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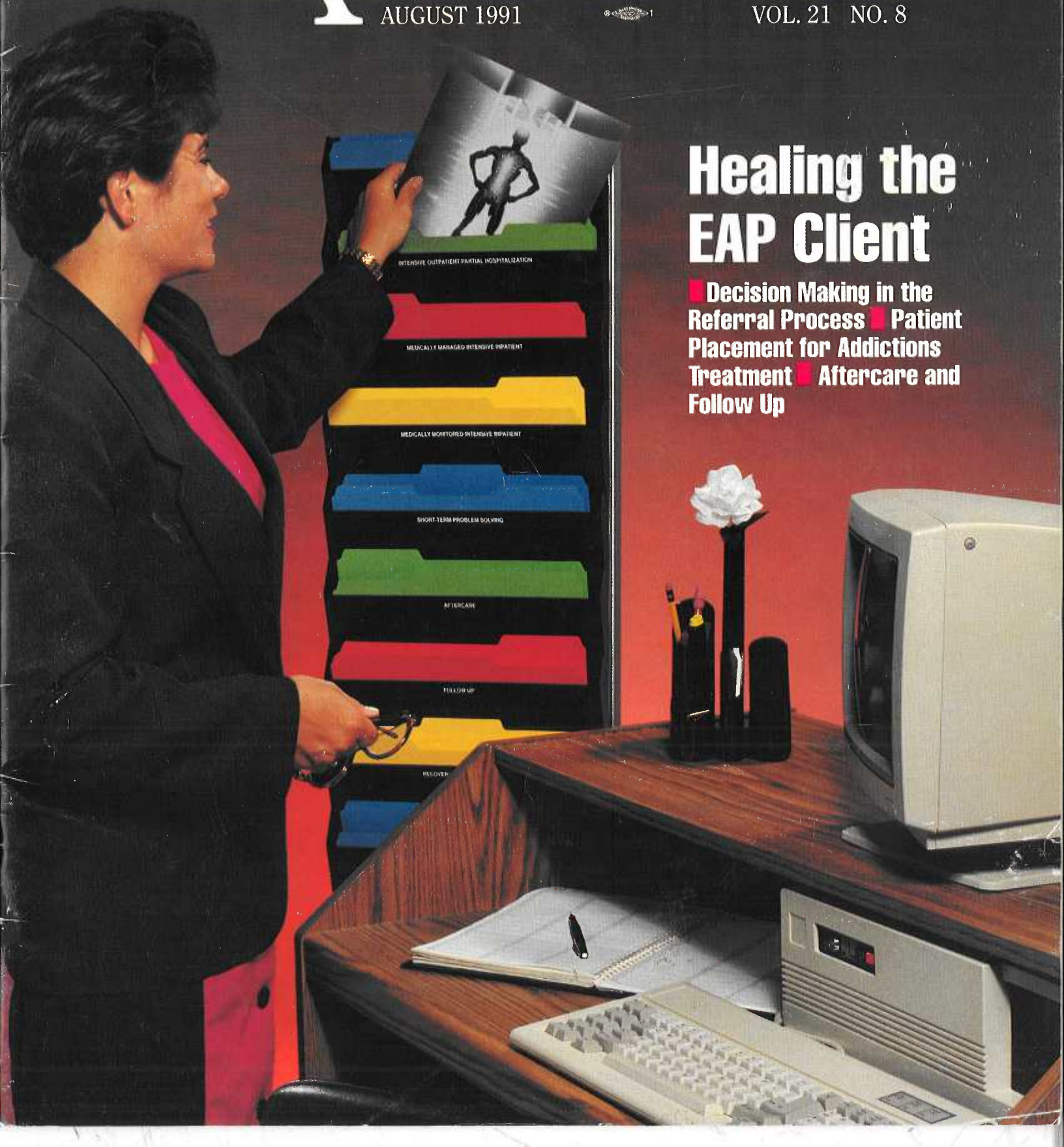
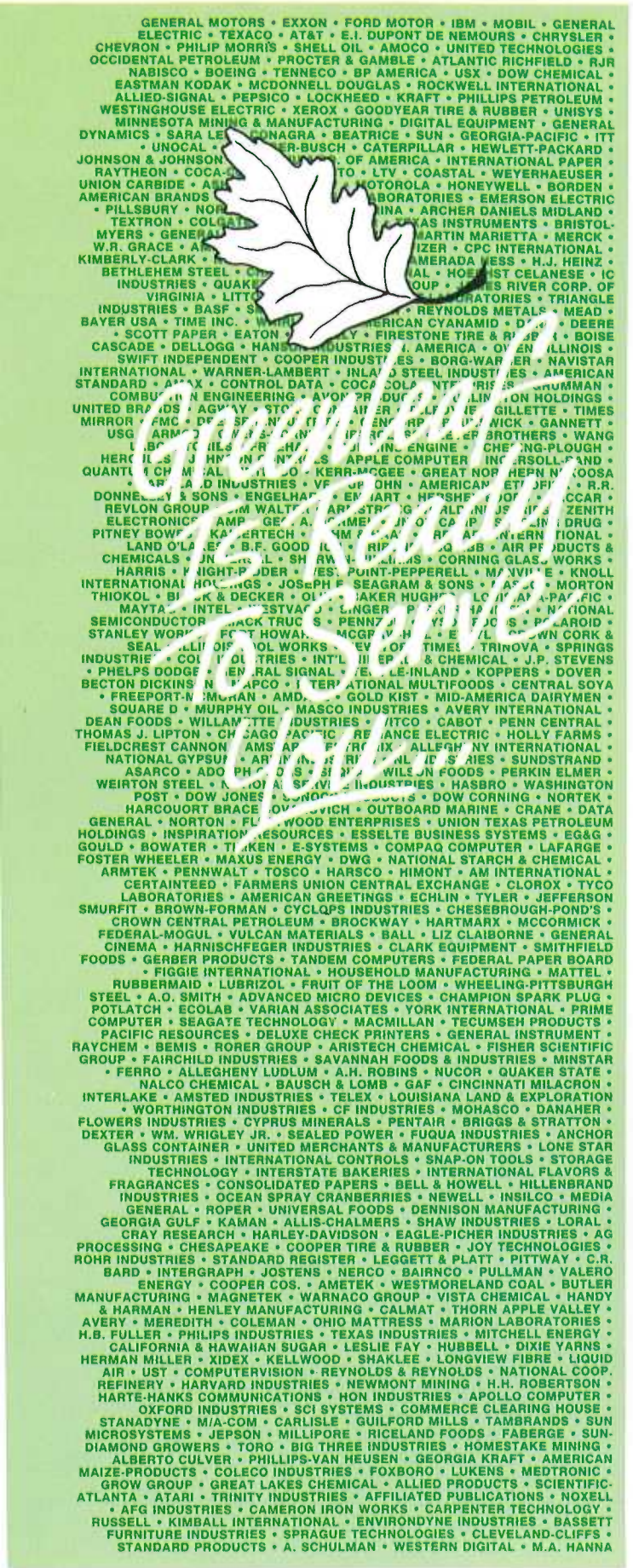


Healing the EAP Client

■ Decision Making in the Referral Process ■ Patient Placement for Addictions Treatment ■ Aftercare and Follow Up



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EDITOR'S COMMENT

Making Prudent Referral Decisions

THIS MONTH'S COVER gives new application to the traditional practice of finding a treatment or counseling "slot" for the EAP client. In the case of addictions treatment, finding an opening at the first available treatment center is passé. We live in a more complicated, stressful society that manifests more diverse and co-existing personal problems. Creating a complete profile of the client problem means assessing the total problem (e.g. cross addiction, dual diagnosis) and taking stock of his or her living situation and its suitability as a recovery environment. If the EAP counselor is appropriately credentialed, s/he can also make a medical assessment of the degree of dependence and its physical consequences. The addictions community calls this a biopsychosocial assessment which, along with quality-of-treatment and costs factors, provides that basis for a pinpoint referral from the EAP.

Does this make the EAP professional's job of client assessment more difficult than in the past? Certainly. In light of this, Michael Wakefield's article, "To Refer or Not to Refer?" builds a case for developing clinical supporting technologies in EAP work. As a follow up to our coverage about the ASAM Patient Placement Criteria which appeared in April, new details about the levels of care are imparted to readers. In ensuing months, these levels may well become the standard for client/patient placement, continued stay and discharge in the addictions-treatment, managed-care and EAP communities.

DESPITE THE INCREASED POTENTIAL for relapse due to more complicated client problems, managed care in many cases has sealed off return visits to treatment settings by closing the benefits spigot. This makes two relatively simple, easy-to-administer functions more vital than ever: aftercare by the EAP or treatment provider, and follow up by the EAP. Jack Canavan and George Cobbs clearly state the case.

AS A SPECIAL SUPPLEMENT, we introduce you to EAPA's headquarters staff of 22 beginning on page 22 of this issue. Meet the people who provide the support services that make EAPA the full-service, professional association that it has become. The EAPA staff, by the way, is working fast and furious to gear up for the 20th National Conference, scheduled for November 10-13 at the Adam's Mark Hotel in St. Louis. Everyone from headquarters looks forward to seeing you there!

Rudy M. Yandrick

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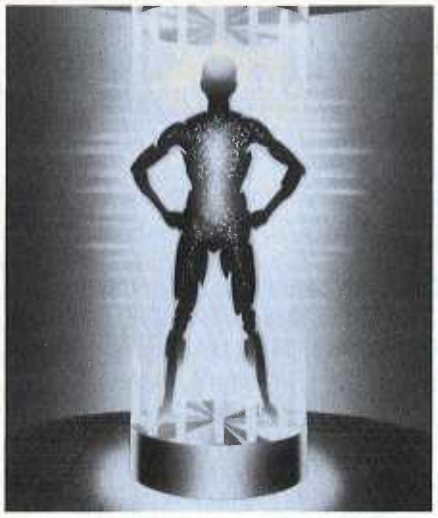

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Also of interest:

FROM THE EXECUTIVE DIRECTOR

Thomas J. Delaney Jr.

by Thomas J. Delaney, Jr., CEAP
EAPA Executive Director

Over the past year, there have been reports in this magazine and elsewhere about the emergence of the concept of "Employee Assistance Services" (EAS). This includes the traditional EAP services but goes beyond to provide management and labor with additional activities in the areas of work/family, legal/financial and job counseling/career development. EAPA president Dan Lanier has spoken about this emerging concept several times and described it in an article in the June issue.

At the same time that both internal and external EAPs are broadening their involvement to these service areas, critical changes are taking place within the parameters of the traditional EAP. It seems to me that there are two key areas of current change. One is the revision of the EAP concept of prevention and the other is the bundling of managed care and insurance. Since several articles of this issue address counseling and treatment, I want to address the latter and devote next month's column to prevention.

The traditional EAP model has relied on the utilization of community services and self-help groups to treat the employee addictions. EAPs had critical roles in system design, training, education, interface with other support functions, and return to work. There were several pioneering efforts to provide treatment. Two of the best known were the United Auto Workers program in Kansas City and the United Technologies program in Hartford, Connecticut. The vast majority of employers and unions decided not to get involved in providing treatment themselves, but to utilize the expertise of the treatment system which had staff and experience, which industry did not.

I sense that industry is still inclined not to get in the treatment business. Industry still feels that the treatment community has the expertise needed to rehabilitate workers and that there are good reasons not to duplicate these efforts. Personally, I believe that this is sound policy. The addiction treatment community which has developed in the past quarter century is a tremendous national resource which must be utilized by industry. As the EAP evolved, however, there emerged a model which included counseling. Much of the discussion about the application of California's Knox-Keene Law was around the issue of determining which EAPs licensed. The EAP Program Standards which were approved last Fall clearly state that "Long-term, on-going treatment is not part of the EAP model" and that "EAP professionals shall determine when it may be appropriate to provide short-term problem resolution services." Short-term problem resolution has long been recognized as an EAP component. However, now it is being identified as a separate component, often called employee counseling services (ECS).

Perhaps the most significant changes occurring in the EAP field are a continuation of the nation's struggle with health care costs. As has been written many times in this publication, been the subject of many speeches and workshops at regional and national conferences and been the focus of a special board committee chaired by Sally Lipscomb, a new "managed care" industry developed in the United States in the last five years. Actually, if use the typology identified by the Institute of Medicine, this is only one of several models of managed care. It is the one that I.O.M. refers to as "high cost management". In my opinion, the labeling of addiction treatment as "high cost" is another sad chapter in the long legacy of the bias of this society against people with alcoholism and drug addictions.

As all EAP providers long ago discovered, however, the new managed care industry is here. A number of EAP service providers developed their own managed care products which they marketed separately or in conjunction with EAP. Some of the large, internal EAPs have become the managed care manager for their employees. Out of this has come some models which are serving their employees well and which will be models for others.

So, managed care vendors and EAP contractors have developed complimentary and duplicate products. Some EAP contractors are providing managed care. Some managed care contractors are providing EAP. Into this has stepped some of the large health insurance companies. Although the insurance industry has been slow to embrace EAP, there have been some historic exceptions. Under the leadership of Mr. James Kemper, Jr., the Kemper Group has long encouraged EAPs for its clients. In his testimony before the House of Representatives sub-committee last Winter, Bill Jernberg reported on the provision of EAP to its policy holders by The Paul Revere Insurance Companies. Now the big companies are getting in. It is bound to have an impact on the EAP field. It could take many forms. It could impact product design, EAP promotion and awareness, the delivery of service, availability of new markets, the specialization of EAP services, staffing patterns and mergers and acquisitions.

The concern about health care costs is also fueling the increasing debate on national health insurance. Dozens of bills have been introduced in Congress this year on the subject of national health insurance. If Senator Rockefeller becomes a presidential candidate, it seems likely that he will use his devotion to this subject as a platform for his candidacy. In my opinion, the national health insurance issue will be the most important public policy issue for the EAP field in the next five years. It is particularly fortunate, that EAPA has now created a full-time staff position of Director of Government relations. I am writing this column on her first day in the office. Her previous experience in the public