Employee Assistance Programs: Then, Now, and in the Future

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Introduction

Employee Assistance Programs (EAPs) are "job-based programs operating within a work organization for the purposes of identifying 'troubled employees,' motivating them to resolve their troubles, and providing access to counseling or treatment for those employees who need these services." (Sonnenstuhl and Trice, 1990: 1). EAPs have evolved, in response to influences within and outside the workplace, into a diverse set of service groups with distinctive structures and services. The purpose of this paper is to discuss the emergence and maturation of modern EAPs, discuss their current characteristics, and speculate about their development in the foreseeable future. Special emphasis is given to the impact of managed care on these programs.

Evolution of EAPs

The most direct and influential antecedent to EAPs were industrial alcoholism programs (Blum, 1988; Steele, 1989; Trice and Schonbrunn, 1981; Steele and Trice, 1995). Many authors have described various stages and key events in the development of EAPs. For the purposes of this paper, the historical evolution of EAPs can be divided into four periods, as illustrated in *Figure I.* As noted there, early occupational alcohol programs (1940-1970) were often initiated and staffed by recovering alcoholics, with the support of medical departments. They were most likely to occur in large, industrial firms. These programs relied on co-worker and supervisor referrals, based largely on symptoms of suspected alcohol misuse. Program staff often provided personal support and counseling, and made referrals to Alcoholics Anonymous chapters. Early programs developed formally and informally within the workplace, and were often kept a secret, for fear of damaging the company's public image (Steele, 1989; Trice and Schonbrunn, 1981).

As Employee Assistance Programs developed from the 1970s onward, they were broadened from an alcohol-exclusive focus to addressing any personal or family concern (Roman, 1981). Sources of referrals shifted from supervisors, based on job-performance criteria, to self-referrals for concerns of which supervisors and managers might be completely unaware. Interventions moved outside of the workplace with the emergence of professional residential behavioral health services (and the concurrent development of health insurance coverage to defray costs of treatment). However, increased treatment costs have contributed to shifts in treatment approaches, including outpatient care. Also, in-house short-term EAP counseling has re-emerged as a means to avoid using workplace group health benefits.

The knowledge base of EAP staff has shifted over time from those with personal experience with successfully coping with behavioral problems, to those trained by government agencies (Steele, 1989). With the rise of professionalism in the EAP field, more staff had formal baccalaureate and graduate level training in social work, psychology, counseling and related disciplines, and received credentials in EAP work from two related professional associations (Steele and Trice, 1995). With

Figure I:
Approximate Stages in the Development of
Employee Assistance Programs

	Occupational Alcohol Programs	**Early Employee Assistance Programs**	**Modern Employee Assistance Programs**	**Managed Behavioral Health Care/EAPs**
Time Period:	1940-1970	1970s	1980s	1990s
Problem Addressed:	Alcohol only	Alcohol emphasis	Personal concerns influencing job performance	Wide range of personal and family concerns
Source of Referral:	Coworker/ Supervisor	Supervisor	Self/ Supervisor	Self
Indication:	Alcohol symptoms	Job Performance	Job Performance/ Personal Concern	Personal/Family Concern
Intervention:	Program support/ Self-help group	Residential Treatment	Residential/Community Treatment Referral	In-EAP Counseling/ Community Referral

the advent of in-house services, and provider reviews instigated by managed care organizations (MCOs), EAP professionals are now more likely to have State and professional clinical licenses.

As external EAP purveyor organizations have developed outside of the workplace, they are increasingly more likely to be housed in (or have developed working relationships with) treatment groups or insurance companies. Many large EAP purveyor groups are now integrated within or closely linked to large health maintenance organizations (HMOs) and MCOs.

Prevalence and Growth of EAPs

EAPs have steadily grown, both in number and in proportion of the labor force served. The National Survey of Worksite Health Promotion Activities estimated that 24 percent of private, nonagricultural worksites with 50 or more employees offered EAP services in 1985 (U.S. Department of Health and Human Services, 1987). The Survey of Employer Anti-Drug Programs, conducted by the Bureau of Labor Statistics (BLS) in the summer of 1988 estimated that 6.5 percent of all private nonagricultural worksites (of all sizes) had an EAP (U.S. Bureau of Labor Statistics (BLS), 1989). In a follow-up study conducted by the Bureau in 1990, the estimated percentage of worksites with a program increased to 11.8 percent (Hayghe, 1991).

Because small companies represent the vast majority of all work sites, the prevalence rates reported by work site obscure the total number of employees covered by EAPs. For example, the 1988 BLS study estimated that 31 percent of employees working in private, nonagricultural work sites were covered by an EAP. More recently, Blum, et al. (1992) reported that 45 percent of full time employees in their National Employment Study worked in firms with an EAP in 1991.

Results of a national prevalence survey of worksites conducted by Research Triangle Institute in 1993 and 1995 are presented in *Table I*. These data suggest that EAPs continue to grow in prevalence and proportion of the labor force employed in worksites that offer EAP services. (For complete discussion of these findings, see Hartwell, 1996 and Hartwell, et. al., 1996). Recently, Oss and Clary (1998) predicted that EAP market penetration could rise from 42 percent of a potential market of employees in businesses with 50 or more employees to 65 percent of that market (or approximately 20 million workers) by the end of the year 2000.

EAP Characteristics: Core Technologies

Of course, not all EAPs are the same in their placement, structure or operation. The National Research Council/Institute of Medicine (NRC/IOM) cautions that comparisons between programs and assessments of EAP effectiveness can be misleading for many reasons, including the fact that they can vary greatly in the services that they offer (Normand, et al., 1994: 257). Some EAPs might provide a comprehensive range of services to many constituencies within the workplace, while others offer relatively few of these services. The NRC/IOM asserts that the evaluation of the effectiveness of EAPs has been hampered by these inter-program differences, and recommends that particular services and activities, rather than whole programs, be studied and compared to more fruitfully understand the impact of EAPs on employees and the workplace (1994: 250).

Table I:
National Estimates of Employee Assistance Program Prevalence Among Private Nonagricultural Worksites with 50 or More Employees: 1993 - 1995

	1993	1995
National Sample Size (work sites)	5240	3206
All Worksites	32.9%	36.5%
Worksite Size		
50-99 employees	20.9%	24.8%
100-249 employees	33.2%	33.7%
250-999 employees	48.4%	52.9%
1000+ employees	76.1%	71.4%
Type of Industry		
Communications/Utilities/Transportation	52.4%	46.0%
Finance/Realty/Insurance	41.5%	48.5%
Wholesale/Retail	33.7%	29.3%
Manufacturing	33.3%	38.3%
Services	24.5%	35.0%
Mining/Construction	20.4%	31.1%
Type of Program		
External		
50-99 employees	87.7%	84.1%
100-249 employees	84.9%	82.4%
250-999 employees	76.9%	86.0%
1000+ employees	57.7%	57.5%
Average	81.1%	80.8%
Internal	16.7%	15.7%
Both	2.2%	4.5%
Proportion of Labor Force labor force employed in work sites offering EAP services	55.3%	67.0%

Grounded in surveys of EAP professionals, Roman and Blum identified a set of important services, or "core technologies," that they felt were requisite to a comprehensive EAP. Their list of services has evolved to some degree over time, primarily in response to changing conditions within the workplace, health service and insurance industries and EAP profession.

The concept of core technologies has been endorsed and promoted by the Employee Assistance Professionals Association (EAPA). In doing so, EAPA has further modified the scope of the core

technologies. A 1988 version of Roman and Blum's listing, and that of the EAPA published in 1997, appear in *Figure II.* The two descriptions differ in that the EAPA version has de-emphasized the focus on alcohol and substance abuse problems, recommends other intervention strategies besides constructive confrontation, and has added assistance in the areas of managing provider contracts, managed care organizations and insurers.

In the 1995 national prevalence survey of work sites conducted by Research Triangle Institute, the provision of a set of core technologies by internal and external EAPs throughout the nation was estimated. As noted in Table II, two core technologies (assess and refer clients, provide short tem counseling) are frequently offered by both internal and external programs. However, all other core technologies are much more prevalent among internal programs than external ones. In general, internal programs are much more likely to engage in services and activities that are likely to occur immediately at the worksite.

Figure II:
Statement of Core Technologies

Roman and Blum (1988)

1. Identify employee behavioral problems based on job-performance issues.
2. Provide expert consultation to supervisors, managers, and union stewards on how to take the appropriate steps in utilizing employee assistance policy and procedures.
3. Appropriately use the constructive confrontation strategy.
4. Create micro-linkages with counseling, treatment, and other community resources.
5. Create and maintain macro-linkages between the work organization and counseling, treatment, and other community resources.
6. Maintain a focus on employee alcohol and substance abuse problems since this strategy offers the most significant promise of producing recovery and genuine cost savings for the organization.
7. Serve as a consultant to the organization at large on issues of personal problems affecting employee welfare.

Employee Assistance Professionals Association (1997)

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 to and education of employees and their family members about availability of EAP 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 establishing and maintaining relations with service providers, managing care organizations, insurers, and other third-party payers.
6. Assistance to work organizations in providing support for employee health benefits covering medical and behavioral problems, including, but not limited to, alcoholism, drug abuse, and mental and emotional disorders.
7. Identification of the effects of EAP services on the work organization and individual job performance.

Table II:
Prevalence of Core Technologies by Type of EAP

Core Technology	Internal	External	All
Assess and refer clients to outside agencies for counseling	92.8%	82.5%	84.0%
Provide short term counseling	80.1%	80.5%	80.3%
Assess external treatment program quality and cost-benefit	68.6%	50.0%	53.0%
Contact programs to determine client's treatment progress	75.3%	48.3%	52.5%
Train managers and employees	87.5%	43.1%	51.4%
Consult with supervisors re: clients and potential clients	72.1%	38.1%	44.2%
Engage in health promotion activities	70.9%	34.4%	40.2%
Consult with managers re: employee issues and policies	71.3%	33.7%	39.7%
Contact supervisors to monitor client progress	64.5%	32.6%	38.5%
Constructively confront poorly performing employees	61.1%	25.9%	32.0%
Consult with union re: clients and potential clients	49.8%	14.7%	19.3%

Emerging Types of EAPs

Five types of Employee Assistance Programs continue to develop and proliferate. These types can be called full service, integrated, wrap-around, compliance, and peer-assistance models of employee assistance, and are described in this section.

1. The Full Service EAP is grounded in the human resource management consultation orientation, and offers a wide range of support for managers. Examples are well-funded and staffed internal programs, and small but growing number of external programs offered by EAP purveyor organizations that offer a broad range of core technologies and other activities for purchase.

In addition to basic core technologies mentioned in the previous section, the Full Service EAP is the type most likely to provide crisis management and critical incident debriefing, and employee counseling in response to organizational downsizing and other types of worksite changes. These programs have been innovators in developing new services such as HIV, legal, and financial counseling, disability management, elder and child care assistance to all employees. In addition, they are the most likely to have expanded into the risk management and prevention aspects of job

performance, and into quality assurance oversight of company's managed behavioral health care (MBHC) vendor. (In era of MBHC carve-outs, corporate administrators are more likely to rely on their EAP staff, rather than their benefits specialists, as behavioral health experts to monitor MBHC vendor performance.) EAP professionals also assist administrators by developing Requests for Proposals and Services and vendor evaluation protocols, and by participating in contract negotiations.

While these programs are expensive to operate ($40-50/employee/yr), there is considerable cost-based competition for them, and they are considered to be a "product of the future" (Oss and Clary, 1998). For example, Ceridian is developing a "full service" approach into its basic EAP package, including legal and financial services. Value Behavioral Health is building an expansive "Workplace Services" product line, and the work-life management firms (i.e., Work-Family Directions) are offering a wide range of consultation services in their product packages.

2. <u>The Integrated Program</u> focuses on behavioral health benefit management by merging MBHC and employee assistance services. This model integrates gate keeping for access to in-program EAP counseling with the approval of out-referral placement for treatment (and utilization of behavioral health benefits). Professionals promoting this model feel that it reduces misunderstanding and conflict by unifying assessment, service and benefit management in one group. Also, they assert that integration has the potential for cost savings by reducing administrative overhead and improving efficiency. Integrated programs are most common in larger, self-insured companies, and among large internal union groups.

A slightly modified version of this model has been in operation since January, 1996 at AT&T. Their internal EAP, working in conjunction with an external vendor, manages the behavioral health chemical dependency (CD) carve out. All employees needing CD care are required to use the EAP as their access to providers. As care manager, the EAP is responsible to provide access to appropriate CD care and to ensure that high quality care is provided to those needing it. (Herpel, 1997)

3. The <u>Wrap-Around EAP</u> develops among smaller employers as a response to restrictions placed by managed care organizations (MCOs) on the use of mental health services. "MCOs are increasingly restricting provider panels and networks, thereby imposing significant restrictions on the EAP-client relationship....(and) insurance companies continue to dictate treatment protocol under the banner of cost efficiency." (Hess, 1998:31). The result is that many employers do not have easy access to mental health services.

Larger employers are in a position to respond to MCO restrictions since they have the flexibility to design customized benefit plans, and integrated program models. But smaller employers do not have this flexibility. As an alternative, small employers contract with EAPs essentially to have a ready access to outpatient behavioral health benefits. The employer thus has confidential access to mental health professionals for their supervisors, employees and employees' families at a fixed fee.

4. The <u>Compliance EAP</u> is a specialized program that has been developed to monitor and comply with conditions of the Drug-Free Workplace Act, Department of Transportation and various State regulations. Relatively few in number, these programs are often implemented internally, or purchased

by employers who are looking for the least expensive mechanism to comply with government regulations (rather than more common motivations such as perceived need by the employer to address substance abuse issues, or as an employee benefit; see Potter, et al., 1995). Central elements of these programs are alcohol and drug testing, counseling services for detected abusers, and medical review officer services.

5. Peer-assistance programs are operated by labor and professional associations in support of their membership. For example, the AFL-CIO has operated trained volunteer counseling programs since World War II (Steele, 1989). Peer-assistance programs are often adopted to serve workers that are not provided with EAP services by their employers, usually due to the small size of the company, the mobility or geographical dispersion of the employee group (Bamberger and Sonnenstuhl, 1995), or the worker-employer relationship (i.e., contracted labor). Peer-assistance programs could also be implemented when employees have concern about the confidentiality of EAP services. These programs often rely on trained peer counselors and referral agents, and often refer to self-help groups. Peer-assistance programs can also develop as a result of dissatisfaction with the restrictions imposed by MCOs.

Predicting the Future Growth and Development of EAPs

There are several factors which have affected the development of EAPs, and are likely to continue to influence their prevalence, structure and operation in the near future. These factors can be roughly divided into three groups: influences internal to the EAP enterprise, those within the workplace as a whole, and those in the broader society beyond the workplace.

The EAP Enterprise. One of these factors is the assessment of Employee Assistance Programs by MBHC, employer and labor groups. EAPs and their predecessors have historically "sold" themselves to employers on assertions of their effectiveness in returning valued employees to productive employment (Trice and Beyer, 1984). However, these programs are difficult to assess (Normand, et al., 1994), due in part to the fact that they are only part of a larger intervention system which also includes treatment providers, MCOs, employers and others. Changes in any of these other groups could positively or negatively affect treatment costs, employer savings, worker rehabilitation, and consequently the acceptance of EAPs as a component in the overall intervention system.

Second, intense market competition among external EAP purveyor organizations, either as independent companies or as divisions of larger MBHC organizations, has driven the development and availability of services in this field. According to Oss and Clary (1998), the EAP field is likely to develop in several directions. One growth direction, noted earlier, is the expansion of the EAP market through the coverage of a larger number of workers and proportion of the labor force. A second area of growth could be in the form of external purveyors continuing to increase their market share at the expense of internal programs. While external EAPs are a cost-effective option for particular types of companies (i.e., smaller, geographically dispersed, governmentally-regulated, etc.), they often gain their cost savings from limiting the range of core technologies offered to those associated with employee services and have little structural impact on conditions within the workplace. However, market expansion is unlikely to accommodate all purveyor organizations, to their satisfaction. Oss and Clary document an ongoing process of the consolidation of EAP purveyor

organizations. The effect of this consolidation is that large organizations serve a larger proportion of EAP enrollees. At the beginning of 1997, the twenty largest purveyor organizations covered 85.9 percent of all EAP enrollees (approximately 33.5 million lives). During 1997, several large purveyors merged, resulting in a consolidation of 88.5 percent of covered lives in the largest 20 organizations. As of November, 1997, one organization (Magellan Health Services, Inc.) controlled 34.1 percent of the market share, covering 13,291,822 lives.

Further, Oss and Clary predict that EAPs will evolve into three tiers of organizations; large national programs serving in excess of 800,000 covered employees, mid-sized regional programs serving between 60,000 and 800,000 employees, and smaller local programs serving fewer than 60,000 employees. The largest providers have the advantage of economy of scale in administrative and technical support, while smaller EAPs have the advantage of local support and personal relationships with employers and employee groups. Intermediate EAPs are likely to feel pressure from both ends of this continuum, and will feel pressure to further the consolidation movement by joining with larger purveyor organizations. The consequence will be that companies will have increasingly fewer choices when selecting an EAP provider organization. Given the increasing costs of full service EAP programs, and limited choices in EAP provider groups, internal and peer-assistance programs could gain more support in specific service niches in the future.

The Workplace. Another influence on the growth and development of EAPs is the real and perceived need for such services. For example, after the Vietnam conflict, employers widely believed that military veterans were likely to import their substance abuse patterns into the workplace (Robins, 1974). Also, the significant increase in the utilization of MBHC services and benefits has paralleled the growth of labor force participation of among women since the 1980s. Similar changes in the needs of labor force participants precipitated by demographic and other social forces could continue to influence the growth and direction of EAP services.

Characteristics of the workplace itself, in terms of stress and cultural influence to participate in the use of alcohol and illicit drugs, could impact the need for EAP services. For many years, researchers have attributed some of the cause for behavioral health problems to the workplace (see Trice and Sonnenstuhl, 1988 for a conceptual overview of these influences). EAPs have historically worked with individual troubled workers and with supervisors on how to managed such workers, but have participated only marginally in the structural redesign of the labor process (Steele, 1995). However, EAP professionals have expressed interest in becoming more involved in the prevention of alcohol misuse and drug abuse by participating in workplace risk management activities, attempting to mitigate the workplace risk factors.

The Society. As indicated by the various types of EAP programs emerging in recent years, the field is quite sensitive to changes in managed care practices. In 1997, approximately 168.5 million of an estimated 223.7 million Americans with health insurance were enrolled in some type of managed behavioral health care program (75 percent). Of the 168.5 million, 149 million are enrolled in specialty managed behavioral care programs and 19.5 percent receive benefits through programs internally managed within HMOs. This latter number represents a 19 percent increase from 1996. EAPs could become more involved in MBHC oversight activities (EAPA, 1997).

The health care industry is only one institution that has made inroads into the workplace. Other social institutions are interested as well in the issues that bring workers to EAPs for services. For example, the criminal justice agencies are interested in issues of illicit drug abuse (U.S. Department of Justice, 1997), inappropriate use of alcohol, domestic violence, violence in the workplace, illegal gambling and sexual misconduct. Detection devices and procedures developed by criminal justice agencies have been adopted by workplace (particularly drug testing) programs. Ethical and legal issues of mandatory crime reporting, such as in the case of child abuse, are under greater scrutiny by law enforcement professionals.

Finally, various EAP, insurance, workplace health, civil rights and substance control legislation has influenced the direction of EAP models and practices. For example, the state licensing of employee assistance programs has influenced their development. Particular Federal legislation with impact on EAPs includes the Americans with Disabilities Act, the Health Insurance Portability and Accessibility Act, the Mental Health Parity Act, the Employee Retirement Income Security Act, the Comprehensive Omnibus Budget Rehabilitation Act, and the Federal Employee Health Benefit Act. In addition, health care reform applicable to HMOs and other MCOs could influence the growth and development of EAPs.

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