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Employee Assistance Programs for the New Millennium: Emergence of the Comprehensive Model

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This article reviews the historical evolution of employee assistance programs (EAPs) in the United States over the past 40 years, and concludes that the future of employee assistance lies with its adoption of a Comprehensive Service Program model. To be successful, EAP providers also will need to move away from their current "commodity focus" and "return on investment [ROI] paradigm." Instead, they must begin to identify the critical functions EAPs perform for work organizations that make them indispensable strategic partners in employers' universal pursuit of productivity and innovation. To achieve this goal, the Employee Assistance Professionals Association (EAPA) and Employee Assistance Society of North America (EASNA) must focus on developing a uniform university-based EAP curriculum; moving assertively toward universal state licensure; and actively promoting an evidence-informed, program-based research agenda.

KEYWORDS employee assistance, workplace, EAP models, core technology, occupational alcoholism, work organizations

An irony of the current decade is that the presence of employee assistance programs may be taken for granted by many in labor, industry, and the service professions. However, they formally began in significant

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number only 43 years ago in an early form known as occupational alcoholism programs. Starting with the Hughes Act of 1970 and the organization of the Occupational Alcoholism Branch at the National Institute on Alcohol Abuse and Alcoholism (NIAAA), a new concern about the need for *workplace* intervention programs provided the ideological impetus (and subsequent funding) of work-site programs to detect, confront, and refer alcoholic employees. To provide a site for service for other troubled workers, and to remove some of the stigma of the alcoholism label, these programs were soon renamed employee assistance programs (EAPs) (see DiNitto & McNeece, 1997, ch. 14; Kurzman, 2008; McClellan & Miller, 1988; McGowan, 1984). Although the staffing and services of these early EAPs made successful intervention with nonalcoholic troubled workers problematic, small in-house EAPs continued to serve as best they could all who were referred to them, primarily by supervisors, when these personnel were able to document serious and persistent performance problems among supervisees.

By the late 1970s, an increasing number of professional health and mental health providers had become active in the employee assistance field, staffing programs in corporate, governmental, and trade union settings, and today it is estimated that over 75% of U.S. employers provide EAP services to their employees and family members (Jacobson & Sacco, 2012). Professional social workers were becoming major players, and the first conference of industrial (occupational) social work educators and practitioners was held in New York in 1978 (Akabas, Kurzman, & Kolben, 1979). The scope of employee services soon began to expand well beyond alcoholism and the addictions to include personal and emotional problems that could, or already were, affecting employees' job performance and use of health benefits. Not only had the range of interventions expanded, but the conceptualization and scope of services had become more sophisticated as well (Kurzman & Akabas, 1981; Akabas & Kurzman, 1982, ch. 9).

This article describes the evolution of the modern EAP, noting the struggles for definition and domain. It explains why the field emerged at this time, provides a rationale for its current development, and makes predictions for its future evolution in the new millennium. I will discuss the contending conceptualizations of the field, along with the implications of several extant models for occupational social work education and practice. This exploration will show that pre-professional approaches, which made an early contribution to the field, demonstrated limitations that could be overcome by a professional comprehensive service model. As well, I will show why social work's unique person-in-environment practice framework has given this profession a clear advantage in the field among the several helping disciplines. Today, social work clearly is the "principal player" in the EAP arena, and this article purports to explain why.

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BOUNDARIES OF THE TERRAIN

In 1985, scholars Paul Roman and Terry Blum published a seminal article entitled, "The Core Technology of Employee Assistance Programs," supported, in part, by a grant from the NIAAA. They proposed to define what constituted the component roles and functions of EAP providers, which they termed, "the core technology of employee assistance programs," to wit:

- Identification of employees' behavioral problems on the basis of their job performance
- Consultation to supervisors, managers, and shop stewards
- Appropriate use of "constructive confrontation" as leverage when employees are referred
- Micro- and macro-linkages with external counseling, treatment, and other community resources
- The centrality of employees' alcohol problems as the focus of programs with the most significant promise for producing recovery and genuine cost savings for the work organization. (Roman & Blum, 1985, pp. 16–17)

Roman and Blum made clear that the principal evidence of the success of EAPs would be the treatment of alcohol problems. This focus and "core technology" soon were adopted by the trade association for EAP specialists (then known as the Association of Labor-Management Administrators and Consultants on Alcoholism, ALMACA, and later renamed the Employee Assistance Professionals Association, EAPA) and became the basis for the Association's certification and credentialing programs. With EAPA's support, Roman and Blum reaffirmed the core technology framework three years later, stating emphatically that, "based on our research, we view the EAP as a Personnel/Human Resource Management (P/HRM) tool which has considerable potential for reducing uncertainty in the general management of employees . . . EAPs are part of the performance-management and control activity in an organization's P/HRM system . . . and contribute to the attainment of an organization's goals" (Roman & Blum, 1988, p. 19). They urged that EAPs continue to focus on alcohol and drug abuse as the clearest and most direct contribution to the managerial goal of cost-effectiveness.

Although no one who has worked in or with an EAP would deny the significance of substance abuse as a workplace (indeed, a societal) issue, few today would likely make as ingenuous a claim as Roman and Blum made in 1985 and reaffirmed 3 years later. The workplace has changed, and issues of concern to employers, employees, and trade unions reflect these transformations. As a direct result, a preferred EAP model has evolved over the past four decades that seems to better meet the needs of all the parties. Experts and authors have referred to this preferred model in different terms: Richard Hellan (cited in *Employee Assistance Programs:*

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Benefits, prospects and problems, 1987, p. 21) spoke of a *full-service system*; McClellan and Miller (1988, p. 39) used the term "health intervention EAPs"; Holosko and Feit (1988, p. 282) conceptualized a "new wave, third generation EAP"; Masi (1984) identified the "comprehensive EAP program"; Vigilante (1988, p. 89) suggested the "full family service model"; Nathan (1984, p. 390) emphasized the emerging "broad-spectrum EAP"; Erfurt, Foote, and Heinrich (1990) preferred the term *mega-brush programs*; and Googins (1991b, p. 17) saw EAPs emerging as "family assistance programs." In their own fashion, each author suggested that modern EAPs would not be successful unless the early "core technology" model were modified or supplanted by a conceptualization that would not only reflect the nature of the modern workplace, but the legitimate vested interests of the *several parties* involved: employers, employees, government, unions, and third-party payers.

Concern has been raised by EAPA leaders, however, that comprehensive EAPs will ignore alcoholism and effectively abandon employees with alcohol problems. They insist that the defense structure of alcoholics rarely permits self-referral and that only the threat of job jeopardy and supervisory referral, followed by constructive confrontation, will ensure that alcoholics are identified and served. Systematic field research, however, would not appear to support this claim. In a study in the Midwest, for example, Gloria Cunningham (1989; 1990b, pp. 38–39) found that the EAPs surveyed were reporting high self-referral rates for all types of presenting problems, including chemical dependence and codependence. A Texas study found that self- and peer referral accounted for nearly four times the number of alcoholics served by the EAP as did supervisors' referrals (Martin, Heckel, Goodrick, Schreiber, & Young, 1985, p. 31). On the basis of many years of experience staffing an in-house EAP program, MacDonald and colleagues (1987) forcefully argued in fact that a primary focus on mandatory referrals was truly outdated. Indeed, Foote and Erfurt (1981, p. 231), early proponents of the core technology–alcoholism focus, forthrightly noted the outcome of their own field research studies: "Programs dealing with a variety of employee problems do not necessarily reduce services to alcoholics . . . it is concluded that comprehensive EAPs are generally no less effective than alcohol-focused programs at reaching alcoholic employees."

Moreover, widely recognized experts on alcoholism have stated that, because it is a progressive disease, alcoholism often takes 10 to 15 years before it reaches its middle stages, when it affects job performance (Googins, 1991b; Masi, 1979; Sonnenstuhl & Trice, 1986). As Keith McClellan noted, "measurable job impairment in alcoholism usually occurs only after an increased tolerance for the drug alcohol has been developed, changes in behavior are manifested and tardiness and absenteeism have become problems" (McClellan, 1985, p. 32). Because deteriorating job performance is generally a middle or a late stage sign of alcoholism, rather than an early sign, Shain and Groeneveld (1980, p. 14) observed that, with the core technology

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model, the whole concept of secondary prevention through an EAP may become meaningless. A worker probably would be seriously and chronically ill before intervention and services via the workplace would begin. Particularly with regard to workers with alcohol problems, by this point much lasting (and usually irreversible) physical damage (cirrhosis, pancreatitis, and cerebellar degeneration) will have occurred, and there may well be a breakdown of lifelong friendships, peer relationships, and family ties—many of which may be hard to restore, even upon recovery. Employers therefore have come to realize that such a tertiary model of intervention should not be the primary focus of their EAPs.

In addition, although studies have shown that alcoholism-focused core technology programs may reach unskilled and semiskilled workers, who are closely supervised, such programs usually are far less successful in reaching skilled clerical, professional, and managerial employees, who now constitute the clear majority of the U.S. labor force. Such classes of employees function under less hierarchical conditions or have secretaries and assistants to cover for them and their illness (Googins & Godfrey, 1987; McClellan, 1985).

Core technology–focused EAPs typically employ an alcoholism counselor (often a recovering alcoholic) who provides counseling, confrontation, and referral to outside treatment programs, but offers few prevention services. These EAPs largely are perceived by workers and supervisors alike as having a primary mission—getting documented alcoholics into detoxification, rehabilitation, and aftercare. Perhaps ironically, more modern EAPs, which Nathan studied (1984), which focus on creating positive changes in employees' life-styles, seem to offer more effective alcoholism prevention programs. Because such programs lack the stigma associated with "alcoholism and addiction," they often are successful in attracting troubled workers (and codependent family members) since their services are perceived as nonjudgmental. An added advantage, Nathan noted, is that the organizational commitment of employers and unions to such broad-spectrum EAPs generally is far greater:

> Many managers have concluded that traditional employee assistance programs, those that focus only on alcoholism detection, referral, and treatment, may not be as effective as programs that extend their purview to a broader range of problems, including familial, vocational, financial, interpersonal, behavioral, and psychological/psychiatric ones. Often, this realization comes when the manager observes that many of the alcohol problems that come to his or her attention are either caused or exacerbated by the problems from emotional, behavioral, or familial areas. Yet the traditional EAP counselor is rarely equipped to offer broad-spectrum counseling. (Nathan, 1984, p. 390)

Given both the human and financial advantages inherent in prevention, Nathan concluded that comprehensive EAPs are clearly the preferred model.

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"Primary prevention of addictive problems," McClellan added (1985, p. 34), "is far more cost-effective than the secondary prevention and treatment that most EAPs have practiced." The new Patient Protection and Affordable Care Act of 2010 in fact acknowledges this reality by providing generous incentives for mounting employer wellness and prevention programs. Staring January 1, 2014, for example, its provisions include special premium discounts to support the initiation of employer-sponsored health contingent wellness plans. (EAPA recently updated its *Standards and Professional Guidelines for EAPs*, (EAPA, 2009), to recognize the importance of prevention, in response to advocacy from some of its leading members.) (See, Bennett & Attridge, 2008; Williams, 2009).

Moreover, the reality is that workers with personal and emotional problems are *not* simply "the worried well." Mental health disorders are pervasive in our society and usually have no relation to the substance abuse of an individual or family member. A federally supported 6-year national study of 20,000 people (cited in McClellan, 1985, p. 30) showed that 18.7% of American adults suffered from at least one mental health disorder during an average six-month period. In their 1986–87 national study of 182 randomly selected EAP practitioners, McClellan and Miller (1988) noted that the overwhelming number of practitioners and programs had begun to shift their focus to respond to this reality. More than half were providing diagnosis, not just assessment; ongoing counseling, as well as referrals; and health and wellness education, in addition to treatment. The nature of the EAPs' services had broadened and deepened in response to the demand from the workplace and employers' needs. McClellan and Miller concluded that neither the core technology nor EAPA's credentialing program adequately reflected the emerging scope of EAP activities. Further, they observed that 17% of the responding EAPs, which reportedly offered mental health services, still did not have the skilled staff necessary to provide these services legally. With a touch of irony, Cunningham further documented the trend. In her study of programs in the Chicago area, she noted that many EAP staff, "were distinctly uncomfortable about acknowledging that short-term counseling is as common a part of their practice as it is, commenting, for example, 'Well, you know we don't do any treatment here,' after having detailed sensitive, perceptive and effective interventions with clients that were clearly examples of sophisticated clinical treatment" (Cunningham, 1989, p. 16).

Alcoholism, of course, is not the only problem in the workplace; as noted, it may no longer even be the dominant one (Cocozzelli & Hudson, 1989; Dickman & Challenger, 1988). Stress, disability, work–family dilemmas, trauma, depression, developmental disorders, dependent care, mental illness, and the addictions (broadly defined) appear to be the principal issues to which EAPs must respond today. Such presenting problems require EAP staff to be able to make complex differential diagnoses and to be

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trained in making sophisticated clinical and organizational assessments, even if ongoing services are provided mainly through referral (Hughes, Elkin, & Epstein, 2004). Staff must be comfortable with a proactive, preventive, problem-solving mode of intervention with a wide variety of systemic issues and personal problems (Cunningham, 1990a). Therefore, whenever possible, the answer has been to form an interdisciplinary EAP team with a qualified mental health professional (generally a social worker) at the helm (Bickerton, 1987, p. 14; Kurzman, 1992; Molloy, 1986). State licensure and graduate-level professional credentials also have become significant legal and risk-management requisites for employers, as several authors have noted (Kurzman, 2006; Masi & Montgomery, 1987; Nye, 1986, 1998, ch. 8; O'Hair, 1987). Unfortunately, the reality is that both EAPA and EASNA have been focusing more on the accreditation of EAP *programs* than on the licensing of EAP *practitioners* (Jacobson & Jones, 2010). As a result, currently only two states in the country (North Carolina and Tennessee) provide for the regulation of EAP providers (Bailey & Troxler, 2009). In addition, with the promotion of SBIRT (substance abuse) screening for *all* EAP clients, *regardless of presenting problem*, EAPA's continuing focus on alcohol and drugs (Greenwood, Goplerud, & McPherson, 2010) may be out-of-step with current preferences, and clear trends in the field.

PROFESSIONALIZATION

In 1986, EAPA established standards for receiving the designation of Certified Employee Assistance Professional (CEAP). Today, applicants for CEAP are required to have EAP work experience, mentorship, professional development credits, and to pass a written examination (see www.eapassn.org). Although such voluntary certification is a sign of the further maturation of the field of practice, many believe that EAPA's use of the term *professional* is open to debate. The classic contemporary hallmark of professional status in the Western world—successful completion of a nationally accredited university course of professional study and a minimum standard of education (usually at the graduate level)—*are not* requirements for the CEAP credential; one need not even be a high school graduate to become a CEAP. Further, there is no national, standardized curriculum that a CEAP must pursue to qualify for "professional" status (Tanner, 1991). By a process of incrementalism, what Roman and Blum (1985, p. 19) referred to, quite appropriately, as the "EAP specialist" became the "EAP professional" 2 years later (Delaney, 1988). In an unsigned 1986 editorial ("On Defending our EAP Turf," p. 5), the leaders of EAPA (then ALMACA) were able to boldly state: "Through ALMACA's certification program, qualified EAP professionals will soon have our CEAP designation beside their names. It will denote the attainment of a professional status that ACSW, PhD, MBA, CAC and others do not." The

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EAP authorities William Sonnenstuhl and Harrison Trice (1986, p. 56), however, thoughtfully responded that, to become recognized as a professional, EAP practitioners "must first lay claim to specialized knowledge and skills and then convince management, labor, employees, other occupations and the state that they actually possess such knowledge and skills." They concluded by stating, "unfortunately, the tested body of knowledge about EAPs remains too small to claim the basis for a new occupation, let alone profession." As the employee assistance scholar Dale Masi (2011) notes in her important recent article in the *Journal of Workplace Behavioral Health*, in reality employee assistance is a field, rather than a profession. She underscores that "university education is essential for a profession"; however, she notes that "many EA professionals have never taken an academic course . . ." (p. 4).

The debate on what constitutes a profession is of course longstanding. It can be traced to Abraham Flexner's pronouncements in 1915 and Ernest Greenwood's widely accepted conclusions some 42 years later in his classic treatise titled, "Attributes of a Profession" (1957). Presently, there are five widely acknowledged criteria for recognition as a profession: (1) requisite university-based education; (2) a nationally accredited academic curriculum; (3) the presence of independent scholarly research; (4) universal government regulation and recognition [i.e., state licensure]; and (5) the application and enforcement of an established code of ethics. Measured against these standards, EAP would not likely merit status as a profession. At the risk of appearing pejorative, EAP activity may be closer to the honorable conduct of a trade, and the performance of a skilled occupation, than the practice of a profession.

Indeed, while social workers and psychologists currently are licensed in all 50 states, employee assistance practitioners, as cited, are only regulated in two. Bailey and Troxler (2009, p. 357) further observe that "the field of Employee Assistance Programs has had almost no movement toward state regulation." Second, a requisite university-based program of education (even at the associate degree level) has never been established, and few such efforts (if any) are currently being pursued (Maiden & Hardcastle, 1986). For example, within social work—the profession with the greatest presence in employee assistance—there is an Employee Assistance subspecialization at one graduate program [Maryland], but other schools of social work [such as Columbia, Hunter, Southern California] simply incorporate employee assistance content in their World of Work or Work/Family concentrations. Third, no universally accepted (or accredited) EA curriculum exists, and there is no national accrediting body, such as is present for the professions of social work, psychology, marriage and family therapy, and mental health counseling. Fourth, while EAPA does have a Code of Ethics to which its members are expected to adhere, it would appear that little in the way of enforcement is undertaken, suggesting that active peer

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adjudication (and penalties) exist more as principles than as practice. Finally, the presence of independent scholarly research presently is modest. EASNA publishes the peer-reviewed *Journal of Workplace Behavioral Health*, which "presents innovative research, applied theory, and practical information to keep workplace human service administrators, counselors, and consultants up to date on the latest developments in the field." The journal plays a very useful function, although perusal of its contents will make clear that its purview is much broader than employee assistance. With EAPA, Paul Roman and colleagues made an effort twenty years ago to establish a scholarly journal (titled the *Journal of Employee Assistance Research*); a few issues were published in 1992–1993 before the initiative was ended, primarily due to a dearth of qualified manuscript submissions. In sum, the field's effort to establish what Flexner (1915, p. 582) termed "a scientific knowledge base," as a requisite for status as a profession, would appear to remain unfulfilled.

PROGRAM MODELS

In the context of the continuing debate over professional status, the differences in educational preparation and evolving EAP models have mirrored the perception of need over time by the major parties who share a legitimate self-interest: management, labor, government, and health care payers. Table 1 conceptually contrasts the variables of the *two most prominent models* of contemporary EAPs.

As one can see, the comprehensive service paradigm focuses away from the medical model, emphasizing workers' health rather than pathology; it points toward a social functioning perspective that underscores the need to identify and harness workers' strengths. Moreover, health is re-conceptualized, not just as the absence of disease, but as workers being able to function to their potential in the central arenas of life, such a love and work. The comprehensive model specifically implies that all people (including workers) have problems coping with an environment that provides too few resources and a world that makes too many demands. Hence, it is the "healthy" worker who seeks help and the wholesome workplace that provides it without stigma. The help is likely to be for a personal problem (rather than an illness or disease) that may be affecting the worker's ability to function. Therefore, the model suggests that staff of the comprehensive EAP should be able to find affordable day care for a worker's young children, elder care for a worker's aging parents, and special education services for a worker's dyslexic child. As a locus of information, advocacy, and human service expertise, such an EAP becomes an oasis from which the anxious and distracted worker can drink. Core technology EAPs may not attract such workers, legitimate such presenting problems, or develop the program expertise to perform these functions well. Further,

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TABLE 1 Two EAP Models: Core Technology Versus Comprehensive Service

Variable	Core technology	Comprehensive service
Design	Management tool	A benefit for workers
Orientation	Alcohol and drug abuse	Personal problems that may affect ability to function productively
Principle	A workplace disciplinary alternative	A workplace social utility
Function	Supervisory training and intervention with workers	Supervisory training, intervention with workers, workplace health, education, wellness, and prevention
Focus	Current job performance	Present and potential capacity to function
Objective	To enhance employees' productivity	To preserve precious human and fiscal resources
Concept	New personnel prerogative for employers	New resource and entitlement for workers
Intervention	Constructive confrontation	Differential biopsychosocial assessment and intervention
Services	Prescribed and proscribed by the Roman-Blum (1985) model	Evolving to meet the changing needs of workers and work organizations
Scope	Assessment, referral, and consultation	Assessment, referral, consultation, prevention, and short-term treatment
Intake	Primarily by supervisors' referrals	Referrals by supervisors, self, and peers
Clients	Workers	Workers, families, and their communities
Prevention	Tertiary	Primary and secondary
Staffing	CEAPs with CASAC counseling credentials	Interdisciplinary team, including CEAPs, led by licensed health or mental health professional
Perspective	A health versus pathology perspective; the goal is to discipline or to heal (cure)	An ecological-life perspective; the goal is to enhance social functioning
Commitment	To provide prescribed services	To provide prescribed services and to promote social change

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the focus on alcoholism in such EAPs sends a message to those who have problems (but do not drink or abuse drugs) that somehow *substance misuse* is what employers are really interested in (and will devote their resources to serve); even worse, that personal, situational, family, and environmental problems are not as important, or will be dealt with by staff who may or may not have adequate professional expertise.

The program research that has been cited shows that the idea that EAP staff do not need clinical skills, because they usually just refer workers to private practitioners or community agencies, may be more illusion than reality. For example, Cunningham's (1990b) Chicago-area study found that whereas salaried professional and managerial workers often had many options, because they had good fringe benefit packages, or could afford to pay for such services out-of-pocket, many wage workers had few or no benefits for outpatient mental health or substance abuse treatment. In reality, the core technology EAP's function of "assessment and referral" meant that these workers would not be professionally served because this model "presumed"

benefits that did not exist. These workers often were left to solve their problems themselves or to seek natural helpers, such as bartenders, beauticians, or clergy who might not have the time, mandate, or adequate expertise to help them resolve their problems.

While the core technology prototype has a history of success in reaching out and serving middle- and later-stage alcoholics who work under close supervision in highly structured manufacturing settings, the model may not be in sync with the variety and complexity of today's presenting problems, or to the realities of a twenty-first-century work environment. As noted, the core technology paradigm may be best suited to a factory pattern of production, which is on the wane. As Peter Drucker (cited in Googins, 1991c, p. 44) presciently predicted, early in this new century manufacturing jobs will constitute less than 10% of employment; and, as Drucker accurately forecasted, assembly-line jobs *already* constitute less than 2% of employment in the country. The increasingly blurred boundary between supervisor and supervisee, as Zuboff (1988) and Peters and Waterman (1984) have noted, makes "control" models much more difficult to implement in nonmanufacturing settings. Indeed, according to Naisbitt and Aburdene (1985, p. 297), one of the most prominent shifts in the American workplace "is the movement away from the authoritarian hierarchy—where everyone has a superior and everyone has an inferior—to new lateral structures, lattices, networks, and small teams where people manage themselves." As McClellan (1985, p. 32) has pointed out, constructive confrontation of the troubled worker in denial (which is the methodological centerpiece of the core technology model), "works best when supervisors are dealing with subordinates, there are clear lines of authority, and there are job descriptions with specific and measurable work performance criteria." Such conditions do not exist for most professional, technical, and clerical workers, and they very rarely exist in small businesses, which are the predominant employers in America today. Hence, a dispersed work force, performing with greater autonomy, makes the premises and precepts of the core technology model far less realistic.

The comprehensive service EAP model, underscoring not only supervisory referral of workers in denial, but the appropriateness of self- and peer referral, proposes a conceptually different paradigm. Here the EAP is viewed as an entitlement; a new occupational benefit; an expert, interdisciplinary resource available to workers and their families by dint of their presence in the work force. In Alfred Kahn's (1979) terms, such EAPs are not stigmatized case services, but social utilities, located in the workplace.

Therefore, I now risk proposing the following definition of the Comprehensive Service EAP model:

> Comprehensive EAPs are free and confidential workplace entitlements that are voluntarily sponsored by employers or trade unions or jointly

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> by both. In-house (internal) and contract (external) EAPs respond to the human service needs of workers and their families and to the corresponding agendas of the work organization. Under the overall direction of professional health or mental health staff, such EAPs address comprehensive current and prospective biopsychosocial programs of education, prevention, assessment, treatment, case management, and referral.

Comprehensive Family Services

In many ways, the evolution of EAPs, from their original occupational alcoholism form, to "broad-brush" programs, and now to a comprehensive service arrangement, reflects the changing workplace and its emerging needs. Today, for example, the hallmark of an organizationally successful EAP is that it can attract significant self- and peer referrals.

If an EAP is labeled (or even informally known) only as a place to which workers are dispatched by supervisors, it will not be successful in providing comprehensive services. As Googins (1989, p. 10) succinctly noted, "If supervisors have the perception that the program over at medical is for drunks, then that is how they will use it." In such a case, the EAP will quickly lose its sense of mission, and the program will be consigned to a residual model of service, focused on "picking up the pieces," rather than on providing a systemic model oriented toward maintaining a physically, structurally, and emotionally healthy workplace. Indeed, the advantage of the comprehensive design is its equal focus on cause and effect, prevention and treatment, self-help and mutual aid, as well as its capacity for professional intervention.

The alternative core technology model, with its reciprocal focus on workers and their supervisors, is easier to apply when the family and the workplace are conceptualized as separate domains. "The factory or office here comes to be seen as a complete, closed autonomous system," Titmuss (1963, p. 111) observed, "pursuing its own goals and developing its own values and norms of behavior regardless of the outside world." Such a closed systems model, however, does not fit well in the actual world as we know it today. Therefore, it was surprising that Paul Roman was willing to say (1991, p. 20): "This leads me to a major assertion regarding the employee assistance program-work/family interface. These issues should *not* be accepted as an employee assistance program responsibility."

But Bradley Googins (1991c, p. 8) wisely observed that "the work system cannot exist unless it draws on the family system for its labor pool." Similarly, healthy families cannot be maintained without the income and occupational social welfare (fringe) benefits generated by their adult members. And yet, "there has been remarkably little attempt to link the two, that is, to locate problems in the work-family intersection, to determine the extent to which

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one system contributes to the health or illness possibilities of the other, or to discover what variations in each system make it more vulnerable to problems from the other" (Kanter, 1977, p. 81). Instead, looking at work and family through separate lenses—as though they are two distinct worlds—is a contemporary myth that must be discarded (Kurzman, 1988, p. 68). I would suggest that an EAP that cannot embrace this explicit reality of the new millennium is risking marginality, if not extinction.

As Googins (1991b, p. 17) noted, in EAPA's own journal, "From many perspectives, the EAP is not only well-situated within the corporate structure, it is also ideologically and programmatically compatible with the work/family movement . . . EAPs have realized for some time now that family issues constitute the majority of their caseload, or at least the highest percentage of cases." In fact, more than 25 years ago it *already* had been noted that two-career families, single-parent families, and unmarried working couples living together constituted more than 90% of the labor force (Sekaran, 1986, p. 95). Any EAP that is unaware of this modern workplace reality, or is unwilling to respond to its demands, will likely lose the support and sanction of management and labor.

By way of illustration, at Burlington Industries, with 35,000 employees at 65 sites, an EAP was initiated to respond to substance abuse problems affecting productivity, using a supervisory referral model. However, the personnel director was surprised to discover that other issues were having an impact on employees' job performance. "Initially, what came out of the EAP right away," he noted, "were a great number of problems that dealt with family situations—financial, emotional problems, conflicts in the family—more so than substance abuse. Obviously, we needed to concentrate on the total scene" (Walters, 1988, p. 103). The survey concluded that "EAPs still deal with alcoholism and other substance abuse; some get into problems such as gambling, compulsive spending or eating disorders. However, almost all find that increasingly it is mental health problems—stress, depression, grief, anxiety, phobias, as well as marriage, family and aging-parent issues—that bring staff members to the EAP" (p. 102). As Columbia Professor Sheila Akabas recently wrote:

> The EAP literature is replete with calls for expansion of the service model. An Internet search of EAPs and service delivery netted suggestions for programs, for example, on debt counseling, health and more general well-being, employee stress and cardiovascular disease prevention, depression, Internet assistance for family caregivers of dementia patients, proactive early intervention and disability management, organizational assessment and development, marriage and family counseling, to name a select few. Many believe that EAP survival and best practices warrant an integrated program that attends to providing care that enhances overall wellness of the workplace. (2008, p. 117)

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Located on the dividing line at which employee and family roles become theoretically distinct, but practically overlapping, comprehensive EAPs are in a perfect position to assist families and employers in identifying and resolving work and family issues (Googins & Burden, 1987).

COST CONTAINMENT

The fundamental motivation for implementing EAPs *does not derive from a* charitable or humanistic concern of industry. Nor is it solely a strategy of modern management to help workers function effectively in the context of a more autonomous, lateral, and participatory workplace. The reason that labor and industry's commitment is so strong largely is a matter of dollars and cents (Donovan, 1984). Scarce health care dollars must be managed well, so they can be contained, on the one hand, and used more effectively, on the other. Health care is costing Americans more than $2 billion a day, far more than the total cost of the country's national defense. In fact, it was estimated that employees suffering from depression alone cost employers 50 billion dollars in 2001 (Hutchison & Spruill, 2009). However, surveys have shown (Kurzman, 1992, p. 87) that companies with comprehensive EAPs—which include attention to health education, fitness, and wellness—are spending about $500 less per employee in their annual cost of providing health care; and such provision now will become *mandatory* for employers (with 50 or more employees) on January 1, 2014. As Donovan (1984, p. 66) long ago noted, "the provision of mental health care and alcoholism treatment seems to contain overall health care costs because of significant reductions to the subsequent utilization of medical care." Many such costs may indeed be contained by comprehensive service EAP programs of education, prevention, and early intervention (Akabas & Kurzman, 2005).

Although the institution of a comprehensive service EAP is no panacea, it is increasingly likely to be one element in a multiphased approach to employers' containment of health care costs. Despite some opinion to the contrary, it is untrue that a core technology EAP will be more valued by labor and management because it is the only model whose cost-effectiveness can be measured. Business and labor leaders are much too sophisticated to accept this line of argument. They know that anxious and depressed workers—not just those with alcohol issues—are making tremendous use of health benefits, and that those who smoke, are overweight, or cannot manage stress well are at a high risk of health and mental health problems (Erfurt & Foote, 1990; Jenkins, 1988; Renner, 1987). Employers also realize that they will pay for emotional problems and psychiatric disorders (even when the mental health benefit is limited or capped) because such employees, for the purposes of eligibility and reimbursement, will be covered under codes for legitimate physical (conversion) symptoms, just as alcoholics frequently are

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covered and reimbursed under codes for pancreatitis and cirrhosis, when a sufficient alcoholism benefit does not exist. Managers realize that anxious and overwhelmed working mothers are applying for expensive disability coverage during times of crisis; that men who are depressed by the sadness of divorce are having more accidents, which result in increased premiums for workers' compensation; and that middle-aged daughters at work, who are caught without adequate support in caring for both their young children and their aging parents, show higher rates of tardiness and absenteeism and may ultimately be discharged, under conditions that entitle them to six or more months of costly unemployment insurance.

Aware of these realities, even 34 years ago, leaders of labor and management made the following observation at a National Wingspread Conference on Human Service Needs in the Workplace:

> For an assistance program to yield its greatest potential, it must intervene in a greater scope of cases than only those where workers' personal problems have grown to interfere with their work performance. The scope must comprise cases where workers generally manage satisfactorily at their job but nonetheless suffer temporarily from personal or emotional problems . . . Intervention is more cost effective when it is undertaken early than when it is applied after their problems have spilled over into the workplace. (Meeting Human Service Needs in the Workplace: A Role for Social Work, 1980, p. 8)

From a cost–benefit perspective, waiting for a worker's performance to decline—whether from substance misuse, family problems, or mental illness—to the point at which he or she is in job jeopardy (which is likely to result in mandatory referral) is much too costly to the employer. Instead, as McClellan (1985, p. 34) presciently observed many years ago, "If EAPs are to avoid being part of the problem of rising health care costs, they must actively become part of the solution. They must re-evaluate their emphasis on waiting for supervisory referrals for problems that have already progressed to the point where they are adversely affecting job performance. They must proactively advocate health promotion and disease prevention programs." The die has been cast.

SOCIAL CHANGE

Paul Roman (1991, p. 20) wrote that "Employee Assistance workers are expert at changing individuals' behavior, but altering environments is not in their kit bag. " Such a proposition, if accepted, would pose a problem for social workers who are professionally committed both to social service and social change. The issue tends to be moot in most labor and management settings, however, because the needs of the employing organization

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generally govern the outcome of the debate. Hence, what employee assistance workers may be expert at doing is far less important than what labor and industry (who employ them) determine they need. Staff who can see the big picture—who can conceptualize the nature of long-range institutional requisites and can help the work organization to position its human resource functions wisely in a rapidly changing and competitive world—will be the truly valued EAP staff. Experience has shown that this is what most work organizations want, even though employers may not set such an explicit contract at the very beginning.

For the social work profession, this is an old and honored issue, embracing Richmond's (1917) focus on the tension between "retail" and "wholesale," Schwartz's (1969) discussion of "private troubles" versus "public issues," Wilensky and Lebeaux's (1965) concern with the "residual" and "institutional," and the Mildford Conference's (*Social Casework: Generic and Specific—A Report of the Milford Conference,* 1974) attention to "cause" as well as "function." Inseparable from this discussion is the issue of social control and whether occupational social workers' professional use of self will be exclusively in the service of the individual or of the employing organization (Briar & Vinet, 1985; Kurzman, 2012). A fundamental question that social workers in these settings must ask is: "Whose agent am I?" (Kurzman, 1999). It is suggested that the profession's dual commitment to service (private troubles) and to change (public issues) implies that social workers must embrace and balance both functions.

As Walsh (1982, p. 514) noted, "while EAPs that are oriented principally toward organizational effectiveness or productivity continue to administer emotional first-aid to employees they scoop out of the rapids, they should also move upstream in search of explanations for why so many tumble in." Such an *institutional* perspective is valuable to a work organization because it addresses the possibility of prevention, which generally leads to a far less costly human resources solution. However, raising such "public issues" has risks. For example, if an EAP director concludes that a senior manager is sexually harassing employees (many of whom have come to the EAP as victims), a residual response alone would be insufficient—even unethical. Nevertheless, intervention "upstream" to deal with the cause may bring on a period of systemic disequilibrium, especially if the problem is reconceptualized as being the result of a "troubled manager" or "troubled workplace," *rather than* a troubled employee. If the occupational social worker is not willing or able to define the problem properly, there may be a displacement of goals, whereby EAP practitioners (as some critics have noted) could become as much agents of social control as providers of social service (Bakalinsky, 1980; Walden, 1978). "To run an effective EAP," two wise corporate program directors observed, "the social worker must make the EAP compatible with the environment without sacrificing professional values" (McCarthy & Steck, 1989, p. 23). Otherwise, as Googins (1991a, p. 54) noted, the EAP can get "coopted in very subtle ways to support

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unhealthy work environments and strategies that do not contribute to the overall well-being of employees and their families." In short, the EAP "kit bag" must be large enough (and the commitment clear enough) for EAP staff to embrace both the delivery of professional human services and the promotion of progressive social change (Kurzman, 1988).

SUMMARY OBSERVATIONS

There have in fact been some useful and bold moves by EAPA and EASNA leaders in the EAP field in recent years. EASNA continues to sponsor a respected peer-reviewed journal (*Journal of Workplace Behavioral Health*) and to partner with the National Council on Accreditation Standards to develop accreditation criteria for employee assistance programs. EAPA has supported the National Business Group on Health with its exploration toward the development of a recognized EAP scope of practice, and in encouraging EAP practitioners to actively engage in peer-reviewed research (Rothermel, Slavit, Finch, Marlo, & Dan, 2008). And EAPA and the newly formed Employee Assistance Research Foundation recently co-sponsored a National Research Summit to launch a program of research grants and the formation of a practice-based EAP research network.

Nonetheless, problems remain. Relatively little progress has been made toward establishing national academic accreditation, scholarly EAP research periodicals, state licensure of employee assistance practitioners, or a university-based EAP curriculum. The last of these four presents perhaps the most serious obstacle to professional recognition. As Anastas (2012, p. 34) recently observed, most of the health service professions, "including nursing, physical therapy, nutrition and pharmacy have made the doctorate the entry degree for the profession, or the sole credential for advanced practice." The decision of employee assistance, and its member organizations, not to move in this direction—indeed not to create minimum university-based educational standards at all—may mean that employee assistance will remain a skilled occupation, and an honorable trade, but effectively eschew any opportunity for further status and recognition (Royeen & Lavin, 2007). Like child welfare service specialists, skilled laboratory technicians, and trained home health care aides, EAP staff likely will be seen as valued members of a team, with useful skills, but not as practitioners of a profession. As Paul Maiden suggested (in Bailey & Troxler, 2009, p. 360), employee assistance will be conceptualized as a "field of practice" wherein many will serve, including those with non-academic, employment-based credentials (e.g., CEAP, SAP, CASAC), under the direction of those who are graduate trained and state licensed professionals.

The manner in which proprietary EAP firms market their services to employers may further mitigate against sought after professional recognition.

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It is not uncommon to hear the following conversation at an EAPA conference: EAP service representatives manage their firm's book of business in order to ensure that their company's EAP product will achieve a dominant position by capturing a greater market share in the industry! If EAP leaders perceive themselves as selling a commodity (instead of a service), a commercial product (rather than an indispensable function), for customers (rather than clients), EAPA will not achieve its goals. For if we follow a ROI (Return on Investment) framework we become a commodity, easy to replace. In a business setting, EAPs *should not have to defend the cost of their services*, any more than legal, human resources, risk-management, or training departments would be required to do. Similarly, EAPs are *strategic partners*, essential to the success of the work organization, and absolutely central to achieving the employers' goals of productivity, profit, and innovation. EAPs perform unique and pivotal functions, like Human Resources and Legal, and thereby provide a critical support function to the work organization. *Clearly, this conceptual framework is our future*.

CONCLUSION

More than 35 years ago, Paul Roman already was lamenting a change he observed in the preferred EAP model. Occupational programs, he wrote then, are showing a "decreasing emphasis throughout the country on employee *alcoholism* programs, and the employee *assistance* model, with its broad implications for comprehensive mental health programs, is coming to dominate the scene" (1977, p. 9). Roman, and his colleagues in sociology and industrial relations, somewhat ingenuously argued that this shift had occurred not because work organizations preferred the comprehensive model, but because mental health providers had been successful in selling labor and management what they really did not want. However, anyone who has worked with corporate and labor leaders would know that they are beholden to their own shareholders for their jobs (or members for reelection), not to social workers or mental health counselors. Trade union and corporate leaders tend to be shrewd managers who know how to protect their individual and organizational self-interest. In fact, they are tough negotiators, who guard their bottom line as shrewdly as they can. Therefore, anyone who thinks that businesses are rapidly adopting the comprehensive service model because social workers are good salespersons is naïve with respect to decision making in industry. That is apparently why the prominent scholars John Erfurt and Andrea Foote (1977, p. 3) many years ago concluded that "there is general agreement . . . that occupational programs should be of the *comprehensive* type, rather than focus on specific types of employee problems." This fact is as true today as it was then.

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The many shifts I have noted here are not occurring in the context of a static environment. Seminal transformations, which are taking place in society today, naturally are being reflected in the workplace. These demographic, economic, and ecological changes, more than anything else, have shaped modern EAPs and have had an impact on—and perhaps even have resolved—conflicting opinions about the role, services, and domain of EAPs in the new millennium. The comprehensive service EAP model is replacing the core technology design not because professionals prefer it. The comprehensive model is being adopted because it best responds to the legitimate vested interests of labor and management for the stable and productive work force upon which they both depend.

The future of the employee assistance movement will in part depend on its practitioners' ability to embrace the realities of automation, globalization, and privatization, all of which are likely to increase both in pervasiveness and speed. The certainty of this truth should make EAP services of ever greater value, if properly conceptualized and proffered. In fact, if we are clear about our critical function, the services we offer to employers and employees should prove to be a remedy, which is as comprehensive as the need.

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