The Employee Assistance Industry Alliance: Context, History and Initial Vision

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Introduction

The employee assistance industry faces unique challenges as the behavioral health field continues to change. The following is a characterization of how collaboration is emerging around a national Employee Assistance Industry Alliance (hereafter called the Alliance) to provide leadership for the field. This paper discusses the context in which the Alliance is developing and the initial vision for the Alliance. The context is divided into three components, epidemiology of disorder and care, and the Federal Substance Abuse and Mental Health Services Administration, known as SAMHSA, and the history of the Alliance.

Field Context

Epidemiology of Disorders

America is experiencing an epidemic of substance abuse and mental health diseases. To demonstrate these staggering proportions, one in five adults as well as one in five children and adolescents experiences one or more disorders annually. In aggregate numbers, this represents above fifty million adults and more than 15 million children and adolescents. Disorders range from the extremely debilitating conditions such as schizophrenia, depression, and alcohol psychosis to more moderate conditions requiring less intensive interventions.

Epidemiology of Care

An important question is, "To what degree is the specialty mental health and substance service system responding to this epidemic?" Again, numbers are very informative. One in twenty adults, or about 25% of people who need behavioral care, get it from a specialty service provider such as a psychiatrist, psychologist, social worker, or licensed marital therapist. In addition, one in twenty adults only receive care through their primary care provider. From this information, we can conclude that at least one half of all adults needing care receive no care at all (Surgeon General's Report, 1999). Anecdotal data suggests that mental and addictive care provided by primary care physicians is increasing, while, conversely, specialty care is decreasing. There is also mounting evidence that consumer and family member self-care and self-management of conditions are growing rapidly (Goldstrom, et al, 2004).

Turning briefly to children and adolescents, the most recent data show that only one in forty children and adolescents get behavioral care from an organized delivery system of care such as a community mental health center, hospital, or outpatient clinic (Report of a Surgeon General, 2001). Currently, good information is not available about private specialty practices. However, the National Co-morbidity Survey II (Kessler; http://www.hcp.med.harvard.edu/ncs) will soon provide the first national data on this topic.

Change in Insurance and Payment Systems

The insurance coverage for mental and substance abuse disorders is characterized by two features:

1. The lack of parity between behavioral health benefits and physical health benefits

2.   The extensive management of behavioral health benefits by managed behavioral health

companies (Tompkins, et al, 2000).

It has long been documented that provider reimbursement in behavioral health is

disproportionately smaller than that of other health services. For example, a Medicare ambulatory

procedure for a mental health service requires a 50% consumer co-pay compared to 20% co-pay

if the service was a physical or medical procedure. In many private insurance programs, annual

and lifetime benefits, as well as the limits on visits and hospital days, are lower for behavioral

health care.

Through various types of mergers and acquisitions over the past 15 years, several large managed

behavioral healthcare companies have emerged to manage public and private systems of care.

Most notable is the management of the Medicaid benefits for state agencies. In general, good data

are not available to evaluate if this type of management has had a positive effect on consumer

outcomes and system costs.

Prompted partly by the management of benefits and also downsizing and outsourcing, many

private sector industries are beginning to link EAP services to health benefits. In simple terms,

employees may be required to visit the EAP prior to access of health and mental health benefits.

Hence, EAPs are becoming the gatekeepers of behavioral health benefits in a planned linkage.

SAMHSA

SAMHSA, an agency of the U.S. Department of Health and Human Services (HHS), was

established by an act of Congress in 1992 under Public Law 102-321. This agency was created to

focus attention, programs, and funding on improving the lives of people with or at risk for mental and substance abuse disorders.

Much has changed since then in the mental health and substance abuse fields, and so, too, has SAMHSA. To that end, SAMHSA's mission and vision have been more sharply focused and aligned with HHS goals and Administration priorities. It is a vision consistent with the President's New Freedom Initiative (New Freedom Commission on Mental Health, 2003) that promotes a life in the community for everyone. Moreover, SAMHSA is achieving that vision through a mission that is both action-oriented and measurable: to build resilience and facilitate recovery for people with or at risk for substance abuse and mental illness (Power and Manderscheid, 2004).

To bring that mission and vision to reality, SAMHSA's budget and its policy and program activities – including discretionary grant programs and communications initiatives – have been aligned to reflect a series of core priority areas, among them: co-occurring mental and substance abuse disorders, criminal justice, children and families, aging, substance abuse treatment capacity, strategic prevention framework for substance abuse, mental health system transformation, homelessness, disaster readiness and response, seclusion and restraint, and HIV/AIDS. The priority program areas are linked to crosscutting principles that help ensure that SAMHSA's work will meet the highest standards, driven by a strategy to improve Accountability, Capacity, and Effectiveness – ACE. With this strategy, SAMHSA can assure that its resources are used both wisely and well in State and community programs to treat addiction and dependence, to prevent substance abuse, and to provide mental health services (see Figure 1).

Figure 1 SAMHSA Priority Matrix

SAMHSA is comprised of three Centers that engage in program activities focusing on mental health services, substance abuse treatment, and substance abuse prevention. A brief description of the Centers follows.

The **Center for Mental Health Services (CMHS)** seeks to improve the availability and accessibility of high-quality community-based services for people with or at risk for mental illnesses and their families. While the largest portion of the Center's appropriation supports the Community Mental Health Services Block Grant Program, CMHS also supports a portfolio of discretionary grant programs, called Programs of Regional and National Significance, to apply knowledge about best community-based systems of care and services for adults with serious mental illnesses and children with serious emotional disturbances.

The **Center for Substance Abuse Prevention (CSAP)** brings effective substance abuse prevention to every community, nationwide. Its discretionary grant programs – whether focusing on preschool-age children and high-risk youth or on community-dwelling older Americans –

target States and communities, organizations and families to promote resiliency, promote

protective factors, and reduce risk factors for substance abuse.

The **Center for Substance Abuse Treatment (CSAT)** promotes the availability and quality of

community-based substance abuse treatment services for individuals and families who need them.

It supports policies and programs to broaden the range of evidence-based effective treatment

services for individuals who abuse alcohol and other drugs and that also address other addiction-

related health and human services problems.

The Employee Assistance Industry Alliance

EAPs are becoming exceedingly important to behavioral health for a number of reasons. First,

EAPs operate through workplace settings thus they have the potential to access 120 million

workers and their family members. They can provide access early screening and preventive care,

as well as other types of treatment. Second, EAPs, as noted above, are becoming the front door to

behavioral health benefits. Third, EAP are in the process of transformation from a narrower form

of behavioral health services to a broader form of life care services. They represent a microcosm

of the goals the *President's New Freedom Commission on Mental Health* is trying to achieve

(New Freedom Commission on Mental Health, 2003).

For all these reasons, SAMHSA's three centers, CMHS, CSAP, CSAT, undertook the formation

of a national EAP Alliance. Subsequently, the Alliance began to develop a common outlook on

behalf of the industry. Important initial tasks focused on:

- Accreditation standards for the EAP industry in the U.S.

- Development of industry performance measures for EAPs in the U.S.

- A review of current human resources training and practice activity surrounding EAPs

- Development of a clear purpose and objectives statements to guide the Alliance

Work in each of these areas was essential because the EAP industry lacked national leadership to provide guidance to the entire field. Over the succeeding three years, the Alliance membership has expanded to include representation from Europe and Canada (see Figure 2).

Figure 2 Current Employee Assistance Industry Alliance Membership as of July 2004

Bernard Beidel Director, Office of Employee Assistance *U.S. House of Representative*	Dotty Blum President elect, *EAPA*	James Carbone President *The International EAP Collaborative*	Paul A. Courtois *EAP Roundtable*
Ruhal Dooley Information Specialist *Society for Human Resource Management (SHRM)*	Deborah Galvin Social Science *Substance Abuse & Mental Health Services Administration*	Mandie Hajek *Mercer Human Resource Consulting*	Louise Hartley President *EASNA, Canada*
Steve M. Haught, Executive Director Personal Support Program *AFSCME*	Warren Hewitt Special Assistant *Office of National Drug Control Policy*	Renee Kennish Vice President of Service Delivery *Ceridian Corporation*	Richard Klarberg President and CEO *Council on Accreditation for Children and Family Services*

Kathie Lingle	Ronald W. Manderscheid,	Dale A. Masi	Rich Paul
Director, Alliance for Work-life Progress, *World at Work*	Chief *Survey and Analysis Branch Center for Mental Health Services*	President and CEO *Masi Research Consultants, Inc.*	Vice President of Health and Performance Solutions *ValueOptions*
Michael Reddy	Karen Seward	Tracy R. Tanner	Lisa Teems
Chairman *European Forum United Kingdom*	Vice President, Marketing *Warren Shepell Consultants, Inc., Canada*	Health and Welfare Senior Associate *Towers Perrin*	Director, EAP Services *U.S. Department of Health and Human Services*
Christina Thompson	George Watkins	Charles E. Williams	
Vice President, EAP and Addiction Services *Magellan Behavioral Health*	President *Performance Resource Press, Inc.*	Senior Public Health Advisor *Center for Substance Abuse Prevention/SAMHSA*	

History

The Alliance held its first meeting on September 7-8, 1999. Dr. Ronald Manderscheid had asked

Dr. Dale Masi to act as a consultant and convene the initial group. The original private sector

membership included the Presidents of EAPA and EASNA, representatives from the Society of

Human Resource Management, the EAP Roundtable, organized labor, Ceridian, Magellan,

Towers Perrin, the Council on Accreditation, a Canadian representative and the *EAP Digest*. The

public sector representatives were from CSAP and the White House Office of Drug Policy. At

the first meeting, Dr. Manderscheid expressed the need for the EAP to become an industry and

develop standards, performance measures and initiate a uniform glossary and terminology. He

stated that the EAP field needed a voice in Washington to advocate for the profession. At this

meeting, representatives from COA and EASNA explained their interest in cooperating to

develop a uniform accreditation system. At that point, CMHS and CSAP exhibited strong

support for such a move and volunteered financial assistance to get the process underway.

Subsequently, the Alliance receives reports and updates on the accreditation process and continues to support the need for accreditation.

The initial activities undertaken by the Alliance included a committee concerned with the identities of EAP professionals and Human Resources issues. Questionnaires were distributed at the annual meetings of EAPA and EASNA. The need for professional training became readily apparent as a result of the committee work.

The performance measurement committee was formed and its extensive activities are described in a separate chapter.

A third committee around the question of the integration of managed care and EAPs as a single product was formed. Surveys among EAP membership from EAPA and EASNA resulted in strong negative reactions to the integration concept.

The glossary committee is also described in a later chapter and continues its work in this area.

As the Alliance continued to meet, it was informed of current developments in the behavioral and substance abuse area. Dr. Manderscheid briefs the group at each meeting. Numerous experts were invited to present to the committee. This activity is also described in a separate chapter.

When action was called for, the Alliance participated. A chapter was written by all the Alliance members entitled *Employee Assistance Programs in the Year 2002* (see attachment 1). This is the first time a chapter on EAPs in the Mental Health USA Report published by SAMHSA was included. In September, 2003, Dr. Masi testified on behalf of the Alliance before the President's Commission on *Mental Health and the Importance of EAPs in Mental Health Delivery*. The

Alliance also prepared a statement for the field regarding professional practice across state lines and distributed it to its members to be distributed to the members' organizations. The entire Alliance rendered support and suggestions when John Maynard, the EAPA CEO, came before it to request assistance on the issue of Health Savings Accounts.

One of the major activities of the Alliance is the involvement and collaboration with Decision Support 2000+ and how the EAP field may develop its own portal. This is also described in a separate chapter.

The Alliance has now grown to number 23 members and includes additional organizations as Mercer Consulting, Association of Work Life, Regional EAP Organizations and Value Options. The European Forum is also part of the Alliance. Public organizations now include the House of Representative and USDHHS.

Conclusion

The Alliance represents organizations and is not a membership group. It is more an umbrella of the EAP stakeholder groups. It welcomes ideas and input. Our goal will be to eventually become an independent entity with a strong voice in Washington around issues of importance to the EAP field. One of the most important by products has been the interchange and open sharing of information by all members. It truly is a professional Alliance.

It is imperative that the EAP industry continues to promote the full development of the Employee Assistance Industry Alliance to guide the future of this essential field. Much must be done to

complete the tasks undertaken by the Alliance. SAMHSA is pleased to be a partner with the

Alliance in helping to undertake this important work.

References

Goldstrom ID, Campbell J, Rogers J, Lambert D, Blacklow B, Henderson M,
   Manderscheid RW. "National Estimates for Mental Health Mutual Support Groups, Self-
   Help Organizations, and Consumer-Operated Services." (2004). Forthcoming.

Kessler RC The National Co-Morbidity Survey Website (NCS-2)
   http://www.hcp.med.harvard.edu/ncs/index.htm

Masi, D et al. "*Employee Assistance Programs in the Year 2002.*" Center for Mental Health
   Services. *Mental Health, United States, 2002.* Manderscheid, R.W., and Henderson,
   M.J., eds. DHHS Pub No. (SMA) 3938. Rockville, MD: Substance Abuse and Mental
   Health Services Administration, 2004.

New Freedom Commission on Mental Health.
   Achieveving the Promise: Transforming Mental Care in America.
   Final Report.(2003). DHHS Pub. No. SMA-03-3832. Rockville, MD.

Power AK, and Manderscheid RW.
   Recovery, Now!". (2004). Forthcoming.

Tompkins C, Glavin M, Miller K, Winger T.
   "Does Managed Care Differently Affect Services for Behavioral Health? An examination
   of Utilization in Private Health Plans." (1999). The MEDSTAT Group Medicare,
   Medicaid and Managed Care Analyses Project.

U.S. Department of Health and Human Services, Public Health Service, Office of the
   Surgeon General. Substance Abuse and Mental Health Services Administration, Center
   for Mental Health Services, National Institutes of Health, National Institute of Mental
   Health Surgeon General's Report (1999).*Mental Health: A Report of the Surgeon
   General.* Rockville, MD.

U.S. Department of Health and Human Services, Public Health Service, Office of the
   Surgeon General. *Report of a Surgeon General's Working Meeting on: The Integration of
   Mental Health Services and Primary Health Care.*(30 November-1 December 2000),
   Atlanta, GA). Rockville,MD.