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Social work education for employee assistance program practice

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SOCIAL WORK EDUCATION FOR EMPLOYEE ASSISTANCE PROGRAM PRACTICE

by

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Abstract

SOCIAL WORK EDUCATION FOR

EMPLOYEE ASSISTANCE PROGRAM PRACTICE

by

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This study surveyed social workers employed in New York Metropolitan area Employee Assistance Programs (E.A.P.'s) and asked them to evaluate how well their social work education prepared them for E.A.P. work. Results indicated that the 71 respondents felt that they received a good basic social work education but that the curriculum lacked sufficient material in certain key areas of E.A.P. work. Descriptive profiles of the respondents and the E.A.P.'s are presented as well as recommendations for curriculum enhancement to prepare students entering the E.A.P. field.

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Table of Contents

Abstract		iv
Acknowledgements		v
	Introduction	1
Ch.1	Development of Social Work Education	4
Ch.2.	What is Generic Social Work?	13
Ch.3	Historical Roots of Employee Assistance Programs	38
Ch.4	Employee Assistance Programs as an Area of Practice	63
Ch.5	Education for E.A.P. Practice	79
Ch.6	Design of the Project	88
	Development of the Survey Instrument	91
	Selection of the Sample	92
Ch.7	Survey Results	95
Ch.8	Summary and Implications	125
	Summary	125
	Conclusions and Implications	129
	Appendix A	146
	Bibliography	157

List of Tables

Table 1	Social Work Methods Studied	96
Table 2	School of Social Work Attended	97
Table 3	Area of Practice in Studies	97
Table 4	Type of Overall Organization	101
Table 5	Type of Work Site	102
Table 6	Percentage of EAP's Time Devoted to Specific EAP Functions	103
Table 7	Percentage of Respondent's Time Devoted to Specific EAP Functions	106
Table 8	Percentage of EAP's Cases Falling into Specified Problem Areas	108
Table 9	Areas of EAP Work Ordered Least to Best Prepared	110
Table 10	Mean Scores on Preparedness for Respondents Needing Further Training vs. Not Needing Further Training	112
Table 11	T Test Results for EAP Practice Areas for Respondents With and Without EAP Placements	115
Table 12	Clusters of Responses Regarding Major Limitations in Masters' Program for Present EAP Work	117
Table 13	Clusters of Responses Regarding Major Benefits of Masters' Program for Present EAP Work	120
Table 14	Percentage of Respondents Reporting Need for Further Training by Practice Areas	123
Table 15	Areas for Potential Curriculum Enhancement	131

Introduction

Social work education faces a perennial dilemma in confronting the question of how to prepare students for work in a multifaceted, multiple-setting profession. How does one include in the curriculum material of sufficient commonality to be applicable in the broad range of programs in which social workers are employed while at the same time including material of sufficient specificity to prepare a student for work in a particular field or agency? There have been numerous attempts over the years to resolve this dilemma: through identifying common methodology, values and knowledge; through development of over-arching theoretical frameworks to encompass all the areas of practice; and through dichotomizing classroom and field learning.

One of the major thrusts to resolve the dilemma was the development of "generic" social work practice. This approach attempts to distill the knowledge and skills from the various methods and fields of practice into a basic core of learning to prepare students for beginning practice. The approach presumes that learners may want to continue their education after attaining a BSW degree to become "specialists' in particular areas or to become "advanced generalists", but assumes that the generic curriculum will allow new graduates to walk into any social work setting prepared to practice.

The reality of social work in the work world immediately calls this assumption into question. As Lewis (1982) has noted:

"The practice of social work is never static. It is constantly responding to economic and political pressures and to changes in the knowledge base on which it operates" (p. 41).

First among the factors complicating the educational task is the large and proliferating number of areas in which social workers practice. The large number of areas of practice for social workers suggests the challenge in providing content in the curriculum which will adequately address the need of beginning practitioners for practice-grounded knowledge. Secondly, the expanding and rapidly changing body of information within a particular area of practice demands that students receive state of the art information on policies, resources and interventive techniques to be able to practice effectively. Given these demands, the question emerges as to whether the social work curriculum has swung to the generic at the expense of the specific and to the detriment of graduates entering the work force.

This project addressed this question by looking at a relatively new area of practice for social workers, employee assistance programs (EAP's), and asking current practitioners how well their graduate education has prepared them for their work. Utilizing a questionnaire focused on areas of study within the graduate social work curriculum, the project attempted to identify areas of knowledge and skill which would enhance the curriculum's effectiveness in preparing graduates for work in this field. In looking at the incorporation of additional specific content into a

generic curriculum, one is aware of the challenge which the Council on Social Work Education (CSWE) outlined in its 1991 curriculum policy:

> Education for a professional career in social work is a complex process involving a multiplicity of skills and a continually expanding and changing body of knowledge. Sound curriculum designs give the educational program the integrated focus inherent in the profession's enduring philosophical base. This ensures historical continuity and provides a stable framework from which to assess and incorporate practice innovations, emerging knowledge, and interdisciplinary exchanges. This combination of curricular stability and flexibility is essential if the program is to respond effectively to changing social forces and provide leadership in the profession's ongoing quest for progressive social change. (pp. 105-106)

Chapter 1

Development of Social Work Education

Putting this project in context requires a brief review of the development of social work education. Social work education is professional education which differs from general education. If the goal of general education is the development and dissemination of knowledge for its own sake and for the development of an informed citizenry, the goal of professional education is the collection, tailoring and dissemination of knowledge to prepare a student for practice in a particular field of work. Thus, professional education uses knowledge selectively to improve the ability of those in the profession to fulfill the societal function with which the profession has been entrusted.

Social work education like all professional education is thus market driven. It is market driven in a number of ways. First, it is market-driven in the sense that graduates must have the skills which the market demands if they are to obtain jobs.

Secondly, it is market driven in the sense that society places changing demands on the professions which it recognizes. In the case of medicine, for example, American society has recently been demanding more accountability for the public and private dollars expended on health care. This has produced a greater number of strictures on doctors and has produced a number of trends in the field: a move toward group practice; an increase in patient suits against doctors with a corresponding increase in

insurance costs; and a greater degree of interaction between medicine and outside groups. These changes have in turn pressured medical schools to adjust their curricula to include more material on building relationships with patients and on the business side of medical practice.

Thirdly, professional education is market driven in the sense that as consumers influence professions to produce new or modified services, professional schools must incorporate the knowledge and skills needed by practitioners to provide these services. The development of industrial social work and the corresponding development of "world of work" material in the social work curriculum is a good example.

In a provocative article, Weick (1983) has posited that social work has in fact adopted a "market model of education" that is analogous to a free market model in economics.

The market model of education is based on certain assumptions similar to assumptions made in the marketplace:

- ...that professional practice is best served by allowing all relevant knowledge to compete in the educational marketplace.
- the configuration of theory and practice skills that each student assembles during the educational process is assumed to have equal merit in serving the best interest of the client
- ...that it is not desirable to constrain educational

> outcomes by choosing a theoretical perspective that is feared to be too narrow. (p.6)

Weick asserts that using the market model is an implicit policy choice about what social work education will be and that the choice

> ...is characterized by a belief that theories from other disciplines can be selectively and collectively used as grounding points for social work practice, by a preference for an unconstrained array of choices, and by the expectation that students who are presented with a sufficient array of bits of knowledge will choose a combination that will fit them for professional practice. (p.6)

In fact, Weick states the choice to take a laissez-faire approach has contributed to problems in establishing educational standards and in assessing educational outcome, and leads to a "disjunction between our values and our practice" because "the array of behavioral theories and interventive strategies are not tested against these values for a goodness of fit" (p.7).

Despite these disadvantages, the laissez-faire, market model remains unchallenged because in Weick's view, it provides "some modicum of cohesion amidst seemingly irreconcilable diversity" (p.7). The theme of seeking unity in the face of diversity is one that has many echoes in the history of social work as a profession and in the perennial debate over "generic vs. specific" in social work education.

The implication of this brief discussion of the market forces on professional education is that social work education, like all professional education, is in a continual process of evolution and change. The idea that there is an ideal, unchanging curriculum toward which we are gradually moving is a chimera. Instead, the curriculum will evolve based on the interactive relationship among the profession, the schools of social work and the changing society which both sanctions the profession and is served by it. The flexibility mentioned above in the C.S.W.E. statement is necessary to accommodate this evolution.

The stability referred to in the same statement has much to do with professional identity. Indeed, without some balance, the force of market demands - and enticements - can lead to the dilution or fragmentation of a profession. Towle (1954) has noted that

> If a profession is a field of service established to serve the common good rather than for the commonweal of its practitioners, the profit motive either in prestige or economic gain cannot operate to the same extent as in many occupations . . . A profession has a philosophy by which its practitioners are guided to the extent that they are not free agents but, instead, are obligated to act in accordance with the rationale, the ethical system of the profession . . . a profession establishes some form of group discipline in support of these values. (pp. 10-11)

It is thus professional identity which provides the balance to market forces and will form a stable part of the curriculum.

Towle's book on professional education provides a good general framework in which to examine social work education. She has looked at education among different professions and has identified five aims which are shared:

1. Our first aim is to develop in students the capacity to think critically and analytically and to synthesize and to generalize; a capacity to break a thing down in order to build it up for use; a capacity to use knowledge and a well-established habit of seeking it, using it, testing it critically, and formulating principles - in short, the objective of developing and entrenching the spirit of scientific inquiry . . .
2. Our second aim in imparting essential knowledge for use in a profession is to develop feelings and attitudes that will make it possible for the student to think and act appropriately . . .
3. Our third aim in professional education is to develop a capacity for establishing and sustaining purposeful working relationships. Working together characterizes all professional activity , whether the relationship be that of practitioner with the recipient of his services, supervisor-practitioner, administrator-staff member or between the members of an interagency or intraprofessional

team . . .

4. Since a profession is a field of service established to serve the common good, professional education has as its fourth objective helping its prospective practitioners develop social consciousness and social conscience. This implies their identification with profession and agency . . .

5. The fifth objective of professional education is closely related to the preceding one. This final aim is concerned that students be oriented to the place of their profession in the society in which it operates. This implies a depth of understanding of democracy as a way of life. (Towle, 1954, p. 6-16)

Towle (1954) goes on to differentiate social work from the other professions by pointing out its mandate to address "social ills":

> It serves a group that needs to be protected and at times actively defended. It serves society, which also seeks protection through social work. (p. 13)

Because of this focus social work must give a greater emphasis to the development of social consciousness and conscience than other professions. Each profession has "a defined scope and function . . . " and "a content of knowledge and method peculiarly its own, to which other professions contribute but for which they cannot substitute" (Towle, p. 16). Social work, as a relatively

young profession, and due to the nature of its work, has more of a problem than other professions in defining its field of practice, and consequently in developing an educational focus.

Hartman (1974) explicates part of the reason for this difficulty. In summarizing the early development of the profession, she comments:

> It is well known that social work developed in a direction quite different from the pattern of many other professions - from specialist to generalist, rather than the reverse. In fact, the profession was slowly built in successive stages from quite disparate groups and movements. The settlement houses, the child-saving movement, the charity organization societies, psychiatric and medical hospitals, the schools, and the child guidance movement all provided the settings for an early practice which developed with rather loose connections. (p.200)

The roots of social work education go back to apprenticeships in these various organizations and movements. The earliest "friendly visitors" and settlement house workers learned from doing on the job. Social agencies gradually moved to a paid work force to provide more reliable and uniform services and later developed their own training programs for their employees. The move to more formal educational programs came at the request and with the backing of the social agencies, primarily those engaged in family casework. The Charity Organization Society of New York

started the first School of Social Work as a six-week summer school in 1898. Other schools in Boston, Philadelphia and St. Louis were "independent training centers" for family casework agencies. The first university sponsorship of a school was the Chicago School of Civics and Philanthropy, affiliated with the University of Chicago in 1907 (Hollis and Taylor, 1971, pp. 9-10).

While group work and community organization were developing from separate roots in the recreation and community welfare council movement,

> . . . The practical and pressing demands of many agencies shaped the curriculum of the schools toward a major emphasis on casework and toward the preparation of practitioners to work in family welfare, child welfare, medical and psychiatric social work. (Hollis and Taylor, 1971, p.12)

Hollis and Taylor note that the development of general practitioner associations, like the American Association of Social Workers in 1921, contributed to a fruitful liaison between schools and agencies. It marked more of a pulling together of the profession. It also continued the influence of agencies on curriculum development.

Anderson (1982) makes the interesting observation that "Each time we have had strong movements in the profession to define social work by practice methods, we have been polarized to the point that we have sought some unity. We searched for the

'generic'."

He points out that the first attempt to define the generic was made at the 1929 Milford Conference "in an attempt to preserve social work as a single profession using the social casework methodology in response to the trend for practitioners to identify more with specialties in agencies and fields."

The same pressure to create unity was apparent in the 30's and 40's when the profession attempted to bring casework, group work and community organization under the social work umbrella. The development of a generic curriculum in social work stemmed from the desire to prepare graduates for practice in a broad range of agencies but equally from a desire to pull the profession together. The very different histories and development of the major methods, and their beginnings as separate occupations created a tendency toward separatism which the unified curriculum tried to counteract. As Middleman and Goldberg (1974) note:

> The relatively short history of social work has been characterized more by diversity than by unity...that this apparent lack of professional identity has drawn concern from various quarters is evidenced in the many individual and committee attempts to find the "generic", to find some underlying something that bridges the diversity and attests to the fact that there is a single social work profession. To date, the similarities have emerged largely in values...
>
> (pp. 17-18)

Chapter 2

What is Generic Social Work?

What has come to be known as the "generic -specific controversy" has engaged the profession for the last six decades or more. Unfortunately, the controversy shows few signs of abating. In substantial part the controversy seems to stem from a lack of agreement over the purpose of social work and the meaning of "generic" social work practice, and significant linguistic fuzziness in the use of the words "generic," "generalist," "specific" and "specialist."

To start with, the Social Work Dictionary describes the generic-specific controversy as:

> A debate among social workers that has existed at least since the 1920's. One faction sees the profession as comprising a group of different specialists, each with a unique body of knowledge and highly refined skills that require considerable training to master and that are applied to a specific and relatively narrow part of the total spectrum of social welfare needs. The other faction sees professional social work as being made up of generalists – people who have a macro orientation and who can be useful by developing and integrating services and channeling people to them (Author's emphases). The generalist faction also believes that social work skills are sufficiently similar from one specialty to another so that a worker can be effective in a

> variety of settings. Since the 1929 Milford Conference was convened to attempt to resolve the controversy, most social workers have taken positions that fall somewhere between these extremes. (Barker, 1987, p. 63)

The generic-specific argument has become entangled at times with the debate over cause vs. function. The dichotomization between what Hartman calls "systems changers" vs. "people changers" has been reflected in the curriculum. The clear demarcations for many years among methods directed to individual clients vs. methods directed to the community or social policy embodied the dichotomy. Hartman (1983) notes that

> A major agenda of those who worked to develop generalist or integrated methods a decade ago was to heal the dichotomy in the profession and equip social workers to move across system boundaries, seeking solutions to problems wherever they could be found. (p. 18)

The quest for a generic method in the 1970's and 1980's was ironically accompanied by a polarization in the curriculum between micro level and macro level practice. This differentiation by targets of intervention was touted as non methods-based, but in practice the interventive skills for micro level practice were the old casework and groupwork skills, while the practice skills for macro level were essentially community organization and administration. One questions whether this ongoing shifting in the curriculum is simply a case of "old wine in new bottles."

Hartman's study of concentrations and specializations in curriculum design indicates that, at least as of 1983, the efforts to integrate methods or put a "generic method" in the curriculum were largely unsuccessful:

> In summary, despite efforts toward integration, it would appear that there is still dichotomization between direct and indirect practice. Moreover, a large percentage of MSW students are in clinical practice concentrations or in fields of practice, such as health and mental health, that have tended to support primarily a clinical focus. Furthermore, the other fields of practice may also be conceptualized primarily as arenas for clinical practice. (1983, p. 23)

The semantic fuzziness in the use of the words "generic", "generalist," "specific" and "specialist" has also contributed to the confusion. To return to The Social Work Dictionary, the definition for the generic-specific debate given above illustrates the problem. In the definition, the discussion is about specialists and generalists rather than generic and specific. When the definitions for some of the key terms are examined, further evidence of the confusion of these terms in social work parlance is apparent:

> Generalist: A social work practitioner whose knowledge and skills encompass a broad spectrum and who assesses problems and their solutions comprehensively, the generalist often

coordinates the efforts of specialists by facilitating communication between them, thereby fostering continuity of care. (p. 62)

Generic social work: The social work orientation that emphasizes a common core of knowledge and skills associated with social service provision. A generic social worker possesses basic knowledge that may span several methods. Such a worker is not necessarily a specialist in a single field of practice or professional technique but would be capable of providing and managing a wider range of needed client sources and intervening in a greater variety of systems. (p. 63)

Specialist: A social work practitioner whose orientation and knowledge are focused on a specific problem or goal or whose technical expertise and skill in specific activities are highly developed and refined. (p. 157)

Implicit in the definitions of generalist and specialist given above is the idea that generalists would essentially supervise specialists in practice. Yet when one examines the Council on Social Work Education (CSWE) statements on educational qualifications for generalist vs. specialist practice, generalists are seen as entry level, BSW workers, while specialists would be MSW's with some experience. Why would an entry level person with

less training and experience be supervising a more highly trained, experienced social worker?

The answer which would presumably be given by those espousing a generalist approach is that generalists would approach problems from a broader perspective and be attuned to interventions on a macro as well as micro level. One might then ask whether these generalists were expert enough in casework, community organization or policy approaches to be able to choose and direct specialists in these areas. Again, if generalists are entry-level workers, the answer would likely be no.

As this brief discussion indicates, the generic-specific argument has also become entangled with the question of levels in the curriculum, or the so-called "continuum", since BSW programs were initiated. The CSWE conceptualization of the continuum is that BSW's are trained in generic/generalist skills and that MSW's build on this base and develop expertise in specific areas, *becoming* "specialists." There are several flaws in this conception of the continuum. First of all, the majority of MSW's do not have BSW's. Therefore, it cannot be assumed in the master's curriculum that students will have already learned the generic/-generalist base. Thus this base must be given in the master's curriculum as well. Secondly, as indicated in the discussion above, common sense dictates that entry level workers (BSW's) would be ill-equipped to oversee the work of specialists (MSW's). Although the analogy used in the field is that generalist social

workers are like general practitioners in medicine, each of whom refer people to specialists, a closer analog is the old guild system continuum of apprentice-journeyman-master, wherein BSW's are apprentices, MSW's, journeymen and DSW's, perhaps, masters. Thirdly, as Hartman has pointed out, one could just as logically and accurately describe BSW's as being trained in specific skills. Her study of curriculum in child welfare indicates that

> ...the BSW courses tend to be broader and more field specific in their child welfare context, whereas the MSW courses are more likely to focus in clinical treatment methods. In summary, it would appear that, at least in child welfare, BSW programs tend to be more, rather than less specific. (1983, p. 24)

She goes on to argue:

> ...it is perfectly reasonable to turn the generalist-specialist continuum around, to define the BSW program as a more specific program where knowledge and skills are made concrete in specific applications, to make competence in action more possible and the BSW more desirable in the labor market. The greater demands of mastering a wider and more varied range of knowledge and skill and a higher level of abstraction could occur at the MSW level, and the doctoral level could go in both directions, as it now does. (P.25)

Such a re-ordering of the continuum would be a shift to an inductive base at the BSW level and a deductive base at the

masters level, rather than the present deductive base at BSW, inductive base at MSW model. This makes sense in light of Lewis' ordering of concepts in social work learning from rule-based learning at the lowest level to principle-based learning and further to the development of theory. In Lewis' conceptualization, rules are informed by principles and theory but a brand new worker would learn rules first and then move up in the hierarchy (Lewis, 1982).

Returning to a focus on the masters' level, the continuum is something of a straw man in terms of resolving the generic-specific question at the masters' level. While it is conceptually neat to place the generic at the BSW level and, the specific at the masters' level, it begs the question of the learning needs of the majority of MSW students who do not have a BSW.

The evolution of the concept of the generic in social work is outlined in the following historical review. Linguistic confusion about the terms involved as well as efforts to clarify distinctions will be apparent.

The Milford Conference Report of 1929 marked a turning point in the development of the profession. Entitled "Social Casework: Generic and Specific," it recognized that despite its disparate fields of practice social work, (or at least Casework) was one profession. The report's identification of "the generic" marked the beginning of the continuing discussion about what is essential learning in social work education of which this project is a

modest part. To quote the report:

> This report testifies to the importance of the specific fields of social casework and to the specific demands which each specific field makes upon caseworkers practicing within it. Nevertheless, the outstanding fact is that the problems of social casework and the equipment of the social caseworkers are fundamentally the same for all fields. In other words, in any discussion of problems, concepts, scientific knowledge or methods, generic social casework is the common field to which the specific forms of social casework are merely incidental. (American Association of Social Workers [AASW], 1974, p.11)

The report identified generic social casework as composed of:

1. Knowledge of typical deviations from accepted standards of social life.
2. The use of norms of human life and human relationships.
3. The significance of social history as the basis for particularizing the human being in need.
4. Established methods of study and treatment of human beings in need.
5. The use of established community resources in social treatment.
6. The adaptation of scientific knowledge and formulations of experience to the requirements of social casework.

7. The consciousness of a philosophy which determines the purposes, ethics, and obligations of social casework.
8. The blending of the foregoing into social treatment.

This sixty-five year old statement remains a remarkably accurate description of casework across settings. It formed the basis for much of the curriculum development over the next twenty years. Its concentration on only casework made it less useful for pulling together all the practice methods into some unified professional whole.

Hartman (1983) describes what she calls "the myth" of the Milford Conference: "Method is generic and field or organizational context is specific." She sees a distortion in this myth, since the Conference was discussing only casework practice not social work practice. Rather than describing the generic Hartman sees the Milford report as implying "two rubrics for defining the specific in social work: method and setting." (p. 17) Within casework, the Conference established "that the casework method had common features wherever it was practiced and eventually led to the general abandonment of casework courses specifically tailored to fields of practice." It also promoted the "transferability of method"; i.e., that caseworkers could move from field to field (p. 17).

Hartman discusses another possible effect of the Conference: the definition of casework as "the core, generic or nuclear method of all social work" (p. 17) She notes that in typical curriculum

designs up into the 1960's, students were required to spend up to a year in casework before taking other methods. She cites Annette Garrett as explaining that Smith School of Social Work taught generic social work because casework was "the core of all social work practice." Schools then started adding methods to the casework core, more as "rubric for specialization" than as providing a generic base. From Hartman's perspective, it was not until the late 1960's and early 1970's that the field started tackling the issue of generic social work practice.

An example of the added methods can be seen in the "basic eight" curriculum. By 1944 the American Association of Schools of Social Work had formulated the "basic eight" curriculum which identified the basic subject matter of social work "in any area." The eight were " . . . public welfare, social casework, social group work, community organization, medical information, social research (statistics and research method), psychiatry (human behavior and psychopathology), and social welfare administration" (AASW, 1974, p. 15).

The 1951 Hollis and Taylor report from the National Council on Social Work Education marked the next effort to look at generic social work across all method areas. Hollis and Taylor (1971) looked at the "basic competencies" expected of social workers with explicit proviso that they be broadly applicable

1. in all areas of social work practice (administration, casework, community organization and social planning,

group work and research);

2. in responsibilities in a wide range of social work positions (practitioner, supervisor, administrator, consultant, and teacher);
3. in a majority of welfare programs and social agencies . . . (p. 47)

They go on to group the competencies into three categories: "(a) perceptual and conceptual knowledge; (b) skills, methods, processes and procedures; (c) personal professional qualities" (p.221). The competencies within each category are listed but there is little explication of the linkages, if any, among them or any broader framework within which they can be understood.

Hollis and Taylor later comment on the "dichotomy" between classroom and field work portions of the curriculum and recommend that field work be brought under the educational control of social work schools and brought more in line with classroom courses which teach concepts and generalizable principles. They criticize field work experiences of the time which tended "to center too largely on specific knowledge and skills related to the practice of social work" (p.222). They do not address the question of when or where these specifics should be learned: in postgraduate courses, on the job training?

Schatz, Jenkins and Sheafor (1990) note that Hollis and Taylor concluded that "graduates should be prepared in the multimethod practice approach" (p. 219). Teigeser (1983) comments that

this generalist approach came to be accepted "as an alternative to method-bound approaches...This approach continued to prepare students for traditional roles, but attempted to increase the number of roles for which an individual practitioner would be prepared" (p. 79).

The 1958 "Working Definition of Social Work Practice," while not looking explicitly at Social Work education, offers another take on what constitutes "generic" practice. The statement notes that " . . . some social work practice will show a more extensive use of one or the other of the components but it is social work practice only when they are all present to some degree." It goes on to identify value (including the first statement with a systems orientation I found), purpose, sanction (from governmental agencies, voluntary incorporated agencies and/or the organized profession), knowledge and method as the components of social work practice (Brieland, 1977, pp. 344-345).

As Ann Hartman (1974) noted, different routes have been taken in trying to identity the generic or as she put it, " . . . to define and describe a shared professional identity":

> One has been to pull out the common base of knowledge, values and skills shared by the different methods. Another has been to move toward the construction of a framework through which all practice could be conceptually unified. Still another approach has been to attempt to dissolve method boundaries and to develop a definition of generalist

practice. These approaches overlap and cross . . . (p. 201)

An example of the first approach is Bartlett's book The Common Base of Social Work Practice. In this work she distinguishes between the base of practice, which is generic, and the practice itself, which is specific:

> The common base of social work practice consists of concepts, generalizations and principles relating to knowledge, value and intervention, i.e., abstract ideas. Practitioners learn these 'common elements' in school and apply them in their professional practice. The base is not the doing but what underlies the doing. (Bartlett, 1970, p. 129) (author's emphasis)

She goes on to describe four elements in the base:

1. Central focus on social functioning, which looks at the balance between people coping and environmental demands
2. Orientation, which she states is "the primary concern for people in the situation"
3. The body of values which are concerned with human growth and potential, and the body of knowledge which centers around social functioning
4. The interventive repertoire, which includes working with individuals, groups and social organizations directly and through collaborative action. (Bartlett, 1970, pp. 129-130)

She sees the practice as following from this base and is in

favor of developing social work intervention as interrelated types of intervention rather than separate tracks or methods. This is close to what is currently called generalist practice in some curricula.

Schatz, Jenkins and Sheafor (1990) note that in the late 1960's and early 1970's

> ...a multimethod conception of a generalist gave way to the view of the generalist social worker who had the tools to work in various settings with a variety of client groups, addressing a range of personal and social problems and using skills to intervene at practice levels ranging from the individual to the community. (p. 219)

Quoting Ripple, they describe this view as seeing the generalist as "the all-purpose 'utility worker' who, at an unspecified level of competence, could provide an initial response to virtually any client problem" (p. 219). Teigeser (1983) describes this alternative to the multimethod approach as an attempt to reach for

> ...new conceptualizations for practice characterized by attention to human systems and to the context in which the intervention was occurring. (p. 79)

She comments that developing curricula for this approach proved difficult and that there were and are "both conceptual and pragmatic questions" about the approach.

This more systemic approach to describing the generic ties into both the conceptual framework and generalist practice ap-

proaches mentioned by Hartman.

An example of the framework approach mentioned by Hartman is the ecological systems approach presented by Hepworth and Larsen. They start with the assumptions that certain practice theories are more effective for certain problems, that no one theory has proven more effective than others and that practitioners should choose interventions which best fit particular clients and problems, rather than the other way around. Being able to choose specific interventions for specific problems is an opportunity, but it is matched by the challenge that the broad range of knowledge now available is fragmented. Hepworth and Larsen (1982) propose the ecological systems model first presented by Germain as "a generic framework capable of encompassing such theories and interventions . . . " (p. 16).

Noting that "ecological systems theory posits that individuals are engaged in constant transaction with other human beings and with other systems in the environment and that the various persons and systems reciprocally influence each other," Hepworth and Larsen's approach requires a knowledge of the many systems involved and that practice involves "assessing the sources of problems and determining the focuses of interventions" and then determining "what is to be done vis-a-vis the pertinent systems involved in the problem situation" (1982, pp. 16-18).

They go on to suggest "systematic eclecticism" as the best way to choose the most appropriate theory or model to address a

specific situation. They suggest four criteria for choosing among the plethora of models which might be included in a systematic eclectic approach:

1. The extent to which a given theory has been supported by empirical research . . .
2. . . . if two interventions have both been proven effective, the intervention that produces results with the least expenditure of time, money and effort is the more efficient and is preferable to the other . . .
3. . . . the extent to which interventions and techniques subsumed under the theory are specifically delineated . . .
4. . . . ethical implications and the practitioner's level of knowledge and skill with respect to given interventions. (Hepworth and Larsen, 1982, pp. 18-19) (italicized in original)

The ecological systems approach has its major strength and weakness simultaneously embodied in its breadth. Hepworth and Larsen see this as an advantage in that

> typical human problems involving health care, family relations, inadequate income, mental health difficulties, conflicts with law enforcement agencies, unemployment, educational difficulties and so on can all be subsumed under this model, enabling the practitioner to analyze the complex variables involved in such problems. (1982, pp. 17-18)

Such analysis in any one of the fields mentioned involves quite specific knowledge, however. Applying this "generic" model again begs the question of where students learn the specifics. Further, when the authors proceed to the interventive or "change oriented phase," what is presented is an amalgam of snippets from the various methods, theories (ranging from behavioral to psychodynamic) and techniques (from cognitive to confrontation to relaxation techniques). The attempt seems to be more a smorgasbord of the specific than an application of the general. To use Lewis' perspective this is a rule-based rather than principle-based approach.

Two examples of the generalist practice approach which Hartman mentions are those of Middleman and Goldberg, and Pincus and Minahan. Middleman and Goldberg present a "structural approach" which "aims to adjust the environment to the needs of the individuals" (1974, p. 9). It addresses microlevel practice, defined as focused on "the plight of individuals" as opposed to "the perspective of general problems such as poverty and delinquency" and purports to present a "methodology equally applicable in a one-on-one, group, or community context" (pp. 5-6). It hence rejects the traditional social work methods and concentrates on social change through daily practice. Rather than looking for underlying commonalities or overarching frameworks, as the previous two approaches presented, this approach proposed to look at what the profession does as a definition of what it is.

Using the dimensions of locus of concern (plight of an individual sufferer vs. plight of all sufferers of the same condition) and person(s) engaged (individual client vs. others), the authors present four types of social work activity ranging from work with the individual on his own behalf to work with nonsufferers on behalf of all sufferers in the category. Although the approach looks at the relationship between people and their environment, it states that "the social environment is the primary target of change" (Middleman and Goldberg, 1974, p. 32). The authors present four principles upon which the structural model is based:

1. The worker should be accountable to the client.
2. The worker should follow the demand of the client task.
3. The worker should maximize the potential supports in the client's(s') environment.
4. The worker should proceed from an assumption of least contest. (Middleman and Goldberg, 1974, p. 32)

Numbers one and three are relatively self-explanatory. Number two "requires the worker consistently and systematically to look beyond the client to see if others are facing the same task, and to assume different roles at different times as he performs different types of activities" (Middleman and Goldberg, 1974, p. 40). Number four "directs the worker to exert the least pressure necessary to accomplish the client task" (p. 50), for example, taking the role of broker before mediator, and the role

of mediator before advocate.

The authors go on to describe twenty-seven behaviors and the conditions for their use. This approach is, again, a rather rule-based one. The authors group the behaviors into six areas of skill: "(a) stage setting; (b) attending; (c) engaging feelings; (d) engaging information; (e) managing interaction; and (f) engaging barriers" (Middleman and Goldberg, 1974, p. 84). These are essentially interviewing and communications skills. While they are indeed general, they are so general that they could describe any number of professions or occupations, not just social work. Even the four activity areas which are seen as central to social work could describe a minister, lay counsellor or social activist as well.

Pincus and Minahan (1973) utilize a general systems approach (the predecessor to an ecological approach) to describe a model of "social work practice as a goal-oriented planned change process" (Preface, p. xiii). As do Middleman and Goldberg, Pincus and Minahan focus on the interaction between people and systems in the social environment; also similarly, they "do not view problems as attributes of people . . . (but) people's problems as an attribute of their social situation" (pp. 11). Unlike Middleman and Goldberg's model, however this model does address change in the individual(s) as well as the social system.

The authors define the practice of social work as:

Social work is concerned with the interactions between

> people and their social environment which affect the ability of people to accomplish their life tasks, alleviate distress, and realize their aspirations and values. The purpose of social work therefore is to (a) enhance the problem-solving and coping capacities of people, (b) link people with systems that provide them with resources, services, and opportunities, (c) promote the effective and humane operation of these systems and (d) contribute to the development and improvement of social policy. (Hepworth and Larsen, 1982, p. 9)

The authors go on to describe "four basic systems" which will be part of the "change effort":

1. Change agent system: The change agent and the people who are part of his agency or employment organization.
2. Client system: People who sanction or ask for the change agent's services, who are the expected beneficiaries of the service, and who have a working agreement or contract with the change agent.
3. Target system: People who need to be changed to accomplish the goals of the change agent.
4. Action system: The change agent and the people he works with and through to accomplish his goals and influence the target system". (p. 63)

These definitions and the use of the term "change agent" to describe the social worker reflect the fact that the underlying

ideas in this model were borrowed from the much broader field of "planned change." Later chapters on assessing problems, collecting data, negotiating contracts and exercising influence are equally broad conceptually although social work examples, largely from group work, are used throughout. The approach is more action-oriented than insight-oriented, with change seen as coming from the exercise of the workers influence rather than being internally generated. It seems to have more explanatory power for social action kinds of efforts than casework with individuals. This is reminiscent of the cause-function dichotomy mentioned by Hartman.

In a 1982 article, Joseph Anderson attempts to sort out some of the confusion between "generic" and "generalist" approaches. Although he was writing specifically in the contest of BSW programs, his comments are helpful in the general discussion.

In Anderson's view," 'generic' refers to the elements of social work that are characteristic of all social workers." He contrasts this with "generalists" which "refers to the social worker's knowledge and skills for practice" (pp. 38-39). He notes that "There is a generic base for social work methods, but methods, at least in direct service, are generalist, not generic" (p. 38).

His further discussion on this distinction are illuminating:

> Historically, we have had particular confusion when we try to determine what is generic about methods rather than about

> social work. This problem is based on the illusion that we can establish a generic methodology with enough breadth and depth to produce competence in practice. ...We may find some generic principles and skills for this practice, but we will not find a method, instructed by a unitary practice theory, that is applicable to all events that we confront in practice with individual, family, group, organization and community processes. We can seek the generic, however, in our basic purpose, function, focus, objectives and values in practice and in aspects of knowledge and skills. (p. 38)

Anderson also clarifies the distinction between "specific" and "specialist." In his view "'specific' refers to social work influenced by concrete aspects of practice, in particular agencies and fields" while "'Specialization' is continuous and disciplined effort in relation to some particular problem over many years" resulting in "a special technical expertise of intervention in relation to the problem" (p. 38).

Anderson goes on to present what he calls "the gestalt of direct service practice." This consists of the "generic base of social work" which includes:

> purpose: matching
>
> function: mediating
>
> focus: person - environment transactions
>
> objectives: self-actualizing services

The generic base is "consistent with social work's generic <u>values</u>

of individual dignity and worth, individualization, and self determination and based upon generic knowledge of human behavior in the social environment, some generic communication and problem solving skills, and particular practice theories which inform the methods used for influencing individual, family, group organization and community processes" (p. 35). The generic base in turn informs the "generalist base of social work." The generalist base includes assessment, goals, methods and processes, skills and practice wisdom. Practice wisdom in turn feeds information back into the generic body of knowledge.

Schatz, Jenkins and Sheafor (1990) use a similar model in describing initial and advanced generalist social work." There are differences in the elements included in the generic vs. generalist categories. The authors present the "generic foundation of social work education and practice" as including the following:

1) liberal arts base
2) social work knowledge base (biological/sociocultural/-psychological/human development material, systems and ecological perspective, and social work/social welfare history)
3) social work purpose
4) focus on person-in-environment
5) professionalism
6) sanction for practice

7) social work values and philosophy

8) basic communication skills

9) ethnic/diversity sensitivity

10) change process directed at problem resolution

11) understanding human relationships (p. 221)

The authors see these elements as the "foundation" for initial generalist, advanced generalist and specialist practice.

They describe initial generalist practice, as containing, in addition to the generic foundation.

> Perspective: (1) informed by sociobehavioral and ecosystems knowledge; (2) ideologies that include democracy, humanism, and empowerment; (3) theoretically and methodologically open; (4) direct and indirect intervention; (5) client-centered and problem-focused; and (6) research-based.
>
> Initial Competencies: (1) engage in interpersonal helping; (2) manage change processes; (3) use multilevel intervention modes; (4) intervene in multisized systems; (5) perform varied practice roles; (6) able to assess/examine his or he own practice; and (7) function within a social agency (p. 224)

For advanced generalist practice, the authors add on yet additional elements:

(1) increased knowledge of theories, concepts and models to understand practice with individuals/groups/organizations/

organizations/communities; (2) advanced practice skills to address complex direct practice situations including individual/family/group techniques; (3) increased skills to address more complex indirect practice situations including supervision/administration/policy/program evaluation techniques; (4) ability to conduct disciplined and systematic eclectic practice through extrapolation, synthesis, and refinement of generic and generalist competencies; and (5) ability to engage in theoretical and practice research and evaluation (p. 226).

The authors do not delve into the "specific"/"specialist" confusion other than to cite the 1988 CSWE curriculum policy statement that specializations can be organized around fields of service, population groups, problem areas, or practice roles and interventive modes. They see the generic elements as forming the base for either generalist or specialist practice. They hedge their bets by suggesting that social workers could either go directly to a specialized masters' program or complete a generalist (baccalaureate) program and then enter an advanced generalist or specialist program at the masters' level.

As this review indicates, agreement is far from unanimous on what constitutes generic social work, and where there is agreement on generic elements (knowledge and values, e.g.), there is little on where the specifics of practice are to be taught.

Chapter 3

Historical Roots of Employee Assistance Programs

In order to place the present study in context it is worthwhile to examine the roots of present day employee assistance programs and their development into a dynamic field of social work practice.

Writers in the EAP field have traced its roots back to the Middle Ages. Kurzman (1987) notes that medieval guilds provided for the financial security of members and maintained schools and almshouses. He notes that "...the guild...was, along with the Church, the central social welfare institution for guild workers and their families throughout the Middle Ages and until the advent of the Poor Laws of 1601" (p. 901). The guilds were the first example of assistance and services provided to people based on their work affiliation.

Midanik (1991) explains that there were two later historical threads which led to the development of EAP's: occupational alcohol programs and occupational social work programs. The history of occupational alcoholism programs is better known. Midanik comments that "...there is little acknowledgement or appreciation for the contribution of occupational social welfare in the early formation of non-salary benefits for employees" (p. 70).

Occupational Alcoholism Programs

Trice and Schonbrunn (1988) note that "Ironically, the

common use of alcohol as a mainstay of the workplace was the ground in which the first roots of job-based programs took hold" (p. 11). They note that in 18th century England, taverns were the employment agencies of the time and, not surprisingly, encouraged or required drinking. They note that "...drinking was deeply imbedded in both the leisure and job behavior of working class people" (p. 11). This pattern was transferred to the United States by English immigrants; immigrants from other societies "...had somewhat different, but generally supportive drinking norms" (p.11).

In a fascinating article, Harry Levine (1984) traces the sea change in social attitudes towards drinking from colonial times through the 19th century in the United States. For the colonists who were used to often impure water supplies in Britain, beer and other alcoholic beverages were seen as more healthful. Levine gives a summary of colonial attitudes toward drinking:

> In the 17th and 18th centuries alcoholic beverages, and especially rum, were highly esteemed and universally valued and were in no way stigmatized or regarded as tainted or evil. All liquor was regarded as good and healthy; alcohol was tonic, medicine, stimulant and relaxant. It was drunk at all hours of the day and night, by men and women of all social classes, and it was routinely given to children. Legal regulations and Puritan ministers commonly referred to alcoholic drink as 'the Good Creature of God.' During the

> 18th century per capita consumption was higher than in the 19th century and higher than it is today, and drunkenness was common. New England's Puritan ministers praised alcohol but denounced drunkenness as a sinful and wilful misuse of the 'Good Creature.' Most colonials, however, regarded drunkenness as unproblematic and unsurprising; drunkenness was seen as the natural, normal and harmless result of drinking. (p. 10)

Levine goes on to describe the transformation in ideas about alcohol which took place between 1785 and 1835, spearheaded by Dr. Benjamin Rush and other leaders of the temperance movement. The temperance movement

> ...identified liquor as the cause of many undesirable, unwanted and unhappy conditions and events (especially poverty, crime, violence, broken families and orphaned children, personal failure and business collapse) and also many diseases and illnesses (including ulcers, jaundice, liver disease, consumption, leprosy, madness, epilepsy and gout)...in the more extreme but often most common form of the argument, drinking became an all-purpose explanation for social problems — it became a scapegoat. (p. 109)

The 19th century temperance movement led to the demonization of alcohol, though it had "a very sympathetic and supportive attitude toward habitual drunkards who they regarded as addicts with a condition beyond the control of the will; often they called

this condition a disease" and some temperance organizations were the forerunners of Alcoholics Anonymous in their efforts to help "inebriates give up alcohol and stay sober" (p. 112).

The temperance movement led to the development of various prohibitionist movements, some "assimilative" and some "coercive." The prohibitionist campaign of the 20th century was driven by one organization, the Anti-Saloon League, a change from the heterogeneity of the 19th century temperance movements. It focused on coercive rather than persuasive strategies and aimed to eradicate two perceived enemies of the middle class: "the liquor industry which was pictured as an enormously powerful and corrupt force; and the saloon, especially the urban, working class and immigrant drinking place" (p. 113).

Levine argues that the prohibitionist movement which led to the national Prohibition Act in 1919 would not have succeeded without the support of business. In arguments prescient of those offered for industrial alcoholism programs, Levine comments:

> Members and representatives of the corporate elite supported prohibition in large part because they became convinced they would receive substantial economic benefits from it; more sober and abstaining workers would mean greater efficiency and productivity; less money for worker's compensation and court settlements; workers would have more money to spend on other commodities; there would be fewer strikes and wage demands because workers would not drink away their wages;

> the saloon would not be available for unions and socialist organizations...Further, at a time when corporations were feared and widely regarded as greedy and immoral, supporting prohibition was a way for corporations to deflect attention from themselves and to demonstrate a concern for the problems of American society...It was a way to show social and moral concern without having to acknowledge their responsibility for the problems. (p. 114)

With Prohibition observed mainly in the breach, pressure grew for its repeal. Interestingly, though, there was not the widespread public support for repeal as there had been for prohibition; people simply disregarded it. Levine comments that "there was virtually no organized opposition to prohibition until 1926 when one group – the Association Against the Prohibition Amendment – took over" (p. 115). This group was "organized, led and financed by some of the wealthiest and most conservative men in America.":the heads of Dupont Chemicals, General Motors, American Telephone and Telegraph, United States Steel and others.

Levine traces their interest in repeal to three basic reasons:

1. economic – "they believed if liquor taxes were restored their business and personal income taxes would be significantly reduced"
2. fear of "lawlessness" – disobedience to Prohibition was seen as leading to disrespect for all laws including

property law. Even John D. Rockefeller, who was a staunch prohibitionist and later campaigner for liquor control, came out for repeal in 1932 "because he had concluded that prohibition was seriously undermining respect for all law and order."

3. "economic panacea claims" — a revived liquor industry would put men back to work and ultimately end the depression. :"Just as prohibition had promised to bring about a new era of productivity and prosperity, repeal was promised to do likewise." (p. 115)

After repeal of prohibition, alcohol control became the province of state governments and alcohol lost attention as a public issue. Alcohol control addressed the legal distribution of alcohol, leaving the "temperance" concerns to private organizations. By the 1930's people no longer saw alcohol as inherently addictive as the temperance movement had. Levine notes that the founders of Alcoholics Anonymous revived the addictive idea by shifting the "locus of alcohol addiction from the substance itself to the body of the individual addict" (p. 116). Otherwise, Alcohol Anonymous adapted other temperance ideas pretty much wholesale.

The importance of Levine's historical work is to place the development of industrial alcoholism programs in the context of societal attitudes and changes. Ideas about alcohol and drinking have changed as other factors in U.S. society have changed;

similar ideas have emerged, later to submerge but not entirely disappear. Later still, they re-emerge in somewhat different clothing. Thus, the reformist idea in the temperance movement — that removing drinking would remove certain social problems — is echoed today in ideas about drunken driving and the impact of illegal drugs on poor urban communities.

Trice and Schonbrunn (1988) identify the first expression of concern about on-the-job drinking as occurring in the late 1800's. The Washingtonians, a temperance group which was active in the mid-1800's, had a policy of reaching out to drinkers and having "each one bring one." Trice and Schonbrunn state that "members frequently would seek out excessive drinkers from their work settings, often asking employers and coworkers for suggestions about whom to approach with their message" (p. 12). The authors note that "the Temperance Movement, Taylorism and Workmen's Compensation combined to drive alcohol from the workplace" during the early decades of the 20th century. The influence of the temperance movement was noted above. Taylorism, which highlighted efficiency and maximum use of time, created a work environment intolerant of unproductive workers, and heavy-drinking employees certainly fell into this category. The workmen's compensation laws in various states created a financial incentive to eliminate drinking on the job, since it was feared that drinkers could hurt themselves or other workers, with companies having to pay for the compensation.

Trice and Schonbrunn attribute the subsequent development of workplace programs in the early 1940's to three influences:

> First was the birth and sudden growth of Alcoholics Anonymous (A.A.). Second, influential and dedicated medical directors came to support and actively initiate programs during this period, providing a high status leadership to the emerging programs. Third, this development converged with the unique labor market conditions during World War II. (p. 14)

This third item refers to the fact that given the enlistment of a large proportion of working men in the armed services, and the demand for peak production for the war effort, companies were hiring marginal workers who might not otherwise have found employment. Among those hired were a larger number of people with drinking problems, and it was in the companies' interests to rehabilitate them, since they had no other pool to tap.

The programs that emerged in the 1940's were predominantly management-based and relied heavily on the A.A. model. In fact a number of the key players who developed inside programs or consulted with companies were recovering people themselves. Often the activities to reach drinkers in the workplace were kept quiet.

By the 1950's there was increasing publicity about the pioneer programs and recognition of their successes. Trice and Schonbrunn note that "there was a sharp increase in the number of formal written policies and a diminution of the 'quietly started'

ones" (p. 31). They cite a number of reasons for this increase in addition to publicity:

- A.A.:"its General Services Office continued to respond to inquiries about job-based programs from both members and nonmembers."
- The efforts of the Yale Center for Alcohol Studies including the active efforts of Ralph Henderson and Selden Bacon to reach executives of large corporations
- The efforts of the Christopher D. Smithers Foundation:"Although its focus was much broader than industrial alcoholism, it soon came to regard industry as a major arena for programs and prevention efforts. Moreover, its early emphasis was on the need for labor and management participation in joint planning and action."
- The formation of a committee on Alcoholism in the American Association of Industrial Physicians and Surgeons and chapters on alcoholism in medical textbooks.
- the proliferation of conferences and research focused on alcoholism including Jellinek's seminal 1947 article estimating the impact of drinking on the workplace.
- the emergence of union interest in work-based programs. (pp. 31-38, passim)

Masi (1984) also notes the creation of the National Council on Alcoholism in 1949, formed when it separated from the National Committee for Education on Alcoholism which was under the auspices

of the Yale Center (p.7). Another key development in the early 1950's was the publication by Henderson and Bacon of the "Yale Plan for Business and Industry":

> The Plan contained a series of specific suggested policy guidelines a company could follow to openly deal with the problem drinking employee, containing sections on the pivotal role of line supervisors, location of coordinators in the company, and counselling-referral. It put frequent emphasis upon alcoholism as a health problem and upon the alcoholic as a sick person. (Trice and Schonbrunn, 1988, pp. 28-29)

Masi describes the 1960's as a period of growth for occupational alcoholism programs and a time of "initial steps toward a merger of programs that focused on alcoholism with those that focused on behavioral problems, including problems of an emotional or financial nature" (p. 11).

Things really accelerated with the passage of the Hughes Act in 1970. This law established the National Institute of Alcoholism and Alcohol Abuse (NIAAA) in the Department of Health, education and Welfare. The Occupational Program Branch was mandated to offer technical assistance and support to work organizations in order to establish programs. What was significant was that these programs were not identified as "alcoholism" programs but employee assistance programs. Midanik (1991) comments on this broader approach:

> One highly significant result of NIAAA's involvement in this

> area (worksite programs) was the broadening of these early programs to include a variety of problems and issues that went well beyond the initial concern with alcohol problems. One explanation for this new "broad brush" approach was that NIAAA was striving to destigmatize existing workplace programs. It was felt that programs which only emphasized alcohol problems might not be given priority within an organization because "alcoholism" is a stigmatized problem both within and outside the workplace. Second, it became clear that waiting until an individual's problems became so severe that work performance was affected might not be as effective as trying to work with an employee whose problem, alcohol-related or otherwise, was in its earlier stages. (p. 72)

Roman (1988) notes NIAAA's goal of increasing the number of occupational programs, and comments about the broader EAP approach: "With such an increase in latitude and potential acceptability, use of this model maximized the number of programs that could be adapted and developed" (p. 64).

This new "broad brush" approach was not without controversy in the alcoholism field. Strong opposition to the EAP approach was expressed at the 1974 meeting of the Alcohol and Drug Problems Association of North America. Roman states that the National Council on Alcoholism (NCA), the Community Services Department of the AFL-CIO and some of the individual state consultants paid

through NIAAA were opposed:

> NCA alleged that inclusion of alcohol problems in a larger service package would lead to their receiving equal or lower priority than other problems; NCA also maintained that the broad-brush approach would reverse the destigmatization achieved with a model directed at alcohol problems. National labor representatives viewed the broader program as too vague for working agreements between labor and management, as a potentially unlimited mechanism of social control that could be abused by management, and, much less explicitly, as a model that overlapped and competed with pre-existing union counselling programs. The individual consultants supporting the model emphasizing alcohol problems based their advocacy on their own and their clients' commitment to alcohol problems. All of these groups contended that the use of NIAAA funds earmarked for alcohol problems to support the development of employee assistance programs was illegitimate. (1988, p. 64)

Masi had met with a group of occupational alcoholism administrators during the early 1980's when NIAA's shift in focus was emerging. She comments:

> When this shift occurred, I pointed out that opening up the program to employees who were not alcoholics would justify other professions entering the field and claiming expertise. This statement was disregarded at the time, but today the

> EAP field is becoming dominated by human services professionals, many of whom are without training in alcoholism. Although I advocate the broad-based model, I acknowledge that the lack of professionals trained in alcoholism remains a critical issue and source of tension in the field (1984, p. 12).

Indeed, Roman sees this shift as moving the field into greater linkage with other groups including occupational medicine, organized labor, social work and treatment agencies.

Scanlon (1986) highlights a number of other milestones in the growth of occupational alcoholism programs and EAP's:

1971 Association of Labor-Management Administrators and consultants on Alcoholism (ALMACA) formed

1972 NIAAA offers staffing grants to support the work of two Occupational Program Consultants (OCP's) in each state

1973 Approximately 500 occupational alcoholism programs in operation nationwide

1974 Seventy-five percent of Blue Cross plans (62 percent of Blue Shield) have some degree of alcoholism coverage available

1977 2,400 employee alcoholism programs are at some state of development in public and private employment centers in all 50 states

1983 Several states pass legislation mandating insurance

companies to offer coverage for alcoholism/drug abuse treatment

1984 8,000 employee assistance programs addressing alcohol, drug and other troubled employee problems are in place and operating

1985 ALMACA hires credentialling specialist in first step of process to build database and develop criteria for credentialling EAP's

1986 Rockefeller College, State University of New York of Albany, plans to develop curriculum offering graduate degrees and/or certificates in employee assistance programming. (pp. 23-24, passim)

Credentialling of alcoholism counsellors became a big issue in the field during the late 1980's and early 1990's. The push for credentialling, first on a state by state basis and then nationally, came from two directions. First, the entry of professionals – notably social workers – into occupational alcoholism programs in the 70's (as noted above) threatened the position of the traditional alcoholism counsellors who were largely recovering people with only their own addiction and recovery experience and A.A. as training. Credentialling was seen as a way of legitimizing the work of these traditional counsellors and protecting their position in the field. Interestingly, in the training offered for alcoholism counsellors the place of other professionals (doctors, nurses and social workers) is included in understanding the

operation of the "treatment team."

The second direction for the push came from treatment programs who wanted more assurance of competency in hiring workers and who wanted to project a professional image in their programs. In another interesting twist, credentialed alcoholism counsellors in the 90's have begun describing themselves as "professionals" based on the credential. This has again caused controversy in the field since the alcoholism counsellors generally do not need to meet any educational standards other than having taken the prescribed courses for the credential. This obviously in sharp contrast to the professions which require graduate level training.

The credentialling of alcoholism counsellors fits within the change from alcoholism-focused programs to the broader EAP programs described above. Indeed, ALMACA itself recognized the dominance of the EAP model by changing its name in 1989 to the Employee Assistance Professionals Association (EAPA). EAPA went on to develop its own credential – the Certified Employee Assistance Professional (CEAP) – again contributing to the fuzziness in the use of the work "professional" in the alcoholism field. An often unstated but clear underlying reason for this jockeying for position within the field is that alcoholism and drug treatment became a real growth industry in the 1980's, and a lucrative one at that. In the generally dismal social service climate during the Reagan and Bush administrations, drug and alcoholism treatment

and EAP's stood out as beacons of employment. No wonder that the stakes for social workers and alcoholism counsellors in respectively gaining and holding ground in the field became so high. This competition has continued into the 1990's although the growth in the field has slowed.

By the 1980's the broader EAP model had clearly come to dominate the field and absorbed the occupational alcoholism programs of the past.

Several federal laws contributed to the growth of EAP's since the 1970's. Section 504 of the Rehabilitation Act of 1973 provided protection and rights for handicapped persons in the workplace and included alcoholism in its definition of handicapping conditions. The Drug Free Workplace Act which went into effect in 1990 focused on keeping illegal drugs out of the workplace and required employers receiving federal grants to have a policy prohibiting the use, sale or distribution of illegal substances (ironically, because it is a legal drug, alcohol was not included under the Drug Free Workplace Act). It also required grantees to make a "good faith effort" including having a drug awareness program. While it did not mandate the creation of EAP's, it specifically mentioned EAP's as a vehicle to meeting part of the requirements.

The Americans with Disabilities Act enacted in 1990 and effective in 1992 prohibits employers with twenty-five or more employees from discriminating against qualified disabled persons

in application, hiring, advancement, dismissal, compensation, job training and all other terms and conditions of employment. The ADA requires employers to make "reasonable accommodations" to allow disabled employees to perform effectively on the job. Under the ADA, disability includes alcoholism and addiction although it does not extend coverage to employees actively using illegal drugs. It does cover employees who are in treatment or who have successfully completed a drug rehabilitation program. EAP's commonly serve a liaison function in getting employees into treatment and helping them re-adapt to the workplace.

Occupational Social Work Programs

The roots of occupational social work programs in the United States go back to the late 19th century when the country was becoming increasingly industrialized. Some of the work force were farmers who migrated to the cities; many were immigrants from Europe who also came from rural backgrounds. Googins and Godfrey (1987) note that the metamorphosis "of the world of work as a separate sphere from the home brought with it cultural and social changes to which the new industrial workers adjusted with difficulty." They comment that "...the uneducated immigrant was unsocialized to any norms of the workplace, often adjusting only marginally to an urban existence of squalor, sprawl and density" (p. 19). They comment as well on the great social unrest among labor, with strikes widespread and fear of social revolt. The need to socialize the work force and the desire to control

workers' unrest led to the creation of "welfare capitalism."

> From roughly the beginning of the post-Civil War industrialization movement through the Great Depression, American business and industry have sponsored a host of programs aimed at creating a working and community environment that would insure healthy and productive workers while ameliorating the potentially disruptive conditions mentioned above. During this period housing was built for employees and their families, schools were established, churches were constructed, medical care was provided, pension funds were introduced, recreation centers were established, magazines were published, and profit sharing and stock ownership were introduced. Just about every problem discussed under today's social welfare programs was addressed by industrialists in this early form of welfare capitalism. (p. 19)

Companies hired "social secretaries" or "welfare secretaries" to oversee the provision of these services. Since many of the early factory workers were women, the welfare secretaries were also responsible for supervising their wellbeing and keeping them away from "vice." Most of the secretaries were women and initially they had no formal training. Somewhat later, some of the secretaries were trained at the New York School of Social Work or the Bryn Mawr School of Social Economy (Midanik, 1991, p. 74). Social workers thus were associated with the welfare capitalism movement.

Although the welfare secretaries were the means of access to the goods and benefits provided by the companies, they were not viewed as benign. The welfare secretaries were closely connected to management and perceived by some workers as paternalistic and intrusive. They were also perceived by labor leaders as anti-union. Kurzman (1987) comments that they had a "covert responsibility to investigate employees and to see that labor unions did not gain a foothold in industry" (p. 901). By the 1920's the job of welfare secretary started disappearing with the functions dispersed to personnel officers and industrial nurses.

The legacy of the association of social work with welfare capitalism remained for years afterwards, however, and it was a legacy of distrust by working people and their labor leaders. Googins and Godfrey (1987) comment:

> This association engendered animosity between unions and social workers, particularly since many early social workers were wives of industrial capitalists. For all the activism of social workers in the social reform movement early in this century, there was a dark side of social work which naively colluded with industrialists to diffuse and weaken the forces of unionism. While modern-day occupational social work can be traced to a different ideological base, it cannot entirely disassociate itself from these roots. (p. 21)

A new force which encouraged the development of social

services in the workplace emerged in the 1930's and 1940's in the human relations movement. This ideology, which emerged in response to and reaction against Taylorism, focused on how workers felt about their work and their relationship with coworkers and supervisors on the job. It was perceived that these human relations elements had a large role to play in determining if employees voluntarily cooperated in the work of the organization. This was in sharp contrast to the engineering perspective of Taylorism which viewed workers as essentially interchangeable parts of the machine.

The human relations movement espoused the provision of fringe benefits to protect workers from the exigencies of life and encouraged a humanistic view of workers with "needs for belonging, dignity and even participation in problem solving and decision making" (Googins and Godfrey, 1987, p. 22). As with all strategies adopted by management, the bottom line was a perceived increase in productivity if workers were content in the workplace. Quoting Bartell, Googins and Godfrey note that a number of external pressures led to the adaption of the human relations movement by business:

- a broad social movement emphasizing the social responsibility of industry and desire by industry to prevent government from legislating such responsibility;
- development of psychological theory stressing higher human needs and the importance of being fulfilled (job

satisfaction or a sense of purpose);

- growth of labor unions;
- increased size of organizations and resultant bureaucratization with greater spans of control (with resulting problems of maintaining control);
- improved education of workers and higher work expectations;
- specialization of workers and greater costs of training;
- emergence of a specialized group in industry whose role was to negotiate between labor and management (Bartell refers to this group as a "prime consumer of human relations ideology");
- belief in an industry maxim that "a happy worker is a productive worker," with a corresponding investment of money in studies to that effect;
- institution of industrial relations schools in major universities, often subsidized by industry. (pp. 22-23)

The authors see the provision of human services at the worksite as arising directly from the human relations philosophy and point out that current personnel and human resources practices flow directly from this movement.

World War II created a new need for industrial social work. As noted in the occupational alcoholism section above, wartime demands and the unavailability of the traditional work force caused industry to draw on different labor pools. Women and

minorities, as well as people with marginal work histories, entered the factories and munitions plants and faced both adjustments to the workplace and, for women, demands as single parents.

Kurzman (1987) notes that social workers were better accepted in the workplace at this time for a number of reasons:

- There had been a "rapprochement with the trade union movement in the 1930's through active support of CIO organizing drives and through their caring service to unemployed workers during the Great Depression"
- Social workers in the wartime industries and unions were unions members themselves and "handled themselves not as therapists, but as advocates for members"
- Social workers participated in the armed forces during the War, notably an army officer corps of social workers. (p. 902)

Kurzman notes that these gains did not lead to immediate postwar growth in occupational social services. Although companies in Europe and South America employed social workers companies in the United States were more concerned with the return to a postwar economy and the re-integration of veterans into the work force. He traces the emergence of "modern" industrial social welfare practices to the mid-1960's, with the development of a management-sponsored employee counselling program at Polaroid and a union-based mental health program sponsored by the Amalgamated Clothing Workers of America.

The proliferation of occupational programs from the mid-1970's on is attributable to a number of factors, primarily the change in makeup of the work force and the passage of a number of Federal laws promoting worker rights and safety in the workplace. The work force increasingly included women, minorities and persons with disabilities. The growing participation of women, who traditionally carried major family responsibilities, and the human relations philosophy noted above, contributed to a less dichotomous view of the world of work as separate from the workers's home life. It was increasingly recognized throughout business that workers come as "whole people" and that their personal concerns and problems are not checked at the door to the office. Life issues like child care and elder care drew attention in the business press as well as in bargaining units. As the scope of legitimate work-family issues became broader, the place of social work became clearer and businesses increasingly turned to social workers to staff EAP's and corporate counselling programs.

Kurzman points out that unions were active in establishing new services for their members during this period. As a result of their success in winning financial benefits at the bargaining table, the unions turned to services like continuing education, extended benefits and counselling programs as a way to hold their members' loyalties. Many member assistance programs were born in the 1970's.

The streams of occupational social work and occupational alcoholism programs started to flow together in the 1970's, as both were influenced by the Hughes Act and the efforts of NIAAA. Also, as social workers started recognizing opportunities in the occupational alcoholism programs of business their movement into the for-profit world became more apparent. The broader biopsychosocial perspective of social work in turn started influencing how occupational programs were perceived.

Schools of social work recognized the opportunities and took the initiative in conceptualizing social work practice in the world of work. The establishment of the Industrial Social Welfare Center at the Columbia School of Social Work in 1970 was followed by the introduction of industrial social work programs at Boston College, Hunter College and the University of Utah. (Kurzman, 1987, p. 904) Kurzman notes the growth in the number of schools of social work offering occupational social work specializations, affirming the place of this field of practice in the mainstream of the profession.

The convergence of the two streams of occupational alcoholism programs and occupational social work programs in the EAP field was largely completed by 1980 although debates about the proper amount of emphasis on treating alcoholism and addictions remain. As Kurzman summarized:

> A broad model of service, customarily offered under the auspices of an employee assistance program or, in unions,

under a personal service or member assistance program, has become the prevailing model. The focus is direct service but...direct service in these settings is an all-encompassing term. It includes counselling, organization of support groups, concrete services, consumer advocacy, linking an individual to community services, training and staff development for union representatives and management personnel, and consultation to union and industrial decision-makers. (1987, p. 906)

Chapter 4

Employee Assistance Programs as an Area of Practice

The previous section follows the evolution of employee assistance programs from their roots in occupational alcoholism and occupational social work. This chapter provides a look at the state of EAP's today.

First of all, what is an employee assistance program? Spicer (1987) offers a good basic definition:

> An employee assistance program can be defined as an employer- or labor-sponsored service designed to assist employees and often their dependents, in finding help for drug, mental/emotional, family, health, or other personal problems. EAP's are typically funded and supported by an employer or union, and are considered an employee benefit as well as a means of improving employee (and therefore employer) productivity through reducing personal problems that may negatively affect an employee's job performance. (p. 5)

Scanlon (1986) notes that "'Employee assistance programming' is a generic term used to identify any such service that addresses the personal problems of an employee. It is sometimes described as an employer-sponsored employee benefit consisting of diagnostic and referral services for employees and their families" (p. 17).

Within this broad definition there are many variations on the EAP "theme." There are a number of models of EAP's and the models mix and match features on several dimensions.

One dimension is sponsorship. The program may be sponsored by an employer, by a union (in which case it is known as a member assistance program) or jointly sponsored. Sponsorship has significance in terms of how the program is perceived by potential clients. For example, an employer-sponsored program must address implicit client concerns about confidentiality and whose interest are primary to the program (employee or employer?). Union sponsored programs clearly come down on the side of the employee's interest but must address legitimate workplace concerns to have credibility. A jointly sponsored program might require a more explicitly stated and negotiated agreement on how employer and employee interests are balanced.

A second dimension is location. An EAP program may be located on-site at a work location, at a central service location within the same company or at an external location. Concerns about confidentiality are probably highest at on site EAP's although confidentiality as an issue must be addressed by all EAP's. Leavitt (1983) has noted that there are advantages and disadvantages for both internal and external programs. For internal programs he cites as the advantages:

1. Program control is completely internal
2. Knowledge of organization
3. Communication within organization
4. Ownership of program, i.e. "it's our program"
5. More credible with some supervisors

6. On-site problem assessment capability

An additional advantage which he does not cite is ease of access for employees.

He cites as disadvantages:

1. Problems of confidentiality or the appearance of such problems.
2. Only large organizations can justify full-time staff.
3. A part-time person for smaller organizations usually will mean an inadequately trained person with insufficient time.
4. Level of person(s) in program will usually limit the level of employees participating.
5. Numerous roles to fill by limited staff
6. Skills and expertise limited by small staff
7. Possibility of staff "burnout" with one person program (p. 4)

Leavitt notes two types of external programs: an independent EAP provider ("service center") and "treatment or social service agency based program." The advantages which he cites for such external programs are:

1. Less costly for small or medium size employers
2. Confidentiality easy to maintain
3. Off-site counselling
4. Better identification and utilization of community resources

5. Increased range of employees served
6. Better communications with professionals in community resources
7. In rural areas or small towns, the primary treatment resource may be the only resource capable of providing such services (p. 6 and p. 8)

The disadvantages which are noted for external programs are:

1. Usually no on-site counselling capability
2. No ownership
3. Some supervisors reluctant to deal with "outsiders"
4. Lack of knowledge about organization
5. Communications between service center and work organizations are sometimes difficult.
6. Validity of assessment or diagnostic service
7. Validity of referral (p. 6 and p. 8)

A third dimension is the employment status of the EAP staff. Are they employees of the employer's organization, employees of a contracted nonprofit or for-profit EAP provider, or consultants? Staff who are employees of the employer's organization may have some of the same advantages noted for an internal location: knowledge of the organization, communication within organization, ownership of the program as well as a direct understanding of "what it's like to work here." The disadvantages are also similar to those noted for location. The EAP worker who is a direct employee must be particularly mindful of how they are perceived by

clients. If they are seen as part of the disciplinary mechanism in the workplace, as an arm of management, the client is unlikely to trust their motives. EAP workers who are consultants are in a similar position as it is generally understood that they must meet management's needs in order to keep their contracts. EAP workers employed by nonprofit or for profit providers may be perceived as more neutral or more attuned to client needs; the disadvantage is they may be seen as not really understanding what the employing organization is like and unattuned to political elements within the organization.

In actuality, EAP workers in each of these statuses need to be cognizant of Akabas and Kurzman's (1982) caveat:

> The world of work is an adversarial setting where the parallel interests of the individual and those of the organization may not be readily apparent. Issues around whose agent the practitioner is, confidentiality of information and protection of clients' jobs sometimes strain professional role and function in such a setting. Cooptation, especially around the goal of productivity, is understandable and tempting, but, given the mandate of our professional code of ethics and our dedication to individuals and their needs, it must be avoided. Such avoidance may be more difficult for those who choose to work for management than those working with trade unions where organizational self-interest is more likely to be akin to protection of the individual's needs

than in the profit-making organization. (p. 198)

A fourth dimension is the professional training and status of the EAP staff. EAP staff range from peer counsellors with no professional training, to alcoholism counsellors with or without credentials, to licensed social workers, psychologists, nurses and in rare cases medical doctors. The professional status of the staff has significance in terms of client willingness to use the service (e.g. senior and professional employees may be more likely to see a professional EAP worker); the problem focus (e.g. on substance abuse vs. a broad range of problems), and the type of service offered (e.g. a peer counsellor is more likely to offer information on community services while a professional might offer actual treatment).

A fifth dimension is whether the program is focused on alcohol and substance abuse problems among employees or whether it is a "broad brush" program. Kurzman (1993) presents a useful comparison of what he terms the "core technology" (after Roman) and "comprehensive service" models of EAP's. Historically, comprehensive programs developed later and were in some ways a natural evolution from the core technology programs. At the heart of the core technology programs is the concept of "constructive confrontation" which uses documented deterioration in an employee's job performance as leverage for pressuring/encouraging him to seek help with a drinking problem. Erfurt and Foote (1977) note that there is a fundamental principle underlying this ap-

proach which logically extends to comprehensive programs.

> ...no employing organization has a right to interfere in the private lives of its workers... It is only when a personal problem interferes with work performance that an employer may intervene formally and ask the worker to take corrective action. But the reasons for deterioration of work performance are not confined to alcoholism. Therefore, a program based on the work performance principle must be prepared to respond to all types of employee problems. (p.2)

In his comparison, Kurzman notes that "the core technology model has a history of success in reaching out to middle-and later-state alcoholics who work under close supervision in manufacturing settings" but factors like the major decline in manufacturing jobs; "the increasingly blurred boundary between supervisor and supervisee;" and a switch from hierarchical to more lateral structures and teams in the workplace, lead to difficulty in applying the constructive confrontation approach which assumes a hierarchical structure and clear job performance criteria (p. 35). Kurzman posits that the comprehensive model is "a conceptually different program. It is an entitlement; a new occupational benefit; an expert, interdisciplinary resource that is available to workers and their families by dint of their affiliation with the workplace" (p. 35). Moreover, the comprehensive model focuses on health and promotion of social functioning, in contrast to the core technology approach which focuses on the disease of substance

abuse. Kurzman (1993) gives a complete comparison of the two models in a table, which is reproduced below.

Two EAP Models: Core Technology versus Comprehensive Service

VARIABLE	CORE TECHNOLOGY	COMPREHENSIVE SERVICE
Design	Management tool	A benefit for workers
Orientation	Alcohol and drug abuse	Personal problems that may affect ability to function productively
Principle	A workplace disciplinary alternative	A workplace social utility
Function	Supervisory training and intervention with workers	Supervisory training, intervention with workers, workplace health, education, wellness, and prevention
Focus	Current job performance	Present and potential capacity to function
Objective	To enhance employees' productivity	To preserve precious human and fiscal resources
Concept	New personnel prerogative for employers	New resource and entitlement for workers
Intervention	Constructive confrontation	Differential biopsychosocial assessment and intervention
Services	Prescribed and proscribed by the Roman–Blum (1985) model	Evolving to meet the changing needs of workers and work organizations
Scope	Assessment and referral	Assessment, referral, prevention, and short-term treatment
Intake	Primarily by supervisors' referrals	Referral by supervisors, self, and peers
Clients	Workers	Workers, families, and their communities
Prevention	Tertiary	Primary and secondary
Staffing	CEAPs with CAC counseling credentials	Interdisciplinary team, led by licensed health or mental health professional
Perspective	A health versus pathology perspective; goal: to discipline or to heal (cure)	An ecological-life perspective; goal: to enhance social functioning
Commitment	To provide prescribed services	To provide prescribed services and to promote social change (p. 34)

In addition to the core technology and comprehensive models, Spicer (1987) notes that in recent years, there have been other emerging EAP models. He mentions wellness and health promotion; EAP marketing model; and cost containment model. The wellness and health promotion EAP's generally maintain counselling as a core service but offer individual or group programs addressed to wellness, e.g. a healthy heart education program, a stop smoking program, stress reduction program.

Spicer describes the marketing model as having the "EAP service...discounted or provided free as a way of increasing referrals to the provider" (p. 5). This model might emerge for companies who use outside EAP providers as a way of economizing. There are some ethical issues raised by this model: will services be geared to the needs of the employee and employer or more to the self interest of the provider in obtaining referrals? Would the client be given other choices for service or only "steered" to the single provider?

In the cost containment model the EAP serves as a "gate-keeper" for clients receiving services and an explicit goal is cost containment for the employer. A number of private, for profit EAP companies have already adopted this role under managed care initiatives. Again there is a potential conflict of interest question raised in this model: can the EAP impartially and accurately assess the employee's need for service if its strong mandate is to control costs for the employer?

A sixth dimension is whether the EAP offers a limited number of contacts/sessions to clients or whether contact is open-ended. Concerns about cost-savings and the establishment of managed care systems in many companies has encouraged a limited contact model in many settings. Often an EAP offers a limited number of sessions for assessment and then refers the client out for treatment. At the other end of the spectrum are EAP's which offer unlimited contacts. These EAP's are more likely to offer treatment and have staff who are employees of the parent organization.

A seventh dimension is whether the EAP operates on a supervisory referral model, a self-referral model or both. The supervisory referral model is historically connected to alcohol-focused programs and is implicit in the "constructive confrontation" approach used in these programs. The advantage of a supervisory referral model is that it may pick up a greater number of alcohol and substance abuse cases. There are disadvantages with this model, however. As Masi points out

> The supervisory identification approach was designed to train supervisors to recognize the symptoms of alcoholism among subordinates and to encourage these people to get help. Since first-line supervisors were usually the people trained to be the diagnosticians, seldom was anyone above that level identified. Such a system enabled management to view alcoholism as an affliction of the lower echelons of the corporation. The approach came to resemble a witch-hunt

> and forced alcoholics simply not to show their symptoms while working. This was possible, since most employees did not exhibit the late-stage symptoms, which were the focus of the program. (1984, pp. 8 and 9)

Shain and Groeneveld mention an ethical issue present in the supervisory referral model. Since this model hopes to identify employees with alcohol or substance abuse problems early in the course of their illness, when the prognosis for recovery is much more positive, supervisors are generally encouraged to refer employees as soon as they perceive problems. Shain and Groeneveld note that

> The trouble is that in order to be on safe ethical ground we must assume that all <u>early</u> signs and warnings eventually mature into <u>later</u> signs and fulfilled prophecies. That is, we must assume that alcoholism is a deteriorative condition without spontaneous remission which is guaranteed to progress to a chronic stage. We must also assume that we know what all the early signs and symptoms are. This is a deterministic view of alcoholism. The fact of the matter is, however, that not every person who exhibits early-warning signs will become alcoholic whether some intervention occurs or not. Therefore, the earlier the alleged "sign" the more we are dealing in probability than certainty. (1980, p. 13) (authors' emphasis)

They go on to point out that an employee labelled as a

potential alcoholic or drug abuser may go on to "act as though he really possessed the attributes ascribed to him by the labeller," i.e. create a self fulfilling prophesy. (p. 14) An additional issue not mentioned by the authors is that the label of alcoholic or drug abuser still carries a good deal of stigma, and erroneous labelling does employees a great disservice. Still another issue, which is present particularly in unionized settings, is that employees and their representatives may justifiably object to supervisors being placed in a diagnostic role since clinical expertise is not generally part of their training or responsibility. Indeed such diagnosis may be grounds for a grievance.

The self-referral model resolves these issues, as the employee seeks help on his own. Presumably the motivation of such employees to use help is higher than employees who are referred by supervisors. Such self-referrals fit comfortably into the comprehensive model EAP described by Kurzman:

> The comprehensive model suggests that all people (including workers) have problems coping all the time with an environment that provides too few resources and a world that makes too many demands. Thus, it is the "healthy" worker who seeks help and the wholesome workplace that provides it without stigma. (1993, p. 33)

The disadvantage with the self-referral EAP is that it may not get a proportion of employees who truly need help but will not

seek it on their own, particularly those with addictions or other emotional problems which involve denial as a defense, as Masi points out. She further argues that relying on self-referrals moves EAP's closer to "typical community family agencies" (1984, p. 20). While some may applaud this, she notes that this change would represent a shift from focusing on cost effectiveness and job performance, usually key selling points for EAP's, and that "United Way family agencies are already available to workers on a self-referral basis and are supported by both employers and employees, so funding a duplicate service effort is unnecessary" (p. 20).

As implied earlier, this dimension of self-referral vs. supervisory referral has implications for how broadly the EAP may penetrate the levels of the organization. In a supervisory referral model, the implicit message is that a lower-level employees have problems but supervisors or administrators above them in the organizational hierarchy do not. This message is not only erroneous factually but can serve as a real barrier to having higher level personnel seek help.

The last dimension is the range of services offered by the EAP. Leavitt comments that "...the services may range from providing information on how and where to get help to diagnosis, referral, and counselling or treatment" (1983, p. 3). Kurzman notes that the now prevalent comprehensive EAP's include education, prevention, assessment, treatment, case management and

referral (1993, p.35). Many EAP's have expanded still further to offer health and wellness programs. The range of services offered will be determined by a number of factors including funding, the professional level of staff and the program focus.

In summary, EAP's are marked by a great deal of diversity although certain central tendencies, such as the dominance of the comprehensive model, emerge. Googins and Godfrey's comments are to the point:

> EAP's have not evolved in an orderly, rational fashion; rather development is best described as idiosyncratic, producing numerous program types and philosophies. Thus the occupational alcoholism/employee assistance field lacks a universal model and is characterized by a variety of program types. (1987, p. 101)

As one would assume from the above description of EAP's, social workers who practice in EAP's have a broad range of functions and roles which are determined by the particular model and services their EAP has adapted.

The primary role for most EAP social workers is clinical, including doing assessment, treatment (short or long term) and referral. Social workers are particularly well suited for assessing clients who come to comprehensive EAP's which are the majority of the programs. The biopsychosocial assessment which is at the core of social work clinical practice allows the EAP social worker to assess the broad range of physical, emotional,

psychiatric, interpersonal, financial, legal, housing and other problems which clients present. Though each individual EAP social worker may not have an in-depth knowledge of each of these problem areas, her training in working in systems including research to identify resources and working collaboratively with intramural and extramural colleagues, allows her to access the assistance her clients need.

In addition to the clinical role, EAP social workers often carry administrative, supervisory, research and educational functions. Since most EAP's are small programs, one social worker may carry a number of these functions. The administrative function includes both the "maintenance functions" needed by the EAP program and accountability to the sponsoring company or union. The supervisory function covers supervision of staff and often graduate social work students. The research done in EAP's is generally marketing research addressing questions like what is the profile of the client and potential client population, what the needs and interest of this population are and what services the EAP might offer to meet these needs. The educational function includes general education to the employee population about health, mental health and family life issues; education to supervisors about their role in identifying and referring troubled employees; and education to graduate students in social work skills and, particularly, EAP practice.

The range of roles which they fill and problems which they

address suggest that social workers in EAP settings need a solid combination of education in generalist social work skills and specific content on practice in EAP's.

Chapter 5

Education for EAP Practice

What do social workers need to know in order to practice effectively in EAP's? There have been a few efforts to address this question.

Hoffer (1989) utilized the Delphi technique to interview a panel of social work educators and practitioners on "what educational ingredients are essential for preparing students for competent practice in the field of occupational social work in the 1990's." Eighty-four panel members (39 educators and 45 practitioners) completed three rounds of questionnaires on this question. The respondents agreed on fifteen knowledge items which would be of highest priority for occupational social work students. The top-ten items were

1. Community resources and ways of access
2. Advance understanding of ethical practice issues
3. Models of social service delivery in occupational and traditional settings
4. Adult life cycles and related crisis
5. Labor/Management/Industrial relations and issues
6. Addictions and their effects
7. Alcoholism and substance abuse – theories and treatment
8. Power, use of power, and powerlessness
9. Organizational development and practice
10. Work: Significance and meaning to individuals,

organizations, and society. (p. 215)

The respondents further agreed on seventeen skill items. The top ten skill items were

1. Advanced problem-solving skills
2. Referral skills and techniques
3. Development and utilization of support networks
4. Crisis intervention
5. Development of framework for assessment, planning and intervention within context of person, family and workplace
6. Short-term counselling
7. Ability to define and resolve value conflicts
8. Consultation skills
9. Skill in utilizing confidential information
10. Program planning. (p. 217)

Finally, the respondents identified personal and professional traits which were considered important for occupational social work. Hoffers grouped these traits into three clusters:

- communication
- personal and professional confidence and maturity
- commitment to the legitimacy of social work practice in the workplace. (p. 219)

Googins and Godfrey in their book on occupational social work note that "the traditional OSW educational programs have offered (and must continue to offer) an educational core that

introduces students to work, work organizations, and social work roles and functions within this environment" (1987, p. 187). They go on to comment more specifically for EAP's that "... counselling within an E.A.P. will require specialized knowledge and skills particularly in the areas of substance abuse, disciplinary processes and supervisory roles" (1987, p. 187). The authors cite an unpublished 1983 study of Minneapolis-St. Paul area EAP professionals by Birkland which posed two pertinent questions. In answer to the question "How important do you think it is for an EAP to have staff who possess the following skills or knowledge," the four categories rated most important were:

- Ability to assess chemical dependency
- Familiarity with social service agencies and health care delivery systems
- Ability to conduct crisis counselling
- Knowledge of professional ethics and legal liabilities

In answer to the question "How important do you regard the following skill or knowledge for people just entering the EAP field?", the five categories ranked most important were:

- Knowledge of professional ethics and legal liabilities
- Ability to conduct short-term counselling
- Familiarity with social service agencies and health care delivery systems
- Ability to assess chemical dependency

(Googins and Godfrey, 1987, p. 190)

Googins and Godfrey assert that the skills needed by social workers in EAP settings are so broad and vary so widely by the roles they play that it is next to impossible to include them all in class based learning. They note that "...most practitioners wear multiple hats – clinical consulting, administrative, evaluative." and could potentially use skills in all the traditional social work methods of casework, group work and community organization (1987, p. 189).

On the knowledge needed by occupational social workers the authors are more hopeful of building a manageable curriculum. They suggest that the knowledge needed in an occupational social work curriculum, as opposed to general social work education, would include knowledge pertinent to the work and work organizations and knowledge pertinent to the practice and programs of occupational social work. They list six curriculum elements related to work and work organizations: economics, labor-management, unionization and collective bargaining, organizational theory and analysis, values and corporate social responsibility and community relations. For the occupational social work section of the curriculum they include five areas: occupational social welfare, program types and roles, alcohol and drugs, program development and special employee populations (pp. 191-192).

Googins and Godfrey comment that "No two year program can begin to cover all these areas in depth, but the curriculum should attempt to acquaint the student with each to some degree." They

mention a number of "vehicles" which can be used to provide this education: separate and specialized courses; material integrated into the existing curriculum; mini-courses; or non-credit seminars for students placed in work settings (p. 193).

The N.A.S.W. Commission on Employment and Economic Support published a national survey of occupational social workers in 1987. Among the questions on the Job Analysis Questionnaire employed was one asking about "desired additional training." Although this question did not specifically address the respondents' social work training, the answers indicate areas which might enhance the curriculum. Based on the write-in responses of 386 individuals, the top five topics listed, with percentage of respondents, were:

General Management	19.4%
Organizational Development	9.8%
Drug and Substance Abuse	6.7%
Psychotherapy	6.2%
Marriage and Family Counselling	5.7%

(Teare, 1987, p. 67)

Another question in the national survey which sheds light on useful areas for the curriculum was one listing the "needs, issues and problems dealt with by respondents." For 498 respondents, the areas with the highest number of responses (given in parentheses) were alcoholism (381); marital or family problems (373); mental health (296); drug addiction (223); and job

frustrations or stress (187) (Teare, 1987, P. 70).

In writing on the experience and skills needed by social workers in world of work settings (which include, but are not limited to EAP's), Akabas and Kurzman suggest several areas of training or coursework beyond general graduate training in social work:

> Experience in both direct service and administrative functions
>
> Course work in economics, organizational behavior, trade union history, and labor market and manpower policy
>
> Competence in alcoholism and drug abuse counselling and in research and computer technology. (Akabas and Kurzman, 1982, p. 203)

In a recent article, Michael Mor-Barak and his colleagues at the University of Southern California, Los Angeles, presented a model curriculum for occupational social work. This model uses an ecosystems perspective and is "...designed to provide social work knowledge and skills that are based on generic social work principles, yet are unique and relevant to the practice of social work in work-related agencies" (Mor-Barak et al, 1993, p. 64).

The first year of studies under this curriculum provides a "generic base" common to all social work practice. In the second year students select from five concentrations. In the industrial-/occupational social work concentration for the second year, students take six required courses, one elective related to

occupational practice and are placed in an agency serving workers and their families. The required courses and field placement are designed around two organizing themes and four overarching objectives. The organizing themes are:

1. A continuum of the work experience – this expands the focus from current workers to include those at the point of entry or departure from the workplace, and those who are temporarily or chronically unemployed.
2. Diversity in the workplace – this theme addresses the changes in the work force in recent years, including the increase in aging, female, disadvantaged, and racially and culturally diverse workers (Mor-Barak, et al, 1993, p. 66)

The overarching objectives they list are as follows:

1. Students will understand the process and consequences of global economic restructuring and the impact of these changes on work, prospects for workers, and for social work practice.
2. Students will learn how the linkages between the individual and other social systems bind the conceptualization of intervention with each level of practice.
3. Students will develop and apply professional ethics to a range of social issues, problems and programs that define corporate and individual social responsibility in the world of work.

4. Students will develop an understanding of and sensitivity to culture, race, religion, gender, sexual orientation, and the differently abled worker to assess, plan, intervene and act as a change agent with employees and employers and in the broader community. (p. 66)

The six required courses attempt to apply social work knowledge and skill in the context of the workplace. The required courses are Social Policy; The World of Work; Human Behavior in an Industrial Society; Social Work Practice in Working Settings — Micro Practice; Social Work Practice in Work Settings — Mezzo Level; Administration and Community Organization in Work Settings — Macro Practice; and Evaluation of Research: The World of Work (pp. 67-73).

The U.S.C. — Los Angeles curriculum is admirable in its integration of specific knowledge relevant to work place practice into broader courses like policy and micro-practice. The micro practice section is perhaps most directly applicable to EAP work. The authors note that this clinical class focuses on three areas:

1. "advanced knowledge in a variety of micro practice intervention methods", including crisis intervention, task centered approach, marital counselling and family therapy, and group work.
2. "social problems commonly experienced by people in the world of work", including stress-related problems, and drug and alcohol abuse.

3. "effective practice with today's diverse work force", including looking at issues of work-related practice with women, minorities, older people and the disabled, as well as issues regarding confidentiality. (pp. 69-70)

The specificity in these areas is desirable. One wonders, however, at what depth the methods and problems are addressed. In looking at drug and alcohol abuse, for example, do students learn a different approach in treating clients with these problems or only that these problems exist in the workplace? Covering the four intervention methods mentioned in two semesters is an ambitious undertaking; do students leave with a firm grasp of these methods or just a taste? Despite these questions, the U.C.L.A. curriculum at least tackles the question of including the specific knowledge needed for practice in occupational social work.

Finally, Michael Lane Smith raises the additional question of whether even specialized learning in occupational social work is broader than the specific needs of EAP practitioners. He asks "...how extensive or comprehensive should occupationally focused social work education be? To what extent can (and should) social work educators prepare students for specialties within the broad industrial arena?" (Gould and Smith, 1988, p. 346). Indeed, one could regard the problem somewhat as nesting boxes: where does preparation for EAP practice fit within preparation for occupational social work practice fit within overall social work education?

Chapter 6

Design of the Project

The theory of curriculum development underlying this project is that a generic social work program provides the basic learning which social workers need for any area of practice and that it allows workers to move readily into different areas of practice. To test this theory the project focused on one area of social work practice, employee assistance programs. EAP's provide a good test example of the relevance and applicability of the knowledge and skills taught in the generic curriculum because they are a relatively new field with evolving practice issues.

To assess the goodness of fit between the masters' social work education and the demands of practice in the EAP field it was decided to survey the consumers of the education, namely, the social workers employed in EAP's. It is worth noting that other measures could be used: surveying directors of EAP's to determine how well prepared they found recent social work graduates, for example. The decision to survey the practitioners themselves was based on the fact that most EAP workers provide direct service and the heart of the social work curriculum addresses clinical knowledge and skills used in direct service.

As Atherton and Klemack (1982) note, the survey is the most common method of data collection in social research(p. 87). The advantage of a survey is its flexibility and adaptability to a variety of research situations. In this project, the survey was a

logical instrument to use to gather both descriptive and evaluative data from the EAP social workers. The decision was made to use a mailed self-administered questionnaire because it would permit a greater number of respondents to be surveyed than an in-person interview.

The basic question addressed in this survey is an evaluative one: Did their graduate social work education effectively prepare EAP social workers for practice in their field? The type of research used is descriptive, i.e. it looked for associations between the amount of specific EAP-related content a graduate had in her education and her assessment of preparedness to do EAP work. The instrument also gathered some strictly descriptive data about the respondents themselves: demographic data, schools attended, courses taken, etc.

Sampling became a question from the beginning. The original intent was to survey as close to the entire universe of EAP social workers in the New York area as possible. The target population was graduates of accredited social work masters' programs who had been out of school for at least one year and who worked in EAP's or related settings. For the purposes of the study, this group included union based member assistance programs and corporate human resource and personnel departments which function as EAP's. Attempts to obtain a comprehensive list through the New York Chapter of the National Association of Social Workers and from the New York regional office of the Employee Assistance Professional

Association proved fruitless: no such list exists. This made it impossible to do a random survey of EAP social workers since there was no way of knowing what percentage of the universe a particular sample would comprise, nor whether the sample was representative of the wider group.

The attempt was then made to construct as comprehensive a list of EAP social workers as possible by putting together a number of small existing lists and by using snowball sampling. As defined by Atherton and Klemack, "snowball" sampling is a technique in which "a researcher will select a sample and then allow those who were sampled to specify who else should be studied" (1982, p. 168). In this survey a question was included at the end of the questionnaire asking respondents to share the names of other social workers in EAP's whom they knew. The technique was relatively successful. Forty three out of the 268 persons or 16% surveyed were identified through snowball sampling.

The resulting sample is a non-probability sample and thus there are questions about how accurately the results can be generalized to the entire population of EAP social workers. A total of 77 questionnaires were returned out of 268 distributed for a response rate of 29%. This is a relatively good response rate for a mailed survey. However, it means that there is a possible lack of generalizability to the entire sample.

The goals in undertaking this project were to assess the usefulness of the generic curriculum for social work practice in

EAP's and related work settings; and to elicit practitioners' opinions on modifications or additions which would increase the curriculum's relevance to practice in this field.

The project was based on certain hypotheses. First, it was assumed that social workers need specific as well as generic information in order to practice effectively. There are different routes by which to obtain this information: through graduate classroom education, field placement, on the job training or experience, or through postgraduate courses taken outside the workplace. The project focused on only the contribution of the master's level social work education, including classroom and field learning.

Secondly, it was hypothesized that the degree of specificity of information which the social worker got in his/her graduate education would positively affect the evaluation of the education's relevance. The degree of specific information received was assessed by asking respondents about their field placement and specific courses which they took in industrial social work, organizational development of EAP work.

Development of the Survey Instrument

The questionnaire consisted of twenty individual questions, some containing a number of subsections. In a small pre-test it was determined that the questionnaire could be completed in under fifteen minutes. The initial draft was screened by the author's committee to address any unclear, overlapping or hard to code

questions. A second draft was shared with colleagues at other EAP's to identify any EAP work areas that might have been left out. A third draft was pretested with members of the New York City N.A.S.W. Work and Family subcommittee. This pretest elicited some suggestions for additional categories and some changes in wording. Two additional drafts were made and screened by the Committee with the fifth draft becoming the final version.

The questionnaire consists of a cover page with identifying data; twelve descriptive questions covering type of work organization, type of worksite, school of social work attended, year of graduation, methods studied, age, sex, ethnicity and other degrees or credentials held by respondent; and eight forced choice questions. The forced choice questions ask respondents to rate the percentage of the EAP's time and their personal time devoted to specific EAP job functions and the percentage of the EAP's time addressed to certain problem areas; to rate how well their M.S.W. education prepared them for sixteen areas of EAP practice and to identify whether they feel they need further training in any of the same sixteen areas. A copy of the full questionnaire is included in the appendix.

Selection of the Sample

One of the first discoveries in trying to identify the target population of social workers who work in New York area EAP's is that there is no comprehensive listing of these workers available. The first task therefore was assembling as compre-

hensive a mailing list as possible. Mailing lists from existing organizations of which the author is a member, namely those of the New York City Chapter of N.A.S.W.'s Industrial Social Work Committee, the N.A.S.W. Work and Family Subcommittee, the Municipal Employee Assistance Programs and the Occupational Clinical Professional Group (an informal organization) were compiled. These mailing lists were screened to select only people who were both social workers and in identified EAP programs.

In addition, the author called colleagues to see if they knew of other organizations which might be contacted for mailing lists. This produced a list of the EAP Health Care Network as well as a list of union-based M.A.P. administrators. These were combined with the original list and duplications were eliminated.

An initial mailing was made to 210 respondents; fifteen additional questionnaires were distributed at a staff meeting by a helpful M.A.P. administrator. On the questionnaire itself, respondents were asked to write in the names and addresses of other EAP social workers to whom the survey might be sent (an example of "snowball sampling"). An additional 43 names were gathered in this way. In total, 268 questionnaires were distributed at the end of November 1992. Those who did not respond were sent a postcard six weeks later. Those identified as part of the snowball sampling were sent follow-up cards three weeks later.

A total of seventy seven questionnaires were returned, a response rate of 29%. Two were not completed because the respon-

dents were not in EAP's. Four were from out of area respondents. These six were removed from the sample for a total of 71 usable responses.

As previously noted while this is a relatively good response rage for a mailed questionnaire, it is not large enough to preclude questions about generalizability to the entire sample and to the wider population of EAP social workers.

Chapter 7

SURVEY RESULTS

Profile of Respondents

Of the seventy one respondents, 28 were male and 43 were female. The respondents ranged in age from 26 to 70 with an average age of 40.5. The ethnic background of respondents was 78% white, 11% African American and 11% Hispanic.

Education

The majority of the respondents (64.5%) attended two year, full-time masters' programs in Social Work. Nearly 18% graduated from a one-year residency program and about 15% attended other types of M.S.W. programs (e.g. advanced standing, combined B.S.W./M.S.W. programs).

One year residency programs are masters' programs which admit applicants who are already working in social service settings, perhaps at a paraprofessional level. Once admitted to the program they are permitted to use their work agency as their field placement. Their course schedule is generally adjusted to accommodate their work.

There seems to be a steady stream of graduates into EAP work, if the respondents are an indication. Respondents graduated in every year between 1970 and 1992 with the exception of 1971; one respondent graduated in 1953.

Respondents were asked to check off what methods they studied from a list, given in Table 1. In their master's

programs, most respondents (nearly 79%) studied casework. The response rates for each social work method studied are listed in Table 1. The totals add up to more than 100% because respondents checked off all methods studies.

Table 1 Social Work Methods Studied (N = 71)

Method	Percentage
casework	78.9
group work	46.5
community organization	15.5
administration	16.9
research	11.3
generic practice	28.2
systems work	19.7

It is interesting to note that while academics consider most of the M.S.W. programs being offered to be "generic", only a small percentage of respondents categorized their studies this way.

Most of the respondents studied in New York area schools of social work. Staying in EAP work in the New York region following graduation may reflect the wider availability of E.A.P./M.A.P. jobs in a large corporate center like New York which also has a higher number of union-based member assistance programs than many other areas of the country.

The number of graduates from the schools of social work is listed in Table 2.

Table 2 School of Social Work Attended

School of Social Work	Number of Respondents
Columbia	16
Hunter	24
New York University	12
Fordham	5
Adelphi	5
Wurzweiler	1
University of Michigan	2
Rutgers	2
University of Pittsburgh	1
Virginia Commonwealth University	1
Boston University	1
University of Maryland at Baltimore	1
	71

The respondents were asked what percentage of their studies were in certain focused areas of social work. Interestingly a majority reported no studies in industrial social work. The percentage reporting having some studies in the specified areas of practice is give in Table 3 below.

Table 3 Area of Practice in Studies (N = 71)

Area of Practice	Percentage reporting some Studies in the Area
Industrial/occupational social work	39.4
Mental Health	94.4
School Social Work	19.7
Family Work	85.9
Gerontology	25.4

Respondents were asked if they had additional education or training besides the M.S.W.. Over one quarter (25.4%) reported that they had an additional advanced degree (e.g. M.Ed., M.B.A.),

Only 2.8% reported having a Doctor of Social Welfare degree and none reported Ph.D.'s in other fields. In training areas related to EAP work, 12.7% of the respondents reported that they were Credentialed Alcoholism Counsellors (C.A.C.'s) and 22.5% reported that they were Certified Employee Assistance Professionals (C.E.A.P.'s). Credentialed alcoholism counsellors are required to take specified hours of training in the disease concept of alcoholism, psychopharmacology, treatment approaches, counsellor-client relationship, ethics of professional practice, AIDS/HIV, the impact on families and other related topics. They must pass a statewide exam and submit hours of work experience to receive their certification and must agree to abide by a code of ethics and take continuing education courses to retain it. CEAP's are persons working in EAP settings who have been certified by the Employee Assistance Professionals Association, a national organization. Applicants must submit proof of training in six EAP content areas: work organizations, human resources management, EAP policy and administration, EAP direct services, chemical dependency and addictions and personal and psychological problems. They must pass an examination to get the certification and take ongoing professional development hours to retain it.

Respondents were asked to list their field placements during their masters' program. Of the 70 respondents who completed the question, 29 (41%) reported that they had an EAP placement for at least one year. Four of the 29 reported that

they had been placed in EAP's both years of their two year program. Forty-one respondents (59%) did not have any EAP placements; however, eight of the forty-one had at least one year's placement in an alcohol or substance abuse program. In the section on preparation for EAP work, the scores of those who had EAP placements vs. those who did not are compared.

Comparing those who had EAP placements vs. those who did not it emerges that there were significant differences between these two groups of respondents in the areas which they had studied. In the area of industrial/occupational social work, two-thirds of those with EAP placements had some studies in the area, while for those who did not have an EAP placement, three-quarters had no studies in the area. Thus, having had an EAP placement was significantly associated with having had some studies in industrial/occupational social work ($p < .0001$).

In the area of family work, the opposite picture emerges. Eighty percent (80%) of those who had EAP placements had none or fewer than 20% of their studies in family work, while those who did not have EAP placements had 21% to 80% of their studies in this area. The association between an EAP placement and fewer studies in family work is significant at the .0005 level.

For the other areas of study listed in Table 3, there were no significant differences between those who had had EAP placement vs. those who had not.

In focusing further on their preparation for EAP practice,

respondents were asked if they took any courses addressed specifically to industrial social work, employee assistance work or organizational development. The percentage of respondents answering affirmatively were

Industrial social work	25.7%
Employee assistance work	20.0%
Organizational development	44.3%

When the respondents were broken into those who had EAP placements vs. those who did not, there were significant differences in all three of these areas. For courses in industrial social work, respondents who had EAP placements were evenly split with 50% having had such courses and 50% not. For those who had not had EAP placements, only 3 people had taken courses in industrial social work, with 92% having taken no such courses. The association between having an EAP placement and taking industrial social work courses was significant at the .00007 level.

Fewer respondents had taken any courses in EAP work but on balance those who had EAP placements were more likely to have taken such courses. Thirty-six percent of those with EAP placements had taken EAP courses vs. 5% of those who had not had EAP placements. The association between EAP placement and taking EAP courses was significant at the .0009 level.

A greater number of respondents took courses in organizational development, 43% of the total group. Fifty-eight percent of respondents with EAP placements had taken such courses vs. 42%

of those who had not had EAP placements. The association between having an EAP placement and taking an organizational development course was significant at the .02 level.

Description of Work Settings

Respondents were asked to describe their immediate work site and the overall organization in which they work. They were also asked to break out the percentage of the EAP's time and their personal time which is devoted to each of a number of traditional EAP functions.

Respondents work in a wide range of organizations. The largest segments were unions (33.8%) and for profit corporations (22.5%). Table 4 lists the percentage of respondents who work in each of seven types of overall organizations.

Table 4 Types of Overall Organizations (N = 71)

Type of Overall Organization	Percentage responding
For-profit corporation	22.5
College or university	5.6
Hospital or health setting	14.1
Union	33.8
Government agency(federal,state or city)	12.7
Other non-profit organization[1]	7.0
Private practice	4.2

A number of respondents reported working in more than one type of organization. The combinations were private practice in addition to their primary work organization; hospital based EAP's which provided for profit EAP services to outside organizations;

[1]The other nonprofit organizations were railroads(3), family service agency(1) and alcohol and substance abuse prevention program(1).

and a court-mandated, union based member assistance program.

In describing their immediate work site, over one-third (38%) said they worked in on-site employee assistance programs and close to a third (29.6%) worked in union-based member assistance programs. The complete break out of types of work sites is given in Table 5. There were no respondents in two of the categories included in the questionnaire: corporate health/wellness department and human resources departments.

Table 5 Type of Work Site (N = 71)

Type of Work Site	Percentage responding
On-site employee assistance program	38.0
Contracted employee assistance program (outside)	18.3
Consultation service	4.2
Member assistance program (union based)	29.6
Other[2]	5.6

Again, some respondents reported that they worked in more than one type of worksite. The combinations were contracted, on-site EAP programs; court mandated member assistance program; on-site EAP and human resources department; and contracted EAP with services to on-site employees.

Respondents were asked to estimate the percentage of their EAP's time which was devoted to each of a number of EAP functions. The respondents could choose "none" or one of five quintiles in their response (1-20%, 21-40%, 41-60%, 61-80% and 81-100%). The

[2]The other immediate work sites listed were a contracted, on-site EAP; a joint management-union program; working with clients part-time; and union based legal services program

full table of responses is listed in Table 6 below.

Table 6 Percentage of EAP's Time Devoted to Specific EAP functions (N = 71)

	Percentage of your time					
	None	1-20	21-40	41-60	61-80	81-100
Counselling/therapy with individuals	7.0	26.8	22.5	11.3	16.9	15.5
Counselling/therapy with couples and families	32.4	56.3	4.2	7.0	-0-	-0-
Group programs e.g. presentations on wellness, lunchtime seminars, parent education groups	20.0	61.4	14.3	-0-	1.4	2.9
Supervisor/management training e.g. educating managers on how to recognize drug, alcohol or mental health problems; or what the EAP does	19.7	54.9	14.1	8.5	1.4	1.4
Consultation with other departments/units on organizational issues e.g. how to conduct staff meetings	37.7	44.9	8.7	7.2	-0-	1.4
Assessment and referral e.g. assessing an employee's problem and connecting them with an outside agency for treatment or service	4.2	35.2	21.1	15.5	11.6	12.7
Research, e.g. needs assessment for your client population, program evaluation	27.5	55.1	10.1	2.9	1.4	2.9
Administration in overseeing the program and fiscal operations of the EAP	41.4	22.9	14.3	14.3	4.3	2.9
Supervision of other staff or students	40.3	26.9	17.9	10.4	3.0	1.5
Other (please specify)						

For counselling or therapy with individuals, 95.7% of the respondents reported that their EAP's devoted time to the function with the responses fairly evenly distributed over the quintiles. Over 40% of the respondents reported that individual counselling composed at least 60% of the EAP's time.

For counselling or therapy with couples and families 83.8% of the respondents reported that their EAP had the function; however, 72.1% of the total reported that it took up only 1-20% of the EAP's time, hence it is not a major function.

For group programs such as seminars or presentations on wellness or educational topics, 88.4% of the respondents said their EAP's had the function, but for 65.2% it comprised only 1-20% of the E.A.P.'s time.

Similarly for supervisor/management training (e.g. educating managers on how to recognize drug alcohol or mental health problems), 89.9% of the respondents said the E.A.P. had the functions, with 65.2% saying it comprised between 1 and 20% of the EAP's time.

Fewer respondents (62.3%) said their EAP's devoted time to consultations with other departments on organizational issues (e.g. how to conduct a staff meeting). 37.7% reported that the EAP did not have the function and another 49.3% reported that this function only took 1-20% of the EAP's time.

A different picture emerged for assessment and referral. This makes sense, since many EAP's, particularly contracted services, allow only a certain number of EAP visits followed by referral to outside agencies for ongoing service. A full 98.6% of

the respondents said the EAP had this function, with 48.6% of the respondents saying it comprised at least 41% of the EAP's time. It is thus a major function for many EAP's.

For research, 82.4% of the respondents said their EAP had the function, although for 66.2% it took only 1-20% of the program's time.

The social workers were next asked to estimate how much of their individual time was devoted to the same seven functions and two additional ones: program administration and supervision of students. The full findings are reported in Table 7 below.

A full 93% of the respondents reported that they did counselling or therapy with individuals. The responses were distributed across the quintiles, with nearly a third reporting that this activity comprised at least 61% of their time. For family therapy, on the other hand, 67.7% of the respondents said they performed this function but for 56.3% it took only 1-20% of their time.

For group programs 80% of the workers said they spent time on the functions but for 61.4% it comprised between 1 and 20% of their time.. 80.3% of the workers said they were involved in supervisor or management training with 54.9% saying it comprised 1-20% of their time.

Consultation with other departments took the time of 62.3% of the respondents; for 44.9% it took 1-20% of their time. Assessment and referral was a function for nearly 96% of the respondents and it fell into the top three quintiles (41-100%) for nearly 40% of them.

Table 7 Percentage of Respondent's Time Devoted to Specific EAP Functions (N = 71)

	Percentage of your time					
	None	1-20	21-40	41-60	61-80	81-100
Counselling/therapy with individuals	7.0	26.8	22.5	11.3	16.9	15.5
Counselling/therapy with couples and families	32.4	56.3	4.2	7.0	-0-	-0-
Group programs e.g. presentations on wellness, lunchtime seminars, parent education groups	20.0	61.4	14.3	-0-	1.4	2.9
Supervisor/management training e.g. educating managers on how to recognize drug, alcohol or mental health problems; or what the EAP does	19.7	54.9	14.1	8.5	1.4	1.4
Consultation with other departments/units on organizational issues e.g. how to conduct staff meetings	37.7	44.9	8.7	7.2	-0-	1.4
Assessment and referral e.g. assessing an employee's problem and connecting them with an outside agency for treatment or service	4.2	35.2	21.1	15.5	11.6	12.7
Research, e.g. needs assessment for your client population, program evaluation	27.5	55.1	10.1	2.9	1.4	2.9
Administration in overseeing the program and fiscal operations of the EAP	41.4	22.9	14.3	14.3	4.3	2.9
Supervision of other staff or students	40.3	26.9	17.9	10.4	3.0	1.5
Other (please specify)						

Research was part of the job for 72.5% of the respondents but took a fifth or less of their time for 55.1% of them. For both administration and supervision of students over 40% of the respondents reported they had no involvement (41.4% and 40.3%, respectively). For those who did administration (58.6%) more than half said it took 1-40% of their time. For those who supervised students, three-quarters spent 1-40% of their time on it.

What emerges from these last two questions is a picture of EAP's with diverse functions, though heavily focused on work with individuals either in direct counselling or information and referral. The same is true for individual workers who indeed need to be generalists. It is significant that a healthy majority of the respondents included research, administration, supervision and group presentations among their responsibilities. This indicates that there is not as clear a demarcation between management and line workers among EAP social workers as there is in many other social work specialty areas. Put another way, EAP social workers carry both clinical and administrative responsibilities in most cases.

In the next question the social workers were asked about the types of problems which their EAP's addressed. The percentage responses are listed in Table 8 below. All the respondents reported that mental health and family or relationship problems were addressed in their EAP's. Mental health issues were involved in 21-60% of the caseloads of 60% of the respondents. Family and relationship problems were involved in 1 to 40% of the cases of 71.5% of the respondents. Alcohol and substance abuse problems

were in the caseloads of 98.6% of the respondents and it comprised 21-60% of the caseload for 58.6% of the respondents.

Table 8 Percentage of EAP's Cases Falling into Specified Problem Areas (N = 71)

	Percentage of EAP's Cases					
	None	1-20	21-40	41-60	61-80	81-100
Mental health (e.g. depression, anxiety, phobias)	-0-	20.2	32.9	27.1	15.7	4.3
Alcohol and Substance abuse	1.4	21.4	40.0	18.6	11.4	7.1
Family or relationship problems	-0-	28.6	42.9	8.6	15.7	4.3
On the job problems (e.g. work-related stress, problems with a supervisor)	1.4	45.7	22.9	15.7	8.6	5.7
Life adjustment issues (e.g. divorce, birth of a child, promotion, layoff)	2.9	55.7	30.0	2.9	8.6	-0-
Government entitlements e.g. Medical, unemployment, disability benefits	20.6	55.9	10.3	8.8	1.5	2.9
Issues around care of aging relatives	14.7	67.6	11.8	2.9	1.5	1.5
Day care, school problems or other child care issues	0.1	72.5	10.1	5.8	1.4	-0-
Other(please specify)						

The other problem areas listed were also included in the caseloads of a large majority of the respondents but comprised a smaller part of their workload than the three problem areas listed above. On the job problems were included in the caseloads of 98.6% of the respondents but made up from 1-20% of the cases for 45.7%. Life adjustment issues (such as divorce, birth of a child,

promotion or layoff) were listed by 97.1% of the respondents but made up 1-20% of the caseload for 55.7%.

Government entitlements were addressed in the caseloads of 79.4% of the respondents; for 55.7%, it made up 1 to 20% of the caseload. Issues around care of aging relatives was reported by 85.3% of the respondents but again was in a minority of cases; it was in 1 to 20% of the EAP's caseload for 67.6% of respondents. Day care, school or other child care issues appeared in the caseloads of 80.9% of respondents with 72.5% reporting that it made up 1 to 20% of their caseloads.

It is clear from this data that the EAP's represented are "broad brush" programs providing a range of services and dealing with a range of problems.

Preparation for EAP Work

The social workers were asked to rate how well their graduate education had prepared them for practice in sixteen different areas of EAP work. The five possible ratings ranged from "very poorly" prepared, defined as meaning that the worker needed to learn extensive or basic information or skills in the area, through "very well" prepared, defined as meaning that the worker could perform in the specified area with no additional training.

A number of respondents wrote in that while they had needed to know more about certain areas at the time they graduated, they had subsequently taken courses or received on the job training in the areas. Others commented that they always needed or wanted to know more.

Table 9 lists the rankings of the areas of EAP work in

order from those in which respondents felt least prepared to those in which they felt best prepared. Respondents could rate an area from 1 to 5. The middle score would thus be 3. It is therefore noteworthy that the range of mean scores reported is from slightly below 2 to slightly above 3, i.e. from "poorly" to "fairly well" prepared. None of the areas received an average rating of "well prepared"(4) or "very well prepared"(5).

Table 9 Areas of EAP Work

Ordered least to best prepared (N = 71)

(scale: 1=least prepared, 5=best prepared)

Area of Work	Mean Score
Employee Benefits	1.97
Stress Management	2.16
Child care issues	2.23
Working with physically/sexually abused	2.24
Workplace interventions to get people into treatment	2.41
Working with alcoholism/substance abuse	2.55
Issues around care of aging relatives	2.57
Supervision of other staff or students	2.72
Identifying competent agencies/practitioners for referrals	2.79
Working with adolescents	2.86
Understanding entitlement programs	2.86
Working with older adults or older family members	2.94
How to match outside treatment programs to client needs	3.05
Organization development/team building skills	3.07
Research	3.13
Family treatment	3.13
Average Score	2.66

Using a different measure, i.e. the percentage of respondents reporting themselves as "very well prepared" or "well-

prepared" in an area, the areas in which respondents considered themselves best prepared were organization/team building skills (with 40.6% saying they were well or very well prepared); how to match outside treatment programs to clients' needs (36.8% well or very well prepared); family treatment (34.8% well or very well-prepared); and research (34.7% well or very well-prepared).

The areas in which respondents considered themselves least prepared were employee benefits (with 75% saying they were poorly or very poorly prepared); stress management/reduction (with 72% poorly or very poorly prepared); working with people who have been physically or sexually abused (with 69.6% poorly or very poorly prepared); day care, school problems or other child care issues (68.6% poorly or very poorly prepared); and workplace interventions to get people into treatment (61.9% poorly or very poorly prepared). The very high percentage of respondents rating themselves as poorly prepared in these areas identifies them as good potential target areas for curriculum improvement.

It was a common sense hypothesis that those who said they did not need further training in a given area would rank themselves as better prepared than those respondents who felt they needed further training. The mean scores of the two groups (needing further training and not needing further training) were compared and the results are listed in Table 10. The results supported the hypothesis, with the mean scores for those not needing further training being consistently higher than for those needing further training. Eleven of the sixteen areas showed statistically significant differences in the scores of the two groups.

Table 10 Mean Scores on Preparedness for Respondents Needing Further Training vs. Not Needing Further Training (N = 71)

	Needing further training	Not needing further training
Working with alcoholism/substance abuse*	2.36	2.81
Working with physically/sexually abused	2.18	2.50
Family treatment	2.94	3.33
Working with adolescents*	2.63	3.09
Working with older adults/older family members	2.85	3.14
Workplace interventions**	2.02	2.79
Stress management/reduction**	1.89	2.48
Matching outside treatment programs to Client needs**	2.59	3.37
Identifying competent agencies/practitioners***	2.06	3.32
Employee benefits	1.86	2.18
Organization development/team building skills***	2.53	3.76
Research***	2.71	3.72
Supervision of other staff/students***	2.20	3.27
Understanding entitlement programs***	2.50	3.33
Issues around care of elderly relatives	2.51	2.62
Child care issues*	2.07	2.52
Average for group	2.03	3.01

t-test probabilities *p<.05 **p<.01 ***p<.001

It was reasonable to ask whether graduates who had taken courses in industrial social work, or more specifically, EAP work and organizational development, would rate themselves as better prepared than those who had not. The mean scores on preparedness of those who had taken courses were compared with those who had not for each of the sixteen areas of EAP practice included in the survey. An overall rating on preparedness was obtained by

averaging the scores across the sixteen areas for each group (those who had studied vs. those who had not).

The results did not show a significant difference in the overall ratings of preparedness between those who had not had specialized studies and those who had taken courses in industrial social work, EAP work or organizational development. There were small differences in ratings on specific EAP areas, however.

Those who had taken courses in industrial social work rated themselves as better prepared on ten of the sixteen areas of EAP practice. The biggest differences were reported in three areas: supervision of other staff and students (mean score of 3.16 for those who had taken courses vs. 2.53 for those who had not); workplace interventions to get people into treatment (2.83 for those who had taken courses vs. 2.26 for those who had not); and how to identify competent practitioners and agencies (3.22 vs. 2.68).

Those who had taken courses in EAP work, rated themselves as better prepared than those who had not on half of the sixteen areas of practice. The largest reported differences were in workplace interventions to get people into treatment (mean score of 3.21 for those who had taken courses vs. 2.20 for those who had not), and employee benefits (2.64 for those who had taken courses vs. 1.43 for those who had not).

Those who had taken courses in organizational development rated themselves as better prepared than those who had not in fourteen of the sixteen areas. The largest reported differences were in organization development and team building skills (3.70

for those who had taken courses vs. 2.54 for those who had not); research (3.67 for those who had taken courses vs. 2.67 for those who had not); and supervision of other staff and students (3.13 for those who had taken courses vs. 2.35 for those who had not).

Another common sense hypothesis was that respondents who had EAP placements would rate themselves as better prepared in the areas of EAP practice than those who had not had EAP placements. One of the assumptions generally made by those who support a generic or generalist curriculum is that students or beginning practitioners will get the specifics in the field. This assumption would be supported if the respondents who had EAP placements rated their preparation more highly than those who did not have EAP placements.

The two groups were compared utilizing the t-test with the assumption that there would be a positive association between an EAP placement and a higher rating of preparedness in the sixteen EAP areas. The results showed that there was not a significant difference in the overall (average) rating of preparedness between the two groups. However, there were significant differences between the groups in seven of the sixteen areas. The t-test results for these seven areas are listed in Table 11 on the next page.

Table 11 T Test Results for EAP Practice Areas for Respondents with and without EAP Placements

1) Working with alcoholism and substance abuse

	Mean	Standard Deviation	T value	p lvl
EAP Placement	2.83	.87	1.62	.05
No EAP Placement	2.42	1.15		

2) Working with adolescents

	Mean	Standard Deviation	T value	p lvl
EAP Placement	2.64	1.02	-1.87	.03
No EAP Placement	3.08	.86		

3) Workplace interventions to get people into treatment

	Mean	Standard Deviation	T value	p lvl
EAP Placement	2.76	1.19	2.16	.017
No EAP Placement	2.13	1.18		

4) Stress Management/reduction

	Mean	Standard Deviation	T value	p lvl
EAP Placement	2.36	.71	1.59	.05
No EAP Placement	2.0	1.08		

5) How to identify competent agencies/practitioners to whom to refer clients

	Mean	Standard Deviation	T value	p lvl
EAP Placement	3.13	1.22	1.88	.03
No EAP Placement	2.57	1.20		

6) Employee benefits, e.g. health coverage/pension

	Mean	Standard Deviation	T value	p lvl
EAP Placement	2.43	1.22	3.23	.001
No EAP Placement	1.62	.82		

7) Research

	Mean	Standard Deviation	T value	p lvl
EAP Placement	3.40	.89	1.96	.027
No EAP Placement	2.97	.88		

In six of the seven areas where there were significant differences between the two groups, the association was in the expected direction, i.e. those who had had EAP placements rated themselves as better prepared than those who had not. These six areas were: working with alcoholism and abuse; workplace interventions to get people into treatment; stress management/reduction; how to identify competent agencies/practitioners to whom to refer

clients; employee benefits; and research.

In one area, having had an EAP placement was negatively associated with being better prepared. This was the area of working with adolescents. One might speculate that despite the fact that many EAP's offer services to family members of employees, few adolescents actually utilize EAP services.

As an overall observation, it should be noted that despite the more positive ratings on preparedness given by respondents who had EAP placements, the ratings were still not too high. The areas with the highest average rating for respondents with EAP placements were research with a mean rating of 3.40 and how to identify competent agencies/practitioners with a mean rating of 3.14. This is at the "fairly well prepared" level, which was perceived by the author as a neutral to slightly positive rating.

To summarize their preparation for EAP work, respondents were asked two open-ended questions. The first asked them to describe as specifically as possible the major limitations of their masters's education as preparation for their present job. The second asked them to describe the major benefits of their master's education.

The responses to the questions were clustered by content with similar responses put in the same group. The clusters of responses on limitations are listed in Table 12; the clusters of responses on benefits are in Table 13.

Table 12 Clusters of Responses Regarding Major Limitations in Masters' Program for Present EAP Work (N = 71)

Limitation	Number Reporting
1) Lack of education in alcoholism and substance abuse	27
2) No courses in work organizations, organizational theory, importance of work, marketing	13
3) No courses or placements in industrial social work or EAP work, no industrial social work "track"	10
4) Coursework too general or theoretical, not practical	7
5) No content in human resources, insurance, employee benefits	7
6) Lack of courses in EAP technologies	5
7) No short term psychotherapy courses	5
8) No content on networking, referrals, resource development	4
9) No coursework in sexual or physical abuse	3
10) A policy/administration focus in courses, no clinical work	3
11) Not enough administration content	2
12) No specific occupational issues in curriculum	2
13) No content on multicultural diversity	1

For the first question on limitations, a range of answers was given from those who said there were no major limitations to those who said their education bore next to no relevance for their work. There were two limitations that were listed by a significant number of respondents: lack of training in alcoholism and substance abuse and lack of education about work organizations and occupational/EAP issues. The second limitation is an amalgam of clusters 2,3,6 and 12 from Table 12 which were related content

areas.

For alcoholism and substance abuse education, 38% of the respondents saw their lack of training as a major limitation of their master's education. Some illustrative comments include:

- "substance abuse training – my program only offered one course."
- "The practical clinical tasks of working with substance abuse (were) not addressed in school. If you got it in field work you were lucky."
- "Little or no education re: substance abuse illnesses despite the prevalence of these disorders in the population. More Americans suffer from alcoholism or drug abuse than any other mental disorder."
- "Had virtually no chemical dependency education and treatment of chemically dependent clients was seen as problematic and unsuccessful."
- "My graduate education was extremely limited in the area of substance abuse and treatment modalities for substance abusers."

Concerning the lack of education about work organizations and occupational/EAP issues, 42% of the respondents considered this lack a major limitation. Some representative comments include:

- "Lack of sophistication in relationship between work performance and personal problems and lack of understanding of work organizations"
- "Very little training was given re: the work organization

workplace intervention, the relationship between work and overall functioning, employee benefits, resource evaluation, etc."

- "Little or nothing is taught about the world of work even though we spend approximately half of our time awake at the workplace."
- "The minimal time spent on discussing the area of industrial/occupational social work. Most classmates learned of this area by my sharing with them."
- "The masters program did not focus on any EAP issues at all. My job trained me altogether for my job. No EAP base found in the curriculum at all."
- "Classes tended to be very generalized — they weren't able to specifically focus on many of the problem areas confronted in EAP work."

For the second question on the major benefits of their master's education, a similarly wide range of answers was given. The clusters of responses on benefits are listed in Table 13.

Table 13 Clusters of Responses Regarding Major Benefits of Masters' Program for Present EAP Work (N = 71)

Benefit	Number Reporting
1) Courses in Casework, mental health theory and practice	27
2) Good generic training in basic counselling, assessment	17
3) Field placement	15
4) Understanding systems approach	6
5) Administration Course	5
6) Group work, group dynamics content	5
7) Policy and organization development course	4
8) Preparation for individual and family intervention and clinical assessment	3
9) Good clinical supervision	2
10) Good overview of importance of work	2
11) Short-term treatment	2
12) Exposure to working with people especially substance abusers	2
13) Content on alcoholism and substance abuse	2
14) Content on communication and facilitation	2
15) Developing skills in looking past the obvious	1
16) Resource development and information and referral capability	1
17) Exposure to a variety of clinical situations	1

There were several key areas which emerged as major benefits of the masters' program: clinical education, including casework and mental health theory; basic assessment and counselling; and fieldwork.

For clinical education, 38% of the respondents felt they had received good training in casework and mental health theory and practice. Typical comments include:

- "Good curriculum for overall casework and mental health theory and practice."
- "The courses in psychopathology were most helpful in my current efforts to diagnose and treat patients."
- "Solid psychotherapy base. Basic understanding of mental health issues, developed diagnostic skills, interactive skills."
- "Clinical training, short-term treatment course. Crisis intervention work. Overall psychopathology training."
- "Clinical skills learned in school and through field instruction are applicable to all areas of work and were very valuable. Clinical classes were helpful."

Another significant group of respondents (28%), reported that they had gotten good basic training in counselling and assessment. Representative comments include:

- "M.S.W. has a good generic training in basic counselling, assessment, engagement and short-term treatment."
- "Assessment of psychiatric illness other than substance abuse; formulating a psychosocial evaluation; exposing me to a variety of clinical situations."
- "Good overall counselling skills, fair knowledge of psychodynamics, understanding of the general need to understand systems."
- "Education provided me with a good basic overview of human development/psychopathology which is helpful in assessment and treatment planning for clients. Focus of having a psychosocial framework taking into account

psychological, socioeconomic, cultural factors in assessment was also helpful."

- "Excellent clinical assessment and treatment skills. Developed an ability to take a comprehensive look at problem and determine multiple stressors beyond overt presenting problem."

Interestingly, 21% of the respondents said their field placement was a major benefit of their master's education for their present job. Most of these respondents stated that having one or two field placements in EAP's or M.A.P.'s provided their real training in E.A.P. work and made them interested in working in this field. Some illustrative comments include:

- "Field placements were excellent e.g. second year placement at District 65 M.A.P."
- "Being exposed to the EAP field through the field placements was the most beneficial."
- "Placement in two EAP's which was crucial in training me to administer an EAP"
- "Gave me the opportunity to find out what I was best suited for through the "right" second year field work placement."
- "The benefit was having an excellent field placement in an EAP setting and instructors familiar with EAP concepts."

Areas for Further Training

Respondents were asked whether they needed further training beyond what they had received in their masters' programs in each

of the sixteen areas of EAP work. The complete results are listed in Table 14 below.

Table 14 Percentage of Respondents Reporting Need for Further Training By Practice Areas (N = 71)
(Ranked from highest to lowest need)

Area of Practice	Needing further training	Not Needing further training
1) Working with people who have been or sexually abused	77.1	22.9
2) Working with older adults and older family members	66.2	33.8
3) Employee benefits e.g. health coverage	64.8	35.2
4) Issues around care of aging relatives	61.4	38.6
5) Day care, school problems or other child care issues	60.6	39.4
6) Working with alcoholism and substance abuse	58.6	41.4
7) Research, e.g. needs assessment for your client population, program evaluation	55.7	44.3
8) Family treatment	55.1	44.9
9) Organization devlopment/team building skills	54.9	45.1
10) Understanding government entitlement programs such as medicare, unemployment, disability, food stamps	53.5	46.5
11) Stress management/reduction	52.1	47.9
12) Supervision of other staff or students	49.3	50.7
13) Workplace interventions to get people into treatment e.g. for alcohol or substance abuse	49.3	50.7
14) Working with adolescents	47.9	52.1
15) How to identify competent agencies/ practitioners to whom to refer clients	42.3	57.7
16) How to match outside treatment programs to clients' needs	40.0	60.0

In eleven of the sixteen areas, over half of the respondents reported that they needed further training. The areas with the highest percentages of respondents saying they needed further training were: working with people who have been physically or sexually abused (77.1%); working with older adults and older family members (66.2%); employee benefits (64.8%); and issues around care of aging relatives (61.4%). It is interesting that working with physically or sexually abused people received the highest ranking. This presumably reflects the problems presented at EAP's.

This strong indication of the need for further training is consistent with the respondents' generally low scores in preparedness. The areas with the highest reported need for further training correspond very closely to the areas in which respondents said they were least well-prepared. These would appear to be fruitful areas for curriculum enhancement.

It should be noted that a number of respondents wrote in comments on this question that shed an interesting light on the responses. Several noted that "you always need to know more" making them perhaps "tougher customers" in evaluating their masters' programs. On the other hand, a number wrote in that at the time they graduated, they needed to know more but they subsequently addressed these educational needs through post-graduate courses and on the job training. In general these write-in comments indicate a healthy respect for the need for continuing professional education.

Chapter 8

SUMMARY AND IMPLICATIONS

Summary

Seventy-one usable questionnaires were returned, a response rate of 29%. While this is a respectable return rate for a mailed survey, it means that the findings may not be generalizable to the larger group surveyed or the entire population of EAP social workers.

The respondents ranged in age from 26 to 70 with an average age of 40.5. Twenty-eight respondents were male and 43 were female. Ninety-seven percent of the respondents had the MSW as their terminal social work degree.

The great majority of respondents studied casework. Despite the fact that most academics see the masters' curriculum as imparting generic knowledge and skills, only 28% of the respondents in this study listed generic practice as a method studied.

In trying to gauge how much information respondents received about EAP practice, knowledge or skills, they were asked if they had any studies in industrial/occupation social work. Only 39% reported any studies in the area, meaning that a majority of the EAP practitioners reported no studies in industrial social work. Respondents were further asked if they had taken any courses addressed to industrial social work, employee assistance work or organizational development. Again the majority reported none. Of those answering affirmatively, 25.7% reported having taken courses in industrial social work; 20% reported courses in EAP work; and 44.3% reported courses in organizational development.

Respondents were asked about their field placements as well as course work. Forty-one percent (41%) reported having an EAP placement for at least one year. This corresponds closely to the 39% reporting studies in industrial social work, although, interestingly, it is double the percentage reporting having taken courses in EAP work. This discrepancy may be attributable to a disjunction between class and field learning; for half of the respondents reporting EAP placements, it may have been assumed that they would learn what they needed to know from their placements, without supportive class content. Indeed, some of the open-ended responses indicated that they had learned "everything they knew" about EAP's from their placements.

Respondents worked in a range of overall host organizations; the organization types with the highest response rates were unions (33.8%); for profit corporations (22.5%); and hospitals or health settings (14.1%). For type of work site, the responses were highest for on-site employee assistance programs (38%); union-based member assistance programs (29.6%); and outside contracted employee assistance programs (18.3%).

The respondents' descriptions of their EAP's by functions performed and problems addressed indicated that the majority are "broad-brush" or comprehensive programs. The functions performed by EAP social workers were similarly diverse; though the majority of respondents reported that most of their time was spent in individual assessment or counselling, they reported having administrative, research, supervisory, group program, and consultation functions as well. There is less of a demarcation between admin-

istrative and clinical staff among EAP social workers than there is in some other areas of social work practice. The implication is that EAP practitioners would benefit from a generalist approach which exposed them to the range of social work methods, while also providing the specifics of practice issues in EAP settings.

The respondents were asked to rate how well their masters' programs had prepared them for sixteen areas of EAP practice. Their average ratings were relatively poor. The range of mean scores reported is from "poorly prepared" to "fairly well prepared" (which is perceived as a neutral rating). None of the areas of EAP practice received an average rating of "well prepared" or "very well prepared."

The areas in which respondents considered themselves best prepared were organization development/team building skills; how to match outside treatment programs; family treatment; and research. The areas in which respondents considered themselves least well prepared were employee benefits; stress management/reduction; working with people who have been physically or sexually abused; day care, school problems or other child care issues; and workplace interventions to get people into treatment. For these areas over 60% of the respondents considered themselves poorly or very poorly prepared.

The results did not show a significant difference in the overall ratings of preparedness between those who had not taken specialized courses and those who had taken courses in industrial social work, EAP work or organizational development. However, there were small differences in the ratings in a number of the

areas of EAP practice. Those who had taken courses in industrial social work rated themselves as better prepared on ten of the sixteen areas than those who had not taken such courses. Those who had taken courses in EAP work rated themselves as better prepared than those who had not on half of the sixteen areas of practice. Those who had taken courses in organizational development rated themselves as better prepared in fourteen of the sixteen areas, compared to those who had not taken such courses.

It was hypothesized that respondents who had EAP field placements would rate themselves as better prepared in the sixteen areas of EAP practice than those who did not have EAP placements. This hypothesis was not supported in the majority of the areas; however, in six of the sixteen areas there was a significant positive correlation between having had an EAP placement and a higher rating on preparedness. These six areas were working with alcoholism and substance abuse; workplace interventions to get people into treatment; stress management/reduction; how to identify competent agencies/practitioners to whom to refer clients; employee benefits; and research. There was one area in which there was a significant negative correlation between having had an EAP placement and rating oneself as better prepared; this was working with adolescents.

Respondents were asked to summarize their preparation for EAP work by answering two open-ended questions: the first asking the major limitations of their masters' program as preparation for their current job, the second asking the major benefits of their

masters' education. The major limitations which emerged were in the lack of education in alcoholism and substance abuse, listed by 38% of the respondents, and the lack of education about work organizations and occupational/EAP issues, listed by 42% of the respondents.

The major benefits listed by the respondents were their courses in casework, mental health theory and practice, listed by 38% of the respondents; counselling and assessment, listed by 28% of the respondents; and field placement, listed by 21% of the respondents.

Respondents were asked whether they needed further training in the same sixteen areas, beyond what they had received in their masters' program. Over half of the respondents felt they needed further training in eleven of the sixteen areas. The areas with the highest percentage of respondents reporting the need for further training were working with people who have been physically or sexually abused (77.1%); working with older adults and older family members (66.2%); and employee benefits (64.8%).

Conclusions and Implications

In returning to the question of how well the generic curriculum prepares graduates for beginning work in a specific area of social work, in this case employee assistance programs, the study findings give a mixed answer.

Overall, the social workers responding saw the strength of their programs in basic skills like biopsychosocial assessment and casework. This is interestingly reminiscent of the Milford Conference report's conclusions that method formed the generic in

social work. Since the majority of the EAP social workers responding were primarily clinicians (although most carried other responsibilities as well), it makes sense that casework forms the core of their practice skills and that in this regard, their masters' training held them in good stead.

On the other hand, when they were questioned about basic areas of EAP practice – the specific – the respondents' ratings of their preparation in their masters' programs were quite low. In none of the sixteen areas did the majority of practitioners rate themselves as well prepared or very well prepared. The average rating for each area was between poorly and fairly well prepared. In addition high percentages of the respondents felt they needed further training in the EAP practice areas. In the area in which the lowest percentage of respondents felt they needed further training, (how to identify competent agencies/practitioners to whom to refer clients) a full 42% felt they needed further training. In the area receiving the highest percentage of respondents reporting the need for further training (working with people who have been physically or sexually abused), 77% felt they needed further training. The combination of low ratings on preparedness and high levels of expressed need for further training in the EAP practice areas suggests that there are significant areas for curriculum development in the masters' programs.

What were the specific areas which the curriculum might better address? Looking at three sections in the findings, those in which respondents rated themselves as least prepared, those in which they reported the highest need for further training and

those that emerged in the open-ended question regarding the major limitations of their masters' programs, certain EAP areas consistently emerge. In Table 18, the six EAP areas receiving the greatest response in each of those three sections are listed side by side as areas for potential curriculum enhancement.

Table 15 Areas for Potential Curriculum Enhancement

Least Prepared Areas	Areas with highest need for Further Training	Major limitations in MSW program
1.employee benefits	1.working with physically/sexually abused clients	1.lack of training in alcoholism/ substance abuse
2.stress management/ reduction	2.working with older adults/ family members	2.lack of content on work, work organizations
3.child care issues	3.employee benefits	3.lack of courses in industrial social work/EAP work
4.working with physically/sexually abused clients	4.issues and care of aging relatives	4.coursework too general
5.workplace interventions	5.child care issues	5.lack of training in employee benefits/human resources issues
6.working with alcoholism/ substance abuse	6.working with alcoholism/ substance abuse	6.lack of courses in EAP technologies

The items that appear in all three sections are alcoholism/substance abuse and employee benefits/human resources issues. Two other areas emerge in both the least prepared areas and the

areas with the highest need for further training: working with physically or sexually abused clients and child care issues.

In examining the areas for potential curriculum enhancement from another perspective, i.e. how they might cluster logically and giving greater weight to items listed as major limitations, two clusters emerge.

One cluster emerges concerning education about work organizations and occupational social work/EAP issues. This cluster emerged as the major limitation in their masters' education for 42% of the respondents. Included among the responses in this cluster were topics like organizational theory, understanding work organizations and marketing as well as responses regarding a lack of focus on occupational social work or EAP issues in their social work courses. If one then looks at the items in the least prepared areas and in the areas with highest reported need for further training, employee benefits appears in both areas and is clearly connected to understanding work organizations. Child care issues and issues around aging relatives and older adults which also appear in both areas fall into the realm of work/family issues, i.e. issues which relate to the employees' personal lives which have an impact on their ability to work, or work performance. These work/family issues would also be logically connected to an understanding of how work organizations' policies affect employee well-being.

The second cluster that emerges concerns education about alcoholism and substance abuse. This item appears in all three sections and was the item appearing at the top of the major

limitations listed; it was listed as a major limitation by 38% of the respondents. Workplace interventions, which is number five on the list of least prepared areas, is also related to alcoholism and substance abuse. In the questionnaire, workplace interventions were listed as "to get people into treatment e.g. for alcohol and substance abuse." The concept of intervention was developed by the Hazeldon Institute to reach persons with alcohol/substance abuse problems who were resistant to treatment.

One area which receives mention in both the least prepared areas (number 4) and areas with highest need for further training (number 1) is working with people who are physically or sexually abused. This area does not fit into traditional work/family issues nor directly into alcoholism and substance abuse.

How can these areas be built into the curriculum? This is not an easy question, as the typical masters' curriculum is already packed with required courses in policy, human behavior, casework or other method, research and administration. However, it appears from this study that classroom teaching in content areas like understanding work organizations and alcoholism and substance abuse is necessary, not just reliance on exposure to these areas via a field placement. In this survey, even those respondents who had EAP placements rated themselves as relatively poorly prepared and in need of further training in these areas.

One possible approach would be offering the content via elective courses. The advantage of this approach is the potential to really focus on the specifics needed in working with alcoholism and substance abuse, and in understanding work organizations. The

disadvantages of the approach outweigh the advantage. In all likelihood, more than one elective course would be needed in each of these areas. It is unlikely that most students could accommodate these elective courses given the heavy weighting of required courses. Secondly, there would likely be little integration or differentiation of the material covered in the elective courses with that covered in core courses like casework or policy. For example, it would be useful to be able to compare treatment approaches used with alcohol or substance abusing clients with those used with other clients.

A second approach would be to offer specialization in EAP work, or in occupational social work with a focus on employee assistance programs. The specialization approach has received attention over the last fifteen years. In his article on "Educational Ingredients For Occupational Social Work Practice," Hoffer's (1989) respondents identified an understanding of work organizations and the impact of work policy, as well as knowledge about alcoholism and substance abuse as critical elements in a specialization in occupational social work.

In her 1982 article, Brooks reported that forty schools of social work, almost half of the eighty-three she surveyed, had specializations focused on fields of practice, problem areas or specific population groups. Of the forty, three quarters offered specialization in a matrix pattern, i.e. with a method concentration combined with a special focus. Industrial social work was reported as a specialization by only one school at that point in time.

In 1987, McCaslin analyzed curricula at sixty schools of social work and found that thirty-nine offered substantive specializations. Over half of those with specializations offered them concurrently with methods concentrations. McCaslin notes that specializations were most frequently organized by fields of practice, with 87.2% of the schools reporting one specialization of this type. In this survey industrial social work was offered as a specialization by 10 of the thirty-nine schools, a much higher percentage than in the earlier Brooks survey. This, perhaps, indicates an awareness on the part of the schools of the emergence of occupational social work and EAP's as a growing area of employment for social workers.

The model curriculum for occupational social work offered by Mor-Barak and his associates at the University of Southern California, Los Angeles is a specialization model. The first year of this curriculum offers a generic base for social work practice. The second year offers a concentration in industrial occupational social work. Information specific to occupational social work practice is integrated into policy, human behavior, practice and research as well as into the field education. From the description of the concentration courses given in his 1993 article, the occupational social work content appears to be more than an "add-on," in which a general casework or policy or research course is given with a few pertinent examples added for relevance. Instead, there appears to be an effort to look at these areas of learning through the "lens" of work, its meaning to people, and the impact of work-related factors including policies on employees

and their families.

The type of specialized curriculum offered by USC, L.A. would be an effective way to build in the content in work organizations and alcoholism/substance abuse suggested by this study. The description of the core courses in fact includes specific mention of content in these areas.

The advantage of this type of specialization approach is that the specifics of social work practice in occupational settings is integrated throughout the student's courses and field experience. Presumably the student is spared the step of "translating" how casework or policy or research principles are used in the work place, because her learning is contextually based in the work place. The potential disadvantage of this approach, is the risk of superficiality in the treatment of specialized areas. For example, if treating alcohol or substance abusing clients is included in the casework courses in second year, is there sufficient time to really spell out and demonstrate the differences between alcoholism treatment and casework with non-substance-abusing clients, or is the difference simply alluded to? Despite this reservation, the specialization approach to occupational social work described in the Mor-Barak et al article seems to be a well thought out and viable way to give students a good beginning understanding of practice in occupational social work settings.

In contrast to the specialization approach one could include the material suggested by this study by expanding the generic base. It is possible to expand the generic base in three ways:

1. Human Behavior courses should include more material related to adult life. Human behavior courses are currently weighted heavily toward covering child development. One could argue that adult developmental issues have been relatively neglected. Looking more at adult life would include material on work and on substance use and abuse. Psychopathology courses could be expanded to include material on alcoholism and substance abuse as well.
2. Generic education should also include examination of the impact of setting on the nature of the work for social workers. This factor is evident in all fields of practice not just occupational social work. The setting largely determines the types of clients who are seen and the problems presented. The generic curriculum currently presents material on how to understand and work with differential factors in the client, e.g., age, ethnicity, income level, disability. It would be useful to examine how the work is differentially affected by factors in the setting, e.g., if the agency is dealing with mandated clients; if it offers only short term treatment; if it offers concrete services a well as counselling services. In EAP's factors like whether the client is in job jeopardy; whether there are supervisory referrals; and which model of EAP is used all affect what kind of work a social worker will be able to do. As an active learner the student should be asking "How

am I going to be affected by this agency" much as they might ask "how am I going to be affected by this client or this problem?"

3. The generic base should include material on the benefits, rights and responsibilities for people both in the workplace and in society. This material can be examined in policy courses from the perspective of how the mutual obligations between a citizen and society are shaped by public policy. An appreciation for the central place which work holds in the society would be evident in comparing the benefits offered through employment and through public agencies.

Regarding understanding work and work organizations, Kurzman (1987) comments on the existence of an occupational social welfare system, analogous to the social and fiscal welfare systems with which social workers are more familiar. He quotes Weiner et al (1971) in defining the "occupational social welfare system in the United States as composed of

> benefits and services, above and beyond wages, directed at social and health needs, provision for which is not legislatively mandated. Entitlement to these benefits and services results from affiliation with a job in a particular company, or membership in a particular union, or a dependent relationship to an entitlee. (Kurzman, 1987, p. 899)

While social workers more commonly are exposed to the history and workings of the public welfare system because of

social work's long association with advocacy for the poor, the reality is that most of our social work clients, in agency settings and private practice, are more likely to be tied in to the occupational social welfare system than the public welfare system. For example, Asch and Abelson (1993), citing O'Brien, note that 212 million people or 80% of Americans, obtain health care through their own or their family's employment (p. 124). Indeed, even those clients who are unemployed are often eligible for unemployment, health or disability benefits because of their former employment. An understanding of how this system works is critical both to an understanding of our clients' experience and to effective advocacy on their behalf.

On a broader level, an understanding of how this occupational social welfare system works contributes to an appreciation of the significance to the individual of living in a capitalist society like the United States in the 1990's. Part of the individual's experience is being affected by the downsizing of corporations, the shift in demand to information-based skills, and the shift to a concept of shared responsibility between employees and employers for health and benefits. The sense of job insecurity and financial anxiety which permeates the society at this point in time filters down to the kind of family tensions, individual anxiety and substance abuse which commonly present themselves as problems in social service agencies.

On a public policy level, the current national debate over health care is intrinsically tied to a discussion of the scope of the occupational social welfare system. Much of the current

debate is focused on having employers provide health coverage. There has been a recognition that there is currently a three tier system of health coverage in which employees of large companies with full-time jobs at the top, and persons on public assistance at the bottom, have adequate health coverage, but those in the middle, who either work part-time or work for small or mid-size companies, have no organizationally provided health insurance and frequently lack the resources to purchase health insurance privately.

As even this brief discussion indicates, material on the occupational social welfare system would be meaningful to all students and could be incorporated into Human Behavior in Social Environment courses as well as Policy courses. A similar argument could be made for including material on the structure of work in the United States and the meaning of work to the individual. These issues affect all our social work clients directly or indirectly. Indeed, they affect <u>us</u> as social workers directly since we are workers, too.

Regarding education on alcoholism and substance abuse, a similarly strong argument can be made that all social workers, whether employed in occupational social work or more traditional social work settings, need a basic understanding of the incidence, dynamics, consequences and effective interventions for these conditions.

Why is this understanding needed? Because the problem is so widespread. Steinglass (1987) cites two broad- based national surveys that place the incidence of <u>heavy</u> drinking at 12-13% for

men and 2 to 3% for women in the general population (p.26). He notes that most researchers believe that survey data of this kind tend to under-represent the magnitude of drinking. He further cites the breakdown in heavy drinkers by age, noting that 36% of men aged twenty-one to thirty in 1974 were heavy drinkers and 9-10% of women aged 31 to 50 were heavy drinkers. He goes on to comment:

> These figures become particularly telling when one stops to think about how drinking practices might be playing themselves out in the typical family context. For these two age ranges are, of course, the ages when most families are launched and children are raised. Thus for many families, the critical formative years — the years when children are being reared and when adolescents are first experimenting with alcohol — are also the years when the adults in these families show the greatest prevalence of heavy drinking patterns. (pp. 27-28)

The National Institute on Drug Abuse conducts a national survey periodically on drug abuse. The agency published 1990 population estimates which give a good picture of the magnitude of both alcohol and drug consumption. The survey estimates that one hundred million Americans or 51.2% of the population aged 12 or older currently consume alcohol (survey notes those who consumed in the previous month). This includes 4.8 million children aged 12 to 17 years. For illicit drugs, which include marijuana, inhalants, cocaine, hallucinogens, heroin and non-medical use of prescription drugs, 1.29 million Americans or 6.4% of the total

population reported use in the past month, including over 162,000 children aged 12 to 17 years.

The Encyclopedia on Alcoholism (1991) notes that among full-time workers, 14% of men and 7% of women are considered "heavier drinkers" defined as having 14 or more drinks per week. Among part-time workers, 35% of the men and 4% of the women are heavy drinkers (p. 209).

The encyclopedia also documents some of the health costs associated with alcoholism. In 1986, over 26,000 deaths were attributed to liver cirrhosis. In 1987, more than 1.4 million persons were treated for alcohol abuse and dependence.

These statistics are from surveys of the general population. One would expect that the incidence of alcoholism and substance abuse among the client populations of the various family agencies, mental health clinics, community agencies, hospitals and other social work settings would be higher. The higher incidence is further suggested by studies indicating a high rate of co-morbidity of alcohol and substance abuse with other common presenting problems.

In the DSM IIIR, for example, psychoactive substance abuse is specifically listed as a potential complication or associated feature of the following disorders: bulimia, depression, mania, dysthymia, panic disorder, social phobia, obsessive compulsive disorder, post traumatic stress disorder, insomnia, pathological gambling, antisocial personality disorder, borderline personality disorder, and passive aggressive personality disorder. In the social work and psychiatric literature substance abuse has been

strongly linked with domestic violence and child abuse. Because alcohol is a legal substance in our society it is readily available to adults and children, so its use in relation to a wide range of conditions and stressful situations which people may experience is not surprising. Alcohol and substance abuse is present in every caseload, but social workers need to have had specific training in order to recognize it.

An additional concern is that certain symptoms associated with alcoholism or substance abuse are similar or identical to symptoms of other psychiatric or neurological disorders. Alcoholics commonly display symptoms like sleep disturbances, appetite disturbances, depressed mood and a bleak outlook which mimic the symptoms of major depression. The amnesia associated with alcoholic blackouts looks like amnesia associated with certain neurological disorders. Symptoms of suspiciousness and paranoia associated with cocaine use are identical to these symptoms in a paranoid person. It becomes a critical issue for clinical social workers to be able to do a differential diagnosis: to sort out which symptoms are the result of an underlying psychiatric disorder versus which are the sequelae of substance abuse, which in most cases will abate if the client abstains from the substance. In order to make a sound differential diagnosis, the social worker must be familiar with the symptoms associated with alcohol and drug use. She must also be able to intervene with abusing clients to help them achieve abstinence in order to get a clear picture of the person's underlying profile.

In working with substance abusing clients the social worker

has to use herself differently than she might in work with non-abusing clients. The worker must be more direct, didactic/ educational, directive and behaviorally-focused than she would be with a client whose ego functioning was not impaired by alcohol or drugs.

Given these factors, it does the social work student or beginning worker in any social work setting a grave disservice not to have a basic knowledge about alcohol and substance abuse and treatment for clients with these problems. Ignorance about these problems only contributes to their continuation and ties in with the denial which substance abusing clients frequently use.

Knowledge about the incidence, dynamics and impact of alcoholism and substance abuse could be integrated into human behavior in the social environment courses. Treatment issues, particularly differential use of self, could be integrated into casework courses. Social factors contributing to or delimiting substance use could be integrated into social policy courses.

Having cited the arguments for including the material identified by this survey in the generic curriculum, fairness dictates that the disadvantage of doing so be cited. The disadvantage, essentially, is that the core courses already have a great deal of material to cover. Including this material may mean eliminating some other material viewed as important.

A re-examination of what's included may be beneficial, however. Social work started as a field primarily addressing the need and concerns of children and women, who were the primary caretakers. For many years the clients of social agencies were

almost exclusively women and children who were de facto, those outside the workforce.

The nature of the world has changed. The majority of women now work outside the home. Parenting has become more than just a women's issue. More men are utilizing social work services particularly in agencies like EAP's. Businesses have recognized their stake in certain family issues like child care. The nature of social work practice has changed to reflect the nature of the world today. It makes sense for the curriculum to change as well to reflect the nature of social work practice today.

APPENDIX A

Survey on Social Work Education
for EAP Practice

Name_____

Address_____

_____

Home Tel.#_____

Job Title_____

Workplace_____

Address_____

_____

Work Tel.#_____

Informed Consent Statement

You are being asked to complete the attached questionnaire which should take about 15 minutes of your time. The anticipated benefit of the study is the provision of information to improve the social work curriculum as it prepares graduates to work in employee assistance programs.

Your participation in the survey is totally voluntary. Data collected from the survey will be kept separate from identifying data about you and all results will be reported in the aggregate to protect confidentiality. You will be provided with a copy of the survey results and a copy of this consent statement if you request them. I would be happy to answer any questions you may have. You may reach me at the number listed below.

Please sign the following statement if you understand this statement and agree to participate. Thank you for your help!

I understand these instructions and the information provided and do agree to participate in the research described.

_____ _____

Signature Date

Please return the questionnaire to:

Patricia McDonald, C.S.W.
Program Administrator
Hunter College E.A.P.
695 Park Ave. Room 1305W
New York, NY 10021
(212) 772-4052

Thank you for your help in completing the questionnaire!

Employment

In this section I would appreciate some information on your EAP and your individual job.

1. Which of the following best describes the overall organization in which you work? (for example, if you are in an onsite EAP in a college, the college would be the overall organization)
   ___For-profit Corporation
   ___College or university
   ___Hospital or health setting
   ___Union
   ___Government agency (federal, state, or city)
   ___Other non-profit organization (please specify)_____

   _____

   ___Private practice

2. Which of the following best describes your immediate work site?
   ___Onsite employee assistance program
   ___Contracted employee assistance program(outside)
   ___Consultation service
   ___Member assistance program (union-based)
   ___Corporate health/wellness department
   ___Human resources department
   ___Private practice serving EAP clients
   ___Other (please specify)_____

3. If you were to categorize what your EAP/department does, what percentage of the agency's time would be devoted to the following activities?

	Percentage of EAP's time					
	None	1-20	21-40	41-60	61-80	81-100
Counselling/therapy with individuals						
Counselling/therapy with couples and families						
Group programs e.g. presentations on wellness, lunchtime seminars, parent education groups						
Supervisor/management training e.g. educating managers on how to recognize drug, alcohol or mental health problems; or what the EAP does						

	Percentage of EAP's time					
	None	1-20	21-40	41-60	61-80	81-100
Consultation with other departments/units on organizational issues e.g. how to conduct staff meetings						
Assessment and referral e.g. assessing an employee's problem and connecting them with an outside agency for treatment or service						
Research, e.g. needs assessment for your client population, program evaluation						
Other(please specify)						

4. In describing what <u>you personally</u> do at the EAP/department, what percentage of your time is devoted to each of the following activities?

	Percentage of your time					
	None	1-20	21-40	41-60	61-80	81-100
Counselling/therapy with individuals						
Counselling/therapy with couples and families						
Group programs e.g. presentations on wellness, lunchtime seminars, parent education groups						
Supervisor/management training e.g. educating managers on how to recognize drug, alcohol or mental health problems; or what the EAP does						
Consultation with other departments/units on organizational issues e.g. how to conduct staff meetings						

	Percentage of your time					
	None	1-20	21-40	41-60	61-80	81-100
Assessment and referral e.g. assessing an employee's problem and connecting them with an outside agency for treatment or service						
Research, e.g. needs assessment for your client population, program evaluation						
Administration in overseeing the program and fiscal operations of the EAP						
Supervision of other staff or students						
Other (please specify)						

5. In what percentage of the EAP's cases are the following problems addressed? (total percentages may add up to more than 100)

	Percentage of EAP's Cases					
	None	1-20	21-40	41-60	61-80	81-100
Mental health (e.g. depression, anxiety, phobias)						
Alcohol and Substance abuse						
Family or relationship problems						
On the job problems (e.g. work-related stress, problems with a supervisor)						
Life adjustment issues (e.g. divorce, birth of a child, promotion, layoff)						

	Percentage of EAP's Cases					
	None	1-20	21-40	41-60	61-80	81-100
Government entitlements e.g. Medical, unemployment, disability benefits						
Issues around care of aging relatives						
Day care, school problems or other child care issues						
Other(please specify)						

Preparation for EAP Work

6. Please rate how well you feel your graduate social work education prepared you in each area listed below.
   very well = know or could perform with no additional training
   well = needed some additional information or skills
   fairly well = needed to learn a moderate amount of information or skills
   poorly = needed to learn a substantial amount of information or skills
   very poorly = needed to learn extensive or basic information or skills

	very well	well	fairly well	poorly	very poorly
1) Working with alcoholism and substance abuse					
2) Working with people who have been physically or sexually abused					
3) Family treatment					
4) Working with adolescents					
5) Working with older adults, and older family members					

	very well	well	fairly well	poorly	very poorly
6) Workplace interventions to get people into treatment e.g. for alcohol or substance abuse					
7) Stress management/reduction					
8) How to match outside treatment programs to clients' needs					
9) How to identify competent agencies/ practitioners to whom to refer clients					
10)Employee benefits e.g. health coverage, pension					
11)Organization development/team building skills					
12)Research, e.g. needs assessment for your client population, program evaluation					
13)Supervision of other staff or students					
14)Understanding entitlement programs such as Medicare, unemployment disability, food stamps					
15)Issues around care of aging relatives					
16)Day care, school problems or other child care issues					
17)Other(please specify)					

Please summarize your preparation for EAP work by answering the following questions.

7. As specifically as possible, please describe the major limitations of your master's education as preparation for your present job.

_____

_____

_____

_____

8. As specifically as possible, please describe the major benefits of your master's education for your present job.

_____

_____

_____

_____

Areas for Further Training

9. To improve your capacity at your present job, in which of the following areas do you need further training beyond what you received in your Master's program?

	Need to know more	Don't need to know more
1) Working with alcoholism and substance abuse		
2) Working with people who have been physically or sexually abused		
3) Family treatment		
4) Working with adolescents		
5) Working with older adults, and older family members		

	Need to know more	Don't need to know more
6) Workplace interventions to get people into treatment e.g. for alcohol or substance abuse		
7) Stress management/reduction		
8) How to match outside treatment programs to clients' needs		
9) How to identify competent agencies/ practitioners to whom to refer clients		
10) Employee benefits e.g. health coverage, pension		
11) Organization development/team building skills		
12) Research, e.g. needs assessment for your client population, program evaluation		
13) Supervision of other staff or students		
14) Understanding government entitlement programs such as Medicare, Unemployment disability, food stamps		
15) Issues around care of aging relatives		
16) Day care, school problems or other child care issues		
17) Other(please specify)		

Education

In this section we would like to know a little about your social work education

10.Which School of Social Work did you attend? _____

11.When did you graduate? _____

12.What method(s) did you study? (Check all that apply)
___casework
___group work
___community organization
___administration
___research
___generic practice
___systems work

13.What percentage of your studies were in each of the following areas?

	Percentage of Your Studies					
	None	1-20	21-40	41-60	61-80	81-100
Industrial/occupational Social Work						
Mental Health						
School						
Family						
Gerontology						
Other (please specify)						

14.Please give the names and areas of practice of your field placements

First year

Agency_____

Area of practice_____

Second year

Agency_____

Area of practice_____

15.What type of MSW program did you attend?

___Two year full time ___Part time
___One year residence ___Combined BSW/MSW
___Other (Please specify)_____

16.Did you take any courses addressed to

Industrial social work	Yes___	No___
Employee Assistance Work	Yes___	No___
Organizational development	Yes___	No___

Personal Information

I would appreciate it if you would provide the following information. Please be assured that all answers will be kept totally confidential and that results will be reported aggregately.

17. Age at last birthday _____.

18. Sex:

male ___ female ___

19. Ethnicity:

White	___	Asian	___
African American	___	Native American	___
Hispanic	___	Other	___

Other Credentials:

20. a. Are you a Credentialled Alcoholism Counsellor? Yes___ No___
    b. Are you a Certified Employee Assistance Professional? Yes___ No___
    c. Do you have a DSW? Yes___ No___
    d. Do you have a PhD? Yes___ No___
    e. Do you have another advanced degree? Yes___ No___

If Yes, please specify_____

Do you know another social worker, either at your worksite or elsewhere, to whom I could send this questionnaire? Yes___ No___

If yes, please list his/her name and address_____

_____

_____

Would you like a copy of the survey results? Yes___ No___

Would you like a copy of the informed Consent Statement? Yes___ No___

If yes, should it be mailed to: ___home
___work

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