Selected Papers of William L. White

www.williamwhitepapers.com

Collected papers, interviews, video presentations, photos, and archival documents on the history of addiction treatment and recovery in America.

The Evolution of Employee Assistance: A Brief History and Trend Analysis

William White, M.A., David Sharar, M.S., PhD Candidate
Chestnut Health Systems

Workplace responses to employees experiencing performance-impairing problems have undergone remarkable changes over the past 250 years. This paper: 1) describes the evolution of such responses through five historical periods, 2) analyzes the major trends across these periods, and 3) speculates on the future directions of employee assistance (EA) as a professionalized endeavor. It is our hope that this paper will stir discussion and debate about the EA field's evolving identity and its future as a professional specialty.

The History of Employee Assistance

Alcohol Promotion/Suppression. Alcohol was integrated into the early American workplace as it was integrated into all aspects of American colonial life. Concern about problems created by alcohol-impaired workers grew as per capita alcoholic consumption rose dramatically between 1790 and 1830 (Rorabaugh, 1979). The resulting temperance movement played a major role in removing alcohol from the workplace and sobering up the American workforce. By the end of the nineteenth century, this major cultural movement and

the growing awareness of alcohol-related accidents within the country's increasingly mechanized industries combined to suppress the open use of alcohol in the workplace. It was then that concern shifted from alcohol consumption by all workers to the problem of a small number of workers for whom alcohol continued to produce significant impairments in productivity and health (Levine, 1978).

Informal Paternalistic Intervention The first significant efforts of organizations to help individual employees resolve alcoholism and other personal problems that might impair their performance began in the nineteenth century. Typical of these efforts were informal policies of police and fire departments that encouraged alcohol-impaired employees to sign a pledge of abstinence, involve themselves in temperance groups, or to undergo a period of care in an inebriate home or inebriate asylum (Baumhol, 1991). One of the earliest inebriate homes, the Chicago Washingtonian Home, was birthed in 1863 out of a successful experiment of Robert Law who rehabilitating one of his alcoholic employees by moving the employee into

Law's own home (White, 1998). Such efforts were part of the "rescue work" that emerged within the American temperance movement, and were aggressively pursued within companies whose leaders viewed themselves as the head of the company "family." The growth of medical and personnel departments within American business and industry grew, in part, out of such paternalism.

Industrial Alcoholism Programs As American businesses and industries became larger and more depersonalized in the opening decades of the twentieth century, companies responded to alcohol-impaired employees in one of two ways: They were either fired, or they were retired on the job. It was in this context that occupational counseling programs rose in the 1940s. These programs were frequently rooted in the informal assistance offered to alcoholic employees by other employees who had sobered themselves through involvement in Alcoholics Anonymous (Trice and Schonbrunn, 1981; White, 2000a). The desire to reach a larger number of alcohol-impaired employees led to a formalization of these efforts within companies such as Eastman Kodak, Allis Chalmers, and Kennecott Copper Company (Steele, 1989; Presnall, 1981).

These more formalized programs were christened "industrial (or occupational) alcoholism programs," and spread through the efforts of a rising "alcoholism movement" led by the Yale Center of Alcohol Studies and the National Committee on Education on Alcoholism. The Yale Plan for Business and Industry promoted a nine step plan for implementing an occupational alcoholism program: 1) education of top management, 2) assignment of program responsibility to an existing department, preferably the medical department, 3) selection and training of a coordinator to administer the program, 4) mobilization of internal intervention resources, 5) development of a company-wide policy regarding relationship of treatment to discipline, 6) linkage to alcoholism treatment services, 7) supervisory training, 8) employee orientation and education, and 9) periodic surveys to assess the extent of the problem within the company (Henderson and Bacon, 1953).

Internal Employee Assistance Programs During the 1950s, companies such as Consolidated Edison, Standard Oil of New Jersey, and American Cyanamid extended their alcoholism programs to also cover employees that were experiencing mental health problems. This marked the beginning evolution from industrial alcoholism programs to workplace employee assistance programs (Presnall, 1981, Roman, 1981; Steele and Trice, 1995). The pivotal event in this transition was the establishment of an Occupational Programs Branch within the National Institute on Alcohol Abuse and Alcoholism (NIAAA) in the early 1970s. Will Foster and Donald Godwin pushed the position within NIAAA that workplace intervention should not be focused on alcoholism but on the broad spectrum of behavioral health problems encountered by employees. One of the goals of NIAAA leadership from its earliest inception was to break down the stereotype of the alcoholic as a Skid Row wino and take the issue of alcoholism to the heart of middle-class America (Roman, 1981). NIAAA funded two "Occupational Program Consultants" (OPCs) within each state whose responsibility was to organize occupational alcoholism programs in business and industry. These first OPCs became known as the "Thunderin' Hundred," and their efforts led to a dramatic rise in the number of occupational alcoholism programs in the U.S. The emergence of occupational alcoholism as a professional specialty was marked by the 1971 founding of the Association of Labor Management Administrators and Consultants on Alcoholism (ALMACA). The rapidly evolving philosophy that guided the OPCs led first to a shift in emphasis from identifying alcoholic employees to identifying employee performance problems and then to a transition in identity of these programs from alcoholism intervention programs to "broadbrush" employee assistance

programs (EAPs). As they spread, the focus of these new EAPs shifted from the alcoholic employee to employees encountering a broad spectrum of behavioral health problems (Roman, 1981; Wrich, 1974, 1980).

External Employee Assistance/ Managed Care/Work-Life Programs During the evolution from industrial alcoholism programs to employee assistance programs, there was also a shift in where such programs were placed. The trend was from placement of these programs within a company to the practice of contracting for such services from local or national behavioral health organizations (Oss and Clary, 1998). A large number of community-based agencies and proprietor-owned organizations involved themselves in the delivery of EAP services, and contributed to the rise of new local and national organizations specializing in the delivery of contractual EAP services. During the 1980s, these vendors helped support a drug free workplace movement that saw the widespread introduction of drug testing (and mandatory referrals to EAP) in the American workplace. The "zero tolerance" philosophy that buttressed this movement created a new kind of role tension. EA professionals who had long played a role in the "rescue and recovery" of substance-impaired individuals within the workplace now found themselves participating in the exclusion and extrusion of these individuals from the workplace (Bennet, et al., 1994). The mission-diversification of EA was further extended with growing concerns about workplace violence. In response to this concern, EAPs provided violence-related training, consultation, crisis intervention and critical incident debriefing services. As EA professionals redefined their "customer" as the corporation, they offered a growing variety of organizational development and consultation services that went far beyond their original role of assisting individual employees.

A more recent trend is the role EAPs are assuming in helping companies directly manage their behavioral health care costs. This role ranges from screening and selecting behavioral health care providers, gatekeeping employee access to behavioral health services, approving types and duration of services, and providing aggressive case management of the whole service delivery process. A small number of EA/managed care firms who now control 70% of the cumulative managed behavioral health market share, as well as a growing number of smaller, regionally based vendors, are pushing this trend toward providing all behavioral health services on a carved-out basis, using a discrete contracted network and a staff of behavioral specialists who manage care (Oss, 2000, Jeffrey and Riley, 2000). For plans that "integrate" EAP with the managed behavioral health benefit, this model shifts the traditional EAP role from one of assessing needs and brokering service connections to the role of behavioral health plan administrator. It also erodes the distinction between the EA service and outpatient counseling or therapy with the prevalence of six and eight visit EAP models replacing the original "assess, refer, and follow-up" EA model (Jeffrey and Riley, 2000). These short-term EA counseling models imply that EA clinicians generally function as private practice therapists, providing one to eight visits about 60-70% of the time, preventing "costly" referrals beyond the EAP to the benefit plan.

Another recent trend in the EA field is the potential integration, if not mutation, of EAP and Work-Life (W-L) into a single unified program. Both EA and W-L share the mutual goal of addressing issues that hinder employee performance, although W-L provides assistance with "normal life events" such as child/elder care, adoption, college placement, financial/legal concerns, pregnancy and parenting, and consumer affairs. Unlike EAP, W-L can trace its roots to the "Great Society" when the federal government formed county-based child care coordinating councils designed to coordinate child care resources in close proximity with Head Start centers (Herlihy, 2000). Similar to the way EAPs moved from occupational

alcoholism to "broad brush", these child-care resource and referral programs expanded to include elder care and other life event services. Given that the operational components (call centers, assessment and counseling, education and referral) of EA and W-L are similar, and many employers seem to believe this combination reduces stigma and implementation/ communication costs, there is a growing consensus that integration is more beneficial than two distinct programs (Williman, 2001, Herlihy et al, 2002). Despite this natural "fit", W-L and the "behavioral health" related disciplines are traditionally two separate areas of training and disciplines and have held separate organizational "turf" with employers. The inclusion of benefits management and W-L within the EA umbrella mark a further migration of the EA field away from its historical expertise in intervening with the substance-impaired employee.

Growth and Stability of EAP's The growth of EAPs has been quite phenomenal. The number of companies with formal occupational alcoholism programs rose from a handful in the 1940s to approximately fifty in 1959 to more than 175 in 1965. Three Hundred new EAPS were initiated in the first year of NIAA's OPC efforts in the early 1970s. By 1979, 59% of Fortune 500 companies had established formal employee assistance programs and estimates of the number of American companies with formal EAPs at the end of the 1970s ranged from 2500 to 4,000 (Roman, 1981; Milgram and McCrady, 1986). This estimate climbed to 12,000 by 1985 (Blum, Roman, Tootle, 1988), and presently over 65 million U.S. citizens are covered by an EAP or integrated EAP/managed behavioral health carve-out (Oss, 2001). Today more than 7,000 professionals work in an arena that less than twenty worked in during the 1960s. In the second half of the 20th century, industrial alcoholism programs were born, were transformed into broadbrush employee assistance programs, were professionalized, grew explosively,

incorporated a drug free workplace movement, and then further expanded their mission to include behavioral health care management and work-life/dependent care programs.

Despite the impressive growth in EAP enrollment and number of working EA professionals, several trends threaten the character and future of the field.

1. Intense competition and an oversupply of EA vendors have caused an extended period of restraint on price increases and significant consolidation among larger vendors and smaller vendors aggregating regionally (Oss, 2001, Findlay, 1999, Sharar and White, 2002).

2. With the infusion of low-wage workers and public welfare recipients into the workforce, EAPs are attempting to serve greater numbers of multi-problem, at-risk populations (e.g. poor single mothers, older workers, persons with co-occurring disorders) via serial episodes of brief interventions (Maiden, 2001).

3. With significant declines in employer spending on behavioral health benefits (Jeffrey and Riley, 2000), EAPs are at risk of becoming an inadequate service replacement for employers with minimal or no benefits for outpatient behavioral health services.

4. Telephone and Web-based interventions are increasingly viewed as a primary clinical medium rather than as a screening, educational, or motivational medium in spite of the fact that very little is known about how clinical outcomes of these less costly telephone or computer mediums compare to "in-person" intervention.

5. The original focus of EAPs is being obscured by a wide spectrum of related services and products, causing consumers and employers to see EAPs as "ill-defined and amorphous" (Blair, 2002), despite the field's two professional associations, program standards, a Core Technology, an

accreditation process, and a practitioner-oriented certification process.

Trend Analysis

Our discussion of the major trends within the history we have just reviewed as well as our discussion of the future of the EA field will focus on six questions that address the mission of EA, the role of labor in the EA field, the organizational placement of EA services, the qualifications of EA service providers and programs, the financial future of the EA field, and the effectiveness of EAPs. Our speculations about the future are observations that we hope will stir examination about the present and future status of the field. In trying to predict future evolutions in EA, we are guided by a recognition that trends tend to generate their own excesses and set the stage for readjustments that are often depicted as pendulum swings. For example there are many fields in which there are predictable cycles of organizational centralization/decentralization and generalist/specialist role preferences.

If there are certain predictable cycles within the long history of professional fields, then perhaps we could predict some future trends, or at least some adjustments or corrections that will grow out of current excesses within the EA field.

What is the Primary Mission of EA Field?

One of the clearest trends in the above-encapsulated history is the progressive expansion of the scope of employee assistance as an activity and a discipline. We have charted the evolutionary shifts from a single specialized problem (alcoholism) to a boundaryless spectrum of employee problems; from substance-impaired employees to substance-using employees (via the drug free workplace movement); from problem-intervention to problem prevention, wellness promotion, and life events management; and from employee recovery (health) and retention to cost-containment, risk management,

benefits management, and critical incident management. The history of the employee assistance field could thus be portrayed in three stages; it's incubation within the alcoholism field, its emergence and professionalization, and its territorial expansion (See Figure 1).

(Figure 1: Funnel diagram showing widening scope of mission)

This expansion reflects both quantitative shifts (the number of activities embraced within EA contracts) and qualitative shifts (e.g., the shift in focus from the recovery and retention of substance-impaired workers to the detection and control of substance using employees). As the primary "client" (ultimate loyalty) shifted from the employee/family, it should not be surprising that the dose (intensity and duration) of services provided by and through EAPs declined in tandem with this shift.

New professions face two threats to their long-term survival. They can fail to thrive due to overspecialization or they can rapidly diversify until they encounter and are devoured by more powerful forces within their operating environment. The mission of the EA field has become so diffuse that one could argue that the weakened identity and lost boundaries of the field have left it ripe for colonization (or that such colonization has already occurred). If the speed of boundary erosion and diversification continues, we envision the potential collapse (progressive dissipation) of the EA field as a specialized professional field. The most likely scenario would be a loss of the field's historical core functions with the continued illusion that the EA field can maintain its identity and mission fidelity in the midst of this ever-expanding menu of services. Even employer purchasers seem confused about how these moving pieces once called "EAP", each with its own rate structure, fit into a cohesive behavioral health/life management plan that saves them time and money while improving clinical efficacy and performance outcomes.

Rapid diversification poses the risk of eroding the quality of one's original core products and services. It has been argued that the EA field is less capable of salvaging the substance-impaired employee today than it was twenty-five years ago (White, 2000). We have entered a time when more and more company managers and union leaders, having lost direct knowledge of and participation in successful recoveries, see the employee with a behavioral health disorder as a nuisance and an unacceptable cost and safety risk. If there really are natural cycles of specialization and generalization, then we would predict a day in the future when progressive employers will tire of losing some of their best and brightest employees to alcoholism and will call for a program of intervention to restore them to productivity. Perhaps this new program will be called something befitting its form and function–something like occupational alcoholism program (White, 2000b).

What is the Role of Labor in the EA Field?

The history of EA as a field is marked by the diminishment of the role of labor within the field. Labor leaders have played a significant role in addressing the problem of substance-impaired workers. As early as, 1827, American labor leaders advocated a ban on alcohol use in the workplace, and American labor leaders such as Leo Perlis played a significant role in the rise of union-based alcoholism programs and union-management collaboration in the development of alcoholism intervention programs. The emphasis on labor involvement in the design and operation of employee assistance programs waned as the EA client shifted from the employee and his/her dependents to the company. Also, the now prevalent external vendor model of using a contractual network of "EAP Affiliates" has resulted in a shift away from the natural web of support historically provided by recovering employees and labor-based peer volunteers to short-term counseling with a professional in a consulting room. Ironically, this shift represents less of a community-based,

work-site focus and has contributed to the gradual erosion of connecting troubled employees to indigenous community and workplace recovery support systems in favor of professionally directed therapy (White, 2002).

The authors see two potential adjustments to this trend: 1) a renewal of the relationship between the EA field and national and local labor leaders, or 2) a dramatic increase in the number of labor unions that organize their own labor assistance programs as a backlash against the growing coerciveness of the EA program and ineffectiveness of company-contracted EA services to rehabilitate and retain employees with behavioral health disorders.

What is the best organization and location of EA Services?

We see several trends in the locus of EA services, each of which moved the point of contact of assistance further away from the line employee. First, there was the transfer of indigenous "wounded healers" from their normal work responsibilities to a specialized helping role within the company. While this move provided more time for work with troubled employees, it removed the helper from the network of natural peer relationships in which they were closely connected to and trusted by other employees and created status barriers that had not existed before professionalization of this role. Eligibility for EA services was also extended from the employee to the employee's dependents, and, in a prophetic milestone of demedicalization, EA services were gradually moved organizationally from company medical departments to their human resources or benefit departments.

The next trend was to outsource EA services to local, then regional, then national and, more recently, to international vendors. The expansion by national vendors is reaching its saturation point in the U.S., leaving growth opportunities for these mega-companies only through the acquisition of smaller, local contracts, the expansion of EA

services outside the U.S., or the expanding the service scope (and income) from existing contracts. Many of these companies are investor-owned and insurance-based and "bundle" an EAP as a "cheap" add-on to a managed behavioral health plan, work-life program, health insurance plan, or disability management program. EAPs are simply one "menu" item in the "one-stop shopping" behavioral health/life management marketplace, and occasionally viewed as a "loss leader" in an effort to sell more lucrative service lines that complement EAP.

The trend toward nationalization and centralization has had three consequences: 1) the EA service provider has been removed from the work site, 2) the EA service provider is less knowledgeable about the resources of the local communities in which employees reside, and 3) the problem identification and resolution process is shifting from a face-to-face relationship to a telephone conversation or on-line connection. Acknowledging the profound and important impact of communications technology and centralized efficiency does not diminish the need for personal human contact and the comfort of another human being's physical presence as a remedy for stress, personal problems, and behavioral health disorders. What the historical EAP provided, particularly for employees requiring sustained or episodic support, was continuity of in-person contact in a primary helping relationship and an intimate knowledge of the changing availability and quality of local resources. That continuity has been replaced with an EA service process marked by remoteness, impersonality, transience, and reduction in the physical presence of a helper offering personalized comfort and support.

As larger, external vendors have garnered control of the marketplace, EA services have migrated to an out-of-area call center and the controlled use of sub-contracted affiliate clinicians who have no real connection to the workplace and are frequently not even know to the local employer, manager, or union. Many local affiliates complain that some external EA vendors actually forbid contact between the affiliate and the local work-site, inhibiting the ability of the affiliate to gain the trust of local employees and management and be integrated into the organizational culture (Sharar, White, and Funk 2002).

We anticipate a growing challenge to national/regional vendors and predict a relocalization of certain EA functions and a growing emphasis on organizing support systems inside the workplace and inside local communities. To survive such challenges, national/regional vendors will need to re-engineer EA services to combine elements of national and local service delivery models and be both "high tech and high touch". Vendors who implement geographically diverse, multi-location programs will need to ensure improved, constructive involvement with the local employer and attempt to align the goals and expectations of the local employer and EA affiliate with the vendor headquarters and account management process. Vendors also need to examine their increased reliance on telecounseling, especially when serving out-of-area employee clients, and evaluate when it compromises community-based quality of care and needed collaboration with the local EAP affiliate.

The authors predict that employer purchasers will begin to question the theoretical connection between the size and location of the vendor and claims of performance related to outcomes or responsiveness. What is the connection, if any, between size, market dominance, location, medium of service, and superior outcomes in EAP? If the EA field cannot sustain ownership of its current functions within all locations of business and industry, and integrate with the local work site, we suspect that many of these services will be provided by occupational medicine or primary care physicians and the growing interdisciplinary teams that will surround them. Sustaining (or restoring) these core functions will require EA vendors (local and national) to move away from feudalism and

suspicion of competitors to the most significant human capital management change that business has witnessed in 40 years…the move toward collaboration (Fitz-enz and Davison, 2002). The field cannot just declare itself to be collaborative partners with both customers and local affiliate providers. Partnerships must be earned by acquiring and demonstrating the necessary communication skills and links between the various stakeholders, regardless of clinical mediums and location of service.

Who is Qualified to Provide EA Services and Call Themselves an EA Program?

The early staffing of the EA field grew out of a "wounded healer" tradition which assumed that people who had resolved a particular problem were credentialed by experience to help others who were facing that problem. Staffing occupational alcoholism programs with recovered alcoholics reflected this belief. The credential of personal recovery became less credible in the transition from occupational alcoholism programs to broadbrush EAPs.

Since 1986 the Employee Assistance Professionals Associations (EAPA) has offered a voluntary certification credential, "Certified Employee Assistance Professional" (CEAP) as a way to qualify the competency of EA practitioners. As a competency-based credential, the CEAP has no formal educational requirement and relies on EA work experience, mentoring, and a knowledge test focused on the Core Technology. As a "stand-alone" credential, the CEAP is based on the premise that certified practitioners can perform both "non-clinical" organizational skills, such as management consultation, and individual clinical skills, such as a screening for chemical dependency. With such a wide variation of diverse backgrounds in the EA field, EAPA and its certification commissioners chose to include non-licensed practitioners. Specifically, there were real concerns that non-educated recovering counselors, labor-based peer counselors, and non-clinical practitioners

with expertise in organizational intervention would be systematically excluded from holding the credential.

This decision to include non-licensed practitioners resulted in many EA professionals who were licensed clinicians to question why they needed to supplement their license with a certification. This sub-group of licensed professionals also criticized the CEAP as being "too easy and lenient" and cited examples of CEAPs without graduate degrees or licenses performing complex clinical activities such as post-positive drug test "fitness-for-work" assessments, forensic type assessments for threats of workplace violence, and return-to-work evaluations following leaves for psychiatric disability(Sharar, White, and Funk, 2002).

National EA vendors who contract with EAP affiliates to provide services on an "as needed" basis may value practitioners who have earned the CEAP but certainly do not usually require it to perform EA assessment and counseling. The main requirement to join an EA affiliate network is a graduate degree in a helping profession and an unrestricted license to practice, not evidence that affiliates have even a rudimentary understanding of EAP Core Technology. In fact, many vendors combine their EA affiliate network and managed behavioral health network into a single blended network, diluting what is distinct or specialized about counseling in the EA context (Jeffrey and Riley, 2000). This practice is a declaration that the CEAP is not needed to do the majority of EA work that takes place and that all practitioners credentialed in the vendor's network can provide EA services, outpatient therapy, or both. It is mere speculation if or when an EAP affiliate will assess the employee's problem within the context of work and job performance or utilize an "early intervention/workplace wellness" perspective as opposed to a tertiary, psychotherapeutic perspective. The authors suspect the former perspective is occurring less and less in today's EAP climate, even

with the advent of the CEAP as a specialized credential for EA practice.

The CEAP is simply one measure that an EA practitioner has some basic awareness of the distinguishing aspects of EAP practice, not evidence of competence to evaluate a variety of mental health or addictive disorders, find the very best provider match for a particular condition, or consult with management on the potential referral of a poorly performing employee. The CEAP has found itself in a conundrum; it needs to elevate its own criteria to further enhance the field's credibility without alienating its constituency and revenue base. It is also not clear whether this debate about EAP credentials is important to anyone outside the field, particularly employer purchasers or service consumers.

A related issue is what are the requirements for a program to label itself an "EAP"? Programs that call themselves an EAP but are in reality quasi telephone-based services, have little workplace emphasis, no supervisory training or management referrals, and fail to meet the definition of "EAP Core Technology" as originally identified by Roman and Blum (1988), may merely be camouflaged as EAPs. The danger here is that employer purchasers are limited by their lack of knowledge and information to determine whether or not EA services meet minimum standards of quality to actually function as an EAP or be labeled an EAP. In an effort to address this concern, both the field's professional associations, Employee Assistance Professionals Association (EAPA) and Employee Assistance Society of North America (EASNA) promulgated "two" sets of standards, provided support to "two" different accreditation organizations to administer "two" accreditation processes whereby an independent third party evaluates the EAP based on one of these two sets of generally accepted standards. The plan is to use EAP accreditation, as offered by the Council on Accreditation (COA) or Rehabilitation Accreditation Commission (CARF) as a way to separate those EAPs that meet minimum of standards of quality from those that do not, along with a method to recognize the EA field as having a unique and essential knowledge base and set of skills. The accreditation of EAPs is viewed by its proponents as having the potential to improve quality, accountability, and reduce abuses associated with the mislabeling of the name "EAP" and its functions. The COA began accrediting EAPs in 1992 and reports that over 100 EAPs are COA accredited, many of them Canadian-based vendors (Stockert, 2002). CARF has offered EAP accreditation since 1998 and over 20 EAPs are CARF accredited (Migas, 2000). COA and EASNA, as supported and funded by the Center of Substance Abuse Prevention of Substance Abuse Mental Health Services Administration, and with the help of Masi Research, Inc. have recently ran tests on a revised set of standards at five "Beta Sites" including both national EA vendors and internal programs (Haaz, 2002).

It remains unclear whether or not accreditation will be an integral part of improving the quality of EAPs as well as an important means of demonstrating quality to company decision-makers. If accreditation encourages the field to migrate towards the adoption of universal standards, then perhaps it can play a vital role in restoring some fidelity to the original core technology model that combines to address employee personal concerns that overlap with workplace productivity. Achieving this noble goal requires that advocates and sponsors of accreditation collaborate to resolve a myriad of challenging issues:

1.   Making accreditation affordable for an industry that is already wrestling with slim margins or operating losses.

2.   Making the accreditation process sensitive to the wide variation and diversity of EA models and levels of implementation across multiple "host" organizations and yet still have a meaningful accreditation process.

3. Making sure both the standards and the accreditation process do not favor one type of vendor or program at the expense of another type, creating real or imagined perceptions in the field that certain vendors have an unfair advantage.

4. Convincing employers, as funders of EAPs, that requiring accreditation will be an important measure of quality and best practices.

5. Countering the confusion over multiple EAP accreditation standards and processes.

6. Convincing EAPs based in multi-service organizations that are already accredit their managed behavioral health care services or treatment/behavioral health care services through the National Committee of Quality Assurance or Joint Commission on Accreditation of Healthcare Organizations that there is value in having their EAP departments or divisions participate in a separate and distinct accreditation process.

What is the financial future of EA Services?

Despite an extended period of unprecedented growth in EAP enrollment, the field has not benefited from price increases in well over a decade. While the U.S. economy of the past twenty years expanded, prospered, contracted, stagnated, crashed, and stabilized, with marked inflation in health care costs, average EAP rates remained relatively unchanged (Melek, 2000). In a highly competitive market, EAP vendors routinely submit unreasonably low bids in order to capture market share and then under-resource the program in order to contain costs within the "per-employee-per-year" capitated rate structure (Sharar, White, and Funk, 2002). Lower utilization of EA services equals higher margins for the vendor, so vendors are tempted to deliver substandard levels of service in order to make up for lost profits resulting from low capitated bids. EAPs are under-priced and over-sold, contributing to a type of gradual financial suicide and the hope of making up losses by offering collateral products as a new source of revenue that end up diluting the definition and expectation of what an EAP should be.

The one side effect of rapid diversification of services within EA contracts is that it's focus and value may become less clear. As long-tenured client company executives, managers, and human resources professionals leave who still attribute high value to EA services because of the program's known tangible impact over the course of their career, a new generation of managers without such history and facing bottom line accountability of their own performance, may view EA services as a discretionary expense that can no longer be justified. These new managers may take a hard look at EA contracts and discover phantom EAPs whose expensive marketing materials and boasts of high employee "contacts" turn out to be more smoke and mirrors than substance-- resources that exist on paper but are rarely used because they increase the EA contractors operating costs and lower profits.

Reforming this price, commodity driven market by educating purchasers to choose EAPs on the basis of quality, value, and outcomes, rather than price, may be the single most important step to preventing the field from being absorbed by other services. Getting the attention of senior managers and human resource executives, and providing return-on-investment data above and beyond subjective testimony, will preserve and enhance our economic base as well as our historic mission. The authors forecast that if this strategy is not aggressively pursued and supported by a clear vision from the field's leadership, the EA field will not survive as a distinct profession. As a field, we urgently need to analyze why commodity pricing has become the "rule" rather than the exception and help employer purchasers differentiate between EA programs based on factors other than price.

How effective are EA Services?

There is a strident call in many health and behavioral health fields to bridge the gap between clinical practice and clinical research, but the EA field finds itself in an unusual position. It lacks a foundation of rigorous scientific studies (Roman, 1996; Arthur, 2002) and has no identified academic discipline at its foundation. There is less methodologically sound research in the EA field than any comparable field of behavioral health or social service. There are no federal institutes supporting multiple-site, randomized clinical trials to test the efficacy and effectiveness of EA models and all of the published research on EA effectiveness has significant design flaws, e.g., the absence of control groups. There are no accepted standard benchmarks used to measure performance across EA models and programs. Even where research has shown a positive effect of EA programs, no effort has been made to disassemble such programs within the evaluation designs to identify the potent ingredients of these programs (Roman, 2002). EA services have competed so intensely in the arena of service costs, product enhancements, and market dominance that the true outcomes of EA services have been virtually ignored. When outcomes are reported, it is nearly always a one-group pretest/posttest design with a short follow-up period where the impact of the EAP is confounded with the treatment effect when referrals beyond the EAP are made.

It is time the EA field stopped citing out-of-date, methodologically weak studies that evaluated EA models that no longer even exist within the EA landscape, and began constructing a scientific infrastructure that can compete with the marketplace in shaping the design of EA products and services. It is time to foster the development of EA professionals who will conduct and publish EA research rather than just engage in EA practice.

Summary

The EA field has evolved from: 1) a focus on rescuing alcoholic employees to an ever-widening scope of employee problems and needs, 2) a localized, peer-led model of intervention to an external, national/regionalized professionally-directed model, 3) high dose/intensity services to low dose/intensity services; and 4) a focus on employee health and performance to a focus on benefits management and other company needs. Depending on one's vantage point, these trends represent a dynamically evolving field that has continually re-engineered itself within a turbulent behavioral health marketplace, or a field in decay that in its search for professional credibility and financial security and profit has become detached from its historical roots and its core values and technologies. The authors confess leaning toward the latter position, but any pessimism that view might bring is offset by our anticipation of a renewal movement within the EA field that will re-link the field to its historical mission as is moves through the early twenty-first century. That renewal movement will: 1) reinstall interventions with addiction and other behavioral health disorders at the center of the field's mission and competencies; 2) rebuild the partnership between management and labor in responding to the impaired employee; 3) re-localize the delivery of EA services and the development of EA service networks; 4) persuade colleagues and employers to sell and buy EAPs on the basis of compliance with generally accepted quality standards rather than the lowest bid, and 5) create a research infrastructure that can place the EA field on par with other arenas of behavioral health care.

REFERENCES

Arthur, A. (2001). Employee assistance programs: Do they work? EAPA Exchange July/August, pp. 21-23.

Baumohl, J. (1991). Administering the Pledge: Episodes in San Francisco's

Management of Drunken Public Employees, 1858-1920. Journal of Drug Issues, 21(4) 825-838.

Bennet, N., Blum, T.C., and Roman, P.M. (1994). Presence of drug screening and employee assistance programs: Exclusive and inclusive human resource management practices. Journal of Organizational Behavior, 15(6): 549-560.

Blair, B. (2002). Providing Added Value to Employers. EAPA Exchange, 32: 21-23.

Blum, T., Roman, P., and Tootle, D. (1988). The Emergence of an Occupation. Work and Occupations,15: 96-114.

Findlay, S. (1999). Managed Behavioral Health Organizations in 1999: An Industry at the Crossroads. Health Affairs, 18: 116-124.

Fitz-enz, J., and Davison, B. (2002). How to Measure Human Resources: McGraw Hill Companies.

Haaz, E. (2002). EASNA Standards and Accreditation History. Presentation at the EASNA Institute, May 4: Quebec City, Quebec

Henderson, R. and Bacon, S. (1953). Problem Drinking: The Yale Plan for Business and Industry. QJSA, 14:247-262.

Herlihy, P., Attridge, M., and Turner, S. (2002). The Integration of Employee Assistance and Work-Life Programs. EAPA Exchange, 32: 10-12.

Jeffrey, M., and Riley, J. (2000). Managed Behavioral Healthcare in the Private Sector. Administration and Policy in Mental Health, 28: 37-50.

Levine, H. (1978). The Discovery of Addiction: Changing Conceptions of Habitual Drunkenness in America. JSA, 39(2):143-174.

Maiden, P. (2001). The Evolution and Practice of Occupational Social Work in the United States. Employee Assistance Quarterly, 17: 119-161.

Melek, S. (2000). Unpublished data provided by Milliman & Robertson, Inc. Actuaries and Consultants. Denver, CO.

Migas, N. (2000). Accreditation Option for EAPs: CARF. EAP Digest, Winter: 15-17.

Milgram, G. And McCrady, B. (1986). Employee Assistance Programs (Center of Alcohol Studies Pamphlet Series). New Brunswick, NJ: Alcohol Research Documentation, Inc.

Oss, M. and Clary, J. (1998). The evolving world of employee assistance. Behavioral Health Management, July/August, pp. 20-27.

Oss, M. and Fox, A. (2001). The Yearbook of Managed Behavioral Health Market Share in the U.S. Gettysburg, PA: Open Minds.

Presnall, L. (1981). Occupational Counseling and Referral Systems. Salt Lake City, UT: Utah Alcoholism Foundation.

Roman, P. (1981). From Employee Alcoholism to Employee Assistance. Journal of Studies on Alcohol 42(3):244-272.

Roman, Paul M., and Terry C. Blum (1988), "The Core Technology of Employee Assistance Programs," The ALMACAN, August, pp. 17-22.

Roman, P., Blum, Tc.C. (1996) Alcohol: A review of the impact of worksite interventions on health and behavioral outcomes. American Journal of Health Promotion. 11(2):136-149.

Roman, P. (2002). From big stick to broad brush to brush-off? Historic and futurist perspectives on the value of EAPS for employed substance abusers. Presented at the 14th Annual Institute of the Employee Assistance Society of North America, Quebec City, Quebec, May 2-4, 2002.

Rorabaugh, W. (1979). The Alcoholic Republic: An American Tradition Oxford: Oxford University Press.

Sharar, D., White, W., and Funk, R. (2003) Business Ethics and Employee Assistance: A National Survey of Issues and Challenges. Employee Assistance Quarterly, 18: 2.

Steele, P. (1989). A History of Job Based Alcoholism Programs: 1955-1972. Journal of Drug Issues, 19:511-532.

Steele, P. and Trice, H. (1995) A history of job-based alcoholism programs: 1972-1980. Journal of Drug Issues, Spring, pp. 397-422.

Stockert, T. (2002). EAP Accreditation Trends: A Discussion About the Latest Developments. Presentation at the EASNA Institute, May 4: Quebec City, Quebec

Trice, H. and Schonbbrunn, M. *1981) A history of job-based alcoholism programs: 1900-1955. Journal of Drug Issues, Spring, pp. 171-198.

White, W. (1998). Slaying the Dragon: The History of Addiction Treatment and Recovery in America. Bloomington, IL: Chestnut Health Systems.

White, W. (2000a). The history of recovered people as wounded healers: II. The era of professionalization and specialization. Alcoholism Treatment Quarterly. 18(2):1-25.

White, W. (2000b). Listening to history: Lessons for the EAP/managed care field EAP Digest. 20(1):16-26.

White, W. (2002). A lost vision: Addiction counseling as community organization. Alcoholism Treatment Quarterly 19(4): 1-32.

Williman, M. (2002) Work-Life and EAP Convergence: A Matter of Economics. Employee Benefit News, October.

Wrich, J. (1974). The Employee Assistance Program. Center City, Minnesota: Hazelden.

Wrich, J. (1980). The Employee Assistance Program: Updated for the 1980's Center City, Minnesota: Hazelden.