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Brief article

Integrated employee assistance program/managed behavioral health plan utilization by persons with substance use disorders

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Abstract

New federal parity and health reform legislation, promising increased behavioral health care access and a focus on prevention, has heightened interest in employee assistance programs (EAPs). This study investigated service utilization by persons with a primary substance use disorder (SUD) diagnosis in a managed behavioral health care (MBHC) organization's integrated EAP/MBHC product ($N = 1{,}158$). In 2004, 25.0% of clients used the EAP first for new treatment episodes. After initial EAP utilization, 44.4% received no additional formal services through the plan, and 40.4% received regular outpatient services. Overall, outpatient care, intensive outpatient/day treatment, and inpatient/residential detoxification were most common. About half of the clients had co-occurring psychiatric diagnoses. Mental health service utilization was extensive. Findings suggest that for service users with primary SUD diagnoses in an integrated EAP/MBHC product, the EAP benefit plays a key role at the front end of treatment and is often only one component of treatment episodes.

Keywords: Employee assistance programs; Substance use disorders; Managed care; Utilization; Behavioral health

1. Introduction

Understanding access and utilization patterns for treatment of substance use disorders (SUDs) in the private sector is critical. National policy recommendations have called for improving the access to and quality of care for individuals with mental health and substance use conditions (Institute of Medicine, 2006). The 2008 federal Mental Health Parity and Addiction Equity Act of 2008 (Federal Register, 2010) and the Patient Protection and Affordable Care Act of 2010 (PPACA, 2010) extend that focus on access and quality.

SUDs and substance misuse, such as risky drinking, are of major concern in the workplace, specifically, where they impact productivity and health care costs, as well as the well-being of individuals and families (Merrick, Volpe-Vartanian, Horgan, & McCann, 2007). Commensurate with the concern about substance use problems in the workplace is the potential of the workplace as an opportunity to intervene. The private sector is important for many persons with SUDs since 60% of the nonelderly population has privately financed, employer-purchased health insurance coverage (Kaiser Family Foundation, 2009). About three quarters of workers in private industry who are participating in medical care plans have at least some coverage for treatment of SUDs in addition to detoxification (Bureau of Labor Statistics, 2008).

Employee assistance programs (EAPs) and managed behavioral health care (MBHC) provided by vendors such as

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managed behavioral health care organizations (MBHOs) are frequently the vehicles for providing behavioral health treatment to employees and dependents through contracting with employers or health plans (Horgan, Garnick, Merrick, & Hodgkin, 2009). EAPs are designed to identify and address a range of behavioral health and other problems that can negatively affect employees' productivity and well-being (Masi et al., 2004; Roman & Blum, 2002). They provide assessment, short-term counseling, and referral to further levels of behavioral health care. From their origins as internally run occupational alcoholism services, EAPs have evolved to the contemporary model, which is typically based on external contracting with an MBHO or an EAP vendor.

EAPs have been viewed historically as a means to identify alcohol and drug problems earlier and facilitate effective intervention and referral to treatment when needed. Current EAP models typically take a "broad-brush" approach in which a wide range of work/life problems of employees and family members are addressed. The changing nature of the contemporary EAP in terms of contracting arrangements, focus, and service delivery creates a need to better understand where it fits in the spectrum of services for persons with SUDs.

MBHC services differ in several ways from EAP. MBHC services include higher levels of care, such as intensive outpatient, residential, and inpatient treatment. They also include psychiatric services, such as pharmacotherapy evaluation and management. Similar to EAP, MBHC services include outpatient assessment and counseling. However, as opposed to MBHC outpatient services, clinical EAP practice has traditionally focused on EAP "core technology," which includes an emphasis on helping with problems that affect job performance (in addition to services unique to EAP such as consultation to supervisors). Vendors sometimes have separate networks or subnetworks of providers for MBHC versus EAP, with the latter providers having EAP- or workplace-specific expertise. At the same time, recent research has found less differentiation between MBHC and EAP practice than was historically the case (Sharar, 2008).

MBHOs may furnish either a stand-alone EAP product, a stand-alone MBHC product, or an integrated EAP-MBHC product in which an initial level of EAP services is offered to enrollees (Masi & Jacobson, 2005; Merrick et al., 2007). In the integrated product, enrollees who use the initial EAP benefit have a seamless continuum of case management and access to services across both EAP and MBHC benefits within the same plan. They may also have the option of continuing with their EAP provider when they begin to use MBHC benefits for outpatient care. The most recent national survey of enrollment in vendors' specific MBHC and EAP products was conducted in 2002 (Oss, Jardine, & Pesare, 2002). Approximately 17.4 million individuals were enrolled in an integrated product (Oss et al., 2002). This represented about 22% of total enrollment in EAP products and 15% of total enrollment in products that include MBHC services. Most major vendors continue to offer both integrated and stand-alone products. Thus, the integrated product represents a substantial minority of enrollees.

However, there is little research on treatment utilization by persons with SUDs in this model of integrated EAP/MBHC benefits. Research by Cuffel and Regier (2001) found increased value for each dollar spent in terms of behavioral health care access when EAP benefits were integrated with MBHC benefits but did not focus on treatment for SUDs specifically or examine utilization patterns in detail. Recent analyses of utilization within an integrated product versus a "standard" MBHC product from the same MBHO as in the current analysis found that use of any services for treatment of SUDs was significantly higher in the integrated product compared to the standard MBHC product, although overall use of SUD specialty services was low (Levy Merrick et al., 2009). In addition, there were some differences in patterns of care between the two product types, including greater use of regular outpatient treatment in the integrated product (Merrick et al., 2010). However, these studies did not focus on utilization patterns for the subgroup of service users with primary SUD diagnoses or on the role of EAP as an initial service point or facilitator of ongoing care. Other studies have examined the relationship between EAP and behavioral or other medical service use but not in the MBHO context. For example, Zarkin, Bray, and Qi (2000) found that use of a large employer's EAP was associated with greater use of behavioral health and other medical services, suggesting that the EAP helped to identify problems and prompt clients to access additional needed care.

There is also a need for updated information on detailed utilization patterns for persons with a primary SUD in an MBHC environment. Gaining a better understanding of specific service utilization, including the role that the EAP benefit plays, will help to inform service planning, outreach and program promotion efforts, and other aspects of behavioral health services. Greenfield et al. (2004) examined utilization and costs for treatment of SUDs in a different MBHO than the current analysis, using 1997 data. Among other findings, less than 1% of those eligible used any services for SUDs, the most prevalent services were outpatient and intensive outpatient services, and about half of treatment clients with an SUD had a co-occurring psychiatric disorder. The study did not include a focus on EAP services.

The 2008 federal parity law has important implications for EAPs. The overall thrust of the legislation is to improve access to behavioral health services when such coverage is offered. Because of EAPs' hallmark focus on providing low-barrier access and helping to direct individuals to needed care, the parity law raises the importance of the role of EAPs. The regulations prohibit plans from requiring exhaustion of a set number of EAP sessions before accessing standard behavioral health benefits, as some plans have done in the past, but explicitly allow plans to offer EAP services as long as use of the EAP is voluntary (Federal Register, 2010). The

2010 federal health reform legislation, which places particular emphasis on wellness and prevention, also contributes to an environment in which EAPs can play a very useful role.

This study examines utilization in an integrated product by service users with a primary diagnosis of SUD. Research questions included the following:

1. How are all services in the behavioral health continuum used by this group of enrollees?
2. To what extent are EAP services the entry point (initial service) in a treatment episode?
3. To what extent are EAP services followed by additional services?

We sought to answer these questions in the context of a national MBHO with an integrated product in which EAP services are offered but not mandated prior to use of other behavioral health services.

2. Materials and methods

2.1. Data and sample

The data source was Managed Health Network (MHN), a national MBHO covering 11 million members. MHN contracts with employers, health plans, and other payers to manage and deliver specialty behavioral health and EAP services. In this analysis, we focused on enrollees in MHN's integrated product, which combines both EAP and MBHC services in the same benefit package with a centralized intake process. To observe overall patterns similarly for all enrollees, we selected those who were continuously enrolled during 2004 (n = 580,600). The full sample consisted of 1,158 enrollees in the integrated product who used services during 2004 and had a primary SUD diagnosis on at least one claim. We excluded the additional 399 enrollees who had only secondary SUD diagnoses to focus on persons whose SUD was a primary focus for treatment at some point during the year.

For some of the analyses, we constructed episodes of care. Various periods have been used to define new episodes of care. For example, new episodes in the National Commission on Quality Assurance's HEDIS substance abuse measures are based on a 60-day gap (National Committee for Quality Assurance, 2009). We used a slightly more conservative approach with a 90-day gap to further add confidence that we were observing new episodes. For analyses focused on initial service use, we included only the subset of enrollees who were also eligible during the last quarter of 2003 but had no claims during that quarter in order to observe the beginning of new treatment episodes (n = 748). We wanted to ensure that we were not erroneously labeling continuing care from 2003 as *initial* care in 2004. Analysis of the relationship between prior-year (2003) use of any services and type of initial service used in 2004 was further restricted to a subset of 685 enrollees with new episodes in 2004 who were eligible throughout 2003. For analyses focused on subsequent utilization following initial EAP use, we included only the subset of enrollees who were also eligible during the first quarter of 2005 but had no claims during that quarter in order to observe the end of new treatment episodes (n = 151). We used 2003–2005 administrative data, including deidentified claims and eligibility files. Claims included EAP, specialty substance abuse, and mental health services covered by MHN. For EAP claims, only clinical services were included, not assistance such as legal or financial consultation.

The study was approved by the Brandeis University Committee for the Protection of Human Subjects.

2.2. Treatment entry process

Member access to either EAP or MBHC services involved calling a single toll-free number for authorization. Authorization was a routine process in which eligibility was verified, a brief intake was performed, and enrollees were approved to see a network provider. During the telephone intake, enrollees assessed as needing regular outpatient care are typically offered the opportunity to use the EAP portion of the benefit first. Although EAP use was voluntary, it carried a financial incentive in that there was no copayment or other cost sharing. When an enrollee reached the EAP visit limit and needed more services, the MBHC portion of the benefit was accessed, after reauthorization. Some enrollees, such as those needing a higher level of care, requesting a medication evaluation, or continuing with prior treatment arrangements, would initially access services under the MBHC part of the benefit. MHN seeks to refer persons using the EAP benefit to their EAP subnetwork of providers who have particular expertise in workplace-oriented services.

2.3. Key variables

2.3.1. Behavioral health diagnoses

Claims data contained *International Classification of Diseases, Ninth Revision, Clinical Modification* (*ICD-9-CM*) diagnoses, which were then grouped into behavioral health categories using Agency for Healthcare Research and Quality's (AHRQ's) Clinical Classification Software, which provides algorithms to collapse diagnoses into a smaller number of clinically meaningful categories (AHRQ, 2003). We also included all behavioral health-related diagnoses such as *ICD-9* v-codes. SUDs were defined as *ICD-9-CM* codes 291, 292, 303, 304, 305.0, and 305.2–305.9. At MHN, providers are directed to list the most salient diagnosis first, and we considered this the primary diagnosis. Other diagnoses listed are considered secondary. Having a primary diagnosis of SUD in 2004 was required for sample inclusion, but we also report on the frequency of mental health, alcohol, and drug diagnoses specifically including either primary or secondary diagnoses during 2004.

2.3.2. Service type

Service category codes were used to determine level of care/type of service. Services were categorized as primarily for either mental health or SUDs based on service category and primary diagnosis. For regular outpatient services or other categories that were not specific to either SUD or mental health, we assigned based on primary diagnosis. For services that by definition involved either SUD or mental health, such as detoxification or mental health day treatment, we assigned based on service category unless the primary diagnosis disagreed (e.g., mental health service category/SUD diagnosis). In the latter case (<3% of all claims), we used all available information including procedure descriptions to assign claims to either SUD or mental health.

2.3.3. Initial service use

We define initial service use as the first EAP or MBHC service used during 2004 following an absence of such claims during the last quarter of 2003. We consider this to represent the first service in a new episode of treatment. Only the first service of the year is designated this way, including for persons who may start more than one type of service during that time.

2.3.4. Prior service use

This is defined as any EAP or MBHC claim during the prior year (2003) among enrollees who were covered by MHN throughout both 2003 and 2004.

2.3.5. Subsequent service use

For the subsample of service users in 2004 who initially used EAP services and for whom we can observe the end of a treatment episode (defined as absence of claims during the first quarter of 2005), we define subsequent service use as the first non-EAP service (if any) following EAP utilization.

2.4. Statistical analysis

Univariate statistics are presented to describe key characteristics of the sample of service users with SUD diagnoses and utilization patterns including proportion of the sample using specific services and mean number of days or visits per user. We compared, using chi-square tests, demographic and clinical characteristics for the sample of persons with primary SUD diagnoses with those of other continuously enrolled persons in the same product who did not have a primary SUD diagnosis during the year. For the subset of enrollees with primary SUD diagnosis during 2004 who were also eligible in 2003, we used chi-square tests to examine the bivariate association between whether any services were received during the prior year (2003) and the initial type of service used in 2004. This analysis used a single observation for each enrollee, containing information not only for initial service received in 2004 but also for whether services were received in the prior year.

3. Results

3.1. Service user characteristics

This sample of 1,158 service users with a primary SUD diagnosis was predominantly male (67.8%; see Table 1). Most were aged 18 to 35 years (33.8%) or 36 to 54 years (42.8%). More than two thirds lived in the west and south regions of the country. About half (46.1%) had alcohol-related diagnoses only, 38.0% had drug disorder diagnoses

Table 1
Characteristics of service users with a primary SUD diagnosis compared to other plan enrollees

	Service users with primary SUD diagnosis		Other enrollees	
Characteristics	*n*	%	*n*	%
Total	1,158	100.0	579,442	100.0
Gender *				
Female	373	32.2	289,066	49.9
Male	785	67.8	290,376	50.1
Age *				
<18	220	19.0	165,220	28.5
18–35	391	33.8	148,758	25.7
36–54	496	42.8	201,106	34.7
≥³55	51	4.4	64,358	11.1
Relationship to subscriber *				
Employee	505	43.6	259,103	44.7
Spouse	292	25.2	121,680	21.0
Dependent	361	31.2	198,659	34.3
Region of residence *				
Northeast	149	12.9	74,276	12.8
Midwest	202	17.4	105,000	18.1
South	321	27.7	196,826	34.0
West	486	42.0	203,340	35.1
Primary substance abuse diagnosis, any claim during year				
Alcohol abuse	209	18.1	0	0.0
Alcohol dependence [a]	487	42.1	0	0.0
Drug abuse	136	11.7	0	0.0
Drug dependence [b]	469	40.5	0	0.0
Combination of alcohol and drug diagnoses (any diagnosis on any claim) during year [c]				
Only drug	440	38.0	167	0.03
Only alcohol	534	46.1	224	0.04
Drug and alcohol	184	15.9	8	0.00
Mental health diagnosis on any claim during year	671	57.9	31,919	5.5
Anxiety disorders *	104	8.9	5,524	1.0
Mood disorders *	377	32.6	14,252	2.5
Adjustment disorder *	109	9.4	11,956	2.1
Other mental health, v-codes, unclassified *	85	7.3	5,116	0.9

[a] Includes a small number of alcohol-induced mental disorder claims, mainly withdrawal related.

[b] Includes a small number of drug-induced mental disorder claims, mainly withdrawal related.

[c] For "other enrollees" by definition, SUD diagnoses were secondary diagnoses.

* $p < .01$.

only, and 15.9% had both drug and alcohol diagnoses during the course of the year. For both alcohol and drug disorders, diagnoses of substance abuse were much less common than dependence and other (mainly withdrawal related) SUDs. Among persons with primary drug abuse or dependence diagnoses, the three most common types of drugs designated were opioids, either alone or in combination with other drugs (21.8%); cannabis (26.4%); and nonopioid combinations of drugs, unspecified type of drug, or a drug other than opioids, sedatives, cocaine, cannabis, amphetamines, hallucinogens, or antidepressants (27.3%; all data not shown). More than half of the sample also had a mental health diagnosis recorded on claims during the year, with mood disorders most common.

The demographic and clinical characteristics for this sample of service users with a primary SUD diagnosis differed from other plan enrollees in important demographic and clinical characteristics (Table 1). In contrast with the proportion of service users with a primary SUD diagnosis, a significantly greater proportion (49.9%) of the other 579,442 plan enrollees were female (χ^2 = 144.4, $p < .01$). The distribution of enrollees across age categories differed significantly between enrollees with and without a primary SUD diagnosis (χ^2 = 135.0, $p < .01$); there were lower proportions of persons younger than 18 years or 55 years and older among the SUD sample. A significantly lower proportion of the enrollees without primary SUD diagnoses had a mental health diagnosis recorded on any claim during the year (5.5%, χ^2 = 5,997.7, $p < .01$).

3.2. Research Question 1: overall utilization patterns

More than a quarter of the sample with primary SUD diagnoses used EAP services during the year (7.6% EAP only, 19.5% EAP plus some MBHC services), whereas the remainder only used services through the MBHC part of their benefit package (Table 2). Among those using non-EAP, SUD outpatient office visits specifically, 24.0% also used EAP services (data not shown). The mean number of EAP visits per user was 3.3 (*SD* = 2.2). Most EAP services were for SUDs as the primary diagnosis. In terms of MBHC service use, the most frequently used SUD services were non-EAP outpatient office visits (41.8% of service users, *M* = 6.7 [*SD* = 8.0] visits per user), intensive outpatient/day treatment (38.8%, *M* = 15.2 [*SD* = 11.3] visits per user), and inpatient/residential detoxification (24.4%, *M* = 4.6 [*SD* = 3.0] days per user). Although all persons in our sample had a primary SUD diagnosis at some point during the year, we found that many also used services for a primary mental health diagnosis. The largest mental health service category was non-EAP outpatient mental health office visits (36.0% of service users).

Table 2
Type of benefit and service utilization by enrollees with a primary diagnosis of SUD: any service use during year and initial service used

Variables	*n* with any utilization during year	% with any utilization during year	*M* (*SD*) days/visits per user	*n* utilizing as initial service[a]	% utilizing as initial service[a]
Use of EAP and MBHC benefits					
EAP only	88	7.6	NA	NA	NA
MBHC only	844	72.9	NA	NA	NA
Both	226	19.5	NA	NA	NA
Specific service use					
EAP claim					
Any EAP	314	27.1	3.3 (2.2)	187	25.0
EAP substance abuse only	185	16.0	2.9 (1.7)	123	16.4
EAP mental health only	104	9.0	3.3 (2.1)	64	8.6
EAP both substance abuse + mental health	25	2.2	5.8 (3.8)	NA	NA
MBHC claim					
Substance abuse					
Inpatient/residential detoxification	283	24.4	4.6 (3.0)	145	19.4
Inpatient substance abuse rehabilitation	110	9.5	6.3 (7.3)	15	2.0
Residential substance abuse rehabilitation	134	11.6	16.3 (14.2)	20	2.7
Substance abuse intensive outpatient/day treatment	449	38.8	15.2 (11.3)	108	14.4
Outpatient substance abuse office visits (non-EAP)	484	41.8	6.7 (8.0)	125	16.7
Other substance abuse services	73	6.3	1.4 (0.9)	37	5.0
Mental health					
Inpatient hospital mental health	104	9.0	8.8 (12.1)	30	4.0
Residential mental health	6	0.5	17.8 (8.9)	0	0.0
Mental health day treatment/intensive outpatient	34	2.9	9.3 (6.9)	4	0.5
Outpatient mental health office visits (non- EAP)	417	36.0	9.1 (9.0)	74	9.9
Other mental health services	29	2.5	2.0 (1.5)	3	0.4
Total	1,158	100.0	NA	748	100.0

Note. Specific service percents in "% with any utilization during year" column do not total to 100% since they are not mutually exclusive; also in EAP subcategories that are mutually exclusive, percents may not total to 100% due to rounding.

[a] Subsample consisting of enrollees with new episodes of care (no claims during last quarter of 2003).

We also examined the combinations of service types that enrollees used during the year (data not shown). The five most common patterns, which cumulatively accounted for the utilization of 40% of the sample, were regular outpatient SUD treatment only (13.5%, $n = 156$), EAP only (7.6%, $n = 88$), regular outpatient SUD treatment plus regular outpatient mental health treatment (7.4%, $n = 86$), SUD intensive outpatient/day treatment only (7.3%, $n = 85$), and EAP plus regular outpatient SUD treatment (4.2%, $n = 48$).

3.3. Research Question 2: use of EAP as initial service

To examine the beginning of new treatment episodes, we investigated initial service use by enrollees who had no claims during the first quarter of 2004 (Table 2). For this subsample ($n = 748$), 25.0% used the EAP as their initial service. This was the most common initial service type, followed by 19.4% who used inpatient/residential detoxification, 16.7% who initially used outpatient SUD office visits, and 14.4% who used SUD intensive outpatient/day treatment services. A substantial minority (14.8%) initially used a mental health service of some type.

Even when focusing on individuals who appear to be starting a new treatment episode during 2004, it is possible that treatment during the prior year could affect initial service type. Of the 748 with a new episode, 685 were eligible for MHN's services throughout 2003. Using this subsample, we examined the relationship between occurrence of any prior-year (2003) behavioral health claim and use of EAP as initial service type in 2004 (data not shown). About 18.3% of these enrollees had a claim during 2003. A significantly lower proportion of enrollees with prior-year claims used EAP as their initial service in 2004 (19.2% compared to 28.0% for those with no prior-year claims; $\chi^2 = 4.1$, $p < .05$). There was not a statistically significant association between having a prior-year EAP claim and using EAP as the initial service in 2004. However, a significantly lower proportion of enrollees with a prior-year MBHC claim used EAP as their initial service in 2003 (12.8% vs. 28.8% for those without prior-year MBHC claims; $\chi^2 = 11.5$, $p < .01$).

3.4. Research Question 3: EAP as gateway to additional care

To examine the role of EAP as a facilitator of ongoing care, we investigated post-EAP utilization. To enable us to observe through the end of treatment episodes, we conducted this subanalysis for enrollees with initial EAP service use during 2004 and eligible but with no claims during the first quarter of 2005 ($n = 151$). Of this subsample, we found that 67 service users (44.4%) used only EAP services during this episode in 2004. However, 38 (25.2%) used non-EAP, outpatient SUD office visits after their initial EAP use, 23 (15.2%) used non-EAP outpatient mental health office visits, 14 (9.3%) used SUD intensive outpatient/day treatment, and 9 (6.0%) used some other service. Of those who started in EAP and went on to non-EAP outpatient office visits ($n = 45$), 73.8% remained with same provider.

4. Discussion

We found that there was frequent utilization of the EAP benefit by persons with primary SUD diagnosis within the integrated product offering of this large MBHO. In particular, close to one quarter of clients' new treatment episodes featured use of EAP as the initial service. This supports one traditional use of the EAP as a low-barrier entry point for the assessment and treatment process for SUD. This voluntary initial use of the EAP suggests that EAPs can continue to play an important role in the postparity era for a substantial proportion of persons with SUDs who use services.

Many individuals started treatment episodes in higher levels of care for which EAP was not a clinically appropriate alternative (e.g., detoxification, intensive outpatient treatment). The high proportion of persons with initial treatment in a higher level of care suggests that there may be additional opportunities for earlier screening and intervention for SUDs via the EAP. For example, EAPs may provide an enhanced opportunity for screening, brief intervention, and referral to treatment (SBIRT), an initiative focused on at-risk drinkers and drug users (Substance Abuse and Mental Health Services Administration, 2010). There is early evidence that SBIRT in the EAP setting may be efficacious in reducing alcohol consumption among at-risk drinkers (Osilla, Zellmer, Larimer, Neighbors, & Marlatt, 2008; Substance Abuse and Mental Health Services Administration, 2010).

We found that prior-year behavioral health service use within the plan was significantly associated with initial service type in a bivariate test. Those with prior-year MBHC claims were less likely to use EAP as the initial service. To the extent that the primary focus of EAP services is on work/life problem assessment and short-term counseling, it makes sense that persons with recent MBHC treatment experience within the same plan would bypass the EAP.

The most common type of care following initial EAP use was regular outpatient mental health or SUD treatment. This could suggest that EAP served as a bridge to further care. At the same time, it is possible that EAP services were simply substituting for regular outpatient care. These data do not allow determination of the focus or content of services or the impetus for the enrollee calling in to the centralized intake system for services. For example, an enrollee might call seeking EAP services specifically, perhaps in response to workplace promotion of EAP as an open-door resource for people with a range of work or life issues or in response to a supervisory referral. Alternatively, it might be that they decided to use their EAP benefit as they embark on outpatient care due to the no-copayment feature. One survey of providers in a different

vendor network found only partial differentiation in how most clinicians treated EAP clients compared to standard outpatient clients (Sharar, 2009). Additional research should seek to identify similarities and differences between services used under the EAP benefit and other outpatient behavioral health care in integrated products.

Our results indicate that persons with SUDs in this MBHO sample are receiving treatment from across the service continuum. Several aspects of the non-EAP utilization findings are qualitatively similar to those reported earlier by Greenfield et al. (2004) from their study of SUD treatment in a different MBHO. In both studies, the most commonly used services were regular outpatient and intensive outpatient treatment. Use of inpatient or residential detoxification for SUDs was more common in this study than in Greenfield et al., which may reflect our decision to limit service use analyses to persons with primary SUD diagnoses. Persons with only secondary diagnoses of SUD may have less severe problems. On the other hand, in the Greenfield et al. study, the sample had a higher proportion of service users with both alcohol and drug diagnoses (32.6% compared to our finding of 15.9%) and similar proportions of co-occurring psychiatric diagnoses (just over half of sample). However, we are very limited in our ability to determine clinical status based on claims data. We note that the samples are similar in terms of gender and average age, although our sample had a somewhat lower proportion of employees as opposed to spouses and dependents.

Limitations of the study include the standard constraints of claims data, such as lack of detailed clinical information. We could not, therefore, determine the specific content of services delivered or the motivation of persons using EAP or other services. As in all claims data, the diagnoses are based on provider coding, so that SUDs may be underreported or missed by providers. Some SUDs may also be masked by mental health diagnoses, due to patient presenting symptoms and also the possible avoidance of highly stigmatizing diagnoses. In addition, any services that were accessed outside of plan benefits were unobservable. The sample comes from a single MBHO, thus limiting generalizability. The integrated product model studied here is structured similarly to that offered by some other major vendors, for example, in offering EAP as an optional entry point to care and requiring telephonic authorization for either EAP or MBHC. However, generalizability is limited to the extent that arrangements do vary. Finally, there are numerous factors that can influence utilization patterns that we do not attempt to control for in this largely descriptive analysis. For example, utilization rates may vary across employer groups or based on the extent of program promotion. However, our findings do present a useful picture of overall utilization patterns. Future work might investigate in a multivariate context some of the issues we explored here.

The study findings provide useful insight into utilization patterns for persons with SUDs within an integrated EAP/MBHC product, particularly with regard to the role of EAP services. The nonmandatory EAP benefit was quite commonly used, suggesting that EAPs may be well positioned in the postparity environment to act as an initial entry point to assessment and short-term counseling and as a bridge to further services.

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