The Evolution of External Employee Assistance Programs Since the Advent of Managed Behavioral Health Organizations

A dissertation submitted in partial fulfillment of the degree of Doctor of Philosophy from New York University School of Social Work

Jay E. Sandys

May, 2012

Examining Committee Members:

Lala Straussner, D.S.W. (Advisor)

Victoria Stanhope, Ph.D.

Helle Thorning, Ph.D.

Daniel Hughes, Ph.D.

Copyright © 2012 by Jay E. Sandys

THE EVOLUTION OF EXTERNAL EMPLOYEE ASSISTANCE PROGRAMS SINCE THE ADVENT OF MANAGED BEHAVIORAL HEALTH ORGANIZATIONS

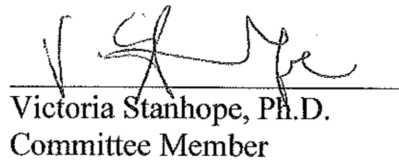
Jay E. Sandys

A dissertation submitted in partial fulfillment of the degree of
Doctor of Philosophy from New York University School of Social Work.

[✓] Accepted Without Revisions

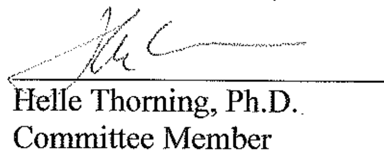
Lala Straussner, D.S.W.
Committee Chair

[ ] Minor Revisions Required
(Chair to supervise)



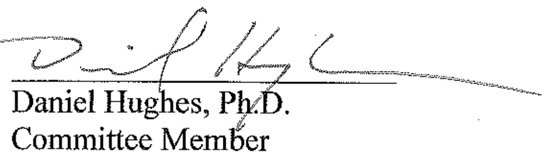
Victoria Stanhope, Ph.D.
Committee Member

[ ] Revision and Review Required
(Full Committee)



Helle Thorning, Ph.D.
Committee Member

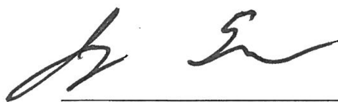
[ ] Rejected



Daniel Hughes, Ph.D.
Committee Member

Date: May 3, 2012

I hereby guarantee that no part of the dissertation which I have submitted for publication has been heretofore published and (or) copyrighted in the United States of America, except in the case of passages quoted from other published sources; that I am the sole author and proprietor of said dissertation; that the dissertation contains no matter which, if published, will be libelous or otherwise injurious, or infringe in any way the copyright of any other party, and that I will defend, indemnify and hold harmless New York University against all suits and proceedings which may be brought and against all claims which may be made against New York University by reason of the publication of said dissertation.



Jay E. Sandys

5/10/12

Date

Dedication

To my wife and partner Shawna, with deep gratitude and love.

Acknowledgements

I would like to thank Lala Straussner for her guidance, support, and responsiveness during the long process that led to the completion of this dissertation. I would also like to thank Victoria Stanhope for patiently and clearly explaining some of the subtle elements of qualitative research. Thanks also to Dan Hughes for his support over the years, and to Helle Thorning for graciously stepping in near the end.

I would also like to thank my good friend Victoria Dexter for all of her excellent advice and empathy, and for making this arduous journey slightly less painful and even, at times, enjoyable.

In addition, I would like to thank all the study participants who devoted their valuable time to take part in my study, and also for their enthusiasm and insight, and their continued belief in the concept of EAP.

Finally, I want to acknowledge how grateful I am for the unwavering support of my parents, Judith and Howard Sandys.

Sandys, J.E. The evolution of external employee assistance programs since the advent of managed behavioral health organizations. New York University, PhD, May, 2012.

Employee assistance programs (EAPs) evolved due to market changes, including the emergence of managed behavioral health organizations (MBHOs), and pressure to be defined as a healthcare benefit instead of a workplace productivity tool. This study used a qualitative, grounded theory methodology to interview 26 top leaders at external, non-MBHO EAPs in the United States. Complex adaptive systems, industry life cycle, and organizational life cycle theories assisted in the interpretation of organizational change. Emergent findings include three primary changing market themes, and seven primary survival strategy themes. Influenced by social workers in the industry, EAPs adapted in a unique way that incorporates both business and social service values. Along with more sophisticated business practices, EAPs continue to focus on human services. While most services kept focus on workplace productivity, some EAPs offer services that do not have a workplace focus, a change that may threaten the ongoing viability of the program.

Contents

Chapter 1: Statement of the Study Issue……………………………………….. 1
Introduction…………………………………………………………………... 1
Purpose……………………………………………………………………….. 5
Significance…………………………………………………………………... 7

Chapter 2: Literature Review……………………………………………………… 11
Introduction…………………………………………………………………... 11
The Need for Employee Assistance…………………………………..……… 12
The importance of work…………………….……………...……….. 12
Personal problems in the workplace…………………..……..………… 14
Welfare Capitalism………………………………………………………… 16
Occupational Social Work…………………………………………………… 19
Social work and the world of work…………………..………………... 19
Origins and history of occupational social work………………………… 20
Modern occupational social work…………………………..……..…... 23
Social work's focus on mental health…………………………..…... 25
Occupational social work definition……………………………………... 25
Occupational social work and employee assistance programs…………… 26
History and Evolution of Employee Assistance Programs…………………... 27
Occupational alcoholism programs………………………………..…..…. 27
From occupational alcoholism to employee assistance…………………... 31
Commoditization of employee assistance programs……………………... 36
Attributes and Theory of Employee Assistance Programs…………………… 37
Definition of employee assistance program……………………………… 37
Employee assistance program core technology………………………….. 41
Theories of employee assistance program practice……………………… 43
Employee assistance program services and dimensions…………………. 46
Employee assistance program prevalence……………………………... 73
Integration of employee assistance, wellness, and work/life programs….. 74
History and Evolution of Managed Behavioral Health Organizations………. 77
The managed care concept……………………………………………….. 77
Managed behavioral health organizations ……………………………….. 81
Integration of EAPs and MBHOs……………………………………….... 82
MBHOs' impact on EAP pricing………………………………………… 89
MBHOs' influence on EAP accreditation and credentialing…………….. 91
Mental Health Parity……………………………………………………... 92
Outcomes and Effectiveness of Employee Assistance Programs……………. 93
Theoretical framework…………………………………………….……… 99
Organizational change…………………………………………………… 99
Complex adaptive systems theory…………………………………….. 101
Industry life cycle theory………..………………………………………. 106

Organizational life cycle theory…………………………………………….. 109
Conclusion………………………………………………………………………. 110

Chapter 3: Methodology………………………………………………………… 112
Statement of the Research Questions…………………………………………… 112
Research Design..………………………………………………………………. 112
Epistemology…………………………………………………………….. 112
Qualitative design………………………………………………………… 116
Sample…………………………………………………………………………... 118
Sampling method………………………………………………………… 118
Sampling frame…………………………………………………………... 118
Data Sources…………………………………………………………………….. 129
Overview…………………………………………………………………. 129
Instruments……………………………………………………………….. 130
Data Collection Procedure……………………………………………………… 131
Semi-structured interviews……………………………………………….. 131
Interview subject survey………………………………………………….. 135
Employee assistance program questionnaire…………………………….... 135
Methods of Data Analysis……………………………………………………… 135
Qualitative data analysis………………………………………………….. 135
Quantitative data analysis………………………………………………… 142
Trustworthiness of Data and Research Rigor…………………………………… 143
Discussion of Ethical Issues…………………………………………………….. 145

Chapter 4: Findings……………………………………………………………... 147
Sample Description Section……........…………………………….....………… 147
Study participants………………………………………………………… 147
EAP organizations………………………………………………………... 150
Thematic Section………………………………………………………………... 155
The changing EAP market….…………………………………………… 155
Survival strategies……..…………………………………………………. 164
Summary of Findings…………………………………………………………… 187

Chapter 5: Discussion…………………………………………………………… 189
Changing EAPs…………………………………………………………………. 189
Service changes…………………………………………………………… 189
Other EAP changes……………………………………………………….... 190
Model of EAP Evolution……………………………………………………….. 191
Impact of changing market………………………………………………… 193
Purpose of survival strategies……………………………………………… 195
Application of Theoretical Framework to Inform Evolutionary Process ……. 197
Implications for Practice and Policy…………………………………………… 199

Implications for Future Research…………………………………………….. 201
Statement of Limitations…………………………………………………... 203
Conclusion…………………………………………………………………… 205

References…………………………………………………………………… 208

Appendix A: Inclusion Survey……………………………………………….. 242
Appendix B: Statement to Subjects…………………………………………... 244
Appendix C: Interview Guide………………………………………………... 246
Appendix D: Interview Subject Survey…...…………………………………… 252
Appendix E: EAP Questionnaire…………………………………………….. 254
Appendix F: UCAIHS Approval Notice……………………………………….. 262

List of Tables/Figures

Table 1. Participant demographics………………………………………………. 148
Table 2. Participant professional characteristics………………………………… 147
Table 3. General organizational characteristics………………………………….. 151
Table 4. Staffing……………………………………………………………………. 150
Table 5. Core technology services currently offered by EAPs…………………... 154
Table 6. Location of service providers for integrated services………………….. 152
Table 7. Changing market themes and subthemes………………………………. 156
Table 8. Survival strategy themes and subthemes……………………………….. 165
Figure 1. New form of EAP service provision…………………………………... 190
Figure 2. EAP evolution model………………………………………………….. 192

Chapter 1: Statement of the Study Issue

Introduction

An important access point for services that address mental health, alcohol and drug abuse, and other personal problems for millions of working Americans and their families is the Employee Assistance Program (EAP) (Sharar & Hertenstein, 2006a). EAPs were conceived as a method of identifying and addressing issues related to employees with personal problems that impact their job performance (Blum & Roman, 1989; Erfurt & Foote, 1977). In addition to direct interaction with troubled employees, EAPs assist employing organizations to address behavioral health risk through consultation with management and supervisors (Mannion, 2004). Therefore, EAPs have two primary missions: to assist individual employees and to assist organizations with personal and organizational problems that impact work performance.

Identifying employees in need of assistance based on declining work performance is an essential aspect of EAP services (Attridge et al., 2009a; Attridge et al., 2010). By targeting performance problems, at both an individual and organizational level, EAPs are able to justify their existence to employing organizations; improving performance provides a positive return on investment in relation to the cost of the EAP (Attridge, Amaral, & Hyde, 2003; Hargrave, Hiatt, Alexander, & Shaffer, 2008; McLeod, 2001). In addition, job performance is related to employee job retention, a value that is important to individual employee wellbeing. Furthermore, focusing on employee performance problems is an effective way to identify employees in need of intervention that does not require that supervisors have clinical knowledge or expertise (Wrich, 1980), making it

easier for supervisors to identify and refer troubled employees who may need EAP services.

EAPs are the primary employers of occupational social workers, a field of practice within the social work profession dating back more than 100 years (Kurzman, 2008; Maiden, 2001; Mor Barak & Bargal, 2000). Professional social workers have traditionally been leaders in the EAP field and are the profession of choice for EAPs due to their diverse skill set and dual micro and macro focus (Bates & Thompson, 2007; Cunningham, 1994; Straussner, 1990; Tanner, 1991).

EAPs have changed significantly from their original conception. Most early EAPs were internal programs operated by large organizations (Blum & Roman, 1989; Cunningham, 1994). In the internal model, the EAP counselor and the employee receiving services are employed by the same organization, whereas in the external or contracted-out model services originate externally, and the EAP counselor is employed by an outside organization different from where the client is employed (Lewis & Lewis, 1986; Masi, et al., 2004). The external, contracted-out model first emerged in the 1970s and early 1980s (Csiernik, 1999; Blum & Roman, 1989; Sharar 2009), and external models gradually began to replace the internal models (Blum, Martin, & Roman, 1992). Today most EAP services are offered by external EAPs (Cagney, 1999; Hartwell et al., 1996; Merrick et al., 2007).

Another important change in EAPs is related to the emergence of managed behavioral health organizations (MBHOs) in the early 1990s. While originally located within the medical or personnel departments of a company, or standing independently as

private contractors, today the majority of EAP services in the U.S. are provided by MBHOs (Fox, Oss, & Jardine, 2000; Open Minds, 2002; Oss, Morgan, & Miller, 2011), in what can be referred to as MBHO-EAPs; however, MBHOs did not even exist when EAPs were first conceptualized. Managed behavioral healthcare (also know as managed behavioral health insurance) is a system that controls access and costs related to the provision of mental health and substance abuse services (Hersch, 1995).

MBHOs' entry and domination of the EAP industry has significantly impacted the entire EAP field, even those EAPs that are not directly affiliated with MBHOs. Due in part to MBHOs' influence, EAPs have changed significantly in terms of what services are requested by employers, how these services are provided, and by whom (Sharar, 2009). EAPs' focus on the workplace is part of what made them unique and different from other behavioral health interventions with a broader, non work-related focus, such as psychotherapy and substance abuse treatment (Roman & Blum, 1988). One of the most significant changes is that many EAPs are moving or have moved from their traditional focus on employee productivity towards a focus on controlling the costs incurred by employers and insurers related to the provision of behavioral health services, a shift in focus that threatens to undermine EAPs' primary purpose and mission (Mannion, 2004; Sharar, 2009; Tisone, 2008).

MBHO-EAPs, the primary form of EAP service provision in the U.S. today (Fox et al., 2000; Open Minds, 2002; Oss et al., 2011), may have significantly impacted the EAP industry with respect to quality and effectiveness (Bjornson & Sharar, 2004; Sharar, 2009). In addition, MBHO-EAPs tend to use a capitated pricing model that often limits

utilization and eliminates prevention activities that are an essential part of EAP services (Bjornson & Sharar, 2004). However, there is currently a dearth of research examining the overall quality and effectiveness of MBHO-EAPs.

Another aspect of MBHOs that may impact EAPs is related to the fact that managed behavioral health insurance is a benefit, and along with other benefits such as medical insurance, vacation time, and short term disability coverage, makes up part of the total compensation provided to employees (Rosenbloom, 2005). Evidence that EAPs are being perceived as a benefit can be seen by the fact that the majority no longer report to the human resource department of client companies, but instead report to the benefits department (National Business Group on Health, 2008). The identification of EAPs as a benefit changes the original intention and unique nature of the program, and may impact EAP's ability to effectively address individual employee and workplace issues, and lead to the elimination or reduction of traditional EAP practices such as supervisory consultation, prevention services (Bjornson & Sharar, 2004), a focus on substance abuse (Sharar, 2009), and formal manager referrals (Bjornson & Sharar, 2004; Sharar, 2009).

Continued focus on the workplace, and specifically on factors related to individual and workplace performance, is the best way to insure that an important social work value, individual (employee) wellbeing, remains on the forefront of EAP practice. Addressing both individual problems and problems in the workplace itself fits well with the person-in-environment aspect of social work practice. In addition, maintaining a focus on the workplace provides an important avenue for social work practice because the workplace is an ideal place to identify troubled employees (Akabas & Kurzman,

2005; Googins & Godfrey, 1987). Therefore, EAPs that maintain a traditional focus on employee performance, and the workplace itself, are more closely aligned with social work values and occupational social work practice than are EAPs that focus on behavioral health cost savings.

Purpose

Despite the many changes affecting the entire EAP industry, there has been no research that has systematically reviewed the impact of these changes on EAP organizations in terms of strategy, structure, services provided, modes of service delivery, outcomes, focus, and populations served. Research into the changes that have occurred in EAPs since MBHOs became prevalent is necessary in order to understand how these changes may impact EAP effectiveness and focus, and to provide industry leaders with information to help guide strategy and planning decisions.

In order to effectively study the impact of MBHOs on EAPs, it is necessary to examine traditional EAPs that have been in existence since before MBHOs became prevalent. MBHO-EAPs have their own service model that, as already mentioned, differs markedly from traditional EAP practice. Therefore, EAPs that were based on a more traditional service model can be used as a baseline to examine the impact that MBHOs may have had on these organizations. Research into non-MBHO EAPs is the best method of determining how MBHOs may have impacted the industry. In addition, external EAPs are by far the most prevalent form of EAP practice in the U.S. today (Cagney, 1999; Hartwell et al., 1996; Heck, 1999; Merrick et al., 2007). Therefore, the aim of this study was to examine the changes that have occurred in external non-MBHO

EAP organizations since the advent of MBHOs in the early 1990s. Such research is needed in order to determine how EAPs have evolved from their original conception, and how these changes may impact service provision.

The study used a qualitative format comprised of semi-structured interviews with top EAP managers and leaders at external, management-sponsored, non-MBHO EAPs in the United States, and supplemented by several surveys. The surveys were used as a method of describing the study sample. The primary units of analysis for this study are the EAP organizations themselves. However, the primary sources of data used to examine the changes that have occurred in EAPs are the top managers and leaders at the organizations being studied. The sample includes only those EAP organizations that have been in existence since 1993 or earlier. While MBHOs in general began increasing in prevalence in the early 1990s (Feldman, 2003), there was a huge expansion in their prevalence and scope and between 1993 and 1998 (Mark et al., 2000). The year 1993 was chosen as a starting point for this study as this was the beginning of the initial large expansion of MBHOs, and the likely starting point from which they may have started to significantly impact the EAP industry.

The qualitative analysis of the interview data was interpreted through a theoretical framework that consisted of several theories of organizational change including complex adaptive systems theory (Stacey, 2000; Waldrop, 1992), industry life cycle theory (Klepper & Grady, 1990; Klepper, 1997; Peltoniemi, 2011; Potter & Watts, 2011), and organizational life cycle theory (Phillips & Straussner, 2002). These theories helped to illustrate the evolution of EAP organizations since the advent of MBHOs in the early

1990s. This study focused on the ways EAPs have changed and the perceived impact and rationale for the various changes. It is the intention of this study to help to illustrate industry-wide trends using data reported by representatives of individual EAP organizations.

Significance

EAPs are an important access point for both employees and eligible family members with mental health or substance abuse problems (Sharar & Hertenstein, 2006a), and have been shown to be effective in addressing numerous workplace performance issues including absenteeism (Blum & Roman, 1995; Hargrave et al., 2008; Harris, Adams, Hill, Morgan, & Soliz, 2002; Selvik & Bingaman, 1998), presenteeism (Hargrave et al., 2008; Harlow, 2006), productivity (Hargrave et al., 2008; Harris et al., 2002), work relationships (Harris et al., 2002; Masi & Jacobson, 2003), mental health and substance abuse (Mcleod, 2001; Reynolds, 1997), turnover (Blum & Roman, 1995; Hughes, Elkin, & Epstein, 2004), and employee health and wellness (Mcleod, 2001; Selvik & Bingaman, 1998).

There is a significant need for EAPs due to the prevalence of mental illness and substance abuse in American society, and the fact that most Americans with mental health or substance abuse disorders receive no treatment or inadequate treatment (Wang et al., 2005). It has been estimated that approximately half of all Americans will have a diagnosable mental health disorder in their lifetime (Kessler et al., 2005) and most binge and heavy drinkers as well as most illicit drug abusers are employed (SAMHSA, 2009). It was estimated that in 2008 there were 9.8 million American adults who were diagnosed

with a serious mental illness (SAMHSA, 2009), and 37% of Americans with a serious mental illness are employed (Lutterman & Gonzalez, 2006). Furthermore, in 2008 12.5 million Americans who were employed full time abused or were dependent on illicit drugs, and 44.6 million Americans employed full or part time were classified as binge drinkers, while 13.1 million were classified as heavy drinkers (SAMHSA, 2009).

Another concerning effect of mental health and substance abuse problems in the workplace is the economic impact; mental health and substance abuse is costly to individuals, employers, and society as a whole. The most recent estimate of the economic impact of substance abuse in the U.S. due to lost productivity (and not including the related costs of healthcare and crime) was $128.6 billion per year (Office of National Drug Control Policy, 2004). The total annual cost of mental illness in the U.S. was estimated to be $193.2 billion in lost personal earnings (Insel, 2008; Kessler et al., 2008). Employee turnover has been shown to impact business profits (Kacmar, Andrews, Van Rooy, Steilberg, & Cerrone, 2006; Simons & Hinkin, 2001) and the cost of replacing a highly trained worker with a mental health or substance abuse problem has been estimated to be five times more expensive than rehabilitating that same worker (Collins, 1999).

As already mentioned, EAPs are an effective way to address mental health and substance abuse problems in the workplace, and they have been shown to help employees maintain employment (Blum & Roman, 1995; Hughes et al., 2004), and improve work relationships (Harris et al., 2002; Masi & Jacobson, 2003; Selvik, Stephenson, Plaza, & Sugden, 2004). This is significant because employment plays an important role in the lives of Americans. Employment is a way for individuals to achieve status, social

recognition, and concrete material rewards, and it plays a significant role in psychological and emotional development (Chestang, 1982). Work also serves an important function in the provision of fringe benefits, and work, or the absence of work, is one of the most important issues in the lives of people served by the social work profession (Akabas & Kurzman, 2005).

The type of EAP services offered and their effectiveness is significant not only because of their potential impact on troubled employees and dysfunctional work environments, but also due to the large number of Americans who have access to these programs. Though based in part on different methods of measuring enrollment, the number of employees and family members in the U.S. who were eligible for EAP services increased over 1000% between 1993 and 2011; an estimated total of 309.1 million individuals had access to an EAP in the U.S. in 2011 (Oss et al., 2011), and approximately 65% of all American employers currently offer EAP services to their employees and their family members (Galinksy, Bond, & Sakai, 2008). In addition, there has been significant market consolidation among EAP organizations; many smaller EAPs were acquired by larger organizations (including MBHOs), and a number of regional organizations merged (Fox et al., 2000; Sharar et al., 2002).

However, while the effectiveness of traditional EAPs is well known (Blum & Roman, 1995; Csiernik, 2004; McLeod, 2001) the changes that have occurred in EAP organizations and service provision since MBHOs' entry into the field brings into question the purpose and effectiveness of modern EAP organizations (Sharar, 2009). This study is the first of its kind to examine the impact of MBHOs on EAPs. By

examining how and why EAPs have evolved, this study helps to illustrate the impact of the adaptive strategies employed by EAPs on the original goals and intentions of the program.

The Evolution of External EAPs.

Chapter 2: Literature Review

Introduction

This literature review will cover seven main areas that are related to the formation and evolution of employee assistance programs in the United States. The review is meant to give a comprehensive overview of the variables that have impacted EAPs since the beginning of the concept, with special attention being paid to the influence and impact of managed behavioral health organizations. The first section reviews the need for EAPs including the importance of work, and personal problems in the workplace. The following section helps to explain the some of the theoretical roots of EAP practice by outlining an early precursor to the modern EAP, welfare capitalism. The next section deals with the history and evolution of occupational social work and its relationship to EAPs. The history of employee assistance is then examined, beginning with the formation of occupation alcohol programs that evolved into "broadbrush" employee assistance programs. The next section discusses the attributes and theory of EAP including various definitions of the EAP concept, EAP core technology, theories of EAP practice, EAP services and dimensions, and the integration of EAP with ancillary services. The history and evolution of managed behavioral health care and its impact on the EAP industry is discussed next, as well as the recent Mental Health Parity Act and its possible impact. This is followed by a review of some of the research that has been done concerning EAP outcomes and effectiveness, including some methodological issues and research gaps. A discussion will then be presented of the organizing theories that will be used for this study in order to provide a framework through which to examine the

evolution of external EAPs since the advent of MBHOs. The organizing theories include the concept of organizational change, and more specifically complex adaptive systems theory, industry and organizational life cycle theory, and their application to EAP organizational change. Finally, the conclusion offers a summary of the literature review that clearly establishes the logic and need for the study.

The Need for Employee Assistance

EAPs are one of a series of strategies employed by business organizations as a means to address employee problems that impact performance (Blum & Roman, 1989; Hargrave et al., 2008; McLeod, 2001). EAPs are an effective way to address mental health and substance abuse problems in the workplace, and they have been shown to help employees maintain employment (Blum & Roman, 1995; Hughes et al., 2004). The following section will discuss the importance of work to wellbeing, followed by a discussion of the prevalence and impact of employees' personal problems, particularly with respect to work performance.

The importance of work. Work, or the absence of work, is one of the most important issues in the lives of people served by the social work profession. Most individuals in the United States are members of a working family, and the typical American adult spends half of his or her waking hours at work. American men and women are more productive and spend more time at work today than ever before. In addition, work organizations and labor unions have immense power, and "may influence the family, the community, and the political arena more than any other entity" (Akabas & Kurzman, 2005, p.1).

Work is a method for individuals to achieve status, social recognition, and concrete material rewards; it links people to a social network, and helps to integrate them into society. The act of working and one's profession is an essential part of personal identity, and it is important in giving meaning to one's life and in fostering self-esteem (Chestang, 1982).

Work plays a significant role in psychological and emotional development. Work serves "as an internal organizer" (Chestang, 1982, p.64) and the impulse control, discipline, and cooperation required for work serve to reinforce ego integrity (Perlman, 1968). Children are socialized from a very young age to prepare for membership in the world of work (Chestang, 1982). Erikson (1963) views work and the preparation for work as an important developmental milestone. A child must begin to recognize the importance of work as a method of gaining recognition from others, and preparation for a career is instrumental in forming a "sense of ego identity" (Erikson, 1963, p.262). Conversely, the inability to adequately form an "occupational identity" (Erikson, 1963, p. 262) can lead to role confusion.

Work has been described as one of the best methods of channeling aggressive drives into useful activity, and "the most practical and obvious of all sublimations" (Menninger, 1942, p. 171). Menninger also observed that "three fourths of the patients that come to psychiatrists are suffering from an incapacitating impairment of their satisfaction in work or their ability to work,… [often] it is their chief complaint" (Menninger, 1942, p. 177).

The Evolution of External EAPs.

Especially in the United States, work serves an important function in the provision of fringe benefits upon which most individuals and families rely. Some work-related benefits are mandated by law, and may be paid in part or in full by the employer; these benefits include worker's compensation, unemployment insurance, Medicare, and Social Security. In addition, most American employers offer other voluntary benefits such as health insurance, paid vacations, pensions, as well as daycare and educational subsidies. Individuals who are not employed or part of a working family often must purchase these benefits in the open market, usually at a much higher rate if available at all (Akabas & Kurzman, 2005).

Personal problems in the workplace. It has been estimated that as much as 20 percent of the American workforce has decreased performance related to employees' personal problems (Masi, 1992), and the cost of replacing a highly trained worker with a personal problem has been estimated to be five times more expensive than rehabilitating that same worker (Collins, 1999). Employees' personal problems may be related to a number of issues including mental illness, substance abuse, marital problems, financial or legal concerns, stress, grief, discrimination, and problems in the work environment (Masi et al., 2004). Many employee problems overlap, and so the impact of one problem may affect another. For example, issues with substance abuse may also be related to financial problems; the cumulative impact of these problems can have a significant impact on absenteeism and other measures of workplace productivity. In addition, most Americans with mental health or substance abuse disorders receive no treatment or inadequate treatment (Wang et al., 2005), and EAPs provide an important access point for services that address mental health, alcohol and drug abuse, and other personal problems for

millions of working Americans and their families (Sharar & Hertenstein, 2006a). The following section will outline the prevalence, impact, and cost of employee personal problems in the workplace and in American society, highlighting the need for EAPs that address these issues.

It has been estimated that approximately half of all Americans will have a diagnosable mental health disorder in their lifetime (Kessler et al., 2005). It was estimated that in 2008 there were 9.8 million American adults who were diagnosed with a serious mental illness (SAMHSA, 2009), and 37% of Americans with a serious mental illness are employed (Lutterman & Gonzalez, 2006). Depression and other forms of mental illness have been shown to impact productivity. Employees who suffer from depression are twice as likely to be absent from work for health reasons than those who are not depressed, and seven times more likely to be less effective at work (Druss, Schlesinger, & Allen, 2001). Mental health problems are costly to American society, and the total annual cost of mental illness in the U.S. has been estimated to be $160.8 billion (NIH, 2000).

Another issue that significantly impacts Americans is substance abuse. Alcohol and drug abuse can affect employee turnover, absenteeism, accidents, and health care spending (Reynolds & Lehman, 2003). Most binge and heavy drinkers as well as most illicit drug abusers are employed (SAMHSA, 2009). Furthermore, in 2008 12.5 million Americans who were employed full time abused or were dependent on illicit drugs, and 44.6 million Americans employed full or part time were classified as binge drinkers, while 13.1 million were classified as heavy drinkers (SAMHSA, 2009). The most recent estimate of the economic impact of substance abuse in the U.S. due to lost productivity

(and not including the related costs of healthcare and crime) was $128.6 billion per year (Office of National Drug Control Policy, 2004).

Work stress related issues also have been shown to impact productivity. The Bureau of Labor Statistics conducted a survey of work stress, which they define as a "neurotic reaction to stress" (U.S. Department of Labor, 1999, p. 1). They found that there were 3,418 cases of work stress reported in 1997 resulting in a median work absence of 23 days, four times the incidence of nonfatal workplace injuries and illnesses (U.S. Department of Labor, 1999). Stress and health factors have also been associated with presenteeism and lost productivity (Burton et al., 2005), and marital distress has been estimated to cost American employers $6.8 billion annually (Forthofer et al., 1996).

Financial issues and poor financial planning by employees can also result in extensive costs to employers and is related to many of the other problems already mentioned. It has been estimated that 15% of American workers experience financial problems that impact their work performance and have been correlated to absenteeism, lateness, conflicts with co-workers, substance abuse and mental illness among other effects. Though the total cost to employers is unknown, it is estimated to be substantial (Garman, Leech, & Grable, 1996).

Welfare Capitalism

In order to fully understand the concept of employee assistance programs, it is important to understand the history and theoretical underpinnings of some precursors to the modern EAP. Welfare capitalism can be seen as one of the origins of many occupationally focused service programs and professions including occupational social

work (Brandes, 1976), EAPs (Bickerton, 1990; Blum & Roman, 1989), and work/family and work/life programs (Helihy, 2000; Helihy 2005). An examination of the origins and history of welfare capitalism is helpful in situating and understanding the future development of these related fields.

Welfare capitalism has been defined as "any service provided for the comfort or improvement of employees which was neither a necessity of the industry nor required by law" (Brandes, 1976, p. 6). Welfare capitalism arose in response to increasing worker dissatisfaction, which was a result of the changing nature of work in America. The industrial revolution significantly impacted individual workers and their families, forcing them to move from rural to urban areas and work together, often under difficult conditions. The new working conditions caused increasing disconnection between management and labor as the size of businesses became larger and prevented personal contact. In addition, the introduction of increasing numbers of women and immigrants into the workforce was a significant factor in creating labor unrest. American workers, dissatisfied with working conditions, reacted in numerous ways including malingering, poor productivity, alcohol abuse, sabotage, and leaving the job (Brandes, 1976). However, one of the most concerning actions, from the perspective of business owners, was unionization and the related labor strikes. All of these issues had a measurable impact on profits and productivity, and welfare capitalism was a response that many business leaders chose to address these problems (Brandes, 1976; Popple, 1981).

Welfare capitalism included the provision, by employers to employees and their families, of such things as housing, education, medical services, and recreation. A major

issue addressed by businesses operating under the ideology of welfare capitalism was assisting workers to acculturate to the newly industrializing society and to American culture. In addition, many companies set up schools, company stores and restaurants, company housing, and even orphanages. There were several goals of welfare capitalism; it was used as a defensive strategy against unionism, and also as a method of assisting, appeasing, controlling, and retaining workers. Welfare capitalism was not merely a defensive strategy; it also attempted to shape workers to more closely adhere to the business leaders' view of a productive, moral worker. Though some of the practices that were initiated under the banner of welfare capitalism were clearly humanitarian, the primary driver of the movement was that is was thought to make good business sense in terms of productivity and profits. While welfare capitalism had some positive aspects, it was often paternalistic, controlling, and often employed highly questionable, coercive, and unethical tactics to achieve its ends (Brandes, 1976).

While welfare capitalism was generally seen as effective in the 1920s, due to fewer strikes, evidence of lower turnover, and generally improved labor relations, the movement did not last through the Great Depression. Several factors led to the demise of the movement including increasing disconnection between management and workers as companies grew ever larger, as well as the belief by many business leaders that welfare programs made them appear "weak" to union organizers and therefore more vulnerable to unionization. The Depression itself affected companies' ability to afford welfare programs, and after the New Deal the government itself became hostile to certain forms of welfarism that were perceived as being too controlling of workers' lives (Brandes, 1976).

There are two aspects of welfare capitalism that are particularly pertinent to the later formation of EAPs: employers efforts to address problem drinking by their employees, and the employment of "social secretaries" (aka industrial welfare workers) to address other personnel-related issues (Straussner, 1986). Social secretaries can be seen as early occupational social workers, and a precursor to the EAP movement. A review of the origins, history, and evolution of occupational social work and its relationship to EAPs will now be presented, followed in turn by an examination of the origins and evolution of alcohol-related programs in the workplace.

Occupational Social Work

Occupational social work and EAPs are closely linked, though they are not the same. The following section situates the workplace within the overall field of social work, and outlines the history and evolution of occupational social work. A discussion of social work's focus on mental health is also offered as this is pertinent to the subsequent evolution of EAPs. A discussion of the various definitions of occupational social work is also offered, followed by an examination of social work's role in the EAP industry.

Social work and the world of work. In general, social workers and other human service and mental health professionals often focus on individuals and families, paying little attention to work-related issues. Work issues are often viewed as outside the expertise of professional social workers (Akabas & Kurzman, 2005). Only one percent of licensed social workers in the United States report that they are employed as occupational social workers, with an additional one percent reporting that they work for the military, which can be considered a form of occupational social work (Center for

Health Workforce Studies & NASW Center for Workforce Studies, 2006). However, occupational social work was one of the first social work specialties in the United States, though it did not maintain a prominent role in the profession (Maiden, 2001). Perlman (1982) explains the lack of attention to work-related factors by social work professionals as being related to mistrust or disagreement with business values, contradictory research findings about the importance of work to individuals, unconscious bias about the nature of certain types of work, value judgments about the benefits and detriments of specific work situations, and issues related to women's roles in the world of work. However, the recognition that personal and work related functioning are interconnected did, at some level, regain acceptance in the profession (Kurzman & Akabas, 1981). Attention to the world of work by professional social workers has gained additional prominence due to recognition of the importance of work to human wellbeing, but also because the workplace is an ideal environment in which to contact people requiring assistance (Akabas & Kurzman, 2005; Googins & Godfrey, 1987).

Origins and history of occupational social work. The origins of occupational social work in the United States can be traced back to the 19th century with the emergence of welfare capitalism. A popular kind of welfare capitalism was the "industrial welfare worker"(Brandes, 1976, p. 111), also known as social welfare secretaries (Maiden, 2001), an early precursor to the modern occupational social worker. Industrial welfare workers emerged at a time when women began to enter the workforce due to the high demand for workers. Employers who had historically employed only men were unaccustomed to dealing with "women's issues" and consequently hired "specialists" to address this problem. The first such specialist was Ms. Aggie Dunn,

hired in 1875 by the H.J. Heinz Company, to serve as “social secretary”(Brandes, 1976, p.111). Dunn supported the female workers by interviewing, hiring, counseling, and otherwise supporting them in their employment (Brandes, 1976).

Social secretaries expanded to other businesses as well, and they functioned in numerous roles including those of travel agents, personal shoppers, real estate agents, recreation leaders, and teachers (Brandes, 1976). In addition to directly hiring social secretaries, many companies used contracted-out agencies to provide social work services (Popple, 1981), a precursor to the contracted-out EAP of today (Straussner, 1986).

The original role of social secretaries was to improve communication between employers and their employees, as well as to offer support. However, the positive aspects of the position were undermined when the role evolved to include the gathering of information about employees. Social secretaries became a tool of management with a paternalistic focus on transforming employees into the kinds of workers that management desired, paying special attention to employees’ morals and behavior (Brandes, 1976).

Social secretaries all but disappeared in the 1920’s for several reasons including changes in the economy following the first world war, changing ideologies, as well as worker dissatisfaction. Workers often felt that social secretaries were paternalistic and anti-union, both valid criticisms (Brandes, 1976). Social secretaries did not truly disappear so much as evolve away from a social work focus towards a more business focus. Many of the functions of social secretaries evolved into what is now known as personnel management (Popple, 1981) on the one hand, and industrial health and subsequently occupational mental health on the other (Greiff, 1978).

The Evolution of External EAPs.

The Second World War temporarily increased the cooperation between social work, labor, and management due to labor shortages and increased pressure for productivity (Akabas & Kurzman, 1982). In addition to the need to increase productivity, social secretaries, now commonly referred to as industrial social workers (Maiden, 2001), re-emerged during World War II to assist workers to adjust to the war and to address issues related to the increased role of women in the workforce. Industrial social workers also found employment in the armed forces, assisting soldiers and their families (Akabas & Kurzman, 2005).

One of the best-known programs also occurred during World War II, when Bertha Reynolds was hired by a joint program of National Maritime Union and the United Seaman's Service. Ms. Reynolds, a professionally trained social worker, supervised a staff of seven Master's-level social workers to provide services to union members. Similar to other wartime programs, this program did not last long after the war ended, and despite being deemed successful it closed in 1947 (Reynolds, 1951). In the post war period there was a glut of civilian workers, and this served to lower recruitment and training costs, and made social work services aimed at productivity less valuable. In addition, unions began to give individual members the responsibility for accessing services on their own, and used trained union volunteers to refer members to community services. The social work profession further alienated the working class by focusing on professionalization and by incorporating Freudian psychoanalysis into their practice (Akabas & Kurzman, 1982).

Modern occupational social work. Modern occupational social work can be traced back to the 1960s with the establishment of two programs focused on the mental health needs of employees. Both programs were highly successful, one at the Polaroid Corporation in Boston, and the other at Amalgamated Clothing Workers of America in New York City; both programs were directed by professional social workers. The field of occupational social work gained further prominence with the establishment in 1969 of the Industrial Social Welfare Center at Columbia University's School of Social Work. Columbia's program was followed in 1974 by other industrial social work programs established at Boston College, Hunter College, and the University of Utah (Akabas & Kurzman, 2005; Straussner, 1990). Columbia's program, now called the Center for Social Policy and Practice in the Workplace, continues to play a prominent role in the education of professional occupational social workers and in conducting pertinent workplace-related research. In addition, by 1986 there were approximately 25 universities with occupational social work programs. However, today there are only four schools of social work that offer occupational social work programs: Columbia, Hunter, Maryland and University of Southern California. Each of these programs has a somewhat different orientation, but they have all have been operating for 25 years or more. The primary reasons for the decline are a lack of succession planning; in general, one person championed the program, and junior faculty involved in the programs often did not get tenure, ultimately resulting in the fact that as senior faculty members retired, they were not replaced (Maiden, 2008). Another possible reason for the lack of occupational social work programs is the emergence of MBHOs and the re-orientation of occupational social work as a for-profit business endeavor as opposed to a social service,

similar to the evolution of industrial social workers towards a business focus (Popple, 1981).

Occupational social work began to expand rapidly beginning in the mid-1970s as employers began to deal with a changing workforce as well as a plethora of new social legislation. The new legislation included the Civil Rights Act (title VII), the Hughes Act, the Occupational Safety and Health Act, the Vocational Rehabilitation Act, the Employee Retirement Income Security Act, the Pregnancy Discrimination Act, and the Age Discrimination in Employment Act, all of which affected industry in one way or another. Added to this was the fact that minorities, women, and people with disabilities were entering the workforce in greater numbers than ever. These new workers, empowered by legislation, were demanding accommodations such as flexible schedules, accessible worksites, and other quality of life concessions. In addition, employers were noting increased turnover and higher costs to train and replace workers, as well increasing costs related to health and mental health benefits. Organizations had to address the changing needs of their workforce, and human resources, medical and training personnel were not equipped to do so. Social workers were hired by many companies in order to meet these changing needs; they provided services such consulting about how to adjust personnel policies to meet the needs of disabled, minority, and female employees, as well as participating in corporate drug and alcohol education programs, conducting out-placement counseling, and consulting on how to formulate more flexible benefits options. However, the primary role of an occupational social worker was direct employee counseling (Akabas & Kurzman, 2005; Kurtzman, 1987).

Social work's focus on mental health. The largest practice area in the profession of social work today is the mental health arena (NASW, 2006). In fact, the social work profession began as far back as the 1920s to move away from social activism and reform in favor of a focus on the individual, and at that time began to adopt psychoanalytic theory into practice as a method of increasing professionalization (Ehrenreich, 1985). The ongoing focus on individual behavioral health issues by the social work profession has impacted the practice of occupational social work in the United States. American occupational social work's focus on mental health and substance abuse in the workplace has de-emphasized a broader focus that could address a plethora of work-related issues (Googins & Godfrey, 1987).

Occupational social work definition. Occupational social work, also known as industrial social work, has several overlapping definitions. An exact, all encompassing definition has not yet been found due to the broad and expanding range of services performed by professional social workers in the workplace (Googins & Godfrey, 1987). Straussner (1990) defined occupational social work as " a specialized field of social work practice which addresses the human and social needs of the work community through a variety of interventions which aim to foster optimal adaptation between individuals and their environments" (Straussner, 1990, p. 2). Googins and Godfrey defined occupational social work as "a field of practice in which social workers attend to the human and social needs of the work community by designing and executing appropriate interventions to insure healthier individuals and environments" (Googins & Godfrey, 1987, p. 5). Kurzman (1987) defined occupational social work as "programs and services, under auspices of labor or management, that utilize professional social workers to serve

members or employees and the legitimate social welfare needs of the labor or industrial organization. It also includes the use, by a voluntary or proprietary social agency, of trained social workers to provide social welfare services or consultation to a trade union or employing organization under a specific contractual agreement" (Kurzman, 1987, p. 899). This definition, unlike the latter, includes reference to the importance of both labor and management in occupational social work practice, emphasizes the use of professionally trained social workers, and pays special attention to the auspices under which social workers are employed in workplace settings (Akabas & Kurzman, 2005). The social work dictionary adds further specificity to the definition of occupational social work, pointing out that occupational social work: "provides professional services to employees and their families. The service may include clinical activities (such as family therapy, psychotherapy, educational counseling, and treatment for drug addiction) or macro practice (such as interventions on behalf of employee groups)" (Barker, 2003, p. 302). This definition identifies clients as both employees and families, a distinction omitted from earlier definitions.

Occupational social work and employee assistance programs. EAPs are the most well-known form of occupational social work, and along with MAPs they employ the largest number of occupational social workers (Akabas & Kurzman, 2005; Googins & Godfrey, 1987; Kurzman, 2008; Maiden, 2001; Straussner, 1990). Social workers have traditionally been the profession of choice for EAPs due to their diverse skill set and their ability to address both the macro issues of the organizational environment, as well as to intervene directly with employees on an individual level (Bates & Thompson, 2007; Tanner, 1991; Cunningham, 1994). Social workers' person-in-environment perspective,

their well-defined code of ethics, professional identity and already existing standards for professional practice make them ideal for EAP work (Cunningham, 1994). Furthermore, EAPs gave legitimacy to the practice of organizational social work, which prior to their emergence was essentially limited to small, narrowly defined programs in schools of social work and in specific industries (Googins & Godfrey, 1987).

In the United States, EAPs "reflect the merging of both the EAP and occupational social work traditions of practice"(Cunningham, 1994, p.12). The occupational social work movement and that of EAPs are closely linked; however, despite many similarities, parallels, and co-evolution, the field of occupational social work and that of EAPs are not the same. EAPs are only one setting in which occupational social workers are employed. In fact, occupational social workers may be employed in numerous ways, such as through a trade union, peer group, through a joint labor/management arrangement, or by the management of a public or private organization (Straussner, 1990).

History and Evolution of Employee Assistance Programs

Occupational alcoholism programs. Though modern EAPs generally deal with a broad range of employee issues, the movement's origins can be traced to workplace alcohol programs (Lewis & Lewis, 1986; Van Den Berg, 2000; White, 2000); EAPs did not form spontaneously, but evolved over time from their predecessor, the Occupational Alcoholism Program (OAP) (Wrich, 1980). An examination of the formation and evolution of OAPs is helpful in order to understand the underlying logic upon which EAPs were created. While the cost of alcoholism to the organization in the form of

absenteeism, illness, accidents, and turnover was well known, it was not until views concerning the possibility of effective treatment were embraced that workplace alcohol programs began to emerge (Lewis & Lewis, 1986; White, 2000). One of the first non-punitive responses to workplace alcohol use emerged in the U.S. in the form of the Washingtonians, a society that promoted total abstinence and group meetings, much like the later Alcoholics Anonymous (AA). Employers' desire to remove alcohol from the workplace was further increased by the emergence of the workmen's compensation laws, which held the employer responsible for workplace accidents regardless of fault. AA was founded in 1935 and was embraced by numerous members of the American workforce. The processes expounded by AA to treat alcoholism were eventually incorporated into the ideology of the industrial medical departments, thus setting the stage for the formation of OAPs (Trice & Schonbrunn, 1981).

The effectiveness of AA's approach in helping alcoholics began to gain recognition, and some companies began to re-hire employees after they had shown the ability to maintain sobriety with AA's support. Many companies recognized the benefits of early identification of employee drinking problems before they impacted performance, and programs that addressed alcoholism began to emerge (Wrich, 1980).

The formation of the National Committee for Education on Alcoholism (NCEA) in the 1940s marked the beginning of a more formalized approach to alcoholism. The NCEA changed its name to the National Committee on Alcoholism (NCA) in 1950, and then to the National Council on Alcoholism (NCA) in 1956 (Blocker, Fahey, & Tyrell, 2003). This organization became what is known today as the National Council on

Alcoholism and Drug Dependence (NCADD), an organization staffed by volunteers whose mission is to provide education, public information, and policy advocacy related to alcoholism, and later, substance abuse. The mission of NCEA/NCA was seen as applicable not just to the general public, but also to industry. In 1959 the organization began working with industry to develop workplace programs that are precursors to the modern EAP (Bickerton, 1990).

By the 1940's OAPs were prevalent at many large American corporations. The OAPs were found to be extremely effective in terms of increasing productivity, saving money, and assisting in the rehabilitation of workers. The acceptance of OAPs by employers was influenced by the acute shortage of male workers during World War Two that made employee retention and rehabilitation more valuable (Trice & Schonbrunn, 1981).

Lewis Presnall played a major role in focusing NCEA/NCA's involvement with industry. Presnall developed a program whereby managers who observed employee problems with performance were able to make referrals for assistance to address these problems. Presnall's case finding techniques also included referrals from co-workers, union stewards, and family members. Presnall's program focused not just on alcoholism, but also on containing costs related to employees on sick leave, referrals for other personal issues that impacted work performance and attendance, corrective action policies, and guidelines for coordination between management and labor representatives (Bickerton, 1990). Presnall's view of employee issues beyond alcoholism was reflected in the evolution of OAPs into broader-focused EAPS.

The Evolution of External EAPs.

The development of what became modern EAPs was further impacted by federal legislation such as the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970, more commonly known as the Hughes Act. The Hughes Act marked the U.S. government's recognition of alcoholism as a treatable illness, and a key part of the act designated 100 occupational consultants known as the "Thundering Hundred" with the goal of reaching out to employers across the country and improving their education about alcoholism and also encouraging them to adopt formal alcohol referral and identification programs (Bickerton, 1990).

OAPs had two major thrusts in terms of how problem drinkers were identified; the first was based on the identification of problem drinking symptomatology, and the second was based on the impact of drinking on performance. The identification of problem drinkers was done for the most part by first line supervisors who received training related to this endeavor. However, there were several problems related to the symptomatology model. One problem was the fact that though workers at any level could, and often did have drinking problems, only lower level employees were identified by their managers, with higher level executives often receiving no attention whatsoever. Another issue was that early detection was unlikely as it could take years before the problem progressed to a level that would be recognized by the program. In addition, many supervisors who themselves had drinking problems refrained from identifying or referring any of their employees regardless of how obvious the problem might be. In the 1960s OAPs began to shift focus from alcohol symptomatology to impaired job performance resulting from alcoholism. While performance was a better method of identifying employees with alcohol problems, supervisors still had to make a diagnosis of

alcoholism in order to refer an employee to the program. Supervisors who were unsure of the cause of an employee's poor performance might not make a referral to the program unless they were certain that alcohol was part of the problem; this limited the effectiveness of the program (Wrich, 1980).

Despite some flaws in the concept, OAPs were found to be highly successful in rehabilitating workers with alcohol problems. Success rates as high as 50 to 80 percent were cited, a rate much higher than recorded for other types of referrals for this issue. A likely reason for the success of these programs was the motivation inherent in the employee's desire to retain employment, and the employer's ability to use the threat of job loss as a motivator. However, problem identification often came only when the alcoholism had progressed to a late stage, and most programs were thought to be ineffective in early detection and intervention (Wrich, 1980). Once performance-based measures started to be used in the identification of alcoholic employees it relieved supervisors of the responsibility of diagnosing alcoholism. In addition, performance-based measures were more specific and easier to identify than alcoholic symptoms, and were less vulnerable to employee manipulation and excuses (Blum, Roman, & Tootle, 1988).

From occupational alcoholism to employee assistance. Once OAPs started to use performance as a criteria for indentifying alcoholic employees, other factors that also impacted performance such as family problems, marital issues, depression, and stress, began to be identified as well, leading to the formation of broader-focused programs (Gornick & Blair, 2005). The use of the title "Employee Assistance Program" to

designate a workplace intervention program was intentionally broad in conception in order to show the intention to address a range workplace performance issues regardless of origin, and also to remove the "alcohol" label in an effort to de-stigmatize the program. In addition, the title and function of an EAP is broader than an OAP, and addresses a wider range of issues, while still utilizing a powerful motivator wielded by the employer: the threat of job loss (Wrich, 1980).

The Hughes Act of 1970 mandated the formation of the National Institute on Alcohol Abuse and Alcoholism (NIAAA), which was formed in 1971. NIAAA's mission was to promote the development of EAPs across the United States. Around the same time individuals who shared an interest in workplace counseling came together to found the Association of Labor-Management Administrators and Consultants on Alcoholism (ALMACA) (Bickerton, 1990; Herlihy & Attridge, 2005; Gornick & Blair, 2005).

Another important piece of legislation that impacted EAP development was the Drug Free Workplace Act that passed in 1988, and requires that most federal employers adhere to the tenets of the act including creation of a drug-free workplace policy, offering support and education to employees concerning substance abuse, and reporting workplace drug violations. Due to these requirements, federal employers were strongly encouraged to develop EAPs. Other industries such as defense, transportation, and nuclear energy have also come under similar federal requirements. Most positions in these industries that are considered "safety sensitive" are required to have routine drug and alcohol testing (Masi et al., 2004).

The Evolution of External EAPs.

EAPs offer numerous services aimed at supporting drug-free workplace policies including education of staff, training and consultation to supervisors about the identification of alcohol and drug problems, coordination of testing programs, and providing Substance Abuse Professionals (SAPs) to conduct assessment, referral, and follow up to employees with substance abuse problems (Masi et al., 2004).

EAPs today tend to have a more holistic, ecological approach than their predecessors. This approach differs from the constructive confrontation approach that was primarily aimed at alcohol-abusing employees, and instead recognizes the broad range of emotional, physical, family, and organizational issues that impact an employee's performance (Van Den Berg, 2000). Modern "broad brush" programs address a range of mental health, personal, and workplace related issues (Bickerton, 1990; Van Den Berg, 2000) including wellness/health promotion (Gornick & Blair, 2005; Masi, 2005), work/life services (Gornick & Blair, 2005; Herlihy, 2000; Masi, 2005; Van Den Berg, 2000), behavioral health benefits gatekeeping/administration (Sciegaj et al., 2001; Van Den Berg, 2000), and much more.

There was, and to a certain extent continues to be, considerable controversy over whether EAPs should provide "broad brush" services to employees that address other life issues such as family problems, mental illness, financial concerns, and the like, or to maintain a clearer more exclusive focus on alcoholism. NIAAA, ironically, had an influence in EAPs move away from a focus on alcoholism. Due to the belief that OAPs had limited success due to the emphasis on alcohol problems and supervisors' involvement in identifying these problems, NIAAA recommended broader-focused

programs that were believed to be less stigmatizing and therefore more appealing to employers (Roman, 1990).

The controversy about a EAPs' focus on alcoholism came to a head in the 1980's when members of ALMACA who were dissatisfied with the broad brush approach that was gaining favor, broke off from the organization and together with some Canadian EAP professionals formed the Employee Assistance Society of North America (EASNA). EASNA members felt that since alcoholism was the primary drug of choice and led to the most problems in the workplace, a specific focus on this issue was needed; there was also concern that issues related to alcoholism would be lost or watered down if a more general approach was implemented (Bickerton, 1990). Roman and Blum (1988) in their original conception of the EAP core technology, felt that EAPs should maintain a specific focus on alcohol and drug use among employees because this "offers the most significant promise of producing recovery and genuine cost savings for the organization in terms of future performance and reduced benefits usage"(Roman & Blum, 1988, p.21). However, in a review of EAP research by Masi, Jacobson, and Cooper (2000) it was found that only 18.9% of cases were identified as being related to alcohol or drug use, though the authors estimate that the true incidence is much higher and that clients are not being adequately screened for substance abuse issues.

Substance abuse patterns among EAP clients have also changed significantly since EAPs were first conceived. In the past EAPs dealt mostly with late-stage alcoholics, whereas more recently EAPs have had been confronted with clients who are cross-addicted to a combination of drugs and alcohol, and some that have other

addictions and compulsions relating to such things as gambling, sex, and food (Cunningham, 1994). The traditional treatment model that had been used for alcoholics is not necessarily applicable to the new forms of addiction and dysfunction that impact employees (Cunningham, 1994).

The organization formerly known as the Association of Labor-Management Administrators and Consultants on Alcoholism (ALMACA) was renamed the Employee Assistance Professionals Association (EAPA) in the late 1980's to more accurately represent the broader range of services provided, namely a broader approach that focused on more than alcoholism alone (Bickerton, 1990). However, some believe the name change reflected a move away not just from a primary focus on alcohol but also from collaboration with labor and management to address workplace performance problems (Mannion, 2004).

EAPA helped to legitimize a profession that had been dominated by non-professional recovering addicts; OAPs and early EAPs were originally staffed by employees in recovery (Blum & Roman, 1995; Blum et al., 1988; Cunningham, 1994; Masi et al., 2004). It was thought that the increase in professionalism among EAP staff would increase the focus on primary and secondary substance abuse prevention in the workplace (Blum & Roman, 1995). However, increased professionalism in the industry actually served to decrease the emphasis on substance abuse issues. Most, though certainly not all EAP professionals were actually in agreement with the de-emphasized focus on alcohol and drugs. Furthermore, the decrease in the identification of alcohol and drug abuse issues in the workplace may be related to the increasing role of mental health

professionals; mental health professionals tend to identify fewer alcohol and drug abuse problems, and make fewer referrals for these issues because they often do not have substance abuse training, and tend not to view substance abuse as "primary illnesses but merely as the secondary effects of psychiatric problems" (Mannion, 2004, p. 42).

Commoditization of employee assistance programs. Another important phenomenon that had a major influence on the evolution of EAPs is the concept of commoditization. Commoditization, sometimes referred to as "commodification," is one of the greatest challenges impacting EAPs today (Sharar & Hertenstein, 2006a; Sharar, 2008). Commoditization of EAPs occurred when purchasers became unable to distinguish one program from another on any variable other than price. Especially with respect to marketing materials, many EAPs appeared to offer similar services and had similar or identical websites, providers, call centers, and promotional materials. Quality differentiators were often not apparent or well understood by purchasers (Sharar & Hertenstein, 2006a).

Additional factors that influenced the commoditization of EAPs included the lack of universally accepted quality standards (Burke, 2008; Sharar & Masi, 2006), the capitated pricing model used by most programs (Sharar & Hertenstein, 2006a), strong competition from other EAPs, including free and low cost programs (Burke, 2008), and the emergence of benefits brokers and consultants (Sharar & Masi, 2006). The primary impact of commoditization was the lowering of prices for EAP services, and the related issues of unethical business practices, lower quality service provision (Sharar & Hertenstein, 2006a; Sharar & Masi, 2006; Tisone, 2008), devaluation of EAPs, and a

move away from their traditional focus on workplace productivity (Tisone, 2008). In addition, some EAP professionals report that commoditization reflects the adoption of business as opposed to professional values in the industry (Tisone, 2008).

Attributes and Theory of Employee Assistance Programs

Definition of employee assistance program. It is helpful to begin a discussion of this rapidly changing industry by exploring and contrasting the various definitions of the concept of the employee assistance program. There continues to be debate about the exact definition of what constitutes an employee assistance program (Beidel, 2005; CONSAD, 1999; Cooper, Dewe, & O'Driscoll, 2003; DeFalco, 2001; Googins & Godfrey, 1987; Shain & Groeneveld, 1980). In fact, a specific and consistent operational definition for the modern "EAP" does not exist (Sharar, 2008). The lack of a common definition of EAPs is adversely affecting the industry (DeFalco, 2001) and impacts the ability to define specific predictors of EAP quality (Blum & Roman, 1989). Part of the confusion may be related to the fact that the concept of "EAP" evolved over a number of years, had multiple, competing influences, and was never based on a preconceived, precise definition; the evolution of the EAP concept can therefore be seen idiosyncratic and without clear boundaries or direction (Googins & Godfrey, 1987).

EAP definitions in the law are also problematic. There is no clarity in how EAPs are defined in state or federal law. The U.S. Department of Labor defines EAP services based on COBRA and ERISA laws, which tend to regard EAPs as mental health services that are then subject to the same licensure and regulatory guidelines as mental health service providers. Some states, such as Texas, categorize EAPs in the same way as

Health Maintenance Organizations (HMOs) because they accept payment more than 45 days before the service is provided and because EAPs are often marketed as an employee benefit instead of a risk management tool (DeFalco, 2001).

Two well-known pioneers in the EAP field, Blum and Roman, defined EAPs as "worksite based programs designed to help identify and facilitate the resolution of behavioral, health, and productivity problems that may adversely affect employees' wellbeing or job performance" (Blum & Roman, 1995, p. 1). The Employee Assistance Professionals Association (EAPA) has a definition of "EAP" that resembles that of Blum and Roman, though EAPA's definition is more specific about issues that impact performance, and also specifies a dual focus on helping both individual employees as well as work organizations. Accordingly, EAP is defined as:

> A worksite-based program designed to assist: (1) work organizations in addressing productivity issues, and (2) "employee clients" in identifying and resolving personal concerns, including, but not limited to, health, marital, family, financial, alcohol, drug, legal, emotional, stress, or other personal issues that may affect job performance. (EAPA, 2003, p.vi).

Similar general definitions can be found throughout the EAP literature (e.g. Berridge, Cooper, & Highley-Marchington, 1997; Googins & Godfrey, 1987; Shain & Groeneveld, 1980; Wrich, 1980). An important component of the latter definition is that it identifies EAPs as being "worksite based," something that is consistent with almost any definition of an EAP. However, the idea of "worksite based" must be understood to mean a focus on the workplace as the arena for practice, and not literally to mean that the

EAP must be physically based on the work premises. There are in fact numerous models of EAP practice in addition to the more traditional in-house programs such as external or contracted programs, consortiums, union based or joint labor/management programs (Masi, 1982; Straussner, 1986) as well as affiliate/subcontractor models (Masi, 1994) and various forms of integrated and hybrid programs (Attridge, Herlihy, & Maiden, 2005). All of these programs, though not necessarily on site, still maintain a focus on workplace issues. However, concerns about showing EAP value in light of their re-orientation towards a broader behavioral health focus and away from a focus on alcoholism and employee productivity (Straussner, 1986) have been prevalent for more than 25 years.

Some more recent definitions of EAP help to illustrate some of the changes that have occurred in EAPs. According to Derr (2005), the term “EAP” is used to describe a variety of services that had formerly been provided separately, by distinct organizations. He describes a modern EAP as a type of service “offered as part of a purchased behavioral health benefit provided by an external provider company through a network of contract affiliates” (Derr, 2005, p. 13). Derr’s definition reflects the fact that the majority of EAP services today are offered by integrated EAP/MBHOs or by EAPs controlled by MBHOs (Open Minds, 2002; Oss et al., 2011; Sciegaj, et al., 2001), as well as their integration with work/life and wellness programs (Masi et al., 2004). Integration with work/life and wellness, as well as the evolution of MBHOs and their subsequent integration with EAPs will be discussed at length in the following chapter.

A more recent definition of EAP is offered by the National Business Group on Health (2008) that created a workgroup of prominent EAP professionals to examine the

current state of the industry. Their definition incorporates all of the consultative and direct practice functions of EAPs previously mentioned, though the authors note that their definition is more of an ideal rather than a true reflection of current practice:

> Employee assistance programs provide strategic analysis, recommendations, and consultation throughout an organization to enhance its performance, culture, and business success. These enhancements are accomplished by professionally trained behavioral and/or psychological experts who apply the principles of human behavior with management, employees, and their families, as well as workplace situations to optimize the organization's human capital (National Business Group on Health, 2008, p. 15).

Difficulty in settling on a definition of "EAP" is also due to the fact that service provision has changed drastically from its original conception. EAPs often add services in order to gain market share, but these add-ons often obscure the core functions of the industry (DeFalco, 2001). Some in the industry have even called for EAPs to rebrand themselves to better reflect the current reality of a broader service provision (Burke, 2004). In light of the numerous changes in the industry, and in order to situate the concept of employee assistance, it is helpful to look at some of the early methods of conceptualizing EAPs.

Employee assistance program core technology. Blum and Roman (1985, 1988) were the first to systematically define EAPs through the concept of a core technology, which was based on their research observations of numerous EAPs. They felt the need to establish a core technology of EAPs in order to define what is distinctive about EAPs,

who can be identified as an "EAP professional," and also to provide "a clear-cut basis for understanding who we are and what we do" (Roman & Blum, 1985, p. 9). The core technology has also been embraced, with minor revisions, by the Employee Assistance Professionals Association (EAPA). EAPA cites "EAP Core technology" as being:

1. Consultation with, training of, and assistance to work organization leadership (managers, supervisors, and union stewards) seeking to manage the troubled employee, enhance the work environment, and improve employee job performance; and outreach/education of employees/ dependents about availability of EA services;

2. Confidential and timely problem identification/assessment services for employee clients with personal concerns that may affect job performance;

3. Use of constructive confrontation, motivation, and short-term intervention with employee clients to address problems that affect job performance;

4. Referral of employee clients for diagnosis, treatment, and assistance, plus case monitoring and follow-up services;

5. Assistance to work organizations in managing provider contracts, and in forming and auditing relations with service providers, managed care organizations, insurers, and other third party payers;

6. Assistance to work organizations to support employee health benefits covering medical/behavioral problems, including but not limited to: alcoholism, drug abuse, and mental/emotional disorders; and

7. Identification of the effects of EA services on the work organization and individual job performance. (EAPA, 2008, p. 1)

The applicability of EAP core technology as a method of defining modern EAPs is controversial (Mannion, 2004; Sharar, 2008; Van Den Berg, 2000; White, 2000). Blum and Roman (1985, 1988) had conceptualized the core technology of EAPs in response to concerns about the broadening scope of EAP service provision, first away from alcohol and towards all troubled employees, and subsequently towards an even broader definition that included educational, training, and prevention programs such as wellness, stress management, and prevention/health promotion initiatives (Roman & Blum, 1985) as well as drug testing programs, benefits management and treatment review (Roman & Blum, 1988). Another concern was that managers and union representatives were becoming less involved in EAP implementation (Roman & Blum, 1988). The concern focused on the possibility that EAPs would "lose focus on [their] original mission" (Roman & Blum, 1988, p. 18). This concern continues to this day, with the integration of EAPs with wellness, work/life, and MBHOs representing the changes and dissolution of the EAP concept that Roman and Blum (1985, 1988) had envisioned.

The discussions of the importance of the core technology continue to impact the EAP field today. Some leaders in the industry believe that not all EAP services have the same impact on workplace effectiveness and cost savings, stating that "services that comprise the EAP Core Technology yield the most impact per EAP case" (Attridge et al., 2003). Mannion (2004) believes that the concept of an "EAP" ceases to exist without the core technology, and that the industry's lack of clearly defined boundaries have left it

open to market influences that move it away from its original focus on workplace issues. For example, EAPs offering ancillary and integrated services tend to lose some of their focus on the workplace (Sharar, White, & Funk, 2002). The original mission of EAPs, to identify and treat troubled employees with performance problems (Blum & Roman, 1989; Erfurt & Foote, 1977), has "given way to a wide range of mutated products and services that build upon the EAP platform" (Sharar, 2008, p.8). There is widespread agreement in the industry that MBHOs have played a significant role in this evolution (e.g. Mannion, 2004; Sharar, 2008).

Theories of employee assistance program practice. EAPs were conceived to be a method of identifying and addressing issues related to employees with personal problems that impact their performance. As mentioned, employees' personal problems may be related to substance abuse, mental illness, family problems, as well as financial and legal issues (Blum & Roman, 1989; Erfurt & Foote, 1977). EAPs are valuable to employers in three primary ways: promoting the organization's investment in human capital, addressing the costs of doing business, and minimizing business risk (National Business Group on Health, 2008). Furthermore, it has been shown that companies that have programs that address the health and productivity of their employees have better financial outcomes (Watson Wyatt, 2009).

In general, EAPs provide a means by which supervisors can address employee problems, as well as an opportunity for troubled employees to access services on their own behalf. EAPs conduct assessments of employees' issues, referral and assistance in accessing community resources, follow up with the employee returning to work, and

consultation and training of supervisors about EAP procedures and practices (Blum & Roman, 1989; Erfurt & Foote, 1977). EAPs assist organizations to protect their investment in their workforce by promoting employee engagement, improving employees' ability to address personal challenges, offering short-term problem resolution and referral, and improving organizational response to workplace stress. In addition, EAPs address the costs of doing business by reducing absenteeism, decreasing workplace accidents, lowering turnover, facilitating return to work of employees on leave, lowering health care expenditures, offering wellness and health promotion initiatives, and by improving efficiency with respect to health care utilization through early intervention and care management. Finally, EAPs minimize business risk by reducing the risk of workplace violence, managing critical incidents, assisting with transitions such as mergers or division closures, reducing legal liability or litigation, promoting a drug and alcohol free workplace, and training managers to identify and address workplace issues that impact performance (National Business Group on Health, 2008).

EAP services are delivered by many different disciplines: social workers, psychologists, marriage and family therapists, substance abuse specialists, and work/life professionals (Masi et al., 2004) among others, working in a variety of settings including hospitals, mental health clinics, unions, EAP companies, managed care organizations, and directly for employing organizations (EAPA, 2003). EAPs have traditionally recognized that employee problems may be unrelated to a formally diagnosed substance abuse or mental health disorder (Sharar, 2008; Sonnenstuhl & Trice, 1986) and have offered services that address a wide range of issues that impact employees including medical, financial and other personal issues (EAPA, 2003). EAPs also had a traditional

focus on addressing larger workplace issues that impact individual employee performance (Feinstein & Brown, 1982). "The essence of employee assistance is the application of knowledge about behavior and behavioral health to make accurate assessments, followed by appropriate action to improve the productivity and health functioning of the workplace" (Blair, 2004, p.3).

The primary goals of EAP service provision, according to Blum and Roman (1989) include:

- Employee retention.
- Provide an alternative to supervisors' and managers' inefficient counseling efforts with troubled employees.
- Provide a systematic process for employees whose personal problems are impacting their performance.
- Humanitarian support for employees
- Legal protection for employers
- Assistance in controlling costs to employers related to employees' health care utilization
- Gatekeeping with respect to employee access of behavioral health benefits
- Improvement of employee morale

The theories upon which traditional EAP practice is based are: that individual and workplace issues can impact employee performance; that these problems can result in both economic and human costs; and, that services that address these issues can be economically and socially justified (Feinstein & Brown, 1982). The philosophy of EAP

practice is based on the belief that employees who are emotionally and mentally stable are more productive than those who are not (Harris et al., 2002). However, despite attempts by EAP practitioners such as Roman and Blum (1988) and Yandrick (1994), the theory of EAP practice has never been consistently defined, and was largely developed in an informal, inductive manner based on professional experience and practice wisdom (Sharar, 2008). The lack of a consistent underlying practice theory for EAPs affects the industry's ability to accurately measure its impact on employee performance and well being (Balgopal & Patchner, 1988).

Employee assistance program services and dimensions. Traditionally, EAPs provided clinical assessment, referral and short-term counseling services to employees whose alcohol, drug, mental health or other personal problems may impact their work performance. EAPs also traditionally provided management consultation, training, and education (Masi, 1992; Masi et al., 2004). However, EAPs are now increasingly adopting an add-on model that offers organizations the choice of additional services that are not typically part of the core technology (Masi et al., 2004). The addition of many of these services has been controversial because they were in large part driven by market forces and the demands of employing organizations rather than through the consensus of EAP professionals (Mannion, 2004; National Business Group on Health, 2008). Market forces have resulted in the creation of numerous types of EAPs to address the changing needs of organizations and employees. However, due to a lack of standardization, there is confusion about the scope and guiding principles upon which these EAP services are based. In addition, due to a lack of boundaries, there is often overlap between EAP functions and that of other programs such as health and wellness and work/life; this may

be inefficient with respect to cost and may also be confusing to employees (National Business Group on Health, 2008).

The broad range of EAP services offered today include providing support with drug-free workplace compliance (Masi, 2005), legal and financial issues (EAPA, 2003; Masi et al., 2004; Sharar & Hertenstein, 2003), wellness/health promotion (EAPA, 2003; Gornick & Blair, 2005; Masi et al., 2004; Masi, 2005), disability management (Conti & Burton, 1999), cultural diversity (Masi, 2005), work/life services including child and elder care (Gornick & Blair, 2005; Herlihy, 2000; Masi et al., 2004; Masi, 2005; Van Den Berg, 2000), critical incident management (EAPA, 2003; Masi, 2005), disaster preparedness and response services (Paul & Thompson, 2006), workplace violence support (Masi, 2005; Sharar & Hertenstein, 2003), behavioral health benefits gatekeeping/administration (Sciegaj et al., 2001; Van Den Berg, 2000), executive coaching (Sharar & Hertenstein, 2003), outplacement services (Sharar & Hertenstein, 2003), career counseling (Ensuring Solutions, 2006), and organizational consulting (Masi, 1992; Herlihy, 2000; Zare, 1990) along with many other services. EAPs are also helping organizations to interpret and implement legislation that impacts employees such as the Americans with Disabilities Act, and the Rehabilitation Act (Masi, 1992).

In the years since they first appeared, EAPs have evolved into many different forms, with different practice philosophies and services. The numerous types of EAPs can be distinguished based on the following dimensions: general approach (Sharar, 2008); sponsor; service model; location; eligibility; and session limits (Masi et al., 2004).

A discussion of each of the dimensions will be offered in order to clarify the various forms and services of the modern EAP.

***General approach*.** Subscribing to a theoretical orientation entails the acceptance of a particular interpretation of human behavior and thus the types of interventions that are used to facilitate change (Carroll, 1996). Sharar (2008) outlines two general approaches to the provision of EAP services, one that focuses on intervention in the workplace, and another that focuses on prevention and early intervention. The following categorization of EAP approaches, listed as *workplace intervention approach* and *prevention and early intervention approach* were adapted from Sharar (2008).

The workplace intervention model focuses primarily on EAPs' impact on health care claims and human capital issues such as absenteeism, mental health and substance abuse issues and is achieved primarily through individual utilization of the EAP. The prevention model tends to address broader organizational outcomes and is achieved primarily through management consultation, risk management and prevention initiatives. These initiatives include crisis intervention, educational programs, management consultation, and organizational development (Attridge et al., 2003). It is important to note that these models often overlap, and frequently an EAP will offer services that are focused on both prevention as well as workplace intervention. However, for the purposes of clarity, these two general models are broken down and described in some detail in the following sections.

Workplace intervention approach. As noted by Sharar (2008), the workplace intervention model is based on Roman and Blum's (1985, 1988) concept of a core

technology. The workplace intervention model postulates that employees' personal problems lead to problems with their performance, and that EAPs provide a tool for management to address these problems and return the employee to optimal performance and productivity (Roman & Blum, 1988; Wrich, 1980).

An essential aspect of EAPs is that employees are identified as needing intervention based on problems with their job performance. Performance is related to workplace conduct such as attendance, interactions with co-workers and clients, alcohol or drug use, as well as other issues. The identification of the troubled employee as needing referral to the EAP can only be made once other issues, such as problems with the work environment itself, have been ruled out. Work environment issues might include such things as lack of appropriate training and dangerous working conditions. It is expected that the source of the employee's poor performance will be related to personal rather than environmental problems (Roman & Blum, 1988).

Employees can access EAP services through self-referral (or the suggestion of an employer, colleague, or friend) or through mandatory referrals from their employer. Mandatory referrals are often the result of a corrective action plan when an employee's performance does not meet standards. Mandatory EAP referrals can also result from an arbitrator's recommendation when an employee is reinstated to a position after being wrongfully terminated, but where there are concerns that the employee has some personal problems that are affecting performance (Keaton & Yamatani, 1993). A related aspect of EAP intervention in the workplace is the concept of constructive confrontation. Constructive confrontation is the leverage exerted by the employer on the troubled

employee, giving them the choice of referral to the EAP to address their "problem", or the prospect of disciplinary action and possible termination; this process is often referred to as a formal manager referral (Roman & Blum, 1988; Sharar, 2008). Collins (1999) explains that formal manager referrals of employees are important because they:

- Can assist employees who are otherwise in denial to access treatment services.
- Provide an avenue for employees who have tested positive for alcohol or drugs to maintain employment.
- Provides an alternative to employers who have recourse other than termination of the troubled employee.
- Assists employers to minimize legal liability concerning substance-abusing employees who may become involved in workplace accidents.

According to Roman and Blum (1988) and EAPA (2003), the primary elements of the workplace intervention model are:

- Management and supervisory training
    - Assisting managers and supervisors to identify employee performance problems that are related to employees' personal issues.
    - Training about how to refer to the EAP and what services the EAP offers.
    - Training about the effective use of constructive confrontation.
    - Guidance in documentation of employee performance issues.
- Management and supervisory consultation
    - Review EAP policies and services.

  - Motivate and support supervisors and managers to refer troubled employees to the program.
  - Consulting about EAP functions that are directly related to a particular situation.
  - Assistance in distinguishing between employees' personal problems vs. other problems such as the work environment or lack of appropriate training.
  - Assisting managers and supervisors to maintain compliance with the organization's labor-relations policies and procedures.
  - Reducing the possibility of union grievances by consulting with union officials.
  - Organizational consulting about issues that affect the health and wellbeing of employees.
  - Strategies related to promoting/advertising the EAP to ensure adequate utilization among staff.
  - Evaluation of program effectiveness.
- Benefits management and community connections
  - Knowledge of available community services.
  - Knowledge of insurance benefits plans and available treatment options; assist employees to access benefits by negotiating with benefits plans.
  - Assist troubled employees to access community mental health and substance abuse services.
- Direct services to employees

- Assessment and problem identification.
- Formulation of action plan.
- Short-term, problem focused counseling.
- Referral to community resources.
- On-site crisis intervention services.
- Follow-up and case management.

Prevention and early intervention approach. This approach was conceptualized by Sharar (2008) and based on the EAP literature. It has been noted that a core function of EAP is to help to "bridge the gap between prevention and treatment" (Blum & Roman, 1995, p. 9). Preventive strategies are part of the core technology of EAPs and include education and outreach efforts as well as interventions aimed at improving the work environment and employee wellbeing (EAPA, 2003). Some common types of EAP workplace prevention initiatives are training and education programs aimed at addressing health and mental health concerns among employees by increasing awareness of these issues and providing training in coping techniques (Cooper et al., 2003). Some examples of this type of programming are seminars focusing on stress reduction, smoking cessation, healthy eating, and other related health and wellness programs. In addition, EAPs can contribute to changing the workplace culture related to alcohol and substance abuse. Some methods of primary prevention related to alcohol and substance abuse are the provision of educational materials to employees and family members, and the education of supervisors and union representatives about the identification and management of substance abuse issues (Blum & Roman, 1995).

Early intervention is also an essential component in EAP service provision. EAPS are designed to offer early intervention before the employee's personal problems become more serious (Wrich, 1980), and EAPs have been shown to improve early access to behavioral health services (Merrick et al., 2009). In addition, EAPs have been shown to improve treatment access by employees with less severe conditions such as adjustment disorders (Merrick et al., 2009), who might otherwise wait until their condition has worsened before seeking assistance. Early intervention initiatives therefore include encouragement to employees and their family members, who may otherwise be reluctant or unable to use the service, to voluntarily access EAP services before personal problems begin to impact productivity. Efforts aimed at increasing self- referrals include a 24-hour hotline, online services, work/life services, and various promotional activities (Sharar, 2008).

Employee assistance program sponsor. An important distinction in defining an EAP is the sponsor of the program. However, before beginning a discussion of sponsorship, it is important to note that terminology in the field is not consistent with respect to this term. Some EAP researchers refer to program "auspices" as being the endorsement for the program, which can be either management or union, as compared to the "sponsor" of the program, which can be individually sponsored or part of a consortium (Straussner, 1988a). For the purposes of this study and in the following sections the term "sponsor" is used to describe the support, endorsement and funding of the EAP program and can be considered to be a synonym for "auspices." There are numerous EAP sponsorship configurations including management-sponsored, colleague-sponsored, consortium programs, labor-sponsored, and joint labor-management

sponsored (Masi et al., 2004). The following sections will briefly outline the EAP sponsorship configurations; however, for the purposes of clarity the discussion of labor-sponsored and joint labor-management sponsored programs will be in its own section devoted to EAPs and organized labor.

In a management-sponsored program, a business organization sponsors the EAP as a method of addressing issues related to troubled employees. The management-sponsored program is the most common form of EAP (Masi et al., 2004), and 98% of EAPs are employer-sponsored (Hartwell et al., 1996). Unless otherwise stated, the EAP models discussed in this study are all management-sponsored.

Another model is the colleague-sponsored program that is established by a professional organization (Masi et al., 2004). This type of program is offered to members of a specific profession and are intended to address issues related to professional conduct. The threat of revocation of licensure is often utilized with these programs, as all professional members share a common interest in maintaining professional standards. This model is most common among lawyers and physicians, though other professions including nursing, social work, psychology, dentistry and pharmacy also have programs for their members (Blum & Roman, 1989).

Another alternative EAP format is the consortium model. A consortium model is formed by several sponsoring organizations together, often as a cost-savings measure (Masi et al., 2004). Consortium models allow organizations that are too small to support their own program to be able to access EAP services.

The Evolution of External EAPs.

Organized labor and employee assistance programs. Labor-sponsored programs are often referred to as member assistance programs (MAPs), and are commonly viewed as an alternative to EAPs. Union counseling programs tend to be sponsored uniquely by the union and tend to be more concerned with human health and welfare than with productivity. The likely positive side effects of union counseling, such as decreased absenteeism, grievances, and turnover, are secondary to the union's primary goal of member emotional wellbeing (Perlis, 1980).

Unlike EAPs that utilize supervisors and professional counselors to get treatment for troubled workers, MAPs utilize peer counselors to act as program specialists (Blum & Roman, 1989). Peer counselors are non-professional union members who have volunteered their time to develop and coordinate programs and to provide direct assistance to members around areas such as alcohol and drug abuse as well as other personal problems (Bacharach, Bamberger, & Sonnenstuhl, 1994; Perlis, 1980). Peer counselors are most often used since most unions do not want to involve management with the identification and referral of troubled employees (Blum & Roman, 1989). Union members who provide peer support for other member have often received training and support from mental health professionals, including social workers (Carter, 1977; Perlis, 1980). Social workers train union counselors about community resources, assessment techniques, referral procedures, and other pertinent issues related to workers' health and welfare (Carter, 1977).

The idea of peer assistance is not new, and assisting union members through labor-based programs has occurred since the beginning of the organized labor movement

(Bacharach et al., 1994; Perlis, 1980). A good example of a long-standing labor-based program is AFL-CIO's Community Services Department that has been in operation since World War II. The program has trained a large number of union members to counsel their colleagues about alcohol and other personal problems (Sonnenstuhl & Trice, 1986). The program has been described as "the oldest and largest continuing employee assistance program in the country" (Perlis, 1980, p.81).

Historically, unions have been ambivalent about EAPs (Sonnenstuhl & Trice, 1986) and related services created by management. While they appreciate the services EAPs can offer to their members, union leaders are often threatened by EAPs whom they perceive as undermining their authority and their traditional role as helper (Brandes, 1970; Carter 1977). The unions' concerns were not unfounded (Sonnenstuhl & Trice, 1986), especially with respect to initiatives of the past. For example, the National Civic Federation attempted to deter unionization through the promotion of social betterment (Brandes, 1970) and the Hawthorne experiments and their related counseling programs were at least in part begun as a method of deterring unionization at Western Electric (Baritz, 1960). Similarly, the welfare capitalism movement was begun primarily as a method of deterring unionization (Brandes, 1976; Popple, 1981).

Despite conflict, many unionized settings do have EAPs. While union officials tend to share management's desire to help workers, management tends to focus on productivity and unions tend to focus on increasing worker solidarity. Due to unions' perception of EAPs as an instrument of control by management, a balance between labor and management concerns needs to be maintained in order for EAPs to succeed in

unionized settings (Sonnenstuhl & Trice, 1986). In fact, EAPs cannot be successful without cooperation between management and labor (Wrich, 1980). Union participation in developing the policies, procedures and implementation of an EAP is essential in order to establish mutual trust that the program will serve the interests of both labor and management (Scanlon, 1991).

Bringing together the management sponsored program and the union sponsored program is the joint labor-management sponsored program that is funded jointly by management and labor. The joint programs are created based on the belief that EAPs benefit both labor (and the employees they support) as well as management (Masi et al., 2004). Joint labor-management EAPs were instrumental in the formation of the Association of Labor-Management Administrators and Consultants on Alcoholism (ALMACA), which was eventually renamed the Employee Assistance Professionals Association (EAPA). Though they played an important role in EAPA, most union EAP representatives were non-professionals who had personal experience with substance abuse treatment. However, conflict arose with respect to EAPA's certification of professionals in the EAP industry in contrast to those without professional training. By the late 1990s the conflict came to a head, and many union EAP members chose to quit EAPA (Root & Dickinson, 2009).

Joint labor-management EAPs also played a role in the move towards managed care, a trend that can be seen through the examination of one of the largest and most influential manufacturing sectors in the United States, the auto industry. Similar to other industries, EAPs in the auto industry had a primary focus on alcohol abuse by employees.

On-site EAP representatives, especially UAW appointees whose full time job was to provide EAP services, played a significant role in negotiating with treatment facilities to provide services to employees. However, concern over the growing cost of treatment, due in part to EAP advocates' ability to secure high-level services for employees, led to increased oversight. Auto companies began to use third party organizations such as Family Service of America to serve as gatekeepers to determine the medical necessity of inpatient admissions for substance abuse treatment, coinciding with the larger movement towards managed care (Root & Dickinson, 2009).

Employee assistance program location and access. Employees can access EAP services in several ways: by telephone, in-person, or via the internet (Masi et al., 2004; National Business Group on Health, 2008). The method in which employees access EAP services depends in part on the location where services are offered. On-site programs provide services to employees at their work location. Off-site programs offer services outside of the work location (Masi et al., 2004). Some organizations offer both on-site and off-site services to their employees (Csiernik, 1999; Hartwell et al., 1996; Masi, 2000). In addition, some EAPs have virtual programs that provide services online or by telephone, and mixed programs offer a combination of on-site, off-site, and virtual service provision (Masi et al., 2004).

Online services are a new and developing technology used by EAPs. The internet is an effective tool that enables EAPs to promote their services to a wider range of employees, and also to directly provide services in a convenient, confidential, inexpensive, and efficient manner; online services are particularly helpful for employees

who wish to remain anonymous, or who are not able to meet in person due to time constraints, disability, childcare responsibilities and the like (Masi et al., 2004). EAPs offer online services such as educational information and webinars, self-assessment tools, wellness resources and information (Masi et al., 2004), as well as counseling (Attridge, 2011a).

Counseling via the internet is a relatively new development for EAPs that is expected to grow (Attridge, 2011a). Online interventions differ based on the type of service (communication with a therapist or use of a self-help program), whether the communication is synchronous and asynchronous, as well as the method of communication (i.e. text, audio, or via webcam) (Barak, Hen, Boniel-Nissim, & Shapira, 2008). Online interventions have been shown to be effective for some mental health conditions (Barak et al., 2008; Griffiths & Christensen, 2006). However, there are a number of concerns related to internet-based counseling related to confidentiality and questions about the laws and regulations concerning online clinical practice (Barak et al., 2008).

Another new development is the provision of EAP counseling services via telephone. Telephone counseling has been shown to be effective and well-received by clients, and similar to online services, offers users a certain degree of anonymity and confidentiality (Hargrave, Hiatt, Dannenbaum, & Shaffer, 2007; Reese, Conoley, & Brossart 2002; Stephenson et al., 2003).

Organizational reporting and affiliation. Historically, EAPs were primarily affiliated with human resources or the medical department of an organization (Hartwell et

al., 1996; Straussner, 1986). However, in a recent survey of 42 companies that are members of the National Business Group on Health, 66% reported that their EAP was affiliated with their benefits department, 36% reported that their EAP was managed by their human resources department, 6% reported that it fell under their medical department, and 2% reported that it fell under their occupational health department (National Business Group on Health, 2008). However, professionals in the industry argue that in order to ensure that EAPs are used as a method of managing performance that they "be structured as an independent human resource function in relation to employee health benefits plans and related human resource functions" (National Business Group on Health, 2008, p. 18).

Internal, external, and hybrid employee assistance programs. EAPs are run as an internal unit or through an external contractor, depending on the resources and needs of the organization (Hartwell et al., 1996; Straussner, 1986). In the internal model, the EAP counselor and the employee receiving services are employed by the same organization, whereas in the external or contracted-out model services originate externally, and the EAP counselor is employed by an outside organization different from where the client is employed (Lewis & Lewis, 1986; Masi, et al., 2004). The hybrid model is a planned combination of both internal and external EAP structures; this model uses internal EAP providers for short-term counseling and other services, but is integrated with outside providers who can address larger organizational issues, longer-term counseling needs or who specialize in specific types of counseling (Csiernik, 1999).

The Evolution of External EAPs.

Large organizations with over 1000 employees are more likely to offer EAP services to their employees than are smaller firms (Hartwell et al., 1996; Sciegaj et al., 2001). Though most EAP services today are offered by external EAPs (Cagney, 1999; Hartwell et al., 1996; Merrick et al., 2007), larger companies tend to use the internal model more frequently than do mid-sized and small companies with less than 1000 employees (Brummett, 2000; Hartwell et al., 1996; Straussner, 1985).

There is little agreement in the industry with respect to internal versus external utilization rates. The debate is related to the flawed method of quantifying utilization rates, as there is no consistent, universally accepted definition in the industry (Attridge et al., 2009b; Beidel, 2005; Mcleod, 2001). In a study of Canadian EAPs, Cisernik (1999) found that internal programs had a higher utilization rate than did external programs. Conversely, Straussner (1988a) found higher overall utilization rates in external programs.

Internal and external programs have been shown to differ with respect to the demographics of the employees whom they serve. While internal programs were found to see a proportionally representative number of male and female employees, external programs saw a proportionally higher level of women (French, Dunlap, Roman, & Steele, 1997; Straussner, 1988a). However, employee demographics in general are poor indicators of EAP utilization, suggesting that most employees would access the EAP if the need arose (French, Dunlap et al., 1997). In addition, external programs tend to see higher-level workers than do internal programs (Smith, 1987; Straussner, 1988a). Whites were found to be more likely to use an external EAP program (82% vs. 55%), while

minorities, who were also more likely to be lower level workers, tended to be referred to or to access internal programs more frequently (45% vs. 18%) (Straussner, 1988a). It must be noted that the sources cited for this data are not recent; however, in a review of the literature there were no recent studies that compared internal and external EAPs.

History of internal and external models. Early EAPs were internal programs operated by large organizations (Blum & Roman, 1989; Cunningham, 1994). External EAPs tended to have originated as broadbrush programs, whereas internal program often originated as occupational alcohol programs (Straussner, 1988a). The external, contracted-out model first emerged in the 1970s and early 1980s and began to challenge the then-prevalent internal model (Csiernik, 1999; Blum & Roman, 1989; Sharar 2009). The first external EAP contractors were hospitals with internal programs that began to market their services to other organizations as a method of generating income (Cunningham, 1994). Mental health clinics, family service organizations, and coalitions of private practitioners also started to offer externally contracted EAP services to employers (Cunningham, 1994; Straussner, 1985). In the late 1970s and early 1980s, private for profit companies began to take an interest in the provision of contractual EAP services (Sharar, 2009; Straussner, 1985). Many external non-profit EAP contractors then began to be absorbed into large, for-profit firms that included health care providers (Cunningham, 1994). Based on the services provided by some of these organizations, they can be seen as precursors to the managed behavioral health care industry (Sciegaj et al., 2001).

The Evolution of External EAPs.

Most EAP services today are provided by external, contracted EAPs that employ their own staff to provide services to the organization (Cagney, 1999; Ensuring Solutions 2006). Though there is a broad range of external programs, externally contracted EAPs usually have a formal contract with the employing organization that defines the fee structure and the scope of services to be provided (Blum & Roman, 1989). Some external EAPs are managed by large national or international organizations including MBHOs (Feldman 2003; Fox et al., 2000; Gornick & Blair, 2005; Heck, 1999). In the U.S., EAP services are provided primarily by large, nationally-based vendors, the majority of which are MBHOs (Fox et al., 2000; Oss et al., 2011). Some EAP professionals report that the shift from local to national vendors has compromised the quality of service provision (Sharar & White, 2001; Sharar et al., 2002).

Blum, Martin, and Roman (1992) noted a trend in which EAPs were moving from internally based programs towards externally contracted programs, and they found that 15% of EAPs surveyed in 1984 had moved from internal to external programs by 1988. In 1993, 81% of EAPs were external (Hartwell et al., 1996), and it was estimated in 1997 that 90% of EAPs were external, while only 10% were internal (Heck, 1999). More recent data on the prevalence of external programs is not available, though it is very likely that the majority of EAP services today continue to be provided by external programs.

Reasons for the move from internal to external model. Smaller companies (with less than 1000 employees) have always had a tradition of using external contractors for such things as medical and legal services as, well as consulting services such as

organizational development (Straussner, 1985). It is therefore no surprise that smaller companies tended to embrace the external EAP model; the more significant change is that today larger companies (i.e. with 1000 or more employees) are also predominantly using an external EAP service provider. EAP service models moved from primarily internal to primarily external for a number of reasons including costs, and the need to ensure uniform service provision across multiple sites (Blum, Martin, & Roman, 1992; Hartwell et al., 1996). Other reasons for the move include aggressive marketing efforts by contractors (Straussner, 1985), the influence of MBHOs (Van Den Berg, 2000), as well as the perception that the organization has less liability in counselor malpractice with external programs (Carroll, 1996). The following discussion will look briefly at the issue of EAP costs in internal and external programs, as well as some of the other explanations for the move from internal to external EAP service model.

EAP costs per employee per year are determined based on the total annual cost of the EAP divided by the total number of eligible employees (French, Zarkin, Bray, & Hartwell, 1999). Costs of EAPs differ based on company size, industry, location within the U.S., and types of services offered (French, Zarkin et al., 1997). External EAPs are generally thought to be better suited for small and medium-sized companies (with less than 1000 employees) where an internal EAP is prohibitively expensive; external EAPs are thought to have lower expenses per eligible employee due to economies of scale (Hartwell et al., 1996). There is some controversy in the field about the relative costs of internal versus external EAPs. For example, Straussner (1988b) found that external EAPs cost relatively more per employee when compared to internal programs. However, more recent studies have confirmed that external programs tend to cost less than internal

programs (French et al., 1999; Hartwell et al., 1996). In addition, the efficacy and impact of internal versus external EAPs continues to be debated (Csiernik, 1999).

Managed behavioral health organizations (MBHOs) have also been influential in the move from internal to external EAP service provision (Van Den Berg, 2000), partly due to aggressive marketing techniques. A detailed discussion of the emergence and impact of MBHOs on the EAP marketplace will be offered in the MBHO section.

Pros and cons of internal versus external employee assistance programs. Since the emergence of the external EAP model in the 1970s there has been considerable debate in the industry about the efficacy of internal versus external EAP service provision (Csiernik, 1999). In a review of EAP research, McLeod (2001) found no significant differences between internal and external programs with regard to effectiveness or utilization (McLeod, 2001). However, empirical evidence for the pros and cons of each model remains weak, with most data coming from practice experience and anecdotal evidence (Csiernik, 1999). In addition, the pros and cons of internal versus external EAPs depend on the perspective of the stakeholder or user; top managers may have differing views and incentives concerning EAPs when compared to mid or lower level employees and vice-versa. For example, top managers may be more concerned with cost and adaptability, whereas employees may be more concerned with confidentiality and accessibility (Straussner, 1988b).

When compared to internal programs, external EAPs make more community referrals related to client's insurance coverage (Straussner, 1988a), are more likely to offer short-term counseling to employees (French, Zarkin et al., 1997), are more

accountable to management, report to higher level staff within the organization, and are more likely to have regular communication with top management (Straussner, 1988b). In addition, external programs identify clients with marital, family, and emotional problems more frequently than do internal programs (Csiernik, 1999), and they tend to be less affected by organizational politics (Carroll, 1996). External programs also have a faster start-up time and smoother program implementation because they have an infrastructure for service provision that is already established, compared to internal programs that often must be created from scratch (Straussner, 1985). External programs also tend to provide greater accessibility than internal programs. Many external programs have on-site counselors, and they are much more likely than internal programs to have 24-hour hotlines as well as weekend/evening emergency coverage, and are more accessible to family members (Straussner, 1985, 1988b).

Another important factor that favors external EAPs is that of confidentiality. Employee perceptions about confidentiality were found to have a significant impact on an employee's choice about whether or not to use the EAP (French, Dunlap et al., 1997). External EAPs are generally thought to better protect employee confidentiality (Carroll, 1996; Smith, 1987; Straussner, 1988a) and internal programs report more problems related to confidentiality than do external programs (Straussner, 1988b). Higher numbers of self-referrals in external programs may be related to confidentiality concerns (Straussner, 1988a) and the perceived ability of external programs to better protect confidentiality than internal programs.

The Evolution of External EAPs.

Although there are many positive aspects to external EAPs, there are also negative consequences of the move to this model. One of the major drawbacks to the use of an external EAP model is related to affiliate networks. Many external EAPs use an affiliate model to provide services (Merrick, Volpe-Vartanian, Horgan & McCann, 2007), especially if they are serving clients in other cities or countries where they do no have an office. Affiliate models use a network of contracted providers to conduct EAP assessments and interventions in their own private offices or clinics (Masi et al., 2004; Masi et al., 2000). Sometimes the affiliates are located through MBHOs' contracted networks (Merrick et al., 2007). There are serious concerns about the use of affiliate models, because many affiliates have a limited knowledge or understanding of EAP technology, and they often view the EAP as simply the front end to a behavioral health benefit; the majority of EAP affiliates treat EAP clients in the same way as non-EAP clients (Sharar, 2008).

Internal programs also have some positive aspects when compared to their external counterparts. Compared to external programs, internal EAPs tend to receive more employer/supervisor referrals (Smith, 1987; Straussner, 1988a), see more clients with work-related problems (Csiernik, 1999), and are more likely to address substance abuse issues (Csiernik, 1999; Straussner, 1985). Internal EAPs are also much more likely than external programs to provide consultation to supervisors, take part in constructive confrontation of employees, be involved in employee health promotion activities, and follow up with supervisors to check on employee performance after treatment (French, Zarkin et al., 1997). In addition, internal programs tend to be more familiar with organizational culture and are more likely to advocate for employees than are external

programs (Carroll, 1996; Straussner, 1988b). Some other advantages of internal programs are counselors' access to formal and informal organizational contacts, greater ability to adapt practice to the needs of the organization, greater flexibility of service provision, and provision of on-site services that may be easier for employees to access (Carroll, 1996). In addition, unions tend to favor internal programs, possibly due to the perception that they have more control over an internal program than a program that is external to the organization (Straussner, 1985). In addition, internal programs more frequently provide training and consultation to unions than do external programs, likely due to a better relationship with unions (Straussner, 1988a).

The debate over internal versus external EAP service provision continues today. However, as mentioned already, there are no recent studies that examine internal versus external EAPs. Therefore, the data used for the following discussion is somewhat outdated. A possible reason for the lack of recent comparisons of internal and external programs is that 90% of EAP service provision is now provided by external EAPs (Heck, 1999), primarily in the form of integrated EAP/MBHOs (Feldman, 2003; Fox et al., 2000). Further research is required in order to determine how current EAPs differ from those in the past.

Internal and external EAPs were found to offer about the same amount of assessment and referral services, and both have about the same rate of follow up with providers concerning employee's progress in treatment (French, Zarkin et al., 1997). External EAPs' decreased emphasis on alcohol and drug abuse (Csiernik, 1999; Straussner, 1985), workplace issues (Csiernik, 1999) and the fact that they receive fewer

formal referrals (Smith, 1987; Straussner, 1988a) and offer less supervisory consultation (French, Zarkin et al., 1997) compared to internal programs, are examples of the industry's move away from its roots as an internal program (Blum & Roman, 1989; Cunningham, 1994) and may impact EAP effectiveness (Roman & Blum, 1988). Csiernik (1999) believes that the best way to mitigate the negative aspects of internal and external services models is to offer hybrid models that offer a mix of internal and external service provision.

employee assistance program utilization. Research findings about utilization rates vary widely across programs and across studies. For example, Straussner (1986) reported an average annual utilization rate of 4.4 % with a range of 1.1% to 10%, and Blum and Bennett (1990) report an average annual utilization of 5%. McLeod (2001) reported an average utilization rate across numerous studies as being 7%, with a range of 1-20%. Others report overall EAP utilization rates as being 5-8% on average (Merrick et al., 2007). The inconsistency of utilization rates may be related to the fact that the industry does not have a universally accepted definition of what constitutes the EAP utilization rate (Attridge et al., 2009b; Beidel, 2005; Mcleod, 2001). In addition, EAPs have a built-in incentive to inflate utilization rates as a method of demonstrating value to the employing organization (Sharar et al., 2002). Another factor related to EAP utilization rates is whether the EAP is internal or external, as each type has different reported utilization rates (Csiernik, 1999; Straussner, 1988a). EAPs' attempt to get utilization rates to reflect organizational demographics, but often certain groups are over or under-represented. High-ranking executives are usually under-represented in terms of EAP utilization (Masi, 1992; Straussner, 1986), and minorities often access the EAP less

frequently than do whites (Masi, 1992). However, there is no clear consensus about proportional utilization of the EAP. In general, women tend to use the EAP more frequently than men (EAPA, 2006; Prottas, Diamante, & Sandys, 2011; Straussner, 1986), smaller organizations tend to have proportionally higher utilization rates than large ones, and workplaces with higher levels of educated personnel tend to have higher utilization rates (EAPA, 2006).

Masi et al. (2000) summarized findings from 42 clinical reviews of EAPs nation wide. The sample consisted of data from clinical reviews conducted by MASI Research Consultants, Inc. between 1984 and 1998. Most EAPs reviewed were external. They found that of 4000 EAP service users, 80.6% were employees, 53.1% were women (46.9% were men), and 27.4% were minorities; 63.6% were self referrals, 18.4% were referred by others (colleague, friend), and 17.6% were referred by management suggestion. This review also found that the average number of face-to- face sessions was 3.32 based on an eight-session model (Masi et al., 2000).

In a systematic review of over 80 published and unpublished research studies from 1950 to 2000, McLeod (2001) found no trend with respect to the type of employee that accessed the service based on seniority, age, status, or type of work, though female employees were shown to access the EAP at a proportionally higher level than their male counterparts. However, the presenting problem and the demographics of service users depends largely on whether the EAP is internal or external (Csiernik, 1999; Straussner, 1985).

The Evolution of External EAPs.

EAP utilization has been significantly impacted by numerous natural disasters and other significant events including Hurricane Andrew in 1992, the Oklahoma City bombing in 1995, and especially the September 11th, 2001 terrorist attacks. In addition to large increases in EAP utilization following the 9/11 attacks, particularly in the form of on-site crisis response services, EAPs' overall visibility with client organizations increased (Paul & Thompson, 2006). In fact, EAP utilization had been dropping off somewhat prior to the attacks, largely related to the rising cost of healthcare, and misunderstandings about the benefits of EAPs; the September 11th attacks helped to revitalize the EAP industry (Prohofsky, 2007). Furthermore, EAPs became better prepared to respond to crises and large-scale disasters, and continue to be sought after by client organizations to provide disaster preparedness and response services (Paul & Thompson, 2006).

EAP utilization has also been affected by the economic recession in 2008. Client calls related to financial issues, including stress related to financial problems, and related issues such as job loss, bankruptcy, retirement, and financial planning, was found to have increased by 13% in 2008 compared to 2007 (Shepell-FGI Research Group, 2009). Nearly half of the organizations in a recent survey by Watson Wyatt (2009) reported a significant increase in utilization of their EAP programs following the economic crisis. In addition, a survey conducted by EASNA in December 2008 found that there was an 88.2% year to year increase in client requests for financial services. In addition, requests for assistance with stress were up 82.4%, and requests related to legal issues were up 41.2%. Calls from clients reporting substance abuse and domestic violence issues were both up 11.8%. In addition, the majority of EAP providers saw an increase in requests to

assist workers who had been laid off, as well as in downsizing and outplacement service requests (EASNA, 2008).

Employee assistance program eligibility. EAPs generally provide services to employees of the sponsoring organization (Masi et al., 2004). In addition, EAP services are usually extended to include family members (Merrick et al., 2007), though the definition of what constitutes a "family member" may vary from one program to another (e.g. whether domestic partners or non-nuclear family relatives are included) (Masi et al., 2004). In summary, EAPs generally provide services to two groups: employees and their family members, and organizational executives and leaders; the organization as a whole, which includes both front line employees as well as executives, is often considered to be a third group that receives EAP interventions (EAPA, 2003).

Employee assistance program session limits. In general, EAP counseling is provided on a short-term basis, usually making referrals for longer-term treatment when indicated (Lewis & Lewis, 1986). EAPs typically offer 3-8 sessions for assessment and short-term counseling (Merrick et al., 2007). In the "assess and refer" model, clients generally receive up to three sessions with a counselor with the goal of problem identification and connection with appropriate community resources (Masi et al., 2004).

In the short-term counseling model, clients are offered additional sessions beyond the initial assessment if the problem is deemed appropriate for short-term work. If the problem is not able to be resolved in a short-term counseling modality, the client may then be referred to the appropriate community resource. This model typically offers 4 to 8 sessions including assessment (Masi et al., 2004). Limits in service provision may be

based on the need to limit costs and ensure prompt service to a large number of clients, as well as belief in the efficacy of short-term counseling (Carroll, 1996). There is considerable controversy over the efficacy of short-term versus long-term treatment, especially with the advent of managed care; however, it has been shown that 3-8 sessions of counseling can have a significant positive effect on clients receiving services (McLeod, 2001). It has also been shown that brief counseling comprised of 5-7 sessions can improve clinical and work performance outcomes (Harlow, 2006).

Employee assistance program prevalence. In 2011, enrollment in all types of EAPs in the U.S. was reported to be 309.1 million individuals, an increase of over 1000% since 1993; however, the increase in reported enrollment is partly due to the inclusion of work/life assistance programs as well as employees' dependents in the tally (Oss et al., 2011). Despite the changes in how enrollment is reported, there was still a significant increase in the number of programs and the number of eligible individuals since 1993 (Open Minds, 2002; Oss et al., 2011). In addition, there are currently 56 million individuals enrolled in integrated EAP and managed behavioral health programs, reflecting an increase of 220% from 1993 to 2011 (Oss et al., 2011). It is estimated that 92-95% of Fortune 500 companies in the U.S. offer some sort of EAP services to their employees (Heck, 1999; Sciegaj et al, 2001), and 65% of all American employers report that they provide EAP services to their employees (Galinsky et al., 2008). The prevalence of EAPs differs somewhat based on industry, and whether the organization is public or private. 45 percent of employees in private industry have access to EAP services (US Bureau of Labor Statistics, 2009a), whereas 73 percent of state and local government employees have access to an EAP (US Bureau of Labor Statistics, 2009b).

In addition, over 90% of firms in the finance and insurance, communications, and manufacturing industries reported offering EAP services to their employees. However, only 75% of wholesale/retail firms, and 73% of firms in the service sector offered EAPs (Sciegaj et al, 2001). Furthermore, larger firms are more likely to offer EAP services than are smaller firms (Galinksy et al., 2008; Sciegaj et al., 2001).

Though the number of individuals with access to EAP services has increased significantly since 1993 (Oss et al., 2011), there has been significant market consolidation among EAP organizations; many smaller EAPs were acquired by larger organizations (including MBHOs), and a number of regional organizations merged (Fox et al., 2000; Sharar et al., 2002). In addition, though there is no data in the literature that reports EAP closures, it is also likely that a number of EAP organizations went out of business since 1993.

Integration of employee assistance, wellness, and work/life programs. Most EAPs today have some level of integration with work/life services such as child care, elder care, and other forms of information and referral regarding "life" events and work/life balance (Masi et al., 2004; Oss et al., 2011). Van Den Berg (2000) states that EAPs may be able to justify a separation from MBHOs by offering broader services such as prevention, early intervention, and health and wellness programs in addition to traditional organizational interventions. Integrated EAP and work/life services have been shown to be effective in addressing the broad range of issues affecting employees and family members (Masi & Jacobson, 2003). In addition, EAPs are expanding to include wellness services, something that is of particular interest to managed care organizations

(DeFalco, 2001) due to the preventive and cost-savings aspects of health and wellness programming.

The Workforce 2000 initiative emphasized cultural diversity, work/family, and health promotion and encouraged the establishment of programs that addressed these issues. In addition, changes in the workforce and the changing needs of employees were significant factors in the expansion of work/life and wellness programs (Masi et al., 2004).

The 1980s saw a large increase of women in the workforce, who began to have problems balancing child care with work responsibilities. In addition, many baby boomers began to take on responsibility for caring for their elderly parents. Employers became aware of the need to provide support for their employees who need help balancing child care and elder care responsibilities in order to decrease their impact on work performance (Masi et al., 2004).

Private companies began to appear that provided information and referral for both child care and elder care issues. However, many EAPs had already been providing resources and referral related to dependent care, and there was controversy about which program was better suited to provide this type of service to employees (Masi et al., 2004). Many work/life companies began to embrace a broader view of support for employees, offering services that encompassed a wider range of topics aimed at supporting work-life balance. These services included financial information programs, concierge services, educational information and referral, and legal consultation and discount services, among others (Masi et al., 2004).

The Evolution of External EAPs.

By the 1990s many EAP and work-life companies began to form partnerships in order to provide a single access point to employees seeking EAP or work-life services. Many large, national EAPs merged with work-life companies (Masi et al., 2004). Many EAPs also provide work-life services to employees by contracting with third party work-life vendors, and providing seamless services to employees who access the service through the EAP. In 2011, 136.9 million individuals were enrolled in integrated EAP/work-life programs (Oss et al., 2011).

Similar to work/life programs, wellness programs and initiatives are often combined with EAPs. In fact, the primary form of wellness program worldwide is the employee assistance program (Buck Consultants, 2007). Large managed care organizations are also interested in wellness initiatives, as they have been shown to reduce health care expenditures (Buck Consultants, 2009). Workplace wellness programs are designed to offer early intervention in order to prevent or address employee health risks that can impact productivity (Butcher, 2008), and due to their focus on productivity are a natural partner for EAPs. Buck Consultants (2009) conducted a survey of wellness programs at over 1103 organizations in 45 countries. With respect to the United States, the survey found that employers' primary goal for their wellness programs was reducing health care expenditures; secondary goals included improving productivity and reducing absenteeism. Many large insurance companies, such as Wellpoint, Cigna, and Kaiser Permanente are increasing their wellness offerings due to employer demands for such programs; however, large insurance providers are facing stiff competition from specialty vendors who have a more specific focus on wellness programs and initiatives (Butcher, 2009).

The Evolution of External EAPs.

In addition to partnerships with work-life and wellness providers, EAPs also began to provide behavioral health gatekeeping services and other behavioral health services (Wagman & Schiff, 1990) and to partner with MBHOs (Steele, 1998). The following section will outline the history and evolution of managed care, the specialized industry of managed behavioral health care, and the subsequent integration with EAPs.

History and Evolution of Managed Behavioral Health Organizations

A review of managed care, and specifically managed behavioral health organizations will now be offered. MBHOs have had a significant impact on the EAP industry, and examination of their origins and goals will help to explain their influence. The following section reviews the general concept and history of managed care, the evolution of MBHOs and their subsequent integration with EAPs, as well as some of the consequences of this integration to the EAP industry.

The managed care concept. Managed care organizations (MCOs) have existed in the U.S. as far back as the 1960s, but were peripheral and less prevalent than the fee-for-service insurance model at that time. The shift in the prevalence of managed care insurance in the U.S. can be traced to many changes in the health care environment. A main characteristic of the U.S. healthcare delivery system that set the stage for managed care was the lack of universal healthcare coverage. Other problems included ever-increasing health care costs combined with increasing demand due to an aging population and the availability of higher cost technologies and treatments. Employers bore responsibility for much of the increased costs in healthcare expenditures, and the percentage of revenue allotted to employee health benefits began to increase. This

provided an incentive for organizations to lower their healthcare expenditures by forming cooperatives to increase bargaining power, negotiating lower rates from a select number of providers, beginning to self-insure, and beginning to set limits on the amount and type of healthcare services that would be covered (Barton, 1999).

Managed care is a type of reimbursement mechanism for the delivery of healthcare services, including behavioral health services. In managed care, both the utilization of services by patients and the practices of providers are overseen by an organization that has an interest, in terms of quality and cost, in how these two groups interact (Barton, 1999). There are numerous types of managed care arrangements that appear in various forms and can be divided into three general categories: Prepaid health plans, utilization review organizations, and high-cost case management (Mechanic, Schlesinger, & McAlpine, 1995). These general categories can be further subdivided into various managed care models such as Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), Exclusive Provider Organizations (EPOs), Integrated Delivery Networks (IDNs), and variations within each of these models (Barton, 1999). These managed care models vary in the ways they limit costs and control access to services. Methods used to control costs include limiting the number of sessions, reducing the length of inpatient stays, and using lower level or less trained providers (Sanchez & Turner, 2003). Most managed care models also encourage the use of the least restrictive treatment environment (e.g. outpatient vs. inpatient treatment) based on strict "medical necessity" protocols. In addition, many managed care models tend to operate using a fixed premium that is independent of the actual services provided (also known as capitation). Capitation can be problematic because it tends to put pressure on

the payor (i.e. the managed care organization) to limit access to services to avoid financial loss. In addition, managed care models control access to services by requiring pre-authorization for services, limiting the number of services available in a calendar year (as well as lifetime limits), and limiting which providers are able to provide services. For example, HMOs tend to provide coverage only to in-network providers with whom they have negotiated a discounted fee. PPOs limit costs by encouraging the use of in-network providers, and by requiring larger copays for out of network services (Barton, 1999; Mechanic et al., 1995).

Prior to the advent of managed care in the U.S., most people had "fee-for service" (Barton, 1999, p.25) insurance coverage. In the fee-for service model individuals could access health care services from the provider of their choice, and the providers were reimbursed for each service they provided to individual patients. In this model services could be seen as an interaction between individual patients and individual providers. The shift to managed care focused on a more comprehensive model of service delivery that provided services to whole populations of patients who received care from a defined group of providers (Barton, 1999).

Some authors contend that individual fee-for-service providers and facilities are to blame for the emergence of managed care because they did not adequately control costs and length of treatment (Iglehart, 1996). Another factor that led to inadequate cost and usage control, and thus contributed to the growth of managed care, is related to built-in incentives in the fee-for-service model. Fee-for-service insurance coverage paid providers for each service they provided to a patient. Since providers are paid for the

number and type of services they provide, this can be an incentive for them to offer services that may not be necessary or may be of questionable value. The fee-for-service model also allowed consumers to seek care from the specialist of their choice, without a referral from the primary care physician. Consumers had the ability to seek treatment from as many doctors as they chose, sometimes leading to the overuse or misuse of services. As with providers, consumers' unrestrained use of healthcare services increased total costs to insurers, and were not necessarily associated with better health outcomes. In addition, the nature of the fee-for-service model led to potentially unlimited healthcare expenditures, making cost-containment difficult if not impossible. Furthermore, the fee-for-service model was deemed to be inefficient in terms of health outcomes versus expenditures. The managed care model tends to limit the potential for duplicative or unnecessary services with respect to both providers and consumers, thus limiting the total cost (Barton, 1999).

Managed care uses various mechanisms to control costs and access to services. For example, MCOs often use utilization review, which includes prior authorization for services such as hospitalization, and concurrent review, which determines if ongoing services are deemed necessary (Mechanic et al., 1995). MCOs also use provider profiling, a method of monitoring the efficiency of specific practitioners. Other methods include limiting the number of sessions, reducing the length of inpatient stays, and using lower level or less trained providers (Kiesler, 2000).

Managed behavioral health organizations. Out of the general managed care model, came the managed behavioral health model. Managed behavioral healthcare was

created as a response to drastically increasing costs related to mental health and substance abuse services in the late 1970s and early 1980s. The increased behavioral health costs were related to an oversupply of resources such as available hospital beds and providers, commercialization and expansion of chemical dependency and psychiatric facilities, reduced stigmatization of behavioral health disorders, the increased use of insurance benefits to cover behavioral health services, and the limited expertise of benefits administrators with respect to behavioral health benefit design and terminology (Wagman & Schiff, 1990).

Managed behavioral healthcare, similar to managed medical care (i.e. physical or "general" medical), is a system that controls access and costs related to the provision of mental health and substance abuse services (Hersch, 1995). Managed care organizations often separate or "carve-out" behavioral health benefits from general medical coverage for recipients (Feldman, 2003; Hersch, 1995) and they usually contract with outside organizations to administer behavioral healthcare services (Iglehart, 1996). Managed care organizations that administer behavioral health benefits are often referred to as managed behavioral health organizations (MBHOs) (Feldman, 2003; NCQA, 2008b). The National Committee for Quality Assurance (NCQA) is a non-profit healthcare quality assurance organization that audits and accredits managed care organizations including MBHOs (NCQA, 2008a). NCQA defines a MBHO as "a system of behavioral healthcare delivery that manages quality, utilization and cost of services, and which measures performance in the area of mental and substance abuse disorders" (NCQA, 2008b, p. 6). Additionally, a MBHO is defined as "a legal and licensed entity that provides managed behavioral healthcare services to a specific group of members. The

organization provides a practitioner or provider network from which its members choose practitioners or providers, and the MBHO should have a single set of Utilization Management, Credentialing, and Member Rights and Responsibility policies and procedures"(NCQA, 2008c, p.11-12).

MBHOs began developing in the late 1980s and early 90s (Feldman, 2003), with the period between 1993 and 1998 seeing a huge expansion in their prevalence and scope (Mark et al., 2000). It was estimated in 2011 that 171.2 million individuals were enrolled in a managed behavioral health program (Oss et al., 2011). Further discussion of MBHO market share and prevalence is offered in the following section.

Integration of employee assistance programs and managed behavioral health organizations. Experts in the field argue that managed care organizations filled a void left by EAPs, who allowed more efficient and better organized organizations to take responsibility for providing services to employees (Bickerton, 1990). In addition, the fact that many EAPs distanced themselves from direct interaction with management left the industry vulnerable to take-over by MBHOs (Mannion, 2004). Furthermore, occupational social work's focus on behavioral health issues may also have influenced EAPs to become more vulnerable to takeover by MBHOs.

The social work profession's focus on behavioral health may have influenced EAPs to focus more exclusively on mental health and substance abuse, as opposed to other traditional EAP functions found in the core technology such as education, training, outreach, and enhancing the work environment; the focus on behavioral health service provision may have added to the confusion experienced by employers with regard to the

differences between EAP services and the provision of behavioral health interventions. Over-emphasis on behavioral health likely made the industry more in line with and vulnerable to takeover by MBHOs (Mannion, 2004; Sharar, 2009).

Many EAP companies have been absorbed by MBHOs, and the majority of EAP service provision today is offered by integrated EAP/managed behavioral health programs or by EAPs owned by MBHOs (Open Minds, 2002; Oss et al., 2011). MBHOs have continued to dominate the EAP industry since at least 2000 or earlier (Fox et al., 2000), and the top three organizations (Magellan, ComPsych, and Aetna respectively) together control 43.8% of the U.S. EAP industry; the top ten organizations (mostly MBHOs) together control 78% of the industry (Oss et al., 2011).

MBHOs' services include designing mental health and substance abuse benefit plans, negotiating rates with service providers, referral to providers, and case management. EAPs often provided similar, overlapping services (Gornick & Blair, 2005). However, the concept of managed care was not initially prevalent among EAP providers. Before the late 1990s most companies considered EAP and managed care to be entirely separate services. The use of EAPs as behavioral health gatekeepers and claims processors was adopted by some companies in the late 80s and early 90s, but it did not become a dominant model at that time. EAP professionals generally encouraged the separation of EAP and managed care roles, citing concerns about a conflict of interest between appropriate treatment and pressure by employers to lower costs. It was believed that this conflict of interest would be mitigated through the use of third party insurance companies (MBHOs). However, it was soon discovered that the MBHOs controlled

access to behavioral health benefits, and often they would deny access to services that the EAP recommended. EAPs and MBHOs were conflicted about each other's practices, with EAPs believing that MBHOs did not truly understand the treatment needs of beneficiaries, and MBHOs believing that EAPs did not understand the realities of cost issues and pressure from employers (Heck, 1999).

MBHOs, often themselves subsidiaries of larger managed care organizations, determined that while separating the EAP and benefit management function was found to lower costs, an integrated model where the EAP controlled the initial assessment as well as referral, case management, and benefit authorization led to higher employee satisfaction with the program. MBHOs began acquiring EAP companies and providing direct EAP services to employees through integrated EAP/MBHOs (Gornick & Blair, 2005; Heck, 1999).

Increasing healthcare costs in the United States in the 1990s were instrumental in the development of MBHOs and in the reorientation of many EAPs to be part of health care benefits packages. Simultaneous to the expansion of MBHOs, EAPs began to be more in demand in their own right, due in part to the Drug Free Workplace Act of 1988 (Masi et al., 2004) as well as other legislation. EAPs grew in number and expanded the type and scope of services offered, and in so doing their organizational structure became more complex (Sciegaj et al., 2001). Beginning in the early 1990s, MBHOs began acquiring EAPs and work/life organizations, and integrated MBHO/EAP/Work-life programs began to emerge (Feldman, 2003). The integrated EAP/MBHO model was thought to increase administrative efficiency, with a focus on managing the behavioral

health benefit. However, EAPs and MBHOs sometimes work at cross purposes; EAPs seek to increase access to services as part of prevention and early intervention efforts, and MBHOs function as a barrier to services in order to direct clients to the most appropriate level of care. An alternative is the integrated model, which can use aspects of both EAP and MBHO models to offer early intervention services as well as effective gatekeeping services, simultaneously reducing behavioral health costs and providing easy access to appropriate services (Cagney, 1999). The move to integrate EAPs with MBHOs was also related to the demands of client companies who wanted comprehensive services in a single access point, and MBHOs largely adopted the EAP model in order to remain competitive (Mannion, 2004).

Many employers contract simultaneously for EAP and behavioral health services, and though these services can be offered separately, many large self-insured companies and unions opt for an integrated model (Cagney, 1999; Merrick et al., 2009). Integrated EAP/MBHOs have "become the rule rather than the exception" (Drotos, 1999, p. 19) and the majority of EAP service provision today is provided by integrated EAP/MBHOs or EAPs that are owned and operated by MBHOs (Fox et al., 2000; Merrick et al., 2007; Oss et al., 2011). Many professionals in the industry believed that MBHOs' use of EAPs as gatekeepers for mental health and substance abuse services posed a threat to EAPs long-term viability (Van Den Berg, 2000), and that EAPs needed to distance themselves from managed care (DeFalco, 2001; Mannion, 2004). Concern over MBHOs' impact on EAPs' mission and service provision continues today (e.g. Sharar, 2009; Tisone, 2008), though there has never been any systematic research that examines this issue directly.

The Evolution of External EAPs.

Managed care tends to define EAP services as a healthcare function (DeFalco, 2001). When EAPs began to be more closely aligned with, and in many cases part of, MBHOs, they began to be perceived by employers as part of the "healthcare world" as opposed to the "work world" (Blair, 2004). While many EAPs showed their value to employers by helping to contain rising behavioral health costs, the focus on cost containment instead of productivity has been problematic (Blair, 2004; Sharar, 2009). Furthermore, an exclusive or primary focus on clinical issues within an EAP impacts effectiveness because it excludes the traditional EAP functions of addressing behavioral health risk through consultation with management and supervisors, in addition to direct interaction with troubled employees (Mannion, 2004).

Healthcare programs and costs change, but an employer's need for a healthy and productive workforce is always pertinent (Blair, 2004). One of the unique functions of an EAP is that it recognizes the relationship between employee health and performance (Sharar, 2009). EAPs that are too closely aligned to healthcare may begin to lose focus on providing support for employee productivity (Blair, 2004). In addition, the prevalence of mental health professionals, including social workers, in the EAP field has influenced the move towards behavioral health (and alignment with MBHOs) and away from more traditional EAP practices:

> Many mental health professionals do not see employee assistance as a valid or legitimate field of endeavor in and of itself, but merely another opportunity for therapy or a kind of referral service designed only to channel people into the therapist's office (Mannion, 2004, p. 40).

The Evolution of External EAPs.

There is widespread confusion on the part of employees as well as organizations about the core functions and role of an EAP, and this confusion has been exacerbated by the entry of MBHOs into the marketplace with their conception of EAP as an employee benefit. In a recent survey of 42 organizations, the National Business Group on Health (2008) found that 90% of respondents considered their EAP to be a counseling service for employees, 43% considered it to be a healthcare benefit, and only 21% considered it to be a program that addresses workplace performance. Often employers don't realize the full scope of EAP services and fail to fully leverage these services (National Business Group on Health, 2008).

EAPs' focus on the workplace is part of what made them unique and different from other behavioral health interventions with a broader, non work-related focus, such as psychotherapy and substance abuse treatment (Roman & Blum, 1988). Many EAP professionals and scholars continue to debate the impact of the integration of EAPs with MBHOs, and whether it has decreased EAPs' traditional focus on workplace performance issues in favor of health care cost containment (Gornick & Blair, 2005; Lee, 2005; Mannion, 2004; Tisone, 2008). Further research is needed in this area in order to determine the impact of MBHOs on EAP services and effectiveness. Furthermore, many in the field argue that MBHOs and EAPs are essentially incompatible (Mannion, 2004; Masi, 1994). MBHOs have the goal of reducing costs, and accomplish this task by limiting services; whereas EAPs' purpose is to address and resolve problems at work, which may for the short-term increase behavioral health costs. MBHOs seek to lower short-term costs while EAP seeks to lower long-term costs. In the case of EAPs, lowered costs are more indirect, and are the byproduct of addressing productivity issues.

MBHOs have no interest in the workplace per se, and are focused almost exclusively on behavioral health cost containment; conversely, EAPs' traditional ties to the workplace, and specifically to workplace productivity, define and give meaning to the industry. EAPs, in their original conception, were never intended to be part of a health care delivery system (Mannion, 2004).

An early conceptualization of EAPs by Erfurt and Foote (1977) described occupational programs using a three-system model. The model included: 1) The workplace or "parent organization" (Erfurt & Foote, 1977, p.9); 2) The employee assistance program; and, 3) The community system of treatment services. A significant change that has occurred since Erfurt and Foote's description of the EAP continuum is that the boundary between the EAP and the treatment services offered to employees has become blurred. Though most EAPs continue to provide assessment and referral services, many also offer short-term counseling that focuses on problem resolution. In fact, problem resolution within the EAP is often a primary, explicitly stated goal. As a direct result of MBHO involvement in the industry, many contracted providers who conduct EAP assessment and referral services continue to provide ongoing psychotherapy services for EAP clients under the managed behavioral health plan (Harlow, 2006). The fundamental changes in EAP service provision and focus bring into question the effectiveness of these interventions, especially with regard to MBHOs' entry into the industry. The question becomes whether modern EAPs "actually improve the work performance of employees impaired by personal problems any more than providing reasonable access to good behavioral health care"(Sharar, 2008, p.119) and EAPs have

become valued due to their effectiveness in controlling behavioral health costs (Hutchison & Vickerstaff, 2009).

The change in EAP focus away from the workplace and employee productivity and towards behavioral health cost-containment and service provision could also be problematic with respect to social work values. Continued focus on the workplace, and specifically on factors related to individual and workplace performance, is the best way to insure that an important social work value, individual (employee) wellbeing, remains on the forefront of EAP practice. Addressing both individual problems and problems in the workplace itself fits well with the person-in-environment aspect of social work practice. In addition, maintaining a focus on the workplace provides an important avenue for social work practice because the workplace is an ideal place to identify troubled employees (Akabas & Kurzman, 2005; Googins & Godfrey, 1987). Therefore, EAPs that maintain a traditional focus on employee performance, and the workplace itself, are more closely aligned with social work values and occupational social work practice than are EAPs that focus on behavioral health cost savings.

Managed behavioral health organizations' impact on employee assistance program pricing. MBHOs have played a role in eroding EAP prices. Competitive prices (i.e. lower prices), due in part to the influence of MBHOs, have limited EAPs' ability to provide comprehensive, quality services to organizations and employees. Many EAPs use a capitated pricing model, generally charging a set fee per employee per year. This model can lead to providers discouraging the use of the EAP, especially if the capitated rate is too low to support the provision of effective services (Lee, 2005; Sharar

& White, 2001; Tisone, 2008). Sharar and White (2001) note that the industry has essentially "ceded leadership to the invisible hand of market forces" (Sharar & White, 2001, p. 14) instead of securing adequate funding to provide high quality services. Furthermore, the EAP industry lacks quality standards (Sharar & Hertenstein, 2006b). Due to lower profit margins, many EAP vendors are employing ethically questionable tactics to maintain profits; tactics include deceptive marketing, predatory pricing, inaccurate or misleading data on utilization reports, and minimal service provision (Sharar et al., 2002).

With healthcare costs increasing, many employers are seeking to lower costs, putting additional pressure on EAPs to provide more services for less money. It has been suggested that many purchasers of EAP services (e.g. human resources or benefits professionals) are more concerned with the cost of the EAP service than the quality and amount of services provided (Lee, 2005; Tisone, 2008). Research is needed in order to determine what purchasers of EAP services are looking for in a program, in additional to further research about the value of traditional EAP services. Without empirically validated data on the value of traditional EAP services, the industry is vulnerable to further commoditization and degradation of quality and effectiveness.

Managed behavioral health organizations' influence on employee assistance program accreditation and credentialing. Accreditation of EAPs and MBHOs and credentialing of EAP professionals is a controversial topic. While accreditation within the healthcare field is not new, it is a relatively new concept for EAPs. There are two main types of accrediting bodies, though some programs may be accredited by both. The

first type accredits private behavioral health networks as well as governmental entities. Organizations of this type include the National Committee for Quality Assurance (NCQA), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and the Council on Accreditation (COA). The second type of organization accredits facilities, programs, and individual providers. This type of organization includes JCAHO, The Committee on Accreditation for Rehabilitative Facilities (CARF), COA, and The Employee Assistance Society of North America (EASNA). The Employee Assistance Professionals Association (EAPA) provides credentialing only to individual practitioners rather than to entire programs or facilities (Drotos, 1999). EAPA was the first organization for provide formal certification for professionals working within the field of employee assistance (Bickerton, 1990).

The demand for accreditation and credentialing are driven by demands for accountability that are present throughout the healthcare industry. Managed care has a large role in this process. As MBHOs' market share increases, employers are demanding more accountability for the services that are provided. In addition, due to the consolidation of more and more MBHOs into larger organizations, employers have less choice in terms of choosing a behavioral health provider, making the quality and accountability of the provider increasingly pertinent. Increased employer liability is also a factor related to increased demands for accreditation. In addition, increases in competitive, for-profit EAPs have put pressure on the EAP industry as a whole to be more accountable and more connected to employer benefit plans (Drotos, 1999).

The Evolution of External EAPs.

Mental health parity

Recent legislation such as the Interim Final Rules under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Act of 2008 (2010), commonly referred to as the "Mental Health Parity Act," may impact EAPs in a number of ways. The main intention of the Act is to insure that mental health and substance abuse coverage is provided at the same level, and without additional costs or barriers, as other medical and surgical benefits. With respect to EAPs, the Act prohibits health insurance plans from requiring EAP gatekeeping, in that plan participants cannot be required to access the EAP before being eligible for behavioral health coverage under their plan. This could negatively impact those EAPs that are tied to behavioral health benefits in that these plans could no longer use the EAP's gatekeeping function, thus lowering utilization and the potential impact of the program (Hagemann, 2010). Plans that utilize EAPs in a gatekeeping function have shown substantial reductions in costs associated with behavioral health services, as well as more efficient use of behavioral health services; therefore, removing the ability of EAPs to serve as gatekeepers may lead to substantial increases in behavioral health costs (Kamilis, 2010). Conversely, the inability of EAPs to provide a gatekeeping function in terms of access the behavioral health benefits may be beneficial in that it will help bring EAPs back to their original focus on workplace productivity (Hagemann, 2010). Other related consequences could be an increase in stand-alone EAPs (as opposed to those that are part of an integrated plan offered by MBHOs or larger insurance companies). In addition, while employers may not be able to mandate that employees use the EAP before accessing their behavioral health benefit, EAP utilization can still be encouraged and promoted by employers, potentially

increasing the traditional EAP functions of prevention and consultation with management.

Outcomes and Effectiveness of Employee Assistance Programs

An examination of EAP outcomes and effectiveness research over the past 30 years will now be presented, followed by a discussion of common methodological problems, and a research gap related to the impact of MBHOs. While there have been a large number of studies conducted over the years, many have limited methodological rigor.

One of the best-known studies showing EAP effectiveness related to absenteeism, health care costs, and overall return on investment was the McDonnell Douglas Corporation's financial impact study (Smith, 1989). Since the McDonnell Douglas study there has been a fair amount of EAP research, most of which found positive outcomes with respect to return on investment, employee satisfaction, and effectiveness (Attridge, 2011b; Blum & Roman, 1995; Csiernik, 2004, 2011; Masi et al., 2004; McLeod, 2001). There have been no notable differences found in outcomes related to client demographics such as gender, job classification, marital status, and education level (Harlow, 2006).

While there is no clear consensus on the exact cost savings for employers using EAPs, even the most rigorous studies have shown that EAPs at least cover their costs (McLeod, 2001). Attridge (2011b) compiled an extensive list of 100 reports and reviews published between 2000-2011 that demonstrate the value of EAP to employers by providing a positive return on investment, and numerous studies have shown substantial cost savings to organizations utilizing EAPs (Hargrave & Hiatt, 2004; Hargrave et al.,

2008; Klarreich, DiGiuseppe, & DiMattia, 1987). For example, Ahn and Karris (1989) estimated that the overall cost-benefit ratio for an EAP is approximately 2:1, and other studies have found a return on investment as high as 14:1 (Collins, 1998). Research has also shown that external EAPs tend to be less costly than internal programs, and that higher-cost EAPs have been associated with higher utilization rates and subsequently with better cost-benefit ratios (McLeod, 2001).

EAP interventions have been shown to reduce employer costs through a positive impact on work outcomes such as productivity (Harlow, 2006; Hargrave & Hiatt, 2004; Hargrave et al., 2008; Selvik et al., 2004), absenteeism (Klarreich et al., 1987; McLeod, 2010; Preece, Cayley, Scheuchl, & Lam, 2005), presenteeism (Hargrave et al., 2008; Harlow, 2006), work relationships (Harris et al., 2002; Masi & Jacobson, 2003), job retention (Hughes et al., 2004; McLeod, 2010), lowering overall health care costs (Dainas & Marks, 2000), and reducing accidents, grievances, visits to the medical department, and worker's compensation claims (Blum & Roman, 1995) among other benefits.

EAP interventions have been shown to have a positive impact on clinical outcomes (Greenwood, DeWeese, & Inscoe, 2005; Harlow, 2006; McLeod, 2010), including substance abuse (Blum & Roman, 1995; Deitz, Cook, & Hersch, 2005; Greenwood et al., 2005), depression (Hargrave & Hiatt, 2004; Preece et al., 2005), Global Assessment of Functioning (Jacobson, Jones, & Bowers, 2011), and employee wellbeing (Collins et al., 2012). Furthermore, studies consistently report a high level of client satisfaction with the EAP services (Selvik et al., 2004).

The Evolution of External EAPs.

Despite consistently positive results for most EAP research, some studies have found conflicting results about the quality of EAP service provision and effectiveness in alleviating issues with job satisfaction, absenteeism and productivity. For example, Macdonald, Wells, Lothian, and Shain (2000) found that EAP users had higher rates of absenteeism before, during, and after EAP intervention than did non-EAP users. In addition, Ahn and Karris (1989) found a more modest cost-benefit ratio when the degree of severity of the presenting problem is considered. Furthermore, concerns about the quality of EAP services have been reported (Masi et al., 2000), as have concerns about ethical practice (Sharar et al., 2002).

In general, the EAP field has not produced a lot of well-designed, methodologically rigorous research compared to the related disciplines of substance abuse, behavioral health and organizational studies (Masi et al., 2004; Sharar, 2008). Much of the EAP research is limited to single case studies (Csiernik, 2011), lacks appropriate comparison groups or controls (McLeod 2001, 2010), or does not adequately address bias (Sharar, 2008). In addition, many private organizations have initiated their own internal studies related to cost-effectiveness and value to the sponsoring organization; however, this type of research tends to be anecdotal and reported in business rather than mental health terms (Masi et al., 2004). Furthermore, despite a lack of empirically-based research, the huge expansion of EAPs in all American business sectors suggests a general acceptance by business leaders of the positive contribution of EAPs to the "bottom line" (Masi et al., 2004) and the industry has largely been able to avoid scrutiny by employing organizations related to outcomes and cost effectiveness (Sharar, 2008).

The Evolution of External EAPs.

Reasons for the lack of rigorous, sophisticated research in the EAP field are many. One reason is related to the fact that there are few academic institutions with specific EAP-related courses or programs, and these settings have traditionally been the sponsor for rigorous studies. Another reason for the lack of research is related to the fact that EAPs tend to be private and self-funded, thus limiting the ability to conduct large-scale studies (Masi et al., 2004). Other reasons that it is difficult to study EAP effectiveness include: confidentiality concerns and issues related to business "secrecy," the fact that services are offered at multiple sites, lack of appropriate or comparable control groups (McLeod, 2001, 2010), and lack of consensus about measurement instruments (Courtois et al., 2004; McLeod, 2001). The lack of consistent benchmarking across the industry is of particular concern because EAPs with similar products are unable to be compared based on the quality and performance of their service components (Courtois et al., 2004; Merrick et al., 2007).

MBHO-EAPs, the primary form of EAP service provision in the U.S. today (Fox et al., 2000; Open Minds, 2002; Oss et al., 2011), may have significantly impacted the EAP industry with respect to quality and effectiveness (Bjornson & Sharar, 2004; Sharar, 2009). However, while the effectiveness of traditional EAPs is well known (Blum & Roman, 1995; Csiernik, 2004, 2011; McLeod, 2001) the changes that have occurred in EAP organizations and the services they provide since MBHOs' entry into the field brings into question the purpose and effectiveness of modern EAP organizations (Sharar, 2009).

The Evolution of External EAPs.

There are some recent studies that examine the EAP industry and EAP organizations. For example, there is some recent research with regard to the challenges facing modern EAP organizations related to business ethics, such as such as Sharar, White, and Funk (2002). In addition, Sharar and Herterstein (2003) examined critical issues faced by EAP organizations, and Sharar and Herterstein (2006a 2006b) looked at the impact of commodity pricing on EAP quality issues. National Business Group on Health (2008) created a buyers guide for organizations purchasing EAP services, and surveyed purchasers' views of EAP organizations. Sharar (2008) conducted research into the adherence of EAP affiliates to the core concepts of EAP practice. However, some of the more comprehensive research that examined EAP organizations and the EAP industry itself is outdated (e.g. Hartwell et al., 1996; Straussner, 1986). Masi and Jacobson (2003) examined outcomes related to the integration of EAP and work/life, as did others such as Eischen, Grossmeier, and Gold (2005), but the effectiveness of integrated programs compared to stand-alone EAPs is lacking. There were, however, several studies that examined the integration of the EAP and MBHO industries (Fox et al., 2000; Open Minds, 2002; Oss et al., 2011), though these studies were primarily focused on prevalence and scope and not on effectiveness or comparative outcomes.

The most recent study into the MBHO-EAP industry was Oss et al.'s (2011) study that reported the number of people eligible for MBHO and EAP services, as well as the prevalence of integrated programs; however, this study did not examine the specific changes, other than integration with work/life, that may have occurred in EAP organizations or any variable related to quality or effectiveness. In addition, Oss et al.'s study reported primarily on MBHOs, and EAPs that were controlled by or part of

MBHOs, and did not specifically examine non-MBHOs EAPs and how they may have evolved; similar previous studies also did not examine the evolution of non-MBHO EAPs (e.g. Fox et al., 2000; Open Minds, 2002).

Empirical studies that did examine the effectiveness of MBHO-EAPs did not address MBHOs' impact on the EAP industry or EAP organizations. There is, however, some evidence that MBHO-EAPs can be effective. For example, Merrick et al. (2009) found that a MBHO-based EAP increased access to behavioral health services, and that services were accessed sooner. However, literature that does discuss the possible impact of MBHOs on EAPs are based on anecdotal information and conjecture (e.g. Gornick & Blair, 2005; Lee, 2005; Mannion, 2004; Tisone, 2008; Van Den Berg, 2000) rather than empirical research, and there has never been any research that has directly examined the impact of MBHOs on traditional EAP organizations and services. Due to the numerous recent changes in the industry, there are questions about contemporary EAPs' impact on cost and outcomes, and further research is required in order to ensure efficiency and effectiveness. This research should include descriptive studies that examine EAP utilization, costs, and outcomes, as well as how substance abuse issues are identified, the relationship between EAP services and other workplace programs, barriers to EAP utilization, and the development and validation of performance measures (Merrick et al., 2007), as well as how the integration of other services such as work-life, wellness, and MBHOs have impacted overall effectiveness and mission.

Research is needed with respect to how MBHOs have impacted the EAP industry in terms of strategy, structure, services provided, market penetration, modes of service

delivery, pricing, profitability, accreditation, outcomes, focus, and populations served. Furthermore, research that examines whether modern EAPs continue to adhere to the core concepts of EAP practice is also needed. This study aimed to fill this research gap by examining how traditional EAPs have evolved since the advent of MBHOs.

Theoretical framework

A theoretical framework was needed in order to assist in the interpretation of how EAPs have adapted to a changing market, including the influence of MBHOs'. The concept of organizational change was therefore examined, along with the application of complex adaptive systems theory and how it helps to explain organizational evolution. Other organizational change theories that were used to interpret data were industry life cycle theory, and organizational life cycle theory. Due to the complexity of the organizing theories, a discussion and definition of each will be offered here in order to inform further discussion of the methodology.

Organizational change. Organizational change is an intrinsic part of any organization, and has occurred for as long as organizations have existed. However, there are many theories of organizational change, and most theorists and researchers agree that overall the concept is not well understood and there is no single, generally agreed upon theory for examining it (Huber, Sutcliffe, Miller & Glick, 1993).

Modern organizational change theories began in the early 1900's with Frederick Taylor's "scientific management," followed by the Hawthorne Studies, the Industrial Psychology movement, and more recently the Organizational Development (OD)

movement (Burke, 2002). Chaos theories and complex adaptive systems theories have also begun to emerge and to be applied to the examination of organizational change (Burnes, 2005; Dooley, 1997; Stacey, 2000).

Organizational change is important because it is related to performance, stress levels, and the creation of new tasks and relationships in the workplace (Huber et al., 1993). Most often organizational changes occur when a change in the external environment necessitates a change in an organization's strategy and mission, which in turn requires a change in culture. A change in organizational culture is accomplished by changing behaviors "that will lead to the desired change in attitudes and values" (Burke, 2002, p.13). Organizational changes can be broken down into two main categories: content and process. Content is "the vision and overall direction for the change… the what" (Burke, 2002, p. 14). Process "concerns the implementation and adoption…the how" (Burke, 2002, p. 14). Huber et al. (1993) consolidate into 5 categories the factors that they consider to have an impact on organizational change. These categories are characteristics of the organization's environment, performance, top manager, strategy, and structure. In addition, these authors examined several types of changes such as externally focused changes, internally focused changes, changes in organizational form, and total organizational changes.

Complex adaptive systems theory. Now that an overview of the general concept of organizational change has been offered, it is important to turn to the more specific theory of complex adaptive systems (CAS). Complex adaptive systems theories, also referred to as theories of complexity or complex evolving systems theories

(Mitleton-Kelly, 2003; Stacey, 2000; Waldrop, 1992) met the requirements of this study because they are explanatory rather than predictive theories, and they offer a plausible framework through which to examine how EAPs have changed. Furthermore, complexity theories are gaining acceptance among organizational theorists and practitioners as a method of understanding and promoting organizational change (Burnes, 2005). The following section will provide a brief explanation of the origins and basic attributes of CAS theories and their application to the examination of organizational change, and specifically to the changes that have occurred in EAPs since the advent of MBHOs. Along with a summary of CAS theories, the main concepts that will be discussed include self-organization, emergence, "the edge of chaos," dissipative structures, and co-evolution.

Complexity theories and complex adaptive systems theories are based on the assumption that while organizational change in general can be predicted, the specific changes within each organization or group of organizations are not predictable, and are the result of the complex interplay between the organization and its environment that produces emergent, non-predictable evolutionary change; these theories are based on an assumption of non-linear causality (Burke, 2002; Mitleton-Kelly, 2003; Stacey, 2000; Waldrop, 1992).

While there is no single, unified theory of complexity, it is based on theories originating from evolution, biology, chemistry, meteorology, computer simulation, mathematics, physics, psychology, and economics (Burnes, 2005; Mitleton-Kelly, 2003; Stacey, 2000; Waldrop, 1992). Complex adaptive systems theories view living systems

as being comprised of autonomous adaptive agents that interact based on a set of simple rules. Instead of focusing on the macro level of the system as a whole, CAS theories are primarily concerned with individual agents that together form the system. CAS theories can be seen as a "bottom up" approach. The local interaction of autonomous agents forms the basis for the concepts of self-organization and emergence, both key concepts in CAS theories (Burnes, 2005; Mitleton-Kelly, 2003; Stacey, 2000; Waldrop, 1992). Further discussion of these concepts will help to clarify the basic attributes of the theories.

Self-organization can be understood as the local patterns of behavior of agents acting according to their own intentions, in the absence of an overall plan for the system they form (Stacey, 2000). Applied to biological evolutionary theory, CAS theories contend that evolution does not result exclusively from the random selection of mutations, "but primarily through an internal, spontaneously self-organizing, cooperative process that presents orderly forms for selection by the forces of competition"(Stacey, 2000, p.291). Kauffman (1993) postulates that incredibly disordered and chaotic systems are capable of spontaneously forming a high degree of order.

The concept of self-organization leads us to another important concept in CAS theory, that of emergence. Emergence is the unpredictable creation of unique order out of chaos. Emergent order is created by the spontaneous self-organizing behavior of agents within a system; the emergent order is unpredictable because it is not based on a blueprint or predetermined plan, but rather is the result of the infinitely complex interaction of individual agents with each other and their environment (Waldrop, 1992).

The unpredictable process of self-organization and emergence can lead to entirely new forms that can be adaptive, and therefore evolutionary in nature (Stacey, 2000).

In a CAS, each system can be considered to be a network of individual agents that act in parallel. In an economy, these agents could be individuals, households, or companies. Each individual agent must interact in an environment made up of other agents in the system, and it must act and react in relation to these other agents. Furthermore, control tends to be highly dispersed in a CAS, with coherent behavior arising out of the cooperation or competition between the individual agents. CAS theories explain not only how adaptive organizational changes are selected, but also the process whereby the organization produces the adaptive behavior in the first place (Stacey, 2000).

A CAS has many levels of organization made up of individual agents at one level that serve as building blocks for the creation of the next level. For example, individual workers together make up a team, a group of teams makes a department, a group of departments makes a division, and so on, progressing up to companies, industries, economies, etc. (Waldrop, 1992). Through the lens of CAS theories, organizations can be considered autonomous agents, and the business environment in which they operate can be seen as one “level” of a CAS. The environment in which an organization operates acts to select certain organizational traits that are best adapted to take advantage of opportunities in the local market. The adaptations are reproduced in other organizations; it is essentially impossible for an organization to avoid the selective pressures inherent in a competitive business environment. In order to survive, organizations must promote

adaptive "mutations" and discourage maladaptive ones, and ultimately must choose between evolutionary change and dissolution (Duening, 1997).

The process where the evolution of one agent in a system is dependent on other agents within the system is called co-evolution (Mitleton-Kelly, 2003). The organization's response to changes in the environment is therefore an adaptive process that affects the organization itself as well as the environment in which it is situated. Because co-evolution depends on the interactions between different parts of a system, the level of co-evolution of individuals within an organization, or organizations with a market depends in large part on their respective levels of connectivity (Miteleton-Kelly, 2003).

Another essential concept of CAS theories is that of "the edge of chaos" (Waldrop, 1992, p. 230), first coined by the scientist Christopher Langton when he was studying phase transitions in computer simulations. Langton found that in certain algorithms where he programmed just enough complexity, but not too much, he could produce ongoing, emergent and novel organization. It is this phase, the boundary between not enough complexity, and too much complexity, that he termed "the edge of chaos". Langton believed that this phase transition was where self organization and the emergence of new forms occurred, and that this concept could be applied to all dynamic systems from computational systems to biological ecosystems and even human social systems (Waldrop, 1992).

The concept of the edge of chaos has been embraced by many complexity theorists (e.g. Stacey, 2000; Waldrop, 1992). Kauffman (1993) explains that there are

general principles that characterize complex systems that are able to adapt: “they achieve a ‘poised’ state near the boundary between order and chaos, a state that optimizes the complexity of tasks the systems can perform and simultaneously optimizes evolvability” (Kauffman, 1993, p. 173).

Another important concept in CAS theories is that of dissipative structures, a term used to describe the ways in which an open system exchanges energy, matter and information with its environment; it is the process whereby a system “dissipates” energy from the environment in order to create new structure. When the system is pushed far from equilibrium (i.e. to the edge of chaos) new structures and new order are created, though the exact nature of the emergent order cannot be predicted in advance (Mitleton-Kelly, 2003; Stacey, Griffin & Shaw, 2000). The concept of dissipative structures can be applied to social and organization processes. Individuals within organizations and the organization as a whole must make choices when faced with environmental constraints. The organization is forced to experiment among the possible alternatives offered within its environment in order to create new order and new patterns of interaction. The non-equilibrium of the system (in this case the organization) allows it to transform energy from the environment into a new behavior, or a new dissipative structure.

In organizations, as in natural systems, survival depends on the ability to develop rules that keep an organization running at the edge of chaos. If the organization is too stable, it does not adapt and eventually fails; if too chaotic, the system may be overwhelmed by change. In either case, the organization can only survive if an appropriate level of order-generating rules is established (Burnes, 2005).

Industry life cycle theory. Another evolutionary theory that is helpful in the examination of EAP evolution is that of industry life cycle (ILC) theory. Industry life cycle or product life cycle are terms used by economists and marketing academics to describe theories that explain how industries tend to evolve in similar, recognizable patterns (Klepper & Graddy, 1990; Klepper, 1997; Peltoniemi, 2011; Potter & Watts, 2011). Researchers tend to use the terms "product life cycle" and "industry life cycle" to describe the same theory; for example, Klepper (1996) describes the work of Abernathy and Utterback as being related to product life cycle, whereas Peltoniemi (2011) discusses the work of the same authors as being part of industry life cycle. For the purposes of this discussion, the term "industry life cycle" (ILC) will be used.

Empirical evidence recognizing the ILC pattern is well established in the literature (Agarwal & Gort, 2002; Peltoniemi, 2011), though it may have limited utility as a predictive theory due to difficulty in determining exact boundaries between stages (Mercer, 1993) and lack of a universally accepted definition (Wood, 1990). Though ILC is often used to describe manufacturing industries, it has also been applied to service industries, though its applicability to this industry is questioned (Peltoniemi, 2011).

ILC is usually described as having four distinct phases (Verreynne & Meyer, 2010) that include *introduction*, *growth*, *maturity*, and *decline* (Day, 1981; Lumpkin & Dess, 2001). Abernathy and Utterback (1978) were credited with one of the most well-known descriptions of the technological and organizational factors involved in industry evolution (Klepper, 1996, 1997), and are often referred to when discussing the four-stage model (Argyres and Bigelow, 2007). However, some scholars, such as Klepper and

Graddy (1990) combine some of the elements of the four-stage model and theorize that there are in fact only three phases of the ILC: *growth*, *decline*, and *leveling off*.

ILC helps to explain the evolution of an organization over time. Systematic changes occur in organizations that impact the probability of survival as the market changes and matures. At the introduction stage, opportunities for technological innovation are often highest. However, as the market matures, the opportunities for technological innovation decline, shifting instead to minor product refinements and a greater emphasis on cost reduction. In addition, as the industry matures innovation is replaced instead with imitation, and overall competition increases (Agarwal & Gort, 2002). The length of time that each phase will last depends on the product and industry in question (Day, 1981).

The introductory stage of ILC is characterized by the introduction of innovative new products that meet an emerging need. The new products tend to have competitive advantage over their predecessors due to "superior functional performance rather than lower initial cost" (Abernathy & Utterback, 1978, p. 42). However, during the introductory stage the products' goals are often not well defined, though they do require "a reorientation of corporate goals" (Abernathy & Utterback, 1978, p. 41). Sales at the introductory phase tend to be low due to various barriers to the adoption of the new product such as lack of awareness by customers, commitment to existing technologies, and the perceived risk of promoting an untested product (Day, 1981).

The growth phase is often characterized by a transition to rapid growth in sales and market share, and an increase of competition due to new entrants in the expanding

market. New entrants are often attracted to a growing industry as there is less uncertainty than at the introductory phase, in addition to emerging opportunities for segmentation and the creation of niche markets (Day, 1981). Profit margins also tend to increase during the growth phase (Levitt, 1965).

As the industry matures and uncertainty about the market is reduced, there is often a standardization of products and processes (Abernathy & Utterback, 1978), often referred to as the dominant design (Abernathy & Utterback, 1978; Argyres & Bigelow, 2007; Peltoniemi, 2011). In a mature industry, there is greater emphasis on process innovation and differentiation of products, with only incremental rather than revolutionary product innovation (Abernathy & Utterback, 1978). In addition, sales and growth tend to level off, and products often become commoditized, with customers choosing products based primarily on price and thus leading to an overall decline in prices (Day, 1981). There is also typically a consolidation of organizations in the industry at this stage, as larger organizations gain market advantage due to economies of scale; larger organizations often gain a cost advantage and are able to force out competing firms by putting them out of business or acquiring them (Argyres & Bigelow, 2007). This process leads to a decline in the number of organizations in the industry, and raises barriers to the entry of new players (Argyres & Bigelow, 2007).

Another notable pattern related to a maturing industry is related to changes in the organizational structure itself. Organizations often create specialized divisions as products and processes evolve. “The structure of the organization will also change as it

matures, becoming more formal and having a greater number of levels of authority" (Abernathy & Utterback, 1978, p.46).

The final stage described in the industry life cycle model is that of decline. There is little description of the decline stage in the literature, and it is often grouped together with the mature stage. In addition, there does not appear to be any clear determinant of when a firm or industry has entered the decline stage. However, some researchers report that a declining industry is characterized by lower prices, lower margins, even fewer competing companies (Levitt, 1965), declining sales, and the emergence of substitute products (Day, 1981).

Organizational life cycle theory. A parallel theory to industry life cycle is organizational life cycle (OLC) theory. While ILC theory was originally intended to describe the manufacturing industry, its application to diverse industries is well known (Peltoniemi, 2011). Conversely, OLC is a theory that was developed specifically to describe the evolution of social service organizations; this is pertinent to EAPs due to the prevalence of social workers and other helping professions in the industry, as well as the fact that some EAPs are non-profit. Similar to ILC theory, the organizational life cycle is conceptualized as having four stages: *formation or entrepreneurial stage, maturation or formalization stage, decline or stagnation stage,* and *ending or renewal stage*. The formation stage is characterized as having informal processes and structure but a strong sense of mission. The maturation stage is characterized by a shift to more formalization with respect to structure and procedures, and subsequently increased rigidity. The decline stage may occur if the organization is not able to adapt to changes in policies,

sources of funding, or clientele. Finally, the ending or renewal stage signals either the exit of the organization or in adaptive changes to its mission, operations, programs, and possibly staffing (Phillips & Straussner, 2002).

Conclusion

As described in the literature review, there has been extensive research done on EAP effectiveness with respect numerous issues including clinical outcomes, workplace impact, access to behavioral health services, pricing and cost, and overall return on investment. In addition, EAP utilization rates, satisfaction with services, and the demographics of clients served have also been examined numerous times. Though extensive, much of this research has been criticized as lacking methodological rigor. In addition, there has been some research that examines the effectiveness and attributes of new forms of EAP service provision such as internal compared to external programs, the use of telephone counseling, the use of affiliate providers, and the integration with work/life, wellness, and managed behavioral health. There have also been a number of reviews and articles commenting on the current state of the industry as well as future directions. However, with the exception of studies examining EAP prevalence and market share, the recent literature that examines the changes in the EAP industry as a whole and specifically in EAP organizations themselves have been largely anecdotal. Recent industry surveys that do examine changes in the EAP industry are not specific to non-MBHO EAPs, and do not provide an in-depth perspective of the EAP organizations themselves. There are no studies that specifically examine non-MBHO EAPs, nor any research that specifically looks at the impact of MBHOs on the EAP industry.

The Evolution of External EAPs.

Despite the huge expansion of MBHOs into the EAP marketplace, and their subsequent domination of the industry, there has been no prior research that examines how traditional, non-MBHO EAPs have changed from their original conception, nor any research that specifically examines the impact that MBHOs may have had on this evolution. Therefore, the aim of this study was to examine how and why external, non-MBHO, EAP organizations have changed since the advent of MBHOs in the early 1990s.

Chapter 3: Methodology

Statement of Research Questions

The primary research question was:

- How and why have non-MBHO, management-sponsored, external EAP organizations in the U.S. changed since the advent of MBHOs in the early 1990s?

Related research questions and topics examined were:

- What other factors, in addition to MBHOs, have influenced changes in EAPs since the early 1990s?
- What is the primary mission and focus of the EAPs being examined, and has this changed since the early 1990s when MBHOs became prevalent?

Research Design

Epistemology. This study is based on a post-positivist paradigm. An examination of the post-positivist paradigm, especially in contrast to that of positivism, will help to clarify the reasoning behind the choice to use a qualitative grounded theory methodology to study the research topic. The discussion will begin with a brief review of the general concepts of positivism, followed by an explanation of post-positivism.

The positivist tradition regards data as objectively real and knowable. Positivist theory is aimed at identifying, specifying, and predicting relationships between concepts, and generating new hypotheses (Charmaz, 2006). Positivist social research involves the identification of objective mechanisms and "laws" of human behavior with the goal of illuminating the cause and effect relationships between the two. Positivist research is

deductive and quantitative in nature (Morris, 2006). In a positivist or objectivist approach, the researcher is seen as objective and unbiased, and the social context becomes irrelevant (Charmaz, 2006).

Post-positivism can be said to be in agreement with the main tenets of the positivist paradigm, namely that there is an objective reality. However, in contrast to positivism, post-positivism posits that objective reality can never be fully known or understood, and that it is not possible to step completely outside of the researcher's subjective point of view. Therefore, since the goal is to attain the highest level of objectivity, a post-positivist researcher must be aware of his or her biases, as well as the social context within which the research is taking place (Morris, 2006).

Grounded theory, a form of post-positivist research, uses an inductive, exploratory technique to gather qualitative data, usually through observations, interviews, and document reviews. The goal is to develop rich, contextualized descriptions and analyses of the topics being researched. Unlike the positivist hypothesis testing, post-positivist research is a theory-building technique (Morris, 2006). The data obtained from surveys of the study participants was used only as a method of describing the sample and triangulating the data (Denzin, 1978; Lincoln & Guba, 1985) obtained in the interviews; since the quantitative data is not in itself theory producing or hypothesis testing, it does not impact the underlying paradigm of post-positivism, nor the inductive nature of a grounded theory methodology.

Interviewing individuals within an organization is an effective method of investigating an organization or a process within an organization; these individuals make

up the organization and carry out the processes being examined. Interviewing is a method of accessing information within the context of an individual's behavior, and provides a method for researchers to understand the meaning inherent in the behavior (Seidman, 2006).

The primary purpose of this study is the illumination of how and why EAP organizations have changed since the time that MBHOs became prevalent. The data obtained in this study cannot be divorced from its context, from the biases of the individual interview subjects, or the researcher's own biases. The data obtained is based on the interview subjects' interpretation of what changes occurred, why they occurred, the change process that was employed, as well as the researcher's own interpretation and ordering of the data.

It is important to identify and acknowledge this researcher's biases to assist in mitigating their influence on the study as much as possible. A brief description of my work history and how I came to be interested in the research topic will now be offered, followed by a discussion of the possible impact.

I have been working in the EAP industry for 5 years, and I currently hold the position of Director of Clinical Services at a New York-based, external, management-sponsored, non-MBHO EAP. In addition, I have over 10 years of experience working in a hospital (in numerous positions, including in emergency mental health and as manager of medical social workers). I have also done part-time work in an outpatient mental health clinic, and have seen private clients on and off for 12 years. In my various professional roles I have made numerous referrals to mental health providers and

facilities, and my original interest was in studying the impact of managed care, and specifically managed behavioral health care, on the quality and access to mental health and substance abuse services. It had been my impression that managed care negatively impacted the quality of services by limiting access to services, and limiting choice in terms of providers. My interest in managed care was combined with a newfound interest in EAPs, based in part on the discovery that MBHOs had begun to dominate the EAP industry and that there was no research to date that examined the impact.

This study was aimed at EAP organizations that are very similar to the one where I am currently employed, and the inside view that I have been accorded has been invaluable in identifying likely trends and issues in the industry. However, though I am aware of the evolution in EAP practice that has occurred with my present employer, I was not aware of the overall trends that had occurred across other, similar EAP organizations. So while I have a number of biases based on personal experience, the question of how or if other EAPs had changed remained open to discovery.

This study is very much situated in time, place, and context as it is aimed at identifying how these factors came together to effect changes in the EAP industry. However, this study aimed to do more than merely explain the process of change in EAP organizations, but also to formulate some theories about EAP changes across the industry. To a certain extent the aim of this study is to explain why the changes occurred, and even if the interpretive nature of the data is acknowledged, this requires that the overall changes be viewed as meaningful beyond the local context and therefore to some extent generalizable.

Qualitative design. This research used a qualitative design. Specifically, the study sought data from 26 top managers and leaders at 26 different EAP organizations in the U.S. using qualitative, semi-structured interviews. The information from the interviews was supplemented by two surveys that served to describe the study sample.

Qualitative research in general is indicated if a topic needs further exploration, and detailed information about the topic is needed. A qualitative design is used if the researcher is seeking to answer questions that describe a process, instead of to specifically determine a cause and effect relationship between variables, as would be found in a quantitative study. In addition, a qualitative methodology is the best method to study subjects within the context of their environment (Creswell, 1998).

A qualitative study design was indicated in this study for several reasons. Firstly, there is a lack of any other research that directly examines the impact of MBHOs on the EAP field as well as EAPs' responses; qualitative research was indicated to begin to systematically analyze how and why EAPs have changed since MBHOs became prevalent. In addition, a qualitative methodology enabled the researcher to obtain rich, subjective data from top managers and leaders and helped to explain in detail the changes in business strategy, service delivery, perceived effectiveness, and numerous other pertinent factors that have occurred since the early 1990s. Furthermore, the information that was gained in this manner is not easily quantified, as it relates primarily to the opinions of the subjects about changes that occurred, the reasons why the changes occurred, and the process for effecting the changes. A qualitative methodology was the most effective way to systematically obtain this information and make sense of it.

Finally, the study examined the opinions of EAP leaders who continue to work in the industry and therefore provides a unique perspective from within this environment.

Though there are common elements to all qualitative research, the choice of a particular qualitative approach is based on the central purpose of the research (Creswell, 1998). With respect to this study, a grounded theory approach was used because it is a method that is used to formulate a theory about individual interactions, actions, or responses to a particular situation (Creswell, 1998) that enhances insight and understanding, and offers a guide for action (Strauss & Corbin, 1998). In grounded theory, research data tends to be gathered through interviews, and through the organization of different categories of information a theoretical hypothesis or proposition is presented (Creswell, 1998). A grounded theory approach was used in this study in order to build a theory of how external EAPs have responded to the influence and changes engendered by MBHOs and the changing EAP marketplace. Specifically, this study aimed to gather insight into the changes that have occurred across numerous external EAPs in the U.S. since 1993 by examining the individual responses and actions taken by EAPs (and their leadership) to the changing EAP environment, and the reasons behind those responses. This information was gathered through interviews with EAP leaders currently working in the industry, and supplemented with survey information obtained from the same participants; it is hoped that the results will serve to build the knowledge base with respect to the ongoing evolution of EAP service delivery and mission.

Sample

Sampling method. This study involved interviewing 26 top managers and leaders at 26 unique EAP organizations in the U.S. In grounded theory studies the researcher will usually conduct 20-30 interviews, or enough to saturate the various categories identified (Creswell, 1998; Padgett, 2008). In adherence to this general guideline, 26 interviews with top EAP managers and leaders was deemed to be a large enough sample to identify meaningful trends in the industry. Furthermore, including more this number of interviews was not feasible given the nature of this study (i.e. an unfunded doctoral dissertation study with the doctoral student as sole interviewer).

The universe of EAP organizations that were studied included external, management-sponsored, non-MBHO EAPs in the United States. More specific details about which EAPs were included or excluded from the sample are discussed in the inclusion and exclusion criteria sections to follow. In addition, a discussion of how the initial list of possible EAP organizations to be included in the sample was derived is offered in the sampling frame section.

The primary sampling method for this study was purposive-snowballing. A purposive sampling technique was employed that sought to obtain a sampling frame that included a broad range of EAP organizations in the U.S. However, within the sampling frame a snowballing technique was used to obtain study subjects.

Sampling frame. The overall sampling frame used for this study was drawn from a list of EAP organizations that was put together from several sources. The primary

sources were the provider list from the Employee Assistance Professionals Association (EAPA; http://www.eapassn.org/public/providers/, retrieved 4/6/08), the member directory from the Employee Assistance Society of North America (EASNA; http://www.easna.org/member-directory, retrieved 4 /7/08), EAP organizations listed on an industry web site called EAP List (http://www.eaplist.com/, retrieved 4/6/08), and EAP organizations listed in Open minds yearbook of managed behavioral health market share in the United States 2000-2001 (Fox et al., 2000). In addition, other EAPs identified by industry experts and other sources (e.g. the internet, industry publications, etc.) that were not found in the previous sources were also included.

The sources used to locate EAP organizations were chosen to ensure a broad spectrum of EAPs located throughout the continental United States were included in the study sample. The largest EAP industry organization is EAPA, and so EAP providers from this organization were initially included in the sample. The EAPA member directory was searched for providers who provide services in all areas of the US and internationally (the search criteria included international, local, national, regional, state/province, and state/province wide). In addition, the following criteria were selected: Designs and evaluates existing EA programs and/or provides consulting services to the EAP or work organizations; Provides EA program services to small businesses; Provides Work/Family services, in addition to EA services; Provides Eldercare services in addition to EA program services. These search criteria were used in order to obtain the widest possible sample of EAP organizations nationally. The initial search yielded 395 individuals or organizations. However, any individuals who were listed alone as EAP providers were excluded from the sample. In addition, any organizations that were not

based in the US were also excluded, as were those that were clearly internal EAPs (e.g. hospital based). Any organizations with more than one location or that were listed individually and as part of a group were counted only once. This left 361 organizations.

Added to the EAPA list were those organizations listed in EASNA's member directory that were not redundant (and as before were based in the continental US, were not individuals, and were likely external), a total of 14 additional organizations. EASNA does not list the attributes of their organizational members, so it was not possible to base inclusion on organizational characteristics. Organizations that were not already included in the first two sources and met the same criteria were added from the EAP List website, a total of five additional organizations.

This list was then cross-referenced with Open Minds list (Fox et al., 2000). In 2000 Open Minds surveyed 680 organizations in the US that provided behavioral health and EAP services in order to summarize market trends. From this survey a comprehensive list was created. This list was compared to the list created from other sources, and any non-redundant organization that met the criteria was included in the sample; Organizations that provided only behavioral health services, were known to be MBHOs (e.g. Magellan, Value Options, etc.), were part of unions (i.e. Member Assistance Programs), or were clearly internal (e.g. hospital based EAPs) were excluded from the sample, leaving 237 EAP organizations. An additional four EAPS were added to the list, from personal communications with industry experts.

In summary, the total population of external EAPs that were included in the general sample, was 361 from the EAPA list, 14 from EASNA, five from the EAP List

website, 237 from Open Minds, and an additional four from personal contacts, for a total of 621 from all sources. However, it must be noted that information on the inception of many of these programs was not immediately available, and so some organizations included in the initial sampling list did not meet the inclusion criteria defined below. In addition, the primary data source was top managers and leaders of the EAP organizations included in the sample; those organizations that did not have managers or leaders who met inclusion criteria were also excluded from the sample (as explained in the following sections).

Inclusion criteria. The inclusion criteria included "external, management-sponsored, non-MBHO EAPs," and "top managers." Specific criteria for each will now be offered.

External, management-sponsored, non-MBHO EAP. Due to the diverse nature of EAP programs an operational definition was required in order to determine inclusion in the study. As this study is focused on the changes that have occurred in EAPs, the organizations being studied must still have been generally considered to be "EAPs," or at a minimum to maintain some basic EAP functions as part of their service provision, in order to be included in the sample. An interesting research finding was that many organizations in the study reported that EAP services were becoming a smaller part of their overall service provision. However, there were no organizations that were contacted that were excluded due to a shift away from EAP service provision in favor of an alternate focus. The operational definition of an EAP therefore included organizations whose primary focus included:

1) Self identification as an "Employee Assistance Program"
2) Having at least some services aimed at employee workplace productivity and wellbeing related to behavioral, health, and personal issues due to alcohol and substance abuse, mental health concerns, family and marital issues, financial, legal, other personal issues, as well as the work environment and other attributes of the workplace.

And who address these issues by:

3) Providing direct services to employees such as problem identification, short-term intervention, referral, and/or case management;
4) Providing direct services to employer organizations such as consulting with and training management about dealing with troubled employees in order to improve their work performance;
5) Provide services to employing organizations based on a written policy statement, agreement, or contract that defines the intent and scope of services (Blum & Roman, 1995; EAPA, 2008).

In addition to the above criteria, the initial sampling frame included only external, non-MBHO EAPs that have been in existence since 1993 or earlier, irrespective of size or location. EAP service provision has not been shown to be affected by geographic location (Hartwell et al., 1996), and though service provision has been shown to differ based on industry served, most external EAPs serve a variety of industries (Hartwell et al., 1996; Sciegaj et al., 2001). In addition, since most external non-MBHO EAPs studied were expected to be small or medium sized (i.e. with less than 100 employees), the sample was not determined based on organizational size. However, information

about organizational size, based on the number of employees, the number of covered lives, and the number of client companies served, was systematically obtained for consideration (see Inclusion Survey, Appendix A).

Not all of the organizations on the original list were contacted, as enough participants were found before going through the entire list, and ultimately most participants were referred through personal contacts in the industry and from those who had already participated in the study. However, there was a two-tier process used when contacting organizations included in the original sampling frame of 621 organizations. Before attempting any contact, the researcher looked up information on the organization, primarily using resources on the internet such as EAPA's member list or by examining the organization's web site, in order to confirm the date the organization was founded, as well as to identify contact information for a top manager or leader who could potentially participate in the study. Organizations that were discovered to have been founded after 1993, were found to be internal or union programs, or for which contact information was not available (in some cases because those organizations were no longer in business or had merged with another organization) were not contacted and were therefore excluded from the study. For those organizations that were contacted, three were discovered to have been founded after 1993, and so were excluded. An additional organization was excluded when it did not meet the inclusion definition of an EAP, as it was in fact a human resources consulting firm that did not and had never provided EAP services.

Top managers. For the purposes of this study, top managers were defined as the top tier leadership of the organization, such as president, CEO, or senior vice-president.

While there was some variation in the title of interview subjects, all were in a leadership role within the organization, and had responsibility, oversight, or in-depth knowledge of clinical, operational, and account-services functions (details about the reported titles of study participants is offered in the findings section). In addition, the top managers/leaders that were interviewed for this study were expected to have, at the time of the interview, at least 10 years or more of experience working in the EAP industry. It was considered important that interview subjects have at least 10 years of experience in the industry in order to be able to speak knowledgeably about their organization in the context of the EAP industry as a whole. While this study aimed to examine changes that have occurred in EAP organization since 1993, an EAP manager with 10 or more years of experience is still likely to be aware of the changes that have occurred in their organization since that time, as well as the ongoing changes in the industry. However, it must be noted that one interview subject had only been working in the industry for nine years at the time of the interview. This participant was included in the study for several reasons: this person had been at the same company for the entire nine years and was knowledgeable about all aspects of the organization; this person was in a senior executive position, and so had extensive knowledge about pertinent changes in the organization and the logic behind them; this was the youngest person interviewed, and so had a unique perspective on the industry; and this person had an exclusively business background (as opposed to a clinical background or a business and clinical background) which was shared by only one other interview subject. Including the interview subject with only nine years of EAP experience, there were no prospective interview subjects who were excluded due to lack of industry experience (see question #10 in the Inclusion Survey,

Appendix A). All other study participants had at least 10 years of experience in the industry or more.

Study participants (top EAP managers as defined above) were located primarily through personal connections with EAP professionals and referrals from other study participants, though cold calling and emails were also used to locate participants for the study. Recruitment of study subjects was enhanced due to this author's work in the EAP industry, and membership in EAP trade organizations (EAPA and EASNA).

Exclusion criteria. Exclusion criteria included internal EAPs, member assistance programs (MAPs), organizations directly affiliated with MBHOs, and organizations founded after 1993. Further description of these criteria are now offered.

Internal organizations and member assistance programs. The decision to use external EAPs as the primary data source and to exclude input from internal EAPs as well as member assistance programs (MAPs) stems from several factors. A primary factor in this decision was that the majority of EAPs currently in existence in the U.S. are external (Cagney, 1999; Ensuring Solutions 2006; Hartwell et al., 1996; Heck, 1999) and are management- sponsored (Hartwell et al., 1996; Masi et al., 2004). Therefore a study of external, management-sponsored programs is the most pertinent given the current state of the industry. While internal programs were very likely affected by changes in the industry (e.g. many were closed down in favor of external programs), internal programs' structure, services, and other variables were likely affected in a different way than external programs. Therefore, in order to maintain consistency, and to compare changes in similar programs, only external programs were studied. In addition, MAPs differ from

traditional external EAPs with respect to their focus, interventions, and structure (Bacharach et al., 1994) and were also likely affected in different ways, and so were excluded from the sample. However, it must be noted that there were some variations with respect to participants' descriptions of the auspices of their programs as well as their definition of the external nature of their organization; despite slight discrepancies in these definitions, these organizations were nonetheless still included in the study sample. A justification for these actions is now offered.

While the majority of the organizations studied described themselves as "management-sponsored," 10 out of 26 reported that the auspices of the program varied based on the contract with the client company, and so described their sponsorship as "other" which included some contracts that were union sponsored, joint union and management sponsored, or consortium sponsored. These organizations were still included in the sample because their primary sponsorship was still management-based. Furthermore, there is no evidence in the literature that mixed program sponsorship differs in any significant way from "purely" management-sponsored programs. In addition, one organization described itself as a consortium in that it was started by a group of organizations to serve their employees, though it functioned for all intents and purposes as an externally contracted program in that it marketed itself as an external program and primarily served clients from outside companies; this program was therefore also included in the sample.

Though all studied organizations described themselves as externally contracted programs, many were owned by or were a part of larger social service or health care

organizations. For example, one organization was owned by a substance abuse organization, four were owned by social service agencies, and another four were owned by health care organizations such as hospitals and healthcare networks. However, these EAPs still functioned as externally contracted programs and so were included in the sample. One organization in the sample reported serving some employees of their parent organization, thus acting as an internal program in this respect. However, since the internal employees only made up a small percentage of the overall number of employees served (i.e. less than two percent), the organization was still included in the sample.

Managed behavioral health organization affiliation. Input from leaders at EAPs that are part of larger MBHOs (e.g. Magellan's EAP, Value Option's EAP, etc.) were excluded from the study because this study is primarily aimed at examining how EAPs have changed due to the influence of MBHOs and not about how MBHO-sponsored EAPs have evolved or changed. However, some companies did have some affiliation to managed behavioral health organizations but were nonetheless included in the study. For example, one organization in the sample is owned by a health care organization that also owns an MBHO. However, this organization operated separately from the MBHO and was therefore deemed appropriate for inclusion. In addition, another organization that started as a division of a hospital now has a "dotted line connection" to a health care system that includes an MBHO; because this organization operates separately from the MBHO is was deemed appropriate for inclusion in the sample.

Year of foundation. Finally, only organizations in existence before 1993 were included in the sample, as this study aimed to gain insight into changes that had occurred

in these organizations since that time. As was mentioned previously, only three organizations that were contacted were excluded after it was discovered that they were founded after 1993, though a number of organizations were never contacted at all because they had already been identified as having been founded after 1993. A complete list of the dates of inception of EAP programs included in the sample is offered in the findings section.

Inclusion survey. Prospective study participants who responded to the initial or follow up request(s) of the researcher to participate in the study were first asked to complete the Inclusion Survey to insure eligibility (see Inclusion Survey, Appendix A). All questions in the Inclusion Survey were derived from the inclusion/exclusion criteria already mentioned. Exceptions to these criteria were already discussed earlier in the methodology section.

Subjects were offered two choices with respect to completion of the survey: 1) The survey could be administered by the researcher over the telephone; or 2) a link to the survey could be sent to the subject. In some cases answers to the Inclusion Survey were reviewed by the researcher prior to the initial interview, though in a number of instances the survey was completed on the phone immediately before the interview.

Potential study participants who met inclusion criteria were informed of the study requirements, and were sent IRB-approved informed consent forms (Appendix B). It was explained to prospective participants that their name and demographics, as well as the name of their organization would be kept strictly confidential, and that only aggregated data or information that does not identify the study participant or their organization

would be shared. In addition, study participants were told of their ability to opt out of the study at any time without consequence.

Data Sources

Overview. This study obtained qualitative data through semi-structured interviews conducted with top managers. In addition, quantitative data was collected to describe the sample and for the purposes of triangulation (Denzin, 1978; Lincoln & Guba, 1985). Descriptive quantitative data was obtained through questionnaires given to top managers and completed by them or by other less senior staff members whom they appointed. A total of 26 interview subjects from 26 unique EAP organizations located in the United States were included in the final sample.

The primary units of analysis for this study are the EAP organizations themselves. The primary sources of data used to examine the changes that have occurred in EAPs are the top managers and leaders at the organizations being studied. Top managers are often "the most veridical informant about important organizational changes" (Huber et al.,1993, p. 222). Top managers were used as the subjects of the study because they can be seen as key informants who were likely to be aware of the environmental changes facing their organization, as well as the corresponding changes within their organization in response. Furthermore, top managers were able to explain the logic behind any organizational changes that have occurred. In addition, interviewing top EAP managers and leaders was the most efficient and feasible method of obtaining data for the purposes of this study.

Instruments. The instruments used in this study include an interview guide, an interview subject survey, and an EAP questionnaire.

Interview guide. The open-ended questions used in the interviews are contained in the interview guide (see Interview Guide, Appendix C). The interview guide outlines questions pertaining to changes that have occurred in EAP organizations since 1993, and specifically how and why these changes occurred. It is important to note that some new questions were added, based on new and unique ideas that emerged as the study progressed. One such question pertained to the prevalence of benefits brokers and consultants that emerged as a significant change in the business environment in which EAPs operate. In addition, questions about ownership and any affiliations with parent companies were added as well when the topic was identified by several participants. Other emerging themes that were explored more systematically once initially identified by some participants included: the creation of specialized programs, the use of standardized substance abuse assessment tools, changes in profit margins, and changes in organizational name or descriptors. The final interview guide reflects the updated questions that emerged throughout the study. In addition, the way some questions were worded changed as the study progressed due to misunderstandings from participants. A primary example of this pertains to the question about the process of change; many participants were unclear about what was being asked in this question, and so a new way of expressing the idea was developed that elicited a better response. The interview guide covered the following areas: general internal changes such as mission and perception of value; specific internal changes such as services provided and staffing; external changes

such as changes in the business environment; and specific questions about the impact of MBHOs.

Interview subject survey. Interview subjects completed a short demographic survey (see Interview Subject Survey, Appendix D). The data from this survey was used to describe the sample of top managers. The survey included questions about participant's demographics and professional characteristics.

Employee assistance program questionnaire. Additional data for this study was obtained through the use of a questionnaire (see EAP Questionnaire, Appendix E). The questionnaires sought information about the current status of the EAP organizations where respondents work, including information on location, size, and clients served.

Data Collection Procedure

Semi-structured interviews. Qualitative data was obtained through semi-structured interviews with 26 top EAP managers and leaders. The 26 initial interviews were conducted from December 2010 through November 2011, using open-ended questions derived from the interview guide. The purpose of open-ended questions is to explore and expand upon the respondents' answers to the questions (Seidman, 2006). The use of open-ended questions in the interview tends to elicit the most in depth, comprehensive information from the research subject (Atkinson, 1998). Semi-structured interviews use the same set of open-ended questions that are asked in sequence and cover the key domains of interest for the study (Padgett, 2008). The researcher referred to the interview guide to insure that the main areas of the study were covered, though the

sequence and actual wording of the questions changed somewhat based on the flow and context of the interview.

The best interviewer is able to observe how the interview process is unfolding, and be adaptive in terms of guiding the interview subject; by anticipating what question to ask next, and encouraging the interview subject with verbal and non-verbal cues, the interviewer can connect with the interview subject and obtain the richest data (Atkinson, 1998). There are three primary types of questions that are effective with narrative interviews: "open-ended descriptive, structural, and contrast questions" (Atkinson, 1998, p. 41). Descriptive questions are open and general, structural questions ask about how knowledge or activities were organized, and contrast questions examine different dimensions of meaning (Atkinson, 1998). All three types of questions were used during the interviews conducted for this study. In addition, as was previously mentioned, some new questions were added based on areas of interest that emerged during the interviews.

The semi-structured interviews were conducted by telephone for interview subjects that do not live in close proximity to New York City or who could not conveniently meet in person; only one interview was conducted in person. Telephone interviews, while not the first choice for qualitative studies, are often used when respondents are not available to be interviewed in person due to distance or other reasons. Telephone interviews allow for audio recording, and so intonation and tone of voice can also be obtained and analyzed. Audio recording allows the interviewer to concentrate on the interaction at hand and can also capture more detailed information than notes such as sarcasm, tone of voice, or other aspects of the live interview that may be pertinent to the

study (Padgett, 2008). All interviews were digitally recorded and later transcribed. Similarly, the in-person interview was recorded in order to insure consistent and accurate data collection.

In-depth interviews are usually set up in advance and are ideally conducted in a private, comfortable setting (Padgett, 2008). Initial contact with potential interview subjects was made primarily through email, followed by a telephone call. For the interviews it was suggested to subjects that they go to a quiet, comfortable place where interruptions could be minimized. All interviews were conducted during work hours, and all but two interview subjects were at their place of work during the interview; interruptions were not a problem and were rare. On three occasions the recording was stopped for several minutes due to a minor interruption or phone disconnection, and then re-started.

At least two interviews or more per respondent are recommended in order to obtain detailed, contextual information from respondents (Seidman, 2006). Interviews were all conducted by the researcher and consisted of the primary interview and in some cases one follow-up telephone interview. Participants were also contacted via email for follow up. Participants were asked to devote 90 minutes to the initial interview, as this is the length of time suggested for qualitative interviews in order to give respondents time to reconstruct, reflect upon, and situate their experience (Seidman, 2006). In addition, participants were asked to devote 30 minutes for the follow-up interview, though this interview was not deemed necessary for all participants due to due data saturation. The average time for all initial, recorded interviews was 79 minutes with a range of 54

minutes to 104 minutes. The time given by all interview subjects was adequate to obtain rich, detailed information that was then used in the data analysis. The initial interviews were all transcribed into a text document in Microsoft Word. All transcripts were single spaced, and averaged 23 pages in length each. All together, the transcripts were 602 pages in length.

All participants received a follow-up email with an attached copy of their interview transcript. Participants were given the opportunity to add to, amend, or delete any statements they had made in the interview transcript. Participants were also asked to confirm the accuracy of the interview data. Communication for this stage of the study was accomplished exclusively via email for all subjects. Three participants did make minor changes to their transcript, and two more asked that names of client organizations be removed from the transcript, which was done.

The follow up telephone interviews took place after all initial interviews had been completed and the data analysis process had begun. These interviews were used to confirm and expand upon themes that were emerging from the data gleaned from previous interviews (Padgett, 2008). In all, 13 such interviews were conducted in January and February 2012. The follow up member checking interviews were not recorded, and were approximately 30 minutes in length each. These conversations served to confirm the primary theoretical model that was emerging in the data. In addition, these interviews helped to further refine some other emerging concepts such as the importance of EAPs' relationship with client companies, the prevalence of specialization, and the lack of changes in pricing for some organizations. In two cases, the EAP survey was

completed during the follow-up conversation for those who had not previously completed it. It was determined that 13 interviews were sufficient when saturation was reached and no new information or clarification was obtained.

Interview subject survey. Interview Subject Surveys were administered by the researcher at the beginning of the initial interview. As previously stated, this descriptive information was used to further describe and contextualize the semi structured interview data by providing information about participants' age, experience, and credentials.

Employee assistance program questionnaire. EAP Questionnaires were sent electronically to participants once they had agreed to take part in the study. Participants received a link to an online survey, and were also given the option to complete the survey in text document and email it back to the researcher. Participants who did not complete the EAP survey received reminder emails and in some cases telephone calls. Out of 26 participants who took part in the study, 22 completed the survey. One survey was partially completed by a participant; only the initial page was completed, representing less than 20 percent of the entire survey. Two participants did not complete the EAP survey at all and did not respond to follow up communications asking for completion.

Methods of Data Analysis

Qualitative data analysis. Grounded theory is primarily inductive, though sensitizing concepts and other theories from the research literature also play a part. Sensitizing concepts are used as a framework for conceptualizing the data (Charmaz, 2006; Padgett, 2008), and are based on research interests, theories, and general concepts

that help to focus the researcher on specific areas to study and the kinds of questions to ask related to the topic (Charmaz, 2006). A review of the theoretical framework will now be offered, followed by a brief description of assistive software used, and the process of theory development.

Theoretical framework. The sensitizing concepts that made up the theoretical framework of this study include the general concept of organizational change and more specifically complex adaptive systems (CAS) theory applied to organizational change (Stacey, 2000). In addition, industry life cycle (ILC) theory (Klepper & Grady, 1990; Klepper, 1997; Peltoniemi, 2011; Potter & Watts, 2011) and organizational life cycle (OLC) theory (Phillips & Straussner, 2002), were also used. These theories helped to illuminate some of the trends seen in the industry, and assisted in the formulation of a theoretical model; a brief explanation of their application is now offered.

CAS theory gives a framework through which EAP evolution can be understood. This theory is particularly helpful in illustrating the complex, non-linear market interactions and influences and how they impacted EAP organizations. EAP organizations can be viewed as autonomous agents that have co-evolved with other EAPs in order to survive in the face of a changing environment. Since the EAPs were all likely to have faced similar market pressures, it was expected that their adaptive responses would also be similar. The process of adaptation can also be explained using the CAS concepts of dissipative structures and “the edge of chaos”. The edge of chaos can applied to the management structure of the EAP organization, which could be expected to be neither too rigid nor too diffuse in order to be flexible enough to adapt. In addition,

dissipative structures are process where energy from the environment is dissipated through the EAP organization, leading to novel new forms; this concept helps to show how market demands are transformed into new services. By examining the data with the CAS perspective it was possible to identify themes and trends in the adaptive responses of EAP organizations, and in this way formulate a theory of EAP evolution.

The theory of industry life cycle was incorporated into the data analysis process due to the emergence of some themes and trends seen in the data related to changes in EAP organizations over time; a theory that could help to explain some of the changes in EAP organizations was sought. The theory of industry life cycle (ILC) was chosen because of its applicability to some of the observed changes in EAPs over time and it's utility in establishing a pattern to these changes. The ILC theory compliments rather than replaces the already defined theory of complex adaptive systems (CAS). ILC theory was helpful in situating and making sense of the data, both in how the data conforms to this theory as well as the ways in which it does not. ILC theory was used primarily as a method of determining the evolutionary stage of the EAP industry.

Finally, organizational life cycle theory was also used to help interpret the data. This theory was helpful because it also examines organizational evolution, but can help explain changes in social service organizations. Because EAPs are staffed by social workers and other helping professions, it was thought that this theory could also help explain some of the changes in EAPs over time. OLC theory was particularly helpful in explaining changes in EAP organizations that were not accounted for by ILC theory.

Data analysis software. In order to assist with the coding process, the Atlas.ti v6 computer program (ATLAS.ti Scientific Software Development GmbH, 2009) was used. This program assists researchers to organize, search and code qualitative data. Atlas.ti is one of the best qualitative data analysis programs available (Lewis, 2004). In addition, Atlas.ti appears to be more user friendly than similar programs, and this researcher was somewhat familiar with the program having taken an introductory course about its use in the past.

Grounded theory analysis. All of the transcribed data from the 26 initial interviews was loaded into Atlas.ti for analysis. The initial process involved open coding of data. Open coding is when the researcher segments the initial information being gathered into general categories, and then into subcategories based on the various properties found in the data (Creswell, 1998). The initial open coding process involved line-by-line coding of two study transcripts that yielded a total of 589 initial codes. In reviewing the codes it became apparent that many were redundant or much too detailed and were unhelpful in making sense of the data; these codes were combined or eliminated. As Padgett (2008) points out "codes are provisional and subject to change, either through clarification and revision or outright elimination" (Padgett, 2008, p.153). For example, "increasing volume of clients served" and "changing number of individual clients served" were combined to "serving more clients." In addition, some very specific codes such as "doing effectiveness surveys –reasons for," and "doing effectiveness surveys – surveying individual clients" were combined to a more comprehensive code, "doing effectiveness surveys." The list of 589 initial codes

was combined and narrowed down to a list of 47 codes such as "changing company name," "commenting on effectiveness," and "changing prices for EAP services." The new code list was input into Atlas.ti and used to analyze a third transcript. While there was much more agreement with the codes and the data, a number of codes had to be renamed to better reflect the data they were representing and reduce confusion about which code was the best fit for a particular concept derived from the data. For example, the code "responding to what client companies value" was revised to describe what the actual responses were, such as "offering new services," and "specializing." Another technique used to increase the utility of the codes was to export the list of quotes attached to a code, and then re-assign some of the quotes to other codes or create new codes that better explained the data. For example, a number of quotes in the code "changing market demands" fit better in two other codes: "marketing and promotion strategy," and "evaluating and showing EAP effectiveness."

Throughout this process, a comprehensive code list was generated that listed categories and primary codes. For example, a category of "offering services" was created with primary codes such as "offering new services," "offering onsite services," and "creating stand alone products." This was the beginning of axial coding. Axial coding entails further categorization of the data after open coding (Creswell, 1998). Specifically, axial coding is the process of reorganizing data that were separated out or fractured during open coding, and helps to contextualize the phenomenon being studied (Strauss & Corbin, 1998). A technique employed to assist with axial coding was to print out all of the codes arranged in a list. The individual codes were grouped according to similarities. In this way a refined coding list was created with categories and primary codes. For

example, a category was "being impacted by changes in the business environment," with primary codes such as "working with benefits brokers/consultants," "being impacted by MBHOs," "changing laws and regulations," and "being commoditized."

By going over several more transcripts the coding list was further refined and collapsed down to 51 unique codes. A code list with specific definitions was used to help keep each code as consistent as possible. Constant comparison, code output review, and consultation were used in an ongoing manner throughout this process. After coding 10 transcripts with the new codes, the list was further narrowed down to 45 codes that were then applied to the remaining transcripts. The final code list included "defining EAP mission," "desiring employee skills and credentials," and "changing modality of service provision." Further analysis was conducted to determine how these codes related to each other in order to develop a theory of EAP evolution.

A helpful technique used to help show how the axial codes fit together was to split them into causal conditions/context, intervening conditions, action strategies, and consequences (Strauss & Corbin, 1998). The primary phenomenon that emerged was "surviving." For example, under conditions/context was included the code "competition from other EAPs." Intervening conditions included "smaller margins," and action strategies included "offering new products and services," and consequences included "increased efficiency."

In order to keep track of the coding process, and the logic for decisions being made, a detailed log was kept. This can be considered a form of *audit trail* (Lincoln & Guba, 1985). The log listed both theoretical concepts as well as coding issues and ideas.

In addition, theoretical memos (Padgett, 2008) were input into Atlas.ti that linked theoretical concepts directly to examples in the data. One of the concepts that was considered in a theoretical memo was "specialization." It was noted that this concept was part of industry life cycle theory, and also that it was a technique used by EAPs to remain competitive. Other survival strategies also became apparent, such as "improving efficiency," and "offering new services." Using the phenomenon of "surviving," the process of selective coding was employed to further flesh out evidence of this emerging theme. Selective coding is the process of further refining and integrating categories in order to form a theory (Strauss & Corbin, 1998). Through the use of selective coding, a set of strategies emerged that all seemed geared toward organizational survival.

The process of *theoretical sampling* is the search for additional data to support or refute an emerging theory (Padgett, 2008). A theory was conceptualized to explain what the survival strategies had in common, and theoretical sampling was used to check whether the new theory fit. Initially, the common thread appeared to be that all EAPs continued to focus on the workplace and on employee productivity. There was ample evidence in the data that supported this trend. Many participants explained that a workplace focus was still an essential part of their mission, and all organizations in the study reported focusing primarily on workplace services. In addition, the importance of a workplace focus was emphasized in the literature (Blair, 2004; Mannion, 2004; Roman & Blum, 1985, 1988; Sharar, 2009). However, it was discovered that though a workplace focus was still prevalent, some EAPs had started creating spin-off services that did not adhere to this principle. Spin-off services are not focused on the workplace and do not serve employees, though they still function using traditional EAP interventions and

infrastructure. The discovery of spin-off services necessitated refinement in the emerging theory to explain all of the variation seen in the data; while not all of the survival strategies kept an exclusive focus on workplace wellbeing, they did all still address the broader concept of human wellbeing.

Simultaneous to the process of theoretical sampling, the process of *member checking* was employed (Lincoln & Guba, 1985). Member checking was instrumental in gathering further evidence directly from participants to clarify elements of the emerging theory. Through member checking the impact of social work and clinical professions on EAPs was confirmed, and the elements that comprised the changing market and survival strategies were further clarified. The theme of human service in all survival strategies was also confirmed. Since the final list of themes and subthemes appeared to capture all pertinent data (Padgett, 2008), the categories were considered saturated.

Quantitative data analysis. Descriptive quantitative data for this study was obtained in two ways: through the Interview Subject Survey (Appendix D), and through the EAP Questionnaire (Appendix E). The data from both questionnaires was aggregated in order to show the overall attributes of interview subjects and the overall attributes of the EAP organizations being studied. In addition, descriptive information about organizational staffing and services was used as a method of triangulating (Denzin, 1978; Lincoln & Guba, 1985) the emergent findings from the interviews.

The aggregated information from these sources is displayed primarily in table format, preceded by a brief summary and explanation of the data displayed in the tables. Univariate analyses were conducted on the quantitative data to show frequencies for

categorical data, and means, averages, and standard deviations for continuous data. Analysis was done using Microsoft Excel.

Trustworthiness of Data and Research Rigor

Lincoln and Guba (1985) identify several methods of improving the trustworthiness and rigor of qualitative data including the concepts of credibility, transferability, dependability, and confirmability that correspond respectively to the conventional research terms of internal validity, external validity, reliability and objectivity. Credibility can be explained as "the degree of fit between the respondent's views and the researchers description and interpretations" (Padgett, 2008, p.181). Transferability refers to the generalizability of the study findings. Dependability, also referred to as auditability, is the degree to which the procedures used in the study are documented and able to be traced. Finally, confirmability is the ability to link the study's findings to the data (Padgett, 2008).

Triangulation, member checking, and peer debriefing are all methods used to improve the credibility of qualitative research data (Lincoln & Guba, 1985). Each of these techniques will now be briefly described, and the logic of their use explained. The first technique, data triangulation, involves the use of multiple data sources in order to provide a more comprehensive view of the study topic (Denzin, 1978). The descriptive information in the questionnaires can be seen as a form of data triangulation because information from the survey was compared and contrasted with information obtained in the interviews in order to improve credibility. The questionnaires were used to supplement some of the interview data with factual information about the organization in

its present form. None of the data from the surveys contradicted information given in the initial or follow up interviews.

Member checking is a technique where groupings and conclusions are tested with members of groups where the data was collected (Lincoln & Guba, 1985). In this study, member checking occurred primarily with the second interview of some of the top EAP leaders. The emerging categories and tentative conclusions were reviewed with participants in the second interview, and several concepts were clarified and confirmed. The second interview also assisted with the expansion and development of themes and ultimately helped to confirm the emergent theory of EAP evolution. It must be noted that only half of the participants took part in the member checking interviews, as this was deemed sufficient to confirm the findings.

Peer debriefing allows members to get the support of other qualitative researchers, and also serves as a method of reducing researcher bias (Padgett, 2008). To this end, this researcher attended NYU's qualitative research support group in order to review tentative research findings and receive guidance and support about the qualitative research process.

An "audit trail" is a method used by researchers to improve the dependability of the research data. This technique involves keeping notes and records about the research process for review during and after the research has been completed (Lincoln & Guba, 1985). Memo writing is used as a method of documenting analytic decisions (Padgett, 2008), and was used in this research as a method of keeping an audit trail. Memos are used to record the thoughts and feelings of the researcher to help to keep track of the progress of the research and to explain decisions that were made along the way; memos

are essential in order to help make sense of the data and are an integral part of theory development (Strauss & Corbin, 1998). Memos were inputted into Atlas.ti that were linked by the program to specific data, and were reviewed frequently during the data analysis process. In addition, a 58 page (single spaced) document was created in Microsoft Word that chronicled the emerging coding process, highlighting thoughts, concerns, and emerging ideas. This process was instrumental in making sense of the data and formulating a theory.

Discussion of Ethical Issues

As human subjects were a part of this study, approval was obtained from New York University's Institutional Review Board, the University Committee on Activities Involving Human Subjects (UCAIHS), before any research began (see Appendix F, UCAIHS approval notice). In addition, all participants were sent a statement of the scope of the study and their rights as potential participants (see Appendix B, Statement to Subjects). However, the information that was obtained for the purposes of this study had a low probability of causing harm to individual participants. The information obtained in interviews and through the questionnaire was unlikely to and did not in fact elicit an emotional response from participants, as it pertained to organizational change and not to personal emotional issues. However, participants were not pressured in any way to participate, and were informed of their ability to withdraw from the study at any time without consequence. Participants were also informed of their right to have any specific information removed from the study report.

One aspect of the study that could have caused some concern on the part of participants was related to confidentiality pertaining to client information and business information. In order to safeguard against disclosure of sensitive information, identifying company information such as organizational name and specific location remain strictly confidential. Interviews were recorded by the author using a digital sound recorder, and then transcribed by a neutral third party from a reputable transcription company. No specific company, individual, or place names appear in the study write up, nor was any sensitive personal or business information shared with anyone. In addition, respondents were given opportunity to review transcripts and remove or amend any statements contained therein. Several participants did in fact make minor changes to their transcript, and several also asked that client company names be removed from the transcript, which was done.

Chapter 4: Findings

This chapter is divided into two primary sections, a sample description section and a thematic section. The descriptive information helps to describe the attributes of the sample. The thematic section summarizes the major themes and subthemes that emerged in the study related to the changing business environment in which EAPs operate, as well as the survival strategies employed in response. Data that answers the research questions pertaining to how and why EAPs have changed, the influence of MBHOs and other factors, as well as specific changes in EAP mission and focus is illustrated in the thematic section and then further examined in the discussion section. Using the emerging themes and subthemes, a grounded theory analysis of EAP evolution is offered in the discussion section.

Sample Description Section

A detailed sample description will now be offered that includes participant demographics and professional characteristics, as well as general organizational characteristics, staffing, service provision, and service integration.

Study participants. As shown in Table 1, the average age of study participants was 55, and most identified as Caucasian and male, though there were eight female participants. In addition, study participants were experienced professionals who had extensive knowledge of their organization and the EAP industry, as shown in Table 2. The majority of study participants held the most senior position at their organization and identified as President, Chief Executive Officer (CEO) or Chief Operating Officer

(COO), and several were owners or co-owners. In addition, the majority of study participants identified themselves as mental health professionals; only three participants did not have a clinical degree, one of which had a business degree (Master of Business Administration). Participants had clinical degrees in social work, psychology, counseling, divinity, education and rehabilitation counseling; the single most prevalent profession amongst participants was social work (Master of Social Work or PhD in Social Work). Two participants had both a clinical degree as well as one of the following business degrees, respectively: Master of Business Administration, Master of Public Administration. A majority reported having a Certified Employee Assistance Professional (CEAP) certification. Three participants also reported having certification in addictions treatment such as Certified Addiction Counselor (CAC), and two had a Substance Abuse Professional (SAP) certification.

Table 1. Participant demographics

Years of age	(N=26)	
M	55	
Range	39-71	
SD	8.18	

Gender	(N=26)	%
Male	18	69
Female	8	31

Ethnicity	(N=26)	%
Caucasian	24	92
Hispanic	1	4
Unknown	1	4

Table 2. Participant professional characteristics

Title	(N=26)	%
President/CEO/COO	17	65
Vice President	4	15
Director	5	19

Credential	(N=26)	%[a]
Ph.D social work	2	8
Other Ph.D.	2	8
MSW	10	39
Other Master's degree	10	39
Clinical licensure	19	73
CEAP	14	54
SAP	2	8
Addictions credential	3	12
MBA/MPA	3	12

Years at company	(N=26)	%
1-4 years	1	4
5-9 years	4	15
10-14 years	2	8
15-19 years	7	27
20 or more years	12	46

Years in EAP industry	(N=26)	%
1-4 years	0	0
5-9 years	1	4
10-14 years	2	8
15-19 years	4	15
20 or more years	19	73

[a] Percentages add up to more than 100 because individual participants had multiple credentials.

EAP organizations. As shown in Table 3, the sample included a wide range of EAP organizations with respect to general characteristics. The study sample included organizations from all four regions of the United States, as defined by the United States Census (2010): Northeast, Midwest, West, and South. In addition, the EAP organizations in the sample were well-established organizations serving a large number of employees nationwide. Nineteen of the organizations included in the sample identified as being for-profit, and seven identified as being non-profit. In addition, two organizations reported that they had an EAP organizational accreditation from the Council on Accreditation (COA), and one reported accreditation from the Commission on the Accreditation of Rehabilitation Facilities (CARF).

***Staffing*.** The EAP organizations in the sample had a wide range of internal staffing numbers and staff credentials, as shown in Table 4. The single most prevalent profession reported on average was social work (i.e. Master of Social Work). However, there was a wide variation from one organization to another, and not all organizations had social workers on staff. The reported addictions credentials of staff included certifications such as Certified Alcohol and Substance Abuse Counselor (CASAC). Data on the reported number of staff with Substance Abuse Professional (SAP) certification, and Certified Employee Assistance Professional (CEAP) certification is also included.

Table 3. General organizational characteristics

Location	(N=26)	%
Northeast	9	35
Midwest	9	35
West	4	15
South	4	15

Service area	(n=23)	%
International	6	26
National	11	48
State/regional	6	26

Covered Lives	(n=23)
Total	8, 617, 600
M	374, 678
Range	26,000 – 1, 500, 000
SD	460, 477.30

Total clients served	(n=20)
Total	284, 196
M	14, 210
Range	540 – 148, 000
SD	32, 965.22

Number of client Companies	(n=23)
Total	3425
M	149
Range	35-350
SD	87.04

Years in business	(N=26)
M	27.6
Range	18-38
SD	5.23

Table 4. Staffing

Total staff	(n=23)	
M	21	
Range	4-83	
SD	17.57	
Staff with MSW	**(n=23)**	**%**
M	6	25
Range	0-38	0-86
SD	9.03	21.85
Staff with clinical license	**(n=23)**	**%**
M	9	39
Range	0-38	0-85
SD	10.14	26.94
Staff with addictions credential	**(n=22)**	**%**
M	2	12
Range	0-14	0-50
SD	2.98	12.01
Staff with SAP	**(n=22)**	**%**
M	2	15
Range	0-11	0-50
SD	2.5	14.72
Staff with CEAP	**(n=20)**	**%**
M	3	22
Range	0-8	0-67
SD	2.42	17.35

Service provision. Participants were asked whether their organization currently offers EAP core technology services as defined by EAPA (2008). As shown in Table 5, the majority offered most or all of the core technology services. The least often reported core technology function was related to assisting organizations with provider contracts.

In addition, not all participants reported offering assistance to client companies with health benefits issues, and one organization reportedly does not measure any impact of EAP services on employees.

Table 5. Core technology services currently offered by EAPs

Service	(n=23)	%
Consultation and training to organizational leaders and managers concerning employee performance issues.	23	100%
Outreach and education of employees and their dependents about availability and services provided by the EAP.	23	100%
Confidential assessment services for employees (clients) with personal or workplace issues.	23	100%
Short-term intervention services for employees (clients) with personal or workplace issues.	23	100%
Referral of employees (clients) for diagnosis, treatment, and assistance of their personal or workplace issue.	23	100%
Case management and follow-up services with respect to clients who received EAP services.	23	100%
Identification of the effects of EAP services on the work organization and individual job performance.	22	95.7%
Assistance to work organizations to support employee health benefits covering medical/behavioral problems, including but not limited to: alcoholism, drug abuse, and mental/emotional disorders.	18	78.3%
Assistance to work organizations with respect to managing provider contracts, and in forming and auditing relations with service providers, managed care organizations, insurers, and other third party payers.	13	56.5%

Service integration. Integration of work/life, wellness, and consulting services was prevalent among EAP organizations studied, as shown in Table 6. All but one organization reported offering work/life services to clients, though several reported offering only web-based work/life services. The majority of the EAPs in this study report offering work/life services using an external contractor, though the majority offered organizational consulting services in-house.

Table 6. Location of service providers for integrated services

Location of work/life provider	(N=26)	%
External contractor	19	73
In-house	3	12
In-house and contractor	3	12
Service not offered	1	4

Location of wellness provider	(N=26)	%
External contractor	13	50.
In-house	5	19
In-house and contractor	4	15
Service not offered	4	15

Location of organizational consulting provider	(N=26)	%
External contractor	3	12
In-house	18	69
In-house and contractor	4	15
Service not offered	1	4

Thematic section

The primary themes that emerged from the grounded theory analysis can be divided into two categories: 1) The changing EAP market, and 2) the survival strategies that were developed by EAPs in response to the changing market. An emergent theory of EAP evolution was developed from these two categories.

The changing EAP market. Study participants were asked a number of questions about the changing business environment and its impact on their organization and the EAP industry in general. Participants' responses about the changing EAP market answer the research question concerning what factors, in addition to MBHOs, have influenced changes in EAPs since the early 1990s. In addition, responses about the changing market begin to answer the research question concerning the reasons why EAPs have changed since the emergence of MBHOs.

The primary market changes can be broken down into the following categories: MBHOs, disability insurance and other insurance products with embedded EAP services, the emergence of brokers and benefits consultants, competition from other EAPs, and changing company demands. The primary themes concerning the impact of the aforementioned market changes on EAPs were the perception of EAP as a benefit, changes in the perception of value, and changing prices. The three themes as well as 10 subthemes are listed in Table 7 and subsequently explained.

Table 7. Changing market themes and subthemes

Theme	Subtheme
1. Perception of EAP as a benefit	1.1 MBHOs 1.2 Benefits brokers and consultants
2. Changes in the perception of value	2.1 Changing company demands 2.2 Benefits brokers and consultants 2.3 Commoditization
3. Changing prices	3.1 MBHOs 3.2 Insurance products 3.3 Devaluation due to price 3.4 Lower margins 3.5 Influences

1: Perception of EAP as a benefit. A noted trend that significantly impacted the evolution of EAPs in the United States is the perception by client companies, MBHOs, and benefits brokers/consultants that EAP services are a medical benefit and not a workplace performance management tool, changing the dialogue about the purpose and main functions of an EAP. This change was attributed by study participants primarily to MBHOs, and reinforced by benefits brokers, benefits consultants, and the client companies themselves.

1.1: MBHOs. MBHOs often use EAPs as an add-on to sell insurance products, causing EAPs to be viewed as "more of a managed care product" and ultimately changing the perception of the original EAP concept. The combining of EAP with behavioral health products causes confusion for some purchasers who are often not able to distinguish a more traditional EAP from a managed care product that has little connection to the workplace. As a participant explained,

> The first six sessions of your mental health and substance abuse benefit are called EAP. And it's sort of moving EAP away from being a workplace service that includes counseling for the purpose of making sure employees are healthy so they'd be at work….but sort of inserting it as the first number of free sessions and then…[making] EAP seem equivalent to counseling. And counseling is part of what we do but it's … it's diluted the message.

1.2: Benefits brokers and consultants. Benefits brokers and consultants reinforced the view of EAP as a benefit by pushing to integrate EAP with behavioral health and defining it as part of a comprehensive behavioral health plan. Brokers' and consultants' tend to apply the same techniques for buying EAP services that they applied to buying health benefits. A participant noted, "they're framing the discussion around what they're used to, which is medical benefits, like an insurance company." In addition, EAPs being viewed as a benefit reinforced the relationship between EAP and benefits brokers. For example, one participant pointed out, "as EAP became more and more viewed as a benefit, employee benefit and living in that space, it started to get, migrate into the broker community much more aggressively."

In the past, most EAPs were able to deal directly with companies seeking EAP services, but today most new EAP business is obtained through brokers and consultants, and it is often not possible for EAPs to speak directly with prospective client companies. As one study participant mentioned, "even 10 years ago, you could reach out to get in the door of XYZ Company. Well, rarely does that happen anymore because the true gate keepers…are insurance brokers." Since most client companies' today tend to access EAP

services through benefits brokers and consultants, they often adopt the same view of EAPs being a healthcare benefit.

2: Changes in the perception of value. Companies often don't realize what the EAP does or why it's valuable. Companies' understanding of EAP value was thought to be a significant factor related to their willingness to pay for EAP services, and the level of attention paid to the quality of service provision. For example,

> You have clients who really understand how an EAP can help them on a number of different levels. Those are the ones that are going to be more engaged, see more of the value in a program like this. You have others who sort of get it but really don't. Middle of the road. Won't put much into the relationship. They just want to have it in case somebody needs it. Then you have another group that they can barely acknowledge the value. Maybe they're checking a box that says must offer EAP...and clients in that latter bucket are more likely to buy an EAP through a disability carrier if they don't really, really see the value or understand the value.

Another participant further emphasized the importance of companies understanding the value of EAP services, stating that,

> Over the past ten years at least, people who didn't value the interaction of the EAP with the management level of an organization have gone to telephone services. And we have kept those who value knowing who they're talking to and who respect our advice.

2.1: Changing company demands. Many companies have changed their view about what EAPs can and should offer, and this influences and is related to their perception of EAP value. Companies are asking that multiple products such as work/life and wellness services be integrated with the EAP to make access and administration easier, and are also asking EAPs to locate ancillary services for them such as outplacement, or to partner with other firms to provide services. Furthermore, most companies are demanding greater geographic coverage, and more services for less money. Client companies are also recognizing EAP's value in areas such as health and wellness,

> What is absolutely on everybody's mind is bringing health care costs down because that's had a significant impact. I think that there's an appreciation for our services and how that can help in terms of having a positive impact on their own, on an employer's health care expenditures. And that's why I stated earlier the relationship between what we do and other health and wellness projects and initiatives.

*2.2: Benefits brokers and consultants***.** Companies' perception of EAP value was significantly influenced by benefits brokers and consultants who often themselves do not understand the value of traditional EAP services and have little incentive to become educated, as their profits related to EAPs are only a fraction of what they receive when selling a healthcare product. Brokers and consultants tend to apply the same techniques for buying EAP services that they applied to buying health benefits, and the questions they use to determine value are based on the same things used to evaluate an insurance

product.

> Everybody grouses about how EAP has become a commodity. And to me the prime reason is because it's health benefit brokers and how they evaluate EAPs is they put everything into a spreadsheet and so instead of looking at sort of the nuances of what we do which is really where the bang for the buck is, they just kind of look at how many therapists do you have in your network? And how many rings, how many seconds to answer the phone? Or things that are non-issues for us but somehow become the basis of an evaluation.

2.3: Commoditization. A significant market factor related to the perception of value of EAP is commoditization. Commoditization occurs when all EAPs are viewed as equivalent and having essentially the same value. A study participant explained,

> I think EAP has become a mature product in the marketplace. I think the marketplace includes a lot of people who are very sophisticated in business and not coming out of a professional or academic environment. Like EAP growing out of that and labor. And I think in some ways as a mature product, it's become a commodity along with much of the rest of behavioral health care and health care in general.

3: Changing prices for EAP services. Most EAPs reported a significant drop in prices for EAP services from 1993 to 2011. Reasons for price decreases are related to the influence of numerous market changes already mentioned such as the entry of MBHOs and benefits brokers into the EAP industry. A study participant summed up these trends and explained how they interacted to lower the overall prices for EAP services.

> A lot of things that contribute to why the prices have reduced. Any product over time is going, the pricing is going to reduce. Demand is less, you've got more companies that offer it. Consultants are involved. Their job is to find the best program at the best price. Just the fact that a consultant is involved is going to force very competitive rates. You have certain EAPs who already have an exit strategy. They're going after business by quote unquote buying the business. So they go in low and everybody has to be close or they won't have a shot. And then the fact that employers are really struggling with all their health care expenses. Everybody is very focused on how much these services cost. It's been the recipe for the perfect storm.

3.1: MBHOs. MBHOs were seen as one of several factors that contributed to lower prices for EAP services. MBHOs tend to offer EAP services for free or at very low prices when bundled together with the behavioral health plan. A participant explained MBHOs' role in impacting EAP prices,

> From 2000 until now, there's been downward pricing pressure. I think when you start talking the early mid 90s you could still get a more sustainable rate but when managed care companies essentially took over the industry, and just sort of saw EAP as the front end to a behavioral health benefit, and you got Magellan going around buying everybody and essentially buying contracts, there's been just enormous downward pricing pressure.

3.2: Insurance products. Another significant factor related to the reduction of EAP prices is related to disability management, life insurance, and other insurance

carriers including free EAP services with their insurance products; this trend is often cited as having had as significant an impact on EAP pricing as did MBHOs. For example, as a participant explained,

> The other things that we're up against now that we weren't before are the free EAPs that …are coupled with disability and life insurance policies;…the HR people buy those because they get their disability and they get a free program until there's a crisis. So we're up against that. And so you can't compete with free.

3.3: Devaluation due to price. Lower prices for EAP services in themselves devalued the product, as one participant explained, "as a field we set these prices so low and we competed against ourselves so fiercely that with these diminishing prices, we don't win the respect of the C level folks." Another participant further explained how lower EAP prices impact perceived value, "when we're so eager to win new business by lowering prices that we eventually give the service away, it's hard to start charging for something that you're giving away. And it just diminishes the sense of value." Furthermore, EAPs are often overlooked by virtue of being a small part of the company's budget. For example, a participant noted, "we're less than one percent of a benefit budget. A fraction of one percent. And with that kind of spend, what kind of attention do you think we will get?"

3.4: Lower margins. Due to increasing costs and lower prices for EAP services, most organizations in this study report significantly lower margins for EAP services. One participant summarized this trend,

> The EAP industry in my opinion is caught between a rock and a hard place, where it's being squeezed through competition, low pricing, some of the larger EAP companies that have actually just low-balled the proposals and so on to get market share. And they have actually shot our EAP's foot and shot us in the foot, all of us because nobody can get a real decent margin on for their professional service anymore.

Another participant explained the impact of lower prices and lower margins: "It's much more numbers driven about how to have a business model that you can still deliver the same quality, the same kind of things that your customers value but as cheaply as you can." Other participants report that lower margins have negatively impacted the quality of EAP services and caused EAP organizations to repackage services. For example, one participant explained,

> the numbers don't add up when you charge so little. How do you possibly have a robust service? And I tried to do the numbers. They simply don't add up. Like three visits or four visits per case with this many follow-ups and this type of case distribution, but I'm charging $14 US dollars per employee per year. Doesn't add up. So that's why I think some of this is getting repackaged.

3.5: Influences. There is some evidence that EAP size and service area may influence EAP pricing. Many of the small EAP organizations (i.e. with 100, 000 covered lives or less) that reported a state/regional service area also reported that their prices have not changed significantly since the early 1990s, and some even report an increase in prices. One participant reported, "we are charging the same or slightly more than we

were in the early 90s." Another participant explained, "we're probably getting a little bit more money on a new program but we're offering more services, like the online service. So…revenue's down." However, since these organizations also report smaller margins similar to other organizations in the sample, they have still had to implement similar survival strategies to remain competitive.

Another reported moderator of price relates to attributes of the client company. Several participants reported that price pressure is often mitigated by companies that understand the value of EAP and who demand high quality services. Companies that value a high level of service tend to be less concerned about price. For example, one participant explained, "we have some big really successful companies that are not very price sensitive. So they want service and they want top-notch service and capable people and they're not going to push aggressively on price."

Survival strategies. Due to changes in the perception of EAP, which is often perceived as a benefit as opposed to a workplace-based performance-enhancing tool, EAPs were put under pressure to justify their connection to, and impact on, the workplace. In addition, changes in the perception of value of EAP services made EAP organizations vulnerable to price pressure and competition from lower cost and lower service EAPs, and forced them to evolve new strategies in order to survive. As a participant points out, the changes in the market required EAPs "to find a survival strategy and to find a way to differentiate themselves from the big insurance companies." The following section answers the research question concerning how EAPs have changed since the emergence of MBHOs in the early 1990s by describing the changes in strategy,

structure, and service provision. Some of the emergent themes also answer the research question pertaining to changes in EAPs mission and focus.

The emergent survival strategies can be split into seven primary themes: Expanding EAP mission, service changes, specialization, demonstrating value, offering more choices, rebranding, and improving efficiency. The seven themes and 18 subthemes are listed in Table 8 and subsequently explained.

Table 8. Survival strategy themes and subthemes

Theme	Subtheme
1. Expanding EAP mission	1.1 Unchanged primary purpose
	1.2 Spin-off programs
2. Service changes	2.1 Continuing to offer basic services
	2.2 Expanding services
	2.3 Integration
3. Specialization	3.1 Task specialization
	3.2 Staff specialization
	3.3 Program specialization
4. Demonstrating value	4.1 Visibility
	4.2 Relationships
	4.3 Utilization reports
	4.4 Effectiveness evaluations
5. Offering more choices	5.1 Unbundling
	5.2 Communication modality
6. Rebranding	6.1 Changing name
	6.2 Changing descriptors
7. Improving efficiency	7.1 New technology
	7.2 Contracting out

1: Expanding EAP mission. In response to questions about any changes in mission since the early 1990s, many participants described their current mission as

broader or having a wider reach that pays more attention to prevention, wellness, and overall wellbeing for individuals and workplaces. In addition to the standard services, EAPs today report having a more holistic and more proactive approach. One participant explained, "there's a much greater emphasis… on issues in everyday living and using the EAP as a prevention tool." In addition, some felt that a new part of the mission of the organization was to "aggregate resources that can impact personal issues as they affect the workplace."

1.1: Unchanged primary purpose. Answering the research question about any changes in EAP focus, participants reported that despite an expansion of their mission, the primary purpose of their organization remained fundamentally the same between 1993 and 2011. Specifically, participants reported a continued focus on the workplace and on employee and organizational performance. "Our primary purpose is to enhance the productivity of organizations by assisting their employees and the employees' family members." In addition, the EAP mission continues to be based on the core belief that "If you have a healthier workforce, they're going to be more productive." Furthermore, a participant explained the intention to keep this focus, "we still believe in what I said at the beginning. That basically helping people so they can do their work better. That's the bottom line, what our goal is. And we never want to get away from that."

Another participant explained the importance of keeping focus on the workplace in terms of the ongoing viability of the EAP industry,

> I see that actually as a thing that will be ultimately the thing that will keep our industry viable. We are the people that have the connection with the workplace

and nobody else does. So I think we're seeing a return to emphasizing those, that element of EAP services.

1.2: Spin-off programs. This emergent theme also addresses the research question concerning changes in EAP mission and focus. In contrast to the majority of EAP organizations studied, six participants reported that for some programs the mission and focus had changed significantly. While the primary mission and focus of most services offered by these organizations was still aimed at workplace issues, they also offered spin-off services such as student assistance and refugee assistance programs; while these programs still focus on human wellbeing, they do not serve the same populations as traditional EAPs and therefore have different respective goals that do not have a workplace focus. As a participant explained,

> You don't just take an EAP and slap it on and call it a student assistance program. It's like two different animals. It's so different. The demands are different, everything is different. The reporting mechanisms, the reasons they want them is different.

2: Service changes. Participants pointed out that the method of accomplishing their mission had changed significantly, even if the mission itself had not. EAP organizations are offering a host of expanded and new services that are broader and more holistic. EAPs now have more resources to draw on to accomplish their mission, and different methods of reaching employees. For example, as a participant explained,

> The primary purpose of our organization is to assist employees and their family

> members in the workplace to be more fully functioning, to provide care in reference to personal concerns, personal issues, that may have an impact upon work performance… That has not changed tremendously I don't think. I do think that we have added a lot of things to our services, but it's a different vehicle of how to reach the people.

2.1: Continuing to offer basic services. Though they have added a significant number of products and services, EAPs included in this study continue to offer most of the basic services they offered in 1993 such as assessment, short-term counseling, and referral. A participant explained that despite an expansion of services, the continued focus on core technology services is an important differentiator.

> Those of us who stuck to our guns in terms of yeah we've done all this new stuff to stay alive but we have kept our core technology and we still pay attention to the workplace, have been able to a lesser and greater degree at various client organizations, continue to be understood as something separate from the mental health and substance abuse benefit.

2.2: Expanding services. EAPs have also expanded services that were previously offered, providing more sophisticated and comprehensive services. For example, as a participant reported, "we had just rudimentary work/life services back in 93 and now we have a comprehensive program with multiple vendors to provide very specialized services." Furthermore, in many cases the traditional EAP product is becoming a smaller part of the total menu of services offered; this trend is exemplified by the following quote from a study participant,

> We need to continue the trend that we're already on in part which is to continue to diversify our offerings beyond traditional employee assistance and work/life into areas that show greater value to organizations and that take more of an organization culture-based focus. That's a trend, that's a realignment that we began in earnest about three years ago and a defining element in the transformation in our business and will continue to be. So it's certainly possible that in five years or so if we are making the right choices in this point in time that EAP will no longer be our primary source of revenue.

2.3: Integration. Another example of the trend of EAP services becoming more holistic is the integration of services that in the past had been offered by separate organizations that contracted directly with client companies. Many such services, including work/life, wellness, and learning and development, still focus on employee and organizational wellbeing and have now been integrated within the standard EAP service offerings. For example, a top EAP leader explained the logic of combining EAP and wellness services,

> We saw that there was a huge connection between the emotional side of the ledger and the physical side of the ledger. That they weren't really in two silos. That in delivering our services we saw where, whether it was a health concern of an employee or a emotional concern, that the bottom line, at the intersection of an employer's concern for productivity and performance. We saw ourselves at the middle of the intersection dealing with employee issues. And issues are defined as any kind of personal concern or health concern.

Despite the trend to integrate services, not all of the EAPs offered integrated services. One participant reported “we do not have a work/life or wellness component to our program,” and others reported simply referring to outside organizations for some services such as organizational development. For example,

> OD we’ve looked into in the past and actually I haven’t really made a move into that, into the arena because it demands a different level of expertise. We do have some OD firms that we would refer to if need be.

3: Specialization. In addition to changes in external service provision, EAP leaders described the need to improve specialization in order to improve quality, efficiency, customer service, and as a method to increase revenue and market share. There are a number of dimensions with respect to specialization including task, staff, and program specialization.

3.1: Task specialization. Task specialization can be viewed as a change in tasks assigned to each staff member. The trend of increased task specialization includes the creation of clinical, sales, and account services teams and task assignments. The logic behind the concept of task specialization was explained by a study participant,

> We wanted to improve the quality of that care. We felt that when we worked with generalists while it was adequate, it wasn’t up to our standards and we wanted people who just you know eat, drink and sleep that and build up a strong experiential base to improve their own ability to be valuable. And so that’s why we went that way.

Another example of task specialization is explained by a participant who describes the separation of functions that used to be performed by the same group of staff members, but are now divided,

> We have some people…that just do kind of the intake. They're catching the clients that come in and getting them referred out to our network. Whether it's clinical or work wise. And then other people that handle kind of our crisis and manager referrals.

However, though the majority of participants reported that their organization used some form of task specialization, this trend was not universal. Some organizations reported that many staff continued to serve multiple functions. One participant explained that "everybody does kind of everything…management consultation, trainings, and counseling cases too, face to face."

3.2: Staff specialization. Staff specialization is a change in the credentials and skill sets of staff hired by the organization. A form of staff specialization is the hiring of more professionals. Participants report market pressure to hire more professionals, often licensed clinicians, a role frequently filled by clinical social workers. Though not all participants reported employing social workers, the profession of social work was the most frequently cited clinical profession. A study participant explained, "social workers are a much more natural fit for EAPs because…they're much more in tune to making referrals for informing people about the services that are available in the community." Another explained that social workers are often interested in the "grassroots of helping people and moving people forward and they're much more, I have found, in tune to the

idea of short term problem resolution as opposed to long term treatment." Furthermore, another participant reported that, "I think the EAP field per se appeals more to social workers than it does to some of the other professions."

Staff skill set is another form of specialization reported consistently. While some organizations reported hiring staff with exclusively clinical or business skill sets, many reported having staff with dual skill sets. For example, one participant reported, "Our account executives all have a clinical degree. That's one of our requirements. We like them to also have a non-EAP business background." Another participant explained the need for counselors to be both empathetic as well as efficient, possessing "an ability to integrate our technology that we have to track cases and locate things, with empathic, clinically oriented response."

Another form of staff specialization relates to the need to hire more business professionals for marketing and sales functions. A study participant explained the need to hire a business professional, "I needed that MBA because you can't start a division without, we needed a business plan. We needed to borrow some money. We needed to flush out the product development piece." In addition, one interview subject described the changes in sales professionals hired by the organization,

> We have both marketing and sales staff. And used to be that the sales staff were people who were EAP specialists who had a certain knack of being able to be in front of a customer and sell them. Again, things have changed. We're now looking at professional salespeople who can be taught an EAP service and speak

> the language of a customer and make the introductions so that then we can come in later on and talk about the special nature of our business.

Despite the trend in some organizations to hire business professionals, other organizations continued to use non-specialized staff for some of these functions. For example, a participant explained,

> We don't have salespeople. And we so we don't have sort of account managers in the sense that there are people who kind of bring the accounts on and then we do the clinical work. All of our account managers are clinicians.

3.3: Program specialization. In order to differentiate themselves and increase revenue and market share, EAPs created specialized programs and services as well as spin-off products that address a wider range of human problems. Specialized programs offer improved human services that recognize the unique aspects of particular professions and industries, and improve utilization rates for these groups. For example, EAPs have created programs specifically for physicians, lawyers, and faculty and staff in higher education, among many other specialties. Specializing is effective because it uses traditional EAP skills but targets them at a specific population or need. For example, one participant described a program designed for disruptive professionals,

> It's a 12-week program that we charge a lot of money for separate from the EAP. So it's good EAP work in terms of the skill set and the knowledge, but we took what we did and targeted it at a specific problem with a somewhat unique solution.

Another form of program specialization is the creation of spin-off products. Spin-off products are structured in a similar way to EAP services, and use many established EAP skills and processes, though they have different goals since they do not serve employees or focus on the workplace. Six organizations in the study reported that they currently offer spin-off products, and an additional two organizations were considering offering spin-off products. Student assistance and outpatient mental health services are the most prevalent examples of this concept. However, though these programs do not focus on the workplace or on employee performance, they have maintained the core EAP value of human service that is instead targeted at a different population. For example, a study participant explained,

> I do think that we're going to increasingly create EAP hybrids if you will. Specialized programs,…if you take the EAP construct and as a template apply it to other kinds of interesting needs and see what results, I think that will take on greater shape and form.

***4: Demonstrating value*.** Demonstrating value to purchasers is reported to be more important than ever due to the competitive market, and it is essential in order to keep contracts and compete on price. For example, one participant pointed out that client companies "value that personal one touch although at the same time, you better be able to demonstrate some sort of economic return on investment." Another participant explained how market saturation has increased the need to show value,

> EAP is kind of so prevalent across the board and most companies have them, know what they are. So I don't think there's so much the value of gee, EAP is

> this great thing anymore. I think it's more a value on how we do it.

EAPs reported several strategies for showing value to client companies, including visibility, responsiveness, relationship with client companies, and effectiveness reports and measures.

4.1: Visibility. Strategies for improving visibility include going onsite for presentations, trainings, and as part of a crisis response. A participant explained the importance of EAP visibility in showing value:

> When you transition a service like an EAP into a benefit, it becomes almost invisible. So having an onsite counselor makes the program more visible. It gives people an idea, wow. There's something tangible there. There's somebody that can help me.

4.2: Responsiveness. Study participants consistently reported that companies' value overall EAP responsiveness, especially related to coming onsite after a death or disaster, and being available to consult with management about difficult employee situations. A participant explained the value of responsiveness,

> The things that get us really good attention and high praise are the situations we respond to immediately, whether that's onsite kind of critical incident stuff or handling HR supervisory consultations and referrals and all that sort of stuff. But those are the things that are visible.

4.3: Relationships. Building relationships with individuals at client companies and learning the workplace culture was consistently mentioned as being important to maintaining contracts and showing value. "The biggest value is the relationship part of it.

High level of hand holding, personal service. They know who they're dealing with on a consistent basis." The connection between relationship with client company and EAP core technology is explained by a participant,

> The EAP role has gotten much more competitive, securing accounts is much more difficult, the retention of accounts has increased exponentially. So we work very hard to not lose any of our current business. And the way to do that is obviously that relationship and that relationship is all about providing EAP core technology services.

4.4: Utilization reports. All participants report offering utilization reports to their client companies. Participants said their reports had become more comprehensive with more visual and esthetically pleasing elements. The new reports are intended to show the broader scope of services provided and emphasize the value that the EAP brings to the organization. For example, one participant explained the reasoning behind more comprehensive utilization reports,

> It's to show that there's, that the value is there. That the value extends beyond the individual client. The value is larger, there's a larger organizational value. So not only are clients coming in at six or seven percent or eight percent of them but their managers call us and we met with your HR team and we delivered seminars to 100 of your employees…So you're just trying to broaden the value and the reach.

In contrast to EAPs that offer more comprehensive reports, a number of participants said that their reports have not changed substantially in terms of information,

> We're pretty much giving them the same data we've always given them in terms of age range, salary range, length of service, job status, presenting problem, primary and secondary assess, closing disposition, whether they were covered under the company insurance plan or not. I mean that pretty much, that data hasn't changed. It's just the way it's presented and packaged has changed. It's pretty now.

Furthermore, despite the prevalence of utilization reports, some participants claimed that they report less often now than in the past,

> We report less. We used to send everybody annual reports. Now we basically send them as requested because most of the companies just don't, most of our companies we've had consistently for 20 plus years and they don't, the numbers are totally irrelevant to them for the most part. They know what the value is. They see it first-hand because of the relationship day to day they have with us.

4.5: Effectiveness evaluations. Another method cited by participants to show EAP value was through the use of various forms of effectiveness evaluation. The most frequent form of evaluation was satisfaction surveys. However, many EAPs realized the limitations of satisfaction surveys' ability to measure impact, and so started to develop more sophisticated outcomes measures. For example, a study participant explained,

> We always did the satisfaction testing but the outcome metrics we've done just over the last few years and really realized that satisfaction surveys are a dime a dozen and they don't really have much impact with the purchaser. I mean they want to see them and they want to see that they're good but beyond that, they

> don't have a big impact. What they really wanted to know was, are your services having an impact on behavior? Are you making people's lives better and that's what they wanted to know and they have a right to know that. So that's why we shifted our focus away from satisfaction and toward outcomes.

Another participant explained the need for pre and post EAP intervention measures as the best way to measure and demonstrate EAP value:

> It's the only move that I know of to sort of show some enhanced value in a credible way. And so we're trying, we're setting up that type of study so that we have a good return rate and do a pre/post measure. And as a post be a measure after the EAP intervention.

After satisfaction surveys, the most frequently cited effectiveness tool was return on investment (ROI) measures. However, similar to satisfaction surveys, several participants voiced skepticism about these measures. For example, one participant said,

> I think ROI measures are a joke…most of them are based on calculators that are suspect to begin with. Many of them are based on presumption of what didn't happen, and if it would have happened it would have cost you this. So it's very spurious in my opinion. Having said that, there's an appetite for it out there and employers like to see it, and I think it's a way of just so they can trot upstairs to the CFO and say look, this is actually saving us money. But if they dug a little deeper into the algorithms as it were, such as they are, that go into these ROI calculators, I think they'd have a second thought about that.

Measuring outcomes is not only about making a business case for EAPs, but also helps to insure that services are truly effective in helping individuals and organizations. A participant pointed out the dual purpose of measuring impact, "it's about client retention. And we want to know how we're doing, too." In addition, another participant pointed out,

> We've spent a lot of time focused on behavioral science research and what works in behavior change, and we try to integrate those research findings into our practices. So we want to know if that is working and if we actually are helping people change their behavior or not.

Despite the trend of some organizations to demonstrate outcomes and impact related to EAP interventions, many participants explained that this was a difficult task to accomplish. "One area we haven't made much progress on and I don't know who has, is this whole impact issue. We've never really done anything that I would say in a really meaningful way demonstrates impact." In addition, some participants also pointed out that few of their clients are asking for outcomes information: "Believe it or not as much as you hear about that, our clients aren't asking for it. And so if they don't want it, I don't give it to them."

5: Offering more choices. Another trend seen in organizations surveyed for this study was that many now offer more choices to client companies as well as to individual employees. Choices include enabling companies to customize the products they are purchasing, and giving employees the choice of how to access services. These adaptations improve overall access to services.

5.1: Unbundling. One method of offering choice to organizations involves "unbundling" EAP services that can then be purchased individually and separately from the traditional EAP package,

> So right now what we have to do is we have basically broaden our approach and deepen our expertise and provide a lot of services, and EAP is really one of them but what we call EAP is really we unbundle it. We're talking about management consultation. We're talking about employee relations consulting. We're talking about crisis response and preparedness. We're talking about a lot of different things that used to be EAP in the old days.

5.2: Communication modality. Individuals are also offered more choices now than in the past with respect to the modality they use to contact the EAP. EAPs have embraced new communications technology, and are able to meet individual clients' demands with respect to how they choose to communicate with the EAP; individuals are able to access EAP services by telephone, online, and in-person. For example, an industry leader explained,

> We have an encrypted instant messaging capability for our customers who prefer to interface with us that way rather than telephone, which we find is increasingly the case with younger workers. And we do some of our consultation work with companies we'll do by video conferencing.

Another example of multiple options offered to individual clients with respect to communications technology is exemplified by the following quote from a study participant,

> We allow our clients to have access to experts through multiple ways, other than the phones. They can email an expert with an asynchronous medium. We have live chat that we offer. We also a moderated chat, that's another way that we reach out to our membership on sort of comparable area where we bring in a subject matter expert on a particular topic and there's a question and answer dialogue amongst a whole community of observers.

Though the majority of EAPs offered telephone counseling and more diverse communication modalities, many EAPs emphasized in-person services. For example, as a participant explained, "We discourage counseling over the phone, just because you can't really get a decent assessment over the phone. There's so much you can't literally see."

6: Rebranding. A number of participants reported that they rebranded their organization in order to better describe the services they are now offering. Rebranding involved changing the name of the organization as well as changing the ways in which the organization is described. A primary reason for rebranding relates to marketing, as a participant explained, "we made changes in terms of how we were going to be perceived in the market."

6.1: Changing name. A number of participants reported changing the name of their organization, frequently shortening the name or removing reference to "EAP".

Name changes reflected a move to a more holistic, integrated menu of services of which EAP is only a part. A participant explained,

> I think the only good reason to change your company name is if you changed your services and approach sufficiently so people can take a new look. Otherwise, it's an incredibly expensive and cumbersome process that's hardly worth it. When we got to the point where we thought that our earlier name…no longer described what we did, that was the point at which we decided to change our name…. [we] wanted it to convey a certain sense of who we are as an organization.

6.2: Changing descriptors. In addition to changing their name, many of the organizations in the sample had started to describe their services more broadly in order to promote ancillary products and an expanded focus. As a participant explained, "in order to meet the change, we're pitching ourselves as something more than what EAP was in the past."

A participant explained that even though descriptors may change, the organization is at core still an EAP.

> Stop calling ourselves an EAP, and focus on health and productivity management firm. In fact that's what some large independent regional EAP's are doing…Some providers don't call themselves an EAP anymore. Talking points are productivity management of human issues. Now, when it gets down to walks like a duck, talks like a duck, yeah I see an EAP.

7: Improving efficiency. Due to smaller margins in the EAP business, most organizations have had to lower operating costs and improve the efficiency of their operations in order to remain competitive. The need for greater efficiency is illustrated

by a participant's comments,

> We have to find ways to work more efficiently and to continue to make money. No one is ever going to get rich as an EAP, owning an EAP company, especially today. So one has to look for as many ways as possible to cut costs and be efficient.

EAP organizations reported several strategies used to improve operational efficiency including the use of new technology, and contracting out to external vendors to provide services. While improving efficiency is a business imperative, the use of new technology and outside contractors also improved the expertise of EAP organizations.

7.1: New technology. EAP organizations have embraced new technology as a method of more efficiently managing data, communicating with clients and vendors, and providing seamless services. New technology includes internet-based services and sophisticated databases. For example, an interview subject explained how a new database was needed to manage information, "What we needed was a way for all of us to be able to access information quickly and access information that was accurate but also confidential."

Another participant further explained how technology could be used to efficiently manage client information and improve service provision. New database technology was used,

> To make our process more efficient. It also helps…so we can be seamless in our service, seamless as possible in the service we offer. Someone's counselor isn't available. Another counselor who picks up the phone can see where someone left

> off. I mean not in terms of seeing the person for sessions, but affiliate calls to double check on something or to fill in about what happened during the assessment. So someone else can do that.

Technology was also used to more efficiently and effectively target at-risk employees and increase cross referrals from other health and wellness vendors. This technique is also an example of prevention in that employees are referred to the EAP by vendors due to usage of health services but not due to performance problems, as explained by a participant, “We’re doing some targeted outreach to at-risk people identified through data analysis queries using claims and pharmacy data.”

Though all EAPs reported offering some form of online service, there were some organizations that continued to document cases on paper. For example, a participant from a small regional EAP reported that “the information is still the old fashioned way. Handwritten notes.” Another small, regional EAP reported a limited need for new technology,

> A lot of our stuff is just managed internally here and we’re not, we’re not doing a lot of the big high tech stuff that a lot of the bigger companies are probably like XXX is. Only because we haven’t had to.

7.2: Contracting out. Though also related to the improvement of expertise, contracting out is primarily a method of increasing organizational efficiency. Many EAPs reported that they contracted for a number of reasons including some services were outside their realm of expertise, and in cases where an external, specialized vendor could provide services more efficiently and at a lower cost. Services that were commonly

obtained from outside contractors include work/life, wellness, and affiliate providers among many others. A participant explained the logic behind using outside contractors to improve expertise,

> We brought on a financial legal partner, thinking about how that sort of increases the breadth and the depth of what we can provide with EAP and what we were finding. People coming in are fighting with their spouse or they're fighting over money. So how can we help support them? I mean we can, we're counselors, we can help with a little bit with budgeting but we're not financial folks. We're not lawyers, we're not trained to do that.

Another participant explained that using contractors can be efficient and allows the organization to concentrate on its primary mission. A participant explained their organization's decision to use a contractor instead of developing a service internally, "our strategy was to not really try to build that ourselves and sell it but to continue to offer core EAP." Another participant explained, "we've kept our infrastructure lean. We use a lot of contracted services, like I think most EAPs do."

However, despite a trend of increasing use of outside contractors, some EAPs continue to offer work/life, wellness, legal, and other services internally. Some organizations made considerable investments to expand their internal infrastructure. This was accomplished in a number of ways such as hiring specialized staff or acquiring companies offering specialized services. Participants reported that offering services in-house gave them the ability to customize, and also assisted with seamless service integration. In addition, internal service provision allowed organizations to better control

quality. For example, a participant reported some of the reasons for creating web content internally rather than using a contractor,

> We felt like we needed to do that ourselves rather than having another company do that so that we have more control over our ability to be innovative and to be customized and to have web and content offerings that didn't look like everybody else's.

Another method of efficient service provision is through the use of affiliate providers. Participants reported an increasing reliance on affiliates to provide services to clients. For example, a participant reported that "in the last ten years that we've increased affiliates and affiliate use." Participants consistently reported having a larger network of affiliate providers and are able to provide services nation-wide and in some cases internationally. As a participant explained, "our network has expanded based on our membership expansion and also kinds of contracts where we've had to develop certain parts of the country where we didn't have a lot of providers."

A reported issue pertains to the efficient management of the affiliate provider network. As a participant explained,

> Our affiliate network has expanded and it continues to expand and we're constantly growing it, which also leads to how we manage it, in terms of trying to keep up with everything. We've really had to tighten a lot of the efficiencies around how we do what we do. Make sure people are still credentialed, licensed, how we track any kind of progress, any kind of complaints. We try to keep really a kind of close eye on the affiliate network.

Another reported concern about using affiliates to provide EAP services is whether they have an understanding of the unique nature of EAP and how it differs from psychotherapy. For example, a participant explained the EAP's vetting process for new providers:

> When we bring someone new on board,…we talk to them about sort of how we operate, what our philosophy is towards EAP. We find out if they've done any EAP work. We specifically sort of ask them who they've been doing EAP work for because the answer to that kind of indicates, …to us whether or not they're doing what we consider to be true EAP or not. And then depending on their answer, and one of the things we're sort of discussing is, do they see EAP as just outpatient counseling? But they can see it a different way or not. And so based on that conversation, if we get the sense that they sort of understand our philosophy and how it works and that they're not, this isn't just a way to kind of feed your private practice, that we take that separation pretty seriously, EAP and outpatient.

Summary of Findings

The EAP market has changed in a number of ways that have significantly impacted EAPs. A primary change has been the perception of EAPs as a benefit as opposed to a tool to address employee and organizational performance. The perception of EAPs as a benefit was influenced to a large extent by MBHOs and benefits brokers; both consider EAP to be a healthcare-related product with no direct connection to the workplace. Due to changing company demands, market saturation, and the involvement

of benefits brokers and consultants in the evaluation of EAPs, there was a subsequent commoditization and devaluation of traditional EAP service provision. In addition, the market changes led to a significant drop in EAP pricing.

In response to the numerous market changes that impacted the industry, EAPs developed a host of survival strategies in order to remain competitive. Strategies include an expansion of the EAP mission to be more comprehensive and to address a wider range of individual and workplace problems. EAPs also became more specialized, efficient, and flexible, offering a broader array of customized services to clients through multiple communication modalities. Though most continue to offer traditional EAP services, the majority of organizations expanded traditional services and incorporated a number of ancillary services such as work/life and wellness. In addition, EAPs developed more sophisticated marketing techniques to demonstrate value, including comprehensive utilization reports, outcomes measures, and the rebranding of the organization. A notable development was the emergence of specialized products that addressed the unique needs of specific populations. However, some of the specialized products no longer serve employees or the workplace, the historic focus of EAPs.

Chapter 5: Discussion

This discussion will include direct answers to all research questions posed in the methodology, and will begin with a review of the ways in which EAP organizations have changed since the advent of MBHOs in the early 1990s. To explain the reasons why EAPs have changed, a grounded theory analysis of the changes will be presented. The grounded theory was formulated using the qualitative data derived from the interviews with study participants.

Changing EAPs

Service changes. The findings from this study confirm and clarify how non-MBHO, management-sponsored, external EAP organizations in the U.S. changed since the advent of MBHOs in the early 1990s. As shown in Figure 1, EAPs have evolved into a new form with respect to service provision. While traditional EAP core technology services still remain, EAPs have expanded already existing services such as consulting and legal/financial services. In addition, EAPs have integrated services such as work/life and wellness that were previously offered by separate organizations. EAPs also offer more choices with respect to communication mediums used by clients to receive services, as well as unbundling services such as management consulting and counseling that can be purchased separately from the standard contract. The new form also includes specialized programs focusing on specific populations such as disaster victims and disruptive professionals. Furthermore, six EAPs (23% of the sample) are now offering spin-off services that use the EAP model to serve non-employee populations such as students and refugees.

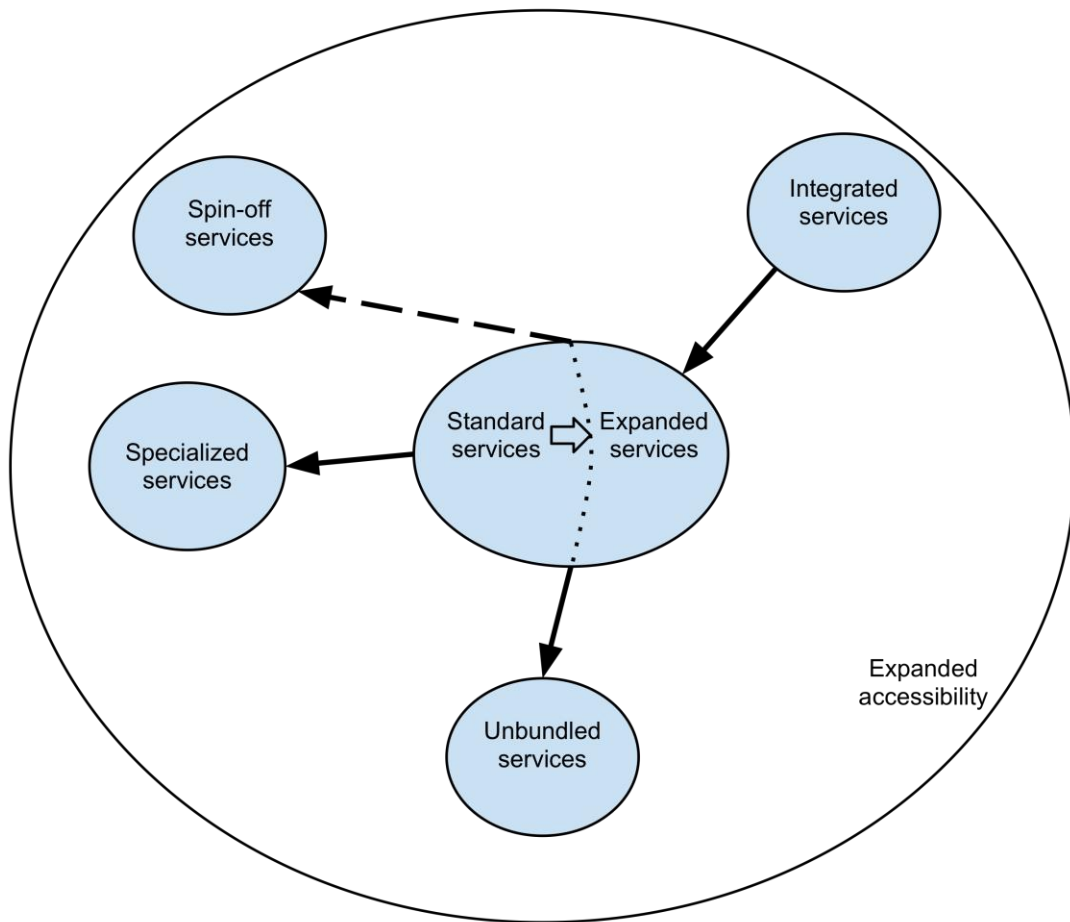


Figure 1. New form of EAP service provision. In the center, standard services are separated from expanded services with a dotted line as both make up the core services. The arrow points from integrated services towards the center oval because those services had been external and were absorbed. The remaining arrows point outwards representing their emergence from the EAP. There is a dotted line pointing to spin-off services as they are no longer tied directly to the EAP concept, whereas there are solid lines pointing to specialized services and unbundled services because both are still based on EAP core technology. The circle around the entire form represents expanded accessibility pertaining to all services provided.

Other EAP changes. In addition to changes in service provision, EAPs have also changed with respect to strategy, staffing, structure, and efficiency. EAPs in this study reported employing more sophisticated marketing techniques, including rebranding, revising utilization reports, and developing more sophisticated outcomes measures. In addition, there were reports of increased hiring of specialized staff, with regard to both

business and clinical functions. EAPs also expanded their infrastructure and improved their expertise and efficiency by contracting out for a number of services including affiliate providers, work/life, wellness, and more. New forms of technology such as databases and online platforms also increased efficiency as well as communication options for clients. Further in-depth review and analysis of the internal and external changes, including changes to mission and focus, are provided in the following discussion that examines the reasons why EAPs have evolved.

Model of EAP Evolution

Using a grounded theory approach, a theory was developed that explains the impact of market variables and the subsequent adaptive strategies used by EAPs in response, answering one of the primary research questions concerning why non-MBHO, management-sponsored, external EAP organizations in the U.S. changed since the advent of MBHOs in the early 1990s.

The EAP market has changed considerably in the study period (1993-2011), and the reported changes have had a significant impact on EAP evolution. Through a matrix of survival strategies, non-MBHO, management-sponsored, external EAP organizations in the U.S. are evolving into a new form, but as such are surviving and maintaining their core values. Due to the influence of social workers and other clinical professions in the EAP industry, EAP organizations have adapted to a changing business environment in a unique way that incorporates both business and social service values; EAPs maintained a primary focus on individual and organizational wellbeing, while simultaneously improving efficiency and effectiveness. The dichotomy and intersection of values can be shown through an examination of some of the market changes and subsequent survival

strategies employed by the EAP organizations studied. The adherence to the core value of human wellbeing as a central concept in all forms of service provision has enabled the survival of the new form of EAP organization.

Figure 2 offers graphic illustration that is helpful in understanding the new theory of EAP evolution. The figure is followed by further explanation of the theory. An interpretation using the theoretical framework is offered in the implications section.

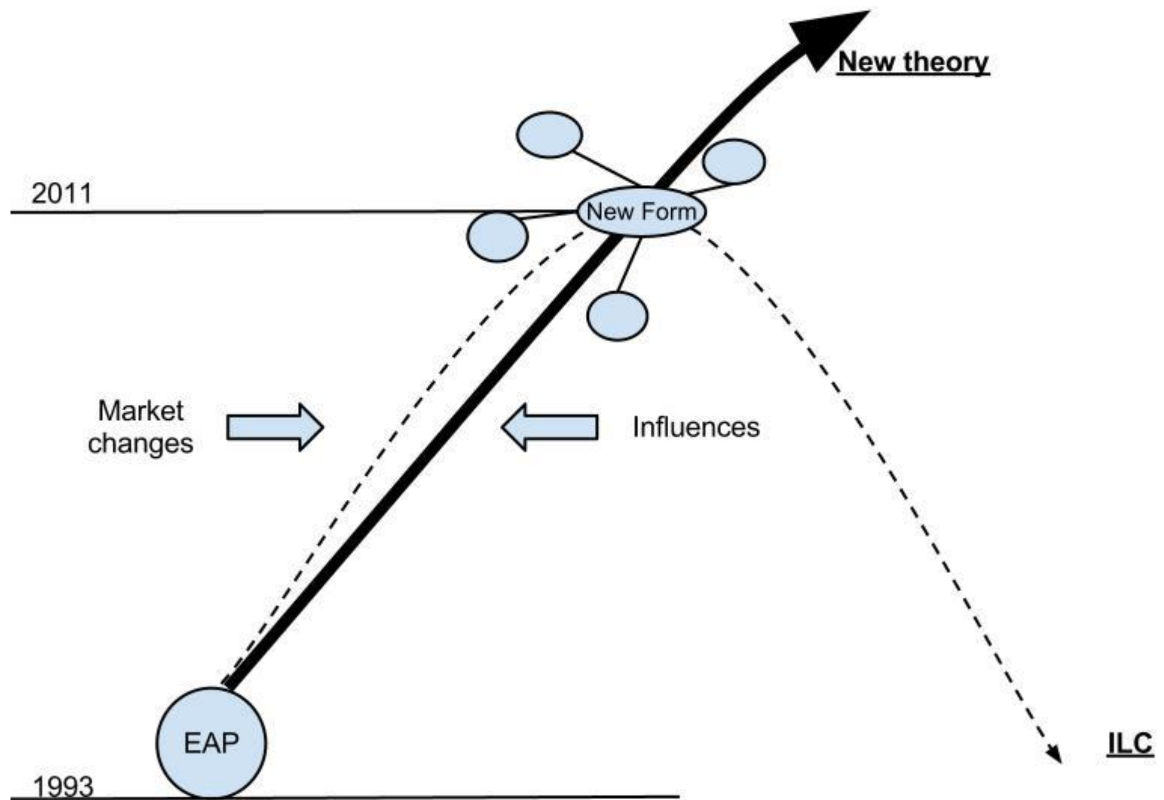


Figure 2. EAP evolution model. Shows the evolution of a simpler form of EAP in 1993 towards a more complex structure in 2011. The dotted line represents the evolutionary trajectory that would be predicted by industry life cycle (ILC) theory. The solid arrowed line represents the evolutionary trajectory predicted by this study. Market changes and influences have arrows pointing towards EAP's trajectory indicating their influence on this process.

Impact of the changing market. The research question concerning what other factors in addition to MBHOs influenced changes in EAPs since the early 1990s was answered by participants' responses concerning the changing EAP market. As expected, participants reported that MBHOs had a significant impact on EAPs; however, participants also reported a number of other factors that significantly influenced EAP evolution. The market factors included the emergence of MBHOs and disability insurance and other insurance products with embedded EAP services, the emergence of brokers and benefits consultants, competition from other EAPs, and changing company demands. The impact of these factors can be summarized in three primary themes: the perception of EAP as a benefit, changes in the perception of value of EAPs, and changing prices for EAPs. These factors influenced each other in a reciprocal, non-linear manner, and impacted the evolution of EAP organizations; an explanation of this interaction will now be offered beginning with a review of how EAP services have changed from their original conception.

Evolving out of occupational alcohol programs (Lewis & Lewis, 1986; Van Den Berg, 2000; White, 2000), EAPs were conceived as a method of identifying and addressing issues related to employees with personal problems that impact their job performance (Blum & Roman, 1989; Erfurt & Foote, 1977). A focus on the workplace is considered by many to be part of what defines an EAP (EAPA, 2003; National Business Group on Health, 2008; Roman & Blum, 1985, 1988). In addition, EAPs were intended to have a broad focus that addressed workplace issues regardless of origin (Wrich, 1980), and their scope and reach has continuously expanded throughout their history (Van Den Berg, 2000). EAPs were originally internal programs operated by the organizations they

served (Blum & Roman, 1989; Cunningham, 1994). However, external, contracted-out model began to emerge in the 1970s and early 1980s (Csiernik, 1999; Blum & Roman, 1989; Sharar 2009), and external models gradually began to replace the internal models (Blum et al., 1992); the majority of EAPs today are external (Cagney, 1999; Merrick et al., 2007). Modern EAPs have also integrated with ancillary services such as work/life and wellness (Gornick & Blair, 2005; Masi, 2005), and have added numerous other add-on products to their menu of offerings (Masi et al., 2004). The addition of add-on products and integration with ancillary services has caused concern that the core mission of the program is obscured (Sharar, 2008; Sharar et al., 2002). In fact, concern about EAPs' loss of focus on employee productivity has been mentioned in the industry literature for over 25 years (e.g. Straussner, 1986).

Participants in this study reported that since the advent of MBHOs in the early 1990s, EAPs have started to be viewed by client companies and the public as an employee benefit rather than as a workplace performance-enhancing tool; this trend was previously noted in the literature (Blair, 2004; Mannion, 2004; National Business Group on Health, 2008). The perception of EAP as a benefit undermined a core function of the traditional EAP, and weakened its ties to the workplace. Being perceived as a benefit reciprocally influenced the perception of value, influencing purchasers to value EAP mostly as a method of lowering behavioral health costs. These factors added to the price pressure that already existed due to a saturated market and strong competition from other EAPs, as well as the availability of low cost and free EAPs offered by MBHOs, disability insurers, and others. Companies that did not understand the value of traditional EAP services, and who were influenced by benefits brokers and consultants, obtained EAP

services through lower cost carriers or demanded lower prices from their current providers. Since purchasers were unable to differentiate programs based on quality or value, EAPs became commoditized and the primary differentiator became price. The resulting prices, reported as being reduced by more than 50 percent at some organizations, combined with client companies' demands for more services, significantly impacted EAP profit margins and necessitated adaptive changes in order to survive.

Purpose of survival strategies. Though all of the EAP survival strategies served business purposes such as lowering costs, and increasing market share and profits, they also served humanistic goals. The expanded EAP mission and the addition of more holistic and integrated services enable EAPs to better serve the wide range of problems faced by individuals, families, and organizations. The continued provision of core technology services provide ongoing, evidence-based services to individuals and organizations. The creation of specialized programs and the improved expertise of EAP staff may improve the utilization rates, quality, and effectiveness of EAP interventions with underserved groups. The use of outcomes evaluations may serve as quality assurance, insuring that services function as intended. Offering more choices may improve the convenience of access and utilization rates for individuals in need of services. Rebranded EAP name and descriptors may serve to de-stigmatize EAP services and make them more appealing to individuals and organizations. Improved efficiency may serve to provide lower cost services to a wider population.

Prevalence of clinical professionals. Though there was some evidence of an increasing role for business professionals in the industry, social workers and other clinical professions were common; though not a majority within the agencies surveyed,

social workers were the single most common clinical profession of staff, including those in leadership roles. In addition, the majority of EAP leaders, such as those interviewed for this study, have clinical credentials and a clinical orientation, and participants reported an increased role for clinical professionals in the industry. It can be theorized that the high prevalence of mental health professionals in leadership positions (including ownership) has impacted the evolution of the industry.

Impact of clinical professionals. The prevalence of those in clinical professions may have influenced the evolution of EAP mission based on human service needs rather than purely on the grounds of maintaining profits or market share. While necessary adaptations for the survival of EAPs, the current form of EAP organizations and the decrease in the central role of traditional EAP services can be seen as a unique adaptation that is not entirely market-driven; the evolution of EAPs has occurred at the intersection between social service values and business values.

Changing mission and focus. While the core values of EAPs have stayed the same, the primary mission and focus of the EAPs being examined have changed since the early 1990s when MBHOs became prevalent. As noted, participants reported that their mission is broader and pays more attention to prevention, wellness, and overall wellbeing for individuals and workplaces. In addition to the standard services, EAPs today report having a more holistic and more proactive approach. Though some EAPs have adapted by incorporating more business practices, the core human service values of the EAP industry have remained. In addition, the majority of organizations continue to focus on employees and the workplace, though a number of organizations offer spin-off services

that have a different mission and focus that is not aimed at the workplace; however, even spin-off services maintain a social service orientation.

Since providing human services is part of the primary skill set of EAPs, even in their new form it can be expected that EAPs will continue this tradition of human service, and that a combination of social service and business values may be a functional adaptation. In addition, the combination of business efficiency and market driven adaptations with a human service orientation may be a model that can be replicated in other social service and social work practice settings.

Application of Theoretical Framework to Inform Evolutionary Process

The CAS concepts of dissipative structures, the edge of chaos, and co-evolution informed how EAPs evolved into a new form since the advent of MBHOs in the early 1990s. Faced with the environmental pressures already mentioned, EAPs were forced to experiment with new alternatives in order to remain competitive. EAPs were pushed into a state of disequilibrium by the numerous market changes (aka "the edge of chaos"); the disequilibrium allowed EAPs the flexibility to adapt. EAPs began to experiment with new services and to refine already existing services. Taking the demands of client companies (i.e. energy from the environment) some of the EAPs adapted by creating specialized programs such as physician and lawyer assistance programs, as well as spin-off services such as student assistance programs. EAPs addressed an emerging market need by adapting already existing skill sets and operational capabilities in order to serve a specific type of client. In addition, the similarity of the survival strategies across EAPs

can be explained by the co-evolution of the various autonomous agents (EAPs) within the system.

Applying the evolutionary theory of industry life cycle (ILC) both confirmed and contradicted the study data. Looking through the lens of ILC theory, the data found in this study provided evidence that the EAP industry is currently in the mature stage of development. For example, interview subjects reported an increased focus on process efficiency, lower prices, commoditization, and market consolidation. This trend was also previously noted in the literature (Sharar, 2009), and was confirmed by participants during follow-up member checking interviews. According to ILC theory, the EAP "product" would be predicted to decline and eventually disappear due to market pressures and the introduction of new, technologically superior products. While EAP organizations are introducing new products, and traditional EAP service delivery appears to have declined as a percentage of overall service provision, the data does not support the decline of this product in the industry, but rather a re-orientation. EAP organizations have maintained their core values and report that their mission has expanded and become more holistic, but has otherwise not changed. This would indicate an expansion of the EAP concept into a more holistic service, but not the dissolution of the EAP concept.

An explanation for the lack of fit of EAP organizational evolution and ILC theory can be found in organizational life cycle (OLC) theory. According to OLC theory, EAP organizations could be said to be in the final stage, renewal. EAPs could be said to be at this stage because they are not declining but rather are adapting by refining and changing some of their practices, services, and staff. The fact that organizational life cycle, a

theory that describes changes within social service agencies, appears to explain EAP evolution may be an indication that EAPs function as much like social service agencies as businesses.

Implications for Practice and Policy

Several study participants expressed concern about how watering down the EAP product may impact quality and long-term viability; similar concerns were voiced in the literature (Mannion, 2004; Sharar, 2009; Sharar et al., 2002). In addition, a number of participants expressed concern about affiliate providers' adherence to EAP values and ability to differentiate EAP from mental health services, a topic also previously noted in the literature (Sharar, 2008). An example of the re-orientation of EAP services that emerged in this study was the creation of spin-off services such as student assistance, fee for service mental health care, and refugee assistance. As previously noted, six organizations (23% of the sample) reported offering some form of spin-off service, and 2 more organizations were considering offering this type of service. Spin-off services were created primarily for business purposes in that they are geared toward increasing profits and market share. However, these services also reflect social service values because they provide human services, even if they are not directed at employees. However, while EAPs may continue to serve human needs through spin-off services, the adoption of these services may undermine the unique nature of EAPs, namely a focus on employees and the workplace; this re-orientation could impact EAPs' ability to differentiate themselves from other mental health and substance abuse services.

A solution to the threat posed by non-work related spin-off services would be to clearly differentiate them from workplace-focused EAP organizations. Since a primary

threat of non-work related spin off programs is that they undermine the core EAP mission, clearly differentiating them from workplace programs would address the primary concern and help to alleviate confusion about the goals of the EAP.

Additional practice implications from this study pertain to differentiating EAP from behavioral health benefits, and continuing efforts to demonstrate EAP value. As discussed, these issues have had a significant impact on EAPs and necessitated adaptive responses. However, the market pressures mentioned continue to impact EAP viability and so require the ongoing attention of the industry. A possible solution may be found in the standardization of EAP definitions and language. For example study data obtained about number of clients served and number of covered lives varied widely; the variation was likely due to different interpretations of how these variables are measured. As previously noted in the literature, EAPs lack a universal definition for these variables (Beidel, 2005), making it difficult to obtain an accurate picture of the industry and its impact. A universal definition of EAP service components and other measures will help to establish universal outcomes and quality assurance measures, and illustrate the unique aspects of EAP services that differentiate the program from other human services.

A further implication pertains to EAP pricing. As noted by several study participants, prices for EAP services are often too low to sustain quality services; this trend was previously noted in the literature (Lee, 2005; Sharar & White, 2001; Tisone, 2008). A contributing factor is related to EAP organizations' underbidding services (i.e. offering services below the actual cost to provide them), a trend also previously noted in the literature (Sharar et al., 2002). Underbidding services contributes to the devaluation

of the perception of value of EAP services, and in the willingness of organizations to pay for EAP services. Possible solutions, as previously noted in the literature (Daniels, Teems, Carroll, & Santiago-Fernandez, 2004; Sharar et al., 2002) include the development and enforcement of ethical standards that prohibit this type of business practice, as well as universal adoption of organizational accreditation.

Implications for Future Research

The findings from this research indicate a need for further research on the changing EAP industry. Further qualitative research is indicated in areas such as the changing needs of employees and workplaces, and MBHO-EAPs' view of EAP core technology. However, the majority of follow-up research called for by the findings from this study require hypothesis testing that would best be conducted using a quantitative methodology. Some research topics include an examination of influences such as size and service area, the role of relationship with client company, the impact of service changes, and the impact of social workers and other clinical professionals. Further discussion of these research topics will now be offered.

There was some evidence that EAP size and service area may influence EAP pricing; small EAP organizations (i.e. with 100, 000 covered lives or less) that reported a state/regional service area were more likely to report no decrease in EAP prices since 1993, in contrast to significant price reductions for the rest of the sample. This may be related to a trend noted in the literature, stating that shift from local to national vendors may compromise quality (Sharar et al., 2002) and smaller EAPs serving smaller organizations have better outcomes in some areas (Brummett, 1999). However, there

were no other consistent trends noted with these organizations, and all still reported the need to provide additional services beyond traditional EAP core technology. While two organizations reported limited offerings of work/life services, less use of technology such as computerized documentation systems, and an emphasis on personal relationships with client companies, this trend was not consistent across all organizations in the same size or coverage area category. Further research in the form of a quantitative study is called for in this area. Specifically, a study examining the relationship between EAP size and coverage area with variables such as prices for EAP services and outcomes would be helpful in establishing if this is a trend and informing overall EAP best practices.

The ability of small regional EAPs to maintain prices at the same or even higher levels may also be related to the quality of the relationship with client companies, and the client companies' understanding of EAP value. The trend of relationship with client company was echoed even by larger EAP organizations with broader service areas, who reported that though prices overall had fallen, some contracts have been maintained at the same or higher prices than in the early 1990s. Further examination of the role of relationship with client company as a method of account and price retention is needed.

As seen in the study data, EAPs have changed significantly and added numerous services in addition to the traditional core technology. However, as pointed out in the literature (Sharar, 2009), the efficacy of modern EAP organizations is in question. There is a need for additional research aimed at examining the impact and effectiveness of the survival strategies already mentioned on individual and organizational outcomes. In particular, quantitative research is called for to test hypotheses such as: whether higher

cost and higher quality EAPs yield better workplace outcomes; the impact of specialized programs on utilization rates and the effectiveness of EAP interventions with underserved groups; the impact of more communication and service choices on utilization rates; and, the impact of rebranding on perception of EAP organizations.

Finally, a quantitative study is called for to test the theory developed in this study. Specifically, research that examines the impact of social workers and other clinical professionals on EAP mission, focus, effectiveness, and types of services offered would help to confirm or refute clinical professionals' impact on EAP evolution and help to guide further development of the EAP industry. In addition, a large national descriptive study of the prevalence and attributes of non-MBHO EAPs in the U.S. would help to confirm some of the descriptive information obtained in this study to gain a more representative picture of the current form of these organizations.

Statement of Limitations

There are a number of important limitations to this study that should be acknowledged. These limitations include the sampling method, interview subject bias, researcher bias, and the retrospective nature of the data being sought. The exclusion of EAPs no longer in business can also be viewed as a type of limitation. Each of these limitations will be discussed briefly, followed by some methods of mitigating them. Due to the use of a convenience/snowball sampling method, there is a possibility of a sampling bias. Every effort was made to ensure that a broad-range of EAPs were included in the study in order to mitigate this possibility. A reporting bias may also be present because the study was retrospective in nature; respondents may have limited

recollection, or may have been biased in some way concerning what they recollect or chose to share in the interview. Indeed, though there were some reports of unethical business practice and instances of low quality service provision such as mentioned in the literature (Sharar et al., 2002), these comments were always made in relation to organizations other than where the participant was employed. This may represent a reporting bias as participants may not have been comfortable reporting their own ethical lapses. This bias may also have been exacerbated because data was obtained solely from top managers. The use of only one informant per organization ultimately biased the responses in favor of the study participant's perspective. However, there are numerous disadvantages to using multiple informants from the same organization including difficulty in getting organizations to commit personnel to the study, the large amount of time it would take to interview multiple participants, additional concerns organizations may have about confidentiality, and most importantly the idea that "the larger the number of informants, the less qualified is the average informant" (Glick, Huber, Miller, Doty, & Sutcliffe, 1990, p. 304). Due to the specific nature of the information that was sought for the purposes of this study, a top manager's perspective was likely to be the most informative and useful. Conversely, it would be expected that many if not most other respondents would have lacked the overall knowledge of changes, both internal and external, to be worth the extra time and expenditure necessary to interview them.

Another important limitation in this study is related to the concept of positionality. Positionality can be described as the researcher's structural and experiential position, and how this perspective influences the perception and interpretation of what is being observed (Salzman, 2002). As previously noted, I am

currently employed in a leadership role at an EAP that is similar to the EAPs that are the focus of this study. It must therefore be acknowledged that this researcher's perspective is biased, and that this perspective did, to a greater or lesser degree, influence the interpretation and focus of the study.

Another limitation of this study was that EAPs no longer in business were excluded from the study; only EAP organizations that were still in business at the time this study was conducted (2011) were included. Those organizations that went out of business, were acquired or merged with other organizations may still have had components that were adaptive and of interest with respect to EAP evolution.

In order to mitigate some of the limitations of this study, such as an interview subject bias, researcher bias, and the retrospective nature of the data being sought, the methods of triangulation, member checking, peer debriefing, and creating an audit trail (as already described) were employed. These methods, while not perfect, helped to ensure the most rigorous and authentic interpretation of the data.

Conclusion

Data in this study illustrated how the marketplace in which EAPs operate has changed considerably since the early 1990s. As expected, participants reported that MBHOs had a significant impact on EAP evolution, though other factors such as benefits brokers and consultants, and free EAPs offered through disability and other insurance products also had a big impact. In response to the changing market, EAPs were forced to adapt and have changed considerably from their original conception with respect to

services, structure, and strategy. EAPs have adopted new forms of technology such as sophisticated databases and new forms of communication. They have developed new methods of measuring impact and in showing value to client companies. They have become more specialized and more efficient. In addition, EAP organizations have integrated with ancillary services such as work/life and wellness and greatly expanded service offerings. EAP services today are more accessible and more customizable. EAPs have also expanded the mission of their organizations to be more preventative and to address more diverse human problems.

There were also some concerning developments in EAP evolution. Some participants reported that EAP service quality has decreased in response to the competitive business environment. In addition, EAPs' viability may be in danger due to continued price-pressure, unethical business practices, issues with quality, and difficulty demonstrating impact and value. Many purchasers see EAP as a healthcare benefit, and do not value its role in addressing workplace performance issues; this problem is exacerbated by MBHOs' continued domination of the industry. Furthermore, EAPs' creation of spin-off services that have no connection to the workplace may pose a danger by further diluting the EAP concept.

Clinical professionals, especially social workers, are still prevalent in the industry, and participants report an increase in clinical specialization. EAPs have also adopted more business skills and hired more business, sales and marketing professionals. Despite numerous business-focused changes, the core mission of human service has remained across all forms of service provision. EAPs have adapted to the changing business

environment through a unique combination of social service and business values. The adherence to both business and social service values may be the best method of insuring EAPs' continued survival.

References

Abernathy, W. J., & Utterback, J. M. (1978). Patterns of industrial innovation, *Technology Review*, 80, 41–47.

Agarwal, R. & Gort, M. (2002). Firm and Product Life Cycles and Firm Survival, *American Economic Review*, 92(2), 184-190.

Ahn, K.K. & Karris, P.M. (1989). Numbers versus severity: The truth in measuring EAP cost benefits. *Employee Assistance Quarterly, 4*(4), 1-14.

Akabas , S.H. & Kurzman, P.A. (1982). The industrial social welfare specialist: What's so special? In S.H. Akabas & P.A. Kurzman (Eds.), *Work, Workers, and Work organizations: A view from Social Work* (pp. 199-204). Englewood Cliffs, N.J.: Prentice Hall.

Akabas, S.H. & Kurzman, P.A. (2005). *Work and the workplace: A resource for innovative policy and practice*. New York, NY: Columbia University Press.

Amaro, H., Ahl, M., Matsumoto, A., Prado, G., Mule, C., Kemmemer, A., Larimer, M.E., Masi, D., & Mantella, P. (2009). Trial of the university assistance program for alcohol use among mandated students. *Journal of Studies on Alcohol and Drugs,* Supplement 16, July. 45-56.

Argyres, N. & Bigelow, L. (2007). Does transaction misalignment matter for firm survival at all stages of the industry life cycle? *Management Science*, 53(8), 1332–1344.

Atkinson, R. (1998). *The life story interview: Qualitative research methods series.* Vol.44. Thousand Oaks, CA: Sage Publications.

ATLAS.ti Scientific Software Development GmbH. (2009). Retrieved from http://www.atlasti.com/copyright.html

Attridge, M. (2011a). The Emerging Role of E-Therapy. *Journal of Employee Assistance, 41*(4).

Attridge, M. (2011b). The business case bibliography: 100 review papers on the workplace value of mental health, addiction, and EAP services. *EASNA Research Notes, 2*(4), 1-10. Retrieved from http://www.easnsa.org/

Attridge, M., Amaral, T., Bjornson, T., Goplerud, E., Herlihy, P., McPherson, T., Paul R., Routledge, S., Sharar, D., Stephenson, D., & Teems, L. (2009a). History and growth of the EAP field. *EASNA Research Notes, 1*(1), 1-4. Retrieved from http://www.easnsa.org/

Attridge, M., Amaral, T., Bjornson, T., Goplerud, E., Herlihy, P., McPherson, T., Paul R., Routledge, S., Sharar, D., Stephenson, D., & Teems, L. (2009b). Utilization of EAP services. *EASNA Research notes, 1*(5). Retrieved from http://www.easna.org/

Attridge, M., Amaral, T., Bjornson, T., Goplerud, E., Herlihy, P., McPherson, T., Paul R., Routledge, S., Sharar, D., Stephenson, D., & Teems, L. (2010). Indicators of the quality of EAP services. *EASNA Research Notes, 1*(7), 1-5. Retrieved from http://www.easna.org/

Attridge, M., Amaral, T., & Hyde, M. (2003). Completing the business case for EAPs: Research on EAP organizational services shows they save money and create opportunities to participate in management initiatives and strategic planning. *Journal of Employee Assistance,* August. 1-3. Retrieved from http://findarticles.com/p/articles/mi_m0PLP/is_3_33/ai_n18616595/?tag=content;col1

Attridge, M., Herlihy, P.A., & Maiden, R.P. (Eds.). (2005). *The integration of employee assistance, work/life, and wellness services.* New York, NY: The Haworth Press.

Bacharach, S.B., Bamberger, P., & Sonnenstuhl, W.J. (1994). *Member assistance programs in the workplace: The role of labor in the prevention and treatment of substance abuse.* Ithaca, NY: ILR Press.

Balgopal, D. & Patchner, M. (1988). Evaluating employee assistance programs: Obstacles, issues, and strategies. *Employee Assistance Quarterly, 3*(3/4), 95-105.

Barak, A., Hen, L., Boniel-Nissim, M., & Shapira, N. (2008). A comprehensive review and a meta-analysis of the effectiveness of internet-based psychotherapeutic interventions. *Journal of Technology in Human Services, 26*(2), 109–160.

Baritz, L. (1960). Chapter 6: Hawthorne and managerial sociology. In L. Baritz, *The servants of power: A history of the use of social science in American industry* (pp. 96-116). Middletown, CT: Wesleyan University Press.

Barker, R.L. (2003). *The social work dictionary*. Washington, DC: NASW Press.

Barton, P. L. (1999). The health services delivery system: Managed care. In Health Administration Press (Ed.), *Managed care essentials: A book of readings* (pp. 25-54). Chicago, IL: Health Administration Press.

Bates, J. & Thompson, N. (2007). Workplace wellbeing: An occupational social work approach. *Illness, Crisis, & Loss, 15*(3), p. 273-284.

Beidel, B.E. (2005). A case for a common language in employee assistance programs. *Employee Assistance Quarterly, 19*(3), 59-73.

Berridge, J., Cooper, C.L. & Highley-Marchington, C. (1997). *Employee assistance programmes and workplace counselling.* New York, NY: John Wiley & Sons.

Bickerton, R.L. (1990). Employee assistance: A history in progress. *EAP Digest*, November/December, 34-84.

Bjornson, T. & Sharar, D. (2004). Bring it on Home. *EAP Digest*. Fall, 16-20.

Blair, B. (2004). EAPs in the world of work. *The Journal of Employee Assistance.* Retrieved from http://www.thefreelibrary.com/_/print/PrintArticle.aspx?id=118183686

Blocker, J.S., Fahey, D.M, & Tyrrell, I.R. (2003). *Alcohol and temperance in modern history: A global encyclopedia* (Vol. 1, pp.3-4). Santa Barbara, CA: ABC-CLIO, Inc.

Blum, T.C. & Bennett, N. (1990). Employee assistance programs: Utilization and referral data, performance management, and prevention concepts. In P.M. Roman

(Ed.), *Alcohol problem intervention in the workplace: Employee assistance programs and strategic alternatives* (pp. 143-161). New York, NY: Quorum Books.

Blum, T.C., Martin, J.K., & Roman, P.M. (1992). A research note on EAP prevalence, components, and utilization. *Journal of Employee Assistance Research, 1*(1), 209-229.

Blum, T.C. & Roman, P.M. (1989). Employee assistance programs and human resources management. In G.R. Ferris & K.M. Rowland (Eds.), *Research in personnel and human resources management* (Vol. 7, pp. 259-312). Greenwich, CT: JAI Press.

Blum, T.C & Roman, P.M. (1995). *Cost-effectiveness and preventive implications of employee assistance programs*. Rockville, MD: U.S. Department of Health and Human Services.

Blum, T.C., Roman, P.M. & Tootle, D.M. (1988). The emergence of an occupation. *Work and Occupations, 15*(1), 96-114.

Brandes, S.D. (1976). *American Welfare Capitalism*. Chicago, IL: The University of Chicago Press.

Brummett, P.O. (1999). Successfully matching employee to substance abuse treatment through non-routinized employee assistance referral. *Employee Assistance Quarterly, 15*(1), 1-18.

Brummett, P.O. (2000). A comparison of employee assistance programs providing internal versus external treatment services: A research note. *Employee Assistance Quarterly, 15*(4), 19-28.

Buck Consultants. (2007). *Buck Consultants Reports Wellness Programs Are Truly Global; Objectives Vary by Region*. Retrieved from http://www.buckconsultants.com/buckconsultants/Portals/0/Documents/PUBLICATIONS/Press_Releases/2007/PR_10_10_07.pdf

Buck Consultants. (2009). *Working well: A global survey of health promotion and workplace wellness strategies, executive summary.* Retrieved from http://www.acsmiawhp.org/files/DOCUMENTLIBRARY/Global%20Wellness%202009_ExecSumm_English-1.pdf

Burke, J. (2004). Defining the business of EAPs: With the scope of EAP services changing from a clinical emphasis to a focus on workplace productivity, the next step is to develop a new branding strategy that will communicate the skills and knowledge the profession has to offer. *Journal of Employee Assistance,* December. Retrieved from http://findarticles.com/p/articles/mi_m0PLP/is_4_34/ai_n17207974/

Burke, J. (2008). The lessons of free EAPs. *Journal of Employee Assistance, 38*(2), 17-18.

Burke, W. W. (2002). *Organization change: Theory and practice*. Thousand Oaks, CA: Sage Publications.

Burnes, B. (2005). Complexity theories and organizational change. *International Journal of Management Reviews*, *7*(2), 73-90.

Burton, W.N., Chen, C., Conti, D.J., Schultz, A.B.,Pransky, G.M.,& Edington, D. W. (2005). The association of health risks with on-the-job productivity. *Journal of Occupational and Environmental Medicine, 47* (8), 769-777.

Butcher, L. (2008). Wellness Programs: No Longer Just an Add-On. *Managed Care Magazine.* Retrieved from http://www.managedcaremag.com/archives/0802/0802.wellness_main.html

Cagney, T. (1999). Models of service delivery. In J.M. Oher (ed.), *The employee assistance handbook* (pp. 59-69). New York, NY: John Wiley & Sons.

Carroll, M. (1996). *Workplace counselling*. London, England: SAGE Publications Ltd.

Carter, I. (1977). Social work in industry: A history and a viewpoint. *Social Thought, 3*(1), 7-31.

Center for Health Workforce Studies & NASW Center for Workforce Studies. (2006). Chapter 3, Supplement: Licensed social work practice. In, Center for Health Workforce Studies & NASW Center for Workforce Studies, *Licensed social workers in the United States, 2004* (pp. 1-23). Retrieved from http://workforce.socialworkers.org/studies/supplemental/supplement_ch3.pdf

Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis.* Thousand Oaks, CA: Sage.

Chestang, L. (1982). Work, personal change, and human development. In S. Akabas & P. Kurzman (Eds.), *Work, workers and work organizations* (pp. 61-89). Englewood Cliffs, NJ: Prentice Hall, Inc.

Collins, J., Gibson, A., Parkin, S., Parkinson, R., Shave, D., Dyer, C. (2012). Counselling in the workplace: How time-limited counseling can effect change in well-being. *Counselling and Psychotherapy Research,* 1-9. Retrieved from: *www.tandfonline.com/doi/pdf/10.1080/14733145.2011.638080*

Collins, K.R. (1998). Cost/benefit analysis shows EAPs value to employer. *EAP Association Exchange, 28*(6), 16-20. (abstract only).

Collins, K.R. (1999). Workplace safety, drug testing, and the role of EAP. In J.M. Oher (Ed.), *The Employee Assistance Handbook* (pp. 387-403). New York, NY: John Wiley & Sons.

CONSAD Research Corporation (1999). Historical overview and evolution of employee assistance programs. *EAP Handbook.* Retrieved from http://www.consad.com/eap/eap_toc.htm

Conti, D.J. & Burton, W.N. (1999). Behavioral health disability management. In J.M. Oher (Ed.), *The Employee Assistance Handbook* (pp. 319-359). New York, NY: John Wiley & Sons.

Cooper, C.L., Dewe, P., & O'Driscoll, M. (2003). Employee assistance programs. In J. Quick & L. Tetrick (Eds.), *Handbook of Occupational Health Psychology* (pp. 289- 304). Washington, D.C.: American Psychological Association.

Courtois, P., Hajek, M., Kennish, R., Paul, R., Seward, k., Stockert, T.J., et al. (2004). Performance measures in the employee assistance program. *Employee Assistance Quarterly, 19*(3), 45-58.

Creswell, J.W. (1994). Combined qualitative and quantitative designs. In J.W. Creswell, *Research Design: Qualitative and Quantitative Approaches* (pp.173-192), Thousand Oaks, CA: Sage.

Creswell, J.W. (1998). *Qualitative inquiry and research design: Choosing among five traditions.* Thousand Oaks, CA: Sage.

Csiernik, R. (1999). Internal versus external employee assistance programs: What the Canadian data adds to the debate. *Employee Assistance Quarterly, 15*(2), 1-12.

Csiernik, R. (2004). A review of EAP evaluation in the 1990s. *Employee Assistance Quarterly, 19*(4), 21-37.

Csiernik, R. (2011). The glass is filling: An examination of employee assistance program evaluations in the first decade of the new millennium. *Journal of Workplace Behavioral Health, 26*(4), 334-355.

Cunningham, G. (1994). *Effective employee assistance programs.* Thousand Oaks, CA: Sage.

Dainas, C. & Marks, D. (2000). Evidence of an EAP cost offset. *Behavioral Health Management, July/August*, 34-41.

Daniels, A., Teems, L., Carroll, C.D., Santiago-Fernandez, E. (2004). Crossing the quality chasm: Opportunities for the employee assistance program field. *Employee Assistance Quarterly, 19*(3), 27-43.

Day, G. (1981). The product life cycle: Analysis and applications issues, J*ournal of Marketing*, 45(4), 60-67.

DeFalco, J.L. (Ed.). (2001). *Employee assistance program management yearbook* (2nd edition). Manasquan, NJ: American Business Publishing.

Deitz, D., Cook, R., & Hersch, R. (2005). Workplace health promotion and utilization of health services: follow-up data findings. *The Journal of Behavioral Health Services & Research*, *32*(3), 306-319.

Denzin, N.K. (1978). *The research act: A theoretical introduction to sociological methods* (2nd ed.). New York, NY: McGraw-Hill.

Derr, W.D. (2005). Envisioning EAP's future by reflecting on its past. *Behavioral Health Management*, March/April, 13-18.

Dooley, K.J. (1997). A complex adaptive systems model of organization change. *Nonlinear Dynamics, Psychology, and Life Sciences*, *1*(1), 69-97.

Drotos, J.C. (1999). EAP accreditation and credentialing. In Oher, J.M (Ed.) *The Employee assistance handbook* (pp. 15-34). New York, NY: John Wiley and Sons.

Druss, B.G., Schlesinger, M., & Allen H.M. Jr. (2001). Depressive symptoms, satisfaction with health care, and 2-year work outcomes in an employed population. *American Journal of Psychiatry*. 158, 731–734.

Duening, T. (1997). Our turbulent times? The case for evolutionary organizational change. *Business Horizons*, Jan-Feb. Retrieved from http://findarticles.com/p/articles/mi_m1038/is_n1_v40/ai_19369679/pg_2

Ehrenreich, J.H. (1985). Casework and the emergence of social work as a profession. In J.H. Ehrenreich, *The altruistic imagination: A history of social work and social policy in the United States* (pp. 43-77). Ithaca, NY: Cornell University Press.

Eischen, B.D., Grossmeir, J., Gold, D.B. (2005). Fairview Alive – an integrated strategy for enhancing the health and well-being of employees. *Journal of Workplace Behavioral Health, 20*(3/4), 263-279.

Employee Assistance Professionals Association (2003). EAPA standards and professional guidelines. Arlington, VA: EAPA. Retrieved from http://www.eapassn.org/public/pages/index.cfm?pageid=1

Employee Assistance Professionals Association (2006). EAP utilization. Retrieved from: http://eapassn.org/public/pages/index.cfm?pageid=1

Employee Assistance Professionals Association (2008). EAP core technology. Retrieved from http://www.eapassn.org/public/pages/index.cfm?pageid=521

Employee Assistance Society of North America. (2008). News release: EASNA Survey Shows an Increase in Employee Assistance Program Utilization in this Declining Economy. December. Retrieved from http://www.easna.org/news.html

Ensuring Solutions to Alcohol Problems. (2006). Eaps: Workplace opportunities for intervening in alcohol problems. *Primer 5.* George Washington University Medical Center. Retrived from www.ensuringsolutions.org

Erfurt, J.C. & Foote, A. (1977). *Occupational employee assistance programs for substance abuse and mental health problems*. Ann Arbor, MI: Wayne State University.

Erikson, E. (1963). *Childhood and society*. New York, NY: Norton.

Feinstein, B.B. & Brown, E.G. (1982). *The new partnership: Human services, business, and industry.* Cambridge, MA: Schenkman Publishing Company.

Feldman, S. (2003). Chapter 1: Choices and challenges. In S. Feldman (Ed.), *Managed Behavioral Health Services* (pp. 3-23). Springfield, Illinois: Charles C. Thomas Publisher, Ltd.

Forthofer, M. S., Markman, H. J., Cox, M., Stanley, S., & Kessler, R. (1996). Associations between marital distress and work loss in a national sample. *Journal of Marriage and the Family, 58*(3), 597-605.

Fox A, Oss M. & Jardine E. (2000). *Open Minds: Yearbook of Managed Behavioral Health Market Share in the United States, 2000-2001.* Gettysburg, PA: Open Minds.

French, M.T., Dunlap, L.J., Roman, P.M., & Steele, P.D. (1997a). Factors That Influence the Use and Perceptions of Employee Assistance Programs at Six Worksites. *Journal of Occupational Health Psychology, 2*(4), 312-324.

French, M.T., Zarkin, G.A., Bray, J.W., & Hartwell, T.D. (1997b). Costs of employee assistance programs: Findings from a national survey. *American Journal of Health Promotion, 11*(3), 219-222.

French, M.T., Zarkin, G.A., Bray, J.W., & Hartwell, T.D. (1999). Cost of employee assistance programs: Comparison of national estimates from 1993 and 1995. *The Journal of Behavioral Health Services & Research, 26*(1), 95-103.

Galinsky, E., Bond, J. T., & Sakai, K. (2008). *2008 National Study of Employers*. Retrieved from http://familiesandwork.org/site/research/reports/2008nse.pdf

Garman, E.T., Leech, I.E. & Grable, J.E. (1996). The negative impact of employee poor personal financial behaviors on employers. *Financial Counseling and Planning*, *7*, 157-168. Retrieved from http://www.afcpe.org/pages/journal.cfm?top_id=21

Glick, W.H., Huber, G.P., Miller, C.C., Doty, D.H., & Sutcliffe, K.M. (1990). Methods for Studying Processes of Organizational Change. *Organization Science, 1*(3), 293-312.

Googins, B. & Godfrey, J. (1987). *Occupational Social Work*. Englewood Cliffs, NJ: Prentice-Hall.

Gornick, M.E. & Blair, B.R. (2005). Employee assistance, work-life effectiveness, and health and productivity: A conceptual framework for integration. In Attridge, M., Herlihy, P.A., & Maiden, R.P. (Eds.). (2005). *The integration of employee assistance, work/life, and wellness services* (pp. 1-30). New York, NY: The Haworth Press.

Greenwood, K.L., DeWeese, P., & Inscoe, P.S. (2005). Demonstrating the value of EAP services: A focus on clinical outcomes. *Journal of Workplace Behavioral Health, 21*(1), 1-10.

Greiff, B. (1978). The history of occupational psychiatry. *Psychiatric Opinion, 15*, December, 10-17.

Griffiths, K. M., & Christensen, H. (2006). Review of randomized controlled trials of Internet interventions for mental disorders and related conditions. *Clinical Psychologist, 10*(1), 16-29.

Hagemann, J. (2010). *Parity overview, part 1: The impact on payors, consumers and eaps.* Retrieved from http://behavioralhealthcentral.com/index.php/20100330218019/Special-Features/parity-overview-part-1-the-impact-on-payors-consumers-and-epas.html

Hargrave, G.E. & Hiatt, D. (2004). The EAP treatment of depressed employees: Implications for return on investment. *Employee Assistance Quarterly, 19*(4), 39-49.

Hargrave, G. E., Hiatt, D., Alexander, R., & Shaffer, I. A. (2008). EAP treatment Impact on presenteeism and absenteeism: Implications for return on investment. *Journal of Workplace Behavioral Health, 23*(3), 283–293.

Hargrave, G.E., Hiatt, D., Dannenbaum, S.E., & Shaffer, I.A. (2007). Effectiveness of a telephone-based anger management program for referred employees. *Journal of Workplace Behavioral Health, 22*(4), 17-27.

Harlow, K.C. (2006). The effectiveness of a problem resolution and brief counseling EAP intervention. *Journal of Workplace Behavioral Health, 22*(1), 1-12.

Harris, S.M., Adams, M., Hill, L., Morgan, M., Soliz, C. (2002). Beyond customer satisfaction: A randomized EAP outcome study. *Employee Assistance Quarterly, 17*(2), 53-61.

Hartwell, T.D., Steele, P., French, M.T., Potter, F.J., Rodman, N.F., & Zarkin, G. A. (1996). Aiding troubled employees: The prevalence, cost, and characteristics of employee assistance programs in the United States. *American Journal of Public Health*, *86*(6), 804-808.

Heck, P.W. (1999). Chapter 15: The evolving role of EAPs in managed behavioral healthcare: A case study of DuPont. In Oher, J.M (Ed.), *The Employee assistance handbook* (pp.291-304). New York, NY: John Wiley and Sons.

Herlihy, P.A. (2000). Employee assistance and work/family programs: friends or foes? *Employee Assistance Quarterly, 16*(1/2), 33-51.

Herlihy, P. (2005). Perspectives on the future of integration. *Journal of Workplace Behavioral Health, 20*(3/4), 407-417.

Herlihy, P.A. & Attridge, M. (2005). Research on the integration of employee assistance, work-life and wellness services: Past, present and future. *Journal of Workplace Behavioral Health, 20*(1/2), 67-93.

Hersch, L. (1995). Adapting to health care reform and managed care: Three strategies for survival and growth. *Professional Psychology: Research and Practice, 26*(1), 16-26.

Huber, G.P., Sutcliffe, K.M. , Glick, W.H. & Miller, C.C.. (1993). Competing Determinants of Organizational Change. In *Organizational Change and Redesign* (pp. 215-267). New York: Oxford University Press.

Hughes, D., Elkin, C., & Epstein, I. (2004). Long term counseling: A feasibility study of extended follow-up services with high risk EAP clients. *Journal of Employee Assistance, 24*(1), 15-18.

Hutchison, W.S. & Vickerstaff, S. (2009). The need and rationale for employee assistance programs. In M. A. Richard, W. G. Emener, & W. S. Hutchison, Jr. (Eds.), Employee assistance programs: Wellness/enhancement programming, 4th ed. (pp. 34-36). Springfield, IL: Charles C Thomas.

Iglehart, J. K. (1996). Managed care and mental health. *The New England Journal of Medicine, 334*(2), 131-135.

Insel, T.R. (2008). Assessing the economic costs of serious mental illness. *American Journal of Psychiatry, 165*(6), 663-665.

Interim final rules under the Paul Wellstone and Pete Domenici mental health parity and addiction equity act of 2008; Final rule, 45 C.F.R. pt. 146 (2010). *Federal Register, 75*(21). Retrieved from http://www.dol.gov/federalregister/HtmlDisplay.aspx?DocId=23511&AgencyId=8&DocumentType=2

Jacobson, J.M., Jones, A.L., & Bowers, N. (2011). Using existing employee assistance program case files to demonstrate outcomes. *Journal of Workplace Behavioral Health, 26*(1), 44-58.

Kacmar, K.M., Andrews, M.C., Van Rooy, D.L., Steilberg, R.C., & Cerrone, S. (2006). Sure, everyone can be replaced..but at what cost? Turnover as a predictor of unit-level performance. *Academy of Management Journal, 49*(1), 133-144.

Kamilis, J. (2010). *Employee Assistance Programs Target Mental Health Parity Costs*. Retrieved from http://www.shrm.org/hrdisciplines/benefits/articles/pages/EAPcosts.aspx

Kauffman, S.A. (1993). Self-organization and adaptation in complex systems. In, S.A. Kauffman, *The origins of order: Self organization and selection in evolution.* New York, NY: Oxford University Press.

Keaton, B., & Yamatani, H. (1993). Benefits of mandatory EAP participation: A study of employees with last chance contracts. *Employee Assistance Quarterly, 9*(1), 67-77.

Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the national comorbidity survey replication. *Archives of General Psychiatry*, *62*(6), 593-602.

Kessler, R.C., Heeringa, S., Lakoma, M.D., Pettukhova, M., Rupp, A.E., Schoenbaum, M., Wang, P.S., & Zaslavsky, A.M. (2008). Individual and societal effects of mental disorders on earnings in the United States: Results from the National Commobidity Survey Replication. *American Journal of Psychiatry, 165*(6), 703-711.

Kiesler, C. A. (May 2000). The next wave of change for psychology and mental health services in the health care revolution. *American Psychologist, 55*(5), 481-487.

Klarreich, S.H., DiGiuseppe, R., & DiMattia, D.J. (1987). Cost-effectiveness of an employee assistance program with rational-emotive therapy. *Professional Psychology: Research and Practice, 18*(2), 140-144.

Klepper, S. (1996). Entry, exit, growth, and innovation over the product life cycle, *The American Economic Review*, 86(3),562–583.

Klepper, S. (1997). Industry life cycles, *Industrial and Corporate Change*, 6(1), 145–182.

Klepper, S., & Graddy, E. (1990). The evolution of new industries and the determinants of market structure, *The RAND Journal of Economics*, 21(1), 27–44.

Kurzman, P.A. (1987). Industrial social work (occupational social work). In A. Minahan et al. (Eds.), *Encyclopedia of Social Work* (18th ed., pp. 899-910). Silver Spring, MD: NASW Press.

Kurzman, P.A. (2008). Occupational social work. In T. Mizrahi & L.E. Davis (Eds.) *Encyclopedia of Social Work*, (20th ed., Vol. 3, pp. 311-319). Washington, D.C.: NASW Press & Oxford University Press.

Kurzman, P. & Akabas, S.H. (1981). Industrial social work as an arena for practice. *Social Work, 26*(1), January, 52-59.

Lee, K. (2005). Low prices drag EAP quality down. *Employee Benefit News*, Jaunuary. Retrieved from http://www.mywire.com/pubs/EmployeeBenefitNews/2005/01/01/694433

Levitt, T. (1965). Exploit the product life cycle, *Harvard Business Review,* November/December, 81-94.

Lewis, R. B. (2004). NVivo 2.0 and ATLAS.ti 5.0: A Comparative Review of Two Popular Qualitative Data-Analysis Programs. *Field Methods 16* (4), 439-464.

Lewis, J. A., & Lewis, M. D. (1986). *Counseling programs for employees in the workplace*. Monterey, CA: Brooks/Cole Publishing Company.

Lincoln, Y.S. & Guba, E.G. (1985). *Naturalistic inquiry.* Beverly Hills, CA: Sage.

Lumpkin, G. T., & Dess, G. G. (2001). Linking two dimensions of entrepreneurial orientation to firm performance: The moderating role of environment and industry life cycle. *Journal of Business Venturing*, 16, 429–451.

Lutterman, T. & Gonzalez, O. (2006). Chapter 10: The uniform reporting system. In R.W. Manderscheid & J.T. Berry (Eds.), *Mental Health, United States, 2004* (pp. 65-86). Retrieved from http://mentalhealth.samhsa.gov/publications/allpubs/SMA06-4195/Chapter10.asp

Macdonald, S., Wells, S., Lothian, S., & Shain, M. (2000). Absenteeism and other workplace indicators of employee assistance program clients and matched controls. *Employee Assistance Quarterly, 15*(3), 41-57.

Maiden, R.P. (1988). Employee assistance program evaluation in a federal government agency. *Employee Assistance Quarterly, 3*(3/4), 191-203.

Maiden, R.P. (2001). The evolution and practice of occupational social work in the United States. *Employee Assistance Quarterly, 17*(1-2), 119-161.

Maiden, R.P. (personal communication, October 6, 2008).

Mannion, L.P. (2004). *Employee assistance programs: What works and what doesn't.* Westport, CT: Praeger.

Mark, T., Coffey, R., King, E., Harwood, H., McKusick, D., Genuardi, J., Dilonardo, J., Buck, J. National spending estimates for mental health and substance abuse treatment, 1987-1997. *Health Affairs, 19*(4), 108-120.

Masi, D.A. (1982). *Human services in industry*. Baltimore, MD: Sheppard Pratt.

Masi, D.A. (1992). Employee assistance programs. In D.A. Masi (Ed.), *The AMA handbook for developing employee assistance and counseling programs* (pp. 1-19). New York, NY: American Management Association.

Masi, D.A. (1994). *Evaluating your employee assistance and managed behavioral care program.* Troy, MI: Performance Resource Press.

Masi, D.A. (2000). Defining employee assistance programs, managed behavioral care, and the integrated program: Implications of health care reform. In D.A. Masi, *Evaluating your employee assistance and managed behavioral care program*(pp. 13-35). Washington, D.C.: Dallen Press.

Masi, D.A. (2005). Employee assistance programs in the new millennium. *International Journal of Emergency Mental Health*, *7*(3), 157-168.

Masi, D.A., Altman, L., Benayon, C., Healy, H., Jorgensen, D.G., Kennish, R., et al. (2004). Chapter 16: EAPs in the year 2002. In R. Manderscheid & M. Henderson (Eds.). *Mental Health, United States, 2002* (pp. 209-223). Retrieved from http://mentalhealth.samhsa.gov/publications/allpubs/SMA04-3938/Chapter16.asp

Masi, D.A. & Jacobson, J.M. (2003). Outcome measurements of an integrated employee assistance and work-life program. *Research on Social Work Practice, 13*(4), 451-467.

Masi, D.A., Jacobson, J.M., Cooper, A.R. (2000). Quantifying quality: Findings from clinical reviews. *Employee Assistance Quarterly, 15*(4), 1-17..

McLeod, J. (2001). *Counselling in the workplace: The facts: A systematic study of the research evidence* (Research Report). Rugby, Warwickshire, UK: British Association for Counselling and Psychotherapy.

McLeod, J. (2010). The effectiveness of workplace counseling: A systematic review. *Counselling and psychotherapy research: Linking research with practice, 10*(4), 238-248.

Mechanic, D., Schlesinger, M., & McAlpine, D. D. (1995). Management of mental health and substance abuse services: State of the art and early results. *The Milbank Quarterly, 73*(1), 19-55.

Menninger, K.A. (1942). Work as sublimation. *Bulletin of the Menninger Clinic*, 6. 170-182.

Mercer, D. (1993). A two-decade test of product life cycle theory, *British Journal of Management*, 4 (4), 269-74.

Merrick, E.S.L, Hodgkin, D., Horgan, C.M., Hiatt, D., McCann, B., Azzone, V., Zolotusky, G., Ritter, G., Reif, S., & McGuire, T.G. (2009). Integrated employee assistance program/managed behavioral care benefits: Relationship with access and client characteristics. *Administration and Policy in Mental Health, 36*(6), 416-423.

Merrick, E.S.L., Volpe-Vartanian, J., Horgan, C.M., & McCann, B. (2007). Revisiting employee assistance programs and substance use problems in the workplace: Key issues and a research agenda. *Psychiatric Services, 58*(10), 1262-1264.

Mitleton-Kelly, E. (2003). Part II: Essentials of complexity theory for organization studies. In E. Mitleton-Kelly (ed.), *Complex systems and evolutionary perspectives on organizations: The application of complexity theory to organizations.* New York, NY Pergamon.

Mor Barak, M.E. & Bargal, D. (2000). Introduction: Human services in the context of work: Evolving and innovative roles for occupational social workers. In M.E. Mor Barak & D. Bargal (Eds.), *Social services in the workplace: Repositioning occupational social work in the new millennium* (pp. 1-11). Binghampton, NY: Haworth Press.

Morris, T. (2006). *Social work research methods: Four alternative paradigms.* Thousand Oaks, CA: Sage Publications.

National Association of Social Workers (NASW), Center for Workforce Studies. (2006). *Assuring the sufficiency of a frontline workforce: A national study of licensed social workers.* Retrieved from http://workforce.socialworkers.org/studies/nasw_06_execsummary.pdf

National Business Group on Health. (2008). *An Employer's Guide to Employee Assistance Programs: Recommendations for Strategically Defining, Integrating and Measuring Employee Assistance Programs*, December. Retrieved from

http://businessgrouphealth.org/benefitstopics/topics/nbghpubs.cfm?topic=0072&desc=Productivity

National Committee for Quality Assurance. (2008a). *About NCQA*. Retrieved from: http://www.ncqa.org/tabid/675/Default.aspx

National Committee for Quality Assurance. (2008b). *Standards and Guidelines for the Accreditation of MBHOs***.** Appendix 6-Glossary of our 2008 MBHO Standards and Guidelines. Appendix 6: 6-6. Washington DC: National Committee for Quality Assurance.

National Committee for Quality Assurance (2008c). *Standards and Guidelines for the Accreditation of MBHOs* (Section 1 of Policies and Procedures, pp. 11-12). Washington DC: National Committee for Quality Assurance.

National Institutes of Health. (2000). *Disease-specific estimates of direct and indirect costs of illness and NIH support: Fiscal year 2000 update.* Bethesda, MD: Office of the Director, Office of Science, Policy and Planning.

Office on National Drug Control Policy. (2004). *The economic costs of drug abuse in the United States 1992-2002.* Retrieved from http://www.ncjrs.gov/ondcppubs/publications/pdf/economic_costs.pdf

Open Minds. (1999). Employee assistance programs on the rise. *Industry News*. Retrieved from http://openminds.com/eprint/1999/070199/070199g.htm

Open Minds. (2002). *Managed Behavioral health & employee assistance program enrollment reaches 227 million in 2002; Magellan, ValueOptions, & United*

Behavioral Health remain in control of 50% of Market. Retrieved from: http://www.openminds.com/pressroom/mbhoyearbook02.htm

Oss, M.E., Morgan, L. & Miller, C. (2011). U.S. behavioral health management market industry report 2011-2012: Executive summary of the largest U.S. organizations in managed behavioral health, employee assistance & disease management markets. Gettysburg, PA: Open Minds. Retrieved from: http://www.openminds.com/e-store/mbho.htm

Padgett, D.K. (2008). *Qualitative methods in social work research* (2nd Ed.). Los Angeles, CA: Sage.

Paul, R. & Thompson, C. (2006). Employee assistance program responses to large scale traumatic events: Lessons learned and future opportunities. In R.P. Maiden, R. Paul, & C. Thompson (Eds.), *Workplace Disaster Preparedness and Management* (pp. 1-19). New York, NY: The Haworth Press.

Peltoniemi, M. (2011). Reviewing Industry Life-cycle Theory: Avenues for Future Research, *International Journal of Management Reviews,* 13(4), 349-375.

Perlis, L. (1980). Labor and employee assistance programs. In R.H. Egdahl & D.C. Walsh (Eds.), *Mental wellness programs for employees* (pp. 78-84). New York, NY: Springer-Verlag.

Perlman, H.H. (1968). *Persona: Social role and personality.* Chicago: The University of Chicago Press.

Perlman, H.H. (1982). The client as worker: A look at an overlooked role. In S.H. Akabas & P.A. Kurzman (Eds.), *Work, workers, and work organizations: A view from social work* (pp. 90-116). Englewood Cliffs, NJ: Prentice-Hall.

Phillips, N.K. & Straussner, SL.A. (2002). Knowledge for client, agency, and policy practice in N.K. Phillips & S.L.A. Straussner, *Urban Social Work: An introduction to policy and practice in the cities* (pp. 148-174). Boston, MA: Allyn and Bacon.

Popple, P. R. (1981). Social work practice in business and Industry, 1875-1930. *Social Service Review*, June, 257-269.

Potter, A. & Watts, H.D. (2011). Evolutionary agglomeration theory: Increasing returns, diminishing returns, and the industry life cycle, *Journal of Economic Geography*, 11(3), 417-455.

Preece, M., Cayley, P.M., Scheuchl, U., & Lam, R.W. (2005). The relevance of an employee assistance program to the treatment of workplace depression. *Journal of Workplace Behavioral Health, 21*(1), 67-77.

Prohofsky, J.A. (2007). Renewing employee assistance programs: the terrorist attacks on America's workplaces provided EAPs an opportunity to prove their value and renewed employers' interest in using them to address changing needs and new challenges. *Journal of Employee Assistance*, January. Retrieved from http://findarticles.com/p/articles/mi_m0PLP/is_1_37/ai_n31039266/

Prottas, D.J., Diamante, T., & Sandys, J. (2011). The U.S. domestic workforce use of

employee assistance support services: An analysis of ten years of calls. *Journal of Workplace Behavioral Health, 26*(4), 296-312.

Reese, R.J., Conoley, C.W., & Brossart, D.F. (2002). Effectiveness of telephone counseling: A field-based investigation. *Journal of Counseling Psychology, 49*(2), 233-242.

Reynolds, B.C. (1951). *Social work and social living.* New York, NY: Citadel Press.

Reynolds, S. (1997). Psychological well-being at work: Is prevention better than Cure? *Journal of Psychosomatic Research*, *43*(1), 93-102 [Abstract only].

Reynolds, G.S., & Lehman, W.E.K. (2003). Levels of substance use and willingness to use the Employee Assistance Program. *Journal of Behavioral Health and Services Research*, *30*, 238–248.

Roman, P.M. (1990). The salience of alcohol problems in the work setting: Introduction and overview. In P.M. Roman (Ed.), *Alcohol problem intervention in the workplace: Employee assistance programs and strategic alternatives* (pp. 1-16). New York, NY: Quorum Books.

Roman, P.M. & Blum, T.C. (1985). The core technology of employee assistance programs. *The Almacan*, *15*(3), 8-12.

Roman, P. M. & Blum, T.C. (1988). The core technology of employee assistance programs: A reaffirmation. *The Almacan*, *18* (8), 17-22.

Root, L. & Dickinson, K.K. (2009). Joint labor-management programs in the auto industry and the shaping of human services. *Journal of Workplace Behavioral Health, 24*(1-2), 45-60.

Rosenbloom, J.S. (2005). The environment of employee benefit plans, In J.S. Rosenbloom (Ed.), *The handbook of employee benefits: Design, funding, and administration* (pp. 3-13), 6th Ed. New York: McGraw-Hill.

Salzman, P.C. (2002). On reflexivity. *American Anthropologist. 104*(3), 805-813.

Sanchez, L. M., & Turner, S. M. (2003). Practicing psychology in the era of managed care: Implications for practice and training. *American Psychologist, 58*(2), 116-129

Scanlon, W. F. (1991). Unions, management, and joint programs. In W.F. Scanlon, *Alcoholism and drug abuse in the workplace: Managing care and costs through employee assistance programs* (2nd Ed., pp. 118-123). New York, NY: Praeger.

Sciegaj, M., Garnick, D.W., Horgan, C.M., Merrick, E.L., Goldin, D., Urato, M., et al. (2001). Employee assistance programs among fortune 500 firms. *Employee Assistance Quarterly*, *16*(3), 25-35.

Seidman, I. (2006). *Interviewing as qualitative research: A guide for researchers in education and the social sciences* (2nd ed.). New York, NY: Teachers College Press.

Selvik, R. & Bingaman, D. (1998). EAP outcomes from the client's point of view. *EAP Digest, 18*(6), 21-23.

Selvik, R., Stephenson, D., Plaza, C., & Sugden, B. (2004). EAP impact on work, relationship, and health outcomes. *Journal of Employee Assistance: Research Report, 34*(2), 18-22.

Shain, M. & Groeneveld, M. (1980). *Employee assistance programs: Philosophy, theory, and practice.* Lexington, MA: Lexington Books.

Sharar, D.A. (2008). *Do employee assistance program (EAP) affiliate providers adhere to EAP concepts? An examination of affiliate fidelity to EAP theory and practice* (Doctoral dissertation). Retrieved from Dissertation Abstracts International Section A: Humanities & Social Sciences (AAT 3314891).

Sharar, D.A. (2009). The changing nature and future of EAPs. *Journal of Employee Assistance 39*(2), 12-15.

Sharar, D. & Hertenstein, E. (2003). The changing face of employee assistance: A survey of critical issues from key informants. *Benefits Quarterly.*

Sharar, D. & Hertenstein, E. (2006a). Perspectives on commodity pricing in employee assistance programs (EAPs): A survey of the EAP field. *World at Work Journal*, *15*(1).

Sharar, D.A. & Hertenstein, E. (2006b). Perspectives on elevating quality in EAP through standards enforcement: A survey of key informants in the EAP field. *Journal of Workplace Behavioral Health, 21*(1), 53-65.

Sharar, D.A. & Masi, D.A. (2006). Crises facing the EAP field. *Journal of Employee Assistance*, *36*(4), 7-9.

Sharar, D.A. & White, W. (2001). EAP ethics and quality: Does national vs local service delivery make a difference? *EAP Digest*, fall, 16-19.

Sharar, D.A., White, W., & Funk, R. (2002). Business ethics and employee assistance: A national survey of issues and challenges. *Employee Assistance Quarterly, 18*(2), 39-59.

Shepell-FGI Research Group (2009). *Financial distress impacts health and productivity: Employees turning to EAP for help (2009 Series), 5*(1). Retrieved from http://www.shepellfgi.com/ENCA/AboutUs/News/Research%20Report/index.asp

Simons, T. & Hinkin, T.R. (2001). The impact of turnover on hotel profits: A test across multiple hotels. *Cornell Hotel and Restaurant Administration Quarterly, 42*(4), 65-69.

Smith, D. (1989). McDonnell Douglas Corporation's EAP produces hard data. *The Almacan.* 19(August), 18-26.

Smith, R.L. (1987). EAPs: Externally or internally based? *EAP Digest, July/August,* 24-26.

Sonnenstuhl, W.J. & Trice, H.M. (1986). *Strategies for employee assistance programs: The crucial balance.* Ithaca, NY: ILR Press.

Stacey, R.D. (2000). *Strategic management and organizational dynamics: The challenge of complexity* (3rd ed.). New York, NY: Prentice Hall.

Stacey, R.D., Griffin, D. & Shaw, P. (2000). Chapter 5: How the complexity sciences deal with the future. In *Complexity and Management : Fad or Radical Challenge?* (pp. 85-105). Florence, KY: Routledge.

Steele, P. (1998). *Employee assistance programs: Then, now, and in the future.* Presented at the Center for Substance Abuse Prevention's Knowledge Exchange, Tacoma, WA. Retrieved from http://www.workplace.samhsa.gov/Prevention/Files/Synopsis_Overview/EAP_Then_Now_Future.pdf

Stephenson, D., Bingaman, D., Plaza, C., Selvik, R., Sudgen, B., Ross, C. (2003). Implementation and evaluation of a formal telephone counseling protocol in an employee assistance program. *Employee Assistance Quarterly, 19*(2), 19-33.

Straussner, L.A. (1985). The nature and growth of contractual EAPs. *The Almacan, 15*(9), 20-23.

Straussner, S.L.A. (1986). *Helping troubled employees: An analysis of selected employee assistance programs under management auspices* (Doctoral dissertation). Retrieved from Dissertation Abstracts International Section A: Humanities & Social Sciences (AAT 8703095).

Straussner, S.L.A. (1988a). A comparative analysis of in-house and contractual employee assistance programs. *Employee Assistance Quarterly, 3*(3/4), 43-56.

Straussner, S.L.A. (1988b). Comparison of in-house and contracted-out employee assistance programs. *Social Work, 33*(1), 53-55.

Straussner, S.L.A. (1990). Occupational social work today: An overview. In S.L.A. Straussner (ed.), *Occupational Social Work Today* (pp. 1-14). New York, NY: Haworth Press.

Substance Abuse and Mental Health Services Administration. (2009). *Results from the 2008 national survey on drug use and health: National findings.* Retrieved from http://www.oas.samhsa.gov/nsduh/2k8nsduh/2k8Results.pdf

Tanner, R. (1991). Social work: The profession of choice for EAP. *Employee Assistance Quarterly, 6*(3), 71-83.

Tisone, C.R. (2008). Employee Assistance Research Foundation: A call to action. *Journal of Workplace Behavioral Health, 23*(3), 205-215.

Trice, H. & Schronbrunn, M. (1981). A history of job based alcoholism programs, 1900-1955. *Journal of Drug Issues* (pp. 171-198). Spring.

U.S. Census Bureau, 2010 Census Redistricting Data (Public Law 94-171) Summary File (2010). Retrieved from *www.census.gov/geo/www/2010census/GTC_10.pdf*

U.S. Department of Labor, Bureau of Labor Statistics. (1999). *Issues in labor statistics: Summary 99-10, September, 1-2*; *occupational stress.* Retrieved from www.bls.gov/opub/ils/pdf/opbils35.pdf

US Bureau of Labor Statistics. (2009A). *Quality of life benefits: Access, private industry workers, National Compensation Survey*. Retrieved from http://www.bls.gov/ncs/ebs/benefits/2009/ownership/private/table24a.pdf

US Bureau of Labor Statistics. (2009B). *Quality of life benefits: Access, state and local government workers, National Compensation Survey.* Retrieved from http://www.bls.gov/ncs/ebs/benefits/2009/ownership/govt/table24a.pdf

Van Den Berg, N. (2000). Where have we been? Where are we going? Employee assistance practice in the 21st century. *Employee assistance quarterly, 16*(1/2), 1-13.

Wagman, J.B. & Schiff, J. (1990). Managed mental health care for employees: Roles for social workers. In S.L.A. Straussner (ed.), *Occupational Social Work Today*. (pp. 53-66). New York, NY: Haworth Press.

Waldrop, M.M. (1992). *Complexity*. New York, NY: Simon & Schuster.

Wang, P.S., Lane, M., Olfson, M., Pincus, H.A., Wells, K.B., Kessler, R.C. (2005). Twelve-month use of mental health services in the United States: Results from the National Comorbidity Survey Replication. *Archives of General Psychiatry, 62(*6), 629-640.

Watson Wyatt. (2009). *The health and productivity advantage: 2009/2010 North American staying@work report.* Retrieved from http://www.watsonwyatt.com/research/resrender.asp?id=NA-2009-13844&page=1

White, W.L. (2000). Listening to history: Lessons for the EAP field. *EAP Digest*, *20*(1), 16-26.

Wood, L. (1990). The end of the product life cycle? Education says goodbye to an old friend. *Journal of Marketing Management, 6(2), 145-155.*

Wrich, J.T. (1980). *The employee assistance program.* Center City, MN: Hazelden.

Yandrick, R. (1994). Has the core technology become an anachronism? *EAPA Exchange,* February, 6-9.

Zare, N. (1990). The EAP and organizational development: Exploring new territory. *EAP Digest, May/June,* 27-56.

Appendix A: Inclusion Survey

1. Name of Interview Subject:___________________________________

2. Name of organization:___________________________________

3. Year organization was founded:__________

4. Is your organization an externally contracted program? YES NO
5. Years working in EAP industry:

- ☐ <1 year
- ☐ 1-4 years
- ☐ 5-9 years
- ☐ 10-14 years
- ☐ 15-19 years
- ☐ 20 years or more

6. Prior to 1993, did your organization focus primarily on employee workplace productivity and wellbeing related to behavioral, health, and personal issues?

YES NO

If no, specify focus prior to 1993:

7. Prior to 1993, did your organization provide direct services to employees including problem identification, short-term intervention, referral, and case management? YES NO
   If no, specify what services were offered:

8. Prior to 1993, did your organization provide direct services to employing organizations such as consulting with and training to management about dealing with troubled employees in order to improve their work performance?
   YES NO

If no, specify services provided to organizations prior to 1993:

9. Sponsorship: management union joint program (union/management)
   Consortium Professional association Other(specify):

10. Are you owned by or directly affiliated with a managed behavioral health organization? YES NO
    If yes, how affiliated?:

11. Does your organization offer services based on a written policy statement, agreement, or contract that defines the intent and scope of services? YES NO
    If no, specify what contracts or agreements exist:

Appendix B: Statement to subjects

You have been invited to take part in a research study about the changes that have occurred in employee assistance programs since the early 1990s when managed behavioral health organizations became prevalent. This study will be conducted by Jay Sandys, Silver School of Social Work, New York University, as a part of his Doctoral dissertation. His faculty sponsor is Professor Lala Straussner, Silver School of Social Work, New York University.

If you agree to be in this study, you will be asked to do the following:

1. Complete an online survey about your professional background and the organization where you are employed to see if you meet inclusion criteria for this research.
2. Complete an online survey that describes your organization in detail.
3. Complete an online survey that describes your current position at your organization.
4. Participate in an interview (in person or on the telephone) concerning changes that may have occurred in your organization since the early 1990s.
5. Participate in 2 follow up interviews to confirm and clarify information that was gathered in the first interview.

Your initial interview will be audiotaped. You may review these tapes and request that all or any portion of the tapes be destroyed.

Participation in this study will take three and a half hours: 5 minutes for the first survey, 50 minutes for the second survey (depending on availability of information), 5 minutes for the third survey, 90 minutes for the initial interview, and 30 minutes each for the follow up interviews. The second interview will conducted approximately 1 month after the first interview; the 3rd interview will be conducted approximately 6 months after the initial interview.

There are no known risks associated with your participation in this research beyond those of everyday life. Although you will receive no direct benefits, this research may help the investigator understand the changes that have occurred in employee assistance programs since the early 1990s.

Confidentiality of your research records will be strictly maintained by keeping all completed survey and interview data in a password protected file accessible only by the researcher. In addition, only aggregated data will appear in the research report that does not have any identifying information concerning specific participants or their organization.

Participation in this study is voluntary. You may refuse to participate or withdraw at anytime without penalty. For interviews, questionnaires, or surveys, you have the right to skip or not answer any questions you prefer not to answer.

If there is anything about the study or your participation that is unclear or that you do not understand, if you have questions or wish to report a research-related problem, you may contact Jay Sandys at 917-442-7970, js1163@nyu.edu, New York University, or the faculty sponsor, Dr. Lala Straussner at 212-998-5947, sls1@nyu.edu, New York University School of Social Work, 1 Washington Square North, New York, NY 10003.

For questions about your rights as a research participant, you may contact the University Committee on Activities Involving Human Subjects, New York University, 665 Broadway, Suite 804, New York, New York, 10012, at ask.humansubjects@nyu.edu or (212) 998-4808.

You have received a copy of this document to keep.

Appendix C: Interview Guide

Internal Changes

general.

- What do you see as the primary purpose and mission of the services that your organization offers?
    - Has the primary purpose or mission changed since 1993? If so, why?
- What do client companies value in your organization? Has this changed since 1993? If so, why?
- Describe the process of change within your organization. Who decides what changes are needed? What are the drivers of change? How are changes implemented? (How do you know when changes are needed? What informs the need for change?)
- Has the structure or ownership of your organization changed since 1993? If so, in what ways and for what reasons?
- Is your EAP part of a larger organization or parent company? Is so, please explain the relationship.

core technology.

- Please describe your view of "EAP Core Technology". Has your organization changed with respect to aspects of the EAP core technology offered today as compared to 1993? If so, in what ways and why?

services.

- Have the type or kinds of services offered by your organization changed since 1993? (Issues to explore: on site services, crisis services, managed care gatekeeping or other functions, organizational development/consulting, other forms of consulting, executive coaching, disability management, workplace violence initiatives, wellness, training, work/life balance or other work life services, legal/financial, prevention services, disaster preparedness, online counseling including skype or other internet media, instant messaging, telephone counseling, in-person counseling).
- Describe the changes and the reasons for the changes.
- Do you have any specialized programs? If so please describe.
- Has the number of EAP sessions offered changed? If so, why?
- Have the number of onsite services (e.g. CISD/CISM) changed since 1993? If so, what is the change and why?

call center.

- Do you offer 24/7 services? Has this changed in any way since 1993? If so, why?
- Is your call center at your main office or offsite? Has this changed since 1993? If so, why?
- Has the way you answer the phone or assess clients changed? If so, how and why?
- Have the credentials or type of staff member who answers the phone changed since 1993? If so, how and why?

affiliate provider network.

- Has your affiliate provider network changed since 1993? If so, how and why?

  (Issues to explore: size of network, size of network compared to total covered lives, credentials of providers, their knowledge of EAP services, how they are located, how they are contracted, how they are paid, whether they can keep clients after EAP sessions).

staffing.

- Has the number of employees at your organization changed since 1993? In what way and why?
- Have the credentials of staff members changed since 1993? If so in what way and why?
- Has the number of social workers employed at your organization changed since 1993? If so, why do you think this has occurred?
- Do you think the role of social work in the EAP industry has changed since 1993? If so, in what ways and why?
- What are the most important skills of counselors at your organization? Has this changed since 1993? If so, how and why?
- What is the most prevalent profession (if any) with respect to your counseling staff? Has this changed since 1993? If so, how and why?
- Do you have any staff permanently on site at client companies? Has this changed since 1993? If so, why?

accreditation.

- What are your thoughts about EAP accreditation and accreditation of EAP professionals?

presenting problems.

- Have the type of presenting problems reported by clients changed since 1993? If so, how and why?
- Have the type or scope of services being requested by client companies changed since 1993? If so, how and why?

clients served.

- Has the number of clients served by your organization changed since 1993? If so, how and why?
- Have the characteristics of the clients served by your organization changed since 1993? If so, in what ways and why?

substance abuse.

- Has your organization's focus on substance abuse issues changed since 1993? If so, how and why?
- Have you found that the number or type substance abuse problems identified has changed since 1993? What do you think are the reasons for the changes in rates, if any?
- What methods do you use to identify employees with substance abuse problems?
    - Do you use any standardized tests to identify substance abuse issues?
- Has this changed since 1993? If so, how and why?

performance measures/reporting.

- Do you systematically evaluate your performance? Has this changed since 1993? If so, why?
- Has the way in which you report effectiveness, utilization or other variables to client companies changed since 1993? If so, how and why?
- Please describe the method of documenting cases currently being used by your organization (e.g. database/documentation system). Has this changed since 1993? If so, why and in what ways? What has been the impact of these changes (if any)?

cost.

- Have your operating costs changed since 1993? If so, why and what measures have you instituted to in order to remain competitive?
- Have the costs you charge clients for services changed since 1993? Why?
- What impact have changes in cost had, if any?
- Have their been any changes with respect to profit margins for EAP services?
- Any changes to your organization's name or the way it is described?
- What other changes do you believe are necessary for your EAP? Please explain the logic behind any future changes (if any) that you believe are necessary.

External Changes

- Benefits brokers/consultants: Describe your experience with them. How much of your business is obtained through brokers? Do you cultivate relationships with them?

- Do you think that the environment in which EAPs operate has changed since 1993? If so, in what ways? What, if any, was the impact? What do you think was the primary environmental change?
- What are client companies asking for now, and has that changed since 1993? How have you responded to any changes in what client companies are requesting?
- What other environmental changes do you believe are occurring or may occur in the next 5-10 years?
- What changes (if any) have you noted in other EAPs or the EAP industry in general?
- What are your thoughts national industry organizations such as EAPA and EASNA? Has your opinion of the effectiveness and value of these organizations changed since 1993? If so, how and why?

Managed Care

- Does your organization offer gatekeeping services or other managed care services? Has this changed since 1993? If so, how and why?
- In what ways do you think that managed care, and specifically managed behavioral health organizations, have impacted your EAP and the EAP industry?
  - How is what your organization does different than services offered by MBHOs?

Appendix D: Interview Subject Survey

Name of interview subject:____

Age:_________

Gender: Male Female

Ethnicity:__________________

Credentials (degrees/licensure/certificates):__________________

Name of organization:__________________________________

Title (current position):______________________________

Years at this Position

- ☐ <1 year
- ☐ 1-4 years
- ☐ 5-9 years
- ☐ 10-14 years
- ☐ 15-19 years
- ☐ 20 years or more

Years at Organization

- ☐ <1 year
- ☐ 1-4 years

- ☐ 5-9 years
- ☐ 10-14 years
- ☐ 15-19 years
- ☐ 20 years or more

Other positions held at this organization:_________________________

Other positions held in the EAP or Behavioral Health industry:_________________________

Appendix E: EAP Questionnaire

General information

Name of organization:

Location of main office (city, state):

Location of any satellite offices (city, state):

For profit: YES NO

Geographic coverage:

- ☐ Local only
- ☐ State/region
- ☐ National
- ☐ International

Accreditation:

Staffing

Total number of employees:

Number of employees compared to number of covered lives (i.e. number of covered lives divided by number of employees = number of covered lives per employee):

Number of employees with (list highest degree only for each):

Bachelors degree:

Masters degree:

Doctorate degree:

Number of employees with MSW:

Number of employees with clinical licensure (LCSW, LMSW, LMFT, etc.):

Number of employees with CEAP:

Number of employees with substance abuse certification (CASAC, CAC, LAC, CADC, etc.):

Number of employees with SAP:

Organizational reporting

Report to:

- ☐ Human resources department
- ☐ Benefits department
- ☐ Medical department
- ☐ Occupational health and safety department
- ☐ Other(specify):______________________________

Companies served in 2009

Number of client companies:

Number of covered lives (employees + dependents):

Clients served in 2009

Average utilization rate per year (% of client company workforce):

Number of individual clients served in 2009:

Gender of clients served in 2009:

Number of female clients:

Number of male clients:

Service model/services offered

Counseling service models (check all that apply and rank from primary method used to model less frequently used)

- ☐ In-person(at the EAP) Rank:
- ☐ On-site (at the company) Rank:
- ☐ Affiliate Rank:
- ☐ Telephone Rank:
- ☐ Internet Rank:
- ☐ Other (specify): Rank:

Permanent on site-counseling offered? Yes No

Total number of onsite crisis services (e.g. CISD/CISM/Grief group) provided in 2009:

EAP core technology (check all services that your organization currently offers):

(Note: Core technology questions adapted from: Employee Assistance Professionals Association (2008). *EAP core technology*.)

- ☐ Consultation and training to organizational leaders and managers concerning employee performance issues.
- ☐ Outreach and education of employees and their dependents about availability and services provided by the EAP.
- ☐ Confidential assessment services for employees (clients) with personal or workplace issues.
- ☐ Short-term intervention services for employees (clients) with personal or workplace issues.
- ☐ Referral of employees (clients) for diagnosis, treatment, and assistance of their personal or workplace issue.
- ☐ Case management and follow-up services with respect to clients who received EAP services.
- ☐ Assistance to work organizations with respect to managing provider contracts, and in forming and auditing relations with service providers, managed care organizations, insurers, and other third party payers.
- ☐ Assistance to work organizations to support employee health benefits covering medical/behavioral problems, including but not limited to: alcoholism, drug abuse, and mental/emotional disorders.
- ☐ Identification of the effects of EAP services on the work organization and individual job performance.

Call center:

- ☐ At main location
- ☐ Offsite
- ☐ Both offsite and main office
- ☐ No call center
- ☐ Other (specify):

Source of referrals in 2009 (# of each)

Voluntary:

Formal manager referral:

Other(specify):

Session model:

- ☐ 1-3
- ☐ 1-6
- ☐ 1-8
- ☐ other (specify):

Percent of clients served within the EAP exclusively (without referrals): ____%

Work/life services offered:

- ☐ In house
- ☐ Outside contractor
- ☐ Not offered

- ☐ Other (specify):

Wellness services offered:

- ☐ In house
- ☐ Outside contractor
- ☐ Not offered
- ☐ Other (specify):

Organizational consulting services offered:

- ☐ In house
- ☐ Outside contractor
- ☐ Not offered
- ☐ Other (specify):

Services offered (check all that apply):

General

- ☐ 24 hour hotline
- ☐ Assessment
- ☐ Short-term counseling (Individual, couples/families)
- ☐ Ongoing counseling (Individual, couples/families)
- ☐ Group counseling
- ☐ Case management
- ☐ General information/referral
- ☐ Legal services/referral

- ☐ Financial services/referral
- ☐ Elder care services/referral
- ☐ Child care services/referral
- ☐ Concierge services
- ☐ SAP services
- ☐ Outplacement services
- ☐ Career counseling
- ☐ Critical incident management
- ☐ Behavioral health benefits gatekeeping/administration
- ☐ Other (specify):

<u>Training</u>

- ☐ Management training (specify):
- ☐ Employee training (specify):

<u>Consulting</u>

- ☐ Drug-free workplace compliance
- ☐ Helping organizations to interpret and implement legislation
- ☐ Executive coaching
- ☐ Workplace violence support
- ☐ Organizational development
- ☐ Benefits consulting
- ☐ Change management
- ☐ Behavioral risk management

- ☐ Work/life balance
- ☐ Wellness programs/employee health
- ☐ Other (specify):

Wellness

- ☐ Health and wellness trainings (specify):
- ☐ Health and wellness initiatives (specify):

Performance measures/reports

Outcome measurements used (check all that apply):

- ☐ Satisfaction surveys
- ☐ Employee productivity measures
- ☐ Return on investment measures
- ☐ Utilization reports
- ☐ Other (specify):
- ☐ None

Written reports given to employing organizations (check all that apply):

- ☐ Weekly
- ☐ Monthly
- ☐ Quarterly
- ☐ Bi-annually
- ☐ Annually
- ☐ Other (specify):

Appendix F: UCAIHS Approval Notice

University Committee on Activities Involving Human Subjects
665 Broadway, Suite 804
New York, NY 10012
Telephone: 212-998-4808
Fax: 212-995-4304
Internet: www.nyu.edu/ucaihs

UCAIHS APPROVAL NOTICE
Initial Review - Exempt

PI Name: Jay Sandys
HS#: 10-8062
Study Title: "The Evolution of External Employee Assistance Programs Since the Advent of Managed Behavioral Health Organizations in the Early 1990s"
Number of Subjects Approved for enrollment: 30
Approved: November 17, 2010

The above-referenced protocol has been determined to be exempt from federal oversight at ***45 CFR 46 101(b)[2] EXEMPT***. No further review is necessary unless modifications to the protocol related to human research subjects are proposed. Your study will remain active for a three-year period after which time it will be placed in the UCAIHS Offices' deactivated files.

This determination was made with the understanding that the proposed research only involves the following activities:

- Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures or observation of public behavior, unless: (i) information obtained is recorded in such a manner that human subjects can be identified, directly or through identifiers linked to the subjects; and (ii) any disclosure of the human subjects' responses outside the research could reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, or reputation.

If you have any questions, please feel free to contact the UCAIHS office at 212-998-4808 or at ask.humansubjects@nyu.edu.

We wish you success with your research.

Sincerely,
UCAIHS STAFF
New York University
665 Broadway, Suite 804
New York, NY 10012

cc: Lala Straussner, Faculty Sponsor