

# Do Employee Assistance Programs Duplicate with Services Offered Through Mental Health Benefit Plans?

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*Employers may be paying multiple premiums for identical or similar services for employees.*

**A**bout 75% of American employers offer Employee Assistance Programs (EAPs) as a prepaid benefit to help workers and their families with a variety of personal problems that may have negative effects on their job performance.<sup>1, 2, 3</sup> EAPs are now a first entry point for more than 100 million American workers seeking easy access to help and referrals for personal, family and behavioral health concerns.<sup>4, 1, 2</sup>

EAPs, which grew out of occupational alcoholism programs, once focused primarily on alcohol problems but have expanded their range to include mental health, marital, family and “work-life” issues such as financial, legal, childcare, eldercare, adoption and career

concerns.<sup>4, 5, 1</sup> The original EAPs were “internal” programs, meaning that services were provided by staff or employees of the sponsoring organization, but today, most services are provided by external outsourced vendors.<sup>1, 3, 6, 7</sup>

The EAP field has identified the skills and knowledge needed to provide EAP as “unique” from other helping professions. Many EAP practitioners have vehemently argued that EAP is distinctive from mental health services in that it is “work based,” operating on behalf of an employer for the purpose of identifying troubled employees, motivating them to resolve their difficulties, and providing interventions or referrals to treatment as indicated.

At the core of EAP is an awareness and assessment of the impact of the employee’s personal problems on job performance and occupational life. EAP practitioners, in theory, use specific EAP “core technologies” to enhance employee work

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performance. But, in practice, is EAP really that different from counseling or psychotherapy services offered through mental health benefits?

The National Business Group on Health's (NBGH) "Employer's Guide to Behavioral Health Services" states that services provided by EAPs "have become duplicative with services offered by the employer's mental health benefit plan."<sup>5</sup> The implication is that contemporary, external EAPs overlap with mental health benefits in a way that makes EAPs redundant. In other words, the boundaries between EAP intervention and outpatient mental health benefits are erased. If the NBGH observation is accurate, some employers may be paying multiple premiums for what amounts to an identical service.

The reasons underlying the NBGH claim are tied to how vendors organize and use provider networks and, more specifically, whether or how these providers apply EAP concepts with EAP cases. The bulk of EAP services are delivered via contractual networks of counseling "affiliates," which are almost always licensed as social workers, counselors, psychologists or marriage and family therapists.

These affiliates, who perform EAP work on behalf of vendors, are based in a variety of settings, such as private practices or agency- or hospital-based mental health clinics. Only a small portion of their caseload tends to be EAP work, and the majority of these affiliates perceive themselves to be "general practitioners" in counseling or psychotherapy as opposed to "EAP practitioners." Until recently, NBGH's claim of redundancy has not been empirically examined.

## Method

A one-time survey with 34 questions was created by experts in EAP drawn from the editorial board of the *Journal of Workplace Behavioral Health*. The survey was deployed in the fall of 2007 over the Internet in a Web-based format—an excellent alternative to the traditional mail-out technique for several reasons, including convenience, rapid data collection, cost-effectiveness, ease of follow up and ample time to complete.

A working population of 3,000 EAP affiliates, which appears to be a microcosm of the general population, was drawn with permission from "emindhealth" (EMH), a provider of behavioral health managed network services. In essence,

EMH leases behavioral health provider networks to vendors and also supplies the back-office support necessary to manage provider relationships. EMH provides network-related operations to EAP and MBH vendors on an outsourced basis that includes EAP-affiliate recruitment, credentialing and referral or reimbursement processing.

At random, 400 potential respondents were selected from the sampling frame of 3,000. Out of the 400, 222 surveys were completed and returned resulting in a *SE* of 3.5% and a response rate of 55%. The McNemar nonparametric test was used in the analysis since the same respondent compared general practice cases with EAP cases. Open-ended questions were analyzed through a process of content analysis and theme identification. Major threats to validity included the potential for desirability, unavailable information leading to "guessing," memory problems, and no direct, naturalistic observations.

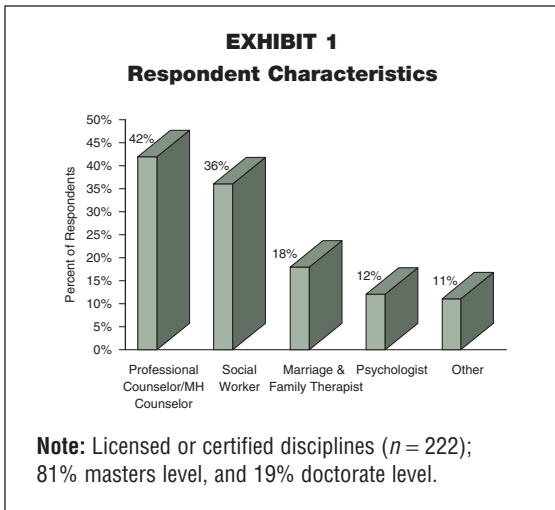
## Respondent Characteristics

This section begins with a description of respondent characteristics followed by findings and concluding remarks related to the primary research question of how EAP intervention, as practiced by affiliates, overlaps or duplicates with general practice counseling or psychotherapy.

The survey asked respondents about their highest educational levels, the discipline under which they were licensed or certified, and their professional identities. Licensing, certification, and educational level are the mechanisms used by EAP vendors to assure their client organizations (and clients) that practitioners enrolled in their affiliate networks are competent to deliver EAP services, and therefore, these characteristics are germane.

Of the respondents, 81% were practitioners with a master's degree, and 19% held doctoral degrees. Clearly, master's-trained practitioners provided the bulk of EAP-affiliate work. This supports the notion that master's-trained individuals are seen as cost-efficient competition to the doctoral-level clinician, especially in the absence of convincing evidence of differences in outcomes as a function of degree level.

Although the respondents' exact academic disciplines were unknown, 43% were licensed or certified as "counselors" or "mental health counselors." The advent of licensure under a counseling title in most states over the past



decade for graduates with a master's in clinical or counseling psychology, mental health counseling or counselor education has created a new supply of licensed professionals doing EAP-affiliate work. Social work, with the licensed Master of Social Work, is the most common academic discipline represented at 36% in EAP-affiliate work.

At 18%, marriage and family therapy (or marriage, family, child counseling in some states) is the third highest category under which respondents are licensed or certified. Similar to "licensed counselor," licensed marriage and family therapists may have varied academic backgrounds in disciplines other than marriage and family therapy, such as social work or family psychology. Psychologists, who have a doctoral-level standard to qualify for practice, represent 12% of respondents. Exhibit 1 shows the percentage of licensed or certified disciplines within the sample.

In terms of self-perception, 76% of respondents reported seeing themselves as "general practitioners" in counseling or psychotherapy as opposed to "specialists" or "EAP professionals." Thus, the vast majority of practitioners doing EAP work perceive themselves as resembling the "family practitioner" or "general internist" in medicine who diagnoses a broad range of medical issues, treats "garden variety" or typical problems, and refers to specialists for particular disease states or disorders requiring specialized expertise.

The term *specialist* implies more training, experience and perhaps compensation in a more narrow area, such as child and adolescent therapy. The primary identity of "general practitioner" among respondents suggests that they believe

their training is broad enough to handle usual or typical cases with enough knowledge to know when to refer to a specialist for particular problems or disorders, populations, delivery settings and intervention techniques.

If an EAP is in fact a distinguishing area of competence within a practice, and most respondents doing EAP work do not identify themselves as EAP practitioners, then the EAP field needs to grapple with an important question: Are general practice competencies, rather than distinctive EAP competencies, acceptable as the prime service orientation in EAP work?

### EAP Overlap With General practice Counseling

Respondents were asked to rate their degree of familiarity with the EAP core technology, or the essential components that distinguish EAP as originally formed by Roman and Blum (see Exhibit 2).<sup>8</sup> In response, 37% reported "not at all," and 26% reported "a little familiar." Therefore, 63% of respondents have little or no familiarity with the core technology. Of the remainder, 19% indicated they had "some knowledge," and 18% indicated "very familiar" (See Exhibit 2 for the Essential Components of EAP Core Technology).

Of course, it is difficult to adhere to the tenets of EAP work when the practitioner is unfamiliar with the key concepts and cannot consciously articulate how they are applied in practice. Although respondents do seem to assess the effects of personal problems on job performance among EAP cases at a high rate, and a majority get the "gist" of EAP, they also lack awareness of the seven essential components that constitute EAP practice, or the core technology.

When asked if EAP clients were treated the same or differently from other (non-EAP) clients, 28% said "completely the same," and 46% stated "more or less the same" (see Exhibit 4). A combined 74% indicated that EAP clients were, for the most part, treated pretty much the same as non-EAP clients. The remaining respondents endorsed "moderately differently" (25%) and "very differently" (2%). When there is uncertainty regarding the components that are supposed to make EAP counseling different, then practitioners will likely rely on the same approach, regardless of the means by which clients come into services.

This is a logical stance given that general practice counselors or therapists may deal with a

**EXHIBIT 2**  
**The Seven Essential Components That Make Up the Unique Approach to EAP Practice Referred to as the “Core Technology”**

- 1. Consultation with, training of, and assistance to work-organization leadership seeking to manage the troubled employee, enhance the work environment, and improve employee job performance; and outreach to and education of employees and their family members about the availability of EAP services.**
- 2. Confidential and timely problem identification and assessment services for employee clients with personal concerns that may affect job performance.**
- 3. Use of constructive confrontation, motivation, and short-term intervention with employee clients to address problems that affect job performance.**
- 4. Referral of employee clients for diagnosis, treatment, and assistance, plus case monitoring and follow-up services.**
- 5. Consultation with work organizations in establishing and maintaining effective relations with treatment and other service providers and in managing provider contracts.**
- 6. Consultation to work organizations to encourage availability of and employee access to health benefits covering medical and behavioral problems, including, but not limited to, alcoholism, drug abuse, and mental and emotional disorders.**
- 7. Identification of the effects of EAP services on the work organization and individual job performance.**

**Source:** Roman, P. M., & Blum, T. C. (1985). The core technology of Employee Assistance Programs. *The ALMACAN*, 15(3), 8-19.

**EXHIBIT 3**  
**EAP Overlap With General Practice Counseling**

**How familiar are you with EAP “core technology”?**

<b>Not at all</b>	<b>37%</b>
<b>A little familiar</b>	<b>26%</b>
<b>Some knowledge</b>	<b>19%</b>
<b>Very familiar</b>	<b>18%</b>

dozen or more different EAP or managed-care vendors, insurance plans and other diverse referral sources. The impact of EAP concepts on affiliate behavior can become quite diluted when that affiliate sees five, six or more clients a day from differing payment plans and contractual arrangements.

Despite the marketing claims of some primary vendors that EAP affiliates make up a type of tiered or subspecialty network within their larger managed behavioral health network, this study indicates there is not much contrast between EAP work and general practice counseling or psychotherapy. This is not the case across the entire

field as 27% reported that EAP cases are treated moderately to very differently.

An open-ended question posed to respondents asked them to describe how their approach to EAP counseling was similar to or distinguished from their approach to general practice counseling. Out of 222 total respondents, 183 provided narrative answers to this open-ended question, a response rate of 82% among those respondents who endorsed this open-ended question.

The overwhelming theme in nearly all the narrative responses centered on the “number of available sessions in EAP” or the “time-sensitive nature” of EAP short-term counseling. The narrative revealed a struggle among respondents to try to accommodate treatment within the parameters of the client’s benefit package (e.g., EAP and outpatient mental health benefits). It seemed as if respondents were trying to cobble various funding options and make the most of the number of sessions imposed by the EAP model. As such, respondents seem to develop treatment plans that have potential to fall in line with various payment sources.

Some respondents indicated that EAP paperwork was easier than billing third-party payers or managed care for insurance reimbursement. These payers require use of the American Psychiatric Association’s *Diagnostic and Statistical*

*Manual of Mental Disorders (DSM)* coding axes and a formal diagnosis, so respondents are pressed to use a diagnosis that yields the greatest likelihood for reimbursement.

Since reimbursement for EAP is not tied to having an approved diagnosis (or meeting “medical necessity” criteria), and co-payments or deductibles do not apply, many respondents see EAP as “less administrative hassle” than the regulations involved with insured or managed-care clients in the general practice setting.

One of the perceived differences, and benefits, in EAP versus general practice is that all presenting problems are covered, and particularly those (nonmental disorder) *DSM-V* codes not covered under an insurance plan, such as marital conflict, parent-child relational issues, career concerns, stress of work-life balance, and academic problems. Interventions directed toward a couple or family, where symptoms are viewed as manifestations of a faulty family system rather than the psychopathology of just one family member, also fit well with the flexibility of the EAP model.

EAP fits with marriage and family therapists or counselors who are frequently opposed to assigning *DSM* diagnoses, with the exception of *DSM-V* codes, because doing so “labels” clients and misrepresents their disorders.<sup>9</sup>

Representative quotes from the open-ended question include the following:

- “Little difference except EAP has fewer visits.”
- “Only difference is some EAPs require switching therapists for additional sessions.”
- “EAP can only be used for here and now issues if the client does not want to access his or her insurance benefits.”
- “EAP focus must be on the most pressing problem due to short number of visits.”
- “I feel rushed with EAP clients when the vendor won’t allow more visits.”
- “I approach all clients the same except EAPs make me cram in the work in a few visits.”
- “I have to be solution-focused if the client won’t stay with me beyond the free EAP visits.”
- “EAP paperwork is less and I don’t have to collect a co-pay since EAP is free to the client.”

There were only a few references contained in the 183 comments related to the EAP approach

<b>EXHIBIT 4</b>	
<b>EAP Overlap With General Practice Counseling</b>	
<b>In terms of therapeutic approach and selection of interventions, are EAP clients generally treated the same as non-EAP clients?</b>	
<b>Completely the same</b>	<b>28%</b>
<b>More or less the same</b>	<b>46%</b>
<b>Moderately different</b>	<b>25%</b>
<b>Very different</b>	<b>2%</b>

being different due to a focus on work-performance issues and assessing the impact of the client’s personal problems on occupational life or job functioning. However, the survey revealed that a segment of respondents have a fairly sophisticated understanding of the dynamics and processes involved with formal management referrals, the bedrock of the EAP workplace-intervention model.

Respondents view EAP as largely but not entirely similar to general practice counseling, and most of the differences reflect the nuances of coverage, reimbursement, benefit design (e.g., the number of allowed sessions), and an awareness that EAP is, on some level, about personal problems that overlap with job-performance issues. The core-technology concepts related to referrals beyond the EAP, follow-up and substance-abuse screening are, for the most part, applied in the same manner for both EAP and general practice cases.

Despite the theoretical underpinnings of EAP as a workplace-performance management program, EAP is only marginally differentiated from standard outpatient employee health benefits in the minds of respondents or affiliates. It is primarily viewed as a quasi-outpatient mental health benefit, or a type of open “employee counseling service” that offers accessible but very brief intervention.

Although speculative, if respondents could offer a recommendation to purchasers regarding EAP, it would likely be to allow more sessions within the EAP model. The NBGH’s concern that contemporary EAPs have significant overlap with services provided through the employer’s behavioral health benefit has merit, although some degree of workplace emphasis, however diluted, is still present in the EAP Affiliate Network Model, as evident in Exhibit 4 (percentage assessing impact of client problem on job performance).

## Implications

The content of EAP counseling, as practiced in the Affiliate Network Model, has drifted from the original EAP core technology. There has been significant “leakage” from general practice into EAP, or the degree to which EAP clients receive general practice counseling, in the form of short-term treatment, as opposed to EAP-specific services.

Given that it is commonplace for managed behavioral health organizations to also offer EAP and that provider networks between these distinct product offerings are frequently identical, it is not surprising to find that affiliates (respondents) combine both EAP and general practice approaches. This blurring of EAP and general practice has perhaps made EAP a bit more “generic” in its application and less of a work-based, performance-management tool.

As previously mentioned, one of the most noteworthy differences is that EAPs’ address the gap between “medically necessary” mental health benefits and more inclusive coverage for non-*DSM* presenting problems. EAP sessions are “free,” not counted against insurance-benefit limits, and usually extend to employees or dependents who opt out of medical-plan coverage.

This difference, however, does not appear to significantly affect affiliates (respondents) except in one important way. They tend to view EAP as another mental health service package with *x* number of available sessions. Their task is to try to patch together a treatment plan using EAP and health-plan benefits to fit the parameters of available benefit packages or simply to rely on EAP when the client is unwilling or unable to use insurance beyond the EAP.

In a way, affiliates have come to see EAP as an additional type of funding mechanism and option within the employer’s package of benefits. The main distinction is that EAPs have fewer visits than benefit plans and lower amounts of reimbursement per session or visit.

Given the similarity between EAP and general practice, some employers are likely paying multiple premiums for an identical or similar service. This finding could potentially cause some employers and their benefit consultants to restructure or even eliminate EAPs provided through external vendors and their affiliate networks.

This restructuring or elimination is advisable only if the current EAP model does not support

organizational management in addressing job-performance problems in a manner that is different from standard mental health benefits. Determining this difference requires a plan to measure EAP-specific outcomes.

What is not entirely clear from the employer’s perspective is whether the muddying of EAP with general practice represents an unwanted drift away from a “pure” EAP model. Why would an employer view investing in an EAP as more valuable than not investing, particularly if employers are paying multiple premiums for a similar service? The crucial question is, does the contemporary EAP (and its use of the Affiliate Network Model) actually improve the work performance of employees impaired by personal problems any more than providing reasonable access to good behavioral health care?

The field needs a study that legitimately compares the outcomes of employees whose behavioral health impairs their work functioning among employer groups that have “EAP plus benefits” versus “no EAP with benefits.” What are the linkages, if any, between the unique components of EAP and actual outcomes? For example, it is common knowledge that untreated depression has a negative impact on productivity and medical expenses.

Would productivity more likely improve for the depressed worker as a consequence of EAP intervention versus seeking help through a health-plan benefit alone? Does the management consultation and formal referral components in the contemporary EAP have an impact on “troubled employee” case finding, clinical outcomes and quality of work that is greater than simply offering a reasonable behavioral health benefit?

The survey analysis revealed an appreciation among some affiliates (respondents) that EAP emphasizes work performance and uses the leverage of the workplace to try to motivate employees to seek help. This is most evident among the small numbers of affiliates who handle formal management referrals, or those employees referred to EAP due to job performance issues. Would the prevalence and outcomes of formal management referrals be more marked in traditional internal EAP models than the contemporary Affiliate Network Models?

The results of this survey implicate contemporary EAPs as being largely, but not entirely, redundant to behavioral health benefit coverage.

Conducting a rigorous outcome study would shed light on any other actual differences and test the value of the core technology.

Employers, as primary stakeholders, need to place a much greater emphasis on outcomes as opposed to looking at administrative efficiency and low price as the main criteria for vendor selection. Vendors (and their affiliates) are advised to invest in better outcomes measurement, even if infrequently demanded or not yet understood by an employer. The predominant practice of simply recording in a progress note that a client is improving or not provides little information on the impact of EAP on work performance or what specific interventions led to improved work performance.

A question that naturally flows from this survey is whether particular vendors, who oversee affiliates, are more or less important than affiliates in terms of how EAP concepts are implemented? In other words, the theory that affiliates are more important in terms of how EAP services are executed has some prima facie validity, but it is not entirely clear that it is correct.

Can and should EAP vendors improve affiliate fidelity to EAP concepts, or are they simply too far removed from affiliate and client care to have an influence? When one EAP vendor accounts for 3% of an affiliate's referral base, can the vendor modify affiliate behavior to use a different approach with EAP clients than with other clients commonly encountered in general practice?

If competitive vendors could consolidate their efforts into a single initiative, they could conceivably construct a "subnetwork" of EAP affiliates who could be trained and coached to adhere to the EAP model. Of course, this requires that actual measures of fidelity to EAP concepts be developed and validated, and this is an important next step.

Until this study, there was no apparent empirical research on the use of EAP affiliates. The hope is that this exploratory and descriptive study will lead to subsequent studies in which hypothesized relationships are examined and outcomes are measured. If practitioners do not routinely practice EAP as conceived, then the field needs to adopt a position to bridge the gap between the EAP model and actual practice.

As a Web-based survey, this study did not authoritatively confirm the affiliates' actual skills at doing EAP work, although it did determine that

a majority of affiliates do not practice the EAP core technology as set forth by Roman and Blum.<sup>8</sup> This finding has implications for all stakeholders, including employers, EAP vendors, affiliate providers and individual employees or clients.

## Notes

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