Employee Assistance Programs

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STATISTICS FROM SEVERAL SOURCES CONVEY THE strong impression that corporate-sponsored counseling for troubled employees, or "employee assistance," is coming of age. The majority of the nation's largest and most prominent corporations now sponsor some form of organized employee counseling, and the alcoholism programs from which these larger efforts have developed are themselves proliferating.

Occupational alcoholism programs expanded at a measured rate for over 30 years, but the pace began to accelerate sharply during the 1970s. In its 1981 report to Congress, the National Institute on Alcohol Abuse and Alcoholism (NIAAA) charted this growth: from 4 to 6 programs from 1940 to 1945; 50 in 1950; 500 in 1973; 2,400 in 1977; and 4,400 in 1979–1980 (U.S. Department of Health and Human Services, 1981). The most recent of a series of surveys of United States corporations, conducted for the NIAAA, found that the number of executives reporting the existence of a company alcoholism program had more than doubled since the first survey seven years earlier (Opinion Research Corporation, 1979). A recent Conference Board report on approaches in the business world to the problem of alcoholism identified a marked diffusion of formal programs

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over the past decade; of the 346 programs described in the 1980 report, only 61 had existed in 1970 (Weiss, 1980).

About 3,000 people from various professional and semiprofessional disciplines are currently employed in the occupational alcoholism field, both inside and outside work organizations. The Association of Labor and Management Administrators and Consultants on Alcoholism (ALMACA) has created a network of 2,200 members; the National Council on Alcoholism publishes a specialized periodical entitled *Labor Management Journal on Alcoholism;* and NIAAA has a section dedicated to promoting company-sponsored alcoholism programs (Roman, 1981).

These activities herald a growing tendency among the nation's corporations to assume—or to have thrust upon them—responsibility for helping employees cope with some pervasive and delicate problems: mental distress, alcoholism and other drug dependencies, marital and financial difficulties—in short, the whole host of personal and family troubles endemic to the human condition.

Astute "helping professionals" and social service agencies have responded; many are offering their services to the vast industrial markets, while consultants are persuading community hospitals to convert their underused beds—for example, in obstetrical wards affected by the declining birthrate—into alcohol treatment units chiefly for privately insured employee populations. As one personnel vice president recently remarked, "You know there's something going on when you start to get more calls from the promoters of new panaceas to reduce worker stress, control alcohol misuse, counsel troubled employees, and foster 'high-level wellness' than you get from the executive search firms."

What is the significance of these changes? For one thing, it marks a propitious time to take a critical look at employee assistance programs. Are they, as some enthusiasts seem to imply, in a class with double entry bookkeeping, an innovation no company can long afford to ignore? Or are they simply a nice employee benefit to offer should a company be so inclined, but not on everyone's list of priorities? These questions elude straightforward answers, but others are somewhat more tractable. How prevalent and costly to remedy are the problems addressed by these company-sponsored initiatives? How satisfactory are the initiatives relative to available alternatives? And what, precisely, do the initiatives involve? To none of these questions is there currently a simple definitive answer. But the field has expanded to the extent that it is possible to point out some guideposts for

exploring the terrain (Trice and Roman, 1972; Schramm, 1977a; Williams and Moffat, 1975; Schramm et al., 1978; Heyman, 1978).

What Is Employee Assistance?

The widely, though not universally, accepted term for workplace-centered efforts to help employees with personal troubles is "employee assistance program," or EAP. As a generic entity, an EAP can be defined as a set of company policies and procedures for identifying, or responding to, personal or emotional problems of employees which interfere, directly or indirectly, with job performance. The program provides information and/or referrals to appropriate counseling, treatment, and support services, for which the company may pay in whole or in part.

Reading between the lines of this definition, one can see the wide berth for variation from one program to the next. Programs vary in their mission and in many aspects of their operations, such as:

- the formality of their policies and procedures, the level in the corporation from which the policy has emanated, and the vehicle through which it has been communicated;
- the organizational locus of the program (medical, personnel, or elsewhere), and the extent of its diffusion throughout the company;
- the process by which troubled employees find their way into the program, especially the interplay between formal referrals through management or labor channels on the one hand, and voluntary seeking of help on the other;
- the extent to which job performance is stressed as the justification for formal referrals to the program, and the ways in which performance is defined and documented;
- the sorts of problems the program tends to address;
- the use of outside treatment agencies and individual providers of care;
- the nature of the outside referral process and the extent of follow-up, of ongoing support to the troubled employee and his or her family, and of efforts to ease the recovering employee's reentry into the workplace;

- the staffing of the program, as to numbers, locations, and types of professional or nonprofessional personnel;
- the financial arrangements, and the amount of attention paid to efficiency and cost-effectiveness.

This diversity notwithstanding, certain features of an EAP have come to be considered fundamental (Figure 1).

The History of Employee Assistance

The concept of employee assistance extends back at least a half century to the early efforts of some companies to coax degenerating alcoholic employees into Alcoholics Anonymous (AA). While many of the newer programs—and an occasional early one (Trice and Schonbrunn, 1981)—have from the outset defined their missions in broader terms, others evolve first through an alcohol-oriented beginning stage. An understanding of these origins is indispensible to an appreciation of the dynamics of the modern programs—whether limited to alcohol or broader in scope—and the issues they face.

In the case of alcohol misuse, the therapeutic imperatives coincide with the managerial exigencies of the work place. Denial of a drinking problem is considered one of the most serious barriers to successful treatment; AA and other treatment agencies long ago concluded that an essential precursor to effective therapy is an admission of the problem by the alcoholic. The work place is viewed as an ideal place to force this self-confrontation because, it is argued, telltale symptoms like lateness and absenteeism will surface early; moreover, the threat of losing a job is a potent stimulus to seeking out needed help. The job's importance is linked to the practical necessity of a paycheck to buy more liquor, or to more subtle psychosocial mechanisms. There is good evidence that alcoholics who still have some social stability—a job, a family, a home—are better candidates for treatment than those whose addiction has progressed to the point where they have nothing further to lose. Whatever else the job may be, it is viewed as one factor, which the effective alcoholism counselor can use to maneuver the recalcitrant alcoholic into treatment.

This tough-minded but basically humanitarian rationale for active intervention into the employee's personal affairs corresponds with the

ASSUMPTIONS

1. Problem identification through supervisor because of impaired job performance.
2. Alcoholism recognized as a treatable medical problem.
3. Disciplinary procedures suspended temporarily while employee enrolled in assistance program.
4. Improved job performance the principal criterion for judging success.

COMPONENTS

1. Written policy and procedures.
2. Labor and management cooperate in program development and operation.
3. Program personnel refer employees to mental health counselors for diagnostic judgment.
4. Supervisors and shop stewards become oriented to their responsibilities.
5. Program information is conveyed to the work force.
6. Health insurance is extended to cover treatment.
7. Total confidentiality is assured.

FIG. 1. Employee assistance programs: an overview

employer's legitimate interest in on-the-job behavior. If an alcoholic employee is habitually absent on Mondays or drunk on the job, or if his or her work suffers noticeably as a consequence of drinking, few would fault the employer for documenting the pattern of behavior and insisting that the employee act to correct the situation or expect to be fired. In fact, unions have sponsored or endorsed alcoholism programs for the very reason that their leaders grew tired of having repeatedly to plead with management for an alcoholic member's job. Some have taken the initiative or collaborated with the company in setting up joint labor-management alcohol programs. It has even been argued that the structure and procedures of EAPs so closely mirror the stages of discipline required before labor arbitrators will approve an employee's dismissal that this may be the true reason for the spread

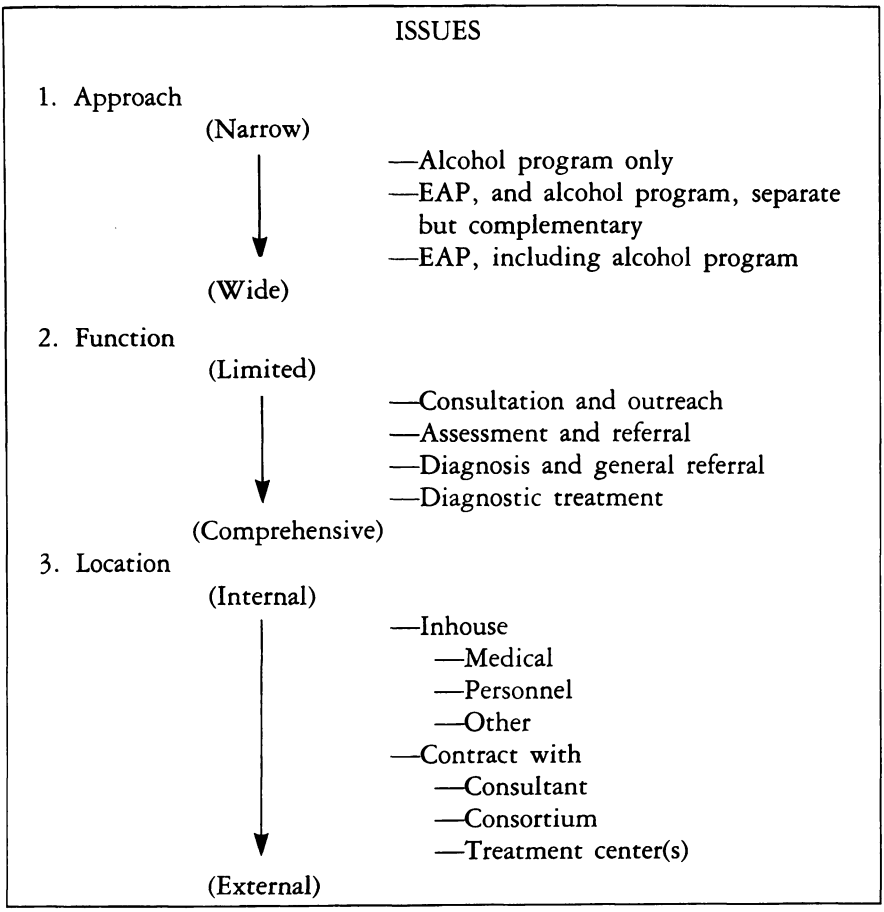

FIG. 1 Continued

Source: Adapted from U.S. Department of Health and Human Services, *Fourth Special Report to the U.S. Congress on Alcohol and Health* (Washington, D.C.: U.S. Government Printing Office, 1981), p. 125.

of EAPs (Shain and Groeneveld, 1980). This hypothesis fails to account for the widespread provision by EAPs for nonunion employees, constituting nearly three-quarters of the American work force.

The genesis of EAPs is actually complex and varied. They grew naturally out of a tradition of hand-holding in the personnel department, informal counseling (often by nurses) in the medical department, and trouble-shooting by unions. Organized EAPs were thus not a new departure but a formalization of an old tradition, and an introduction of specifically trained personnel. Alcoholism was the first focus of these more highly structured efforts, which, in the 1960s, recognized a growing national drug problem by broadening to sub-

sume general substance abuse. It was then discovered that substance abuse difficulties often were rooted in psychosocial and community problems and intertwined with pathologies in family and home life. Thus a broadening of concern developed that included spouses and dependents; during this period Al-Anon and Alateen were for the same reasons founded by Alcoholics Anonymous. Another factor, important because of its timing, was the effective pressure on corporations during the 1960s to hire the hard-core unemployed, a challenge they could not meet without undertaking complex psychosocial supports to facilitate the transition into the work force of people who had been grievously disadvantaged. The final major event in this evolvement was growing interest in the correlations between social stress and coronary heart disease, stimulated by some groundbreaking epidemiological studies (Jenkins, 1971). These public health findings complemented extensive sociological research on organizational stress within work settings (Kahn et al., 1964; Wilinsky and Wilinsky, 1951), and served as the framework for a new phalanx of professionals who set out to improve the quality—or at least mitigate the stresses—of working life in corporate America.

In the course of this evolution, occupational alcoholism programs have fashioned what amounts to a detailed managerial policy for dealing fairly but firmly with alcohol-dependent employees whose job performance has slipped below tolerable levels. The cornerstone of the policy was, and is, a procedure that complements AA and is known as "constructive confrontation" (Trice and Roman, 1972). It places the company—through the supervisor and/or occupational program coordinator, often himself a "recovering alcoholic" and AA stalwart—in the disciplinary role of telling the alcoholic employee to shape up (i.e., to accept treatment and cooperate in a recovery plan) or face dismissal. This leaves to AA the role it plays best: providing ongoing support and inspiration without being coercive or judgmental.

Confrontation is a two-stage process, beginning with the immediate supervisor whose responsibility it is to recognize and confront the employee's declining job performance. In the second stage the organized program confronts and names the personal problem. In the early days it was not uncommon for the program coordinator to take over and become immersed totally for a time in the problem-drinker's life—answering telephone calls in the middle of the night, driving the employee to a detoxification center or rehabilitation facility, being an escort to AA meetings, cajoling him or her either to stay with

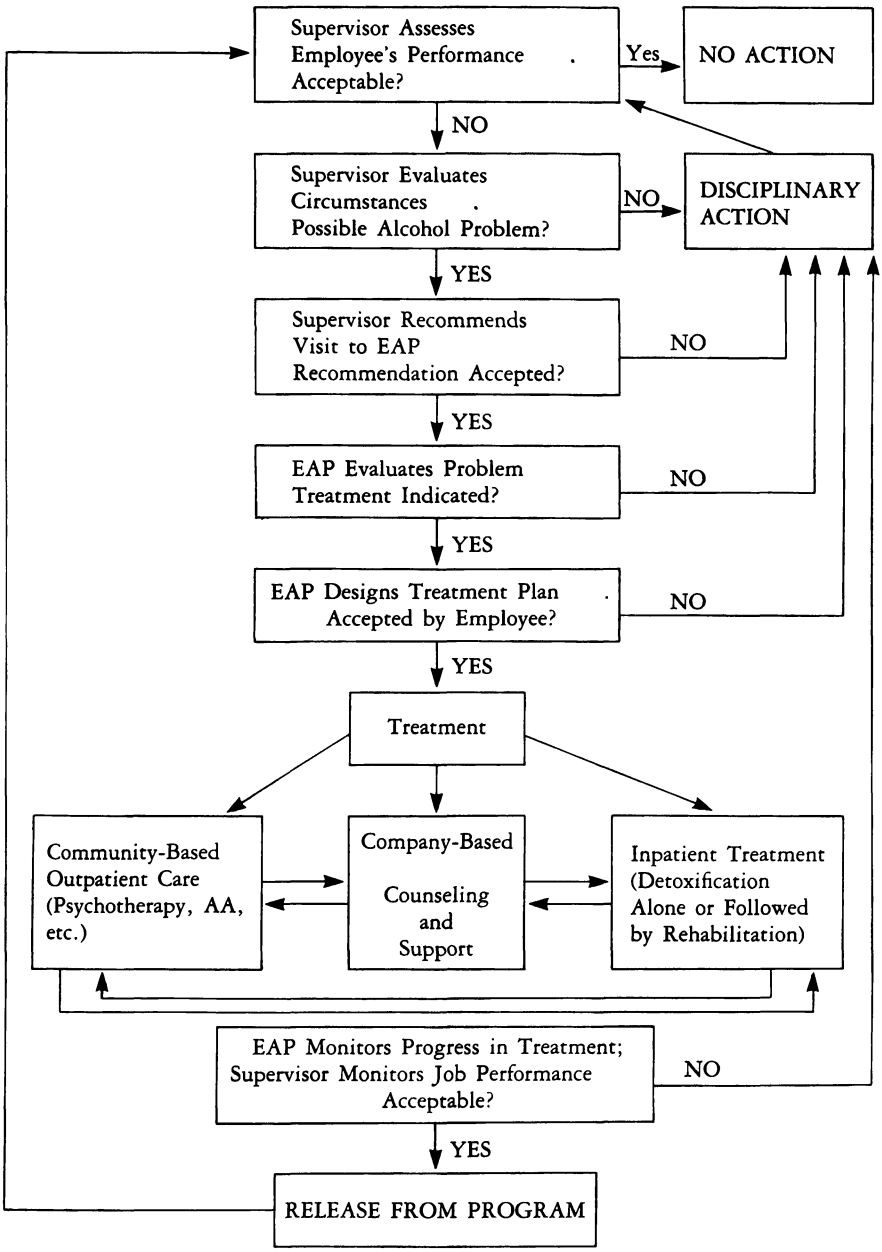

FIG. 2. Occupational alcoholism programs major decision points

the program or look elsewhere for work. This role is prescribed in the AA canon as "twelfth step work," an obligation in the final stages of recovery to help other alcoholics. As client loads have increased and programs expanded, the counseling and administrative duties have become more complex and companies have tended to hire profession-

ally trained counselors to manage their EAPs. The free-wheeling pioneering twelfth-steppers are a vanishing species.

Limitations of the Job-Performance Criterion

The flow diagram (Figure 2) of an occupational alcoholism program shows the major checkpoints through which problem drinkers may pass.

In this scheme, deteriorating job performance provided a theoretical and moral rationale for intervention and the sole criterion for referral to the program. With its dual justification on both treatment and managerial grounds, the system was logically tight. In referring an employee whose drinking was causing concrete performance problems to the in-house program, the supervisor knew how unsatisfactory the alternatives were—either outright dismissal, possibly followed by grievances, arbitration, and temporary reinstatement, or grudgingly tolerated disruptive behavior and case-by-case muddling through. The program represented a rare opportunity to help the needy individual while attending to the organization's needs. All of this remains true, but the job-performance criterion, paradoxically, has provided both too coarse and too fine a sieve.

First of all, it soon became clear that social problems unrelated to alcohol were implicated in a variety of job performance problems. But expanding the scope of the program to encompass other problems (like marital discord) removes the therapeutic rationale for the company's intervention and raises the spectre of paternalism or social engineering. In this sense job performance is too efficient a sieve; it traps a wide range of problems only some of which the company may have envisaged itself confronting head-on.

Meanwhile, it misses many genuinely alcoholic employees whose performance has yet to decline sufficiently to raise a red flag. In rapidly growing companies, and/or those with highly educated work forces, documentation of attendance (a convenient proxy for performance) can be an informal affair. Those exempt employees whose autonomy insulates them from visibility are less likely than are nonexempt ones to enter an organized program through a job-performance door, and job-based programs are generally felt to have fallen short of the need for reaching executive and professional-level problem drinkers.

By stepping forward to seek his employer's help, an aspiring manager who has been successfully hiding a drinking problem (or an emotional disturbance) takes a clear risk—not the immediate risk of losing his job, but a more subtle gamble with lifetime career goals. And that risk is as real as the two opposing stereotypes are pervasive: that managers, by definition, control situations; and that alcoholics (or emotionally troubled people), by definition, do not. One of the messages that good EAPs seek to convey, by work and by deed, is that the company does not discriminate against people who have sought professional help with problems of an emotional or psychological sort.

Most organized EAPs have originated with the performance problems of hourly employees. But even the most bureaucratic companies have found that performance is seldom unmistakably affected by alcoholism until the disease has become quite far advanced, perhaps already having damaged the employee's health and wreaked havoc in the family. And the research literature on occupational alcoholism programs is suprisingly bereft of data on correlations between alcohol and work performance, either before or after an intervention to stem a drinking problem. Despite its pivotal place in the employee assistance philosophy, then, work performance seems on close scrutiny to serve functions more ideological than practical. Certainly it fails as the tracer needed to accomplish early identification or primary prevention of problems related to alcohol. Yet employers have been understandably reluctant to stray too far from the work-performance criterion, without which they have felt on shaky ground, philosophically, legally, and in the eyes of labor arbitrators.

On the Wagon? Or the Bandwagon? Alcohol Only vs. EAP

The clear benefits and equally clear pitfalls of a program built on referrals from supervisors, after careful documentation of declining performance, has spawned diverse programs. Some companies, such as J.C. Penney and several of the Bell System subsidiaries, take a strict constructionist approach and focus as sharply as possible on alcohol and substance abuse. But many others have moved to a broader-gauge approach, for reasons enumerated by Leo Perlis, of the AFL-

CIO: "In the first place, incipient alcoholics do not always perform poorly. In the second place, even hardened drunkards have been known to perform well for a time. In the third place, it is important to reach all problem drinkers, including those who work well . . . finally, problem drinkers may not be the only ones to perform poorly. There are also problem gamblers, problem consumers, problem husbands, and problem people generally" (Perlis, 1977).

The employee assistance trend recognizes these more general needs. Companies like Equitable Life, Control Data, Citibank, Xerox, Polaroid, Continental Illinois Bank, Digital Equipment Corporation, Metropolitan Life, and many others have diversified to offer assistance with a full spectrum of less-overt but presumably also disruptive problems. As is characteristic of diversifications, this one both strengthens and strains the mission and organizational structure of the host entity, here the established alcohol program and the emerging field of alcohol programming in industry. In particular, the expanded approach challenges the alcohol programs' basic underlying rationale of intervention triggered by declining job performance.

If diversification beyond substance abuse was in fact a natural evolution, it was accelerated by the federal government's enactment in 1970 of the Hughes Act which created the National Institute of Alcohol Abuse and Alcoholism (NIAAA). Among many activities, the NIAAA has funded an occupational programs branch, which has tended to support an expanded sociocultural model in preference to the established medical one. As a practical matter, this means an emphasis on diversified employee assistance rather than alcoholism alone. Scholars debate the motivation behind this policy shift, and there is some dissent as to how decisive it is. Paul Roman and Harrison Trice, two well-known researchers in the field, have inferred in the EAP emphasis an attempt on the part of NIAAA to blunt the stigma attached not only to alcohol treatment but also to the traditional alcoholism specialist laboring under a "do-gooder" image. They posit that by redefining alcoholism as part of employee assistance within the personnel department's functional domain, the government may hope to move it under a broader, more ambiguous, and less stigmatized umbrella, and simultaneously, to upgrade the counselor's role by prying it loose from the medical department where nonphysician program coordinators might be given short shrift (Roman and Trice, 1976).

The projected reorientation toward broad-gauged employee assistance is indeed underway, but the issue of program placement is far from being resolved. For example, the U.S. Department of Health and Human Services (1981) observed in a special report to Congress that "there continues to be a move away from placing programs in personnel departments, and toward placing them in medical settings, though personnel areas remain the predominant program location." This finding seems at odds with the hypothesized drift away from a medical orientation. Indeed Roman (1981) sees movement in exactly the opposite direction—away from medical departments and into personnel. Medical departments are in many cases themselves part of personnel, so these may be artificial distinctions, although they do engender turf wars in some corporations. Occupational health nurses, for example, have long served an important latent function as a sympathetic ear for workers in distress. And yet very few companies have recognized and legitimized this role in training or continuing education programs and fewer still have structured their EAPs to strengthen and draw on this established resource.

In some settings, program people contend that confidentiality can more fully and more convincingly be respected within a medical department, where records are protected by professional codes of ethics, while in others, it is asserted that EAP personnel are professionals in their own right, with their own ethical precepts and protections. Locating an EAP outside of the medical sphere *in order* to preserve confidentiality implies an invidious comparison between counseling and medical programs which rankles occupational medicine, a specialty that has for years grappled with issues of confidentiality in a structural situation that potentially divides the physician's loyalty between an employer and a patient who is also a fellow employee (Halberstam, 1974; Roberts, 1978). In the 1940s and 1950s, it was occupational medicine that took the lead in developing company policies to help problem-drinking employees (Roman, 1981). But the AA-based rehabilitation programs are widely thought to have picked up a hot potato that the general medical profession had dropped.

These interprofessional waters were further muddied in 1980 when the Occupational Safety and Health Administration (OSHA) promulgated a new rule assuring employees or their designees access to their medical records, with the exception of those kept by employee assistance programs *if* "the records of those programs are maintained

apart from the employer's medical program and its records" (U.S. Department of Labor, 1980:35,265). Intentionally or not, this distinction appears to give official OSHA sanction to the invidious comparison between medical and counseling programs in industry, setting up a structure to perpetuate it. Quite apart from this problem, the access rule is a target of the current administration's regulatory revisionists, who have yet to make public reference to the employee assistance issues embedded in the larger controversy concerning employers' handling of all medical data (Lubin, 1982).

In or out of medical departments, the well-run employee assistance programs are explicit and punctilious about maintaining confidentiality and trust. Program administrators say they must have the affected employee's express (preferably written) authorization before sharing with supervisors or other third parties any information beyond the simple fact that he or she is cooperating with the program. Some worry about the element of coercion that can enter into the request for permission to reveal a confidence when jobs are at stake, and the majority seem to spend a sizeable portion of their time formally and informally educating supervisors and managers in basic ground rules preserving privacy and confidentiality.

A few medical departments are able even to mask the fact that the employee is being counseled; they counter the supervisor's "need to know" with the more ambiguous fact that the employee in question is cooperating with the medical department's recommendations. This has become a strong argument for housing employee assistance programs in medical departments; another is their ability to rule out organic disorders before channeling an employee into counseling. It also seems that executives with drinking problems are more likely to confide in a corporate physician than to throw in their lot with an organized company program. The physician is closer to being a social peer and the exchange can be handled with the utmost discretion.

In-House Programs or Outside Contracting?

Professionals are expected to bring their norms and standards of conduct into an employing organization, but an alternative approach to

problems of conflict and credibility is to rely on outside contractors for counseling services, as some companies have done individually and in consortium (Erfurt and Foote, 1977). This is the program location issue writ large—not where the program belongs inside the organization, but whether it belongs inside at all. Outside contracting effectively avoids the conflict that can arise when alcoholism treatment and other forms of therapy are offered at the place of employment.

For obvious reasons, the outside-contracting approach works best in cities rich with therapeutic resources. Large, widely dispersed corporations cannot always count on finding adequate coverage. General Mills, for example, reported good success through contracts with agencies in the Minneapolis area (known for the excellence of its alcohol treatment programs), but some difficulty in extending the model to smaller communities lacking comparable resources. Xerox has recently contracted nationally with the Family Service Association of America to solve the problem of equal access for a far-flung employee population. IBM, too, in its new "Plan for Life" program, places a high premium on even-handed treatment of its 200,000 domestic employees and on using existing community resources. Control Data Corporation, by contrast, has recently begun to market to other employers a telephone hotline, "EAR" (Employee Assistance Resource), originally developed in-house. And United Technologies Corporation has established for its alcoholic employees a day-treatment center in a quiet New Britain, Connecticut, neighborhood.

In two-thirds of the 68 programs surveyed in 1977 by the Washington Business Group on Health (Kiefhaber and Goldbeck, 1980), counseling was provided at the work place and exclusively during working hours. The in-house versus contract decision hinges on several factors. Some companies prefer to "keep their flexibility" by "buying the needed expertise" rather than assume the fixed costs attached to permanent staff, who usually lack clear career pathways in the company and thus pose a management problem. Also, company-employed counselors may be harder pressed to protect privacy, not because they will betray to management the confidences of their clients (professionals who understand the occupational setting may actually have better defenses against curiosity and pressure from the organization than will outside counselors who deal only sporadically with corporations), but for the simple reason that employees' coworkers may be in a position to see them using the services.

Outside contracting has the ancillary advantage that it forces consideration of another vital issue: the coordination of direct services with insured benefits. This need was first overtly recognized when it became clear that some alcoholic employees would require hospital detoxification or a period of residential treatment, services they could not afford without insurance coverage and income-replacement guarantees. If alcoholism really is a disease, as nearly every company policy states, one can even argue that "treatment failures" ought to qualify for long-term disability insurance. Instead, the commonly accepted disciplinary dismissal reflects society's general ambivalence toward the "disease" of "alcohol abuse." Often this important problem is said to figure prominently in early managerial deliberations about alcohol programs; data, however, are lacking on the range of company practices with respect to disability coverage for alcohol-related disease. Another inconsistency that reflects the same ambivalence is a requirement, in the government-mandated policies of some companies, to provide "reasonable accommodations" for the handicapped. An employee may step forward and "self-identify" a handicapping alcohol dependency, whereupon he or she would be required to undergo treatment. If a "self-identified" handicap were, by contrast, surgically correctable, the company would make accommodations without requiring or even presuming to suggest that the employee have the condition corrected.

What Direction Next?

Although there has been a progressive diversification of EAPs, striking differences remain in the distributions of diagnoses among programs. For example, in case studies accompanying the Washington Business Group on Health Survey, Firestone reported that just under 2 percent of its program's clients suffered from emotional distress, and 45 percent from alcoholism, while Continental Bank listed emotional distress as the most common problem, with alcoholism accounting for less than 6 percent of its cases. Work forces do differ, but probably not that dramatically. Alcohol problems are commonly believed to beset 5 to 10 percent of the working population, a prevalence estimate that amounts to an educated guess unsubstantiated by solid epidemiological data.

Work forces, too, are changing, individually and in aggregate, and these tides can destabilize an EAP. A younger employee population, for example, may bring poly-drug dependencies into the work place. One more heavily weighted toward females may need help with parenting issues, or an older one, with the multiple stresses of aging. Practitioners sense a general drift in the overall working population away from the stigma that discouraged seeking help. "It's a different breed of cat," one program director observes. "We used to have to drag them in by the scruff of the neck. Now they come in and say 'I hurt; fix me.' And I say to myself, wait a minute, aren't we supposed to fight a while first?" Consequently, he added, many do not need the intensive treatment appropriate for "a person who has been drinking alcoholically for years." A small dose of "coping skills" and a few social supports are often considered sufficient for this new breed of client.

Much of the variation in program statistics may be an artifact: programs find the problems they define as within their legitimate scope. This observation permits two alternative interpretations. It could signify a wide and deep pool of unmet needs, which some companies are recognizing at one point, and some at another. Or it may indicate a demand-pull phenomenon, where the very existence of a service creates the perception that it is needed.

Whatever the extent of employee distress, and the realities of provider-stimulated demand, management remains quite free to choose whether, why, and how aggressively it will address the unmet need it divines in its own work force. Other than general concerns about the cost of the health benefit package and specific laws in some states mandating that it cover certain psychiatric services, companies are experiencing few external pressures to enlarge their efforts in this sphere. In this light, one ought not to misinterpret the newest developments or overestimate their portent. Many firms remain satisfied with no program at all or with the original model of supervisor-coaxed assistance for highly disruptive problems. Seldom, if ever, has the rise in voluntary referrals that tends to accompany the modern EAP caused the complete obsolescence of formal supervisory referral. In companies where self-instigated, insight-oriented counseling has been allowed or encouraged to grow, it has usually done so alongside the older, behaviorally triggered performance-focused model.

An even bolder and still theoretically contiguous extension of the

original concept of helping troubled employees is to adopt a public health stance, and look for disease agents in the work place. The mental health field lacks an equivalent to the elegant public health gesture symbolized by Sir John Snow's removal of the pump handle on the cholera-infected well in nineteenth-century London. But the psychologist employed by one Midwestern bank talks of using EAP data as a barometer to identify stress-engendering units of the firm, and Leon Warshaw, an industrial physician well known for his writings on occupational stress, describes an "organizational program" as one with sensors for causes of stress within the work setting (Warshaw, 1979). Since stress can be a creative as well as a destructive force, the critical unanswered question is how to preserve the creative aspects but prevent the harm that studies have repeatedly associated with overloaded, underloaded, alienating, or dehumanizing jobs (Kahn et al., 1964; Hingson et al., 1981).

Aside from the public health questions, the old and new approaches may be two ends of a spectrum; they are certainly not distinctly different entities. Both are, at their core, managerial solutions to related managerial dilemmas, and both find management support in the pragmatic but largely impressionistic feeling that they seem to make the organization function more smoothly.

The Issue of Cost-Effectiveness

Few companies have conducted extensive evaluations of their programs, nor is there much inclination to invest in experimentation. Outside researchers rarely acquire the access to company records and personnel they would need to design and execute adequately controlled studies. Managers generally feel that the benefits from EAPs are difficult to measure in tangible terms; reduced disruption to the system and improved productivity are real but often subjectively perceived benefits. They seem sanguine, even enthusiastic, about their investments in these programs, but lack empirical evidence to support their intuition. Recently, though, more attention has been directed at the issue of cost-benefit; some favorable but still scientifically shaky evidence has begun to accumulate:

- New York Telephone reported in 1980 that the company's alcohol treatment program has averaged 300 new cases annually for the

past 7 years and has saved the company $1,565,700, assuming a rehabilitation rate of 85 percent (or 225 employees per year) and an average, for late-stage alcoholism, of 60 days absence and $2,000 in treatment costs. To its stress management (meditation) program, assuming that 200 afflicted employees will each annually experience a 10 percent decrease in absences, the company attributed $267,930 in yearly savings, not to mention significant reductions in self-reported symptoms such as hostility, depression, and psychosomatic sequelae of stress (Wood, 1980).

- Kennecott Copper has estimated a 6 to 1 benefit-to-cost ratio per year for its "Insight" psychotherapy program. Kennecott's studies of 150 men who spent 12.7 months in Insight indicated, after therapy, a 52 percent attendance improvement, a 75 percent decrease in weekly indemnity insurance costs, and a 55 percent decrease in medical-surgical costs (Jones, 1977).
- A study of alcohol problems in 7 railroad companies, based on numerous interviews with supervisors and workers, generated the following "conservative estimates" of the company-incurred costs of the problem drinking of 28,000 employees: absenteeism—$3.1 million, assuming 5.2 extra days of absence per year for the 8,670 employees for whom adequate attendance records were available, and an average annual salary of $18,000; lost productivity—$25 to $100.9 million, assuming a 20 percent decline in productivity for alcoholic employees and an average salary, again, of $18,000; injuries—$583,000, assuming that 4 percent of all recorded injuries were alcohol-related; accidents and damage—$650,000, based on the observations and estimates of workers and supervisors interviewed; employee assistance programs—$1 million in operating costs; grievance process—$408,000 in manhours and processing costs. The grand total was estimated at from $33.9 to $108.9 million, or almost $500 per employee. The railroads' employee assistance programs were said to have rehabilitated over 1,100 problem drinkers in 1978, at a cost per rehabilitated worker of $840. This led to the conclusion that "it costs more to dismiss a problem drinker than it does to rehabilitate him" (Mannello, 1979).
- As a follow-up to a 1970 report on 20 years' experience with an alcohol rehabilitation program at Illinois Bell Telephone Company, Drs. Asma, Hilker, and their colleagues published a study documenting the experience of 752 new clients treated between

1969 and 1978. These researchers tracked absences for the 5 years before and after treatment and estimated that the intervention had saved 31,806 days lost from work. At an average wage replacement rate of $40 per day, this represented gross savings to the company of $1,272,240 just in absences averted. The significance of these results for employees, their families, and the company transcends the cost impact according to the authors, and helps to explain the progression of the program from its marginal status in 1950 to its current place as "an integral part of managing the business" (Asma et al., 1980).

- Dr. Carl Schramm studied a multiple-employer labor-management outpatient program in Baltimore, established in 1972 by Johns Hopkins in conjunction with the U.S. Department of Labor. He contrasted treatment costs (labor-management services) with the value of improved work attendance in the year immediately preceding, and the one just following, the treatment. Prior to treatment, 206 referred problem drinkers (from a combined three-company work force of 134,000) tallied absenteeism as much as 8 times the normal rate. Using an estimated cost of $1,300 per capita for 90 days of treatment, Schramm found negative cost-benefit ratios in the first year after referral, but a net positive impact during the second year on the costs of all three companies. This turnabout reflected the accumulated effect over time of the improved attendance records of the 206 treated employees. Schramm labeled the finding conservative inasmuch as it ignores difficult-to-measure but nonetheless probably real benefits other than improved attendance—reduced employer costs related to employee turnover, medical care, on-the-job accidents, morale problems, grievance hearings, and labor arbitration (Schramm, 1977b).

Provocative though they are, these assessments lack adequate controls to permit valid causal inferences and leave unresolved the researcher's nightmare of selection bias and the effects of secular events. What would have happened, for instance, to the treated employees with the passage of time had they been left to their own devices? "Spontaneous remission" is a clearly documented phenomenon in the alcohol-treatment field, although its extent remains unclear (Polich, 1980). And any cost-benefit analysis is only as strong as its weakest

assumption, in this case the operational definitions it uses of a program's true costs on the debit side of the ledger, and its outcomes or benefits on the credit side (Foote and Erfurt, 1981; Foote et al., 1978). The preponderance of cost-benefit estimates in the alcohol sphere reflects the current reality that alcohol treatment is the workhorse of efforts to justify employee assistance on the basis of cost savings. This has occurred chiefly because the financial and social costs of alcoholism are more concrete and quantifiable than are the costs of other problems to which EAPs address themselves. However concrete, these favorable return-on-investment ratios still involve modest outlays when measured against the size of a typical company's total outlay for health-related services. But if an EAP is benefitting 10 to 15 percent of the work force and at the same time paying for itself, it may be somewhat akin to double entry bookkeeping, a management device fully capable of doing the basics well. Should more be expected of it? Perhaps so.

A Wider Perspective on Potential Cost Savings

Were companies to conceive the matter of mental health care from the perspective not only of an employer (concerned with productivity) but also of a payer for the bulk of health care for employees and their dependents (Walsh and Egdahl, 1977), can a convincing case be made that substantial savings could be achieved by a well-designed provision for help with the problems and crises of living?

Alcohol misuse by some 10,000,000 problem drinkers in America is estimated to cost the nation roughly $40 billion annually (President's Commission on Mental Health, 1978), and it is well known that excessive drinking has potentially devastating effects on the body systems that receive, distribute, and eliminate ethyl alcohol. The additional targets of broadened EAPs also exact a heavy toll. For example, it was also estimated in 1978 that at any time 25 percent of the total population suffers from mild to moderate depression, anxiety, and other forms of mental distress, and that 10 to 15 percent actually need treatment (President's Commission on Mental Health, 1978). A study of "high-cost users of medical care" found that 13 percent of patients together consumed as many resources as the remaining 87 percent; that the pattern of use among this 13 percent

tended toward repeated hospitalization rather than a single costly stay; and that personal habits, such as excessive use of alcohol, were implicated disproportionately in the records of the high-cost users (Zook and Moore, 1980).

Looking beyond the confines of job performance and productivity to the overall health-benefit package, we see a large and shadowy population—dependents and retirees. Direct employee assistance has until now been largely what its name implies; few companies have opened their programs to dependents and retirees.

But an adequate cost-benefit analysis should reckon with these satellite beneficiaries, who account for as much as two-thirds of a company's cost for health benefits. The health insurance coverage for which dependents and retirees are eligible does typically include some mental health services still, in the main, weighted toward inpatient care, the most acute distress, and the most expensive treatment. Coverage of outpatient care is often limited to the highest cost providers—psychiatrists—and normally includes a high deductible or coinsurance feature as deliberate disincentives to utilization.

An equally potent disincentive, advantageous to no one, is the fragmentation of the health care system. For example, an intensive 1973 investigation of the overall effort throughout the Commonwealth of Pennsylvania to treat the problem of alcoholism could locate no coherent ongoing treatment system, but found instead a disjointed aggregation of insular programs that left many communities without access to comprehensive or even minimally adequate treatment facilities (Glaser et al., 1978). There is no reason to hope for a markedly better situation in most other parts of the country.

The complexity of the fee-for-service health care marketplace has impelled some employers to look into alternatives to conventional insurance, such as HMOs with mental health components. Others are searching for further coordination of direct services with insured benefits. On this issue, Walter Wriston, chairman of Citibank, writes: "If we were simply to add the cost of mental health benefits to our already expensive health insurance plan, it might be counterproductive. In the past such add-ons have increased the demand side of the equation but supplied little evidence of the promised savings . . . [But] there is increasing evidence that it is possible to design and manage a combination of mental health programs and insured

benefits that can deliver needed care and still be cost-effective" (Wriston, 1980).

As Wriston notes, evidence can be marshaled for the case that by including mental health benefits in insurance and HMO plans the use of services in hospitals and physicians' offices can be reduced. In a comprehensive review article of 22 studies on the "Impact of Alcohol, Drug Abuse and Mental Health Treatment on Medical Care Utilization," Jones and Vischi (1979) found that all but one equated such reductions with treatment for emotional distress. The decline in use of general medical services ranged from 5 to 85 percent, with a mean of 34 percent, for mental health intervention, and from 26 to 68 percent, with a mean of 45 percent, for alcoholism programs. If these studies are indicative of the impact a well-designed EAP can have on the use of insured medical services by employees and their families, then such a program could indeed result in substantial savings.

But Wriston sounds a concurrent warning against the mistake so often made in the curious health care market, with the perverse incentives that attend physician dominance of purchasing decisions, extensive third-party financing, limited consumer information, and other structural flaws. Intended to act as cost-reducing substitutes, new innovations—in manpower, technologies, or, as here, redesigned benefit provisions—have an irritating way of adding incrementally to overall costs instead of triggering the desired substitution effect.

For EAPs to accrete material cost savings through substitution effects, they must satisfy two conditions. First, any services provided in-house at the company's expense (a form of vertical integration) have to replace, and not just augment, services employees would have used on the outside with partial or full coverage under the employee benefit plan. And the in-house services have to be at least as efficient and effective. Second, any mental health services have to replace, and not just augment, the personal health services that the "worried well" are believed to overuse in large numbers. And the mental health services have to perform this function with greater dispatch, more lasting effect, less intensively (for example by avoiding unnecessary tests and procedures), or at lower cost—in short, more efficiently—than is true of the general medical system. The evidence is simply not available yet to base that case on anything firmer than intuition and exhortation.

For EAPs to win their cost-effectiveness stripes on the battleground of organizational effectiveness and productivity, they face a different set of challenges. They have to demonstrate, in the first instance, that it is feasible for a company to provide mechanisms that will support employees who want to continue functioning in their jobs and are having trouble. This the pioneering programs are beginning to do.

For the future, while EAPs that are oriented principally toward organizational effectiveness or productivity continue to administer emotional first-aid to employees they scoop out of the rapids, they should also move upstream in search of explanations for why so many tumble in (McKinlay, 1979). This search may lead to a rethinking of the widespread assumption, derived from psychoanalytic theory, that the causes of emotional distress usually reside somewhere in the individual's personal history. Where conditions of work exacerbate or cause employee problems, even where social supports in the work place might be bolstered to buffer the stresses of everyday life, here lies the future terrain of prevention, health promotion, and enhancement of the potential of working men and women. Here, again, there is a pressing need not only for innovation and experimentation on the part of industry but for carefully controlled, objective research by qualified investigators with no vested interest in the results of their studies.

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