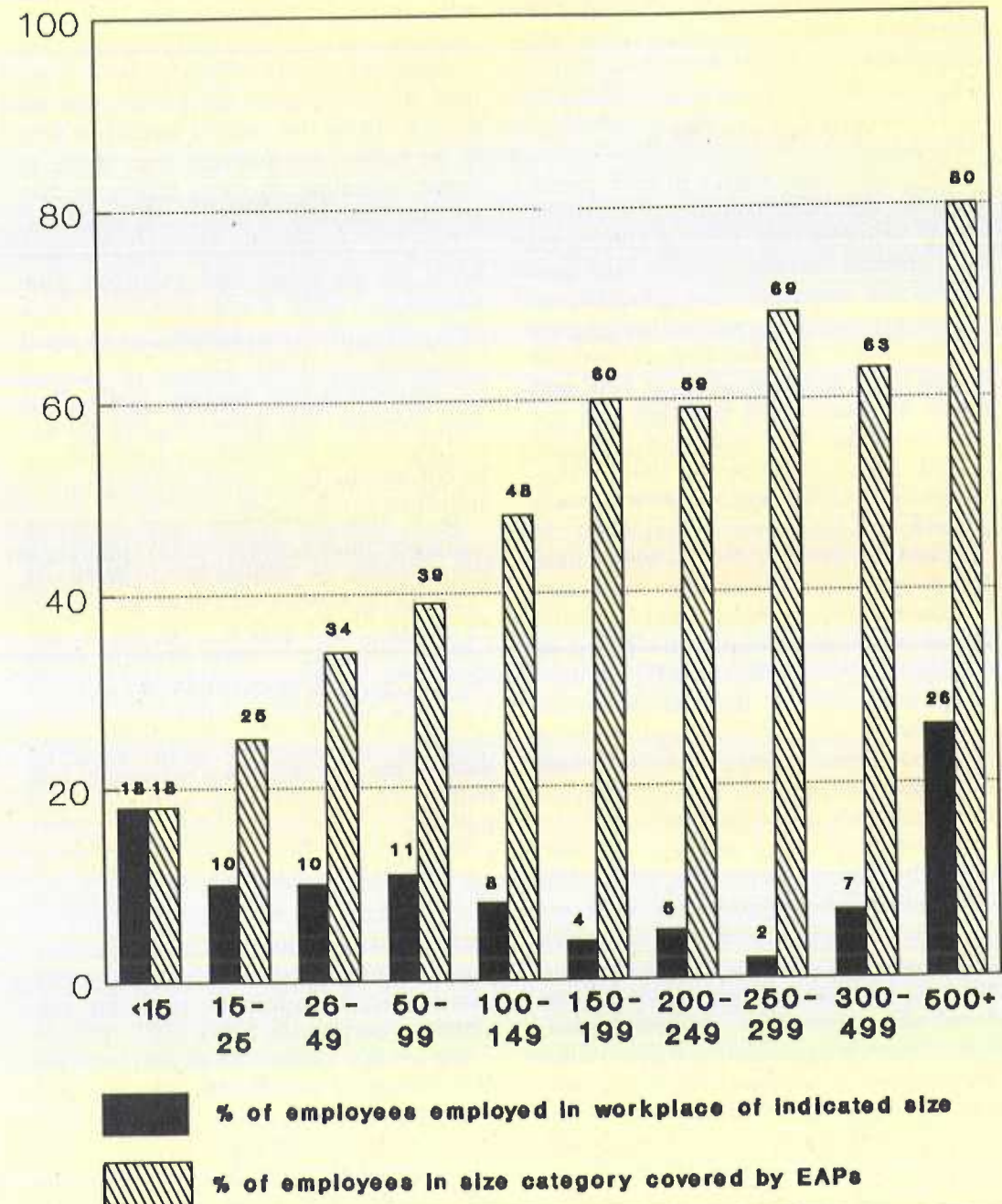
There are few regional differences in the percent of employees covered by EAPs in the 4 major regions of the U.S., as shown in Figure 3. EAP coverage is least likely, however, in New England states with 37% of full time employees covered by EAPs, and in the East South Central states, where 39% are covered. These data on the subregions are aggregated into data presented according to the 4 larger regions.

The industry distribution of EAP coverage is shown in Figure 4, which indicates that the majority of those who work in manufacturing, transportation, communication, professional services and public administration industries work for employers who provide EAPs.

While the above data indicate the distribution of employees who are and are not covered by EAPs, these data do not say anything about the quality of EAP services that are offered or received. The data do however demonstrate the diffusion and adoption of EAPs across a wide

Figure 1
EAP by Workplace Size

N=2,777 Full-Time Employees
1991 National Employment Survey



variety of organizational types, functions and locations. The next section of this research note considers the distribution of EAP components in the panel of EAPs studied in 1984 and 1988, with a concentration on supervisory training.

PROGRAM COMPONENTS

There has been considerable change in EAP staff as well as change in the organizations in which they were based between 1984 and 1988. There is no doubt, however, that the EAP concept has become institutionalized. Even where there is substantial downsizing of staff within particular workplaces, we find repeatedly that the EAP is usually one of the last items to be altered or discontinued. EAPs figure very prominently in the implementation of organizational change, as well as sustaining organizational functioning in organizations that are not undergoing more rapid or extensive change than is usual in American business. The fact that EAPs are markedly institutionalized reflects the reduced variation in structure and process among adequately implemented EAPs, as well as reduced variation among EAP functionaries' experience with important issues.

The EAP concept matured and is integral to the management of human resources in many large and not-so-large organizational settings (Blum and Roman, 1989). There is a core to what makes a good EAP. Despite the management of linkages of employees with treatment on the micro and macro levels being part of the core technology, there is an emerging threat to EAPs. The threat is not necessarily managed care, except insofar as managed care is not integrated with an EAP.

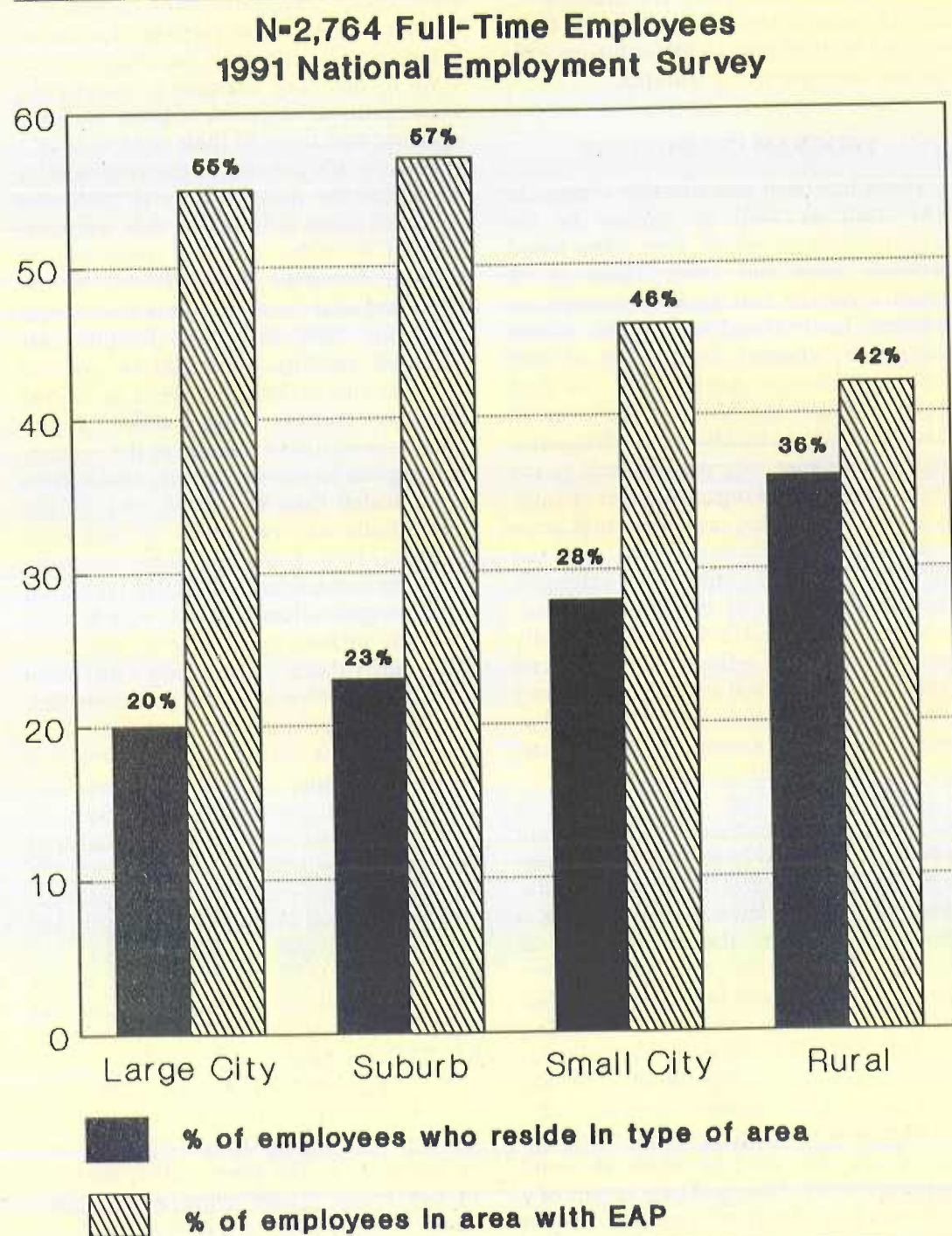
The threat is when EAP standards are not considered, but EAP labels are used inappropriately. Managed care is part of a well run EAP, but EAPs go beyond just managed cost. Good EAPs include components necessary for effective workplace

programs for identifying and dealing with troubled employees, their co-workers and supervisors. Thus with some curves, it is typical for EAPs to be turning to issues of integration, rather than focusing on survival or devoting energies to convincing organizational decision makers in management and labor of their right to exist.

Seventy-six percent of the respondents on which the data analysis is presented were the same individuals that we interviewed in 1984, and the remaining 24 percent occupied the EAP role at the organizational locations since some point after our 1984 interview. Despite this apparent stability, it should be pointed out that the majority of EAPs have had either an address change and/or a program administrator change in the 4 years, making our follow-up process much more complicated than we anticipated. Of the individuals who responded at both time periods, 79% have the same position, with the remainder essentially taking on more organizational roles, which continue to include some role in the EAP. The individuals for which we have information, who left their prior position are (in order from most to least prevalent): transferred out of their EAP role, but still with their same organization; are now with external provider organizations; or left to be an internal EAP coordinator at another organization. In terms of the institutionalization of EAP occupations, it is notable that only a small minority left for non-EAP work.

There has been much change among the organizations that comprised our initial study sample. Thirty-four percent of these organizations have acquired other organizations and another 8% have been acquired by other organizations. The mergers and acquisitions that have been so prevalent in the press are represented in our study. These types of organizational change, particularly organizational closing of a location, are the most prevalent reason why EAPs present in 1984-85 no

Figure 2
EAP by Urban/Rural



longer exist in 1988. Approximately 5 percent of the original internal EAPs have been closed, mostly due to death of the larger work organization where our 1984-85 data were collected. A few cases of internal EAP cancellation are found in hospital/treatment settings where they accompanied these hospitals' efforts to purvey EAPs in 1984, with the internal EAP disappearing along with the EAP marketing component.

About 15 percent of the total number of internal programs from our 1984 study were externally contracted programs in 1988. While there seems to be a movement toward external programs, these programs often include either the old program administrator or some other internal EAP specialist as an overseer of the external provider contract that provides most of the counseling and micro linkage functions. The transfer to external programs tended to be the result of massive organizational downsizing at many of the organization's locations, with questions of the quality and uniformity of EAP services available to employees in various smaller locations raised. Some newly external programs are actually administered directly through the former EAP administrator as an external contractor.

The face of EAPs is changing and is somewhat isomorphic to the ways organizations act with regard to other services and issues related to employee headcount, usually contracting for services to reduce long term commitments and costs, which include benefit packages which must be paid to internal employees. Cost is not necessarily the explanation for such changes, but rather the way the cost is counted and its reflection of internal organizational politics.

The organizational health of the sample company locations in 1988 in terms of number of employees is as follows: 25% are in a period of growth; 25% in a period of decline; 28% in a period of stability;

and 22% in a period of stability after a period of decline. The distribution of these company locations in terms of overall profits are: 43% growth; 41% stability, and 16% decline. We find little association between organizational decline in either numbers of employees or in profits with changes (improvement or deterioration) in EAP support components or their adequacy. Exceptions to this are a decline in organizational profits that is associated with a deterioration in top management support and with a deterioration in recordkeeping, but not with whether or not either is adequate. The strongest association and one for serious concern for the EAP community is found between a decline in profits and a deterioration in the number of adequate staff to cover EAP services.

Although the percentage of responding organizations in a category is subject to distortion from the necessary non-inclusion of the non-respondents, we report, in Table 1, the improvement and deterioration in EAP components. The residual category of no change is omitted from the table. Table 1 also includes the respondent's perceived adequacy of those components. We also report the gamma, a measure of association between two ordered variables, for the relationship between the reported adequacy of the component with the improvement of the component since 1984. Gamma varies between -1 and 1, with a positive coefficient in this case indicating the correlation between improvement (as opposed to deterioration and stability) and adequacy of the component. The table indicates that improvement in EAP training programs, top management support, union support, non-clinical recordkeeping, and staff ratios are significantly associated with the reported adequacy of each of these components.

Figure 3
EAP by 4 Regions

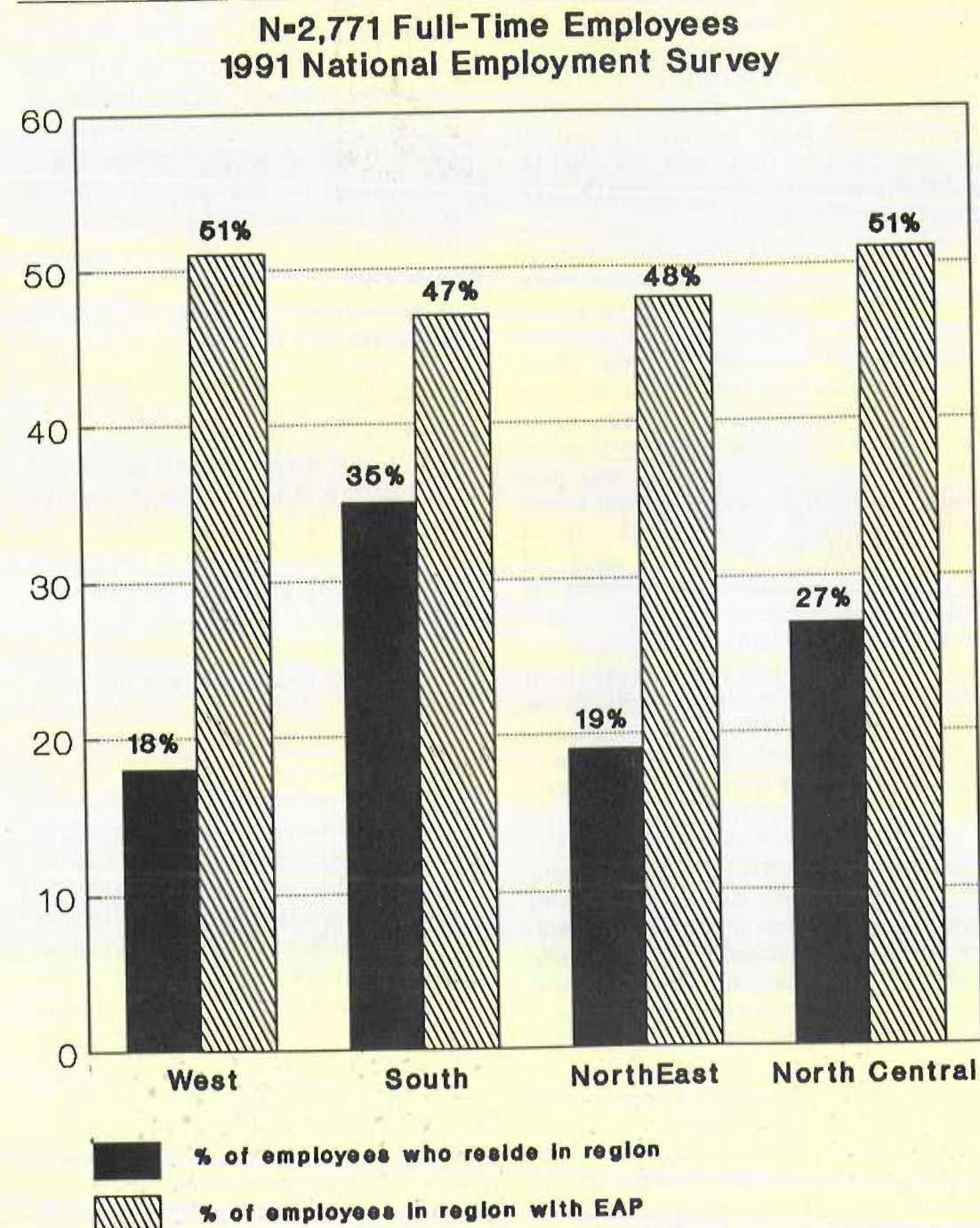
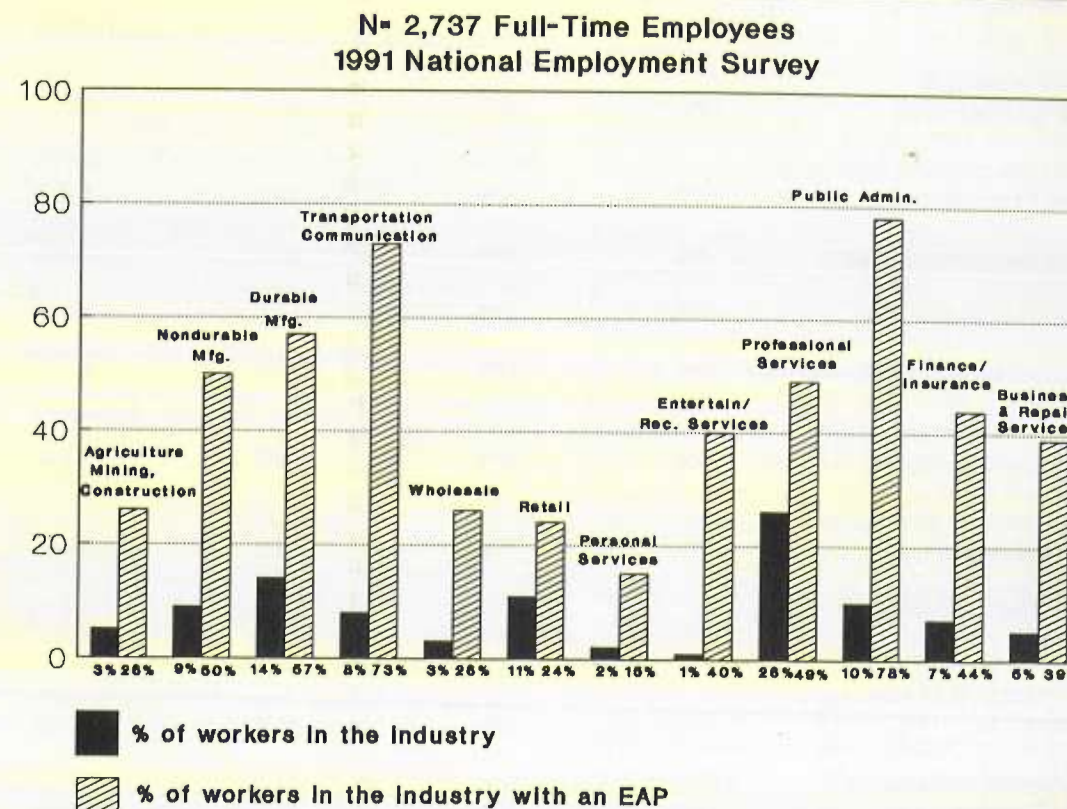


Figure 4
EAP by Industry



Supervisory Training

There has been much concern in the EAP community about the decline of supervisory training. The concern was brought into sharper focus as questions were raised in political arenas concerned with drug testing. These focused on whether EAPs really provided a core technology that could deal with employee drug problems in addition to alcohol problems and other problems that they have traditionally handled. Part of the concern revolved around the idea that supervisors were the "weak link" in the implementation of core EAP concepts. However, it should be pointed out that if supervisors are not held accountable for making appropriate EAP referrals they

will not be any stronger links in a "for-cause" drug screening program. This is particularly true if harsh treatment rather than constructive assistance results from positive drug screens.

It became clear to some of those investigating the EAP concept that some individuals with drug problems may self-refer. Many of what we label self-referrals and think of as the ideal of "early intervention" really were individuals who drag themselves into the EAP after a period of time where it was clear to people around them who did not intervene, including their supervisors, that they were in trouble. However, it is also clear that alcohol and other drug abuse is fraught with denial by the individual,

Table 1
Changes in EAP Components Since 1984 and Their Adequacy in 1988

	Deteriorated	Improved	Adequate	Gamma
EAP training of 1st line supervisors	14%	46%	48%	-.5206*
EAP training of middle managers	11%	44%	49%	-.41818*
Top management support	8%	51%	68%	-.50162*
Union support of EAP	2%	33%	64%	-.20099*
Record keeping about cases	4%	47%	81%	-.29178*
Record keeping about other EAP activity	4%	49%	78%	-.11584
Insurance for alcohol/drug abuse treatment	16%	35%	65%	-.55540*
Insurance for psychiatric treatment	11%	18%	49%	-.51335*
Education of all employees about EAP	7%	54%	51%	-.17926
Adequate staff to cover EAP services	13%	35%	51%	-.36146*
Support from medical dept.	3%	35%	79%	-.20661*
Support from personnel/human resources dept.	3%	44%	78%	-.16113

* $p < .05$

their family members, and their co-workers. There are cases where supervisors and managers will not take the necessary steps to make an EAP referral when it is appropriate to do so. In some instances it is because they do not have the knowledge and skills necessary to make a referral. It is quite possible that performance problems, including em-

ployee demeanor and getting along with co-workers in a constructive fashion, will not show up before family problems. However, it is also quite well known that family members can be enablers, and thereby part of the problem, rather than individuals who will intervene and refer the individual to help. It is because so many individuals with problems do not

get help from family members that the workplace is an important route to help for so many who fall through the family net. Minimizing enabling behavior by supervisors is critical if this role is to be effective.

The 1988 data indicate that the extensiveness of supervisory training about the EAP is associated with EAP integration into the organization and with components of the "core technology," particularly with the EAP aiding supervisors and managers in dealing with troubled subordinates. The extent to which supervisory training encourages supervisors to consult with the EAP before confronting an employee is an important EAP component.

Further evidence of the relationship between supervisory involvement in EAPs and the implementation of the core technology is found in the associations between the job performance identification component of referrals, the integration of the EAP, and the EAPs' supervisory consultation role with:

- the organization's training of first line supervisors about performance appraisal and disciplinary procedures;
- extensiveness of training of supervisors about the EAP;
- the extent to which supervisors are encouraged to use job performance criteria as a tool in identifying and confronting problem employees; and
- the extent to which supervisory training encourages supervisors to consult the EAP before constructively confronting an employee.

The extent of supervisory training in 1984 is associated with a greater likelihood that a reason for the continued support of the EAP in 1988 is to reduce alcohol abuse and to reduce drug abuse. We also find these 1988 program goals of reducing drug and alcohol abuse to be related to the greater emphasis put on availability of EAP staff to supervisors for

consultation about how to use the EAP policy and procedures to appropriately identify and refer a problem employee.

It is important to note that data from other studies (e.g. Blum, 1989) indicate the overwhelming preference of supervisors and managers for employees to "self-refer" themselves, which really means that they would prefer not to have to perform a formally documented referral. There are downsides to this preference, however. If, following an informal and non-documented referral, an individual does not admit to having job performance and disciplinary problems and also does not admit to alcohol or other drug abuse, it may be difficult for the EAP to perform an adequate assessment or even to have the correct assessment accepted by the client. Without the leverage of the knowledge of impaired performance, appropriate assessment and referral may be more difficult for individuals with alcohol and other drug related problems.

In terms of the utilization rates, we find that supervisory training is related to greater rates of utilization and to greater rates of alcohol and drug utilization. These effects are greater for male utilization rates than for female utilization rates, and are stronger for training of first line supervisors than of middle managers. However, data from other research (Blum, 1989) indicate that supportiveness of the EAP by the referring supervisor's supervisor is predictive of referrals. Top management support is not as important an indicator, in established programs.

Greater alcohol and drug utilization rates for males are associated with:

1. More supervisory training that includes the use of job performance data to confront individuals with performance problems,
2. More supervisory training that encourages the EAP consultation role with supervisors before a confrontation is made, and

3. The extent to which performance appraisals are used by supervisors in confronting problem employees.

Though more weakly associated, the cocaine utilization rate is associated with the use of job performance appraisals to identify EAP candidates, the use of job performance data by supervisors to constructively confront employees, and the use of job performance data by the EAP to present to the employee and to adequately assess the employee's problem.

Adequacy of first line supervisory training and training for middle managers is associated with integration of the EAP into organizational functioning. The improvement of training since 1984 is also associated with greater integration and implementation of the core technology, suggesting a continual evolution of the implementation of EAPs.

UTILIZATION

We now turn to an expanded presentation of EAP utilization. The data for this section come from 2 different constituencies and levels of analysis. First, we present aggregate level information collected from EAP professionals based on EAP records in the 1984-1988 EAP panel. Second, we move to an analysis of data collected from the NES focusing on employees with EAP coverage.

Panel Study

While EAPs do much more than assess and refer clients, caseloads are the measures primarily used to reflect the level of EAP activity. While EAPs should not be evaluated solely in terms of their "clinical" work, employee usage of the EAP and the micro linkage of referrals to community diagnostic or treatment agencies is a central EAP activity. While EAPs should be held accountable for problem resolution, this should be done within a

framework that does not hold the EAP totally responsible for treatment failures. However, if an EAP repeatedly uses treatment resources that do not yield adequate results, the EAP is not performing its macro linkage and thereby its micro linkage roles adequately. With these caveats, we describe EAPs' utilization rates, which we define as: (Number of employee cases/Number of employees). The rates are constructed for a 12 month period, and essentially underestimate the portion of a workplace that has used the EAP at any point in time. Given low turnover and/or low re-utilization by the same clients, the EAP utilization rate over a few year period would be much larger than the 12 month rate presented here. This is especially relevant when addressing the question of whether EAPs can address workplace alcohol and drug problems.

Table 2 presents the descriptive statistics for the distribution of utilization, based on the aggregate panel data. On average, 4.5% of the worksite use an EAP in a given year. Because the mean is influenced by extreme values, we look at the distribution of rates of utilization at different percentile levels. The data indicate that 50% (median) of the worksites have utilization rates of 2.8%, while 25% of the EAPs have utilization rates of 6% or higher. Table 2 also presents these statistics for percent of female utilization, which tends to be greater than that of men. The Table also presents the percent of the worksite that uses an EAP in a given year, assessed as having alcohol or drug problems of their own.

While alcohol and other drug cases form the minority of EAP referrals, it is important to note that the respondents indicated that these cases tend to take more of their work time. Fifty-four percent of the respondents said that alcohol and other drug cases require much more of their time; 28% responded that they take somewhat more time; 11% re-

Table 2
1988 EAP Utilization Rates 12 Months Prior to Data Collection

	25th Percentile	Median	75th Percentile	Mean
Overall employee utilization	1.3%	2.8%	6.0%	4.5%
Percent of female utilization	1.1%	3.4%	7.1%	5.1%
Alcohol and other drug utilization	.47%	.82%	1.7%	1.6%
Percent of female alcohol and other drug utilization	.09%	.35%	.85%	1.0%

*The denominator for the categories of utilization by females is the number of females in the organization.

sponded that they take the same amount of time; 5% responded a bit less time; and less than 3% claimed that they took much less of their time. The distribution of amount of time spent on alcohol and other drug cases is positively associated with the percent of female alcohol/drug cases. The less time it takes to deal with alcohol/drug cases relative to the time required by other cases, the less the percent of the alcohol/drug caseload is comprised of alcohol or marijuana as the drugs of choice, but the greater the percent of the caseload is for cocaine as the drug of choice. The less the relative amount of the EAP work time it takes for resolution of alcohol and other drug problems, the greater the percent of the caseload is composed of alcohol and other drug problems.

The best predictor of the utilization rate in 1988 is the utilization rate in 1984 ($r=.55$). The distribution of caseload problems in 1984 is also predictive of the distribution in 1988. Table 3 presents the correlations between the overall 1988 utilization rate (number of employee cases/number of employees), utilization

rate for alcohol and other drugs (number of cases with alcohol or other drug problem/number of employees) and several other utilization variables. Where we are examining the utilization by women, we use the number of women employees in the denominator to standardize for the variation in workforce composition among different worksites. We use the number of male employees in the denominator for the male rates.

As evidenced in Table 3 higher overall utilization rates are associated with higher utilization rates for alcohol and other drug problems. These associations are apparent for the total employee population, for women and for men.

EAP utilization by women, particularly for alcohol problems has been a concern of the EAP field. Overall, women tend to be overrepresented in EAP caseloads, but tend to be underrepresented in the alcohol and drug problem caseloads. Table 4 indicates the utilization rates for women.

Approximately one-third of the EAPs have women equally represented or overrepresented for their own alcohol or drug problems in 1984, while approximately

Table 3
Correlations Between Different Utilization Rates

	Utilization Rate	Alcohol and Drug Utilization
Utilization Rate	---	.73
Female Utilization Rate	.88	.51
Male Utilization Rate	.95	.81
Alcohol and Drug Utilization	.73	---
Female Alcohol & Drug Utilization	.62	.78
Male Alcohol & Drug Utilization	.22	.51
Alcohol Utilization	.67	.95
Cocaine Utilization	.66	.88

two-thirds of the EAPs have women equally or overrepresented for the combination of all problem categories. The average difference in women's proportion in the workforce and their representation in the alcohol and drug caseload is 16.5% for 1988 and 12.6% for 1984.

These data suggest that EAPs can be a good mechanism to aid women who have alcohol or other drug problems, but other analyses indicate that the program has to be adequately staffed and implemented to do so. It is important to take into account epidemiological differences between men

Table 4
Female Representation in EAPs

	1988 All Probs	1988 Alc/Drug	1984 All Probs	1984 Alc/Drug
Overrepresented (Greater % of women in EAP than in worksite)	48%	13%	49%	20%
On par with representation in the worksite	10%	0%	17%	9%
Underrepresented (Lower % of women in EAP than in worksite)	42%	87%	34%	71%

and women, or rates of problems for a particular workplace, in assessing whether EAPs include appropriate rates of both men and women in their alcohol or drug abuse caseloads. Overall, the data indicate that EAPs are doing well in dealing with female employees' substance abuse problems.

NES Data

We now turn to 1991 national survey information reported by full time employees who are not self employed, 45% of whom report that they work for employers that provide EAPs. Of the employees who work for employers that provide EAPs, 15% have contacted the EAP about an employee they supervise. These supervisors tend to be satisfied with their experience in dealing with an EAP for a subordinate, as indicated by 43% of those who had made such use of the EAP claiming that the EAP was very helpful; 42% claiming it was somewhat helpful; 8% claiming it was a little helpful; and 7% claiming that it was not at all helpful.

Of the employees who were covered by an EAP, 48% know someone at work who has used the EAP. Of these employees who know someone at work who used the EAP, 44% claimed it was very helpful to their coworker; 42% claimed it was somewhat helpful; 8% claimed it was a little helpful; and 5% claimed it was not at all helpful to their coworker. The satisfaction with supervisory use and with coworker use is pretty similar. While there is some overlap in the two groups, the second group, knowing someone at work who used the EAP, is much larger.

More than 8% of the employees who were covered by EAPs had used the EAP sometime in the past for a problem of their own, and 5.5% had used the EAP for a problem of a family member. While there is some overlap among those who used the EAP for themselves, their family

members or their subordinates, there is a large proportion who used the EAP for only one of the categories.

The respondents who report that they have a supervisor were asked whether their supervisor supports the EAP. Sixty-seven percent of them claimed that their supervisor strongly supports the EAP; 31% claimed mild support of their supervisors; and less than 2% indicated perceived opposition to the EAP among their supervisors. In an attitudinal question, this sample of full time workers also indicates that they perceived the EAP to have been adopted by their employer to both help workers and to maintain productivity (73%). Fifteen percent of the respondents who worked for employers with EAPs perceived that the EAP was in existence primarily to help workers, while 11% perceived that the EAP was in existence primarily for productivity enhancement reasons.

These data indicate substantial satisfaction with the EAP among those employees who have access to one. The data also indicates substantial use of the EAP among a cross section of full time employees whose employers provide such a service. The utilization data reported in this section, however, is not representative of utilization for a given period of time. Rather it is accumulated usage over the time that the EAP was in existence in a given worksite and is limited by the tenure of a worker at that worksite.

EAP CASELOAD CHARACTERISTICS

The previous sections of this research note described EAP utilization rates collected from two different constituencies, EAP professionals and individual employees. The former reflects aggregate rates based on EAP records, whereas the latter reflects the perceptions of individual employees who know they are covered by EAPs and their reports of whether

they or others they know or supervise have used the EAP. This section reports data collected from 6400 EAP clients and 84 EAP professionals for research purposes.

The demographic distributions of the EAP clients indicate that EAP clients span across various groups in the workforce, rather than being restricted to particular segments. Comparisons of the demographic distributions of these EAP caseloads with those employees in the NES, described above, who are covered by EAPs indicates that women are overrepresented in EAP caseloads. Fifty-five percent of the EAP caseloads are comprised of women, while 43% of the full time workers covered by EAPs are women. EAP clients are 2-3 years younger, on average, than the sample of full time employees who work in organizations that have EAPs. Whites are underrepresented and blacks are overrepresented when compared to the survey distributions. The EAP caseloads are composed of 70% whites while the sample of workers is composed of 85% whites. The NES includes 9% blacks who work in organizations covered by EAPs, while the EAP caseload data is composed of 22% blacks. EAP clients are less likely to be married, and more likely to be separated or divorced, than the NES workers covered by EAPs. The educational level and job levels of EAP caseload and the NES respondents are similar, but EAP clients tend to have 3 years greater tenure with their work organizations, on average, than the NES sample of full time employees who are covered by EAPs.

Each client completed a short form of the Beck Depression Inventory (Beck and Beck, 1972) composed of 13 items, which has been used in help seeking populations. Scores on the inventory are placed in 4 categories, with scores of 0-4 indicating none or minimal depression (category 1), 5 to 7 (category 2) indicating mild

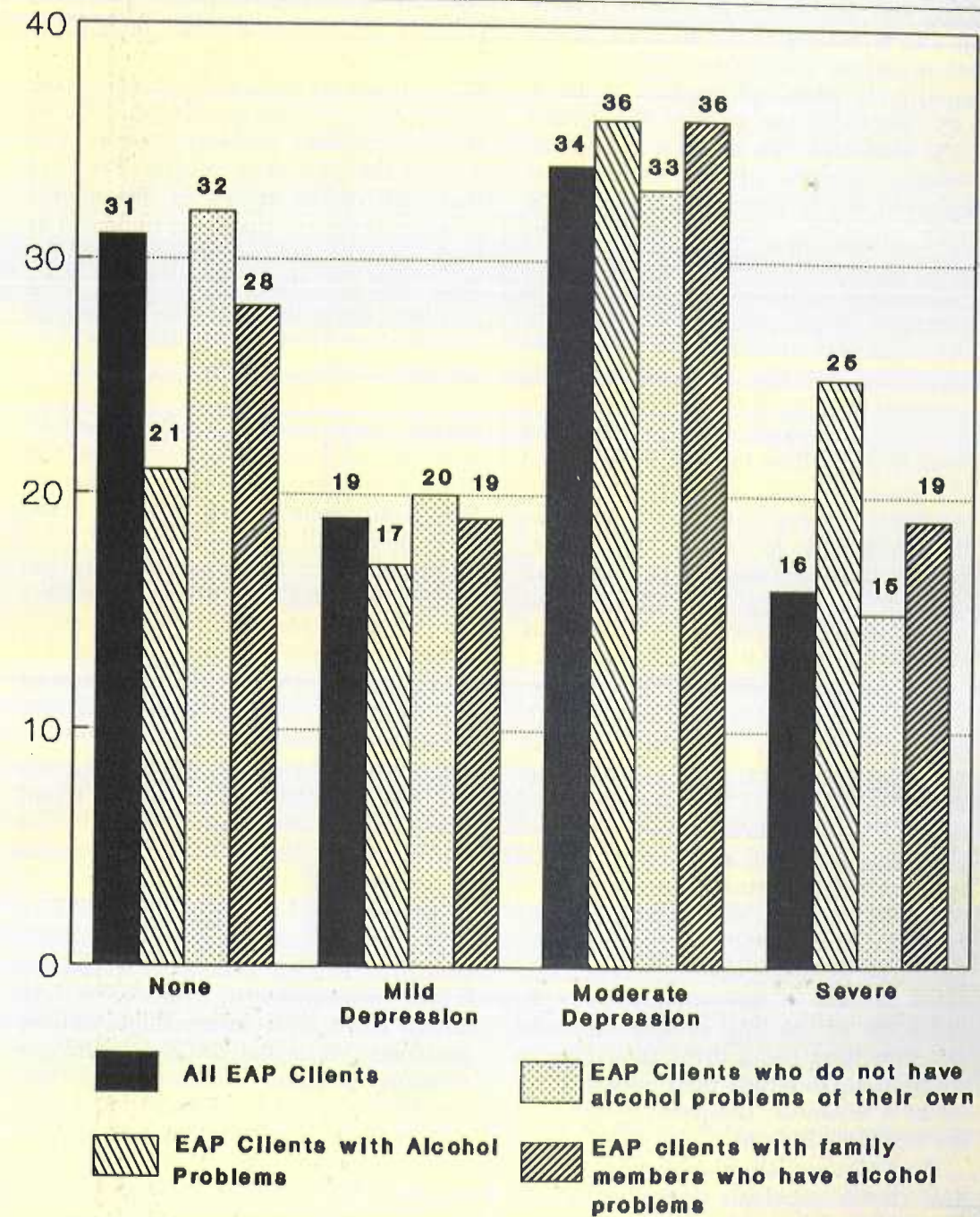
depression, 8 to 15 (category 3) indicating moderate depression, and score of 16 or higher (category 4) indicating severe depression.

The scores on the Beck Depression Inventory (BDI) (See Beck, Steer, and Garbin, 1988, for a review of the psychometric properties of the BDI) indicates substantial depressive symptomatology among the EAP clients (Figure 5). While 31% of the EAP clients' scores fall into the none or minimally depressed category, 19% are in the mild depression category, 34% are in the moderate depression category, and 16% are in the severely depressed category. This distribution indicates that EAP clients are much more impaired, according to the BDI, than in a sample of 298 general population respondents reported by Oliver and Stone (1984). The distribution of this sample indicated that 80% are in the none or minimally depressed category, 11% are in the mild depression category, 9% are in the moderate depression category, and 4% are in the severely depressed category.

When the EAP counselors were asked to indicate, from a clinical perspective, the severity of a client's problem, they indicated an average severity of 3.3 on a scale of 1 to 5, where 1 indicated not severe and 5 indicated very severe. Thirty-four percent of the clients received a severity rating of 4 and 13% received a rating of 5.

The questionnaire also includes the CAGE items (Ewing, 1984) assessing whether the individual has ever thought s/he should cut down on their drinking, felt annoyed by others criticism of their drinking, felt guilty about drinking, or had a drink as an eye opener. The CAGE scale varies from 0 for respondents who answer no to each of the 4 questions to 4 for those who answer yes to all 4. Smart, Adlaf, and Knoke (1991) report that the CAGE is a good instrument to screen a general population, and that a cut off

Figure 5
Beck's Depression Categories



point of 2 is suggestive of a drinking problem. The self-administered CAGE scale, was distributed as follows (Figure 6): 73.1% answered yes to none of the four questions; 7.8% answered yes to 1 of the 4; 8.7% answered yes to 2 of the 4; 6.4% answered yes to 3 of the 4; and 4.1% answered yes to all 4 questions. Nineteen percent of the EAP clients answered yes to 2 or more of the CAGE items, suggesting alcohol related problems (Smart et al, 1991).

The CAGE distribution in the national sample of employees (NES) covered by EAPs indicated substantially lower scores than those for the EAP clients: 75% answered no to each of the 4 items; twice as many answered yes to 1 of the items, 16%, as those in the EAP caseload; 7% answered yes to 2 of the items; one-third as many in the employee sample answered yes to 3 of the items, 2%, as those in the EAP caseload; and less than one-tenth as many in the employee sample answered yes to all 4, .4%, as compared to the EAP caseload.

The percent of affirmative responses varied by item: 23.4% of the EAP clients indicated that they have felt that they ought to cut down on their drinking, compared to 20% of the employee sample; 10.8% of the EAP sample indicated that they have been annoyed by people criticizing their drinking, compared to 5% of the employee sample; 19.8% of the EAP sample indicated that they have felt bad or guilty about their drinking, compared to 10% of the employee sample; and 6.7% of the EAP sample indicated that they have had a drink first thing in the morning to steady their nerves or get rid of a hangover, compared to 2.9% of the employee sample.

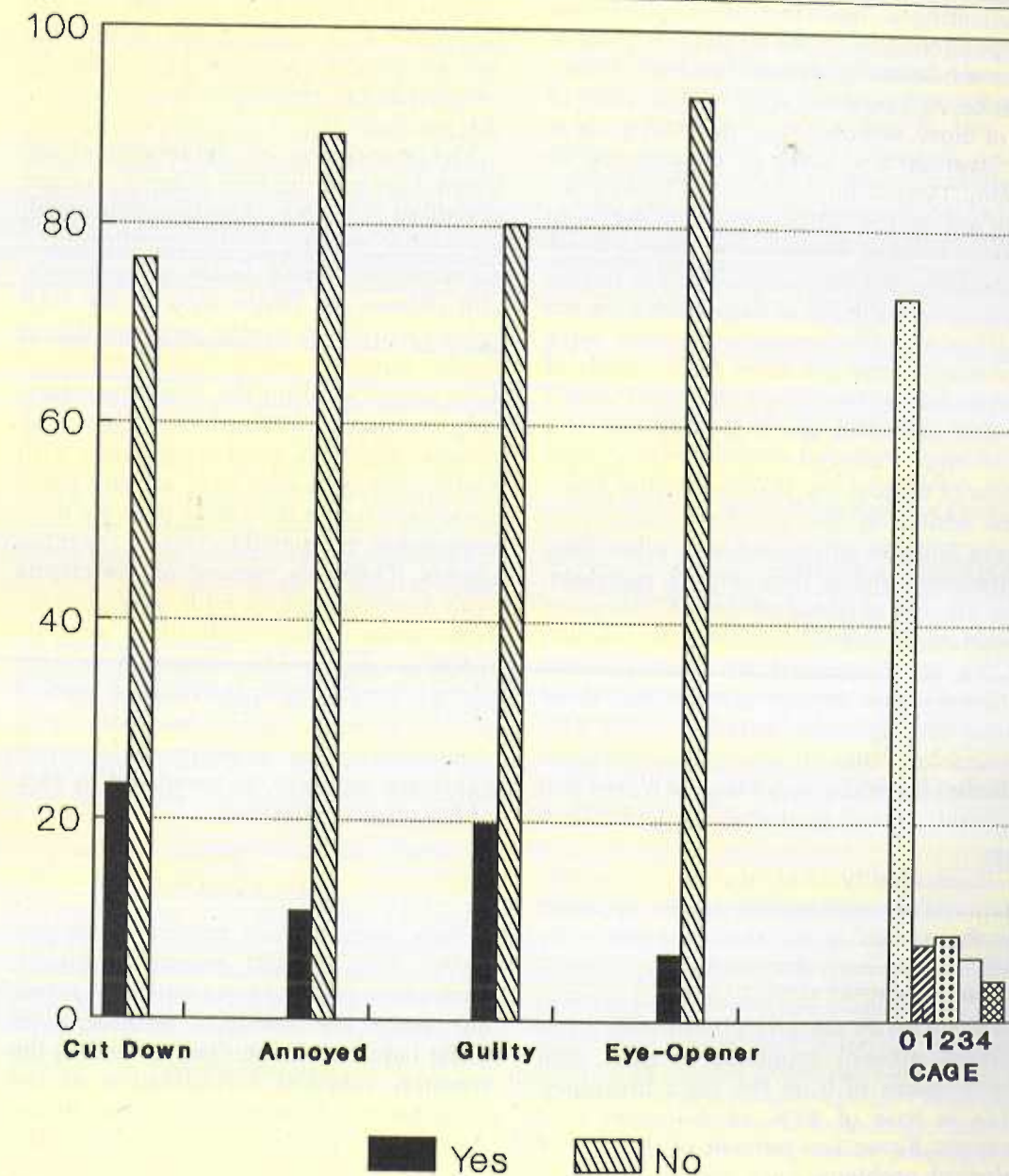
The EAP counselors' assessments of the EAP clients' problems typically take the form of "dual diagnoses," with an average of 2.1 problem categories per client. The most prevalent problem category is psychological/emotional problems, with

43.7% of the clients in this category. The next most prevalent categories are marital (28.1%) and other family problems (30.9%). Alcohol and other drug problems are the next most prevalent, with the EAP counselors indicating 15.9% of the clients with alcohol problems, 3.4% in the cocaine/crack problem category, and 3.9% in the other drug category. For more than half of the clients in the alcohol problem category, alcohol is indicated as their primary problem. By contrast, less than half of those with other drug problems are indicated as having cocaine or other non-alcohol drug abuse as their primary problem.

The EAP caseloads also include employee clients who have come to the EAP with assessments of being troubled by alcohol or other drug problems among their family members. Almost 21% of the EAP clients fall into this category, two-thirds of them being troubled by the alcohol problems of their family members and the other one-third by family members' use of drugs other than alcohol.

In analyzing EAP caseloads, it becomes apparent that there are discrepancies between assessments of clients' problem categories reported by EAP counselors and the answers given on self report questionnaires by EAP clients. If, for research purposes, an EAP client can be considered to have an alcohol problem when the initial assessment of the EAP counselor indicates an alcohol problem and/or if they scored 2 or more on the CAGE screen, almost 23% of the EAP clients have their own alcohol related problems. While the CAGE is a lifetime drinking problem screening questionnaire, comparison of scores on the CAGE with scores on the Alcohol Dependence Scale (ADS) (Horn, Skinner, Wanberg and Foster, 1984) indicate that more than 91% of those who score 2 or above on the CAGE also have ADS scores indicating at least minimal dependence in the past 6 months.

Figure 6
Cage Scores



Of those EAP clients who score 2 on the CAGE, 87% have scores on the ADS indicating at least low levels of alcohol dependence, with 9% of them scoring at the moderate to severe level of dependence. Among those with a CAGE score of 3 or more, 95% score on the ADS scale at a level of low level of dependence or more. Twenty-nine percent of those scoring a 3 on the CAGE have a moderate to severe level of dependence. Among those who score a 4 on the CAGE, 97% have a low to severe level of dependence on the ADS scale. Of these clients, 26% have substantial and 3% have severe levels of dependence according to the ADS scale.

EAP caseloads are thus composed of a minority of alcohol and other drug problems of employees. However, when these are added to the problems employees have because of alcohol and other drug problems among their family members, the alcohol caseload of the EAP becomes substantial. Even though the caseloads of EAPs are composed of relatively few alcohol cases at any given time, these cases take up a predominance of the EAP counselors' time. It is reported that each alcohol case takes more time at intake and referral, as well as at aftercare and follow up.

Co-morbidity of alcohol problems and depressive symptomatology is apparent in these data as in other data sets. The BDI (depression) distribution for various client categories is indicated in Figure 5. While 21% of the EAP clients defined as having alcohol problems of their own have scores of 0 on the Beck Inventory, this is true of 32% of the other EAP clients. Seventeen percent of those with alcohol problems have scores indicating possible mild depression, compared to 20% of the other clients. Thirty-six percent of the clients with alcohol problems have scores indicating possible moderate depression, compared to 33% of the other EAP clients. Twenty-five percent of those with alcohol problems

score in the severely depressed category, as compared to 15% of the other EAP clients. The correlation between the BDI categories and whether the respondent has an alcohol problem is statistically significant, but substantively small ($\eta = .04$, $\gamma = .07$)

The association of depressive symptomatology and the EAP client's problem classified as having a family member with an alcohol problem is also significant but substantively small ($\eta = .05$, $\gamma = .10$) (Figure 5). While 28% of the EAP clients defined as having problems due to family members with alcohol problems have scores of 0 on the Beck Inventory, this is true of 32% of the other EAP clients. Eighteen percent of those with family members who have alcohol problems have scores indicating possible mild depression, compared to 19% of the other clients. Thirty-six percent of the clients with family members with alcohol problems have scores indicating possible moderate depression, compared to 34% of the other EAP clients. Nineteen percent of those with family members with alcohol problems score in the severely depressed category, as compared to 15% of the other EAP clients.

CONCLUSION

This research note presents data collected from several research projects. Each of the projects has merits and flaws, but since the research methodologies differ between the studies, as well as the research subjects, accumulation of the same errors across projects is less likely. Data were presented to indicate the substantial diffusion of EAPs across a wide variety of work settings. At issue now, for the EAP field, is whether standards for quality EAPs can be maintained, and the integrity of the EAP label maintained.

While EAPs vary with the business cycles of the organizations that support

them, the components of EAPs remain generally intact. While EAPs are not all equal in their ability to identify, assess, motivate, refer and follow up with their clients, or to adequately serve their host or contracting organizations, there are components that are necessary for appropriate EAP implementation and integration. These components form the minimum requirements for using the EAP label.

Utilization data indicates that substantial numbers of employees use and are helped by EAPs. Data indicate that EAPs include a demographic diversity in their caseloads. In addition, EAP caseloads are composed of employees with substantial symptomatology. The rates of depressive symptomatology are quite high when compared to the employed population generally. A similar statement could be made about alcohol problems, although it is also the case that some earlier stage alcohol problems are clearly represented in EAP caseloads. The utilization data presented in this research note is based on headcount type data, and clearly underestimates the role of EAPs in their work organizations. It is clear from the data presented in this research note that EAPs do not waste organizational resources in dealing with the "worried well," but instead EAPs are clearly helping employees with substantial problems that affect themselves, their families, their coworkers, their subordinates, their supervisors, and their customers.

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