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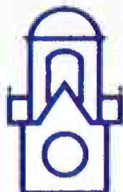

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Thanks, Helen!

Even before I met her, I had heard of her and of the clinic. But I never expected what I saw when I drove up—bars on all the windows, glass in the parking lot and a thick door with an electric buzzer to let you in. But once inside, it was a whole different story. I had come for a job as a substance abuse/family therapist. When I first saw her, she looked older than her years, yet her eyes twinkled, her walk was spry, her manner feisty and oh, all that gray hair—pulled back and held in place with two chopsticks. Yes, two chopsticks!

We proceeded to the associate director's office, which she shared with someone else. In that, it was just like Helen herself. She asked me a little about myself and my work. I rattled off my academic credentials and told her of my experience and training at family services.

Then she zeroed in, "Tell me about how you do substance abuse treatment." Just as glibly I told her of my casework training and experience with the alcohol lecture series with the county highway safety program. (Father Martin's "Chalk Talk" with questions afterward). She listened and asked harder and harder questions. I found myself blushing, but gave it my best shot.

"Well, that's not the way we do it around here," she said matter-of-factly. "You have to love a person back to health." That was a new one on me. She went on to say it probably wasn't the kind of love I was thinking of, either. She had quite a sense of humor. Oh, I'd known about 'tough love' and enabling as concepts before, but I'd never used the concepts with clients and staff, nor understood their place in effective chemical dependency treatment.

Well, I must have said or done something right because both Helen and her associate director invited me to join Robinwood Clinic. But the invitation didn't come until each one asked me for a hug. A hug! This "formally-trained-to-hold-back-displays-of-emotion" social worker was being asked to hug a couple of virtual strangers. I rather uncomfortably obliged. Both women commented, "He's a good hugger!"

That evidently clinched it. I began my tenure at Robinwood Clinic and, more importantly, my training with Helen Pilzner.

It was under her tutelage and supervision that the disease concept took shape. Father Martin's words in Chalk Talk became a reality. Under her disciplined hand, tough decisions were made that meant the difference between an addicted worker living or dying. It was under her eye that I learned more fully to blend my personality with my treatment style, my feelings with my academic casework training. The staff also embodied those feelings. We often would invite guests to staff meetings, and I often sat back and marveled at how she brought together the skills and experience of the staff.

Helen Pilzner's body died a short time ago. Her spirit lives on in those she treated and trained. Treatment works, and chemical dependency and addiction facilities are essential to heal families.

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Improving Patients' Chances

The Step-Down Approach to Patient Placement Calls for a Standardized Criteria to Guide Patients Through a Continuum of Care. A Concensus in Establishing Levels of Care Will Help EAPs Enhance Relationships with Employers, Treatment Providers, Managed Care Professionals and Insurers.

By William Massey, MEd

Over the last several years, there has been an ongoing debate in the chemical dependency treatment field between those who advocate a traditional 28-day hospital stay and those who believe that outpatient programs are the treatment of choice in most cases. The "step down" level of care approach offers a solution that incorporates the advantages of both types of treatment.

Facilities in many areas of the country now offer programs with various levels of care, including detoxification, inpatient rehabilitation, day treatment, evening outpatient treatment and aftercare sessions. Several different criteria determine initial placement of patients and transfer from one level of care to another. Standards vary from one institution to another, causing disagreement and frustration among insurance companies, employers, EAPs and treatment facilities.

NATIONAL STANDARDS. Adoption of national standards for determining levels of care would facilitate establishing a consensus among employers, insurers and treatment facilities. These standards would address how to assess the severity of a patient's illness and identify the most appropriate placement of patients within a continuum of care. Standardized patient placement criteria would also help employee assistance counselors in their placement of patients and enhance their working relationships with employers, treatment centers and insurance companies.

In the late 1980s, the first attempts at integrated criteria occurred with the publication of *The Cleveland Admission, Discharge and Transfer Criteria—Model for Chemical Dependency Treatment Programs*, by the Greater Cleveland Hospital Association and Northern Ohio Chemical Dependency Treatment Directors Association; and *Adult and Adolescent Alcohol and Drug Dependence Admission, Continued Stay and Discharge Criteria*, by the National Association of Addiction Treatment Providers (NAATP). Unfortunately, these criteria were never accepted nationally. What was needed was a set of integrated standards that could be agreed on by treatment centers, third-party payors, physicians and other professionals.

In 1991, the American Society of Addiction Medicine (ASAM) took an important step toward standardizing placement criteria in their clinical guide, *ASAM Patient Placement Criteria for the Treatment of Psychoactive Substance Use Disorders*. This document has been used by many facilities throughout the country in matching patients to appropriate levels of care. While it fell short in addressing all level of care options available at some facilities, the ASAM guide provided the first nationally recognized and widely used criteria for determining patient placement.

The following year, a coalition of nearly 40 national organizations, associations and programs was formed to encourage further patient placement research. The Coalition for National Clinical Criteria has created task forces to address the growing concern over patient placement, treatment standards and outcomes. This is another important step toward creating national standards.

ASAM EVALUATION. According to the ASAM criteria, patients are evaluated on withdrawal, medical condition, emotional/behavioral condition, treatment acceptance or resistance, 12-Step meeting participation, relapse potential and recovery environment and support. Individuals are then placed in one of several levels of care, which may vary among facilities.

Most new patients begin in detoxification and progress to various other levels of care according to individual progress and circumstances. Detoxification is the only level of care with just one necessary requirement. If patients meet the withdrawal criteria—that is; if they are under the influence or withdrawing from alcohol or drugs, they will undergo detoxification regardless of other factors. This condition may be assessed based on vital signs and other objective medical criteria.

Patients are transferred to inpatient programs and day and evening outpatient programs as they meet the criteria for those new levels of care. For instance, a severely medically or psychologically impaired individual is likely to remain in inpatient treatment longer than an individual who is physically healthy and has mastered the tools necessary to deal with psychological problems without using chemicals.

In some instances, a patient may bypass the detoxification level and be placed directly in inpatient treatment if he or she has already undergone detoxification,

continued on page 6

Illustration by Mary Ahern

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but still requires inpatient care. The inpatient program is the most intensive level of care, with a structured, 24-hour plan that includes acute medical care, group education, counseling sessions, case management and participation in 12-Step programs.

CONTINUUM OF CARE. If an individual has completed detoxification or used a drug like marijuana, which doesn't require detoxification, he or she may be placed initially in day treatment. At some point during treatment, the patient should be allowed to leave earlier for clinical reasons, which may include participation in a 12-Step meeting in his or her home community.

Because the ASAM document failed to address day treatment and evening-outpatient treatment as distinct levels of care with separate criteria, we have distinguished between these levels using staff-based and time-based criteria. Day-treatment patients require more staff involvement, but are capable of spending short periods of unstructured time away from the facility. These patients need to have nursing and medical staff available the entire time they are onsite, and they may leave the facility for only up to 15 hours at a time.

It is our understanding that the next revision of the ASAM criteria will include day treatment as a discrete level of care.

For patients without a supportive home environment, the availability of recovery homes has been an important innovation in treatment. In many parts of the country, recovery homes are available to individuals who would qualify for day treatment but have an unsafe home environment. These patients would otherwise need to be placed in expensive inpatient programs or live in dangerous or non-supportive home environments. If clinically indicated, day treatment can be used with a savings of up to several hundred dollars per day.

The most common kind of recovery home offers a safe, inexpensive living environment for six to 12 sober individuals who are involved in a treatment program or have finished treatment. Residents must participate in a 12-Step program and attend daily meetings at the home.

OUTPATIENT CARE. Most outpatient programs meet in the evening, with counseling staff only. Nursing and medical personnel are rarely involved in patients' treatment after admission. Because programs often do not meet every day, an outpatient must be sufficiently stable to go 48 hours without any assistance or intervention by a counselor. Employers often prefer outpatient treatment for chemical dependency, as it eliminates the need to hire and train a temporary replacement. Outpatient services may also enable individuals to receive treatment without their employers' knowledge, encouraging some people to seek help before the company discovers they have a problem.

Maintaining a job and living at home allows the everyday stresses that may have influenced the addictive behavior to surface. Individuals who learn to deal with their problems during treatment are much more likely to practice these coping skills when they are on their own. Families, too,

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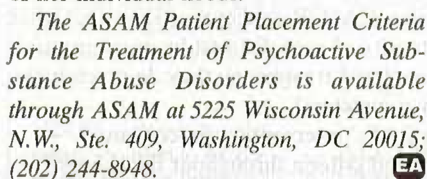
often appreciate the fact that a recovering individual can continue to fulfill responsibilities, and the family can begin to enjoy a more healthy relationship together.

With the step-down treatment approach, each patient progresses through the various levels, so even those who begin with inpatient treatment eventually reach outpatient treatment. This allows a smoother transition to aftercare and continued recovery in the home environment.

Outpatient care also is often indicated when a patent has already successfully completed a treatment program, but has had a relapse. This individual may not require daily medical monitoring and may have a home and work life that is conducive to recovery. In such a case, evening-outpatient treatment would be appropriate to reinforce what has already been learned. In this instance, a skillful pretreatment assessment may indicate the need for a different type of treatment. Psychiatric, dual diagnosis, eating disorders or long-term chemical dependency treatment may be warranted.

ONGOING RECOVERY. Because recovery is an ongoing process, most facilities encourage patients and families to attend weekly aftercare sessions for a year or two following treatment. The family and aftercare services that are customarily offered at no additional charge encourage individuals to continue to maintain sober living and avoid relapse. This fits well into the step-down approach because it supports the transition from reliance on a treatment center to working with 12-Step groups, family members and other community-based systems.

Using the ASAM criteria as a basis for developing standardized national criteria to determine level of care in the treatment of drug and alcohol dependency will ultimately benefit all components of care. With lower costs, employers will continue to be able to insure their workers, insurance companies will save money and, most importantly, each patient will receive the most effective treatment plan based on his or her individual needs.



The ASAM Patient Placement Criteria for the Treatment of Psychoactive Substance Abuse Disorders is available through ASAM at 5225 Wisconsin Avenue, N.W., Ste. 409, Washington, DC 20015; (202) 244-8948.

Massey is program director for the Center for Recovery at the Mt. Diablo Medical Pavilion in Concord, Calif.

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Treatment Effectiveness

EAPs Need to Make Dynamic Use of Data

By Neil P. O'Keefe and Richard Kaplan

Questions on what makes treatment programs effective innundate our offices. As a major outcome evaluator of mental health and chemical dependency treatments, we have been singled out by behavioral health providers, purchasers and payors for user-friendly answers.

At a recent seminar on data measurement, corporate executives, human resource and benefits managers and EAPs provided feedback suggesting that:

- Differing stakeholder's perspectives on value were a challenge to all involved in addressing and defining treatment effectiveness.
- A problem was not a lack of data, but instead a lack of *usable* data (i.e., limits on the development of causal relationships and lack of the clinical use of the outcome measures).
- There was a lack of data on distinctions among employees' behavioral health problems (e.g., severity).
- There was a distinct lack of familiarity with the applications of process and outcome measures to set goals.

There is not a simple answer for a definition of treatment efficacy. Let's assume the starting point to be a simple core formula for treatment—patient + intervention = outcome. The most appropriate match between patient factors (clinical severity and demographic characteristics) and treatment factors (performance and process indicators) will produce the most positive outcome. Even when intangibles, such as denial and motivation, are part of the equation, they fit into the measurement process.

THE PATIENTS. The traditional paradigm of behavioral health treatment depicting patients as needing only prepared "cookie cutter" blocks of treatment is fast disappearing.

Tradtional assessment for chemical dependency and mental health has sadly overlooked fine distinctions achieved by the use of psychometrically-sound instruments for screening, diagnosis and placement. In the development of our chemical dependency risk/severity index, the severity levels of patients have been established on the basis of such *pre-treatment* factors as number of symptoms, type and frequency of drug use and stage of illness. Analysis using the risk/severity index has allowed identifications of patterns in patient severity within the inpatient and outpatient populations, as well as the impact of severity on the likelihood of recovery.

Severity, as measured by the CATOR index, is clearly related to relapse risk. This work on patient risk is being expanded to find relationships among patient severity, length of stay/duration of service, amount of care and outcome measures.

Allowing for the fact that the EAP may be performing the assessment, let's look at some key benchmarks in procedures.

- Does the assessment procedure provide quantifiable verification that a diagnosable condition exists and document the extent of the condition for treatment planning, goal setting and so on?
- Are the instruments and tools used in the patient's assessment process psychometrically sound to justify clinical decisions, such as placement to a particular level of care?
- With the exception of unique information captured in prose, is the assessment in quantified checklist format, which complements clinical observation, case management and quality improvement initiatives?
- Is there a system in place for the EAP to collaborate with providers to monitor the patient's placement, treatment planning and progress, with data as a guide?

THE INTERVENTION. Effective interventions involve expertise and structure, flexibility and variety of response, continuity of services and planning. Our organization has been heavily involved in the development of patient placement criteria, the outstanding example being the ASAM criteria.

To put the data to best use, the ASAM placement criteria, patient-placement measurement tools were developed by New Standards Inc. These placement tools are actually a family of measures comprised of (1) a semi-structured clinical interview called the Recovery Attitude and Treatment Evaluator—Clinical Evaluation (RAATE-CE), a brief self-report instrument that is a companion to (2) the Recovery Attitude and Treatment Evaluator Questionnaire I (RAATE-QI), and (3) checklists for brief adult and adolescent admission, continued stay and discharge/transfer, which put the Level of Care Indices (LOCI) into operation. The RAATE-CE, QI AND LOCI cover the same six dimensions as the ASAM criteria.

These measurement tools and criteria largely presuppose the availability of multiple levels of care within a treatment organization. Effectiveness implies that the patient will receive as much, but no more, than the "dosage" of treatment that individual patient requires. CATOR studies may show that when patients receive the intensity of care dictated by an appropriate treatment plan (i.e., completed treatment), they do much better with less care than non-completers).

Key benchmarks for EAPs' intervention process are:

- credible and standardized criteria throughout the process;
- flexible levels of care present and used appropriately throughout the continuum of care; and
- major problems and goals identified in the treatment plan and

matched with appropriate types of therapy.

THE OUTCOME. Treatment effectiveness is not limited to a particular site, program, philosophy, modality or patient sample. Instead it is about *partnerships*. The partnerships must start with the patient and the patient's family, and include the EAP, managed care, the patient's supervisor, the employer, the provider and the players involved in the patient's referral system.

Treatment effectiveness is also about *monitoring*. Monitoring must take place and be shared by all players involved in the partnership to humanize data, change the course of a treatment plan, question a level of care and arrive, as a body, at a decision on the effectiveness of a treatment episode or a treatment program.

Fortunately, there are some guidelines we can use in monitoring outcomes. After visiting intensively with a cross section of stakeholders (payors, purchasers and providers of treatment) the commonality of the following questions stood out:

- Does the treatment observed work often enough?
- Can it demonstrate it's worthy of the credit for success?
- Does it distinguish the chronically ill from those less severely ill?
- Does it provide low-cost treatment with appropriate lengths of stay?

In the same sense, an outcome study would have common interest to purchasers, payors and providers of treatment if the following variables were addressed:

- Physical, psychological and social functioning of patients following treatment;
- Patient satisfaction;
- Goal attainment; and
- Treatment cost-effectiveness including societal costs (work, medical and legal).

Increases in job functioning levels have important implications for EAPs and employers. In a CATOR study, there was a marked decrease in work-related problems after treatment for employed inpatients.

The EAP, in an ever changing role, must be able to ask for outcome studies from providers and use them as a catalyst in determining treatment efficacy. Outcome studies need to address the following questions:

- Is the study designed on a clinically and psychometrically sound basis?
- Does the provider use the outcome study in a dynamic way to assist in program change and redesign to improve the treatment process?
- Does the study provide information specifically needed by the EAP and employer—such as patient's conformance to continuing care and return-to-work data?
- In the end, will this study help to define treatment efficacy in a practical credible way that leaves the EAP and employer more in control of the management of healthcare? EA

O'Keefe is director of marketing for New Standards Inc., a treatment outcome evaluation service based in St. Paul, MN. Kaplan is president and CEO of New Standards, administrators of the CATOR Registry since 1990. With special acknowledgement to Maurice Smith, PhD, for scientific contribution on RAATE.

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Employee Assistance Lives: Part II

By Paul M. Roman, PhD

While perhaps not intentionally, self-styled friends of the field will kill EA with their self-defined kindnesses wrapped in the vagaries of buzzwords.

I think they are about as wrong as they can be. In the last column, I challenged the contention that the workplace is becoming dominated by employee governance, and that now-central concerns about quality somehow undermine the efficacy of the EA intervention model.

Further, I underlined the always-and-ever critical importance of EAPs motivating employees to seek treatment; providing services from consultation to supervision; assuring due process and smoothing organizational functioning through training and education.

Have EAPs' value been damaged or undermined by workplace changes and the imminence of healthcare reform? Hardly. They are needed more than ever. But the lack of understanding within the field about EA fundamentals risks the possibility that the blind will lead the blind, stumbling right out of existence.

CENTRAL TREATMENT ROLES. The most frightening misconception dogging EA workers at present is the idea that their roles will evaporate if they are not able to choose the treatment agency to which their employee clients are referred. The implication is that by limiting choices through establishing some form of networks, healthcare reform will assure inadequate or inappropriate choices.

First of all, I am certain that the EA role in guiding selection of treatment modalities will be as crucial as it ever has been. A treatment modality and a treatment center are not the same thing.

Second, as mentioned before, the EA role in preparing the client for treatment remains as a unique and centrally valuable role for EA workers.

Third, a true EA professional will monitor the treatment process and keep abreast of progress, setbacks and input from significant others, including work supervisors and peers. Reform will not affect this.

Fourth, within the context of employment, no form of treatment is ever "free," regardless of how it is paid for. Employees typically need to use sick leave or otherwise be absent, creating costs for themselves and the employer. Ensuring that the return to work occurs in the shortest and most reasonable time frame is a key EA role, unaffected by healthcare reform.

Finally, many of my columns have been loaded with discussion of the value of EA roles in post-treatment follow-up. Again, these vitally important and unique contributions will remain of central importance, regardless of the pattern of healthcare reform.

THIS IS NOT SOCIAL WORK. I recently heard a healthcare reform discussion by a person who knows the healthcare system well but knows little or nothing about EA.

She suggested that reform will leave EA workers with little to do, but will present them with golden opportunities to engage the workplace in a range of social-problem resolutions, ranging from illiteracy to childcare and encompassing both eldercare and outplacement counseling.

This is another form of the blighted thinking that is guiding the EA community into fearful fantasies and mindless mission-confusion in the face of projected doom and disaster. While employing many professional social workers, EA work is not industrial social work. Industrial social workers should be the first ones to tell us our roles are not the same.

Attempts at blurring the boundaries between EA work and social work go back almost two decades. Unlike prior attempts, there is little evidence that the field of social work is currently encouraging such involvement.

But the reasoning is just as defective as it ever was. Social work is a distinctive set of functions and strategies, and it does not encompass EA work. Further, there is very little in the CEAP credentialing process that reflects professional social work qualifications among EA workers.

TROUBLESHOOTING. Healthcare reform will offer tremendous potential for value-added EA services in the realm of employee problem-solving. This can only happen if EA work can itself recover from "medicophilia," my label for "the love of all things medical."

Let me explain. It always seems hackneyed for essayists to use the dictionary as a source, but today I turned to Webster to confirm my definition of "troubleshooting." It is defined as locating the source of problems that affect the flow of work, and resolving these problems. This is a sound guideline to attach to what EA practitioners have come to mislabel as short-term therapy, comprised of a limited number of "counseling sessions," an almost universal bargaining chip in employers' negotiating of contracts with external providers.

I have long been wary of the introduction of any kind of therapy or treatment into EA practice. I am not alone in the belief that employers expose themselves to multiple risks when they mandate their own employees or agents (i.e. external EA service providers) to deliver treatment or therapy to other of their employees.

Employees are entitled to receive medical services from professionals who are not entangled in their employment relationship. Internal EA workers or external EA counselors have all or part of their livelihood vested in their relationships with their clients' employer. Having them provide treatment under such auspices risks conflicts of interests from several directions.

Healthcare reform is going to include components that guide access to services.

Employees who access EA services in a workplace are not necessarily going to be referred to treatment because they want to go to treatment. The EA worker also may be unable to develop documentation that an individual needs treatment.

But these employees need advice and guidance. They will benefit from talking to someone who can hear out the multiple dimensions of their problems. From the EA workers' perspective, this is troubleshooting. It is not counseling; it is not therapy; it is not treatment, although the professional egos of some EA workers seem to tell them that they are not really doing their work unless they can make it sound like they are playing doctor.

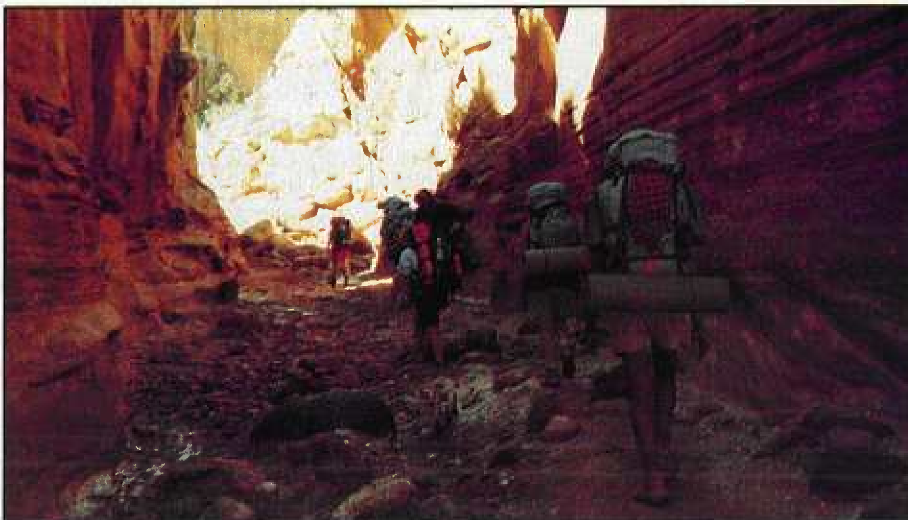
I find it very hard to convince EA workers that it is illogical and contradictory to offer "short-term counseling" as an alternative to external referral. If treatment is not needed, why or how can treatment be delivered? Why can't people in EA work be happy with the idea that they are very capable of helping people solve their problems without attaching medical labels to the problems or solutions?

This "medicophilia" can probably be traced to insecurity. The human service work of today is loaded with people who are uncomfortable unless everyone they talk to has a disease, a dependency or a co-dependency. The "medicalization of everyone" is a major cause of many of the abuses of the healthcare system.

Troubleshooting was, is, and under healthcare reform will be, a vital role for EA workers. Troubleshooting is done with supervisors as well as with problem employees. It can constitute a pivotal emphasis within EA work, and provide the very cost-saving kind of device that healthcare reform is all about.

Thus healthcare reform will not degrade or diminish the importance of EA work. It can escalate and enhance its value. This will happen only if the leaders and soothsayers in the field will let it happen. It is indeed "a time to gather stones together." EA

Roman is a research professor of sociology and director of the Center for Research on Deviance and Behavioral Health at the University of Georgia.



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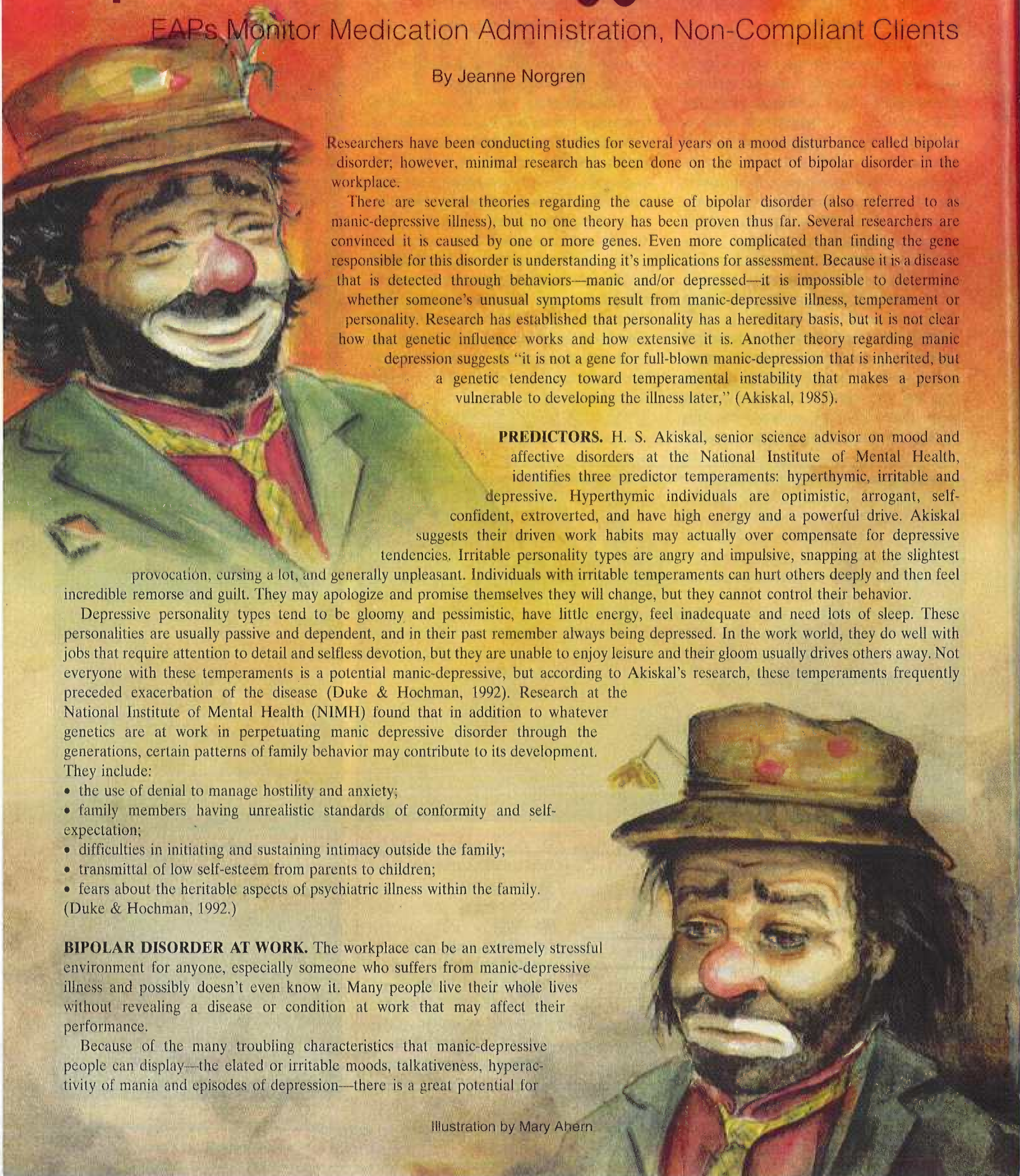
Bipolar Workers Juggle Extremes

EAPs Monitor Medication Administration, Non-Compliant Clients

By Jeanne Norgren



Researchers have been conducting studies for several years on a mood disturbance called bipolar disorder; however, minimal research has been done on the impact of bipolar disorder in the workplace.

There are several theories regarding the cause of bipolar disorder (also referred to as manic-depressive illness), but no one theory has been proven thus far. Several researchers are convinced it is caused by one or more genes. Even more complicated than finding the gene responsible for this disorder is understanding it's implications for assessment. Because it is a disease that is detected through behaviors—manic and/or depressed—it is impossible to determine whether someone's unusual symptoms result from manic-depressive illness, temperament or personality. Research has established that personality has a hereditary basis, but it is not clear how that genetic influence works and how extensive it is. Another theory regarding manic depression suggests "it is not a gene for full-blown manic-depression that is inherited, but a genetic tendency toward temperamental instability that makes a person vulnerable to developing the illness later," (Akiskal, 1985).

PREDICTORS. H. S. Akiskal, senior science advisor on mood and affective disorders at the National Institute of Mental Health, identifies three predictor temperaments: hyperthymic, irritable and depressive. Hyperthymic individuals are optimistic, arrogant, self-confident, extroverted, and have high energy and a powerful drive. Akiskal suggests their driven work habits may actually over compensate for depressive tendencies. Irritable personality types are angry and impulsive, snapping at the slightest provocation, cursing a lot, and generally unpleasant. Individuals with irritable temperaments can hurt others deeply and then feel incredible remorse and guilt. They may apologize and promise themselves they will change, but they cannot control their behavior.

Depressive personality types tend to be gloomy and pessimistic, have little energy, feel inadequate and need lots of sleep. These personalities are usually passive and dependent, and in their past remember always being depressed. In the work world, they do well with jobs that require attention to detail and selfless devotion, but they are unable to enjoy leisure and their gloom usually drives others away. Not everyone with these temperaments is a potential manic-depressive, but according to Akiskal's research, these temperaments frequently preceded exacerbation of the disease (Duke & Hochman, 1992). Research at the National Institute of Mental Health (NIMH) found that in addition to whatever genetics are at work in perpetuating manic depressive disorder through the generations, certain patterns of family behavior may contribute to its development. They include:

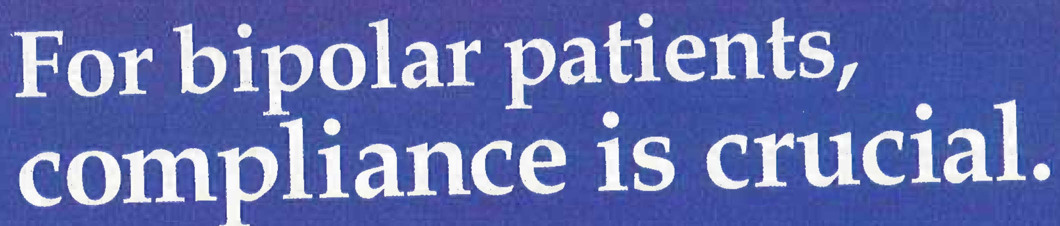
- the use of denial to manage hostility and anxiety;
- family members having unrealistic standards of conformity and self-expectation;
- difficulties in initiating and sustaining intimacy outside the family;
- transmittal of low self-esteem from parents to children;
- fears about the heritable aspects of psychiatric illness within the family.

(Duke & Hochman, 1992.)

BIPOLAR DISORDER AT WORK. The workplace can be an extremely stressful environment for anyone, especially someone who suffers from manic-depressive illness and possibly doesn't even know it. Many people live their whole lives without revealing a disease or condition at work that may affect their performance.

Because of the many troubling characteristics that manic-depressive people can display—the elated or irritable moods, talkativeness, hyperactivity of mania and episodes of depression—there is a great potential for

Illustration by Mary Ahern



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INDICATIONS
Treatment of manic episodes of manic-depressive illness. Maintenance therapy prevents or diminishes the intensity of subsequent episodes in those manic-depressive patients with a history of mania.

WARNINGS
Lithium should generally not be given to patients with significant renal or cardiovascular disease, severe debilitation or dehydration, or sodium depletion.

Chronic lithium therapy may be associated with diminution of renal concentrating ability. Such patients should be carefully managed to avoid dehydration with resulting lithium retention and toxicity. Morphologic changes with glomerular and interstitial fibrosis and nephron atrophy have been reported. Morphologic changes have also been seen in manic-depressive patients never exposed to lithium. During lithium therapy, progressive or sudden changes in renal function, even within the normal range, indicate the need for reevaluation of treatment.

An encephalopathic syndrome (characterized by weakness, lethargy, fever, tremulousness and confusion, extrapyramidal symptoms, leukocytosis, elevated serum enzymes, BUN and FBS) has occurred in a few patients treated with lithium plus a neuroleptic. In some instances, the syndrome was followed by irreversible brain damage. Patients receiving such combined therapy should be monitored closely for early evidence of neurologic toxicity and treatment discontinued promptly if such signs appear. Caution patients about activities requiring alertness.

Lithium may prolong the effects of neuromuscular blocking agents. Such agents should be given with caution to patients receiving lithium.

Lithium carbonate may cause fetal harm when administered to a pregnant woman. If a patient becomes pregnant while taking this drug, the patient should be apprised of the potential hazard to the fetus.

Nursing should not be undertaken during lithium therapy except in rare and unusual circumstances.

Not recommended in children under 12.

Elderly patients often require lower lithium dosages to achieve therapeutic serum levels. They may also exhibit adverse reactions at serum levels ordinarily tolerated by younger patients.

PRECAUTIONS
Caution should be used when lithium and diuretics are used concomitantly. Patients receiving such combined therapy should have serum lithium levels monitored closely and the lithium dosage adjusted if necessary.

Sweating, diarrhea and concomitant infection with elevated temperatures may also necessitate a temporary reduction or cessation of medication.

Indomethacin and piroxicam have been reported to increase significantly, steady state plasma lithium levels. There is also some evidence that other nonsteroidal anti-inflammatory agents may have a similar effect. When such combinations are used, increased plasma lithium level monitoring is recommended. Concurrent use of metronidazole with lithium may provoke lithium toxicity due to reduced renal clearance. Monitor patients receiving such combined therapy closely.

When used with angiotensin-converting enzyme inhibitors, such as enalapril and captopril, lithium dosage may need to be decreased; measure plasma lithium levels more often.

Concurrent use of calcium channel blocking agents with lithium may increase the risk of neurotoxicity in the form of ataxia, tremors, nausea, vomiting, diarrhea and/or tinnitus. Caution is recommended.

ADVERSE REACTIONS
Adverse reactions may be encountered at serum lithium levels below 1.5 mEq/L. Mild to moderate adverse reactions may occur at levels from 1.5 to 2.5 mEq/L, and moderate to severe reactions may be seen at levels of 2.0 mEq/L and above. Fine hand tremor, polyuria and mild thirst may occur during initial therapy and may persist throughout treatment. Transient and mild nausea and general discomfort may also appear during initial therapy. These side effects usually subside with continued treatment or a temporary reduction or cessation of dosage. Diarrhea, vomiting, drowsiness, muscular weakness and lack of coordination may be early signs of lithium intoxication, and can occur at lithium levels below 2.0 mEq/L. At higher levels, ataxia, giddiness, tinnitus, blurred vision and a large output of dilute urine may be seen. Serum lithium levels above 3.0 mEq/L may produce a complex clinical picture, involving multiple organs and organ systems. Serum lithium levels should not be permitted to exceed 2.0 mEq/L during the acute treatment phase.

The following reactions appear to be related to serum lithium levels, including levels within the therapeutic range. *Neuromuscular/Central Nervous System*—tremor, muscle hyperirritability (fasciculations, twitching, clonic movements of whole limbs), hypertonicity, ataxia, choreo-athetotic movements, hyperactive deep tendon reflex, extrapyramidal symptoms including acute dystonia, cogwheel rigidity, blackout spells, epileptiform seizures, slurred speech, dizziness, vertigo, downbeat nystagmus, incontinence of urine or feces, somnolence, psychomotor retardation, restlessness, confusion, stupor, coma, tongue movements, tics, tinnitus, hallucinations, poor memory, slowed intellectual functioning, startled response, worsening of organic brain syndromes; *Cardiovascular*—cardiac arrhythmia, hypotension, peripheral circulatory collapse, bradycardia, sinus node dysfunction with severe bradycardia (which may result in syncope); *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, gastritis, salivary gland swelling, abdominal pain, excessive salivation, flatulence, indigestion; *Genitourinary*—glycosuria, decreased creatinine clearance, albuminuria, oliguria and symptoms of nephrogenic diabetes insipidus including polyuria, thirst and polydipsia; *Dermatologic*—drying and thinning of hair, alopecia, anesthesia of skin, acne, chronic folliculitis, xerosis cutis, psoriasis or its exacerbation, generalized pruritus with or without rash, cutaneous ulcers, angioedema; *Autonomic*—blurred vision, dry mouth, impotence/sexual dysfunction; *Thyroid Abnormalities*—euthyroid goiter and/or hypothyroidism (including myxedema) accompanied by lower T_3 and T_4. I^{131} uptake may be elevated. (See PRECAUTIONS.) Paradoxically, rare cases of hyperthyroidism have been reported; *EEG Changes*—diffuse slowing, widening of the frequency spectrum, potentiation and disorganization of background rhythm; *EKG Changes*—reversible flattening, isoelectricity or inversion of T-waves; *Miscellaneous*—fatigue, lethargy, transient scotomata, exophthalmos, dehydration, weight loss, leukocytosis, headache, transient hyperglycemia, hypercalcemia, hyperparathyroidism, excessive weight gain, edematous swelling of ankles or wrists, metallic taste, dysgeusia/taste distortion, salty taste, thirst, swollen lips, tightness in chest, swollen and/or painful joints, fever, polyarthralgia, dental caries.

Some reports of nephrogenic diabetes insipidus, hyperparathyroidism and hypothyroidism which persist after lithium discontinuation have been received.

A few reports have been received of the development of painful discoloration of fingers and toes and coldness of the extremities within one day of the starting of treatment with lithium. The mechanism through which these symptoms (resembling Raynaud's syndrome) developed is not known. Recovery followed discontinuance.

Cases of pseudotumor cerebri (increased intracranial pressure and papilledema) have been reported with lithium use. Lithium should be discontinued, if clinically possible, if this syndrome occurs.

HOW SUPPLIED
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†Greenberg, R.N. Overview of patient compliance with medication dosing: a literature review. Clin Ther 6:592-599, 1984.

SCIOS NOVA PHARMACEUTICALS IN ASSOCIATION WITH SB SmithKline Beecham Pharmaceuticals

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problems in the workplace. Conflict may arise from the bipolar worker's behavior or from co-workers reactions. In some situations, supervisors are aware of an employee's problems but are reluctant to make a referral to the EAP because they fear referral could cause the employee to lose his or her job, according to John Connor, EAP manager at Torrington Company in Torrington, Conn. Often such reluctance results in supervisors becoming enablers.

Dr. Dale Masi, EAP expert, points out that although supervisors and mangers "are in the best position to monitor employee job performance and recognize potential problems, they are often the last to recognize a troubled employee." According to Masi, one study found that the typical supervisor in a public agency covered up for a troubled employee for about 12 years before taking action and the average private-sector supervisor covered up for 8 years. "It's much easier to close your eyes to problem employees, demote them, promote them, or put them on detail work," Masi contends (Ralfs & Morley).

SEEKING ASSISTANCE. Once supervisors reach the stage where they will no longer tolerate behaviors that occur during manic-depressive episodes, they still may encounter manic-depressive workers' initial resistance to seeking assistance. Consequently, these workers are likely to come to the EAP for assessment because supervisors have mandated them to do so. Paranoia is also a possibility with bipolar disorder and may escalate the mandate for such employees to contact the EAP, but at the same time, make them even more reluctant to seek help for fear management is out to get them.

Unless EAPs have the clinical training to provide counseling for bipolar workers, they don't go beyond the assessment and immediate referral process. However, it is not uncommon for properly certified EAPs to become involved in the monitoring of medication administration for bipolar employees to ensure proper dosages and increments, and is recommended for non-compliant employees.

HIGH PROFILE CASES. There seem to be many cases of manic depressive illness in the high-power business world. Dr. Ronald R. Fieve, president and clinical director of the Foundation for Depression and Manic-Depression in New York, describes what he calls the "manic-depressive entrepreneur." Long, hectic days, with no sleep, nonstop talk, risky deals, and endless energy, abruptly cut off by plunges into desolate depression characterizes some of the country's highest profile business leaders.

"Professional departments of many offices look for this type of person, the kind that has an upbeat approach to things, who is a workaholic, who is overactive, overproductive and who is full of ideas," Fieve says. "And if they don't go crazy over the top or retreat into the pits of depression, as long as their judgment is not impaired or they are surrounded by people who can keep them from going over the edge with disastrous business decisions, these would be ideal people to staff a very productive office. They are envied by their colleagues...until their mania goes too high or a depression washes over them. Then they accomplish nothing, or they get in trouble," (Duke & Hochman, 1992).

In a *New Yorker Magazine* article by Connie Bruck, John Mulheren, Jr., described as a "legendary Wall Street trader," revealed his secret when he protested in court that his

manic-depressive illness distorted his reasoning and judgment; however he also boasted it often enhanced his abilities on Wall Street. The article described some manic and depressed episodes Mulheren experienced. Like many high-powered people, Mulheren did not take his lithium regularly. He was afraid it would dull him, he said, and still believes that when he is not medicated, he is livelier, more creative, more focused—what he calls "one hundred and fifty percent of normal," (Bruck, 1991). Fieve tries to prevent his business tycoon patients from getting into trouble by forming a "committee" around them. The committee could include the patient's lawyer, accountant, medical doctor and Fieve. Having four advisers at their beck and call feeds the patient's narcissism, Fieve says. But the committee has a strategic role: it protects the patient from making outrageously dangerous decisions, such as buying a worthless piece of land in the middle of the desert, or just from extending himself into financial disaster.

Fieve says, "One committee member could never, alone, talk the executive (patient) out of a foolhardy scheme. But a committee frequently can figure out a way to handle it. You are often dealing with someone brilliant and conniving, so you have to outmanipulate him," (Duke & Hochman, 1992).

Kay Redfield Jamison, associate professor of psychiatry at Johns Hopkins School of Medicine, cautions that not everyone who is productive or unusually creative is a candidate for manic-depressive illness. Making that claim, she says, "mocks the notion of individuality," (Jamison, 1989). It is also wrong to equate "workaholism" with manic depression. Many people are compulsive workers that function on few hours of sleep, but are not mood-disordered.

The most common treatment of bipolar disorder is carefully monitored dosages of lithium, an element taken in salt form (lithium carbonate). Lithium is taken regularly and prophylactically every day in the absence of problems to prevent radical shifts in mood (Davis, 1976). One of the side effects of lithium, however, is that it prevents manic-depressives from feeling extremely good on occasion (Honigfeld & Howard, 1978), and it is not always easy for bipolar individuals to give up occasional euphoria. Because of possibly serious, even fatal side effects, lithium has to be prescribed and monitored very carefully (Davison & Neale, 1986).

When manic-depressive clients return to work, the EA professional may become involved in monitoring their aftercare and directing them to available community resources and self-help groups.

The National Depressive and Manic-Depressive Association (NDMDA) was founded in 1978 in Chicago by Marilyn Weiss and Rose Kurland, both of whom have manic-depressive illness. Today the organization has 250 chapters with over 35,000 members. It is the only mental health organization that is run by patients; the executive director since 1989, Susan Dime-Meenan, also suffers from manic-depressive illness (Duke & Hochman, 1992).

There is also an organization made up of mood-disordered

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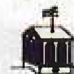

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patients, family members, mental health professionals, and others concerned about mood disorders. Created in 1986, the Depression and Related Affective Disorders Association Inc. (DRADA), was established in response to requests by several patients of Dr. J. Raymond DePaulo, Jr. at the Johns Hopkins University School of Medicine. The organization has over 500 members and 32 support groups primarily on the East Coast (Duke & Hochman, 1992).

In addition, the National Alliance for the Mentally Ill (NAMI) and the National Mental Health Association (NMHA) are very large organizations serving persons with mood disorders.

These are excellent resource possibilities for employees with manic-depressive illness to supplement any continuing therapy. A group could be established within the workplace to provide on-going support for employees suffering from manic-depressive illness; however, it may not be used because manic-depressives may want to keep their illness private from fellow employees. A more productive alternative might be for the company to sponsor informational seminars for all employees and their families on a wide range of topics, including education on bipolar disorder.

FAMILY COOPERATION. Therapy is essential in the initial stages of diagnosing manic-depressive disorder. Emil Kraepelin, psychiatrist, in a treatment case example, determined that when the patient is acutely manic, therapy sessions should be brief. Usually 15 minutes to 20 minutes is as much as the patient and the therapist can handle, because of limited concentration and frustration tolerance. However, sessions should occur frequently, ideally a few times per day, to evaluate fluctuations in the course of the illness and establish a presence with the easily distracted patient. Therefore, inpatient care is the preferred choice although it is not always possible.

If family is a resource, they might be helpful in providing much needed structure for a patient during their psychotic turmoil. According to Kraepelin, family therapy sessions, possibly without the patient present, become absolutely necessary in those unfortunate situations where an outpatient setting is the only alternative. "The family's structure, support, guidance and monitoring of medication will be essential during the early phase of treatment," (Kraepelin, 1985).

CONCLUSION. The exceptionally competitive workplace will be turning out more and more employees suffering from mood disorders, and the employee assistance programs need to be prepared to serve them. Combining medication and providing an on-going therapeutic environment for sufferers of manic-depressive illness will hopefully help EAPs keep these employees in their jobs. EA

Bibliography available on request.

Resources:

National Depressive and Manic Depressive Association (NDMDA), 730 North Franklin Street, Suite 501, Chicago, IL 60610. 1-800-82NDMDA, Executive Director: Susan Dime-Meenan.

Depression and Related Affective Disorders Association Inc., (DRADA), Meyer 3-181 600 North Wolfe Street, Baltimore, MD 21205. (301) 955-4647, Coordinator: Sally Mink.

Norgren is an MSW student at the University of Illinois' Jane Addams School of Social Work at Chicago.

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Exploring Alternatives

Pharmacologic Options to Traditional Treatment

By Scott A. West, MD, and Susan L. McElroy, MD

Editor's Note: Although Employee Assistance *does not usually present deeply clinical material, we believe that biochemical findings on mental illness and the emphasis on medicated treatment modalities under healthcare reform increase the need for EAPs to be knowledgeable about medication options relating to treatment and monitoring of workers with chemical dependency and/or mental health problems.*

Bipolar disorder is an illness that occurs in approximately 1 percent of the population, affecting up to two million people in the United States. It is characterized by recurrent episodes of mania and depression, which are generally incapacitating and often devastating. The progressively deteriorating course that often occurs in people with this illness can become catastophic. Interruptions in personal life, family life and employment can be severe, and may lead to alienation from family and friends who do not understand the nature of this illness. Many people with bipolar disorder do not get adequate treatment, resulting in an alarming mortality rate of 25 percent (most often because of suicide), which is higher than that of most medical illnesses including cardiovascular disease and cancer.

Although the treatment available for bipolar disorder is not perfect, the illness can usually be managed so that people can lead productive and fulfilling lives. Lithium has been the cornerstone of treatment since the 1960s, and since that time our understanding of this illness and how it responds to lithium has grown considerably. For instance, as the illness progresses, lithium may become ineffective in patients who initially demonstrated a good response. Also, there are several subtypes of bipolar disorder that respond better to medications other than lithium. Moreover, many patients are unable to tolerate the side effects of lithium therapy, which include impaired concentration, chronic thirst, frequent urination and tremor.

ADDING MEDICATIONS. Subsequently, intense research into the use of other medications for the treatment of bipolar disorder began and resulted in the addition of several pharmacologic medications available to treat this illness. Medications with established efficacy and safety in the treatment of bipolar disorder include: the anticonvulsants carbamazepine (Tegretol) and valproate (Depakote, Depakene); and the new, atypical antipsychotic clozapine (Clozaril).

Additionally, benzodiazepine (often referred to as a "tranquilizer"), clonazepam (Klonopin), the calcium channel blocker verapamil (Calan, commonly prescribed to treat hypertension) and antidepressants, including the monoamine oxidase inhibitors (Parnate, Nardil), the serotonin-selective reuptake inhibitors (Prozac, Zoloft) and bupropion (Wellbutrin) may have unique roles in the treatment of this disorder.

In this article we will review the use of these medications in the treatment of bipolar disorder, with an emphasis on the anticonvulsants which are becoming a cornerstone of treatment, and clozapine, which is commonly used when lithium and anticonvulsant therapies fail.

Valproate. Valproate is an anticonvulsant medication that has been used for years in the treatment of seizure disorders. However, it has been used extensively since the 1960s in European countries in the treatment of bipolar disorder, resulting in the accumulation of a substantial amount of literature supporting its efficacy. This led to investigational trials in the United States during the 1980s, and since that time, a wealth of literature supporting the efficacy of valproate in the treatment of acute mania has emerged. Indeed, two controlled studies have demonstrated that it is at least as effective as lithium.

Since its efficacy in acute mania is well established, efforts are being made to demonstrate its effectiveness in the prevention of relapse. Although there is limited published data supporting the efficacy of valproate as prophylactic treatment, our experience along with that of many other clinicians is that it is indeed effective in the prevention of relapse.

Therefore, valproate is our treatment of choice in patients who are either intolerant of or have become refractory to lithium therapy. Moreover, in patients who have dysphoric (or mixed) mania or the rapid cycling type of bipolar illness (bipolar variants that respond poorly to lithium), valproate may be a particularly effective treatment. Valproate is commercially available as several different preparations including valproic acid (Depakene capsules), sodium valproate (Depakene syrup), and divalproex sodium

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(Depakote enteric-coated tablets).

In our experience, divalproex sodium is the better tolerated preparation, and discontinuation due to intolerable side effects is rare. Divalproex sodium can be taken in multiple doses throughout the day or as a single dose at bedtime, which provides a fair degree of flexibility so that dosing can be tailored to individual needs.

The average dose range is 1000 mg to 2000 mg per day. As with lithium, valproate blood levels need to be monitored, and there is an established therapeutic range of 50 ng/ml to 150 ng/ml (this is based on the treatment of seizure disorders, but largely holds true for its use in bipolar disorder).

Once a therapeutic blood level is established, which generally takes one to two weeks, monitoring can be done as infrequently as every few months.

The primary side effects of valproate include sedation, mild diarrhea and weight gain. These are generally easy to manage and subside with continued therapy, and are often minimized by taking a single dose at bedtime.

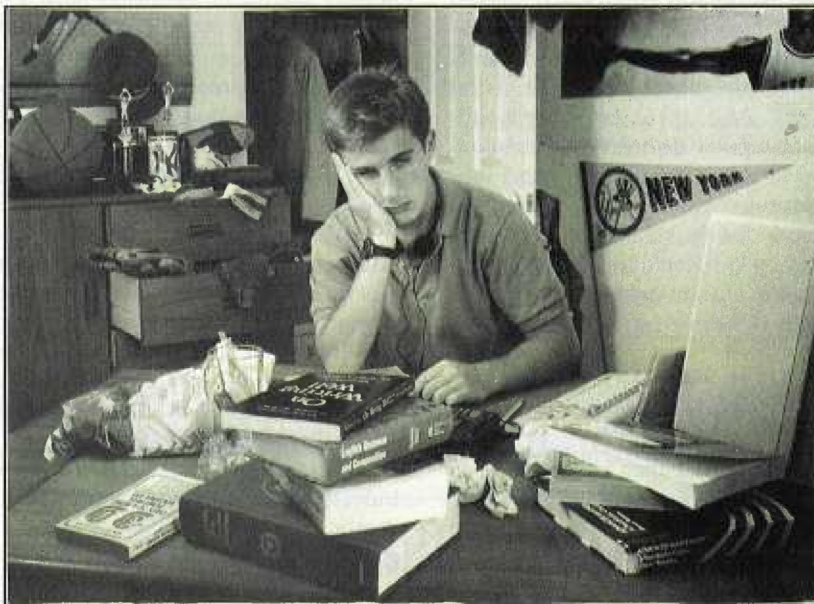
Carbamazepine. Carbamazepine, like valproate, is an anticonvulsant that has been used for years and therefore, has accumulated an extensive database regarding its pharmacologic properties. There are numerous studies demonstrating the efficacy of carbamazepine in the treatment of acute mania and the prophylaxis of recurrence. Prior to the establishment of valproate in the treatment of bipolar disorder, carbamazepine was the treatment of choice in patients who were lithium-intolerant or refractory.

Carbamazepine is often used concurrently with lithium, as it has become clear that some patients respond better to the combination of these two agents than to either one alone. As with valproate, carbamazepine is a much better antimanic agent than antidepressant, although both anticonvulsants clearly have antimanic and antidepressant properties, which is why they are referred to as "mood stabilizers."

While carbamazepine is effective and extensively used in the treatment of bipolar disorder, it has some limitations because of its side-effect profile. The most common side effects include: sedation, which can be severe; malcoordination; and cognitive dulling (the inability to think clearly, which can make patients feel detached from their surroundings).

The metabolism of carbamazepine is complex, as it induces its own metabolism. This results in the need to frequently monitor blood levels and increase the dose after the first six to eight weeks of treatment. The typical dose is 400 mg, taken two or three times a day, although this is quite variable. Additionally, since most drugs are metabolized by the liver, blood levels of many other drugs, including oral contraceptives and antihypertensive agents, can be altered, rendering these medications ineffective or conversely increasing their blood concentration to toxic levels. Thus, the pharmacologic management of patients who require multiple medications in addition to carbamazepine can be quite complex. While carbamazepine can be very effective in treating bipolar disorder, many factors have to be considered during the course of treatment.

Clozapine. Clozapine was approved for



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use in the United States in 1990, although like carbamazepine it has been used extensively in European countries for more than 30 years. Clozapine is an atypical antipsychotic drug, which implies that it does not carry the risk of producing neurological side effects like typical antipsychotic medications (which include drugs like haloperidol and chlorpromazine).

Although clozapine is used primarily for the treatment of primary psychotic disorders, such as schizophrenia, our experience using it as a mood stabilizer in patients with bipolar disorder who are refractory to lithium and anticonvulsant therapy has been very promising. It appears to be particularly useful in patients with rapid-cycling symptomatology. Indeed, the literature regarding the efficacy of clozapine in the treatment of bipolar disorder, especially those patients who present acutely manic and psychotic, is beginning to accumulate, providing further evidence that clozapine can be a very useful medication for this purpose. We have had numerous patients show remarkable improvement on clozapine who had previously demonstrated little improvement on lithium and anticonvulsant therapy.

Although clozapine is effective in some patients, it has the potential to produce agranulocytosis, a disorder in which the white blood cells responsible for fighting most infections are destroyed. This reaction occurs in 0.8 percent of patients receiving clozapine, and occurs most commonly in older females. While this occurs in a very small number of patients, because of the potential lethality, patients are monitored with weekly white blood cell counts in order to detect the development of agranulocytosis as early as possible. More routine side effects of clozapine include: sedation, which can be severe; weight gain; dizziness; and excessive salivation. Most of these, which can be minimized by slowly diluting the drug, are tolerable for the vast majority of patients.

Clozapine has a wide range of therapeutic doses, from 25 mg to 900 mg per day, with the average daily dose around 350 mg to 400 mg. Our experience in treating patients with bipolar disorder is that they usually require doses at the lower end of this spectrum, which is fortunate because the side effects are generally less bothersome at lower doses. Clozapine can be taken as a single bedtime dose or in divided doses, which are generally adjusted to minimize side effects. Unlike the anticonvulsants, blood levels of clozapine are not routinely measured since there is little correlation between blood levels and therapeutic response.

Adjunctive Medications. There are many other medications that are routinely used in the treatment of patients with bipolar disorder. Most are used for limited periods of time, typically during an acute manic or depressive phase of the illness. Typical antipsychotic drugs, such as chlorpromazine (Thorazine) and haloperidol (Haldol)

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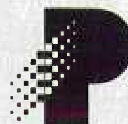

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are used in the acute manic and psychotic states, as are many benzodiazepines including lorazepam (Ativan) and clonazepam (Klonopin).

Many investigators believe that clonazepam has mood-stabilizing properties and therefore, it is commonly used in the long-term management of patients. We have not been that impressed with clonazepam as a mood stabilizer, however, but we do find it particularly helpful during acute manic episodes because of its anxiety-relieving and sedating properties.

It was recently demonstrated that the calcium channel blocker verapamil (Calan) is effective in the treatment of acute mania. Verapamil is commonly used to treat hypertension and in general is very well tolerated. We tend to use this medication primarily in bipolar patients who have concurrent hypertension. This provides the patient with the potential additive benefits of verapamil's probable mood-stabilizing properties along with an anticonvulsant or lithium. We have seen a small number of patients respond very well after the addition of verapamil to their medication regimen, particularly patients with classic type I bipolar disorder.

Although the data is limited supporting its use in bipolar disorder, at the very least, it seems to be an effective adjunctive medication when used with standard mood stabilizers. Finally, although antidepressants are often needed to treat the depressive phase of bipolar disorder, they must be used with caution. Virtually every available antidepressant, including the tricyclics, such as imipramine (Tofranil) and desipramine (Norpramin); monoamine oxidase inhibitors, such as tranylcypromine (Parnate), phenelzine (Nardil), bupropion (Wellbutrin) and trazodone (Desyrel); and the newer serotonin-selective reuptake inhibitors, such as fluoxetine (Prozac), sertraline (Zoloft) and paroxetine (Paxil), can induce mania and rapid cycling when used in patients with bipolar disorder. Therefore, careful consideration and close monitoring are necessary when using antidepressants in treating the depressive phase of this illness.

EXPANDING OPTIONS. The pharmacologic treatment of bipolar disorder has significantly improved over the past decade, with the development of numerous alternative treatment strategies in addition to lithium. The anticonvulsants valproate and carbamazepine have become a cornerstone of treatment, particularly in lithium-refractory patients and patients with dysphoric mania and rapid cycling. Additionally, the antipsychotic clozapine can be very effective in patients who are unresponsive to or unable to tolerate lithium or anticonvulsant therapy.

Preliminary evidence also suggests that verapamil and bupropion may have a unique role in the management of this illness. There are numerous other medications currently under investigation that may add to the already expanding pharmacologic treatment options now available. These advances will hopefully allow us to continue to improve the quality of care for patients with bipolar illness. EA

References available on request.

West is a clinical research fellow with the Biological Psychiatry Program at the University of Cincinnati Department of Psychiatry. McElroy is co-director of the program and an associate professor of psychiatry at the university.

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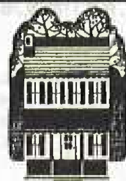

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EAP and Healthy Companies

By Bradley K. Googins, PhD

An EAP exists only in relationship to its organizational context. Without the work enterprise, there is no EAP. Now this may sound overly simplistic. Your first reaction may be, Well, OK, now can we get onto something a little more innovative and exciting? Does a fish examine the water that surrounds it?

It is probably because the work environment is so all encompassing of the EAP that we tend to trivialize its importance or forget its centrality in the life of the EAP. I bring up this topic for a very basic reason: Organizational life within the corporation continues to undergo the most radical transformation since the initial attempts to create work organizations at the beginning of the industrial revolution.

Intense global competition and the shake-out of the American economy have brought forth an unprecedented frenzy in organizations, leaping from quality movements to downsizing and re-engineering that has resulted in a stream of continuous change.

FRONT-BURNER CHANGES. Too often, EAPs are unfortunately only vaguely aware of restructuring developments and their import in the months and years to come. These fundamental changes have not become front-burner items in large part because of the overwhelming managed healthcare agenda that has tended to overshadow most issues for EAPs. This is not to say that managed care is not a central issue for the EAP. However, life does not stop for managed care; and in this case, life outside of managed care may be more critical to the EAP now and in the futurethan even managed care.

By not tuning into the fundamental organizational and cultural changes taking place within work organizations, EAPs run the risk of being pushed to the periphery of organizational life. Examining the turmoil of work organizations in terms of EAPs suggests a series of unique strategic opportunities. Organizations, like individuals, are usually most open to change when the system is in flux, having been unfrozen from their usual impassive state that tends to promote and protect the status quo. It is precisely when traditions, rules and structures have been deemed inadequate that organizations begin to open up new ways of considering things and create new avenues for change.

If EAPs can understand the dynamics of change, they will be in an ideal position to capitalize on this opportunity, making them more critical and integral to corporations. However if, like most organizations, they hold onto the traditions of the past and fight the inevitable changes before them, they will lose any chance for advancing their mission and adding even more value to their organizations.

HEALTHY COMPANIES. One way to begin considering the role of the EAP within the context of the restructuring business is to contemplate how the EAP can be a catalyst in the creation of healthy companies.

For the past several years, I have been a member of a small research advisory committee for a McCarthur Foundation-funded project whose specific aim is to create healthy companies. Given the complexity of these issues, it has been a daunting task. Even the most basic issue of defining what constitutes "healthy" has generated a great deal of discussion and controversy. With a basic premise that most work organizations are operating on a less than healthy basis, the task of the project is to identify what factors contribute to healthy companies.

Had this project been launched a decade ago, the questions would have been framed quite differently than they are today. The upside-down world found in most corporations today cries out for new solutions to old and persistent problems.

How do organizations promote the growth and development of individuals and maximize their talents while maximizing organizational goals? Can corporations become learning organizations where employees become truly empowered within their work spheres? Can the organizational learning disabilities that are so harmful to most companies be identified and dealt with in an innovative fashion?

More to our interest, can EAPs perceive themselves as integral parts of healthy companies? Perhaps more importantly, can EAPs determine a strategic direction and become active agents in creating the healthy company? Are there strategies they can adopt that will both promote the value they bring to the organization and genuinely contribute to creating healthy environments and corporations?

POSSIBLE DIRECTIONS. Let's take a look at a number of possible directions EAPs could take over the next several years that might enhance their value in addressing the vexing problems of the contemporary corporation. EAPs are locked in a life-or-death struggle with managed care. Many have felt this effort is too little, too late. However, it does provide a prototype as well as a warning about the need for them to be proactive.

I can think of a number of areas where the EAP could stake out a very useful and strategic domain—most especially, the area of organizational health. Because the dimensions of health have moved far beyond the confines of the traditional medical clinic, there is an opening for the EAP to argue for, model and create newly organized functional teams—within the company—that could address the broad array of health issues. Just as re-engineering has brought down the traditional lines of manufacturing—engineering, marketing and sales—to ensure both a higher degree of quality and a more integrated effort, so too do the support and human resource components need to rethink their roles and create new

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approaches to the issues of today. Cutting across traditional disciplines and organizational boundaries, such as medical, organizational behavior, training, wellness, work-family and diversity, to focus on the more general topic of organizational health could produce an exciting new approach that is desperately needed. Truly integrated work teams that would operate as a unit and address the issues from organizational stress to depression in the workplace could open up new ways of thinking and working.

STRUCTURAL CHANGES. The EAP might not ordinarily see itself in the role of convening, conceptualizing and implementing such work teams, but neither do medical departments, organizational behavior units or diversity operations within the company. Proactive leadership is not new to the EAP, but it never comes easily. Most EAPs are bogged down with too many tasks and too few resources. However, they must remember the issues of managed care and overburdened staffs are the problems of today. If EAPs hope to be viable for tomorrow, they will have to invest in the future and address the issues of the future. To a certain extent this has already begun to happen.

Look at the number of EAPs currently offering seminars on coping with change, or dealing with the downsized organization. This same type of active leadership could champion new structural and organizational changes. Creating organizational health teams could go a long way in re-examining what corporations can do to more efficiently invest in their employees' health, while at the same time addressing the changing needs of both employees and organizations.

EAPs improve their positions within organizations when they get management to perceive EA's role as contributing to the overall health of the corporate environment.

Of course, there are a number of ways to define what aspect of organizational health is most valued. This determination will depend on the unique situation of each company. However, there is no question that setting goals for healthy companies, creating teams that can assess needs and establish effective programming, and implementing preventive wellness strategies will go a long way in protecting human capital. Although it has been difficult to measure intangible assets, such as those generally found under the broad umbrella of human resources, there will be increasing pressure to do so.

THE CHALLENGE. As a long-term strategic corporate goal, creating healthy companies in all of their complex dimensions will dwarf any single issue, such as managed care. The challenge for the EAP is to manage the managed care issue so that it does not wind up managing the EAP. As a profession, we have to become a great deal more knowledgeable of the shifting trends and the new management technologies that are reshaping organizational structures and life itself. In addition, the EAP will have to become more involved with these changes through greater integration with human resources to begin building the necessary strategy for the next ten years.

This can be seen as an exciting challenge for the EAP field or as a threat to its traditional roles. Just as employees are increasingly asking the corporation for flexibility in balancing their home and work needs, so too, the EAP will have to become more flexible in creating tradeoffs between traditional roles and those roles necessary for meeting the challenges of tomorrow. EA

Googins is director of the Center on Work and Family, Boston University.

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Changing Times, Changing Paradigms

The Place of EAPs in National Healthcare Reform

By David A. Patterson, PhD, MSW

There is an emerging national consensus that we must change the way healthcare is delivered and paid for in this country. The healthcare crisis is fueled by the dual phenomenon of a significant portion of the population being without adequate health insurance coupled with high and rising healthcare costs.

White House Courtesy Photo

Last year, healthcare cost the United States $832 billion. That figure represents three times the defense budget and is 13.4 percent of our gross domestic product. The medical expenditures of all other advanced nations account for only 6.6 percent to 10 percent of their gross domestic product, yet they are able to provide universal coverage without significant differences in outcome measures, such as life expectancy and infant mortality.

In a 1989 Louis Harris survey of employers, 39 percent ranked mental health and substance abuse use as a major cause of rising healthcare costs. What these employers and most politicians are likely not aware of is that mental health and substance abuse treatment have been shown in several studies to reduce the long-term health costs. To control costs, more than one fourth of employers have negotiated price-limited contracts with providers of mental health and substance abuse programs that are separate from the rest of their benefits. As of 1991, 70 percent of employers nationwide were using utilization management, case management, and employee assistance programs to control mental health and substance abuse costs. EAPs, like all other healthcare providers, must begin to prepare for the impending changes in healthcare delivery. To remain competitive service providers, EAP's will need to develop proactive strategies to meet the functional and structural shifts that will likely occur in service delivery networks.

President Clinton's American Health Security Act of 1993 (AHSA), which lays out the administration's blueprint for national healthcare reform, is now before Congress. Despite the fact that political realities ultimately will shape the final legislation, the proposed health reform legislation represents a valuable tool to attempt to discern the trends in mental health and substance abuse service delivery that are most likely to impact EAPs.

KEY QUESTIONS. Three questions will guide this discussion of the impact of national healthcare reform on the management and operation of EAPs. What has been proposed in the American Health Security Act in regards to mental health and substance abuse services? How will this benefit plan's structure change service delivery? What strategies can EAPs employ to meet the challenges ahead?

UNDER HEALTHCARE REFORM. The American Health Security Act of 1993 proposes a guaranteed national benefits package that will provide comprehensive coverage including mental health and chemical dependency benefits. The primary goal of the plan is to provide a range of treatment options across the inpatient/outpatient continuum. There will be a phase-in period until 2001 for the development of the necessary quality-assurance programs critical to the managed care of comprehensive benefits. States will be required by 2001 to detail steps they are taking to move from a two-tiered public/private mental health and substance abuse system to the development of "an integrated comprehensive managed system of care."

A broad spectrum of inpatient and residential options will be covered in the benefits structure, including residential detoxification, recovery centers and community residential treatment. This will allow for the development of less expensive residential options to inpatient treatment. The plan will permit a maximum inpatient benefit of 30 days per episode, with a 60 day annual limit. While this may sound like an extremely generous benefit, PPO and HMO networks will have significant fiscal incentives to control utilization. Moreover, inpatient-hospital substance abuse treatment will cover only "medical detoxification as required for the management of psychiatric or medical complications associated

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with withdrawal from alcohol or drugs." Likewise, inpatient hospital care for mental health and substance abuse disorders will be available only when other less restrictive nonresidential or residential services are judged to be inappropriate or ineffective.

"Family members of eligible individuals receiving mental health or substance abuse services will be able to receive "necessary and appropriate related services in conjunction with the patient (so-called collateral treatment)." The plan imposes an initial limit of 30 outpatient psychotherapy visits per year. There are no limits imposed on outpatient "medical management, crisis management, evaluation and assessment, and substance abuse counseling."

A range of intensive, non-residential treatment options will be covered including day treatment, partial hospitalization, psychiatric rehabilitation, home-based services, ambulatory detoxification, and the use of behavioral aide services. Services in non-residential programs initially will be limited to 120 days per year. These services will be provided only to prevent inpatient treatment or residential treatment, facilitate early release, restore functioning or "develop skills and access supports needed to achieve their previous level of functioning in the community."

CHANGING DELIVERY. Taken together, these benefits represent a progressive approach to mental health and substance abuse treatment that will require and reward healthcare networks for the development of a range of treatment options beyond inpatient care. This plan adds impetus to the growing trend to move substance abuse treatment from inpatient settings to outpatient, partial hospitalization, and residential settings. It is consistent with two recently published studies that estimated that "40 percent to 60 percent of substance abuse inpatient days may be medically unnecessary (i.e., not clinically required for optimum outcome)." A 1991 review article on substance abuse treatment, published by the *Journal of the American Psychiatric Association*, recommended the use of intensive outpatient treatment except in cases where there are severe medical or social contraindications or a history of treatment failures.

EAP counselors are often the first healthcare professional to have contact with an employee experiencing emotional or substance abuse-related difficulties. Between 1988 and 1990, I worked for Alta Health Strategies (now First Health) doing psychiatric and substance abuse utilization review. During that period, I spoke with numerous EAP counselors across the country. When an employee was admitted for inpatient treatment, it was my job to find sufficient clinical information to justify the admission. I routinely called EAP counselors to ask for clinical information supporting the necessity of hospitalization and to ask if inpatient treatment alternatives had been considered. Not once did I hear that an alternative to inpatient substance abuse treatment had been explored with the employee prior to making the referral to inpatient treatment. Nor did any counselor ever offer results from an objective clinical instrument measuring substance abuse severity as a rationale for the admission referral.

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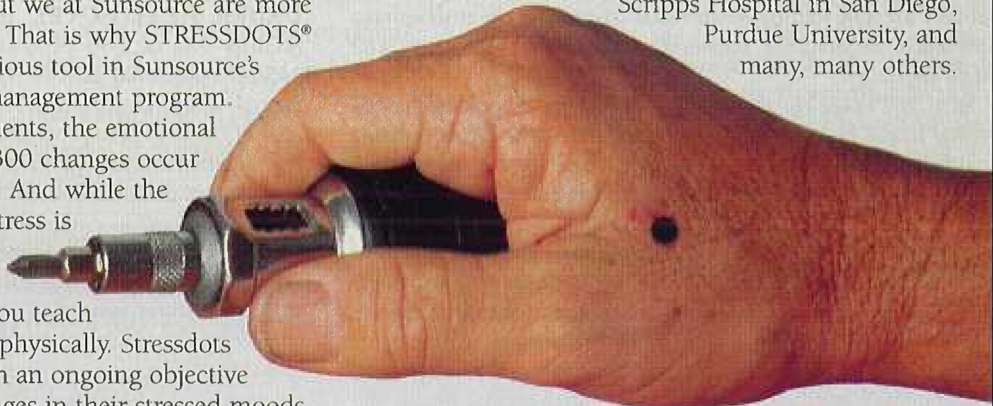

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