



THE HISTORY OF EMPLOYEE  
ASSISTANCE PROGRAMS IN  
THE UNITED STATES

DALE A. MASI

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**DALE A. MASI, PhD**

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## *Foreword*

With a disparate mix of facts, opinions and anecdotes, the Employee Assistance field has evolved into a specialization that endures despite much trial and error, a less than compelling compendium of scientifically validated research and a history that, until now, has existed only in the recesses of the minds of aging and retiring practitioners.

This endurance is due in large measure to the dedication and passion of the legions of EAP professionals over the last several decades. EAP folks enjoy their work and take great pride in bridging the gap between employer and employee - to the benefit of both. Success stories are frequent and numerous, perhaps inadvertently masking the need to have research-based evidence of what works and what doesn't.

The Employee Assistance Research Foundation (EARF), created in 2007, seeks to promote and disseminate research studies which bear credible witness to the theories and practices in Employee Assistance which are demonstrating measurable and efficacious results. EARF is the proud sponsor of this EAP History project.

After funding and distributing several important research projects, it began to dawn on us that there remained a large gap in our collective body of EAP knowledge. Virtually every profession has at some point recognized that its full import can only be passed down through the generations by way of some type of detailed history, composed in an organized and impassionate fashion. Until now, Employee Assistance Programs have had to rely on word-of-mouth narratives and an extreme paucity of academic offerings.

The EAP professional associations (EAPA, EASNA, EAEF, APEAR, etc.) have filled in some of gap; but their focus, as it should be, is primarily on current practices

and innovations. Nowhere could we find an authoritative history of EAP development. Further, it was startling to note that many of the key figures in this history were retiring and/or “shuffling off this mortal coil.”

Thus, the Employee Assistance History Project was born. The EARF Board of Directors wanted to produce a lasting legacy of our rich history for current and future practitioners in the field. Contracts were let to Masi Research Consultants for the U.S. and Canadian histories and to The National Centre for Education and Training on Alcoholism, located at Flinders University in Adelaide, Australia, for the more recent history of EAP development in the rest of the world. The publication you are about to embark upon is the History of EAP development in the United States, the first of these projects to be completed.

The methodology is multi-pronged, comprising a comprehensive literature review, videotaped interviews with key figures and a considerable amount of collaboration between the author and the EARF Board’s History Committee. Input was obtained from a wide variety of sources, as it was quickly discovered that each person’s view of “history” is understandably shaped by his or her personal experience. The final product is an amalgam of academia, governmental efforts, labor advocacy, occupational social work, self-help organizations and commercial EAP entities. No single one of these arenas can lay claim to exclusive “ownership” of EAP . . . but all have an enormous stake in preserving their legacy of involvement in its evolution.

One’s view of the importance of history as a subject is often related to one’s age and thus the amount of ‘history’ one has experienced. A teen in middle or high school is likely to feel that history has no relevance whatsoever to her internet and social media-

dominated life. Rote memory of names, places and dates further alienates young people from the subject. But as Mark Twain is frequently quoted as saying, “History doesn’t repeat itself, but it often rhymes!”

You may be familiar with the old saying, “The more you know, the more you realize what you don’t know.” This may sound like a circular statement, much like “I used to be indecisive, but now I’m not quite so sure.” But it rings true - experience and maturity inevitably lead one to realize that the world is a much more complex place than we thought as a teen. (As an aside, one of my favorites is “You’re 17 - move out, get a job, get an apartment. Hurry - while you still know everything!”)

In any event, a few of us long-toothed greybeards agreed (and we don’t agree on much) that we owed it to current and future EAP professionals (especially the incredibly talented and techno-savvy ‘Millennial’ and ‘Z’ generations) to provide a credible history of the field in which they are or will attempt to make a living.

Of course, it would be impossible to recount every single important event in the history of EAPs. Countless good things (as well as not-so-good things) have occurred - but are undocumented. The videotaped portion of this work will shine some light on these events. Links to the video archives can be found in this document.

Finally, I view this work as a tribute to all who have labored in this challenging field, whether they have been recognized in these pages or not. They can rightfully be credited with improving the well-being, not of hundreds or thousands, but millions of individuals throughout our storied history of Employee Assistance Programs.

*Cheers to all of you!*

*Carl Tisone, President, Employee Assistance Research Foundation*

### *About the Author*

Dale A. Masi, PhD, CEAP is Professor Emeritus of the University of Maryland (UMD), where she chaired the employee assistance specialization at the School of Social Work. As president and CEO of MASI Research Consultants, Inc., a Boston consulting company specializing in employee assistance evaluation, she provides consultation to private and public corporations, non-profits, and government agencies.

Dr. Masi holds a PhD in Social Work from the Catholic University of America. She has served on the International Business Machines (IBM) Mental Health Advisory Board and was named a NASW Social Work Pioneer in Employee Assistance. She was the first recipient of the International Rhoda G. Sarnat award and a recipient of the Employee Professional Association (EAPA) Lifetime Achievement Award. As a Fulbright scholar, she has consulted in forty-five countries for the U.S. State Department and other international entities.

Among her fifteen books and seventy articles, in 1996 she edited the first *International EAP Compendium*, updated and expanded in 2000, 2005, and 2010. In 2009, through a collaboration with the UMD School of Social Work she designed and implemented the International EAP Online Certificate Program and has taught thousands of students from over forty countries. In 2020 this program will be offered through the Employee Assistance Program Association (EAPA). Please visit [Dr. Masi's website](#) to learn more.

### *About the Project*

The Employee Assistance Research Foundation (EARF) is a 501c (3) nonprofit entity that seeks to identify key issues in the EAP field through research and the support of evidence-based studies. Through its strategically placed grants the Foundation is instrumental in its impact for employers, practitioners, researchers, policy makers, and other EAP stakeholders (EARF, 2017).

In April 2016, the EARF released a request for proposals to fund the EAP History Project. Dale Masi, PhD, President and CEO of Masi Research Consultants, Inc., was awarded the grant to provide a comprehensive look at the seventy-year history of EAPs in the U.S. The first part of this effort includes the historical data of the field using the social science literature, trade publications, government documents, other relevant sources.

Part Two consists of eight-hour long video interviews with the pioneers in the field. Each expert offers another layer of expertise and direction through the essential experiences of their individual experience and contributions to the field. Professor Jodi Jacobson Frey of the UMD School of Social Work served as the sub-contractor via the university for this aspect of the project. The interviews were conducted by Dr. Masi and are available through the [EAP archive at the University of Maryland School of Social Work](#).



### Video Interviewees

|                      |   |
|----------------------|---|
| Carl Tisone          | Carl Tisone founded the Employee Assistance Research Foundation (EARF) and was owner and founder of Personal Performance Consultants (PPC) and PPC International. He discusses managed care as well as the development of international EAPs. |
| Dr. Dale A. Masi     | Dale Masi, an international expert in the EAP field, discusses the need for research, evaluation and a specialized education for those entering the EAP field.  |
| John Burke           | John Burke, a leading EAP consultant explains the impact of managed care on EAPs as well as the growth of mergers and acquisitions.   |
| Rick Csiernik        | Rick Csiernik, the leading researcher in Canada describes the early development of EAPs in Canada.  |
| Rita Fridella        | Rita Fridella, one of the major figures in EAPs in Canada, presents the history of EAPs in Canada.  |
| David Sharar         | Dave Sharar, a highly experienced EAP researcher, points out the need for stopping the price war in the EAP field and the need for research in the field.   |
| Fran Sussner Rodgers | DuPont, the original founder of Work-Life Services, presents the role of IBM in the implementation of childcare and eldercare programs.   |
| Jim Wrich            | Jim Wrich, one of the “Thundering Hundred” is credited with giving the name Employee Assistance to the field.   |

### *Acknowledgements*

Special thanks and gratitude to Carl Tisone for his generosity and foresight recognizing the need for a history of the field of Employee Assistance Programs. Thanks to the members of the Employee Assistance Research Foundation History Committee for their guidance throughout the process; Ron Manderscheid, PhD, John Maynard, PhD, Paul Roman, PhD, and David Sharar, PhD I would also like to recognize Bernard McCann, Dr. Robin Masi Carlson, and Todd Mook, senior staff and associates at Masi Research Consultants, for their continued support.



Dr. Dale A. Masi, Author



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## **Introduction**

The history of Employee Assistance Programs (EAPs) in the United States is rich and complex. It has antecedents in the social welfare movement, industrial social work and in the early occupational alcoholism movement. This does not imply that there has been historical linkage of these activities and continuity across time, but that common themes and concepts can be identified within each movement. In the most recent model utilized, the functions of EAPs and the services they provide are dual in nature.

1. Clinical EAP services consisting of problem assessment, brief supportive counseling, referral to higher levels of treatment, and follow-up for employees and/or family members.
2. Non-clinical worksite services to employees such as mental health and wellness educational presentations, as well as training and consultation to supervisors and management on organizational health and productivity (EASNA, 2009).

Generally, the second set of services were essential in facilitating the appropriate delivery of the first.

As presented by those promoting their adoption, EAPs are a vital tool for maintaining and improving worker health and productivity, retaining valued employees, and returning employees to work after behaviorally-related illnesses or injuries. Employers are told that proactive, preventive efforts to help employees identify and resolve personal issues before they have serious medical, family, and/or workplace consequences makes good financial and business sense (DOL, 2009).

The number of companies currently offering EAPs in the United States is substantial, according to evidence and estimates from several sources. In the U.S., over

97 percent of companies with more than 5,000 employees have access to EAPs, and 75 percent of companies with 251-1,000 employees have access to EAPs (EAPA, 2016). According to the Society of Human Resource Management's (SHRM) 2017 annual survey of human resource professionals to gather information on over 300 employee benefits, 77 percent of surveyed U.S. employers offered an EAP (SHRM, 2017). These data need to be viewed with caution. It is clear that there is wide variety in the scope and pattern of EAP services provided in different sites, and that none of the prevalence studies have included any validation that particular program components exist.

### **Methodology**

The purpose of a narrative literature review is to present and report the historical and contemporary summation of the knowledge of a topic (Helewa and Walker, 2000), in this case a historical overview of EAPs in the United States. A historical literature review is focused on examining research throughout a period, often starting with the first time an issue, concept, theory, or phenomena emerges in the literature, then tracing its evolution within the scholarship of a discipline (Onwuegbuzie & Frels, 2016). For this project, the method of narrative overview, or nonsystematic literature review, was the most appropriate. This approach offers a topical and largely chronological narrative of the historical trends to present the literature in a way that is most suited to the general reader. In addition, authors of narrative overviews are acknowledged experts in their fields, themselves often having conducted the original research (Green, et al. 2001).

### ***Conceptual Framework***

To determine the scope of the literature review, a conceptual framework of initial generative themes spanning the history of EAPs in the U.S. was developed.

**Figure 1: The History of EAPs in the U.S.: Conceptual Framework**

| Background and Antecedents       | The Early Years            | Evolution and Diffusion             | Continued Expansion                       | Future Directions                          |
|----------------------------------|----------------------------|-------------------------------------|---|--|
| Welfare Capitalism               | Transition from OSW to EAP | Model Federal Program               | Drug Free Workplace                       | Renewed Focus on Substance Abuse Disorders |
| Occupational Social Work         | NIAAA                      | External Provider Model             | Managed Behavioral Healthcare             | EAPs: A Business or Profession?            |
| Role of Alcoholics Anonymous     | ALMACA                     | IBM and the Affiliate Network Model | Critical Incident Stress Debriefing       | The Marketplace and EAPs                   |
| Occupational Alcoholism Programs | Organized Labor            |                                     | Work/Life Offerings                       | Mergers and Acquisitions                   |
|                                  | Core Technology            |                                     | Integration<br>Embracing New Technologies | Procurement and Pricing                    |
|                                  | Essential Ingredients      |                                     | Research and Evaluation                   | Diversity and Special Populations          |
|                                  |                            |                                     | Professional Associations                 |  |
|                                  |                            |                                     | Accreditation and Certification           |  |
|                                  |                            |                                     | Education and Training                    |  |

### ***Identification of Sources***

To eliminate researcher bias, every effort was made to include a range of sources from academic literature, relevant trade and government publications, and recommendations from industry experts. Due to the specificity and nature of the history of EAPs, the use of industry journals and trade publications was essential. Until recently no readily available comprehensive historical archive of EAP literature has been available to academic researchers. The process for identifying relevant peer-reviewed research journals were from academic search databases including Academic Search, Complete, ERIC, PsychINFO and other social science databases. These searches were performed with the following Boolean queries:

- EAP AND history
- Occupational Alcoholism AND history
- Workplace AND Violence
- Critical Incident Response
- Addiction AND Workplace OR EAPs
- Diversity AND Workplace OR EAPs
- Journal-specific searches

Based on the generative themes, events and issues relevant to the conceptual framework, relevant literature sources were extracted from hundreds of issues of EAP-specific and related peer-reviewed journals and trade magazines, such as *The ALMACAN*, *EAP Digest*, *EAPA Exchange*, *Journal of Employee Assistance*, *EAPA Notes*, *EASNA Research Notes*, *Employee Assistance*, *Employee Assistance Quarterly*, and the *Journal of Workplace Behavioral Health*.

### ***Additional Sources***

In addition to the articles identified through the academic search process, supplemental data sources included articles (140) and books (15) authored or co-



authored by Masi, as well as the professional libraries of several EAP professionals that included relevant chapters, books, and articles (over 250) authored by recognized EAP experts and researchers. Additional topical searches were conducted via online scholarly databases such as Google Scholar, RefSeek, Digital Library of the Commons Repository, HighBeam Research, and online webpages of relevant organizations.

### ***Literature Selection Process and Criteria***

1. EAP subject experts were consulted in the U.S. including; Thomas Delaney, Jodi Jacobson Frey, PhD, John Maynard, PhD, Bernard McCann, PhD, David Sharar, PhD, Paul Roman, PhD, Carl Tisone for specific literature references.
2. Special attention was paid to the organizations, associations, and research journals focused specifically on the field of EAPs.
3. Each publication's table of contents was examined, and relevant articles were selected determined by their match to the initial conceptual framework. This literature formed the References section of this monograph.
4. Articles utilized matched the conceptual framework. Citations for the articles that were included as sources or quotations can be found in the references section.
5. Archival documents and professional policies from various organizations were included: the EAPA Code of Ethics; EAPA Standards and Guidelines for Employee Assistance Programs; The Council on Accreditation's EAP Standards; and EASNA's EAP Professionals Code of Ethics.

### **Definitions of EAP**

The definition and practices of an EAP may vary depending on the type of program, the nature of the services offered, the standards being applied, and the region in which the EAP operates. There is also variation by the amount that employers choose to invest in EAP services and the structure of services provided internally or externally in a given workplace.

In North America, there are two longstanding organizations that promote continued EAP development and to serve as professional membership associations with

those who are occupational or organizational stakeholders in EAP service delivery. Their definitions of EAPs are provided below.

The Employee Assistance Professionals Association (EAPA) describes an EAP.

*EAPs serve organizations and their employees in multiple ways, ranging from consultation at the strategic level about issues with organization-wide implications to individual assistance to employees and family members experiencing personal difficulties. As workplace programs, the structure and operation of each EAP varies with the structure, functioning, and needs of the organization(s) it serves. In general, an EAP is a set of professional services specifically designed to improve and/or maintain the productivity and healthy functioning of the workplace and to address a work organization's particular business needs through the application of specialized knowledge and expertise about human behavior and mental health (EAPA, 2016).*

The Employee Assistance Society of North America (EASNA) defines an EAP.

*An EAP is an employer-sponsored service designed for personal or family problems, including mental health, substance abuse, various addictions, marital problems, parenting problems, emotional problems, or financial or legal concerns (EASNA, 2017).*

In a few instances, workplaces themselves have formalized definitions of EAP services.

The federal government's Office of Personnel Management (OPM) is responsible for human resource policies for the federal workforce, and defines its version of an EAP.

*An EAP is a voluntary, work-based program that offers free and confidential assessments, short-term counseling, referrals, and follow-up services to employees who have personal and/or work-related problems. EAPs address a broad and complex body of issues affecting mental and emotional well-being, such as alcohol and other substance abuse stress, grief, family problems, and psychological disorders. EAP counselors also work in a consultative role with managers and supervisors to address employee and organizational challenges and needs. Many EAPs are active in helping organizations prevent and cope with workplace violence, trauma, and other emergency response situations (OPM, 2016).*

## **I. Background and Antecedents of EAPs**

While the first EAPs appeared in workplace during the 1970s, the existence of related workplace employee outreach efforts date from the turn of the 20th century. While not necessarily linked through later efforts deliberately building upon or revising earlier efforts, there has been a succession of strategies for reducing workforce unpredictability by addressing employee concerns affecting work performance (Blum & Roman, 1989).

As Lorraine Midanik, PhD, professor emerita and dean at the Osher School of Social Welfare at UC Berkeley stated “what we currently call EAPs have also been known as employee counseling, occupational social service, industrial social work, occupational alcoholism, and mental wellness programs” (Midanik, 1991; pg. 70). This is a useful statement, for it demonstrates the diversity of meanings attached to “EAP”. While some of those on Midanik list are antecedents to EAPs, it is not accurate that they are identical to or comprise different forms of EAPs. Three examples of clear forerunners of contemporary EAPs in the United States can be seen in welfare capitalism, occupational social work, and occupational alcoholism programs.

### **Welfare Capitalism**

Beginning in the latter half of the 19<sup>th</sup> century, as America’s economy transformed from an agrarian-based economy to one of manufacturing, skilled labor, business owners sought to populate and secure a reliable workforce. In many industries in the early 20<sup>th</sup> century for those in the working class, the effects of industrial growth introduced new challenges to their prior skills and life experience. Annual rates of 100 percent employee turnover were common in many U.S. industries. (Owen, 2004). At this

time, there were no public programs where employees could turn for assistance in helping to adjust to the life demands that they had not experienced in their former agrarian environments.

Welfare capitalism can be seen as a strategy of management control to shape employee behavior, primarily aimed at strengthening the attachment between workers and employers, obtaining compliance with worksite requirements to ensure efficiency and steady, if not increased, work productivity (Googins & Godfrey, 1987; Steele, 1995). Other goals included Americanization of immigrants and “urbanization” of migrants from America’s rural agricultural areas. To stabilize their labor forces, inspire company loyalty, discourage high turnover, and present a good face to the public, employers began to focus on the well-being of their employees (Googins & Godfrey, 1985). Various employer and industry groups, like the National Civic Foundation, promoted corporate philanthropy.

Companies supplied basic, and sometimes even comprehensive, provisions for their employees such as housing, schools, churches, medical care, recreation centers, educational services, profit-sharing, and stock ownership at companies such as the Ford Motor Company, Pullman Car Company, International Harvester, and National Cash Register (Steele, 1995). Doubtless such investments were partly self-serving and designed to combat worker dissatisfaction that could lead to unionism and prevent costly strikes. These two-pronged efforts were referred to as “humane pragmatism,” by Trice and Beyer (1982).

One researcher defined these features as services provided for the comfort or improvement of workers that were neither an industry necessity nor required by law, reaching their highest point of uptake by employers during and following World War I,

and noting, "the anti-union overtones were definite" (Brandes, 1976, p. 32).

This movement persisted in many industrial worksites until the Great Depression of the 1930s and the near collapse of the American economy (Crafts & Fearon, 2013). At the same time, new notions of the workplace and workers were emerging, including the repetitive and highly monitored production process of Taylorism which sought to apply scientific management practices to employees to gain economic efficiency through labor productivity (Nelson & Campbell, 1972). This was followed by the human relations movement, which sought to utilize the effects of social relations, motivation and employee satisfaction on productivity, which eventually became the discipline of human resource management (Taneja, Pryor, & Toombs, 2011). These ideas viewed workers in terms of their psychology rather than as interchangeable parts in the workplace and were in part influenced from research conducted at the Hawthorne, Illinois, plant of Western Electric. For economists and employers, the novel finding from this research was that the strongest positive influence on job performance were intangible factors including how employees felt they were treated, and how they felt about their working conditions, co-workers and supervisors (Roethlisberger & Dickson, 1939; Googins & Godfrey, 1985).

In 1936, a personnel counseling program was established at Western Electric and used company trained counselors to walk the factory floors, talking with workers about personal and family concerns and generally letting the employees "ventilate." This was not intended to be psychological treatment, but rather a means for letting employees know that the company cared about them and about what they felt. The effort which lasted until 1955, was imitated by a number of other companies in the 1940s and 1950s (Bellows, 1961; Dickson & Roethlisberger, 1966). Ultimately this new approach of

‘human resources’ sought to make the workplace a more efficient and worker-friendly place (Taneja, Pryor & Toombs, 2011) giving rise to features such as the establishment of personnel departments, seniority-based compensation, on-the-job training and internal promotion ladders, which became more widespread and sought to satisfy employee’s security needs through fringe benefits (Nestor, 1986), a revised but clear reflection of what had been offered to employees directly through welfare capitalism.

### **Occupational Social Work**

The roots of social welfare efforts and social work in America can be traced back before the Revolutionary War, when mechanisms of charitable relief, child welfare, and mental health services were offered by private benevolent rescue societies and self-help organizations as antecedents of modern social service agencies (Tannenbaum & Reisch 2001). A century later, rapid economic expansion and industrialization led to the factory system, with its need for large numbers of concentrated workers, fueling mass immigration, urbanization, and a host of consequent social challenges. In general, the expansion of social work efforts was a response to the increased predicaments of mass poverty, disease, substandard housing, illiteracy, starvation, and mental health challenges which paralleled economic growth (Garvin & Cox, 2001) but indirectly reflected the costs to society of the rapid growth intensely profit-oriented industrial sector.

Occupational social welfare in the early twentieth century evolved from nineteenth-century social welfare models yet were largely driven by the interests of industrialists and corporations in the absence of institutionalized social welfare services to provide help to workers with “problems” in order to encourage more satisfied and efficient employees (Popple, 1981).

Contemporary with welfare capitalism, this developing social welfare work in industry created a new category of personnel known variously as social secretaries, welfare managers or welfare secretaries who looked after the health and general well-being of work and plant, in all questions concerning life in the factory, workshop, or store (Brandes, 1976). The first social secretary documented in the literature was Aggie Dunn, hired in 1875 by the H. J. Heinz Company and charged with attending to the needs of young women working in the organization. For 50 years “Mother” Dunn continued interviewing, hiring, counseling and generally watching over 1,200 charges in Heinz’s Pittsburgh pickle factory (Googins & Godfrey, 1985; Maiden, 2001). Similar programs were launched at the Joseph & Feiss Garment Factory in Cleveland, Ohio (Nelson & Campbell, 1972) in Southern textile mills, and at companies such as Kimberly Clark and International Harvester.

From these earliest efforts which in many instances were designed to aid and protect women in their adaptation and day-to-day functioning in both white- and blue-collar workplaces, occupational social workers broadened their reach to the full workforce and provided a wide variety of services including medical and welfare examinations, organizing washing and bathing facilities, lunch rooms, loans, insurance, savings plans, job training, citizenship training, housing assistance, and family care (Fleisher, 1917; Googins & Godfrey, 1985). By the mid-1920s, according to a U.S. Bureau of Labor Statistics survey, most large companies had some type of welfare program (Stern & Axinn, 2011), with some companies employing a full-time welfare secretary and others contracting with outside agencies to provide social services (Poppo, 1981).

Typically, company-hired welfare secretaries often came from religious-based charitable backgrounds, and were well-meaning, untrained and ill-equipped to deal with employees in crisis. The establishment of the welfare secretary function reflected the predominant paternalistic attitude of many businesses, often serving as a rationale for why labor unions were not needed.

Not coincidentally, the corporations most likely to hire welfare secretaries were also firmly anti-union, and thus these positions were typically viewed with prejudice by those in the labor movement (Akabas & Kurzman, 1982). Over time however, an image of the occupational social worker as working for both employee and employer interests has emerged.

Two early examples of social workers performing employee counseling and social services in a work setting occurring shortly after the turn of the century are found at Macys Department Store in New York City and at the Northern States Power (NSP) in Minneapolis. In 1916, a Department of Social Services was created at Macys in New York. Writing in 1944, Elizabeth Evans, a graduate of the New York School of Social Work, defined its focus informational, societal, and psychiatric. Employees were provided with comprehensive health, recreation, and education information and resources.

Caseworkers focused on the conditions of an employee's living situation that could benefit from governmental or charitable assistance. Evans further described the department as "distinct and separate from the Personnel Division. Employees bring their problems to us secure in the knowledge that our relationship with them will be a confidential one" (Evans, pg. 12). As part of this overall effort, Macys was the first and one of the few workplaces to employ a full-time psychiatrist, Dr. Temple Burling.



In 1917, social worker Ruth Gage Thompson was hired to manage the internal employee counseling program (known as the Social Resource Center) at NSP, a small, family-owned operation by its owner, Henry Marison Byllesby, who had a paternalistic, yet caring attitude toward his employees. Still in existence today, the NSP program is perhaps the longest continuously running occupational social work program in the country. Similarly, Metropolitan Life Insurance hired a "housemother" in 1919 to offer counseling services to employees and gradually broadened this employee service to encompass a trained staff and a pioneering program of "pre-retirement" counseling. (Dunkin, 1982; Kemp, 1994).

During World War I women were employed in industrial settings in larger numbers than ever before, according to a 1956 study. Employers were sensitive to the need to help female workers adjust and integrate in the occupational setting and assist them in their family responsibilities as mothers and care providers. Due to the high proportion of females in the workforce, employers often found it helpful to hire females, and in some cases trained social workers, as personnel workers or supervisors. Though no specific historical documentation exists as to actual numbers of social workers hired during this period, Miro (1956) states "...throughout the industrial settings social workers were frequently seen though they were never really regarded as such."

The evolution of the position of welfare secretary refined the paternalism of many businesses. The evolution of the role from the earlier untrained welfare secretary to the emergence of the modern industrial social worker has humanized and democratized that paternalism. Between 1920 and 1940, growth in industry social work programs began to slow, with opposition to such efforts growing from immigrants becoming more acculturated who saw them as paternalistic (Ambrosino, et al, 2015) and

from organized labor which viewed the welfare secretary as beneficially providing social services while quietly promoting an anti-union perspective (Maiden & Kurtzman, 2010). One author notes that the role of welfare secretary was gradually merged from those staff trained in the new disciplines of business administration and personnel management (Popple, 1981). Depression-era economic conditions in the 1930s also likely curtailed the expansion of additional support staffing. As a result, the industrial social worker almost disappeared from the American workplace in the decades after World War I.

However, with the onset of World War II, a new social and economic climate emerged in which millions of American workers required assistance with life during wartime. Employers, unions, and the government each responded to these needs in different ways. Social work services were charged with helping people adjust personally and productively during a time when industrial production to fuel the war effort was a critical common goal. Another major change was the institutional presence of strong labor unions which were used as platforms for the delivery of many of these types of services.

One example of a pioneering wartime social service addressing workers' needs was a joint effort begun in 1943 by the National Maritime Union (NMU) and the United Seaman's Service. In *Social Work and Social Living*, Bertha C. Reynolds recounts her experience as a professional social worker directing a staff of six in the Personal Service Department as the union struggled to cope with the family members of over 5,000 members lost at sea.

Departmental services included assisting members and families in financial distress to procure loans, unemployment or disability insurance, locating seamen

stranded in foreign ports after rescue, counseling or making a proper referral for those needing hospitalization, and assisting bereaved families. Ms. Reynolds was also responsible for fostering this approach through training for other unions such as the United Electrical Workers and Fur Workers. In a prescient observation regarding the rise of mutual self-help groups like Alcoholics Anonymous, Ms. Reynolds, observed "it is not hard to take help within a circle in which one feels sure of belonging" (Reynolds, 1951, p. 54). Subsequent to Reynolds' innovative work, other labor unions in the public sector, garments, hospitals, and manufacturing industries initiated programs that offered a variety of occupational, psychosocial and legal services to their members (Lewis, 1997).

Notable among these programs affiliated with organized labor were the rehabilitation and service project at the Amalgamated Clothing Workers of America; a member assistance and legal assistance program at the American Federation of State, County & Municipal Employees; a social services program for members of the International Ladies' Garment Workers' Union; and a member personal services program at District 65 of the Distributive Workers of America (Akabas, Kurzman & Kolben, 1979). In the 1980s, a joint labor-management Employee Development Program between Ford and the United Auto Workers was formed to deal with the impact of plant closings on displaced workers. They created a Life Education Planning function which, in conjunction with the University of Michigan's School of Social Work, brought in outside counselors called Life Education Advisors who offered a comprehensive service menu of personal development and career counseling, financial education, and retirement planning. This successful program was to lay the foundation for the creation in 1984 of one of the largest joint labor management EAP efforts (Root & Dickinson,

2009).

During World War II, the number of U.S. federal government employees swelled and the need to implement expanded services for this growing workforce became apparent. A 1942 report of the Civil Service Commission's Committee on Employee Counseling Services listed such program features as: dealing with any situation that is likely to affect work productivity; providing information on housing, educational opportunities, social agencies, nutrition, medical and psychiatric facilities; discussing with employees the nature of their problems and working out solutions; and counseling employees regarding various problems connected with their work (Civil Service Commission, 1942). One author of the time noted that employee counseling in the federal service could be one of the new frontiers in social work (Stailey, 1944).

Soon after this observation was made, the social work field accelerated its trend of being enamored with the Freudian approach to helping individuals through in-depth clinical methods. Thus, the profession turned away from the workplace arena to practice and concentrate on the individual clinical approach to helping people. This is still the predominant practice method of the profession.

These historical efforts have clearly contributed to a contemporary definition of occupational social work as a specialized field of practice that addresses the human and social needs of the work community by designing and executing appropriate interventions to ensure healthier individuals and optimal adaptation to their work environment (Googins & Godfrey, 1987; Straussner, 1990). Columbia University and Hunter College label their occupational social work programs as such, to emphasize a broad social work perspective, rather than using the employee assistance nomenclature.

Occupational social work has been practiced in corporations, small businesses, non-profit organizations, unions, schools, hospitals military units, and government agencies (NASW, 1984). Examples of such programs include the CNA Financial Corporation in Chicago, IL which in 1973 hired a social worker to develop and staff an employee-counseling program within its company medical clinic. Northwestern Bell Telephone Company, which employed thousands of people throughout Iowa, also recognized the need to include mental health counseling services as part of its medical program, after it determined a high rate of incidental absenteeism was partly due to employees using work time to obtain outside social services. The services provided in these venues today come under a variety of names, most commonly as EAPs, and have reflected that contemporary occupational social work is firmly established in the EAP as well as other settings (Tanner, 1991).

### ***The Role of Alcoholics Anonymous***

In 1935, a mutual aid fellowship that eventually became Alcoholics Anonymous (AA) was born in Akron, Ohio through a powerful first-time personal encounter between two alcoholics (Bill W. [Wilson]. and Dr. Bob [Smith]) who had each unsuccessfully struggled to cease or control their drinking. From this meeting, the two men's joint ideas began the construction of what proved eventually to be a ground-breaking program for recovery from alcoholism. Following a period marked by great enthusiasm and energy in building a unique organization with a powerful and successful struggle to build and maintain consensus, the publication of the 1939 "Big Book," *Alcoholics Anonymous*, provided important details of how a carefully selected collection of AA members had each managed to gain sobriety through mutual support. The Big Book also set the stage for the founding of local AA recovery 12 step groups, which came to be the

organization's backbone.

AA's single purpose is to provide a series of 12 Steps through which alcoholics can achieve sobriety and then serve to help other alcoholics achieve sobriety, with this activity in turn helping to sustain sobriety. From its beginnings, this group differed from all other alcohol organizations in that it had no interest whatsoever in whether alcohol use in society should or should not be prohibited. This was extremely important to AA's eventual acceptance into American society which was exhausted by decades of the "wet vs. dry" debate. In a March 1, 1941 article by Jack Alexander published in the *Saturday Evening Post* he described AA's astonishing success with the 'hopeless inebriates.' Membership tripled in size within a year and continued to grow exponentially, with estimates a decade later of over 100,000 members.

Simultaneous with the grassroots swelling of AA membership were efforts of key individuals and various organizations, notably the Yale Center of Alcohol Studies (successor to the first research unit dedicated to alcohol studies founded shortly after the repeal of Prohibition in 1933), and the National Committee on Education on Alcoholism (later known as the National Council on Alcoholism [NCA]) and more recently renamed the National Council on Alcohol and Drug Dependence [NCADD]) created in 1944 by Marty Mann and others. From its beginnings, NCA pronounced the challenge of alcoholism as "a disease like any other." This is as an alternative to the conception of the behavior as reflecting moral weakness, and promulgating the ideas that (1) alcoholics can be helped and (2) alcoholism is a major public health problem (NCADD, 2017).

The early growth of AA provided work organizations with both a rationale and scheme for treating employed alcoholics, many of them valued employees. The early and

mid-1940s witnessed a continuing growth of these alcoholism programs in major industrial firms, which helped imbue the new approach with additional legitimacy (Presnall, 1981; Steele, 1989). Trice and Schonbrunn (1981) argue that the unique labor shortage during World War II was one of the primary motivations for employers and unions to support the recovery of the productivity of active and potential employees impacted by alcoholism.

The need for ‘all-hands-on-deck’ to actualize the maximum wartime production, led to hiring workers who would have been passed over in normal conditions (Trice & Schonbrunn, 1981). In the earliest programs the mechanism employed by assignment of an employee known to be a successful AA member to the medical director. With this authority and job assignment, the employee member of AA would attempt to recruit to AA to other workers known to have alcohol problems via AA’s 12<sup>th</sup> Step.

Starting in 1942, DuPont had become one of the first major companies to recognize alcoholism as a disease and to treat it as a health problem after a DuPont family member, (Maurice du Pont Lee) met Bill Wilson and became interested in how the principles of AA could be applied in a workplace setting (Heck, 1999). The program’s success was largely attributed to the mutual efforts of a recovering employee, Dave M. (eventually given a position in the medical department as a counselor) and Medical Director Dr. George Gehrman (Steele, 1995). Quoting Dr. Gehrman in 1952, “...over the past five years, we have a 65 percent recovery rate” (National Industrial Conference Board, 1958:36, cited in Richard, 2006), and “AA had saved the lives of at least [DuPont] 180 employees since 1943” (Callahan, 1952).

### ***Occupational Alcoholism Programs***

The stated aim of these onsite programs was to help those alcoholic, yet still-valued employees to abstain from alcohol and return to productivity, before poor job performance or absenteeism resulted in termination. During this time, AA, while still a relatively new approach was considered the most effective intervention for alcoholism available (Trice & Sonnenstuhl, 1985) and one compatible with the industrial relations concept of progressive discipline (Trice, 1962; Trice & Beyer, 1982). Employees identified by supervisors on symptoms of suspected alcohol misuse were informed of the gravity of job jeopardy, and peer support from those coworkers with sobriety facilitated their entry into AA and often accompanied them. Finally, “the program involves work and education with supervision throughout the company and among the individuals themselves” (Trice & Schonbruun, 1981; Steele, 1989; Kurzman, 1992).

Meetings were held in plants and offices in order to acquaint management and employees with AA, and to break down the old stigmas attached to alcoholism (Callahan, 1952). Another early success story of an occupational alcoholism program was from Consolidated Edison of New York. Dr. S. Charles Franco, Associate Medical Director at Con Edison stated that during the first four years “the overall number of employees reclaimed was 52 percent” (Callahan, 1952).

This innovative concept of a credible workplace alcohol intervention effort was promoted by the NCA and the Yale Center of Alcohol Studies which developed the Yale Plan for Business and Industry, a nine-step strategy for implementing a model occupational alcoholism program targeted at large corporations (Henderson & Bacon, 1953; Steele, 1989; White & Sharar, 2003).



**Figure 2: The Yale Plan for Business and Industry**

| <b>The Yale Plan for Business and Industry</b> |  |
|--|--|
| 1.   | Education of top management about alcoholism and workplace aspects;                    |
| 2.   | Assignment of program responsibility to an existing department, preferably medical;    |
| 3.   | Selection and training of designated program administrator                             |
| 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   |
| 9.   | Periodic surveys to assess the extent of the problem within the organization.          |

In 1948, Ralph “Lefty” Henderson joined the Yale Center as its first industrial alcoholism consultant. His charge was outreach to business and labor to encourage adoption of workplace alcohol programs. Henderson established one of the most heralded occupational alcoholism programs of its time for the 18,000 employees of the Allis-Chalmers Manufacturing Company in Milwaukee, Wisconsin, as well as numerous other successful workplace alcoholism programs. Milton Maxwell, his successor at the Yale Center, described Henderson as the first occupational program consultant, and as a tireless and enthusiastic worker from 1948-1958. Henderson is noted for assisting companies and labor unions in creating industrial alcoholism programs at Scoville Manufacturing, Armco Steel, Marathon Paper, and Standard Oil, among others. Maxwell observed that Henderson “had a small or large hand in just about every occupational program [that came into] existence [during his tenure]”

(Trice & Schonbrunn, 1981, p. 183).

Thus, management and increasingly unions began to realize the importance of this approach to retain valued workers suffering from alcoholism. Henderson and Marty Mann from NCA spoke out about their own recovery to employers and business groups. They revealed that if their own employers had not ignored their alcoholism and its negative impact on job performance, they may have achieved sobriety sooner. This illustrated that employers had the opportunity to help employees suffering from alcoholism by offering early assistance. They promoted a tough love approach based on concern for the employee's well-being and continued employment. This approach was centered on the principles of AA which was considered at the time to be the first and only method for alcoholism treatment.

These recovery presentations did not solely rely on these efforts alone. Henderson and Mann were often accompanied by Professor Selden Bacon of the Yale Center on Alcohol Studies who introduced early formulations of the Yale Plan, lending academic weight to the charismatic testimony of the NCA representatives. This plan remains an excellent example of the blending of Henderson's real world experience with Bacon's considerable scholarly background in the sociology of alcohol problems (Henderson and Bacon, 1953).

While wartime labor conditions may have boosted support for the needs of marginal workers by establishing alcohol and other counseling programs, labor unions, mindful of their roles as protectors of their members' rights, were skeptical of these efforts largely viewing them as a means of corporate control (Trice & Beyer 1984; Steele, 1995). Rather, some unions such as the International Longshoreman Workers

Union in San Francisco established their own programs, hiring social workers to combat excessive drinking among their members (Perlis, 1980). One observer contends these programs were not as well supported as those initiated by management (Steele, 1995).

In addition to corporate programs, there were a few states that offered occupational alcoholism programming for public sector employees. The first state alcoholism agencies had begun to make their appearance in the mid-1940s, providing support (and occasional funding) of fledgling efforts to expand local community alcohol education and treatment (White, 1998). By 1965, three states, Maryland, West Virginia and Florida, had outreach workplace programs. Industrial alcoholism specialists from these state agencies included Willard Foster in Maryland, and Don Godwin in West Virginia, who eventually became leaders in federal occupational alcohol efforts at the National Institute on Alcohol Abuse and Alcoholism (NIAAA) (Steele, 1989).

In 1942, a broad approach to union-based counseling was developed by Leo Perlis while he was at the labor division of the War Production Board in order to assist workers and their families with health and welfare needs in war-impacted communities (Steele, 1989). Perlis was a proponent of greater union involvement with management in alcohol counseling (McClellan, 1984; Miller, 1991), and noted that more workers could be reached by union and management working together rather than by either working alone (McWilliams, 1985). As director of the Community Services Department of the American Federation of Labor & Congress of Industrial Organizations (AFL-CIO), Perlis led the development of the organization's national program on alcoholism under its Department of Community Services which provided educational programs for unions, trained volunteer peer counselors, developed networks of treatment providers and guided

referrals from counselors into community resources (Perlis, 1980).

Singular in the scope of his philanthropic support for occupational alcoholism programming was R. Brinkley Smithers, committing both his personal funds and those of the Christopher D. Smithers Foundation, which he had founded in 1952. The Smithers Foundation website notes it has “influenced the interest of corporate industry and labor giants from General Motors, Exxon, us Steel, and the AFL-CIO in recognizing the problems of alcoholism in the workplace and that they were treatable.” Smithers was an ardent supporter of the efforts of the NCA, and later provided a \$6.7 million gift to Cornell and Rutgers universities for the Smithers Institute for Alcoholism Prevention and Workplace Problems (Fahey & Miller, 2013).

The persistence of institutional support for a new understanding of alcoholism and new avenues for treatment continued into the 1950s. In 1956, this support greatly expanded due to the formal recognition of the disease concept of alcoholism by the American Medical Association. This recognition assisted the recognition among forward-thinking executives, labor leaders, government and public health officials that it was better to address and treat employees with alcohol problems than simply to terminate them (Gitlow 1973).

Despite the successes of early occupational alcoholism programs diffusion of these programs during the 1940s and 1950s beyond these settings was slow. Just six programs were established from 1940 to 1945, 50 by 1950, and 50-60 by the mid-1950s (NIAAA, 1981; 1999; Trice & Schonbrunn, 1981). From 1949-1954, however, AA’s General Services Office reported an increase of almost 50 percent in numbers of inquiries about such programs (Trice, 1958).

Notably, it was claimed that some of the older occupational alcohol programs at companies such as American Cyanamid, Con Edison, Caterpillar Tractor, and Standard Oil began expanding services beyond a simple focus on alcoholism to providing assistance for a variety of emotional, interpersonal or financial concerns (White & Sharar, 2003). These programs were the emerging edge of a transition from occupational alcohol initiatives to the more comprehensive Employee Assistance Program model (Presnall, 1981; Masi, 1982; Steele & Trice, 1995).

**Figure 3: Continuum of Occupational Social Work, Occupational Alcoholism and EAPs**

|                                | Occupational Social Work  | Occupational Alcoholism  | Employee Assistance  |
|--------------------------------|---|--|--|
| <b>Timeline</b>                | Began in 1900s  | Began in 1940s   | Began in 1970s   |
| <b>Origins</b>                 | Welfare Capitalism<br>Paternalism   | Alcoholics Anonymous<br>National Council on Alcoholism<br>Yale Center for Alcohol Studies        | AFL-CIO<br>Community Service<br>NIAAA's Occupational Programs Branch                           |
| <b>University Affiliations</b> | Columbia University<br>Hunter College   | Yale University<br>Cornell University<br>Rutgers University                                      | University of Michigan<br>University of Maryland   |
| <b>Government Affiliations</b> | National Institute of Mental Health (NIMH)  | National Institute on Alcohol & Alcoholism (NIAAA)   | NIAAA's Alcohol Training Branch<br><br>Substance Abuse & Mental Health Administration (SAMSHA) |
| <b>Staffing</b>                | Welfare Secretaries<br>Social Workers   | Recovering Alcoholics<br>Medical Directors   | Peer Counselors,<br>Social Workers,<br>Psychologists,<br>Program Administrators                |
| <b>Member Organizations</b>    | Council on Social Work Education (CSE)<br><br>National Association of Social Workers (NASW) | Association of Labor Management, Administrators & Consultants on Alcoholism (ALMACA)<br>Now EAPA | EAPA<br><br>EASNA  |

## **II. The Early Years of EAP**

### **Transition from Occupational Alcoholism to EAPs**

Before 1955, the development of workplace-based programs to assist employees was characterized by “uncoordinated efforts, unorganized, without leadership, lack of recognized membership, with little guidance or control, and largely ad hoc in nature” (Steele, 1989, pg. 514). With outside aid, particularly from the Smithers Foundation, the NCA continued promoting workplace alcohol programs. Importantly, the Smithers Foundation also supported the first outsider research studies of these programs conducted by Professor Harrison Trice of the New York State School of Industrial and Labor Relations at Cornell. This enabled him to formulate the approach of constructive confrontation as a mechanism for addressing denial with alcoholic workers, and it became a key element in the evolution of EAP program operations (Trice, 1962; Trice & Roman, 1978; Trice & Sonnenstuhl, 1988).

In 1959, NCA hired Lewis Presnall as its first director of labor-management services. He was later joined by Ross Von Wiegand and Harry Stack, all of whom traveled the country reaching out to individual employers, industry groups and organized labor (Steele, 1989). Based on his experience as a pastoral minister and as a personnel specialist working with troubled employees (including alcoholics) at the Chino Mines in Hurley, New Mexico, Presnall fashioned a new approach and first presented it at the Utah Summer School for Alcohol Studies (Presnall, 1956, 1966). This new approach, distinct from the Yale Plan, advocated the identification of the troubled employee should be measured through declines in job performance that were not related to inadequate job training or job requirements. This approach, which avoided discussion of what the

underlying problem might be, emphasized the unacceptability of substandard work, identified workers with alcohol problems along with employees with a range of other personal problems. This suggested the need for resources beyond the identification and treatment of alcohol problems.

Presnall's model also emphasized cooperative relationships with organized labor, which was to become another key factor in employee assistance programming (Steele, 1989). Presnall and Von Wiegand traveled widely, promoting their model plan and reported that during the decade from 1959 to 1969, their efforts created two and one-half times more new programs than the previous period between 1943 and 1959 (Presnall, 1981).

Another important finding, that eventually led to support for the employee assistance model, came from a comprehensive supervisory training evaluation conducted by Trice and Belasco (1968). The research design used two different training formats, one, the alcohol-oriented training, focused on the signs that an employee was developing an alcohol problem that would eventually require supervisory action. The other, the troubled employee model was based on troubled employees who were showing steady declines in job performance about which action was needed. The data compiled before and after the treatment, including follow-up several months after the training, demonstrated that the troubled employee model was much more likely to motivate supervisors to be willing to take definitive action. Conversely, the alcohol-oriented training was significantly less likely to produce such motivation, and in some instances actually reduced supervisory motivation to do something about the hypothetical employee.



An independent developmental thread that would support the employee assistance model but which did not emphasize employee alcoholism was a pre-NIAAA example of federal agency support for employee counseling programs. It was provided by NIMH along with backing from industry and trade unions in 1969 through its financing for the Industrial Social Welfare Center at Columbia University. This project funded the industrial social service curriculum at the Schools of Social Work at Columbia University and Hunter College for several decades, emphasizing worker mental health and the role of unions. As directors of the program, Sheila Akabas of Columbia and Paul Kurzman of Hunter placed numerous graduate social work student counselors in government, corporate and union programs throughout the metropolitan New York area (Akabas, Kurzman & Kolben, 1979).

While various entities were accumulating in largely unconnected settings supporting a broader employee assistance program model, the resources and assembled expertise that followed the creation of the NIAAA, proved to be the catalyst to bringing these ideas together and then vigorously working toward distribution. Now thought to be part of his War on Poverty, then-President Lyndon B. Johnson proved to be the first national leader to begin moving alcoholism issues to the forefront of federal concerns. Johnson appointed the first National Advisory Committee on Alcoholism in 1966, proclaiming "the alcoholic suffers from a disease which will yield eventually to scientific research and adequate treatment." (White, 1998), followed quickly by expanded activities in alcoholism research, training, and treatment services as Congress responded to Johnson's request by establishing the National Center for Prevention and Control of Alcoholism in October 1966 as a unit of the National Institute of Mental Health [NIMH]

(Institute of Medicine, 1991).

In 1967, a monograph was published that stemmed from the work of a study committee funded by the NIMH in 1961. Entitled *Alcohol Problems: A Report to the Nation from the Cooperative Commission on the Study of Alcoholism*, it recommended: 1) establishing a national organization to change American drinking patterns; 2) industry and unions' development of policies for detection, referral and treatment of alcohol problems; and 3) providing adequate support for research (Plaut, 1967). Also noteworthy were two large conferences organized by the U.S. Civil Service Commission in 1967 and 1968, featuring prominent presentations spotlighting workplace alcohol problem counseling services not only for the over two million federal workers, but to also assist private employers to do so (Steele, 1989).

## **NIAAA**

The birthing of the NIAAA which was to provide the major impetus for occupational alcoholism and its morphing into employee assistance represented the results of the continued education and advocacy work of the NCA and its constituent local councils from 1940-1970. The enabling legislation was included in Public Law 91-616, 42 U.S.C. 4582, the Comprehensive Alcohol Abuse and Alcoholism Prevention Treatment and Rehabilitation Act, known as the Hughes Act for its sponsor Senator Harold E. Hughes of Iowa, the chair of the Senate Subcommittee on Alcoholism and Drug Abuse (Wiener, 1981) and himself a recovering alcoholic.

This landmark federal legislation signed into law on December 31, 1970, included acknowledgement that alcoholism is a serious but curable, public health problem and authorized a comprehensive federal program to address prevention and

treatment of alcohol abuse and alcoholism. This legislation established and empowered the NIAAA to conduct demonstration, service, and evaluation projects, and provide counseling and education activities for the prevention of alcohol abuse and alcoholism and the treatment and rehabilitation of alcoholics (NIAAA, 2017).

According to a widely-diffused anecdote, Brinkley Smithers, Thomas Pike and other influencers who were rooted in NCA played critical roles by personally lobbying then-President Richard Nixon on New Year's Eve to sign the legislation just hours before his pocket veto would have killed it, as his cabinet had advised him to do (White, 2003; Weiss, 2010). As a new organization that was not replacing a predecessor, NIAAA had opportunities to shape in new ways public perception of alcoholism by destigmatizing the alcoholic, encouraging people to see alcoholism as a treatable disorder and to bring treatment of alcohol-related disorders into the mainstream of healthcare (Chafetz, 1975; Roman, 1981). While high priority was given to the development of a comprehensive system of prevention and treatment services at the state and community levels (NIAAA, 1977), NIAAA was faced with the challenge of distinguishing its efforts from those of the past, and in particular it became invested in drawing attention to the mainstream hidden alcoholics as a sharp contrast to prior focus on the decriminalization of the public inebriate. Since the enabling legislation provided for substantial growth in alcoholism treatment resources, NIAAA targeted efforts to the development of such resources for employed persons. This task was coupled with the need for the flow of treatment clients into such resources, which set the mandate for the Occupational Programs Branch (OPB) (Roman, 1982). OPB Director Willard Foster proved to be a charismatic leader and recruited a diversely experienced staff, which

included Donald Godwin, who shortly was to become Foster's successor. This group and many in the top NIAAA leadership championed the position that a promising but underdeveloped approach for the prevention and treatment of alcohol abuse was in the workplace and among employed persons (Steele, 1988; Trice & Roman, 1972).

The newly-formed OPB contemplated how best to formulate an innovative strategy to encourage corporations and government agencies to expand health insurance benefits for alcohol treatment and adopt occupational alcoholism efforts (Roman, 1982). At the same time, Foster called together an informal advisory group of experts he named the "Sachems", which included representatives from research, NCA occupational alcoholism consultants and directors of existing occupational alcoholism programs. From 1971 into 1972, this group met regularly to advise NIAAA on the initial focus and goals of the OPB. The group was especially interested in evaluating innovative practices in occupational programming, such as Kennecott Copper's INSIGHT program in Utah, which offered counseling for employees and their families that addressed substance abuse family, marital, financial, and other personal and emotional concerns and was available by telephone 24 hours a day. They invited Otto Jones, MSW, Director of INSIGHT, who had been first assigned to the INSIGHT program as a social work intern from the University of Utah's Graduate School of Social Work, to describe the program's emphasis on job performance indicators used to identify troubled workers and its services aimed at the wide range of employee's personal concerns, as well as other experts (Masi, 1982; Steele, 1989; White & Sharar, 2003). The group also reviewed existing research studies and shared experiences with what worked in motivating employer interest to invest in occupational alcoholism programming.

NIAAA was authorized to distribute grants in order to encourage greater use of alcohol treatment through collaborations with public and private-sector organizations (Wiener, 1981). This mechanism was used to actively support numerous research and service efforts concerned with occupational alcohol programs. A three-year grant was offered to each state and territorial Alcoholism Authority to fund and support staff positions for two Occupational Program Consultant (OPC) positions. The OPC's responsibilities were to disseminate information, develop relationships and consult with existing occupational alcoholism program managers, and encourage occupational alcoholism programs among private sector and public-sector employers (Keller, 1974). Most states submitted applications for the grants in response to the request for proposals (RFP).

To launch this nationwide effort, funding was awarded to East Carolina University to mount a 3-week training program in June 1972 for the OPCs in Pinehurst, NC (Steele, 1989). According to Jim Wrich, hired as an OPC in Minnesota “about half of us were recovering alcoholics who knew a lot about alcoholism and little about anything else, while the other half were trained professionals, nurses, clinical social workers, psychologists, counselors, medical doctors, who knew a great deal about a wide range of personal problems but very little about alcoholism” (Wrich, 2017). The group labeled themselves the “Thundering 100.” They went back to their home states after the training to begin this innovative venture.

Six months after the initial training, the OPCs were brought to San Francisco for follow-up training, which was to continue at various intervals over the next several years under the auspices of NIAAA. In San Francisco, it became evident that the approach of motivating employers to deal with their alcoholic employees was not effective. A great

deal of resistance had been encountered by nearly all the OPCs.

Up to this point, the program model that was being used centered on identifying and providing assistance to employees with alcohol problems, but emphasizing the importance of using hard evidence of job performance problems, not diagnostic evidence, to define the problem, confront the employee and offer assistance in returning her to her prior acceptable level of performance.

There was an inherent contradiction in this model, namely that a focus on job performance problems would generate employee cases who did not have alcohol problems, but other behavioral health issues. Given the central emphasis on employed alcoholics in the overall environment of their hiring and in the training they had received, this was confusing to the OPCs as well as to the leaders who were responsible for directing the overall national project. It was evident that the job-performance basis for identifying and discussing the need for corrective action had many advantages. It prevented employees with alcohol programs from denying signs and symptoms that a supervisor might allege, manipulated the supervisor into a position of accepting excuses and even feeling sympathy for these individuals and all of the life events that pressed them to excessive drinking. Relatedly, supervisors were in their home territory in talking to employees about their deviation from the agreed-upon standards of work performance and attendance. Further, employees themselves may be less resistant to abiding by a policy that did not carry the stigma of alcohol abuse and alcoholism. Finally, and perhaps most important, employers may be more motivated to adopt a program that addressed job performance problems grounded in behavior disorders than addressing alcohol problems in their workforce, perhaps an embarrassment and even worse, the

possible source of bad publicity about their workplaces. There was optimism that, through the use of this broad approach, more alcoholism and addiction would be identified at an earlier stage (Phillips, 2003).

The transition to what became known as the “broad-brush” approach (contrasted by the OPCs to the “alcohol-only” approach) was not immediate and took a number of years to fully emerge. There were concerns, and even conflict, over the issue that attention to employee alcohol problems, the singular concern of NIAAA, might get watered-down or lost if the broad-brush model did not include emphasis on the importance of addressing alcohol issues in the workplace. However, the success of the broad-brush model seemed evident, and by the mid-1970s it became the governing model for workplace behavioral and alcohol issues and treatment.

The OPCs were not in a position to conduct systematic research about their work, therefore, additional demonstration research projects were established through funding from NIAAA (Masi, 1982; Roman, 1981a). These included a number of projects designed to service smaller employment settings in locations such as Reading, PA and Lincoln, NE, a faculty and staff assistance program at the University of Missouri, the 10 Cities Project with NCA to implement jointly administered labor- management programs in ten significantly unionized cities (Blum, 1988). NIAAA grants were also forthcoming to support additional OPCs in states where activities and service demands had grown rapidly. Examples of these expansion grant states were New York, Florida, South Carolina, New Hampshire and Michigan.

Beginning in 1974, the Air Line Pilots Association (ALPA) received an NIAAA grant to fund the Human Intervention Motivation Study (HIMS). HIMS is a peer

recovery program for dealing with alcoholism and recovery among commercial airline pilots. Building on cooperation from the federal Aeronautics Administration which altered its long-standing rules to allow continued licensing of pilots who could provide substantial independent documentation of their recovery from alcoholism. The rationale for establishing a confidential pilot-centered program included the lack of a traditional on-the-job supervisory program, and a belief that a pilot's ability to function effectively was best observed by fellow pilots. Accordingly, given the safety-sensitive nature of a pilot's responsibilities, a peer identification and referral system was developed for the HIMS program. By the close of the initial NIAAA-funded demonstration phase, most major U.S. airlines had endorsed the model, and had HIMS trained management and union personnel on their property. The 800 participating pilots had achieved an 85 percent long-term abstinence rate. In 1992, the FAA began funding ALPA to administer and provide training for the HIMS. The programs continued success is a result of a cooperative and mutually supportive relationship between pilots, airline management, and the FAA's Office of Aviation Medicine. Since its inception, over 4,500 professional pilots have been successfully rehabilitated and returned to their careers (Cuddihy, 2014; ALPA, 2016).

Another category of funding by NIAAA was an award in the early 1970s for a singular training grant to Dr. Masi. As a professor at Boston College's School of Social Work Community Organization and Planning Program, she recalls her first experience learning how the occupational alcoholism concept was impacting the workplace

*I went to an all-day conference at Harvard University on Occupational Alcoholism. It really ignited me. I knew that something exciting was happening. At that time, most of the speakers were recovering from alcoholism. They were*



*eloquent, and it was clear to me that in the future, then dug a little more into the field of Occupational Alcoholism and realized that the National Institute of Alcohol Abuse and Alcoholism was just starting to do a great deal in this area. I contacted them and said, 'I'm in a school of social work chairing the Master's in Social Planning. I think that there might be something here for our graduate students.' I applied for a training grant from NIAAA to train masters students in Occupational Alcoholism. I set up five different centers using my social planning students to manage each program, with two clinical students and one social planning student performing in each area. These five centers became quite successful and we ended up having lots of clients. I learned the importance of staffing the programs with trained workers.” (Dale Masi EARF History Project interview: <https://archive.hshsl.umaryland.edu/handle/10713/6503>).*

The Boston College Occupational Alcoholism and Drug Training Program was the sole NIAAA-funded training effort that would go on to produce social work graduate students in occupational alcoholism and employee assistance programming. At its full development, this program provided a full range of services to 51 companies in 5 locations. Under faculty supervision, students engaged in policy development, organizing of advisory committees, employee education and supervisory training, creation of information and referral services, employee counseling for declining job performance, alcoholism, drug addiction, mental health and emotional concerns, periodic reporting and other administrative functions. Additional funding for the program came from Boston College as well as participant companies including Polaroid Corporation, New England Telephone, Hanscom Air Force Base, the Taunton and Brockton Chambers of Commerce, and the John F. Kennedy Federal Center (Masi, 1979; Maiden, 2003).

Another milestone was the inception of occupational programming for federal civilian non-security employees. The 1970 Hughes Act, which established NIAAA, also mandated appropriate prevention, treatment, and rehabilitation programs and services for alcoholism and alcohol abuse among federal employees. In 1971, the U.S. Civil Service

Commission (CSC) issued a directive to the *Federal Personnel Manual* outlining requirements for federal agency employee alcoholism programs. The recommended program model mirrored that developing among the NIAAA planners, namely that employees with alcohol problems, would be identified by patterns of deteriorating performance or conduct and not by focusing on the signs and symptoms of alcoholism (Phillips, 2003).

Research studies on workplace alcoholism programs, which had begun during the 1950s and 1960s through the support of the Smithers Foundation, NCA and the Yale Center for Alcohol Studies, increased in the early 1970s with NIAAA support and continued to grow up until the early 1990s. Researchers supported by this funding initially included Harrison Trice and Paul Roman, each of whom was funded in 1972 for research on the diffusion and implementation of the federal employee policy described earlier. They both later focused on studies of program implementation in New York State and throughout the U.S. Soon, other NIAAA funded researchers in Michigan (Andrea Foote and Jack Erfurt) produced insights into the integration of these programs into other human resources and employee health initiatives.

Further studies include Norman Kurtz and Bradley Googins who initiated a stream of new research building on older studies by Trice related to the behavior of supervisors relative to alcoholic and other problem employees. Walter Reichman teamed with Marguerite Levy on studies of the identification of employed women with drinking problems. Janice Beyer and Terry Blum, both business school-based organizational research specialists, joined Trice and Roman respectively in broadening both the focus and depth of diffusion and implementation in varying workplaces, as well as adding in-depth data collection on women employees. Later additions to this cohort of NIAAA

supported researchers in the 1980s included Diana Chapman Walsh and Douglas Parker.

The publication of *Spirits and Demons at Work: Alcohol and Other Drugs on the Job* by Harrison Trice and Paul Roman provided a valuable context for employers and counselors to address the challenges of substance use problems at work (Trice & Roman, 1972). More than an informational resource, this book outlined the strategy of constructive confrontation which became one of the guiding principles of dealing with employees with substance abuse issues. Notable was also *The Employee Assistance Program*, authored by James Wrich (an original OPC) published by Hazelden Foundation. Wrich's book laid out the rationale for broad-reaching programming which would reach the alcoholic employee. In addition, it also presented what the employer would be faced with providing appropriate services to employees with other behavior disorders that produced unexplained declines in job performance.

These books, other published research, and the efforts of NIAAA, all renewed and generating a body of knowledge regarding occupational alcoholism programs, as well as describing a new approach, methodology and practice. Programs adopting this shift in emphasis had been informally known as having a "broad-brush" orientation (in contrast to the older model, referred to at the time as "alcohol-only"). With the Wrich book in print, the term "employee assistance program" became the common terminology by NIAAA and by the constituent community that continued to grow and develop quite rapidly, due in large part, to the impetus of NIAAA funding (White & Sharar, 2003).

Indications of the entrepreneurial progress in disseminating this broader mission to assist employees in a wide-ranging spectrum of behavioral health problems is evident by the launch of 300 additional EAPs in 1973-74. This growth figure is equal to the number created in the preceding thirty years (Keller, 1974). This pattern of growth

for EAPs was a preview of the next three decades, which became a time of unparalleled diffusion and evolution.

The mid-1970s represented a period of change and growth for EAPs as the previous narrow focus of alcoholism interventions was subsumed within a wider scope of services (Googins & Godfret, 1987; Bickerton, 1988; Steele & Trice 1995). Existing occupational alcoholism programs, typically located in larger industrial settings began to adopt the broad-brush strategy (Erfurt & Foote, 1977; Blum & Roman, 1989). Similarly, newly established programs, many formed as a result of the efforts of the NIAAA-funded state OPCs, typically adopted this new approach (Midanik, 1991; Attridge et al, 2009). A profile of the U.S. EAP market in the mid-1970s estimated that over 1000 individuals were operating as coordinators of organizational EAPS in approximately 8,000 work organizations (Kinman & Roman, 1982). Reflecting the wide diversity in U.S. work organizations, these efforts spread from the industrial sector to the mainstream of workplaces, functioning under various auspices including employers, joint labor-management, unions and, in some communities, to consortiums of small businesses or local employers (Straussner, 1988; Burke, 2010).

The shift in emphasis from identifying employees with alcohol problems to broad-brush EAPs required the individuals charged with managing these programs to respond to a range of mental health and personal difficulties including financial, parent/child issues, and other concerns. In his book, Wrich argued for the encouragement of self-referral at the point where family/relationship problems and job performance issues were just emerging and not yet crises. By the middle of the 1970s, NIAAA had fully adopted the term Employee Assistance Programs (Weiss, 2010). It was not fully anticipated that the new emphasis could overwhelm the program with self-defined

employee problems, among which alcohol problems might not be likely to appear. With self-referral increases, there was a decrease in the use of the formal, constructive confrontation strategy and supervisor referrals designed for alcoholic employees with clearly declining job performance (Roman, 1981, Steele & Trice, 1995).

## **ALMACA**

The establishment of an occupational association to promote the concept of workplace intervention for substance abuse programs preceded the full acceptance of the EAP model. A meeting of a group of NCA staff, experienced workplace consultants from labor and management, federal government representatives, and other independent consultants in Los Angeles on April 27, 1971 marks the genesis of the organization that ultimately facilitated the definition of a distinctive occupational group (Blum, 1988). Those present agreed to form the Association of Labor Management and Consultants on Alcoholism, known as ALMACA (ALMACA, 1971). Initially, NCA was the patron organization, providing a location and integration within its own annual meetings for the first three annual meetings of ALMACA.

ALMACA's organizational independence and infrastructure was facilitated through support from NIAAA for a two-year research grant of \$575,776. The purpose of the grant was for the new organization to provide back-up for program consultants and administrators by pursuing occupational program cost/benefit studies and other data needs, recordkeeping systems, and to analyze the appropriate skills and qualifications of those engaged in occupational programming. By 1976, the new association was fully independent, supported solely by individual and organizational membership dues, corporate donations and meeting revenues (Blum, 1988; EAPA, 1996).

The scope and depth of interest in the emergent and distinctive specialty are reflected in the growth and activities of ALMACA: as a clearinghouse for job opportunities, reporting information about pending legislation, and providing members with research findings and information about other trends in the field (Masi, 1984). Coincident with the greater demand for workplace programs, interest in this new specialty had increased steadily, as did the new association's membership. In 1974, ALMACA reported its current membership total of 425 as evidence of the "fastest growing professional organization in the country" (Blum, 1988, p. 210). This growth continued reaching 1,000 members in 1976, and totaling 30 local chapters by 1978 (EAPA, 1996). By 1986, the organization counted 4,500 members and 60 chapters worldwide, having expanded into Canada and Western Europe (Blum, 1988). The pattern of communal activity among the members included annual ALMACA meetings and monthly chapter meetings, most of which was directed toward continuing education and development.

A significant increase in the numbers of new EAPs occurred in the 1970s, based on data points from multiple sources. In 1970, William Dunkin, editor of the NCA's *Labor-Management Alcoholism Journal*, had estimated that between 350-400 programs existed in the U.S. (Sonnenstuhl & Trice, 1990). Published in 1974, the *Second Special Report to the U.S. Congress on Alcohol and Health* noted that 344 private employers had developed some form of program to provide assistance to employees with drinking problems (NIAAA, 1974). The efforts of state-based OPCs and other forces were beginning to yield results. From 1974 to 1976, in New York state alone, the OPC network assisted in revitalizing or creating over 320 workplace programs (Trice, Beyer & Coppess, 1981). In its 1981 report to Congress, NIAAA charted this growth: from

under 400 programs in 1973, to 2,400 in 1977, and a total of 4,400 in 1980 (NIAAA 1978; 1981). Other private sector industry sources confirmed this trend, including the Bureau of National Affairs (BNA), estimated the number of existing EAPs in 1987 at 10,000 (BNA, 1987).

During the 1970s, the Executive Caravan Surveys of Fortune 500 Companies, conducted by the Opinion Research Corporation, was commissioned by NIAAA to include questions about EAPs. Its sampling allowed the projection of findings to the Fortune 500 as well as other major U.S. enterprises. The survey found 26 percent of respondents having an EAP in 1972, increasing to 56 percent in 1979 (Roman, 1982). By 1990, data from other sources projected that three quarters of Fortune 500 companies were identified as having offered EAPs (Cunningham, 1994).

### **Efforts by Organized Labor**

As corporations were developing approaches to providing services to employees, other stakeholders were doing the same. American unions have a long history of aiding members with personal issues, and efforts of organized labor have been instrumental in promoting and developing occupational alcoholism and member assistance programs. Unfortunately, few of these efforts were documented (Johnson, 1981). The Burley Tobacco Growers' Association, for example, was reported to have employed three trained social workers to assist members in 1924 (Googins, 1976). In 1934, the International Longshore and Warehouse Union (ILWU) in San Francisco hired social workers to combat drinking among their members (Perlis, 1980) and in the 1940s, the United Mine Workers, the International Ladies Garment Works and the Teamsters Union began providing psychiatric services to their members (Bamberger & Sonnenstuhl,

1995).

Likewise, during World War II, the AFL-CIO's Community Services Department established a peer counseling service that was in some ways similar to Western Electric's Personnel Counseling Program (Sonnenstuhl & Trice, 1988). Its former director called this labor-based effort the oldest EAP in existence (Perlis, 1980). During the 1950s and 1960s, several large unions, including the United Steelworkers of America (USW), the Utility Workers Union of America (UWUA), the International Brotherhood of Electrical Workers (IBEW), the United Automobile Workers (UAW), and others became more active in promoting and supporting workplace alcoholism programs (Trice & Schonbrunn, 1981; Sonnenstuhl & Trice, 1988).

Rather than introducing a program that set the stage for potential conflict between labor and management, it made logical sense to involve the union in unionized settings in formulating policy and implementing an occupational alcoholism, or later, an employee assistance program (Trice & Roman, 1972). Historically, distrust on the part of both unions and management had been barriers for such cooperative efforts. But in cases where the collaboration was based on a mutuality of purpose this enabled both parties to obtain strategic advantages, such as joint programs (Beyer, Trice & Hunt, 1980).

Early efforts to create jointly-sponsored labor-management occupational alcoholism programs received encouragement from the NCA through its Labor-Management Services Department and its Labor Advisory Board. Early members included Walter Reuther of the UAW (Steele, 1989). NCA also sponsored publication of the *Labor Management Alcoholism Journal* which included lay-oriented materials for both labor and management.



With support from the Smithers Foundation, NCA distributed a pamphlet entitled *The Key Role of Labor in Employee Alcoholism Programs* (Trice and Schonbrunn, 1981; White, 2003). Unlike the Yale Plan that has been previously described, a key feature of the joint labor- management program model advocated by NCA and later ALMACA, was a governing committee consisting of union and employer representatives. These groups jointly determined policies, benefits elements and program decisions, such as hiring or selecting diagnostic or treatment providers. One notable joint effort was established in 1975 between the “Big Three” automakers, Ford, General Motors, Chrysler and the UAW, which was perhaps the largest and most extensive joint labor-management EAP initiative in the U.S. This program was staffed by mental health and social work professionals to administer short-term, solution-focused counseling. An important added element was training of union members as peer advocates to encourage self-referrals (Root & Dickinson, 2009).

Since its founding in the early-1970s with strong support from NCA which had long promoted joint labor management programs, ALMACA was a strong advocate of joint labor management approaches and drew many of its members from the ranks of organized labor (Steele, 1989). In 1976, President Paul Sherman created a Labor Committee with representation on the ALMACA Board of Directors. Notable members from organized labor who would ascend to the organization’s presidency included John J. Hennessy, Thomas Pasco and George Cobbs. On the occasion of its 1978 annual conference George Meany, President of the AFL-CIO sent a telegram with best wishes on behalf of his members to ALMACA. In 1979, GM and the UAW were honored by ALMACA with the first Ross Von Wiegand Award, created to recognize exemplary cooperation for joint labor-management EAPs (EAPA, 1996).

In some work settings, such as construction trades and service workers where unions had control over hiring and firing of workers (McClellan, 1982) or if employers had demonstrated a punitive response to alcoholics, joint labor-management programs were not feasible (Trice & Roman, 1972). In these situations, union-initiated programs have arisen, some as peer counseling services staffed by recovering members, frequently as unpaid volunteers (Sonnenstuhl & Trice, 1988). Antecedents of these efforts can be found in the mutual aid and self-help model of AA and were often closely aligned in approach (Bacharach, Bamberger & Sonnenstuhl, 2001). Sometimes called Member Assistance Programs (MAPs) or Labor Assistance Programs (LAPs), these were alternatives to management-created EAPs (Malloy & Kurzman, 1993). Often begun as informal peer alcohol interventions among members, they evolved into union-sponsored member assistance programs, with a broad-brush approach (Bamberger & Sonnenstuhl, 1995).

One example was Project Straight Life started by Ted Gompers in 1983 at the New York City-based Local 802 of the American Federation of Musicians (AFM) with a grant from the N.Y. State Division of Alcoholism, which later merged with the union's Musicians' Assistance Program which provided consultation, assessments, referrals to community resources and short-term counseling by social workers (ALMACA, 1985). Researchers conducting sociological studies of peer intervention efforts have postulated that due to communal voluntarism, these efforts may be more effective than other types of interventions in addressing early problem behaviors, given members' commitment to look out for each other's well-being (Bacharach, Bamberger, & Sonnenstuhl, 1994).

A union peer program addressing a population that is primarily female, was that of the Association of Flight Attendants (AFA), a resource for over 30,000 members.

Established in 1980 with developmental funding from NIAAA, AFA peer representatives were trained to provide services including assessment, support, and referral services for personal concerns, professional standards, and critical incident response. At each domicile where flight attendants are based, attendants who are peer counselors are organized into a local EAP committee to provide services for a wide range of personal concerns, including chemical dependency, marital and family difficulties, stress and eating disorders. In this program, in contrast to those in most of the male dominated craft unions, the majority of peer counselors were not recovering from chemical dependency, but may have experienced family or mental health issues that threatened to affect their job performance (Bacharach, Bamberger, & Sonnenstuhl, 1994).

### **Core Technology**

The EAP Core Technology represents themes drawn from national on-site EAP survey data collections and observational studies conducted by Roman and Blum and underwritten by research grants from NIAAA. The data were used to identify six unique and necessary functions of EAPs that differentiate them from other human resource activities in the workplace. Subsequently in August 1988, after undertaking additional EAP projects, including site visits to many EAPs, Roman and Blum authored an additional article, entitled the *Core Technology of Employee Assistance Programs: A Reaffirmation*, noting there was still “vagueness about what constitutes an EAP” (Roman & Blum, 1988, pg. 18). The authors divided the six content areas into two groups.

#### *Group 1, Supervisory-Management Components*

1. Identification of employees’ behavioral problems based on job performance issues not linked to job skills or training,

2. provision of expert consultation to supervisors, managers and union stewards on how to take the appropriate steps in utilizing employee assistance policy and procedures,
3. availability and appropriate use of constructive confrontation.

*Group 2: Benefits Management Components*

4. The selection, creation and maintenance of micro-linkages of individual employees with counseling, treatment and other community resources,
5. the creation and maintenance of macro-linkages between the work organization and counseling, treatment and other community resources such that these resources were maximally responsive to the needs of a particular work organization,
6. the central importance of sustaining a focus on employees' alcohol problems since research evidence and program methodology offer the most significant promise of producing recovery and genuine cost savings for the organization in terms of future performance and reduced benefit usage (Roman & Blum, 1985, p. 16-18).

By "institutionalizing the areas of expertise believed essential for an operative EAP" the authors noted, "the *Core Technology* serves a boundary-maintenance function so EAPs can be integrated into other systems, but not be absorbed" (Roman & Blum, 1988, pg. 18). Many EAP practitioners have since maintained that the Core Technology is the fundamental and defining approach to providing EAP services, with some asserting that failure to follow this defined scope indicated a lack of adherence to established best practices (Pompe & Sharar, 2008).

Acceptance of this Core Technology as the new paradigm was evident as its publication and ensuing discussions were considered the groundwork for the initiation of ALMACA's scope of practice effort which led to conceptualization of the Association's

Certified Employee Assistance Professional credential, the CEAP, in 1987 (Laws, 1987). Along with knowledge about established workplace practices that are not unique to EAP, the Core Technology was utilized as content for the CEAP certification examination conducted by the Employee Assistance Certification Commission, designed to be partially independent of ALMACA in terms of offering credentialing beyond the ALMACA membership (Blum & Roman, 1989). ALMACA and (known after 1987 by its new name, Employee Assistance Professionals Association [EAPA]) has embraced the Core Technology as its guiding philosophy of professional practice and theoretical basis to frame EAP practitioners as knowledge workers with a unique knowledge of the “relationship between human behavior and workplace performance” (Hughes, 2007; Burke, 2008). In the most recent (2010) edition of *EAPA Standards and Professional Guidelines for Employee Assistance Programs*, appears the following list of the “EAP Core Technology” with the description: “these components combine to create a unique approach to addressing work organization productivity issues and "employee client's" personal issues affecting job performance”:

- (1) Consultation with, training of, and assistance to work organization leadership (managers, supervisors, and union officials) seeking to manage troubled employees, enhance the work environment, and improve employee job performance.
- (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, as well as case monitoring and follow-up services.
- (5) Assisting work organizations in establishing and maintaining effective relations with

treatment and other service providers, and in managing provider contracts.

- (6) Consultation to work organizations to encourage availability of and employee access to health benefits covering medical and behavioral problems including, but not limited to, alcoholism, drug abuse, and mental and emotional disorders.

In 2010 EAPA added two additional components.

- (7) Active promotion of the availability of EAP services to employees, their family members, and the work organization.
- (8) Evaluation of the effects of EAP services on work organizations and individual job performance.

### **Essential Ingredients of an EAP**

In the 1984 book *Designing Employee Assistance Programs*, Masi drew upon the structure of the Core Technology and identified the following listed ingredients to reflect the essential elements of a comprehensive approach to the evolving practice of EAPs.

While not unique to EAPs, these ingredients are the essential infrastructure supporting the Core Technology:

1. *Policy Statement.* The written policy statement defines the purpose of the EAP, its organizational and legal mandates, case record maintenance, client eligibility, roles and responsibilities of various personnel in the organization, and program procedures.
2. *Toll Free Telephone Line.* EAPs offer barrier-free access, typically a toll-free telephone number for 24/7 employee convenience.
3. *Assessment and Referral.* EAP clinicians must be skilled in the art of assessment of the client's presenting issue and appropriate referral
4. *Short Term Counseling.* Short-term counseling, or brief therapy, is not simply a time oriented approach. Brief therapy focuses on a specific, discrete central theme. The clinician utilizes specific problem-solving techniques and limits counseling by giving it a beginning, middle, and an end.

5. *Employee Orientation.* All individuals at their work organization should be oriented to the EAP.
6. *Supervisory and Union Steward Training.* Supervisory training involves the instruction on the EAP policies, procedures, services, and the role of the supervisor and the union steward in the EAP process.
7. *Employee Education and Outreach.* Educational sessions for employees can range from stress workshops to managing work/life balance. In order to ensure effective use of the EAP, outreach measures should include frequent emails, posters, webinars, and listings in company websites.
8. *Legal.* The design and implementation of the EAP must be done in accordance with any local, state and federal laws, regulations, and rulings. Professionals are educated in such areas as child abuse law, privacy regulations, and drug testing legislation.
9. *Staffing.* EAP clinical staff should have educational and work experience from the recognized mental health professions of psychology, social work, psychiatry, counseling, or psychiatric nursing, and an appropriate license.
10. *Confidential Record Keeping System.* In the United States, two pieces of legislation in particular cover the confidentiality of client records: The Privacy Act of 1974 (Public Law 93-579) and the Health Insurance Portability and Accountability Act (HIPAA) of 1996.
11. *Community Resource Referral Network.* Staff counselors and affiliates make referrals to community resources (in-patient and out-patient hospitals, individual psychologists, social workers, psychiatrists, self-help groups, residential treatment centers, etc.). There is very little oversight or review of these programs by vendors or client companies.
12. *Evaluation.* Evaluation efforts are critical to determine if the EAP is reaching its objectives in performing successfully and cost-effectively as a separate, functioning department of the company.

The steady upward trend in the number of organizations with EAPs in the U.S. market has been attributed by some to the phenomenon of organizational imitation, e.g., workplaces' need to prove to themselves and their constituents that they are 'up-to-the-minute' and 'modern' (Meyer & Rowan, 1977). However, the adoption and continued acceptance of EAPs by work organizations at that time were a response to a variety of factors within the external environment. These factors include:

1. an increased recognition of the prevalence of alcohol dependence and of mental health disorders within the workforce;
2. an increased sensitivity the effects of behavior disorders on worker productivity;
3. available federal support for relevant workplace programming;
4. the broadening of worker's compensation coverage and definition of disability in the Rehabilitation Act;
5. enhanced employer-sponsored substance abuse/mental health benefits;
6. workforce demographic shifts; and
7. the imperative to compete for valued labor resources (McGowan, 1984; BNA, 1987; Blum & Roman, 1989).



### **III. Evolution and Diffusion**

Similar expansion can be seen within the EAP profession, both in sheer numbers and in the structural elements which define its professional practice. EAPAs membership increased to over 6000 by the early 1990s (Roman & Blum, 1995), reflecting the growth beyond its previous singular focus on occupational alcoholism to the spectrum of behavioral health issues that may impact an employee's performance. By 1991, the number of individuals providing EAP services had increased to an estimated 20,000, and EAPA membership had grown to more than 7,000 professionals in 80 chapters worldwide (EAPA, 2010).

#### **The Model Federal Workforce Program**

From 1971 onward, with policy development prescribed by the Hughes Act, occupational alcoholism and substance abuse programs were developed, but in very uneven patterns among the multitude of federal agencies. In 1977, the federal government made these guidelines more explicit, directing the creation of EAPs across all departments and agencies, and making this provision an essential part of the government's occupational health policy. The Department of Defense and each branch of the military services also mandated such programs for all employees and were included as budgetary line items.

In his 1979 memorandum entitled *Implementation of Employee Counseling Service* the Secretary of Health, Education, and Welfare (HEW), Joseph A. Califano announced a major initiative to combat alcoholism in the departmental workforce. This led to development of a fully operational program to cover all of HEW (Development Associates, 1985). Dr. Masi served as director from 1980-1985, the Employee

Counseling Services program. (ECS) was created to provide comprehensive coverage of alcohol, drug, and medical/behavioral services to the approximately 175,000 employees of the department of Health, Education, and Welfare (HEW) and to serve as a model for other departments and agencies of the federal government (Masi & Teems, 1983). The Office of the Director of ECS was given responsibility for the program's overall administration and policy direction, technical assistance, implementation of special demonstration projects, and evaluation of the program.

Sixteen operating units were created and responsible for day-to-day operations, including supervisory training, employee assessment, and referral to treatment. In 1980, a formal interagency agreement was signed with the Office of Personnel Management (OPM) that designated the ECS as the model federal program.<sup>11</sup> This was to lead to development of interagency consortiums; creation of a clearinghouse to provide information and technical assistance to organizations outside of the ECS; develop training and orientation programs for supervisors and counselors; and an evaluation system to estimate the program's cost benefit and cost effectiveness. Creation of an evaluation system was of the highest priority, as unless the program could show benefits produced in a cost-effective way, it could be eliminated during times of budget cuts (Development Associates, 1985). Additionally, six special demonstration projects were designated to address the diversity of alcohol, drug and mental health within the federal workforce: 1) a Model Supervisory Training Package, 2) a Model for Drug Abuse, 3) an Evening and Weekend Alcoholism Treatment Project, and model programs for 4) Indian Health Service employees, and 5) Senior Executive Service Members.

Given its broad-brush approach for mental health, personal, and work/life

concerns, it was determined that provision of up to eight sessions of short-term, solution-focused counseling would be the most cost effective. To ensure clinical staff were capable of providing the requisite level of service, counseling professionals with Master of Social Work degrees were recruited.

Staffing guidelines provided one full-time staff person for every 3,500 employees. Notably, the inclusion of a comprehensive evaluation component within the ECS, conducted by a third party, to gauge its effectiveness and cost benefit through employee productivity and absenteeism measures was perhaps the first documented formal assessment of an EAP to date (Masi & Teems, 1983; Development Associates, 1985). Given that the federal policy embracing EAPs affected nearly 3 percent of the U.S. workforce, this initiative was an influential prototype for many work organizations beyond the federal workforce (Phillips, 2003).

Another significant development within the federal arena that provided an impetus for adoption of EAPs was a legal opinion by the U.S. Attorney General Griffin Bell that employees with alcoholism or drug addiction were to be considered "handicapped" under the provisions of Section 504 of the Rehabilitation Act of 1973. This law prohibited discrimination against employees with disabilities, and this decision clarified that such employees were entitled to protected status and accommodations in the workplace. This decision applied to federal government employees as well as workers employed under federal contracts and grants. Since many state discrimination laws are patterned on federal statutes or interpreted similarly, this decision impacted countless work organization, but suggested that implementation of EAP services and their use for employees with alcoholism could protect employers from legal risks related

to discriminatory behavior (Weiss, 2010).

### **The External Provider Service Model**

Many workplaces are too small to have the resources to put in place a full-fledged EAP. A response to this need was the development of EAP consortia. These were typically formed to provide services to a community-based group of small businesses. Several of these efforts were funded in the 1970s as federal demonstration projects by NIAAA and the Department of Labor. Similar projects were initiated through the United Way, offering subsidized EAP services through not-for-profit organizations such as local Councils on Alcoholism or community mental health centers. While some of these efforts found that smaller employers were receptive to the provision of EAP services from a centralized external provider and were willing to gradually provide support via per capita payments per employee, such arrangements had a variety of lifespans, and unfortunately many did not survive after the end of external financial support (Masi, 1979; McCann & Carr, 1994; Maiden, 2002).

By contrast, another EAP delivery model emerged in the 1970s which was very successful in attracting interest was an outsourced commercial delivery version, the externally provided EAP, drawn from proprietor-owned entities that offered contractual services to work organizations typically with fees based on the number of employees and the scope of services rendered (Blum & Roman, 1989; White & Sharar, 2003). Nearly all of these external entities followed the broad-brush approach and included no highlighted focus on client case finding or on alcohol problems, instead following a model of expanding numbers of client self-referrals; hence program management by those with expertise initiated by their own recovery from alcoholism rapidly became irrelevant

(Blum, 1988; Kurzman, 1992).

By the mid-1980s, the growth in EAP services furnished by external commercial vendors had expanded dramatically. Many employers (both new adopters and those with established “internal” EAPs) saw these outsourced, contract EAPs as a more strategic and cost-effective option to the in-house model, offering maximum flexibility and minimal administrative costs. With an external delivery model, employers were able to request customization of EAP services without incurring development costs or committing to long term obligations. If the organization's service needs changed or the quality of services was found lacking, purchasers of external programs had the option of modifying or terminating the contractual relationship. Some organizations may have concluded that turning to third parties was advantageous to resolve questions of problems of conflict and credibility in employers’ direct provision of employee counseling services (Erfurt & Foote, 1977). As one of these early external EAP providers noted on their marketing materials to companies: "You've got a business to run -- let us worry about the alcoholics" (BNA, 1987: p. 99). McClellan (1982) correctly predicted that in the future EAPs would place less emphasis on supervisory confrontation and have a greater focus on early identification, prior to a decline in job performance.

In Utah, Otto Jones, a social worker and former director of Kennecott Copper’s INSIGHT counseling program, created and incorporated a private counseling service, Human Affairs, Inc. It began contracting with organizations such as U.S. Steel to offer employee counseling services at its plants in South Chicago and Provo, Utah. Soon other seasoned EAP professionals with an entrepreneurial spirit identified business opportunities and formed competitive, for-profit EAP companies based on providing the

broad-brush EAP services advocated by NCA and NIAAAA (Burke, 2010). In New York, two professional services firms located in the forefront of this trend were Sandin, Murray & Sutherland and Brown, Dolan & Stein (Tisone, 2017). Another of these pioneering external EAP provider organizations was Personal Performance Consultants (PPC), founded by Richard Hellan and Carl Tisone. Tisone's first experience with employee counseling began in 1972 as manager of a U.S. Air Force personnel counseling program in England. Returning to civilian life in 1973, he became a state-funded OPC in Illinois under the guidance of Ray Kelly, Sr., one of NIAAAA's original Thundering 100 OPCs. PPC grew into one of the leading national providers of external EAP services, twice appearing on Inc. magazine's list of the 500 fastest growing companies in the U.S. As recalled in his video interview for the EARF History Project, he and his associates saw the need to offer these essential services to corporations and other industries.

*I really had no idea that EAPs would become the kind of industry that they did become. The fact that there was no real industry when we started this effort...I think this was a prime motivator. It was a chance to do something new. We used to joke about how we were just making it up as we go along. We didn't have a template to follow but there had been some really good research done by the National Council on Alcoholism and the occupational program division both of NCA and then later NIAAAA set out some very important and useful guidelines.*

*There was a protocol for what was called occupational alcohol programs which my former colleague Jim Wrich, renamed the Employee Assistance Program which we latched on to and it seemed to work very well. (Carl Tisone, EAP History Project interview: <https://archive.hshsl.umaryland.edu/handle/10713/6500>).*

### **IBM and the Emergence of the Affiliate Network Model**

In 1982, in an early departure from the predominant EAP staff delivery model, PPC secured a contract with National Cash Register to provide access to counseling services

through a toll-free call center to link employees with local private practice clinicians at the company's geographically dispersed locations (Tisone, 2017). Subsequently, in 1984, the first coast-to-coast application of an affiliate-serviced EAP for a Fortune 500 employer (IBM) was created. In 1983 IBM was interested in developing an EAP.

*In 1983 two men walked into my office. They had read my book, Social Work in Industry. They represented IBM, which wanted to develop an EAP. We sent out an RFP and from the proposals received we invited five vendors back. Due to the size of IBM we hired two different vendors (HAI and PPC founded by Otto Jones and Carl Tisone/Richard Hellan respectively) to cover all the employees and their families. [Dale Masi EAP History Project interview: <https://archive.hshsl.umaryland.edu/handle/10713/6503> ]*

With IBM sites across nearly every state, many with less than 2,500 employees, hiring and placing staff counselors in each location was not feasible. Thus, to attempt to provide seamless coverage, a nationwide system of affiliate counselors servicing IBM employees was developed. The external vendors contracted with IBM for the delivery of EAP services for ten years. Together, these two EAP providers offered services to 225,000 employees and their families. In addition to the affiliate counselors, this national project included: a call center, eight-session counseling allowance per case, designation of referral resources for those whose problems were not resolved during the allotted counseling sessions, full coverage for family members, and an evaluation process which included clinical case reviews by independent clinicians and client satisfaction reports to try to maximize the quality of services delivered.

Warren (1975) defines two types of communities: geographical or functional. Geographical communities have discreet physical boundaries: states, cities, and blocks. A functional community is a community of interest, e.g., churches, clubs, schools, and work organizations. IBM's EAP changed the traditional occupational social service

model from a geographical community to a functional community delivery system, as the use of an affiliate network provider model was intended to provide an equal level of service delivery across a dispersed workforce including remote locations or with small numbers of employees.

The externally-contracted network affiliate EAP program was marketed to and adopted by many work organizations as a product fitting the needs of work organizations that are functional rather than geographic communities (Pompe, Frey, Sharar et al., 2017). In this model, the multi-site work organization contracts with an EAP vendor to provide a set of services for its employees. The vendor, in turn, contracts with local mental health professionals in employee populated regions to provide EAP direct clinical services. Compared to internally based programs with staff paid by a company in a single location, these affiliate counselors are independent private practitioners and may have less knowledge of the politics, dynamics or culture of the overall work organization, to say nothing of their having sensitivity to the possibly unique politics, dynamics and culture of the organization's units at varying locations (Leong & Every, 1997). They have less accountability than internally-placed or salaried staff, and it may be more difficult for the vendors who contract with them to implement clinical standards and program requirements (Hoffman, 1988).

While the network affiliate model succeeded in providing greater coverage for EAP services across multiple locations and via expanded 24/7 telephonic access at significantly less expense than previous configurations, there were likely effects of having EAP services delivered by network providers that to date have not been reported in published scientific studies. In such arrangements, counseling services may be primarily focused on the therapeutic relationship, replicating services offered by



community-based mental health and family service agencies (Straussner, 1988) rather than counseling which embeds the employee job performance-related concerns. It has also been suggested that employees might perceive a greater sense of confidentiality, experience more consistent services across locations, or have higher rates of utilization of external EAP programs (Csiernik, 1999). Internal EAP programs in contrast, are “thought to offer more customized services, rapid responses, greater insights into the organizational culture and more impact on a macro level across the organization” (Pompe, Frey, Sharar et al., 2017).

These two models are discussed by Tisone in his EAP History Project interview:

*In the 70's, the trend transitioned from occupational alcoholism to broad brush employee assistance for a wide variety of problems and the good part of it is it led to a lot more self-referrals and early stages of problems. The not-so-good part of it is that it diminished the importance of management or supervisory referrals and that did damage in my opinion to the identification and treatment of alcohol and drug problems. The 1980s saw the rise of the outside provider. “External providers” is a bit of a misnomer. There are outside service firms providing largely counseling services. Again, the good part of that is it made services available to dispersed populations and more specific services, specialized services, if you will, to corporations. The downside of that was the influx of people into the field who did not have any alcohol or drug training. It really was a further dampening effect of the successful treatment of alcohol and drug problems. In the 90's, clearly, managed care was the trend. [Carl Tisone EAP History Project interview: <https://archive.hshsl.umaryland.edu/handle/10713/6500> ]*

The benefits and shortcomings of these two EAP delivery mechanisms (internal vs. external) were widely debated and discussed at length from the early 1970s into the late 1980s. However, there were no definitive research studies or other evidence that either could clearly offer better cost savings or improved job performance among employee clients. Given that both models essentially offered the same clinical service,

e.g., face-to-face counseling, and no legislation required any specific EAP model, each employer, union or work organization had to determine the best provider and structure that met its needs (Sharar, Pompe & Attridge, 2013).

In response to client expectations and other influences, EAPs continued to evolve in idiosyncratic fashion and to offer customized program services through the 1980s, with this vagueness precluding a unified descriptive definition of EAPs (Shain & Groeneveld, 1980). As EAPs experienced significant growth and expansion, there was little standardization in what constituted an EAP, and among EAP stakeholders, there was increased concern that some providers identifying themselves with EAPs offered minimal or ineffective services.

This concern motivated the development of EAP program standards, and in 1981, the first *Standards for Employee Alcoholism and/or Assistance Programs* were drafted with a joint committee composed of representatives of ALMACA, NCA, NIAAA, and OPCA (EAPA, 1996; 2010). Additionally, as the demand rose for professionals to provide EAP services, many extant EAP staff in the U.S. felt pressure from psychologists, occupational nurses, and other professionals competing for EAP roles (Kurzman, 1992). The need to articulate a distinctive and unique body of practice and its boundaries was evident. In 1984, noting that “we have little consensus on the appropriate content of this (EAP) definition in the 1980s,” Drs. Roman and Blum. presented at conference at Cornell University in April 1984 and later published a seminal work that provided a basis for this effort. (Roman & Blum, 1985, pg.9)

#### **IV. Continued Expansion**

As in previous decades, EAP expansion during the 1990s and into the 2000s continued exponentially. Similar to findings of earlier employer surveys, however, uptake of EAPs by size of organization showed significant differences, with larger work organizations more frequent adopters. Variation by industry sector was also noted, with greater penetration among communications, utilities, transportation, finance and government employers, and lowest penetration among construction, mining and service sectors (Hartwell, et al., 1996; U.S. Department of Labor, 2008). As additional numbers of employers (from Wall Street corporations, manufacturing plants, sports teams, hospitals, and school systems) adopted EAPs, they became a normative presence, reaching and surpassing a majority of employers, and approaching 90 percent among larger employers and certain industries (Families and Work Institute, 2008, 2014, 2016; SHRM, 2017).

Perhaps more notable were the political, economic and social pressures on the world of work during this period, which proved to be major influences on the delivery of EAP services as they sparked innovations by EAPs responding to new and changing needs of employers, regulatory requirements from government agencies, and requests for increasing levels of support from EAP end users – workers and their families. In 1987, the Hudson Institute released *Workforce 2000*, a prescient forecast of 21st century demographic and labor force trends that predicted employers would soon be faced with imperatives to accelerate productivity increases; maintain dynamism within an aging work force; reconcile the conflicting needs of women, work, and families; more fully integrate minority workers; and improve the health and well-being of all workers (Johnston, Packer, et al., 1987). Googins (1991) also noted the emergent gap between the

needs of the workforce and the ability of existing occupational resource mechanisms to address work-family issues, cultural diversity, healthcare cost containment, increasing individual and organizational stress (Googins & Godfrey, 1987) and its negative influence on productivity (Googins, 1991).

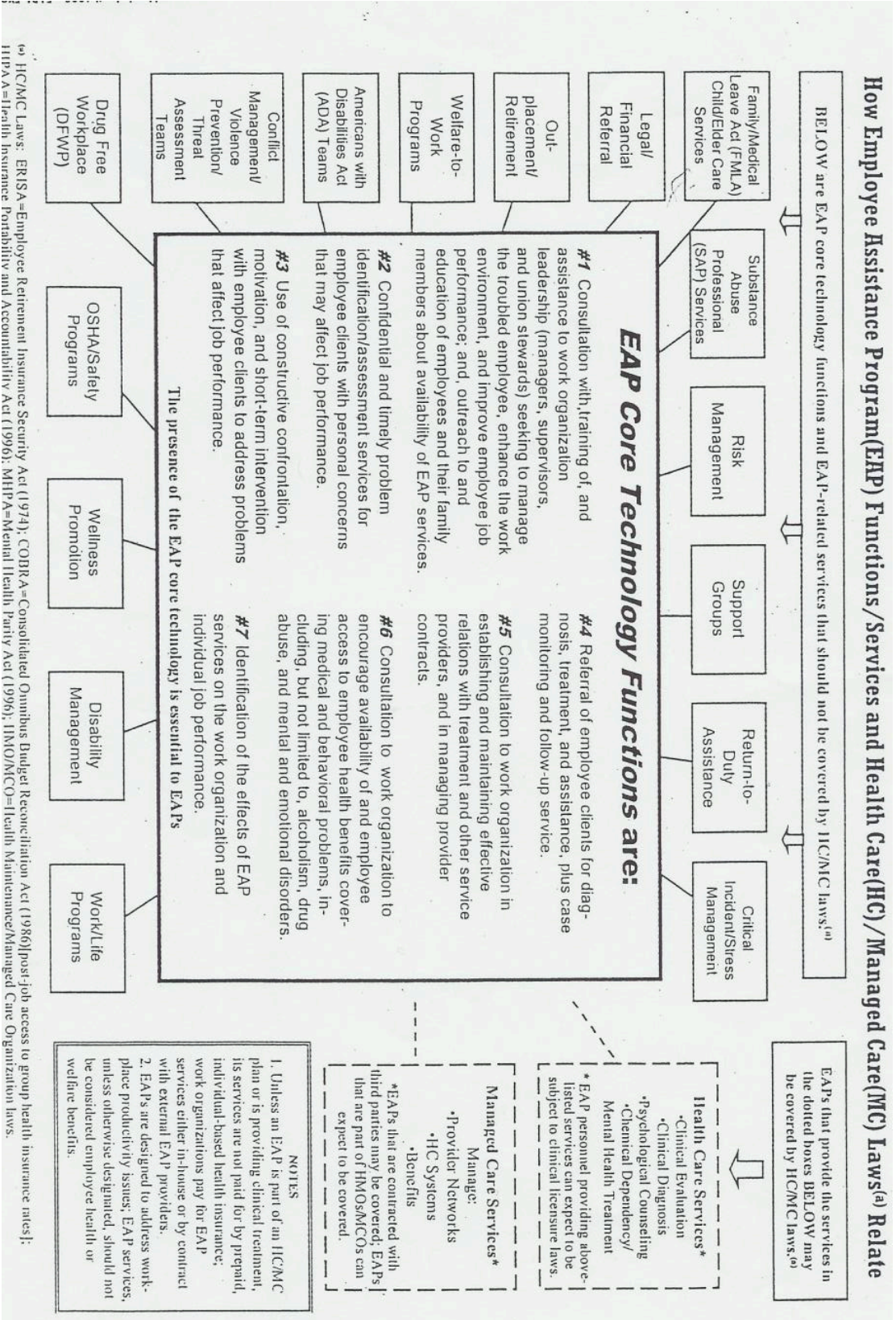
Employers began seeking direction and consultation from EAPs on alternative responses to an ever-widening scope of issues such as stress, workplace violence, child and elder care, disability management, financial and legal matters, and rising numbers of employees seeking counseling services from EAPs (EAPA, 1996). Thus, the boundaries of what had previously been considered the Core Technology of EAP service delivery swelled as EAP providers found themselves called upon to address an increasingly complex mix of what had heretofore been peripheral issues.

The onset of the financial recession of the early 2000s and subsequent corporate downsizing resulted in EAPs becoming called upon to provide additional counseling, coaching and consultation to assist in workforce reduction efforts and adapting to organizational changes. Among EAP providers at the time this issue of boundary maintenance of EAP practice was characterized by some as unavoidable, and others as unfortunate (Yandrick, 1994). The notion of expanded service functions was seen as by EAPs as either an enhancement or a dilution, but ultimately their implementation was primarily driven by marketplace forces (Tisone, 1994).

Figure 4 below was developed by the Professional Standards Committee of EAPA in 1998 to illustrate this progression and help guide EAPs in identifying Core Technology functions from an expanded array of services (Haaz, Maynard, Patrica & Williams, 2003). Listed in the middle box, the Core Technology functions are

surrounded by EAP-related services. The services listed on the right are relevant to EAPs that are integrated within a larger health or mental health care plan. Areas of expanded functions may be wholly serviced by EAPs, or in partnership by integrating with other entities, or employer departments.

**Figure 4: EAP Functions/Services and Health Care/Managed Care (MC)**



Reviewing Figure 4 above, what some EAPs had defined as EAP-related services in the 1990s were to become increasingly integrated into the mainstream of EAP service delivery over the next decade. Notable among these were drug-free workplace/substance abuse professional services, managed behavioral healthcare, work/life, critical incident response, and workplace wellness programming. To meet the needs of work organizations in these areas, services were provided by EAPs at four distinct service levels: individual, managerial/supervisory, organizational development, and administrative (Attridge et al, 2009b). Clearly not all EAPs had the capacity nor were expected to deliver the entire breadth of services, and the actual service combination delivered in a particular worksite was typically customized and unique to that environment.

### **Drug Free Workplace Initiatives**

Beginning in the 1980s, public awareness of the negative effects of illicit and illegal drug use began building. Military concerns about reduced combat readiness, based on survey reports of excessive levels of drug use among personnel, were reinforced by the highly-publicized crash of a jet fighter on the deck of the U.S. Nimitz in 1981 killing 14, injuring 48, and causing an estimated \$150 million in damages. When autopsy reports were released, half of the flight deck crew fatalities tested positive for marijuana. The U.S. military soon implemented a zero-tolerance policy for illegal drug use accompanied by a random drug testing program across all service branches. Stating his concerns “with the well-being of federal employees, the successful accomplishment of agency missions, and the need to maintain employee productivity” on September 15, 1986, President Ronald Reagan issued Executive Order 12534 which set a policy of a

drug-free federal workforce, making it a condition of employment that all federal employees refrain from illegal drug use on or off the job and directed federal agency heads to:

1. Develop policies regarding use of illicit drugs and consequences of policy violations.
2. Implement Employee Assistance Programs for employees.
3. Conduct training of supervisors in drug abuse recognition and intervention.
4. Provide for supervisory referrals and self-referrals of employees to treatment.
5. Instigate drug testing to identify employees in violation of policy.

Two instructive documents, a *Model Plan for a Comprehensive Drug-Free Workplace Programs*, and the *Mandatory Guidelines for Federal Workplace Drug Testing Programs*, were developed as guidance for federal agency drug free workplace efforts. These federal guides quickly became the basis of best practices for private sector drug-free workplace programs.

Within the *Model Plan for a Comprehensive Drug-Free Workplace Programs*, considerable language supportive of EAP services could be identified, including:

*The EAP plays an important role in preventing and resolving employee drug use by: demonstrating the [Agency's] commitment to eliminating illegal drug use; providing employees an opportunity, with appropriate assistance, to discontinue their drug use; providing educational materials to supervisors and employees on drug use issues; assisting supervisors in confronting employees who have performance and/or conduct problems and making referrals to appropriate treatment and rehabilitative facilities; and follow-up with individuals during the rehabilitation period to track their progress and encourage successful completion of the program (NIDA, 1989).*

Notably, although federal agency EAPs were expected to provide education, training counseling and assistance to employees with drug use, they were prohibited from collection of drug testing samples or initial reporting of test results (NIDA, 1989).



Congressional legislation soon followed with passage of the Drug-Free Workplace Act of 1988 and the Anti-Drug Abuse Act of 1988, designed to create a legal framework for anti-drug efforts in the workplace. These included requirements for adoption of a comprehensive drug-free workplace programs by federal contractors and grantees. Information supplied by the U.S. Department of Labor describes the intent of the legislation:

*The Drug-Free Workplace Act of 1988 requires some federal contractors and all federal grantees to agree that they will provide drug-free workplaces as a precondition of receiving a contract or grant from a federal agency. Although all covered contractors and grantees must maintain a drug-free workplace, the specific components necessary to meet the requirements of the Act vary based on whether the contractor or grantee is an individual or an organization. The requirements for organizations are more extensive, because organizations must take comprehensive, programmatic steps to achieve a workplace free of drugs. Employers shall initiate action to discipline any employee who is found to use illegal drugs, provided that such action is not required for an employee who...obtains counseling or rehabilitation through an employee assistance program (U.S.DOL, 2008).*

Subsequently, an accident between two Amtrak and Conrail trains in 1987 in The Chase, MD involving drug use by the crew resulted in 16 deaths. In the aftermath, post-accident drug and alcohol procedures for railway crews (49 CFR 219.200) were overhauled by the Federal Railroad Administration (National Transportation Safety Board, 1988). In 1991, Congress took broader action passing the Omnibus Transportation Employee Testing Act (Public Law 102-143, Title V) which mandated drug testing for all employees in "safety-sensitive" job functions in six different Department of Transportation (DOT)-regulated industry sectors, including trucking, aviation, mass transit, railways, maritime and pipelines, using the previously developed *Mandatory Guidelines for Federal Workplace Drug Testing Programs*.

DOT's Office of Drug and Alcohol Policy and Compliance released its *Procedures for Transportation Workplace Drug and Alcohol Testing Programs* 49 CFR Part 40 which outline specific procedures and requirements for each of the six sectors, including employer responsibilities (program implementation, testing of safety-sensitive employees, maintenance of records and treatment of employers who violate regulations), functions and procedures for sample collectors, medical review officers, and substance abuse professionals. The implementation deadline for these requirements was January 1995 for employers with 50 or more safety-sensitive workers and the following year for those with fewer (U.S.DOL, 2017). By 2001, DOT testing regulations covered more than eight million transportation workers in safety sensitive roles (Cagney, 2001).

Considerable publicity and governmental effort were involved in implementing drug-free workplace efforts and private employers began to correlate high rates of absenteeism, lost productivity, and criminal activity with illegal drug abuse among employees. This affirmed the perception that workplace safety and profitability were being directly affected by employee drug use, enhancing pressure for adoption of similar detection strategies in the private sector (Ackerman, 1991). The tremendous cost to the Exxon Corporation of \$3.4 billion in cleanup costs and another \$5 billion in punitive damages for an oil spill in Valdez, Alaska were noted by employers as an example of the damage from one alcoholic employee (Masi, Reyes & Segall, 1999).

Supported by public opinion, legislation and regulation of safety sensitive industries, the drug-free workplace concept was adopted and promoted to the private sector by national, state and local government agencies, stakeholder organizations, and business groups. Some unions, particularly those working in regulated transportation or

energy industries or with heightened safety concerns (such as the building trades), established their own programs to ensure their hiring halls and apprenticeship programs could supply members who met contractors' drug-free program requirements (Walsh, 1995). These recommendations typically proposed a comprehensive approach based on the *Federal Model Plan* of at least five key components: a written policy, employee education, supervisor training, an EAP, and drug testing, as appropriate (SAMHSA, 2017).

With the onset of public and private sector drug-free workplace initiatives, some expected that EAPs could simply expand their historical Core Technology of assistance for workers with alcoholism to encompass employees with illegal drug use problems. However, a number of factors prevented this: a fear among EAP professionals of damaging their images as confidential providers of assistance by becoming linked with the administration of drug testing and collection of samples; the complexity of the DOT regulations with many specific requirements; and the prohibition in the 1990 Americans with Disabilities Act (ADA) of protected status for employees who were current users of illegal drugs. However, as the implementation of drug free workplace programs and industry-specific drug testing requirements grew, EAPs did still have a key role in assisting many work organizations and workers with substance abuse problems. EAP professionals supplied organizational consultation to employers and unions on the development of workplace policies and procedures designed to encourage self-referrals to the EAP and to provide assessment and treatment referrals to those testing positive for alcohol, and in some cases, for drugs. Existing employee education and supervisory training efforts were expanded to include information about substance abuse, workplace policies and the availability of treatment. The Department of Transportation, in its

definition of Substance Abuse Professionals (SAP) as those who evaluate employees in violation of DOT regulations and make recommendations concerning education, treatment, follow-up testing, and aftercare, specified that certified EAP workers were one of five categories of professionals permitted to perform this function (DOT, 2009), and many EAP professionals have taken the requisite training to fulfill this important role to protect the public interest in transportation safety.

### **Managed Behavioral Healthcare**

Beginning in the 1990s employer concerns about persistent rising healthcare costs were compelling employers to consider numerous avenues for controlling unsustainable increases. As new psychoactive drugs and other behavioral treatment technologies improved, the stigma of seeking help for such conditions faded. Employers became more aware of the role of mental health conditions in work disability, absenteeism, and low productivity, and as purchasers, they responded to the call for improved mental health and substance abuse benefits (Mechanic, 1999). Unfortunately, escalating expenditures associated with greater demand for treatment of mental and substance abuse disorders accelerated the associated costs of these treatments relative to those of other health services, prompting greater scrutiny in the emerging cost-containment era in healthcare (Bernstein & Dolan, 1988). To curb costs, employers began seeking ways to manage behavioral health benefits by placing limits on the amount of reimbursed services that employees and family members could receive annually, as well as instituting annual and/or lifetime dollar limits. Seeking additional cost reductions, many contracted with specialty managed care organizations to provide mental health and substance abuse services to insured individuals (Frank & Garfield,

2007), and thus guide the treatment process from the beginning with an eye toward cost containment.

The term “managed care” refers to programs designed to control access to care, types of care delivered, or the amount/costs of care. The purposes of managed care include cost containment and allocation of resources, as well as monitoring and improving quality and/or outcomes of care (Wells, et al, 1995). Another definition of managed behavioral healthcare (MBHC) describes it as “a market driven system that generates and uses a formal body of knowledge to plan for, organize and quantify the delivery of behavioral care through specific provider relationships for minimizing the cost of care” (Strahan, 1994). Some techniques utilized by managed behavioral healthcare organizations (MBHOs) included stricter precertification criteria, frequent utilization reviews, and increasing user cost-sharing for deductibles and copayments. Founder of Open Minds Monica Oss (1995) writes that “in the broadest perspective, a managed behavioral health program can be defined as a program that intervenes in the relationship between a patient and a behavioral health provider. This intervention can be at any point, from the patient's decision to seek treatment to the selection of a provider to the ongoing management of care.”

These components are considered central to a successful MBHC effort:

**Referral Line.** The referral line handles all incoming calls including emergency, informational, and non-emergency calls to the program.

**Preferred Provider Network.** A provider network comprises: 1) outpatient therapists (psychiatrists, psychologists, social workers, marriage and family counselors, alcohol and substance abuse counselors); 2) hospitals; and 3) alternative levels of care facilities.

**Clinical Case Management or Utilization Review.** The MBH case manages both the client's care and the client's benefits.

**Catastrophic Case Management.** Catastrophic case management occurs when a

client is having a severe problem that may require long periods of care that can be costly or is nearing his/her cap (limit to the benefit).

**Alternate Levels of Care.** A good program will use case managers to investigate alternative levels of care in lieu of hospitalization, facilities that offer quality care and are less expensive than hospitals.

**Benefit Design and Redesign.** Although benefit consultants are also involved in redesign, it is important that MBH companies as well as EAPs offer their opinions to the employer as the health care picture changes.

**Claims Processing.** Some MBH companies handle the entire claims payment process. This reduces the role of insurance companies and explains their entrance into the arena of delivering MBH and EAP services.

**Quality Assurance.** Some quality assurance features include: peer review; random chart audits; examination or audits of readmissions to hospitals within a prescribed period; examination or audits of reapplications for out-patient care; credentialing and updating of provider credentials; and compliance with state regulatory agencies.

Following their introduction in the 1980-1990s, MBHC programs grew steadily within the mental health and addiction healthcare sector in the United States (Mechanic, 1999). In 1997, Open Minds, a behavioral health industry research organization, estimated 168.5 million Americans were enrolled in a MBHC program, an increase of 19 percent from 141.6 million in 1996 (Open Minds, 1997). From 1999-2003, the percentage of health plans contracting with MBHOs grew from 58 percent to 72 percent (Horgan, Garnick, Merrick, et al, 2009). Much of this growth was in development of specialty behavioral health networks to control costs, also known as a MBHC “carve-out,” which utilized an at-risk approach to reduce healthcare expenses and earn revenue (Frank & Garfield, 2007).

Industry consolidation occurred as entrepreneurial EAPs, managed behavioral healthcare organizations (MBHOs) and insurance carriers began to acquire local and regional EAPs to expand their networks, service areas, and product lines (Burke, 2010). These larger organizations were most capable of blending and re-orientation of EAP and

MBH functions to gain optimal system efficiencies and reduce overlap of services (Bernstein & Dolan, 1988). John Burke of Burke Consulting, was very active in the managed behavioral care sector during this period, and made this observation:

*Managed behavioral health really came to the forefront, and the managed care companies that existed at that point in time really got it about the value that EAP brings to managed care, so they took it upon themselves to go out and begin acquiring the capability, either by building it themselves, or by acquiring EAP companies.* [John Burke EAP History Project interview: <https://archive.hshsl.umaryland.edu/handle/10713/6506>]

In an early signal of future trends toward integration of EAPs and MBHOs, in 1986, one of the oldest and largest external EAP providers, Human Affairs International (HAI) was purchased by Aetna Insurance. HAI's President and CEO, Otto Jones noted in an ALMACAN article:

*The most effective programs are designed upon documented needs. They are created through dialogue among the corporations, insurance companies, and EAP/MBHC providers, with input from the utilizers and the providers. They are the result of careful research and planning. They are the product of discussion and design. They incorporate need and budget constraints. They avoid the crapshoot in the selection process and do not expect someone else to determine what is best for them. Instead, they participate in creating a program that is unique to them and most effectively facilitates their needs and resources* (Jones, 1988).

The EAP market was heavily impacted by MBHC, along with the restructuring and re-budgeting processes of purchasers of EAP services in ways that forced organizations to do more with fewer resources, what some have called the third wave – the integrated EAP-MBHC model (Yandrick, 1994). EAPs and MBHC providers with an astute understanding of benefit plans, the ability to negotiate discounts from treatment providers, and to allocate sufficient resources to provide case management with an emphasis on quality of care enjoyed success in this environment, while EAPs without such capabilities became increasingly threatened by providers that integrated EAP

functions into an at-risk MBHC approach (Lung, 1994). Some EAPs expressed frustration with the new MBHC mechanisms, professing fears they were sacrificing their traditional role in assessment and referral to appropriate treatment. Conversely, integrated MBHC-EAP providers had advantages of better linkages, more specialized quality measurement tools, a greater variety of more specialized practitioners, and the ability to provide consistent benefits anywhere in the country (Iglehart, 1996).

As EAPs were perceived as providing access to counseling, and MBHC was perceived similarly, there was a move from the purchaser perspective to integrate service delivery with single call centers, congruent networks, and one set of case managers, creating a one-stop shop for purchasing behavioral health services. These arrangements have flattened the delivery of services for EAPs and outpatient behavioral health to many employer-sponsored plan enrollees by employing a single point of access, usually by a toll-free telephonic intake service. Employer uptake of this integrated product grew quickly as stable pricing and single point of access appealed to work organizations struggling with rising costs and complex benefit designs. As this trend continued, large MBHOs, often subsidiaries of larger healthcare organizations or insurance companies, acquired EAPs and the “integrated EAP/MBHC” product became dominant (Merrick et al, 2011). In the process, many EAPs experienced a fundamental change in scope and function, and which gave rise to fears for a reduction in the traditional unique workplace orientation of EAPs. (Herlihy, 2000).

During the 1990s, IBM was again a pioneer by being one of the first employers to issue a request for proposals for a MBHC program which included a mental health advisory board to oversee the program. The initial board was comprised of two



psychiatrists, one psychologist and one social worker. The author served as the social worker on the advisory board for five years and observed firsthand the functioning of the largest MBHC program in the U.S. Unfortunately, the advisory board mechanism was unique to IBM as other work organizations did not follow suit with this important oversight element.

Anticipating the integration of managed behavior healthcare and EAPs, Carl Tisone wrote:

*While EAPs have typically managed clients, managed care has focused on providers. The integrated approach is a management of the entire process involving not only clients (patients) and providers, but also the sponsor (payer), the administration, prevention, access to care, the full continuum of treatment services and the impact on organizational effectiveness. Integrated behavior care represents the state-of-the-art evolution of two previously conflicting initiatives into a system that eliminates duplication and unnecessary costs for employers while assuring quality behavioral health care for millions (Tisone, 1994).*

In early efforts at integrating these two functions, EAPs and MBHC programs often identified overlaps in services when attempting to incorporate a managed care plan with an existing EAP, or vice versa. Some EAPs did not realize the extensive retooling of processes and procedures and the need for networks of psychiatrists, psychologists, therapists, and other mental health specialists. MBHOs, on the other hand, often lacked understanding of the broad-brush EAP functions, and did not appreciate the variety of EAP services such as dependent care, workplace violence prevention, supervisory consultation, policy development, and others. The channeling of employee behavioral health services designed to ensure productivity through a system oriented to financial savings also raised some organizational, ethical, and policy concerns.

Excellence of service provision and low cost are rarely compatible. If an integrated system simply becomes a cheaper way of delivering services without regard to clearly articulated evaluation mechanisms, any effort to ensure quality care is lost. In looking at these obvious differences, it is understandable why there had often been confusion and operational difficulties in early attempts at developing an effective integrated EAP-MBHC product. Today, a healthy respect exists between both functions and they are viewed as important elements in the delivery of behavioral health services for work organizations. Currently, it is more common for the EAP-MBHC integrated product to be offered by larger health insurance carriers and EAP providers (Merrick et al, 2011). Some smaller, more regional-based EAPs have also developed an integrated product, but many have frequently continued to operate separately from MBHOs within the benefit structure.

### **Critical Incidents in the Workplace**

Addressing the negative psychological effects of traumatic occurrences on employees, such as industrial accidents, bank robberies, workplace homicides and similar incidents has become the province of EAPs over the past decade. It has now expanded to include the impact of natural disasters, and most recently, acts of terrorism experienced at our nation's work sites and the serious negative effects on both individual health and organizational productivity (Paul & Thompson, 2006). As an illustration, the events of September 11, 2001 were horrific examples of workplace violence, for which EAPs were called upon to provide thousands of hours of responsive services. One EAP provider alone reported delivering a total of 10,603 hours of services to employee clients and family members who had been impacted by the September 11 attacks over the following two months. The experiences of EAP providers after this and other large-scale

critical events have raised the level of awareness of the EAP role and expectations among employer representatives, resulting in an increased number of requests for support when traumatic events impact the workplace.

While natural disasters represent a wholly different type of critical incident than terrorist attacks, through experience, EAPs have determined that many aspects of the tenets of a successful response are the same. The magnitude of the destruction left in the aftermath of storms like Hurricanes Katrina and Harvey demanded a swift response. This increased appreciation of the value of EAPs in providing services extend not just for individual workers but also for organizations as a whole, in regard to planning and creating proactive responses. (Paul & Thompson, 2006).

Beginning with an increase of workplace violence in the 1980s and 90s, incidents such as the first World Trade Center and Oklahoma City bombings, as well as attempts to address post-combat trauma of employee/veterans returning from the Gulf War, providing a critical incident response became a necessary service for EAP providers (DeFraia, 2015). One such response, entitled Critical Incident Stress Debriefing (CISD), was originally developed to manage the critical incident stress reaction among first responders in the military, police, emergency medical services, and disaster-relief fields. Jeffrey Mitchell, former President of the International Critical Incident Stress Foundation (ICISF), is credited with developing the critical incident stress debriefing in 1974, defined the process as having two main goals.

1. To reduce the impact of distressing critical incidents on personnel and;
2. to accelerate recovery from the events before harmful stress reactions have a chance to damage the performance, careers, health and families of emergency services personnel (Mitchell, 1988).

By the early 1990s, EAPs began to employ the group debriefing technique to serve any workers who had been involved in a critical or traumatic incident, and such activities were considered yet another function in the broad-brush model of EAP services. In the workplace, critical incidents may include a range of unexpected events, such as an armed robbery, the sudden death of a co-worker, or natural disasters, such as earthquakes, fires, or floods. EAPs are frequently one of the first resources called by managers for assistance in responding to a workplace critical incident, and in most workplaces, form the nucleus for crisis response (Vandepol et al, 2006).

The ICISF has been a leader in training EAP professionals to provide workplace crisis management services, and an inter-organizational collaboration between ICISF and EAPA has encouraged efforts in early intervention and prevention for workplace critical incident response (Jacobson, 2005). To encourage an adequate level of post-incident response, proactive efforts in educating management of the benefit of in providing onsite services after a workplace critical incident are important to ensure they are aware of the benefits.

In its role as primary human resource provider for federal employees, the U.S. Office of Personnel Management recommends that responses to workplace violence include critical incident stress debriefing, post-trauma counseling, and/or use of an EAP to assist victims (U.S. OPM, 2016). Follow-up counseling is another important component of workplace crisis intervention services offered by EAPs and is useful to assisting employees and managers in returning to a state of normality at work, while also identifying those individuals who may be in need of additional assistance or referral to higher levels of clinical care. Additionally, EAPs can offer organizational consultation to managers and employers to evaluate and assess system-wide preparedness for future

critical incidents, and to assist in creating policies and procedures for use in workplace crises and traumas (Plaggemars, 2000).

Recent discussion within the critical incident response arena has centered on the effectiveness, applicability and outcomes of critical incident debriefing modalities, generated by a 1994 editorial published by Brisson and Deahl in the *British Journal of Psychiatry* entitled “Psychological Debriefing and the Prevention of Post-Traumatic Stress,” (Brisson & Deahl, 1994). Some have called for a cessation of EAP-led debriefings in light of a lack of compelling evidence of efficacy and a need for further research (Rose et al, 2003). In 1997, Everly and Mitchell introduced the concept of critical incident stress management (CISM) as a comprehensive, integrative system of multi-component responses to workplace traumatic events in which those exposed to a critical incident are assessed and addressed at each step of impact and recovery, using the most efficient and efficacious methods available. (Everly & Mitchell, 1997). Two other critical incident response (CIR) models, however, have shown promise and may hold a greater level of applicability to the EAP milieu. The first, Psychological First Aid (PFA) was originally developed for large scale disaster response and is an “evidence - informed approach with an emphasis on practical coping skills and basic support for recovery (Young, 2006; Ruzek et al, 2007). The second, the Multi-Systemic Resiliency Approach, is an EAP-structured crisis intervention (Intveld, 2015).

### **The Development of Work/Life Programs**

As the number of women entering the workforce grew, increasing from 18 million in 1950 to 66 million in 2000 (Toossi, 2002), employers became aware of the need for quality childcare services to support the two-parent workforce. By 1985, there were several national providers offering resource and referral services for large multi-site

employers, primarily assisting employees in finding and managing childcare arrangements. As the decade progressed, these issues broadened as baby boomers began to experience significant stress in caring for their aging parents while continuing to perform at expected levels of productivity.

Work/Life (WL) providers had evolved from first addressing only childcare to all dependent care issues to a more extensive, holistic menu of workforce supports, with a global focus on the notion of assisting employees to find a healthier balance between work and family in a fast-paced, knowledge based, competitive economy (Herlihy, 2000). Additional offerings were developed, including educational services, financial and legal counseling, and concierge or convenience services designed to appeal to a broader, more diverse audience. During this time, many EAPs had already been providing childcare assistance to families and it was a natural evolution for them to expand and offer similar services, such as eldercare resources and referrals.

The tension between limited organizational resources and the increasing productivity demands contributes to a variety of problems experienced by employees. These problems are further affected by efforts to balance work with also trying to have a healthy and fulfilling personal and family life (Jacobson & Attridge, 2010). Employers offer EAP and WL services for some of the same reasons, e.g. employee retention, reducing absenteeism, increased employee morale, and health care cost containment (Derr & Lindsay, 1999). Thus, it became clear that EAP and WL service providers could partner in their goal to support a productive work environment and began offering an integrated model of service. Soon many larger national EAPs merged with, acquired or partnered with WL providers to support this integrated model of service delivery (Masi, et. al., 2004). In some workplaces, EAP and WL may be presented in an integrated

fashion, while actually being delivered through a sub-contract with another provider (Attridge, Herlihy & Maiden, 2005).

Fran Rodgers was the Founder and President of Work/Family Directions (WFD), the first national provider of workplace child and eldercare services. In 1983, WFD began providing services to assist employers in addressing the needs of a new generation of employees which were more diverse, more female, and with more family responsibilities. At the time of its sale in 2000, WFD's signature benefit, its LifeWorks services, covered more than three million employees and their family members. It supported employees through normative life transitions and needs such as childcare, parenting, eldercare and personal needs. Rodgers was a leading consultant on women's mobility, demographic changes in the workplace, and on how employers could prepare to meet the needs of this new workforce. Due to the lack of existing historical documentation of this important area, the Rodgers video interview is quoted extensively.

Here Rodgers explains the evolution of Work/Life:

*[In the early eighties] I was working part-time and two people from IBM, who didn't identify themselves, by the way, called up and said, "We're really interested in learning a little bit about what we should do differently. We're a large employer in Westchester. Can we come see you?" These two guys showed up. They told me they had 275,000 people in the United States. I kind of knew it must be IBM. We went out to lunch and they said, "We're 29 percent female now, and we want to make sure our benefits stay at the leading edge of benefits for this new population." At that time, IBM would only do a benefit if it was available to everybody, whether there were 30,000 people in Westchester and five people in Asheville, North Carolina. So, they said, "We're confused about how we can do this and meet our standards." I took out a napkin at the delicatessen, and I drew a picture of how it might work using existing non-profit resources that were beginning to emerge that were helping people find childcare. That happened in June and in November the proposal, along with the AP proposal, went to the IBM board and a new field was born.*

*IBM asked me to design and set-up a national system of helping people find childcare, which did not exist in any form. There is really no infrastructure, still very little actually. We had to identify people in every community who could help*

*people find childcare. Of course, from the very beginning, one of the problems was there wasn't enough childcare. People would call, and they would want something that didn't exist, or they couldn't afford it. We had to do things like computerize the field, identify people to do the work, create databases and then connect people nationally through a call center. That's what happened. When Nixon was President, that was the last time a bill was passed in Congress to create a national childcare system which is what exists all over Western Europe and other places. He vetoed it. At the time, the message said it was because he didn't want to socialize children. We now know he vetoed it because he made a deal with the Republicans that if he vetoed this thing, they wouldn't object to him going into China, to opening up China.*

*IBM paid the full freight for the development. I never looked at cost because I realized it was very important to pay attention to quality. We were very pleased with the quality at the beginning. In retrospect, we had a long way to go. We did it gradually. It was an interesting journey because we never needed marketing. We didn't need marketing until probably 5-8 years into it because we got so much publicity. It was very sexy. It was new. The publicity alone ... At that time, IBM was considered the premier employer in the country and at the leading edge of benefits. They got a lot of attention for everything they did. I didn't know at the time how lucky I was. In retrospect, it's incredible. People just wanted us to work with them. IBM was constantly trying to figure out how to stay on top of things. I don't remember the order exactly, but we also had a service to help people adopt children. We were probably the first place that focused on gay couples adopting, hard to place families. We did a lot of unconventional family work which doesn't sound so unconventional now, but it was at the time. We added adoption and eldercare maybe around the same time. Eldercare of course was a big add-on. I think the more people started to focus on care giving, the more they realized there was an issue with eldercare as well. [DuPont EAP History Project Interview: <https://archive.hshsl.umaryland.edu/handle/10713/6501>]*

The similar methods that EAPs and WL programs utilize to deliver services include: telephone or web-based assessments, brief intervention and referral to resources, providing educational materials through a variety of formats and platforms. Consultation to managers and employer departments are advantageous for today's commonly seen integrated programs (Herlihy, Attridge & Turner, 2002). Contemporary WL services continue to grow and evolve in two ways: 1) providing support to workers struggling to balance demands of work, family and personal life; and 2) organizational consultation to workplaces to provide a family supportive environment to sustain health and



productivity (Heirich, Herlihy, Zullo & Mulvihill, 2008).

EAPs, for the most part today, provide Work/Life services by subcontracting to WL companies. The latter do not, for the most part, provide separate services to client companies, but are subsumed by the EAPs. A more recent development has been the addition of Legal Services as the most utilized Work/Life service, far out-numbering other services such as child and elder care.

Of significance in these developments is the move away from the troubled employees whose behavioral problems were impacting their job performance to serving needs that are defined by employees, and are sometimes the consequence of work design. This of course leads to a totally different concept of referral, and may in some instances lead to an excessive demand on program resources, something that was rare under the troubled employee model.

### ***Workplace Wellness Programs***

Over the past 50 years, the causes of disease and disability for working adults have shifted from infectious and incurable disorders to include those resulting from lifestyle and in some instances from acute challenges to mental health. These emergent risk categories of disease and disability include stress disorders, cardiovascular conditions, and diabetes, with approximately 70 percent of medical claims related to lifestyle factors (NAHU, 2015). Workplace Wellness Programs (WWP) are designed to encourage employees at risk to change behaviors and sustain healthy lifestyles. These healthy habits include engaging in regular physical activity, avoiding obesity through healthy body weight, stress management, maintaining a healthy diet and eating habits, smoking cessation, and reducing health risks (Chapman, 2012).

In their most comprehensive form, WWP's are designed for prevention, reduction, and control of physiological and behavioral health risks before such risks develop into disabilities. According to a research group then at the University of Michigan, the Core Technology of both EAPs and wellness programs should address coordinated implementation of services through the worksite which help employees access and utilize specific health-related programs (Erfurt, Foote & Heirich, 1992). Health promotion and workplace wellness programs may reach employees and their family members from multiple venues: occupational medicine office visits, telephone calls, Internet resources, fitness centers and onsite workplace events, such as employee health and wellness fairs and health screenings (Jacobsen & Attridge, 2010).

For example, obesity has been identified as a greater influence on increased health spending and negative health impacts than smoking or excessive alcohol intake. Obesity is a major driver of chronic diseases and healthcare costs in the U.S. Recently, estimates for these costs ranged from \$147 billion to nearly \$210 billion per year (Cawley & Meyerhoefer, 2012). In addition, obesity is associated with job absenteeism, costing approximately \$4.3 billion annually and with lower productivity while at work, calculated by researchers to cost employers \$506 per obese worker per year (Cawley, Rizzo & Haas, 2007; Gates, Succop, Brehm, et al. 2008). It is quite likely that long hours, work stress, the profusion of advanced technology, and the availability of poor nutritional choices all contribute to the epidemic of overweight adults (Clark, 2005). In 2011, it was estimated that half of all EAP vendors had some type of WWP offering.

In 2015, the organization World at Work found 74 percent of employers planned to increase their spending on employee well-being programs and that the 'primary champion' of such programs has shifted from human resources to an organization's non-

HR senior management. Another survey finding revealed that 70 percent of 225 companies considered the programs to be cost effective (Attridge, 2015), these opinions possibly reflecting the respondents' defense of their investment in these efforts rather than empirical fact.

While WWP offers employee activities related to weight loss, nutrition, fitness, smoking cessation and stress reduction, one widely used feature is health risk appraisal (HRA). Due to the high costs of many health-related conditions, employers began offering incentives (including financial) for employees to complete HRAs and to participate in various wellness and health activities. When different components of wellness programming have been implemented in North America workplaces, the focus has traditionally been on pro-active health behavior such as exercise and reducing employee behaviors believed to increase the likelihood of serious illness or other forms of incapacitation in the future (Csiernik, 1995).

Because of the physical presence of many workers for a third of their day or more, the workplace provides an excellent setting for addressing issues of health. However, as with the troubled employee model of EAPs, there is no assurance that the employees whose behaviors may be the most costly and risky to the employer (alcohol and drug problems that could be addressed by EAPs and obese, severely stressed, and sedentary employees which are target groups for WWPs) will voluntarily come forward to participate in programs of behavioral change. Job performance-based confrontation is a means around this reluctance for EAPs, as are incentives and informal social pressures for WWPs. In reality, excluding these individuals from employment occurs "under the radar," through pre-employment drug screening, the refusal to hire tobacco users and

more subtle means to prevent hiring the obese and the disabled.

Because of the straightforward logic of WWP strategies, many employers have and continue to expend large amounts of energy and financial resources to ensure that healthy workers are retained and supported. The Core Technology of EAP service delivery coupled with its increasing integration with health benefits and activities impacting behavioral health is believed by some to have the potential to empower EAPs as natural allies for WWPs (Clark, 2005).

### **Integration as a New Model for EAP**

Mergers, organizational restructuring and functional redesigns have become common among work organizations. Attempts to integrate services among EAPs, MBHC, WL and WWPs have occurred in a number of settings. EAPs have been integrated with MBHC in recognition of many shared or similar functions that lend themselves to economies of scale. Similarly, support for integration of EAPs with WL programs occurred as professionals realized that both approaches addressed individual as well as organizational issues. Conversely, attempts at integration have met with resistance from various stakeholder groups, as each was unsure how a blended offering would impact their own unique service delivery “turf,” essential functions and professional standing (Herlihy, 1997).

Today, EAP services are most often delivered in-person or over the telephone, with web-based chat or e-mail exchanges becoming increasingly more common. A few studies have examined the experiences of EAP cases from in-person sessions compared to telephone sessions with counselors. The results of these studies found little meaningful differences between the two delivery channels (Masi & Freedman, 2001; Stephenson et al, 2003).

One advantage of web-based service platform approaches may be the relative anonymity which reduces the reluctance some people have about using EAP services (Butterworth, 2001). Offering clinical and prevention services via websites or mobile applications which can be accessed with complete privacy, can reduce the stigma normally associated with personal mental health concerns, and its availability at virtually any time allows greater flexibility and access to users. In a case study of an effort at a Fortune 500 company to integrate online access to EAP, Work-Life and human resource benefits through a single online portal, the result was an increase in the use of the EAP and of the Work/Life services from 8 percent and 12 percent, respectively as separate services, to a combined 25 percent annually versus 20 percent for the prior year (Turner, Weiner & Keegan, 2005).

EAPs, MBHC, W/L and wellness programs are all interventions that have the goals of reducing healthcare costs, improving employee performance, and fostering a healthier workplace culture. The integration and consolidation of these type of programs is a trend that has the potential to offer additional synergistic benefits. An integrative model may boost the preventive potential of each service, with early detection of health and other concerns far more likely than when information is dispersed (Holbrook, 2004).

Current research appears to support the logic of integration. The number of EAPs with “integration activity” across other service platforms is reported to have increased from about 1 in 4 in 1994, to over 1 in 3 in 2002, and is now expected to be the majority (Herlihy & Attridge, 2005). Findings from four studies suggest that integrated and more collaborative kinds of service delivery models tend to have more advantages than disadvantages, especially for employees and covered dependents. Ultimately, however

the degree to which EAP services are delivered separately or via integrated approaches is dependent on the particular culture and preferences of the work organization (Herlihy, 2011).

Two iterations of a National Study of the Changing Workforce, in 1997 and 2002, cite the potential for integrating EAPs and WL programs with respect to the phenomenon of overwork. Results indicate that employees with more demanding jobs and less supportive workplaces experience more stress, demonstrate poorer coping mechanisms, and report less energy off the job. The reverse effect was also noted, when employees' personal and family well-being is compromised by work, they experience more negative spillover from home to work and diminished job performance (Bond et al, 2002).

An alternate view of the integration phenomenon has been offered that warns of EAPs becoming subsumed or buried within larger health benefit plans and employee wellness initiatives to the extent that the historical and defining focus on the workplace becomes diluted or absent. This could result in EAPs that are unable to articulate the differences to purchasers between their EAP services (and expected outcomes) and other types of employee benefit programs. A current debate among EAP practitioners and researchers is if there exists a benign neglect of EAPs within the employee benefit portfolio. Some have argued that EAPs should continue forward with greater integration into the health arena, while others resist that approach as a capitulating the loss of focus on the workplace. Others submit that given the wide diversity of employer purchasers and wide-ranging market for EAPs, both views have a place (Sharar, 2010).

## **Embracing New Technologies**

Among the most important issues facing EAPs today are embracing new technologies for EAP service delivery, increasing research efforts, professional certification and program accreditation, initial and continuing education, and business-related issues in a mature EAP marketplace.

Beginning in the 2000s and proliferating rapidly thereafter, the explosion of technology-assisted health services has brought innovative platforms to delivery of EAP counseling and related services. Once limited to rural or remote communities, tele-health is increasingly being used to expand the geographic reach of health services and improve access to healthcare. These delivery modes encompass a wide range of interactions among providers and patients through email, telephone, Internet, video-conference, and remote devices. Employers appear to be adopting these new technologies rapidly. Nearly 64 percent of work organizations offered some type of telemedicine services in 2016, an increase of 50 percent over 2012. Amid rising concerns with behavioral health issues, many employers have begun embracing tele-behavioral health and tele-psychiatry services, with 24 percent reporting offering these to employees in 2016, and 41 percent predicting they will be making such offering by 2018 (Willis, Towers, Watson, 2016).

For decades, the telephone has been routinely used by EAPs for intake procedures, appointment scheduling, delivering program information, follow-ups, case consultations, crisis intervention, and the predominant delivery model employing a telephone call center as a central access point. However, driven by the need to provide increased access to those in outlying areas, for clients with disability constraints, offering greater flexibility to meet time and scheduling restrictions with availability to counseling

services 24 hours a day, 7 days a week, and reduce costs; EAP providers began to expand remote counseling first via telephone, then through online websites, video conferencing, and most recently with mobile device applications.

Some have noted advantages these technologies offer in reducing hesitancy to seek traditional face-to-face counseling, reducing stigma with the electronic/web environment, and finally to meet preferences of younger generations of workers (Stephenson & Bingaman, 2001; Maheu, Pulier, McMenamin & Posen, 2012). Today, as an increasing number of individuals utilize online technologies in their everyday lives for banking, health care, social networking and other purposes it seems logical many may be open to tele-counseling as a reasonable next step (Rochlen, Zack & Speyer, 2004; McCann, 2017).

Advances in newer technology have enabled EAPs to operate more cost efficiently through inexpensive, yet customizable platforms to deliver psycho-education, or web-based biblio-therapy such as preventive health education, confidential self-assessments and screening tools, resources and tools for managers, coaching and mentoring literature, access to training modules, and follow-up support. Video conferencing in particular shows promise in training, management consultation, critical incident response, account management and other services (Farris & Granberry, 2013) and permits simultaneous participation by multiple clients for supportive group therapy managed by a counselor.

In a study conducted by Dr. Masi and students at the University of Maryland School of Social Work and funded by Ceridian Performance Partners, a review of the literature documenting Ceridian's utilization of telephone and face-to-face services was performed. The researchers identified key categories of available research on the use of



telephone, online, and video counseling including: 1) ethical issues, 2) the use of the telephone in traditional counseling applications, 3) the use of the telephone in support groups, 4) the use of the telephone in crisis intervention, and 5) computer-based and on-line counseling (Masi & Freedman, 2000).

Two common methodologies for web-based services utilize a synchronous or asynchronous approach. Asynchronous web-based communications occur between the EAP professional and the client at different times. Synchronous web-based communications occur simultaneously (in "real" time) utilizing interactive electronic technology such as video and voice or audio via computer or mobile device, with no lag between interactions, such as in chat technology. Examples of contemporary online therapy modalities can take place via e-mail exchanges, or in real time, using chat-based instant messaging, specialized video-conferencing tools, or mobile applications.

International research indicates that telephonic and internet-based delivery of mental health services are as effective as traditional face-to-face treatment conducted in clinical offices, with more than 30 high quality studies using randomized control trial experimental research designs testing the general clinical effectiveness of such services (Griffiths & Christensen, 2006; Attridge, 2011). With these new platforms and applications, however ethical questions have arisen such as confidentiality, privacy, and recordkeeping concerns (Maheu, Pulier, McMEnamin & Posen, 2012). As a result of these changes in technology, EAPA and other professional organizations have published standards to regulate their members' utilization of these applications, such as *Ethical Framework for the use of Technology in EAPs* (London, Nagel & Anthony, 2011).

In the U.S., healthcare regulation is complex, and although the federal government has some national authority, the 50 states have traditionally provided

administrative and regulatory oversight for health services and healthcare professionals within their jurisdiction (Chapman & Talmadge, 1970). Historically, the existence of state-exclusive licensing regulations for mental health providers has prohibited offering services across state lines, and this restriction extends to use of interstate tele-counseling technologies. Therefore, if a counselor holds licensure in Maryland, for instance, he/she cannot offer services to a client in Washington, DC without obtaining a DC license. In addition, if an employee client is using his or her company computer, telephone, or mobile device that has been issued by the company, the company often has access to all of the data and information on these devices. Many employees are not aware of this. Further, EAPs that permit counselors to practice tele-counseling across state boundaries may risk engaging in an unauthorized practice, depending on the state (Sharar, Popovits & Donahue, 2010).

### **Research and Evaluation**

In a keynote address at the 2007 EASNA Annual Institute, Paul Roman, co-author of the EAP Core Technology, spoke of the lack of credibility on EAP effectiveness and warned of future survival crisis of the EAP field due to the lack of rigorous study (McCann, 2013). Some explanations for this lack of experimental research is due to the lack of motivation on the part of larger, for-profit EAP/MBHOs which usually have substantial databases to mount research efforts, with them utilizing these databases in a proprietary manner to improve their own growth and development. In an environment where competition for EAP contracts is often intense, such an attitude can be understood, but it undermines progress to maximize professional delivery of the most effective services. Smaller EAPs and MBHOs may feel they lack sufficient data or resources to engage in data evaluations that have applicability in the broader industry

(Stephenson & Bingaman, 2001).

Because EAPs are staffed by a myriad of professionals from multiple disciplines and some individuals without formal professional education, there has been lack a driving institutional force (e.g. a university or government agency) to champion research efforts, such as the NCA, the Yale Center and NIAAA did for the occupational alcohol movement. Additionally, this dearth of colleges and universities offering a specialization of EAP as a field of study has limited university-based research efforts for EAP.

Business groups and human service professionals often fail to see the need for any research beyond cost-effectiveness while frequently pointing to the rapid growth of EAPs as adequate evidence of their value and effectiveness (Masi, Altman, McCann & Watkins, et al., 2004).

Much of the historical published research has significant design flaws, for instance, the absence of control groups (Merrick, Volpe-Vartanian, Horgan, & McCann, 2007). The published literature on effectiveness and outcomes of EAPs have typically relied on customer/client satisfaction data as the primary measure of program success. Other studies are limited to before-and-after comparisons of EAP clients or the results of qualitative program reviews. Trice & Beyer (1984) noted: "there are no scientific data on the effectiveness" of EAPs.

In an early pioneering EAP cost-benefit study, McDonnell Douglas released the findings for financial offset of employees treated in its EAP for chemical dependency. The research compared two groups, a study group which used the EAP and a group which did not use the EAP. Both groups were followed over a four-year period. Results indicated significant savings in the EAP user group due to less absenteeism, fewer

terminations, and lower medical costs for both employees and family members, with a return on investment in excess of 4 to 1. In the 1990s the McDonnell Douglas findings were widely cited and quoted by EAP practitioners and were apparently influential in promoting EAP adoption and development.

Blum and Roman (1995) presented data from their own national studies of samples of EAPs and separate national samples of employees. Working from the assumption that data analyses using diverse sources and methods (multiple triangulation) supports conclusions that are similar may suggest valid generalizations, they wrote of "an impressive accumulation of evidence about EAP effectiveness," drawing from "a variety of published and unpublished studies, conducted with different methodologies, that indicate the cost-effectiveness of EAPs." Recognizing the quality issue associated with these 30-plus studies, these researchers also confirm that there is a minimal amount of scholarly research on EAP effectiveness that has met typical methodological standards for establishing cause and effect (Roman & Blum, 1995).

French et al. noted in (1997) that "no study has randomly assigned EAP-eligible employees to a control group and an EAP-treated group" (p. 452), they were echoing a long line of critical commentators. In 2000, Arthur emphasized the "embarrassingly thin, largely anecdotal" nature of evidence on EAP effectiveness, citing 5 literature reviews that "are critical of the lack of properly controlled and methodologically sound studies." Brown & Ryan (2003) observed that "reviews of EAPs over the last 15 years have noted the absence of methodologically rigorous evaluation studies" (p. 140), and that "the majority of these evaluations comprise case studies in a single organizational setting, often conducted by the providers of the service" (p. 140). In 2005, Sulsky and Smith

concluded that EAP evaluation studies of even minimal quality do not exist.

Other EAP researchers agreed that there was no evidence of EAPs efficacy and that funding them to produce such evidence was an urgent priority (Pompe & Sharar 2008; Tisone, 2008). There are, however, two studies that should be noted.

1. *United States Department of Health and Human Services* grant to Development Associates for Evaluation of U.S. DHHS Employee Counseling Service, 1985-1988. This study was one of the first to use control groups to measure cost benefit for employees that used the employee counseling program and those that did not. Dr. Masi, Project Director.
2. *The Federal Occupational Health (FOH) Outcome Study of 2004*. FOH provides EAP services to U.S. federal agencies. This three-year study of health and workplace performance for 60,000 EAP clients used self-reports and counselor-assessed measures and found significant improvements in six areas: work productivity as affected by physical and emotional health, work relationships, overall health, work attendance, and global assessment of functioning for those workers who accessed the EAP (Selvik et al., 2003; 2004).

Another development in customer satisfaction was the Workplace Outcome Suite (WOS). Developed by Chestnut Global Partners' Division of Commercial Science; WOS is a series of short psychometrically validated tools that were designed to measure the workplace effects of employee assistance programs. It is used today by a number of EAPs.

### ***Information Dispersal and Technology Transfer Mechanisms***

Beginning in 1985, the *Employee Assistance Quarterly* was established by the Haworth Press as a scholarly, refereed journal published quarterly dedicated to the study of EAPs. In 2005, it was retitled *The Journal of Workplace Behavioral Health* (JWBH) to better reflect its expanded focus of innovative research, applied theory, and practical information on the latest developments in the EAP field. Currently published by Taylor and Francis Group, JWBH is described on its website as “an essential guide to best

practice and research issues faced by EAP professionals who deal with work-related and personal issues including workplace and family wellness, employee benefits, and organizational development.” Since 1985, over 600 refereed articles have appeared in the EAQ/JWBH addressing the various aspects of EAP operations and evaluations and related topics in occupational health and industrial psychology. In 2010, an analysis of 545 of these articles was published (Maiden, Kurzman, Amaral, Stephenson & Attridge, 2010). The most common subjects were: alcohol abuse/treatment, EAP models, drug abuse/treatment, psychological/emotional problems, EAP effectiveness and outcomes, EAP evaluation design and methods, supervisory referrals, critical incidents/trauma and relationship issues.

Introduced at the 2007 EAPA Annual Conference in San Diego and formally established shortly thereafter, the Employee Assistance Research Foundation (EARF) a 501(c)(3) nonprofit foundation, was created as a catalyst to stimulate rigorous academically-based research to raise the power of EAPs to transform individual lives and maximize employee contributions to the success of work organizations. EARF Founder Carl Tisone pledged one million dollars in matching funds to start the organization. EARF’s vision is to define key issues for research by setting a research agenda, providing strategic research grants, and disseminating results to employers, practitioners, researchers, policy makers, and other stakeholders in human resources, safety, labor, occupational health, government, and academia (EARF, 2017). In addition to providing financial support for the EAP History Project, the Foundation has awarded three research grants to study the current state of the EAP field, and determine the impact of EAP services on employee workplace outcomes.

1. ISW Limits, a spin-off of Leuven University in Belgium in partnership with Clinica CAPA and the Universidade Autonoma in Lisbon, Portugal for *EAPs in Continental Europe: State of the Art and Future Challenges*. Principal investigators Deborah Vansteenwegen, PhD and Manuel Sommer, PhD.
2. National Behavioral Consortium, a not-for-profit trade association of regional EAP and MBHO companies were funded for *Comparative Metrics for the External EAP Field*. Principal investigator Stanford W. Granberry, PhD.
3. OMNI Institute received the EARF's largest grant to date for a study entitled *The Impact of Employee Assistance Services on Workplace Outcomes*. Principal investigators Melissa Richmond, PhD and Randi Wood, CEAP (EARF, 2017).

The Practice-Based Research Network (PBRN) is a collaborative effort among EAP researchers and stakeholders founded at a joint EARF, EAPA and EASNA-sponsored research summit convened at the 2012 EAPA Annual Conference. The summit's goals were to assess the current state of EAP research, encourage increased communication among key stakeholders and create the PBRN. Activities of the PBRN included publication of a summary report of the summit's proceedings, several free webinars aimed at increasing knowledge of EAP and related research topics, and in September 2015, a white paper, *Bridging Public Health with Workplace Behavioral Health Services*. The white paper provides specific recommendations to help promote and align EAP research with public and global health as well as the disciplines of workplace health promotion, occupational health, and organizational studies and a call to action for greater collaboration among five stakeholder groups: work organizations, EAP professionals, researchers, educators of EAP professionals, and funding agencies (Bennett, Hughes, Hunter, Jacobson et al, 2015).

Beginning in 2009, EASNA's Knowledge Transfer and Research Committee periodically published *EASNA Research Notes* to address research and practice topics in the EAP and workplace behavioral healthcare field. Examples of past issues' topics

include: EAP Effectiveness and ROI, Utilization of EAP Services, Indicators of the Quality of EAP Services, Workplace Effects of EAP use, and EAP Training of Managers.

The Employee Assistance Digital Archive is a free, open access website dedicated to the archiving of original works, articles, historical documents or other related papers on the subject of Employee Assistance for scholars, EAP professionals and interested parties. This project was launched by the School of Social Work at the University of Maryland which houses the EAP Archives in its Health Sciences and Human Services Library.

### **EAP Professional Associations and Industry Groups**

In addition to the two-long-standing professional EAP associations, EAPA and EASNA, a number of additional industry and affinity groups concerned with EAPs have been established. These include the Employee Assistance Industry Alliance, the EAP Roundtable, and the National Behavioral Consortium.

In 1999, Dr. Ronald Manderscheid, former Chief of the Survey and Analysis Branch of SAMHSA's Center for Mental Health Services (CMHS) and Dr. Masi convened a group of major private and public-sector leaders representing stakeholders in the EAP field to provide national leadership and guidance to the EAP industry. Funded by the SAMHSA's three administrative divisions, CMHS, the Center for Substance Abuse Prevention, and the Center for Substance Abuse Treatment, the group convened as the EAP Industry Alliance. Dr. Manderscheid's vision was for EAPs to have a more united voice within the federal arena, to encourage additional funding for EAP research, and to develop performance guidelines and outcome measurements. Over the next several years, Alliance members began to develop a common industry outlook and



focused on a number of important tasks.

1. The development of purpose and objectives statements to guide the Alliance;
2. the review of accreditation standards for the EAP industry;
3. the development of industry performance measures for EAPs;
4. a review of current human resources training and practice activity surrounding EAPs; and
5. in 2003, the presentation of testimony before the President's New Freedom Commission on Mental Health.

Work in each of these areas was essential because the EAP industry lacked these important elements. Over the succeeding three years, the Alliance membership expanded to include representation from Europe and Canada. In October 2002, as a result of discussions on the *Alliance*, a joint taskforce was created composed of members from EAPA and EASNA to determine the feasibility of merging into a single organization (EAP Digest, 2003). However, after some months of discussion, the potential merger did not gain sufficient support from both sides. Unfortunately, after SAMHSA's financial support ended, the Alliance was disbanded, ending an effort, the full potential of which may have been unrealized.

The Employee Assistance Roundtable (EAR) is an organization of internally-managed EAPs from both private companies and non-profit organizations. Established in 1985, its members include Fortune 500 companies as well as smaller employers from the technology, finance, transportation, construction, energy, manufacturing, healthcare, telecommunications, aerospace, government, and educational sectors. EAR provides for an exchange among its members of data and experiential information and confidential discussion forum at its biannual meetings on topics such as program design, policy development, referral resources, and comparisons of treatment resources. EAR's EAP

directors and managers represent over 3 million employees worldwide.

The National Behavioral Consortium (NBC) is a not-for-profit trade association comprised of regional EAP and MBHO member organizations. NBC provides a forum for regional EAP and MBHO company leadership to discuss clinical, operational and industry trends that enhance the quality of care and advocate for the objectives of EAPs and MBHOs. NBC hosts three meetings each year which provide informative sessions and networking opportunities for its membership and invited guests to collaborate on shared initiatives. In 2013, NBC received a research grant from the EARF to conduct a study of key metrics and operational characteristics that define the external providers in the EAP industry and published the results in a special issue of the *Journal of Workplace Behavioral Health*.

### **Professional Certification and Program Accreditation**

As the EAP movement has grown and evolved, with its own body of theory, knowledge, ethics and skills, criteria for competent practice and delivery of services have also developed, both for individual professionals in the form of professional certification and for the organizations in which these individuals and services are housed. In 1986, the Employee Assistance Certification Commission (EACC) was established to formulate procedures for certification of Employee Assistance Professionals (Blum, 1988). The process involved a number of planning meetings by the Commission, surveys of the membership of ALMACA and use of an outside credentialing expert to develop content areas for a competency-based testing process which denoted expertise in the EAP body of knowledge, standards for practice and professional ethics. The first certification examination was offered in 1987. For those passing the exam and meeting other qualifications, the designation Certified Employee Assistance Professional (CEAP)

was intended to provide consumers and employers assurance they are receiving services from a knowledgeable professional with a specific expertise in Employee Assistance practice (White & Sharar, 2003). The EACC is also responsible for adjudicating and enforcing the comprehensive ethical standards for advanced EAP practice. The CEAP examination and continuing educational content comprise three distinct domains of EAP-specific expertise:

1. *Domain I. EAP Program Design, Administration and Management:* Includes regulatory requirements, staffing, contract management, quality assurance, program effectiveness, current EAP trends & technologies, ethical standards, program promotion & marketing.
2. *Domain II. EAP Services to the Organization:* Includes critical incident preparation & response, behavioral risk management, manager, supervisor & union training, organizational consultation, stress & change management.
3. *Domain III. EAP Services to Employees and Family Members:* Includes assessment, motivational interviewing, short-term problem resolution, referral, follow-up, crisis intervention, employee education, personal, psychological & addiction concerns.

While acceptance of this standard for individual qualification was well-received initially, there has been a significant drop in those receiving and/or renewing their certification. As of February 2018, there are 2,368 EAP professionals worldwide who hold the CEAP certification, a net drop from 4,492 CEAPs in 2000. In a 2010 survey, only 6 percent of those employed by larger EAP providers in North America held a current CEAP certification (Taranowski & Mathieu, 2013). These data clearly suggest that very few of the for-profit external providers see value or necessity in requiring their employees who provide services to employed persons (and perhaps their dependents) to seek the CEAP certificate. This is likely because management of these provider organizations perceives that the actual services provided by them are almost completely clinical and thus solely require clinical credentials, as represented in the CEAP Domain

III, but found in other available (and perhaps required) credentialing systems.

One of EASNA's original goals was to develop an accreditation process for EAPs to promote the highest standards for quality management and service delivery at the level of the program, as compared to the CEAP which is focused on individuals' competency wherever they happen to be practicing. An accreditation process for EAPs programs was designed to ensure that providers meet specific minimum standards for quality practice and that clinical staff possesses the required qualifications and experience needed in order to deliver consistent high-quality services. After developing and initially administering the EASNA accreditation process, EASNA investigated transferring this function to an external organization that could ensure administration of a rigorous accreditation process. (EASNA, 2018). In 2001, the Council on Accreditation (COA) and EASNA released the 1st edition of its EAP Standards and Self-Study Manual, which defined the best practice standards in the Employee Assistance field (Stockert, 2004). As the Employee Assistance industry and practices have evolved, COA and EASNA have continued to work together to offer an evidence-based, peer review supported accreditation process that represents best practices for EAPs. COA's 8th Edition Standards are at the core of its contextual accreditation, representing appropriate best practices and a commitment to client rights and essential life and safety practices.

The accreditation process provided by the COA includes a comprehensive self-study program followed by an on-site review conducted by trained and experienced EAP peer reviewers. With 12 primary components and over 50 sub-areas, the COA Accreditation Standards, now in their eighth edition, are extensive. Accreditation is awarded for a period of three years, after which organizations must undergo the process

of re-accreditation. Unfortunately, in the current U.S. commoditized EAP market, quality remains largely unmeasured. Thus, accreditation is not seen as a prerequisite to demonstrate quality, and the vast majority of U.S. EAPs operate without accreditation. According to COA, as of 2018 there are only 21 accredited EAPs in the United States, almost all of which are family service agencies. As with CEAP, this represents a pattern of decline. In 2009, there were 57 COA-accredited EAPs, a fraction of the estimated 1000-plus EAP providers then operating globally (Amaral, 2010), but still nearly three times more than at present.

It may be that given the saturated EAP market and the competition among external providers for new and continuing organizational clients, many contemporary EAP providers operate within slim financial operating margins and the pursuit of accreditation can consume scarce financial resources in addition to staff time. EAPs operating as components of multi-service healthcare organizations already accredited via other processes may be unconvinced of the value of additional accreditations through a separate process. Alternatively, some large, for-profit EAP and MBHOs have pursued accreditation as a differentiator, designed to increase market and revenues (Sharar & Hertenstein, 2006).

Canadian EAP providers and purchasers, more than U.S. firms, supported the development of accreditation by including accreditation (or the pursuit of it) as a specification in their Request for Proposals for provider services. Today, most EAPs in Canada are accredited. Japan, through its occupational medical school, has purchased the rights from COA to provide accreditation for EAPs.

Another accrediting body, the Council on Accreditation of Rehabilitation Facilities (CARF) began discussions with EAPA in 1995 to develop a joint EAP

accreditation process, but after a negative recommendation by a specially appointed EAPA task force, the proposal was rejected in 1996. CARF subsequently developed an accreditation offering in 1998 based on the EAPA Core Technology approach and recognizing the CEAP as the premier credential for EAP practitioners. In 2000, CARF reported 20 agencies with EAP components had achieved its accreditation (Migas, 2000). CARF-accredited EAPs tend to be smaller, localized EAP providers centered within divisions or departments of community human service, psychiatric or addiction treatment agencies (Sharar & Hertenstein, 2006). Consistent with the overall pattern, this route to accreditation is also in decline. A discussion with CARF staff in February 2018 reveals less than ten EAPs remain accredited through this mechanism (CARF, 2018).

### **Education and Training**

Through the last several decades those in EAP have aspired toward the recognition of professionalization of the field. The definition of a profession is “a calling requiring specialized knowledge and often long and intensive academic preparation” (Merriam Webster, 2020). Educational preparation options for EAP professionals vary depending if one seeks to act as a counselor, administrative staff, or manager. Due to a lack of faculty and funding, for the past three decades most EAP-specific educational offerings in colleges and universities have been short-term in nature. These include academic institutional certification programs and continuing education.

Since its inception in 1985 there has only been a single MSW/PhD program with an EAP specialization. Housed at the University of Maryland School of Social Work, this program was begun by Dr. Masi who taught in and ran the program for twenty-five years. Currently this graduate degree is offered as a sub-specialization. The curriculum

includes coursework in: Human Behavior; Racism and Diversity; Social Welfare and Policy, Community Organization, Practice with Individuals, Substance Abuse, Research, Administration, Supervision and Program Management. The program also includes an internship and exposure to the technological and socio-cultural changes including online counseling, Critical Incident Response, and advances in the prevention and treatment of psychiatric disorders.

A continuing issue for the education for EAP professionals is the lack of recognition by universities. Schools of social work bear a special responsibility in this regard because over 50 percent of EAP practitioners are degree-holding social workers. Currently, there are three schools of social work that offer concentrations in their master's degree programs in occupational social work which are Columbia University, Hunter College, and University of Southern California. However, these programs simply incorporate EAP content in their World of Work or Work/Family concentrations (Kurzman, 2013) rather than as a particular specialization. According to Hughes and Cragwell (2014), EAP non-degree training opportunities continue to be limited and disproportionately offered by internal EAPs, Member Assistance Programs and nonprofit institutions. This picture has not changed significantly since a previous 2011 survey. Graduate program professors in occupational social work remain challenged to find EAP-sponsored internships for their students.

In 2014, the University of Maryland School of Social Work School (UMD-SSW) of Continuing Education and Masi Research Consultants began to offer the International EAP Online Certificate Program initiated and taught by Dr. Masi. Enrolled participants included approximately 450 students from 31 countries. The program offered two

courses which covered the essential ingredients of EAP practice and the assistance of students in preparation for the CEAP certification. In 2019, EAPA acquired the certificate program and will soon offer it in conjunction with UMD-SSW.

1. *EAPs in the New Millennium*. The study of the conceptual framework of EAPs from a global perspective is presented including: essential program components, policy and legal issues, clinical assessments, responding to critical incidents and evaluation methodologies.
2. *EAP Optional Services*. This course provides an overview of the current array of EAP services and the role of the EAP regarding workplace substance abuse, violence and sexual harassment, dependent care services, financial and legal consultation, wellness programs and new technologies in delivering EAP services.

There are other opportunities available for EAP professionals interested in obtaining skill development and continuing education. These include local, regional and national EAPA conferences, webinars, and educational offerings as well as through SAMSHA, National Association of Alcohol and Drug Abuse Counselors. Recent offerings include the Providers Clinical Support System, supported by SAMHSA and specifically geared toward training about medication assisted treatment for substance use disorders.



## **V. Future Directions**

### **Renewed Focus on Addictions**

Alcohol is still the most widely used substance among working adults, and 75 percent of risky drinkers are employed (SAMSHA, 2014). Unfortunately, familiarity with workplace substance abuse issues, historically a strength for EAP professionals, is a casualty of the new demographic profile of EAP service providers. This, coupled with the ever-increasing scientific advances in understanding addictions and their application to EAP practice, has returned the professional development issue of the lack of a comprehensive substance abuse education to central importance. In a positive direction, the last several years have seen renewed interest in the early Core Technology-EAP focus on alcohol and addictions. EAPs are being asked to do more in the area of early identification and encouraging access into professional treatment.

Another major impetus is the research, development, and promotion around Screening, Brief Intervention and Referral to Treatment (SBIRT) an evidence-based approach developed initially for use by primary care and family physicians. With early efforts led by Drs. Eric Goplerud and Tracy McPherson, then at George Washington University, SBIRT appeared to be frequently adopted by EAPs to identify and manage risky and hazardous alcohol use and dependence within workplace settings (McPherson et al., 2009). Curiously, the technology of SBIRT is almost identical to some of the core techniques of EAPs in the 1970s and 1980s, although this has never been formally recognized as a source of SBIRT.

EAPA has endorsed the use of SBIRT as a standard of practice for all EAP clients, regardless of presenting concern. According to EAPA, use of SBIRT has been demonstrated to improve the identification, successful rehabilitation, and productivity of

people whose drinking or drug use is or is becoming problematic (EAPA, 2017).

One reason the lack of knowledge concerning substance abuse exists is that many university-based education programs for social workers and psychologists do not require students to receive any clinical training or courses in addiction. This is in contrast to standards for EAPA, which specifically mention substance abuse training. The EAP field evolved from the occupational alcoholism field and for considerable years the field had the reputation of being quite knowledgeable and responsive in this area. However, this credibility is quickly dissolving. There is no doubt that knowledge of substance use disorders, their assessment and treatment has suffered within the present EAP field due to the lack of education of counselors.

#### **EAPs: A Business or a Profession?**

The very question of whether EAP work is a commercial business interest or a developing profession illustrates the fundamental confusion in role and function within the practice and provision of EAPs. Many regard EAP workers as comprising a profession, as is reflected in the renaming of ALMACA (where members were either “administrators” or “consultants”) as well as the name itself of EAPA (the Employee Assistance *Professionals* Association). Whether a profession can operate and thrive under a for-profit business model is an open question. This defies one of the principles of defining a profession, namely that monetary or profit considerations never should drive professional practice, but that society will adequately recognize and reward professionals because of their commitment to their work which serves essential functions deeply valued by society. Unfortunately, the profit-oriented-professional model has not been supported by the reality of EAPs in the U.S. By embracing the business model to the

exclusion of professional practice, U.S. EAPs now face the consequences of highly competitive pricing (and limited services) and an existential threat posed by the offer of free EAP services bundled with health insurance products – and in truth the EAP services are not free, but rather costs are concealed from purchasers (Sharar, Bjornson & Mackenzie, 2010; Masi, 2011b).

### ***The Marketplace of EAPs***

In the U.S., over 97 percent of companies with more than 5,000 employees have EAPs. 80 percent of companies with 1,001-5,000 employees have EAPs. 75 percent of companies with 251-1,000 employees have EAPs. A 2008 National Study of Employers following ten-years trends related to U.S. workplace policies and benefits shows that the EAP industry continues to grow, with 65 percent of employers providing EAPs in 2008, up from 56 percent in 1998. The U.S. has the most prominent market for EAPs in the world (EAPA, 2016).

Historically, this trend continues to show variation by size, industry, union vs, non-union, and type of employer, and the accompanying variation in characteristic occupational compositions and job functions. Public sector employers and those industries with safety-sensitive considerations and regulatory requirements for EAP and related services have consistently posted near universal adoption of such programs, and both public and private sector union workers had higher rates of access to EAPs than their nonunion counterparts. (Stolfus, 2009). Over 97 percent of employers with 5000+ employees, 80 percent of those with 1001-5000 employees and 75 percent of those with 251-1000 employees provide EAP services (EAPA, 2016).

While such levels of penetration and diffusion in an industry only 50 years old are extraordinary, this rapid growth created a highly competitive market where service quality distinctions defaulted to lower prices and a commoditization effect, whereby some health insurance and managed care enterprises began to bundle EAP services into their core products to offer it as a free service. Yet some point to this stage in the evolution of the EAP industry as a unique opportunity to reinvent EAP services and create new opportunities.

### ***Mergers, Acquisitions and Market Share***

John Burke, Chief Strategy Officer for ORCAS, a health technology company; and founder of ConnectAssist Incorporated, an EAP provider based in Cardiff, Wales discussed the history of major acquisitions and mergers that have taken place in the EAP field. It is helpful to reproduce an excerpt of that interview here:

*The way I look at it is the evolution of any successful industry includes mergers and acquisitions, and consolidation. We take a look at the history of so many industry service sectors, you'll see over time once it matures and becomes successful, you'll see mergers and acquisitions. For our industry, this really began back in the early 1990s, where we began to see mergers and acquisitions take place. We all know, those that have been around for a while, we all know of Human Affairs, and we all know PPC. Those were the two largest players in the country, and Human Affairs sold to AETNA back in the early 90s, and PPC sold to what is now Magellan.*

*If you take a look at the history of how PPC became Magellan, there was just a series of acquisitions that took place that evolved today into what is technically Magellan. If you go beyond that, you'll begin to see other really significant plays. One of the ones that's more of an international approach, or international transaction, was when we had two companies in Canada, FGI and Warren Shepell. A private equity firm named ClearVest came in, and bought each of those two companies separately, then merged them together to become FGI-Shepell, and then later sold to a huge risk management company in Canada, called Morneau Sobeco.*

*We've had other things; Beacon Health Options today- I had a company that I sold to what was Value Health that has evolved to now become Beacon Health Options, which is a merger of Value Options and Beacon Health, so we have that as a significant roll up. Companies like Humana buying Harris, Rothenberg International, seeing Optum bought a few years back, PPC International was sold to what's now Magellan, it helped the international division of that independent of the transaction; in the last three or four years, Optum bought PPC International.*

*Then you've had things like Horizon Health which did a lot of acquisitions that sold to AETNA, and then there's a recent company, E4 Health, that has been around making quite a number of acquisitions. A theme you see in a lot of these major acquisitions is the big players with the money are the ones that are making the transactions and doing the deals. Whether it's a risk management company, whether it's a private equity group, whether it's a health plan, those are the folks with the money, and those are the ones that appreciate the value of the EAP and have been adding EAPs to their portfolios.*

[John Burke, EAP History Project interview:  
<https://archive.hshsl.umaryland.edu/handle/10713/6506>]

Another example of acquisitions in the mature U.S. EAP market was the purchase by Morneau Shepell, Canada's largest EAP provider, of three U.S. providers; Bensinger, DuPont & Associates, Chestnut Global Partners (CGP), and Ceredian Life Works (Morneau Shepell, 2017). This marked the first time an EAP from another country purchased a U.S. EAP. Morneau's purchase of CGP -- which exclusively provides EAP services outside the U.S. -- enhanced its presence internationally and followed its purchase of Canadian EAP providers including Pro Health Group, Solareh and Longpre (Morneau Shepell, 2017a). Given that Morneau has obtained COA accreditation, these acquisitions may increase market pressure for U.S. EAPs to investigate and ultimately apply for COA accreditation.

### ***Procurement and Pricing of EAPs***

The most widely used pricing approach by external EAP vendors in the U.S. is the capitated or per capita fee structure (per employee per year), with a total fee for all

EAP services to the organization divided by the number of covered employees. This pricing mirrors the insurance-based pricing model for other employee benefit services, such as health, life or disability coverage (Attridge et al, 2010). Historically, EAPs were sold via a direct discussion between an EAP provider and an organizational decision-maker or labor advocate, which fostered a direct buyer-supplier relationship. More recently, larger work organizations have outsourced their selection and review process to third party benefit consultants and brokers, whose primary focus is controlling spending on healthcare and employee benefits, and rarely have a full understanding of the theory and practice of EAPs as a long-term strategy to manage behavioral risk and enhance job performance (Masi & Sharar, 2006). In today's commoditized EAP market, EAP providers' service offerings are offered as just another benefit that employees have come to expect. Because of their low price relative to other benefits and their institutionalized presence in the majority of workplaces, few purchasers delve into details and comparisons of service outcomes across EAP vendors as purchasing decisions are made simply on price (Sharar & Hertenstein, 2006; Burke, 2008). Additionally, the use of commissions, sales awards and other incentives to influence broker recommendations for EAP products can skew choices away from quality, individualized or other suitability considerations.

Thus, fewer employers are using or benefiting from informed EAP procurement practices that result in the purchase of a high-value program (Masi & Sharar, 2006). Reforming this price-and-commodity-driven market by educating purchasers to choose EAPs on the basis of quality, value and outcomes should be a goal of the constituencies that are vested in professional recognition for the EAP field (White & Sharar, 2003).

Another area of pricing concern for EAP vendors is remaining profitable while trying to not raise prices, at the risk of compromising quality of services. Masi & Sharar (2006) noted that the per-employee-per-year (PEPY) rates that EAP vendors charge the client company had actually decreased over the past decade. A typical PEPY is \$22 per employee per year. That dollar amount has not significantly changed since the 1980s, despite the difference in the cost of living. EAPs are still considered a very small line item in most company's benefits budgets.

The increased tendency of benefits brokers to bundle EAPs as a "free" add-in with the purchase of another employee benefit, such as a group life or disability insurance plan, has contributed to the relative drop in pricing costs of EAPs. Under this arrangement, a health insurance company acquires an EAP and includes the EAP features as a free "bonus" purchasing the insurance product. In many cases, the "free" EAP services are minimal including nothing more than access to a website, the opportunity to make a toll-free call for brief telephone support, and a non-customized referral for additional care.

In response to these financial and industry machinations EARF founder Tisone writes "The EAP industry has not realized the potential of performance measurement to act as a counterforce to market pressures on price." It is his belief that the field has lost its focus on the roots of EAP namely, the focus on job performance (Tisone, 2008). A similar view is expressed by EAP consultants Attridge and Burke.

*We suggest it is time for the (EAP) industry to get out of the box in which it has placed itself, one of being seen as focusing mostly on providing inexpensive counseling, occasional consultation with managers, and crisis support when needed. One way to address this problem is to restore the core by improve in the quality of what is delivered, the efficiency of how it is delivered, and the relevancy of how it affects outcomes that are important to the purchaser. Other EAP*

*providers who are more daring can go further to reinvent their business model to become more proactive and consultative. They can strive to find new ways to contribute to building cultures of health and emotional well-being at their client organizations (Attridge & Burke, 2012).*

The definition and counting of EAP utilization is an issue which the EAP field (to its detriment) has not clarified. The field is continually criticized for a low annual utilization rate of 5% of employees using the programs. What the field has not explained is that 5% represents 1 year of the program. EAP services are short-term and employees use the program on an average of 3 visits. However, the next year's usage is also 5% of employees but they are frequently not the same employees. When IBM questioned this outcome, Masi, who was the consultant, asked the EAP provider to add up how many *unique* employees had accessed the program over the last 8 years. This total was 35% of the employee population.

### **Diversity and Special Populations**

Due to the changes in the populations in the workforce in the areas of gender, race, religion, and disabilities, the EAP field must also evolve and provide additional services as sociocultural trends have led to a more diverse workforce. Following the introduction of the Individual with Disabilities Education Act (IDEA) in 1990, EAPs are tasked to provide work organizations assistance in the accommodation of qualified employees who have disabilities. With the passage of IDEA, "the EAP role of assisting troubled employees with adjustment is no longer simply a responsibility, it is a legal obligation as well" (Anema & Sligar, 2010).

However, the IDEA does not address other populations where attention to these sociocultural issues in the EAP field have been scarce at best. Cultural diversity, sexual orientation and sexism are examples which are rarely addressed by EAPs in writings or



presentations at conferences or in leading EAP journals and publications.

Vendors will claim that they match the client's specific request for counselors, including gender, sexual orientation, cultural heritage, etc.; however, they do not ask for this specific information from their counselors or affiliates, so is an inconsistent and inaccurate assertion. EAP practitioners need more information about the specialty areas and diversity of their counselors and affiliates so that clients may be more appropriately matched with counselors who meet their specific needs and preferences. Only then will EAPs be able to play "an important role in advocating and maintaining workplace diversity on the legal, emotional, cognitive and behavioral levels" (Chima, 2006).

## **VI. Conclusion**

Today, a dramatically different demographic workforce is emerging, which demands new skills and approaches. If EAPs are to continue to meet the needs of the 21<sup>st</sup> century the field will have to respond to the micro-challenge of interpersonal communication and the macro-challenge of an integrated systems perspective (Kikoski, 1994).

The first EAPs were internally focused programs designed to assist employees with substance abuse issues. In contemporary EAP offerings there is more emphasis on prevention, health, and wellness and on Work/Life services such as financial and legal assistance. EAP providers are looking more broadly at ways to help employees become more balanced and effective, ultimately improving workplace productivity. To some degree, traditional EAP services remain in place, but new services and functions have evolved, been developed and deployed (Sharar & Masi 2006; Burke 2008; Sharar, 2009).

Within the EAP field today there exists a remarkable similarity to the original occupational social work model. The vast majority of EAPs are self-referrals, with very few supervisory referrals. There is low incidence of substance abuse referrals. EAPs claim relationships and personal concern as their main presenting problems from clients. The largest number of EAP counselors are social workers, many of whom have never had a course in addictions.

Most EAP counselors acting as affiliates have no contact with the workplace where their clients are employed. Unfortunately, the professional associations have not addressed this trend and continue to support additional new services offered by EAPs. This diminishes the power of the original purpose of EAPs: the concentration on job

performance as a measure of employee issues; and working with management, supervisors and unions toward the better health of employees.

Dr. Paul Kurzman, Professor of Social Work at Hunter College, has remarked that “to be successful, EAP providers need to move away from their current commodity focus and return on investment [ROI] paradigm.” They must begin to identify the critical functions EAPs perform for work organizations which make them indispensable strategic partners in employers’ universal pursuit of productivity and innovation. To achieve this goal, EAPA and 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 agenda” (Kurzman, 2013).

Due to the increase of workplace violence incidents and acts of terrorism, EAPs continue to be called to the workplace for their expertise in Critical Incident issues which is a key component of the original mission of helping employees and employers in the workplace. The vast majority of these services are contracted out to third-party vendors, usually large national organizations specializing in handling such incidents.

Added to these factors we see the emergence of technology as affecting the modalities for delivering the main product of EAPs, which is counseling. Telephonic, chat, and video counseling modalities are rapidly replacing traditional face-to-face methods. Due to the lower costs such methods charge, EAPs need to be fully aware of and test for outcome before they rush to adopt them.

All of these factors demonstrate the need for conceptual thinking, rigorous research and quality assurance by leading EAP professionals, with the federal

government, as an essential partner in this collaboration. This is an opportune time for the variety of EAP entities to come together, partner and strategize toward these goals.

As we look in retrospect at the EAP field that emerged from the 1940s Occupational Alcoholism movement, it is important to acknowledge the amount of change that has occurred to offer these important services to continually help and service employees. In the continuing evolution of the EAP industry, innovators will need to recognize and address the unique challenges in order to reinvent EAP services and create new opportunities for providers.

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