Ensuring Solutions to Alcohol Problems
THE GEORGE WASHINGTON UNIVERSITY MEDICAL CENTER
Primer 5

Employee Assistance Programs: Workplace Opportunities for Intervening in Alcohol Problems

Introduction

As many as two-thirds of American companies offer Employee Assistance Programs (EAPs) as a prepaid benefit to help workers with a wide variety of personal problems that may be having a negative effect on their job performance. EAPs, which grew out of occupational alcoholism programs, once focused primarily on alcohol problems but eventually expanded their focus to include mental health and other drug addiction problems. They now also commonly address "work-life" issues including financial and legal problems, childcare, eldercare and even career counseling. This has reduced the stigma of using an EAP and produced explosive growth in the past decade: more than 80 million Americans now have access to EAP services of some kind, a 247 percent increase since 1993.

WHAT IS EMPLOYEE ASSISTANCE?

Employee assistance is the work organization's resource that utilizes specific core technologies to enhance employee and workplace effectiveness through prevention, identification and resolution of personal and productivity issues.

Employee Assistance Professionals Association, 2003.

Whether or not a company offers an EAP usually depends on its size. The larger the company, the more likely it will provide this benefit to employees. While 90 percent of Fortune 500 companies and 67 percent of companies with 100-500 employees have EAPs, just 5 percent of companies with fewer than 100 employees do. Smaller businesses sometimes establish local or regional consortiums to deliver this service.

Most workers who use EAPs are self referred, meaning that they initiate contact with an EAP on their own accord with the understanding that the nature of their particular problem will be kept confidential. Employee assistance professionals can provide information to help assist workers with their concerns as well as conduct a complete, personalized assessment with referral to specialized treatment if necessary. In some cases, EAPs also can provide short-term counseling. An employee assistance professional's job requires familiarity with both an employer's health insurance plan and local treatment providers. It often involves working with managed care organizations (MCOs) to try to meet the treatment needs of a client through the health insurance coverage available to the employee through his or her employer.

EAP services are fully financed by the employer. The absence of copayments, deductibles and out-of-pocket expenses make using EAPs attractive to employees because they don't have any claims to file or bills to pay. For some categories of employees without health care insurance, EAPs may provide the only opportunity at company expense to see a trained behavioral health care professional.

The employee, however, does not always initiate use of EAP services. Some employees with alcohol, drug or mental health problems are formally referred to an EAP by their supervisor because of poor job performance. In these cases, supervisors, working in consultation with employee assistance professionals, present employees with evidence of their poor performance and warn them that disciplinary action, including the possibility of termination, will be taken if their work doesn't improve. EAPs typically train supervisors in this process of progressive discipline, known as "constructive confrontation," emphasizing that they should seek direction and advice from EAP staff before initiating a referral.

Originally, most EAPs were internal programs, but today an external vendor often provides the service. In some instances, this may give employees a greater sense of confidentiality and relieve employers of establishing and administering an internal program that can require many different areas of expertise depending on its breadth. On the other hand, it creates more distance between the EAP and the employees, which limits the EAP's knowledge of the workplace environment.

Most EAP vendors charge for their services on a "capitated" basis, receiving a monthly fee per employee for the full range of services provided. Fees of $12 to $30 per employee per year are common. This is a risk-sharing arrangement because EAPs, when calculating their fees, don't know how many employees will actually use the services, though utilization rates of 3-5 percent are the industry norm. If too many employees demand service, the profit margins of EAP vendors can shrink. This has profound implications for delivery of services, particularly when workers seek help for alcohol problems that are more labor intensive than most work-life issues.

Many companies contract with managed behavioral healthcare organizations (MBHOs) to provide EAP services (MBHOs are the entities that provide mental health and addiction treatment services to employers under contract to the employer's health care plan). In fact, a single MBHO, Magellan Behavioral Health Services, has captured nearly 25 percent of the EAP market. Some MBHO contracts also include the provision of alcohol treatment and other types of behavioral healthcare. These are

known as integrated EAPs because they are responsible for treating the problem in addition to diagnosing it. Some 17.4 million Americans are enrolled in these programs. Though integrated EAPs have the potential to deliver services for the full **alcohol problem continuum**, which ranges from light and moderate drinkers who occasionally drink too much to severely alcohol dependent individuals, these programs also may be more susceptible to the financial pressures of the health care market.

Because employees don't have to pay for EAP services, EAPs can serve as a crucial gateway to treatment for behavioral health care problems. EAPs leave the decision to pursue treatment for any problem entirely up to the employee. And no matter how effective the EAP, once employees decide to accept a treatment referral, the extent of their care is dependent on what services their company's health insurance benefits cover.

Employee Assistance Programs can help companies retain valuable employees with alcohol, drug and other behavioral health problems.

Although alcoholism is a disease that affects the whole family, family members may be unable or unwilling to cope with the problem. Researchers have identified primary care provider offices, emergency rooms and the criminal justice and welfare systems as the sites where society has the greatest potential to intervene. The workplace, however, may offer the greatest opportunity of all.

Government statistics indicate that 80 percent of heavy drinkers are employed full- or part- time. Their supervisors and coworkers are likely to notice the signs of problem drinking such as frequent or unexcused absences and hangovers, both of which can seriously interfere with job performance. EAPs can offer these employees life preservers at the same time that they enable employers to maintain workplace productivity.

WHY WORKPLACE INTERVENTION IS EFFECTIVE

- The need to improve job performance provides employers with an objective way to motivate alcohol dependent employees to seek treatment.
- Employers can help increase the effectiveness of treatment for alcohol problems through early identification, assessment and follow-up services.

Employers have another strong incentive to be concerned about alcohol problems in the workplace: in addition to their impact on productivity, they drive up company-borne medical costs through more frequent use of emergency room services and through longer hospital stays for a variety of **alcohol-related injury and health conditions**. Alcohol problems add $19 billion to the nation's health care bill, but **effective alcohol treatment can help pay for itself by reducing these costs**.

Because employers have significant leverage with employees, they are extremely well positioned to encourage working people with alcohol problems to seek help. Employers can use poor job performance to document the need for intervention. The desire to avoid disciplinary action that may result in loss of job, income and prestige is a powerful motivator that can break through the denial that prevents many individuals from recognizing the destructive impact that excessive alcohol consumption is having on their lives.

Referral to appropriate treatment by an EAP can help an employee who is dependent on alcohol. Equally important, EAPs also can help address the **chronic nature of alcoholism**, which like asthma, diabetes and high blood pressure requires constant management to avoid re-occurrence. Just as employers may have the greatest leverage in encouraging employees to seek treatment, EAPs also are ideally situated to help employees who have been treated for alcoholism avoid relapse through close and regular follow-up.

Follow-up is an often underappreciated aspect of EAP work. Though research has proven that continuing care is an **active ingredient of effective alcohol treatment**, it is not widely available in the nation's health care system because service providers rarely have access to third-party reimbursement for these critical post-treatment services.

Good EAP follow-up service includes making sure that patients complete their treatment and are complying with their aftercare plan. It can be particularly helpful for the employees' re-entry into the workplace (as they deal with the responses of coworkers and supervisors) and involves observing not only an employee's behavior at work, but also monitoring his or her absenteeism. While many EAP contracts stipulate that follow-up services will last as long as a year (often with periodic further follow-up), internal EAPs may be better able to provide this service for the longer periods necessary for recovery from a chronic disease such as alcoholism.

Another critical element of follow-up is the employee's understanding that at least one other individual in the workplace knows what he or she is going through. Employee assistance professionals with training in addiction to alcohol and other drugs can serve as a "safe port in a storm." EAPs that offer 24-hour access can be invaluable in the early days of recovery, when relapse is most likely to occur.

EAP follow-up can pay enormous dividends for both the employer and the alcohol dependent employee. Research shows that it leads to fewer relapses; less alcohol-related disability; and lower alcohol treatment costs by preventing the need for additional treatment.

The expansion of EAP services has lessened the focus on alcohol problems.

In one of the last comprehensive, nationwide studies of EAPs conducted more than 15 years ago, researchers learned that 70 percent of employees who had turned to their EAP for help with an alcohol problem were back on the job one year later and performing satisfactorily.

Employee Assistance Programs were once marketed to employers on the basis of their initial, documented success in helping workers with alcohol problems. But the expansion of EAP services may have blunted the effectiveness of this critical human resources tool. According to a recent national survey, just one percent of individuals admitted to treatment for an alcohol problem in 2002 were referred by their employer or an EAP even though the government also estimates that nearly 14 million full-time workers ages 18-49 have alcohol problems, including alcoholism.

An effective EAP is more than a just benefit popular with employees: it can increase the potency of a company's investment in alcohol treatment. Less focus on alcohol problems is particularly troubling in light of the enormous potential that increased access to effective EAPs has for improving early detection, motivation and relapse prevention, all of which contribute substantially to treatment success.

EAP researchers and professionals express growing concern that the field's "historical mission of helping impaired or troubled workers receive proper treatment and return to full workplace functioning has become but one component of a broad array of hybrid integrated delivery systems, reimbursement mechanisms, marketing vehicles and complex managed care models." A brief review of the history of EAPs shows how their expansion has significantly changed what began as a far more focused effort to address alcohol problems in the workplace.

EAPs have their roots in occupational alcoholism programs.

Though the term Employee Assistance Program did not come into usage until the early 1970s, modern EAPs have their roots in the occupational alcoholism programs of the 1940s. These programs developed not long after Alcoholics Anonymous (AA) first demonstrated that support groups could help individuals recover from alcoholism. At a time when companies were more paternal and Americans were much more likely to spend their entire careers working for a single employer, the success of AA proved to employers that they could preserve their investments in long-term employees through support of occupational alcoholism programs. These programs recognized that concerns about job loss, even more than loss of family and friends, could break through denial.

Early occupational alcoholism programs were mostly staffed by men in recovery who encouraged workers with alcohol problems to attend AA meetings. They expected supervisors to diagnose alcoholism, a task that many were reluctant and unqualified to perform. As the programs pushed to identify alcohol problems earlier in the continuum, they acquired an evangelical flavor that alienated some employers and workers who felt that questions about off-the-job drinking were an invasion of privacy.

Relieving supervisors of diagnostic responsibilities for alcohol problems increased acceptance of EAPs.

Fortunately, program proponents realized by the late 1960s that the problem could be approached from a different angle. Instead of asking supervisors to diagnose alcoholism, they found a more objective way to identify alcohol problems: job performance. Adopting the job performance standard was important because both management and labor found it acceptable. It enabled them to support what was called a "constructive confrontation" strategy that eventually formed the bedrock of successful, alcohol-focused EAPs.

EAP staff (many of whom were in recovery themselves and who also functioned as "service providers") trained supervisors in the constructive confrontation strategy. When supervisors observed that employees were absent frequently or not doing their work properly they were taught to first express their concerns informally with the employee. These early conversations, which included mention of the EAP as a resource for help with any personal problem that might be interfering with job performance, emphasized the constructive aspect of the strategy and initiated a process that gave the employee every opportunity over a period of time to access the company EAP. If performance problems persisted, supervisors were advised to become gradually more confrontational and begin a formal disciplinary process, which included written warnings and temporary suspensions prior to termination.

Constructive confrontation succeeded as a strategy for dealing with alcohol problems in the workplace for several important reasons:

- it recognized that few people with alcohol problems seek help on their own;
- it provided labor and management with common ground for dealing with employees who have alcohol problems;
- it relieved supervisors of inappropriate diagnostic responsibility;
- it permitted employee assistance professionals to conduct confidential assessments and make referrals to treatment as necessary; and
- it allowed management to deal with sick employees fairly and, at the same time, leave the decision to seek medical treatment entirely up to the employee.

Constructive confrontation accomplished the mission of the original occupational alcoholism programs and led to the development of an early EAP model and methodology that could be replicated. However, some supervisors were still reluctant to intervene and the emphasis on constructive confrontation did little to encourage voluntary use of EAPs. These drawbacks stimulated efforts to increase supervisory use of the constructive confrontation process and to make EAPs more attractive to employees with other kinds of personal problems that might be less stigmatized but still related to their alcohol use.

Broadening the focus of EAPs helped make them more popular.

The modern "broad brush" EAP movement grew out of research at Cornell University suggesting that supervisors were more comfortable using constructive confrontation if they had been trained to focus on "problem" employees instead of employees with alcohol problems. During the 1970s the newly formed National Institute on Alcohol Abuse and Alcoholism (NIAAA) gave the movement a big boost when it provided seed money to recruit not only alcoholism counselors, but also psychologists and social workers as program consultants in all 50 states. This approach eventually led to a profound change in EAP service delivery.

Employee assistance professionals from the alcoholism field strongly supported the constructive confrontation strategy, while psychologists and social workers were skeptical of any coercive approach. They advocated that EAPs should treat all personal problems equally and that employees should be able to use EAPs on their own without being pressured by their supervisors. And because EAPs now had broadened their focus beyond alcohol problems, they also pushed for professional staff that could clinically diagnose depression and other debilitating mental health conditions, provide counseling and make referrals to treatment. Many employers embraced this view and greatly expanded the portfolio of the traditional EAP.

EAPs gradually became driven by informal or self-referrals, instead of supervisory referrals, leading to a call by researchers for maintaining a "crucial balance" between the informal referral and constructive confrontation approaches. Today, however, the balance has tipped heavily; at least 80 percent of employees with alcohol problems are technically self-referred.

HOW CONTEMPORARY EAPS WORK: THE CORE TECHNOLOGY

1. Consultation with, training of and assistance to work organization leadership (managers, supervisors, and union stewards) seeking to manage the troubled employee, enhance the work environment and improve employee job performance; outreach/education of employees/dependents about availability of employee assistance services;
2. Confidential and timely problem identification/assessment services for employee clients with personal concerns that may affect job performance;
3. Use of constructive confrontation, motivation and short-term intervention with employee clients to address problems that affect job performance;
4. Referral of employee clients for diagnosis, treatment and assistance, plus case monitoring and follow-up services, as well as to organizations and insurers;
5. Assistance to work organizations in managing provider contracts, and in forming and auditing relations with service providers, managed care organizations, insurers and other third-party payers;
6. Assistance to work organizations to support employee health benefits covering medical/behavioral problems, including but not limited to: alcoholism, drug abuse and mental/emotional disorders, and
7. Identification of the effects of employee assistance services on the work organization and individual job performance.

Source: Employee Assistance Professionals Association, 2003.

Yet few of these cases are genuine self-referrals. Research indicates that they often occur in response to pressure from coworkers or supervisors who are reluctant to take formal disciplinary action. Both employees and supervisors prefer these informal referrals for obvious reasons but without an official record of job performance problems, employees may be less likely to act on the recommendations of the EAP. Without a formal referral, a supervisor is unable to play a role in the EAP process. By going through the motions of seeking EAP assistance, an employee can satisfy the supervisor but continue to deny the existence of an alcohol problem. As a result, by the time a supervisor may be ready to take disciplinary action, the opportunity for a progressive constructive confrontation may have been lost because the problem has reached a critical stage. Practically speaking, in some organizations this has meant that supervisory referral is frequently the final step before termination and often made more for legal reasons than to help retain a productive employee.

Market forces in the health care field helped fuel EAP growth.

Market forces began to play an increasingly significant role in the EAP movement during the late 1970s and 1980s. The boundaries between EAPs and treatment programs began to blur. Under pressure to reduce referrals to outside services (not only those for inpatient care), some EAPs began to offer limited counseling sessions. Local inpatient treatment providers, who saw EAPs as a primary resource for patient referral, started to offer EAP services to businesses in their communities. This gave them a regular source of clients and income but it also allowed EAPs to influence treatment: by the late 1980s, more than half of treatment providers said that they had made changes in service (such as adding outpatient programs, reducing length of stay and offering aftercare and patient monitoring services) in response to pressure from EAPs.

This early integration of services, combined with the broad brush approach, created an environment in which external EAPs could flourish. Whereas EAPs once had been mostly alcohol-focused internal programs found only among the largest employers, more external providers began marketing a variety of services (including counseling as well as assessment) to smaller companies that couldn't sustain an EAP on their own – a useful development since the majority of employed Americans work at smaller businesses and organizations. Usually located off-site, external EAPs also had the advantage of relieving larger employers of administrative demands and fostering the sense of confidentiality that helped popularize their use among workers.

But as external EAPs proliferated, they became increasingly divorced from the context of individual workplaces. At times, this limited their accessibility to supervisors who knew to ask for direct guidance and, occasionally, even handholding in dealing with employee performance problems. In addition, more and more employee assistance professionals had little first-hand knowledge of specific worksites, making it difficult for them to appreciate the environmental influences that contribute to alcohol problems.

During the 1990s managed care increased the financial pressure on all EAPs. When health care premiums soared, EAPs were put in the position of juggling the employer's mandate to contain health care costs (reflected in restrictions on health insurance coverage for alcohol treatment) with the employee's need for adequate treatment. Responsibility for placing clients in an appropriate level of care increased the need for a clinical understanding of alcoholism among EAP staff. It also facilitated the eventual integration of EAPs with MBHOs, a trend that continues.

In addition, fierce competition forced external vendors to offer more services at ever-cheaper prices as they struggled to maintain market share. High demand for less labor intensive work-life services (like child care and financial planning) contributed to the shift by EAPs away from their original focus.

Significant consolidation, particularly among MBHO vendors who provide both stand-alone and integrated EAP services, occurred as a result of these pressures. Many of these MBHOs are national or regional in scope and rely on psychologists, social workers and other subcontractors to provide local EAP services.

Today's employee assistance professionals see cause for concern about the changes in the field.

According to a recent national survey of the memberships of the Employee Assistance Professionals Association and the Employee Assistance Society of North America, the competence of employee assistance professionals and subcontractors ranked as their number-one ethical concern. This survey indicated that many employee assistance professionals recognize better than anyone how much their field has changed. They question whether or not individuals working in the field have received adequate training in alcohol and other drug addictions. They also are well aware of the actual and perceived conflicts of interest created by the integration of EAP programs with MBHOs and express discomfort in their dual roles of advocating for clients and rationing care.

Source: Sharar, 2002.

Survey respondents also had no trouble identifying 15 common types of EAP services – including financial and legal consultation, job placement, career testing and counseling, and executive coaching – that fall outside the scope of traditional EAP programs and require completely different knowledge and skills. The heavy demand for these services by self-referred employees, in conjunction with frequent lack of addiction training, have left the new breed of employee assistance professional with less time and perhaps less prepared to deal with alcohol problems.

Most employers select their EAP provider strictly on the basis of cost. As a result, to stay in business as "per employee per year" revenue has continued to decline, some EAPs have started to rely more heavily on toll-free numbers and the Internet to serve clients. While this technology can disseminate information more quickly and efficiently than ever before, it can't take the place of face-to-face consultation in assessing employees with alcohol problems. Examples of "underpricing and overselling" EAP services that were cited by respondents in the employee assistance professionals' survey include:

- selling a short-term counseling service of 1-8 sessions to employers but routinely referring patients to an outside service after a single session to reduce EAP costs. This would prevent an EAP from conducting brief interventions for problem drinkers, which can require as many as five counseling sessions;
- promising face-to-face professional interventions with the option of telephone intervention services and then mainly providing less expensive telephone intervention;
- using unqualified and poorly trained staff to provide telephone intervention services or preliminary assessments;
- offering a "free" EAP when employers purchase a particular health plan and then failing to promote the program or provide adequate training for workplace supervisors; and
- requiring EAP referrals before an employee can access alcohol treatment but failing to promote EAP services (in integrated EAP/MHBOs) in order to discourage utilization of alcohol treatment.

Drug testing influenced employer attitudes about alcohol problems.

The gradual drift away from a primary EAP focus on alcohol problems has been exacerbated by businesses who appear to be paying less attention to alcohol problems overall. The "War on Drugs" and drug testing, which became a standard function of many EAPs in the1980s as a result of the federal Drug-Free Workplace Act, encouraged employers to focus more on illicit drug use than on excessive or inappropriate drinking among workers. Pre-employment drug testing, in particular, may have lulled employers into a false sense of security. It allowed them to believe that they were preemptively eliminating drug problems, but they were neglecting the more pervasive problem of alcoholism which can take years to develop. Drug testing may even have had the unfortunate and unanticipated effect of encouraging workers who were using illicit drugs to switch to alcohol.

Drug testing also caused many industries with strong labor union representation to view company-run EAPs with deep suspicion, reversing the progress that had been made through labor-management collaboration in the 1970s. Company-run EAPs gained a reputation among union members as a punitive tool more likely to be used by management to terminate employees than to help them with

an addiction problem. This led to a renaissance and refinement of Member (or Peer) Assistance Programs, operated by unions and some professional associations (such as those for physicians and attorneys), that some researchers believe are the only programs today that do what EAPs set out to do originally: embrace a "mutual aid ethic" to help fellow workers with alcohol problems and promote greater solidarity. The frequent presence of much better insurance coverage for alcoholism treatment contributes to the strength of these programs.

Lack of scientific research prevents employers from making informed decisions about EAPs.

Since the federal National Institute on Alcohol Abuse and Alcoholism sharply reduced its research funding emphasis on worksite issues and on EAP research specifically during the 1980s, there has been little hard evidence to guide employers in making informed decisions about the value and effectiveness of EAP services, or even what they should entail. Lack of universal standards for EAP services or for the qualifications of program staff further complicates the task of human resource directors and benefit managers who are responsible for contracting with external EAPs or administering internal EAPs.

Some progress is being made in the area of EAP accreditation. The Council on Accreditation (COA), for example, conducts an in-depth examination of an organization's services and management and compares them to best practice standards established for a variety of fields. Included among the requirements for COA accreditation in employee assistance is annual training in alcohol and other drug addictions. The Commission on Accreditation of Rehabilitation also accredits EAPs. While annual training in alcohol and other drug addictions is not specified, accreditation does require competence and ongoing training for employee assistance staff members who are assessing individuals with alcohol problems.

In addition, the U.S. government's Substance Abuse and Mental Health Services Administration has begun developing EAP performance standards in a number of areas – including staff qualifications – through the formation of the Joint EAP Industry Alliance with national and regional EAPs, both internal and external, and representatives from several major MBHOs. MBHO and national EAP contracts with employers typically include performance standards, but these vary according to the terms of each contract. The government hopes to create national benchmarks. Like many behavioral health care performance standards, however, these tend to focus more on more easily measured standards such as customer service and utilization rather than on outcomes.

EAP outcome evaluation for employees with alcohol problems always has been difficult because of confidentiality concerns (particularly among self-referred cases which make it impossible for supervisors to track before and after differences in job performance) and because successful outcomes depend on the kind and quality of treatment received by the employee. The crucial question in research is: should improvement (or lack thereof) be attributed to EAP intervention or to alcohol treatment?

Recent alcohol treatment research suggests EAPs can play a strong role in the delivery of successful interventions for the entire continuum of alcohol problems.

While EAP research has languished, alcohol treatment outcomes research fortunately has improved significantly over the past 10 years. It suggests that the workplace may have a greater role to play in the delivery of successful interventions for the full continuum of alcohol problems, but especially in the area of early detection. **Alcohol screening** and **brief interventions**, for example, have proven to be effective in helping non-dependent drinkers who are experiencing alcohol problems. Nevertheless, few companies screen for alcohol problems and few employee assistance professionals, who also may not recognize the difference between problem drinking and alcohol dependence, have been trained to conduct brief interventions.

Alcohol screening has enormous potential, particularly among self-referred EAP clients. Routine use of alcohol screening by employee assistance professionals could help them spot underlying alcohol problems that frequently contribute to emotional distress that, according to a recent survey of employees in integrated EAPs, ranked as the number-one reason for using an EAP. Training in brief interventions, which can be conducted during the counseling sessions offered by many EAPs, would give employee assistance professionals an effective, cost-saving technique that can reduce the need for formal treatment.

With proper training, annual alcohol screening also could be incorporated into **wellness programs**, which usually target stress, smoking and obesity. Wellness professionals could play a bigger role in reaching workers whose job performance eventually may be affected by their drinking if participants who test positive for alcohol problems were encouraged to contact EAPs.

Wellness programs can best address early alcohol problems if they adopt a "back door" approach by incorporating specific information about **alcohol's negative effects on other health conditions** rather than focusing exclusively on drinking. For example, a woman who doesn't see any need to reduce her alcohol consumption, even though she is drinking excessively in an attempt to reduce stress, might very well enroll in a stress reduction program in which she would learn that having more than one drink a day elevates her risk for breast cancer.

Less is known about disease management programs that have become more popular as employers seek innovative ways to control spiraling health care costs. These programs typically focus on **chronic illnesses such as asthma, diabetes and high blood pressure, which have many similarities to alcoholism**.

Alcoholism disease management programs could be housed within EAPs where the confidentiality of the participants can be assured. With a strong commitment to annual alcohol screening and EAP professionals trained to conduct brief alcohol interventions, employers could intervene earlier than ever before with workers who have a drinking problem. EAP follow-up is equally critical here because research indicates that while brief interventions can help individuals cut back on their drinking, these

reductions may not last longer than a year or two. Voluntary enrollment in a confidential disease management program, however, would permit regular scheduling of "booster" counseling sessions for the duration of employment and possibly prevent the need for more costly alcohol treatment.

Early detection isn't the only area where alcohol treatment research indicates that EAPs can make a big difference. In fact, they can directly influence three other **active ingredients of effective alcohol treatment**:

- **comprehensive assessments** of alcohol dependent employees can be completed by EAPs to make the most appropriate and cost-effective treatment referral;

- **care management** and **continuing care** can be supported by EAP staff who, in consultation with treatment professionals, check to make sure that alcohol dependent employees are adhering to their treatment plans, and who follow-up with these employees for the duration of their employment, and

- **strong patient motivation** can be influenced by employee assistance professionals and supervisors (with the support of management) who engage in constructive confrontation with employees whose job performance has begun to deteriorate, and by MAP peer counselors.

Integrated EAPs, of course, have an even greater opportunity – and responsibility – to influence outcomes because they actually are providing treatment services to alcohol dependent individuals.

The EAP's ability to influence treatment outcomes reinforces why training in alcohol and other drug addictions should be a top priority in the field. People who drink too much frequently access EAP services complaining of stress or emotional problems. EAPs need to properly assess if these people can benefit from a brief intervention or need formal alcohol treatment. These skills can significantly improve access to alcohol treatment for the 80 million Americans now enrolled in EAPs at the same time that they increase productivity in the workplace and make it safer.

Steps to Improve EAP Responses to Alcohol Problems

While neither simple solutions nor an ideal approach for dealing with alcohol problems fit every workplace, experts have made a number of recommendations to help employers, EAP providers and employee assistance and wellness professionals intervene more effectively to assist workers at all levels, from hourly employees to chief executives. These include:

Steps for employers to consider:

- Make follow-up with employees who receive brief interventions or alcohol treatment a top priority for EAPs.

- Establish absenteeism control programs that routinely monitor employee attendance, counsel employees with minor attendance problems and refer employees with major attendance problems to the EAP.

- Refer workers with frequent **emergency room visits** or **alcohol-related illnesses** to the EAP.

- Empower EAPs by using disciplinary and personnel review systems to monitor employee job performance and structure these systems in ways that facilitate EAP interaction with them.

- View EAPs within the context of a broad human resources plan to ensure greater coordination and communication among personnel, human resources, benefits and EAP staff.

- Actively promote EAP services in management training and employee orientation, including:
    - training supervisors in constructive confrontation as the preferred means of addressing job performance problems in their earliest stages; and
    - assuring self-referred employees that accessing EAP services for help with an alcohol problem will be confidential and will not result in any job repercussions.

- Contract with external EAPs to provide on-site services to ensure a degree of familiarity with specific workplace environments.

- Investigate how small businesses can establish consortia to provide EAP services by tapping into the unique business and human resources of local communities.

Steps for employee assistance vendors to consider:

- Educate affiliates and network providers in the latest research regarding the assessment and effective treatment of alcohol problems, including training in screening and brief intervention techniques.

- Use counseling sessions to conduct brief interventions for problem drinkers who are not dependent on alcohol.

- Establish confidential disease management programs for employees with alcohol problems.

- Find creative ways for training supervisors in the constructive confrontation process that recognize the competitive demands on their time.

- Develop confidential recordkeeping systems for both self-referrals and supervisory referrals for alcohol problems to compare outcome success in the two groups.

- Monitor utilization of insurance coverage for alcoholism treatment to prevent revolving door syndrome among employees and to hold treatment providers more accountable.

Steps for employee assistance professionals (including psychologists and social workers who contract to provide EAP services) to consider:*

- Seek training and continuing education in alcohol and other drug addictions.

- Learn the difference between **problem drinking** and **alcoholism** and learn how motivational interviewing can be used to conduct brief interventions, particularly for self-referred employees who are assessed with the former condition.

- Educate employers that EAP programs must be staffed by professionals with addiction training and offer adequate services to identify and assess alcohol problems.

- Advocate that employers provide **health insurance coverage for treating alcoholism and other drug addictions** equal to that for other medical conditions.

- Serve as advocates for alcohol-dependent clients with managed care organizations (MCOs) and treatment providers by:

  - knowing and understanding benefit limitations;
  - explaining the rationale for recommended treatment;
  - becoming knowledgeable about local resources and all relevant employer-sponsored MCO network providers and making recommendations about the use of local providers independent of specific cases; and
  - investigating MCO appeal and denial policies.

- Refer employees who have received brief interventions or alcohol treatment to wellness programs. Participation in these programs can foster healthier lifestyles to help them maintain their reduced alcohol consumption and recovery. Since many individuals with alcohol problems report high levels of stress and nicotine addiction, stress reduction and smoking cessation programs may be of particular benefit for their recovery.

**Some of these steps may also be appropriate for member assistance or peer assistance counselors.*

Steps for wellness and disease management professionals to consider:

- Nest alcohol issues within larger health concerns to encourage less risky drinking behavior and educate employees about government definitions of **moderate drinking**.

- Include annual alcohol screenings in wellness programs and encourage employees who test positive for alcohol problems to access EAP services.

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Since earning his doctorate in organizational behavior from Cornell University's School of Industrial and Labor Relations in 1968, Dr. Roman has researched and written extensively about the impact of alcohol problems on the workplace. In the early 1970s, he was heavily involved with the NIAAA effort to establish EAPs at companies throughout the U.S.

Since 1990, Dr. Roman has written or edited several books and monographs about alcohol in the workplace. These include *Research in the Sociology of Organizations: Alcohol and Drug Abuse in the Workplace* (with William Sonnenstuhl, forthcoming); *Cost Effectiveness and Preventive Impact of Employee Assistance Programs* (with Terry Blum, 1995); and *Alcohol Problem Intervention in the Workplace: Employee Assistance Programs and Strategic Alternatives* (1990). In addition to publishing numerous articles about EAPs and many other alcohol-related topics in scientific journals and textbooks during the past 30 years, Dr. Roman serves on the editorial board of *Employee Assistance Quarterly*.

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Ensuring Solutions to Alcohol Problems (Ensuring Solutions) at The George Washington University Medical Center in Washington, DC, seeks to increase access to treatment for individuals with alcohol problems. Working with policymakers, employers and concerned citizens, Ensuring Solutions provides research-based information and tools to help curb the avoidable health care and other costs associated with alcohol use and improve access to treatment for Americans who need it. The project is supported by a grant from The Pew Charitable Trusts.

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