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EAP Service Use in a Managed Behavioral Health Care Organization: From the Employee Perspective

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SUMMARY

Contemporary employee assistance program (EAP) services are typically provided in broad-brush programs delivered by large external vendors in a network model. Yet research has not kept pace with EAP evolution, including in terms of how EAP clients themselves view services. We surveyed a random sample of EAP service users from a national provider (361 respondents). About one-third of respondents reported getting help for workplace issues. Most learned about the EAP through employer communications such as the company website. The large majority reported that the EAP helped them “a lot” or “some,” suggesting they valued this benefit.

Keywords

Employee assistance programs; consumers; experience of care; utilization; workplace; substance abuse; mental health

INTRODUCTION

Employee assistance programs (EAPs) have undergone radical transformation over the past two decades. The dominant service delivery model is now one in which external vendors such as managed behavioral health care organizations (MBHOs) contract with employers. These vendors generally utilize network affiliate providers to deliver clinical EAP services. The focus is typically “broad-brush” in addressing a wide range of personal concerns and EAP services are often integrated with work-life, behavioral health, wellness or other programs. These changes, along with others, are viewed by leaders in the field as potentially having both positive and negative effects (Sharar, 2009). For example, the expanding scope of EAP services may be helpful in meeting a wider range of clients’ needs, but may also diminish the traditional focus on addressing substance use problems. Similarly, the broader

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scope and increasing provision of employee assistance services by multi-purpose MBHOs or health plans may be beneficial in meeting needs and perhaps fostering integration with other services, but may also dilute the unique workplace orientation of EAPs.

Although this evolution in EAPs has been underway for some years now, there is a research lag in describing and understanding its various aspects, particularly in terms of larger national and multi-site populations (Merrick, Volpe-Vartanian, Horgan, & McCann, 2007). Included within this research gap is the perspective of clients who use EAP services within this contemporary delivery system. These perspectives include: what influenced their decision to seek help, the nature of personal concerns for which the EAP provided assistance; and what happens in service delivery. Data addressing these issues can inform program outreach and service delivery to increase access and improve quality of care.

Prior studies have examined some important issues regarding external, affiliate-provided EAP services. These have included both service provider and enrollee/client samples. For example, Sharar and colleagues delved into the question of how different (or similar) EAP counseling by network affiliates may be compared to their standard, non-EAP behavioral health care practices (Sharar, 2008). Findings revealed that in general, the two types of practice were not highly differentiated. This suggests a move away from, and/or lack of expertise in, the EAP core technology (Roman & Blum, 1985) and a possible lack of attention to workplace issues. Other research has examined organizational and workplace factors affecting EAP utilization in the same MBHO reported on here (Azzone et al., 2009). Results indicated that utilization is related to some actionable factors such as program promotion, suggesting that increasing program visibility may be an important way to reach those eligible to use and in need of services. There also exist valuable studies on outcomes in EAP programs provided by large vendors (Hargrave, Hiatt, Alexander, & Shaffer, 2008; Masi & Jacobson, 2003).

However, relatively little research to date has focused on a broader scope of questions about EAP services from the perspective of employees receiving services through a MBHO affiliate provider network. This study aimed to help address this gap in the literature by surveying a random sample of EAP service users within such a MBHO-covered population. These research questions included:

1. How do employees learn about and decide to use the EAP?
2. For what types of concerns do employees receive EAP help?
3. How do employees use and evaluate EAP services?

These questions address issues within EAP service delivery that are important to better inform efforts to ensure greater access, improve quality of care, and optimally target services to client needs.

METHOD

Study Setting

The study setting was MHN, a national MBHO covering 11 million members. MHN contracts with employers, health plans and other payers to manage and deliver specialty EAP and managed behavioral health services. In this analysis, we focused on MHN's stand-alone EAP product. This is a full-service EAP that typically covers 3–8 sessions per incident or per year for problem assessment and short-term counseling ("clinical EAP services"), resource assistance such as legal or financial consultation, and organizational consultation to supervisors and managers. Enrollees seeking EAP services contact MHN's call center and are referred to a provider. MHN has a network of affiliate providers (contracted providers,

as opposed to employees) who deliver services in their own offices. Enrollees are typically referred to the subnetwork of providers with specialized expertise related to EAP work. EAP counseling sessions may include problem assessment, short-term counseling and referrals for additional services for a wide range of presenting problems including work-related concerns, formal mental health or substance use disorders, relationship issues and other matters that could affect well-being and productivity.

Sample

The sample (n=361) for this analysis comes from a population of 1,851 employees aged 18 or older who were covered by MHN's EAP product for at least 12 consecutive months during 2009 or 2010, and who had a clinical EAP claim during those 12 months. From this population, 1,344 employees were randomly selected. Valid addresses were available for 1,263 employees and current, non-work (home or cell) telephone numbers were available for 680 (either from MHN eligibility records or from directory assistance and Internet searches), of whom 429 responded to the survey and 414 were found eligible for participation upon screening. Screening eligibility criteria included having health insurance during the past 12 months and ability to speak English. The response rate among persons we were able to locate by telephone was 62.9%, based on an estimated eligibility rate of 96.5% among those who did not complete screening.

Respondents received a $20 incentive for participation in the survey. Interviews averaged approximately 20 minutes including the EAP service module. Up to 10 attempts were made to locate and contact each respondent.

This study was part of a larger survey effort. For reasons related to privacy and feasibility, the survey was designed so that interviewers did not know the utilization status of subjects and each subject was asked about their utilization. Of the 414 eligible respondents in this sample, 361 reported receiving EAP services in the past 12 months and were queried further about their service use. These 361 respondents constitute the sample for the current analysis. The study received IRB approval at Brandeis University and at the University of Massachusetts-Boston.

Data Sources and Survey Content

The primary data source for this analysis is a telephone survey we conducted of randomly selected employees covered by MHN's stand-alone EAP product, who had a clinical EAP claim during the prior 12 months. This was part of a broader survey on behavioral health services utilization. The sampling approach and survey response is described above. The survey was conducted from August 2009 through April 2010. The Survey Research Center at the University of Massachusetts-Boston conducted the telephone interviews. In addition, we had access to administrative data including claims and eligibility files which we used for the purpose of sampling and to conduct non-response analysis.

The focus of the survey included respondents' perceptions of the EAP, utilization of other behavioral health services, and experience of care. We also asked demographic and health-related questions, including an item on risky drinking: number of days in the past year when consumed more than 4 drinks (men) or more than 3 drinks (women). This is recommended as a single-item screener by the National Institute for Alcohol Abuse and Alcoholism with an answer of one or more days considered a positive screen (National Institute on Alcohol Abuse and Alcoholism, 2005). It has been validated as a way to identify persons at high risk of alcohol use disorders or hazardous drinking (Dawson, Pulay, & Grant, 2010).

Analytic approach

We present univariate descriptive statistics for sample description and survey items. We used chi-square tests and t-tests for comparison of respondents and non-respondents on categorical and continuous variables, respectively.

RESULTS

Sample description

This sample of 361 EAP service users was predominantly female (55.7%) and married (61.0%) (Table 1). Most respondents were 35–44 years old (32.1%) or 45–54 years old (39.1%). The large majority was white (81.7%) with the remainder evenly split among African-American, Asian, and other racial categories. Over 12% identified themselves as Hispanic. Almost two thirds had a college degree. The sample was about equally divided in terms of salaried versus hourly employees, with a small number (7.2%) reporting themselves not currently employed (perhaps due to recent lay-off or similar event). About one third of those currently employed reported having a supervisory role. Most respondents reported good to excellent health; only 7.8% indicated their health was fair or poor. More than 42% reported there was at least one day in the past year when they drank more than five drinks (for men) or four drinks (for women) in a single day. For almost 17%, this level of drinking occurred on more than five days during the past year.

We also compared the respondents to non-respondents using administrative data (data not shown). We found that among respondents there was a higher proportion of men (46.9% versus 42.1%, marginally significant at p=.109); no significant difference in region of residence; and significantly older age (mean 45.0 [standard deviation=8.8] versus 42.0 [standard deviation=9.6] p<.01) compared to non-respondents.

Focus and delivery of EAP services

Respondents were asked whether they received EAP services for various issues, which were not mutually exclusive. Over three quarters (81.6%) indicated they received help for family issues or other personal concerns, and 47.5% said they received help for mental health or emotional issues (Table 2). One third (34.0%) reported receiving EAP help for job stress or workplace issues. Much smaller proportions indicated help with alcohol or drug use (3.1%) or none of the above (2.2%).

About half reported receiving EAP services in person only, with the remainder split evenly between telephone only and both in-person and telephone services. This item was asked of all respondents who indicated receiving services or having contact with the EAP. Those reporting use of both may have been reporting their telephonic intake services, or may have received authorization for telephonic counseling services as well as—for a different episode of services during the year—a separate authorization for in-person services. More than three quarters (77.9%) reported that the EAP provided them with a referral to mental health treatment. This could have included respondents who had a telephone intake with the EAP and were referred directly to psychiatric treatment, not the EAP, as well as those who had EAP counseling sessions and were subsequently referred for mental health treatment. We also asked about substance abuse treatment referrals for respondents who reported getting EAP help for alcohol or drug use problems but the small subsample size did not support analysis of referral patterns in this group.

Approximately three quarters of the respondents indicated they had at least one scheduled session or appointment during the past year. We then asked these respondents further questions about the nature of their EAP use. For 86.1% of these respondents, EAP services

were the first type of behavioral health service utilized during the year. About one quarter of them (24.9%) reported that their decision to use the EAP was influenced by encouragement or pressure from family or friends, 5.2% indicated a physician or other healthcare provider as an influence, and 13.5% noted their employer or supervisor.

Knowledge and perception of EAP services

The vast majority of respondents correctly believed that their EAP offered assistance with work stress or job performance, concerns about alcohol or drug use, family or relationship issues, and mental health issues (Table 3). More than 96% believed that the EAP was confidential in that what an employee reveals to EAP staff would not be disclosed to their employer or supervisor. Nearly all respondents (n=357) had EAP benefits that also included "life management" services (assistance with child care, elder care, legal, financial or other issues); just over 81% of them knew that their EAP could help with such concerns.

We asked all respondents how they had learned about the EAP. The most commonly endorsed source of information was posters, flyers or human resources department communications (77.3%), followed by their company website (71.0%), and employee orientation, training session or workshop (58.3%) (Table 3). Smaller numbers of respondents reported learning about the EAP from a supervisor, coworker, or union.

Among the respondents whose EAP scheduled sessions were the first service used during the year, over half (59.6%) indicated that the counseling or treatment received from the EAP helped a lot, and about one quarter indicated that it helped some (24.6%). The remainder felt that it helped either a little or not at all.

DISCUSSION

Study findings provide insight into several key areas of investigation. It is not surprising that family, personal and mental health problems were extremely common issues that respondents reported the EAP helped with. However, given concerns in the field that current models of EAP may be simply interchangeable with standard counseling services, it is interesting to note that fully one third of EAP clients in this sample reported they got help with workplace stress or job performance. Thus from the employee point of view, job-related issues were often an issue for which the EAP provided assistance. This does not directly address the concerns about affiliates' lack of EAP-specific or workplace expertise, but it does indicate that employees bring their work-related issues to EAP network affiliates and suggests they received help for this type of concern. The study data cannot shed light on how different the proportion might be for persons receiving non-EAP behavioral health services for comparison purposes. On the other hand, less than 14% indicated that their decision to use the EAP was influenced by encouragement or pressure from an employer or supervisor. This finding supports prior research showing that most EAP use results from self-referral(Chan, Neighbors, & Marlatt, 2004) and further illuminates the fairly limited extent of even informal employer/supervisor influence on EAP use.

Another finding of interest was that few EAP clients reported receiving help for alcohol or drug use issues. This discrepancy between the estimated number of persons in the workplace who have substance use problems and the number of employees seeking help for the condition has been described in the literature (e.g., (Reynolds & Lehman, 2003) and could result from a variety of causes. First, it may simply be that the broad-brush approach brings in far more people seeking help with non-substance abuse problems than traditional internal EAP models did years ago. It is also possible that issues related to alcohol and other drug may be masked in or co-occurring with the family/personal concerns or mental health categories, and may genuinely be thought of that way by some clients (e.g., seeking help for

relationship problems that may be triggered by alcohol abuse). They may have simply been under-reported due to stigma.

Many EAP stakeholders would agree that there is an ongoing need for improving identification of substance use problems in the workplace. The finding that 42% of respondents had indication of risky drinking represents both a problem and an important opportunity. It underlines the potential usefulness of increasing formal screening and brief intervention, as has been found efficacious in the EAP setting (Osilla, Zellmer, Larimer, Neighbors, & Marlatt, 2008). Pilot studies conducted as part of the Brief Intervention Group (BIG) initiative have found that screening enrollees when they contact call centers for EAP services can substantially increase identification of problematic alcohol use (Goplerud & McPherson, 2010). The rate of risky drinking we found may be compared, for context, to findings from the 2009 National Survey on Drug Use and Health indicating that 30.1% of full-time employed persons engage in binge drinking, defined as five or more drinks on the same occasion on at least one day in the past 30 days (a shorter timeframe than the measure we used) (Substance Abuse and Mental Health Services Administration, 2010). The BIG initiative pilot studies reported that 12% to 40% of members who contacted the EAP for services and completed the three-item or full AUDIT instrument screened positive (Goplerud & McPherson, 2010).

In our survey, although a large proportion endorsed this risky drinking item, few respondents indicated they got help from the EAP for alcohol or drug use issues. It is possible that risky drinking was addressed during their EAP services although not reported that way by respondents, however it is also likely that some of these risky drinkers went unidentified and opportunities to address this health risk were missed. To identify individuals in need of intervention for risky alcohol use or alcohol use disorders, MHN has a protocol in which alcohol usage is asked about during intake and appropriate referrals are made; the provider is then required to do an assessment as part of the initial session.

Our findings point to the important role of communication strategies in promoting utilization. Workplace communications including the employer website accounted for the top two sources of information reported by respondents. The amount, type, frequency and prominence of communication about the EAP thus warrant careful attention. Vendor-provided services such as orientations and trainings have been found to be related to increased utilization (Azzone et al., 2009) and our findings support the salience of these opportunities.

The fact that about one fifth of respondents did not know that the EAP could offer help with childcare, elder care, legal or financial problems indicates that use of one type of EAP service does not guarantee awareness of the full range of EAP services. It may be useful to ensure that clients are made aware of the full scope of services available, for future reference and to maximize its benefit to the organization. This lack of awareness may operate in both directions (those using work-life services may not be aware of what else the EAP may offer) although our data do not address this question.

Belief in confidentiality of the EAP was very high among respondents, indicating that among those who obtained EAP services concern about confidentiality was not perceived as a barrier. Prior research regarding beliefs about EAP confidentiality has often focused on employees who have not used EAP services, finding that confidence or trust in the EAP (including belief in confidentiality) or belief in confidentiality specifically is related to willingness to use or actual use of services (e.g., (French, Dunlap, Roman, & Steele, 1997; Milne, Blum, & Roman, 1994). Fewer studies have focused on the views of EAP users in this regard, but some have found substantial concerns among EAP users with particularly

sensitive problems such as intimate partner violence (Pollack et al., 2010). In our study, it may be that MHN and survey respondents' employers and EAP counselors were particularly skilled at conveying information about confidentiality protections. However, the survey data do not address the reasons for belief in EAP confidentiality. Finally, we note that the large majority of EAP clients in our sample felt the services they received helped a lot or some. While this is only a "soft" indicator, this finding does serve to show that for most of the EAP clients we interviewed EAP assistance was quite highly valued.

There are several limitations to our study. The sample was drawn from one large MBHO, thus to the extent that populations served or EAP models differ, there are limits to generalizability. We were only able to interview enrollees for whom we had a current personal telephone number. Those whom we were not able to contact by phone did differ from respondents in that they were younger (mean age 40.9 versus 45.0, $p=.07$) and more likely to be male (58.8% versus 53.1%, $p<.01$). Persons who did not acknowledge using EAP services are of necessity not included in this analysis of self-reported data. It is possible that some respondents who reported receiving a referral for mental health services may have included their referral from telephone intake to an EAP counselor. Finally, there is the possibility of under-reporting of stigmatized issues or behaviors such as getting help for a substance use problem.

The study findings provide useful data to inform outreach and delivery strategies. Future research might fruitfully pursue additional client-focused research to investigate in more depth some of the areas reported here.

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Table 1

Description of EAP Service Users

	N	Percent
N	361	100.0
Female	201	55.7
Age:		
18–34	51	14.1
35–44	116	32.1
45–54	141	39.1
55+	53	14.7
Race:		
White	295	81.7
African-American	20	5.5
Asian	19	5.3
Other	23	6.4
Hispanic ethnicity	45	12.5
Marital Status:		
Married	219	61.0
Divorced/Separated/widowed	96	26.8
Never married	44	12.3
Education level:		
High school graduate, GED or less	40	11.1
Some college	94	26.1
4-year college graduate	139	38.5
More than 4-year college degree	87	24.1
Job status:		
Salaried	164	45.4
Hourly	171	47.4
Not currently employed	26	7.2
Has supervisory role (if currently employed)	101	30.2
Health status:		
Excellent	99	27.4
Very good	154	42.7
Good	80	22.2
Fair/poor	28	7.8
Number of days with >4 (women) or >5 (men) drinks, past year:		
None	195	57.9

	N	Percent
1–5 days	85	25.2
6–10	21	6.2
>10	36	10.7

Note: N varies for some rows due to missing data or conditional response; percents are based on non-missing data, missing <5% for all variables.

Table 2

EAP Focus, Influences on Use, and Service Delivery

	N	Percent
Received any services or had any contact with EAP in past year	361	100.0
Received EAP services for:		
Family issues or other personal concerns	293	81.6
Mental health or emotional issues	170	47.5
Job stress or workplace issues	121	34.0
Issues with alcohol or drug use	11	3.1
None of the above	8	2.2
Mode of service delivery:		
In person	181	50.1
Telephone	85	23.5
Both	86	23.8
EAP provided referral to mental health treatment	275	77.9
Reported having any scheduled EAP sessions/appointments		
Yes	266	73.7
No	81	22.4
(If had scheduled EAP sessions) EAP was first behavioral health service used during year	229	86.1%
(If scheduled EAP sessions were the first behavioral health service of the year) Decision to use the EAP influenced by pressure or encouragement from:		
Family or friends	57	24.9
Physician or other health care provider	12	5.2
Employer or supervisor	31	13.5
None of the above	149	65.1

Note: Ns for each row vary slightly due to missing data, missing <5% for all variables; or due to conditional items; percents based on non-missing data. Totals of mutually exclusive categories may not equal 100% due to rounding.

Table 3

Knowledge and Perceptions of EAP Services

	N	Percent
N	361	100.0
Believes that EAP can help with:		
Family or relationship issues	359	99.5
Mental health issues	352	97.5
Concerns about alcohol or drug use	344	95.3
Work stress or job performance problems	342	94.7
(If had coverage for “life management” services) Child care, elder care, legal, financial or other problems	291	81.5
Believes that the EAP is confidential	348	96.4
Sources of information about the EAP:		
Posters, flyers or human resources department communications	276	77.3
Company website	254	71.0
Employee orientation, training session, or workshop	208	58.3
Supervisor	137	38.1
Coworker	119	33.2
Union	43	13.2
(If scheduled EAP sessions were the first behavioral health service used during the year) How much the counseling or treatment received from EAP helped:		
A lot	136	59.6
Some	56	24.6
A little	25	11.0
Not at all	11	4.8