

Vol. 19, No. 3 March 1989

the **ALMACAN** ©

Published monthly by Association of Labor-Management Administrators and Consultants on Alcoholism



An International Association of Professionals in Employee Assistance Programs

PPOs and the Spectrum of Treatment



**What PPOs are ♦ How they've changed
How they work with EAPs ♦ Where they
fit into the evolution of health care**



Federal anti-drug regulations favor EAPs for drug/alcohol education and training.

What is the best reference information on the subject?



The ALMACA 3-pak.

The federal government has helped to make employee assistance programs a key player in the crusade against drugs in the workplace with the passage of the Anti-Drug Abuse Act and issuance of regulations by the Department of Transportation and other federal agencies. EAPs have been deemed expert in the provision drug and alcohol services to employees of federal government contractors and grantees, as well as to industries that must comply with drug-free workplace provisions.

ALMACA's 3-pak provides comprehensive information on EAP consulting sources and EAP implementation that you, as an EAP professional, can use for your own benefit or to share with prospective clients.

The ALMACA Directory of EAP Consultants. A virtual "Who's Who" of EAP consulting specialists, this publication tells you where they are located and what their specialty areas are.

NIDA Guidelines for the Development and Assessment of a Comprehensive Federal Employee Assistance Program. Published by the National Institute on Drug Abuse, these guidelines provide recommendations on EAP design and implementation, program operations, evaluation and workplace integration. A monitoring instrument provides help in auditing existing policies and procedures.

This publication has been made available to ALMACA by NIDA for distribution.

The ALMACA Continuum of Services: Alcohol and Drug Abuse in the Workplace. This ALMACA publication recommends a specific procedure for addressing alcohol and drug abuse in the workplace. Included are process maps which analyze possible strategies and the efficacy of various forms of drug testing.



If you buy our 3-pak, we will include a portfolio of the provisions of the Anti-Drug Abuse Act that apply to EAPs, as well as relevant information from regulations that either mandate or recommend EAPs for particular industries.

Our charge for the entire package is \$30 for members and \$50 for nonmembers. It's a small investment that can help you reap big rewards.

Yes, I would like _____ copies of the 3-pak. I _____ am _____ am not a member of ALMACA. Enclosed is a check for \$ _____. (Virginia residents: include 4% sales tax)

Send the materials to:

NAME _____

COMPANY _____

ADDRESS _____

CITY _____ ZIP _____

An Emphasis on the *Real* Issues Confronting EAPs

Much of the contemporary EAP literature makes for "polite" reading, but it often misses the meat-and-potatoes subject matter as to what dictates the direction of the EAP practice. In March, April and May, *THE ALMACAN* will look down the barrel at some of these impact issues.

Actually, the proceedings of a recent Employee Assistance Roundtable meeting, published on pages 41-49 of the January issue, provided a foundation for exploring the topics in more depth. If you haven't already, be sure to give the Roundtable report a good once-over.

This, the March issue, features a circumspective account of the PPO field's development and that portion—the mental-health specialty—which abuts EAPs. The field has evolved in such a way that some PPOs are practically indistinguishable from managed health care firms. The articles on PPOs herein explain the differences.

April will look at the relationship between EAPs and benefits departments. Is the portrayal of EAP professionals as the freest spender of corporate health dollars an accurate one? Are benefits managers really the cold-blooded wardens of the corporate health-care

money vault that they may appear to be? Of course, the answer to both stereotypes is "no." In fact, they share many of the same interests. Now more than ever, EAP professionals need to establish alliances with benefits managers, and this issue will look at how the two camps should get along.

May will examine the competitive state of the EAP contracting field, circa 1989. Not only are EAP providers competing amongst themselves, the Drug-Free Workplace Act may very well be a magnet for other service providers who claim to be able to bring employers into compliance with the new law. This issue will provide an investigative report.

EAP professionals already know how to help save lives and restore worker productivity. The intent of the next few issues is to provide information that will help you to continue doing your good work.

Rudy M. Yandrick

RUDY M. YANDRICK
EDITOR

ALMACA'S BOARD OF DIRECTORS AND STAFF

EXECUTIVE OFFICERS

Tom Pasco, President
Tamara Cagney
Vice President—Operations
Don Magruder
Vice President—Administration
Marcia Nagle, Secretary
Bob Challenger, Treasurer

REGIONAL BOARD MEMBERS

Boyd Sturdevant
Central Region Representative
Kevin Parker
Eastern Region Representative
Midgie Brawley
Southern Region Representative
Roger Wapner
Western Region Representative
William G. Durkin
International Region Representative
Morris Golden
Canadian Region Representative

COMMITTEE CHAIRPERSONS

Claire Fleming, Advisory to
THE ALMACAN
Jane Ollendorff, Annual Meeting
Site Selection
Jim Roth, Bylaws
Jack Dolan, Consultants
Jesse Bernstein, Development
Daniel J. Molloy, Education and Training
Gary Atkins, Ethics
Sally Lipscomb, Insurance
Thomas Murgitroyde, Labor
Riley Regan, Legislative and Public Policy
William O'Donnell, Membership
Mary S. Bernstein, Program Managers
Andrea Foote, Research
Bradley Googins, Special Projects
Debra Reynolds, Standards
John Schwarzlose, Treatment
Joanne Pilat, Women's Issues

STAFF

Thomas J. Delaney, Jr.
Executive Director
Judith Evans, Associate Director
Rudy M. Yandrick, Editor

PUBLISHED BY:

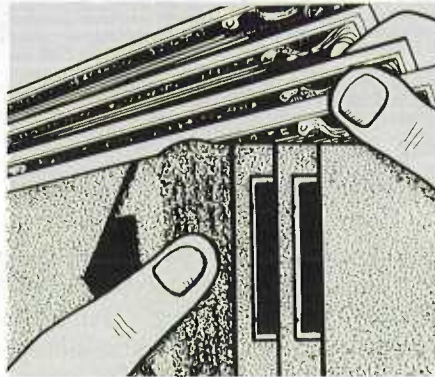
The Association of Labor-Management
Administrators and Consultants on
Alcoholism, Inc.
4601 N. Fairfax Drive
Suite 1001
Arlington, VA 22203
Telephone (703) 522-6272

© 1989 by Association of Labor-Management
Administrators and Consultants on Alcohol-
ism, Inc. Reproduction without written per-
mission is expressly prohibited.
Publication of signed articles does not consti-
tute endorsement of personal views of authors.

TABLE OF CONTENTS



page 34



page 39



COVER STORY

- 22** PPOs: A Historical Perspective, Legal Considerations, and Special Issues for Mental Health and Substance Abuse
by Laura S. Altman, Ph.D.

- 26** Five Examples of PPOs

- 30** Mental Health PPOs: The State of the Art
by Rudy M. Yandrick, editor

PROFESSIONAL LIABILITY

- 11** Certified Employee Assistance Professionals and Their Liability Risks
by William A. Carnahan, ALMACA Legal Counsel
- 13** Application form for ALMACA's CEAP Professional Liability Program

PUBLIC POLICY

- 15** Drug-Free Workplace Regulations Released
- 15** FAA Releases Airline Drug Testing Regs
- 17** Bills in the Hopper
THE ALMACAN introduces a new column which tracks legislative proposals

WOMEN'S ISSUES

- 18** Chemically Dependent and Adult COA Women in Recovery, Part 1
by Patricia A. Pape, ACSW, SCAC

ISSUES AND ANALYSIS

- 34** EAP Salary Data: Selected Results From a National Survey
by Nathan Bennett, Terry Blum and Paul Roman

DEPARTMENTS

- | | | |
|--------------------------------------|-----------------------------------|--|
| 3 Editor's Comment | 37 News From the Outside | 47 Index of Advertisers |
| 5 From the Executive Director | 38 Regions and Chapters | Also of interest: |
| 9 New Appointments | 41 ALMACA & EAP InfoTracks | 2 Offer to purchase consulting publications |
| 21 In Memoriam | 46 Conferences & Workshops | 10 Central Region Conference announcement |

FROM THE EXECUTIVE DIRECTOR



ALMACA moved into its new offices on February 1st. We are still headquartered in Arlington, Virginia and on the Orange Line of metropolitan Washington, D.C.'s subway line. So we continue to have easy access to Capitol Hill, governmental agencies and businesses.

In one way, it does not signify much of a change, but I do think that it is significant in other ways. The offices had been on North Kent Street for almost 10 years, so the fact that a short move was handled as an administrative routine is evidence of the maturity of ALMACA. We have been able to continue the flow of business and focus on the important issues facing the EAP field.

There are several events that occurred at about the time of the move which both illustrate the continuing priorities of EAPs and the important concerns facing us. I made two trips then, one to New London, New Hampshire to attend the memorial services for Dr. John Norris, and the other to Arizona, to participate in a discussion with the Commission on the Accreditation of Rehabilitation Facilities (CARF).

"DR. JACK"

Dr. Norris, known as "Dr. Jack" to many, was responsible for the pioneering and success of occupational alcoholism programs through his positions of medical director and assistant medical director of Eastman Kodak Company, and as chairman of the board for Alcoholics Anonymous. As such, he is an important link between the beginnings of our field and the current EAP state of the art. [See the "In Memoriam" column on page 21.]

While recalling his outstanding work during the services, I was reminded of two questions that I am often asked.

"Do EAPs still pay attention to drug and alcoholism problems, or have they lost their focus on this and attempt to deal with all emotional and social-service problems which appear in the

workplace?"

"Does ALMACA represent the EAP field, since the name reflects its roots—that of occupational alcoholism?"

The one almost answers the other! However, the extremes of our field do give rise to both concerns. There certainly are EAPs that identify smaller numbers of workers with drug and alcoholism problems than incidence and prevalence studies suggest exist among the population of troubled employees. These are just a few programs, but as long as they exist, they represent a challenge to the EAP field.

The ALMACA Employee Assistance Certification Commission (EACC) has been helping to solve this problem by requiring that CEAPs demonstrate knowledge in relation to alcoholism and drug addictions and stay current in this area in order to maintain their certifications. The ALMACA Program Standards Committee is also addressing the issue as chairperson Debra Reynolds leads it in developing new EAP standards.

A word of warning—beware of leg-

islation that purports to "solve" this problem. For better or worse, the vested interests in the individual health-care professions usually have more power in the state legislatures than cross-discipline fields like our own. Right now, in Congress, there is a proposal to recognize "mental health professionals" as appropriate EAP staff. This has apparently stemmed from vested interests in the social work field. Although I regard myself as a loyal professional social worker, I think that workers are better served by EAP professionals who have a broader disciplinary background and the CEAP designation.

In regard to ALMACA's representation in the EAP field, this question always surfaces from outside of the field. Over the 18-year history of ALMACA, the EAP field has embraced ALMACA as its membership organization. We all know that, from time to time, there have been groups that have been unhappy with ALMACA in one respect or another, and they have formed other groups. These people usually maintain

ALMACA Receives a \$10,000 Grant from Ford

In January, midway through the 1988-89 "LEAP Into the Future... The ALMACA Campaign" fund-raising season, a \$10,000 grant from the Ford Motor Company Fund has brought total contributions to \$80,000. The donation has enabled "LEAP" to surpass the halfway point toward our \$150,000 goal!

With this major grant, the Campaign Steering Committee, chaired by Gary L. Atkins, Donald B. Levitt and James R. O'Hair, is confident that the \$70,000 balance can be raised by June 30—the last day of the campaign.

This is the third grant of \$10,000 that ALMACA has received from the Ford Motor Company Fund. The

accompanying letter from E.J. Savoie, director of the Employee Development Office, and J.H. Triebwasser, M.D., medical director, Occupational Health and Safety, stated:

"This contribution recognizes ALMACA's value to our employee assistance activities. It also conveys our continued support for ALMACA's effort with other business, government, labor and community groups involved in helping people deal more effectively with alcohol, drug abuse and other serious personal problems."

ALMACA extends its sincere thanks to Ford for its kind words and financial support.

membership in ALMACA, explaining that they do not want to harm us because it serves the important function of advocating EAPs on a broad scale. At times, these groups think they can influence ALMACA policy quicker from the outside. Other times, they are just industry or market-specific groups who feel the need for a separate group.

Over the years, ALMACA's officers have taken an inclusive position. There has never been talk of disciplining or otherwise taking sanctions against people who affiliate with these newer groups. Most of them are part of the family and have meetings and conferences at ALMACA's national conferences. They include OPCA and the "EAPs in Education" special-interest group. If you look at our National Conference program from the last few years, it is evident that ALMACA is able to handle the wide range of issues.

ALCOHOLISM REHAB STANDARDS

At the CARF meeting, ALMACA was one of several national groups that helped to develop standards for alcoholism rehabilitation programs. As the alcoholism field well knows, whenever you deal with health care and rehabilitation facilities, you have to build in specific requirements for the treatment of addictions, or the broad brush will completely wash away. The alcoholism field has been urging CARF

and other standard-setting agencies like JCAH to do this. Another group of standard-setters are the managed health care providers, and we know that they badly need help in understanding the dynamics of alcoholism and other addictions. The EAP field is well-positioned to do this because we link the situational with the diagnostic.

EAPs must be able to guide people through the thicket of treatment resources. We could not do our job were we not current on the problems caused

by alcoholism and drug abuse, yet trained broadly enough to direct workers to other resources when the situation dictates it. Just as Dr. Norris pioneered the broadening of the original OAPs, and as CARF is presently looking for guidance to assure that alcoholism and drug programs are focused, EAPs and ALMACA are able to stay on course between the extremes of alcoholism and drug addiction only, and no alcoholism or drug addiction at all. □

A "Call for Papers" is Issued for the EAPs in Education Program

During ALMACA's 18th National Conference in Baltimore, the EAPs in Education special-interest meeting will begin on Saturday, October 28 and run through Sunday. The popularity of this program has made possible an extension in format from one day to two.

A "Call for Papers" has been issued. **Abstracts must be returned to program chair Kathleen Beauchesne by April 15, 1989.** This will allow the program committee time to fully review the papers and have the selections included in the 18th National Conference Advance Program, which will be published in June.

The eight content areas on which papers or abstracts may be submitted are:

- Administration and Evaluation.
 - Training and Education.
 - Direct Services and Consultation.
 - Resource Development and Referral.
 - K Through 12.
 - Program Development.
 - Faculty Referrals and Participation.
 - Graduate Programs in EAPs.
- The submissions should be based on short presentations of 15-20

minutes.

CEUs will be offered through ALMACA and the University of Texas at Arlington for the EAPs in Education seminars. For this reason, *12 copies of your abstract and two copies of the resumes of the author and presenter are required.*

Submissions should be sent to: Kathleen O. Beauchesne, LCSW, MBA
Faculty and Staff Assistance Program
Johns Hopkins University and Hospital
Homewood Hospital Center
Room 683
3100 Wyman Park Drive
Baltimore, MD 21211

Questions may be directed to Beauchesne at (301) 338-3648.

Conference registration fees for speakers will *not* be waived, except for those who do not plan to attend any part of the conference besides their own presentation. (A request for waiver must be made in writing to ALMACA National prior to September 26.) Speakers are responsible for their own travel expenses. Also, only nonsmoking meeting rooms will be used.

CORRECTION

A couple of errors appeared in the article "Arizona Holds Fifth Annual Conference," which ran on page 8 of the January issue. Edward Beauvais is CEO of America West Airlines. His name and affiliation were incorrectly identified in the article and photo caption. America West Airlines is headquartered in Tempe, Arizona and has an EAP staff of seven.

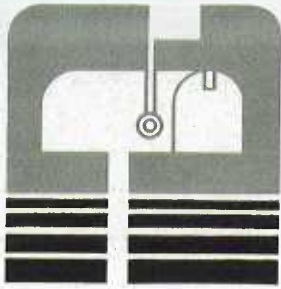
BETHANY CENTER

Bethany Center is a residential treatment program for men and women whose use of alcohol or other drugs is depriving them of the ability to lead productive and rewarding lives. A carefully planned and individualized treatment focus provides group therapy, individual counseling, family therapy, education, twelve-step programs, psychiatric and medical care, nutrition and fitness programs and continuing care.

The focal point of Bethany Center is a stately mansion restored to its original condition. Tree-lined walks, warmly decorated counseling and lounge areas, modern living and dining rooms, and a fitness center complex provide an environment that complements a structured therapeutic program.

Bethany Center
RD5 Box 170
Honesdale, Pa. 18431
1 800 544 1861

A RESIDENTIAL TREATMENT PROGRAM FOR CHEMICAL DEPENDENCY



ALMACA's RAPID RESPONSE SEARCHES

DIRECT FROM OUR LIBRARY TO YOUR DESK

The ALMACA EAP Resource Center (previously called the Clearinghouse for EAP Information), due to the popularity of its 1988 Rapid Response Searches, has expanded its list of offerings. Our updated order form offers 16 new search titles, shown below in italics.

Our order form has been updated to March 1989. *The prices displayed are in effect until September 1989.*

Please note the following restrictions:

- The minimum order is \$5.00.

- Advance payment is requested.
- Only purchase orders will be invoiced.

Here's how to order. Check the boxes to the left of the titles you want. Write a check payable to "ALMACA" for the total amount of your order, based on the prices shown to the right of each title. Mail the form with your check or purchase order to: ALMACA, 4601 N. Fairfax Drive, Suite 1001, Arlington, VA 22203. (Virginia residents: please add 4.5% sales tax.)

TITLE	PRICE				
<input type="checkbox"/> Academia: Creative Use of EAPs	\$ 4.00	<input type="checkbox"/> Ethics	7.00	<input type="checkbox"/> Mental Health	6.50
<input type="checkbox"/> Aftercare	6.50	<input type="checkbox"/> Evaluation/Benchmarks	16.50	<input type="checkbox"/> Minorities/Handicapped	29.00
<input type="checkbox"/> AIDS in the Workplace	37.00	<input type="checkbox"/> Evaluation System, Employee Counseling Service	4.00	<input type="checkbox"/> Needs Assessment	2.50
<input type="checkbox"/> Assessment	3.00	<input type="checkbox"/> Gambling	1.50	<input type="checkbox"/> Nursing	21.00
<input type="checkbox"/> Audiovisual Reviews	27.00	<input type="checkbox"/> Health Promotion and EAPs	10.00	<input type="checkbox"/> Orientation/Training	2.00
<input type="checkbox"/> Behavioral Assessment: Risk-Taking	17.00	<input type="checkbox"/> Health Promotion/Worksite Wellness	13.50	<input type="checkbox"/> Preemployment Inquiries, A guide to	3.00
<input type="checkbox"/> Benefits, Manager's Guide	4.00	<input type="checkbox"/> Higher Education EAPs (Listing)	4.00	<input type="checkbox"/> Positions/PDs	2.50
<input type="checkbox"/> Bibliography, Drug Testing	1.50	<input type="checkbox"/> Higher Education Curricula	25.00	<input type="checkbox"/> Policy	9.50
<input type="checkbox"/> Career Development I	11.50	<input type="checkbox"/> Higher Education Programming	15.00	<input type="checkbox"/> Policy/Procedures/Practice/Process	6.50
<input type="checkbox"/> Career Development II	6.00	<input type="checkbox"/> History	26.00	<input type="checkbox"/> Pricing EAP Services	1.50
<input type="checkbox"/> Casefinding	2.50	<input type="checkbox"/> Illnesses Accompanying Substance Abuse	6.50	<input type="checkbox"/> Productivity	8.50
<input type="checkbox"/> Caseload	3.00	<input type="checkbox"/> Impaired Professional	14.50	<input type="checkbox"/> Program Models/Influences	28.00
<input type="checkbox"/> Case Management	7.00	<input type="checkbox"/> Implementation	6.00	<input type="checkbox"/> Programs: Alcoholism	1.50
<input type="checkbox"/> Collective Bargaining	4.00	<input type="checkbox"/> Incidence/Prevalence	3.00	<input type="checkbox"/> Public Sector EAPs	1.50
<input type="checkbox"/> Confidentiality	11.00	<input type="checkbox"/> Insurance/Health-Care (Utilization Cost)	17.50	<input type="checkbox"/> Referral	7.50
<input type="checkbox"/> Contract Sample	1.50	<input type="checkbox"/> Job Loss	11.00	<input type="checkbox"/> Relapse	10.00
<input type="checkbox"/> Contract Services	1.50	<input type="checkbox"/> Law: Anti-Drug Abuse Act of 1988 (Summary)	5.00	<input type="checkbox"/> Salaries in EAP Field	10.00
<input type="checkbox"/> Controlled Substances/Use, Abuse Effects	1.50	<input type="checkbox"/> Law: Confidentiality of Patient Records	11.00	<input type="checkbox"/> Selecting EAP Contractor	1.50
<input type="checkbox"/> Cost Benefit Analysis (How to)	6.00	<input type="checkbox"/> Law: Drug-Free Workplace Act of 1988	4.00	<input type="checkbox"/> Smoking	15.00
<input type="checkbox"/> Cost Benefit/Cost Effectiveness	40.50	<input type="checkbox"/> Law: Drug Testing	1.50	<input type="checkbox"/> Staff/Organizational Development	19.00
<input type="checkbox"/> Cost Impact/Offset	13.00	<input type="checkbox"/> Law: Duty to Warn	7.00	<input type="checkbox"/> State Resources/Services	12.50
<input type="checkbox"/> Counselor, Becoming/Training	4.00	<input type="checkbox"/> Law: Final Rule on Confidentiality	4.50	<input type="checkbox"/> Stress, Job-Related	18.00
<input type="checkbox"/> County EAPs	4.50	<input type="checkbox"/> Law: NIDA Guidelines/Drug Testing	4.00	<input type="checkbox"/> Supervisory Programming (Education/Training)	15.00
<input type="checkbox"/> Crime	3.00	<input type="checkbox"/> Law: Privacy Act of 1974	4.50	<input type="checkbox"/> Symptoms/Signs	6.00
<input type="checkbox"/> Diagnosis	10.50	<input type="checkbox"/> Law: Traynor/McKelvey v. Turnage (VA)	7.00	<input type="checkbox"/> Training	2.50
<input type="checkbox"/> Disabled Employees	17.00	<input type="checkbox"/> Law: Vocational Rehabilitation Act (1973)	4.00	<input type="checkbox"/> Troubled Professionals/Executives	8.00
<input type="checkbox"/> Drug Awareness/Prevention	5.00	<input type="checkbox"/> Law: Vocational Rehabilitation Act (1974)	2.00	<input type="checkbox"/> Troubled Health-Care Providers	3.50
<input type="checkbox"/> Drug Testing	12.00	<input type="checkbox"/> Managed Care I	18.50	<input type="checkbox"/> Unions and EAPs	13.50
<input type="checkbox"/> Drug Testing: An EAP Perspective	7.00	<input type="checkbox"/> Managed Care II	22.00	<input type="checkbox"/> Utilization	17.00
<input type="checkbox"/> Drug Types/Effects	18.00	<input type="checkbox"/> Management Information Systems	11.00	<input type="checkbox"/> Work and Families: Child Care	13.00
<input type="checkbox"/> EAP Competencies	3.50	<input type="checkbox"/> Management Overviews/Barriers	13.00	<input type="checkbox"/> Work and Families: Eldercare	3.00
<input type="checkbox"/> EAP Function/Staffing/Positions	5.00	<input type="checkbox"/> Marketing	5.50	<input type="checkbox"/> Work and Families: General	10.00
<input type="checkbox"/> EAPs Internal/External (Assessing)	2.50	<input type="checkbox"/> Marketing/Internal	4.00	<input type="checkbox"/> Workplace: Year 2000	18.00
<input type="checkbox"/> EAPs: Intra- and Extra-Organizational Influences	3.00				
<input type="checkbox"/> EAPs: Issues and Trends	7.00				
<input type="checkbox"/> EAP Program Models/Essential Ingredients	13.50				
<input type="checkbox"/> EAP Rationale	20.00				
<input type="checkbox"/> Employer Anti-Drug Programs	8.00				
<input type="checkbox"/> Enabling	3.50				

Cost of Searches \$ _____
 Virginia residents
 add 4.5% sales tax _____
 TOTAL \$ _____

Please rush the Rapid Response materials to:

NAME _____

ORGANIZATION _____

ADDRESS _____



You'll be hearing from us soon!

NEW APPOINTMENTS

President Tom Pasco has announced two appointments; one is chair of a standing committee on the Board of Directors, the other is chair of a newly created *ad hoc* committee. The vacancy left by Terry Cowan on the Advisory Committee to *THE ALMACAN* has been filled by Claire Fleming.

John Hooks, chair of the *ad hoc* Minority Issues Committee, would like to hear from members who would like to serve on the committee. Interested persons should contact Michele Jones of the ALMACA National staff at (703) 522-6272. To help the committee establish its goals and objectives, a survey of ALMACA's individual members—i.e. EAP practitioners—is being mailed in March. We would greatly appreciate your response to it.

Another committee chair due to be filled is for the Legislative and Public Policy Committee. However, Riley Regan continues to act as committee chair until a successor is named.

ADVISORY COMMITTEE TO THE ALMACAN

CLAIRE FLEMING

Claire Fleming, CEAP, CSW, CAC, has been director of the New York City Department of General Services since May 1988. Prior to that, she was EAP coordinator for the Long Island Jewish Medical Center, located in Queens. She earned her MSW from Adelphi University in Garden City, NY. She has also obtained a post-master certification in clinical social work.

Claire is presently vice president of the New York City Chapter of ALMACA and served as secretary for the prior two years. She also chairs the Chapter's Women's Issues Committee, which is sponsoring a special chapter program on March 28.



MINORITY ISSUES COMMITTEE

JOHN M. HOOKS

John is manager, Employee Assistance and Health Promotion for Ford Motor Company, which is housed in the Department of Occupational Health and Safety in Dearborn, Michigan. Since joining Ford in 1979, John has also been the total health coordinator for Body and Assembly Operations, coordinator of employee health services for the Cleveland Casting Complex, and health services counselor for the P. & O. staff.

John has also completed graduate work in public administration at Wayne State University. He joined ALMACA in 1978 as a member of the Greater Detroit Chapter and, after a job transfer to Cleveland, participated in the Northern Ohio Chapter. There, in his capacity as chair of the Legislative Monitoring Committee, he was a member of the chapter's Executive Committee. He returned to the Detroit area in 1985.



The Dual-Focus Program

at Gracie Square Hospital*

Dedicated to Quality Care and Personal Regard

The Dual-Focus Program is one of our special treatment units at Gracie Square Hospital. It was developed precisely because of the unique challenges represented in treating the dually diagnosed, sometimes referred to as a MICA (Mentally Ill Chemical Abusing) individual.

The Dual-Focus Program provides this patient with a program design that offers comprehensive psychiatric evaluation and treatment concomitantly with substance abuse treatment. Dual-Focus treatment at Gracie Square Hospital takes place in a climate characterized by dedication to quality care and personal regard.

For additional information about or for formal consultation, evaluation and assessment related to admission to the Dual-Focus Program, call (212) 988-4400 ext. 476.

At Gracie Square Hospital, dedication to quality care and personal regard distinguish all of our centers of special care, including:

- General Psychiatric Services.
- The Dual-Focus Program for the Dually Diagnosed.
- The Eating Disorders Program.
- The Alcoholism & Drug Abuse Programs Conducted by Breakthrough Concepts, Inc.

GSH Gracie Square Hospital
420 East 76th Street
New York, New York 10021
Telephone (212) 988-4400

*JCAHO Accredited. Licensed by the N.Y. State Office of Mental Health, the N.Y. State Division of Alcoholism and the N.Y. State Division of Substance Abuse Services.

T U L S A

CENTRAL REGION CONFERENCE

MAY ♦ 19 ♦ 20 ♦ 1989

DOUBLETREE HOTEL AT WARREN PLACE
TULSA OKLAHOMA

LELA FRENCH 918-832-2464 **CONTACT**

AIRLINE RESERVATIONS

VICKI HASBAR 1-800-433-1790

RESERVATION NO. S83073

HOTEL RESERVATIONS

1-800-528-0444

SPEAKERS

TOM DELANEY ALMACA EXECUTIVE DIRECTOR **KEITH McCLENNAN**
CORPORATE HEALTH SERVICES **DAVID MILLER** CERTIFIED RELAPSE
PREVENTION SPECIALIST **DAN FRIGO PhD** AND OTHERS

HIGHLIGHTS

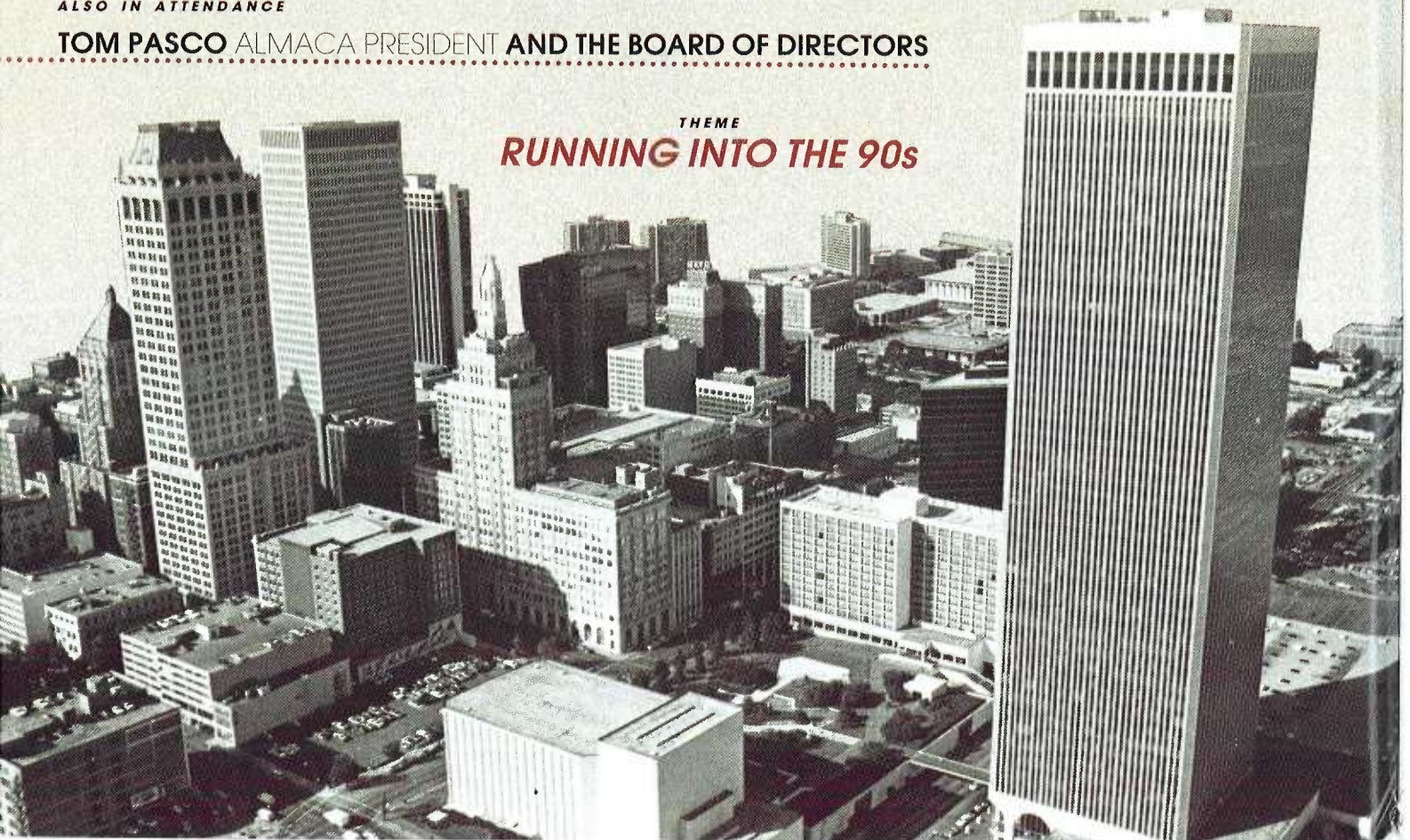
MAYFEST
A TULSA STREET FESTIVAL
DESSERT RECEPTION

ALSO IN ATTENDANCE

TOM PASCO ALMACA PRESIDENT AND THE BOARD OF DIRECTORS

THEME

RUNNING INTO THE 90s



Certified Employee Assistance Professionals and Their Liability Risks

ALMACA NOW OFFERS LIABILITY INSURANCE COVERAGE FOR CEAPs. HERE ARE THE TENETS ON WHICH THE POLICY IS BASED.

by William A. Carnahan
ALMACA Legal Counsel

One sign that the Certified Employee Assistance Professional is coming of age is the availability of specifically tailored professional liability insurance. To create the program by which the insurance is being offered (see page 13), it was necessary to define the scope of CEAP practice, assess the frequency and severity of expected claims, and calculate a premium.

SCOPE OF PRACTICE

Generally, a policy of professional liability provides for indemnity and representation arising from alleged "wrongful acts" under the policy. In this case, indemnity is provided for claims of wrongful acts arising from the provision of services as an *employee assistance professional*. Such services are those entailed by providing the employee assistance functions of assessment, referral, evaluation and consultation affecting employee job performance. Simply stated, what a CEAP does is determined by what an EAP does. Thus, we begin with the definition of EAP.¹

An Employee Assistance Program (EAP) shall be a worksite-based program designed to assist in the identification and resolution of productivity problems associated with employees impaired by personal concerns including, but not limited to: health, marital, family, financial, alcohol, drug, legal, emotional, stress or other personal concerns which may adversely affect employee job performance.

The specific core activities of EAPs shall include both of the following: (1) expert consultation and training to appropriate persons in the identification

and resolution of job-performance issues related to the employee personal concerns listed above. (2) confidential, appropriate and timely problem-assessment services; referrals for appropriate diagnosis, treatment and assistance; establishing linkages between workplace and community resources that provide such services; and follow-up services for employees who use those services.

Should any of these core activities be performed in a negligent manner resulting in monetary, emotional or physical damages to an employee (or

his/her dependents), professional liability would be found.

PROFESSIONAL CONDUCT

In addition to properly performing these core activities, the CEAP, as a professional, has engaged him- or herself to perform in a particular manner. Chief among professional contracts is the obligation of confidentiality.²

(1) *The CEAP will treat all employee and family member information as confidential.*

May 13, 1989

The next date for the Certified Employee Assistance Professional (CEAP) exam is May 13, 1989. *The deadline for the receipt of applications is March 31.*

Over 3,000 people have attained "professional" EAP status. If you aspire to lofty career goals and longevity in the EAP field, you need the right qualifications. CEAP, the mark of the EAP professional, is a valuable enhancement for your experience portfolio.

For more information, write the EACC, c/o ALMACA, at 1800 N. Kent Street, Suite 907, Arlington, VA 22209, or call (703) 522-6272.



This could be the most important date in your EAP career.

1989 ENROLLMENT PERIODS FOR PROFESSIONAL LIABILITY INSURANCE

Advertisement in
THE ALMACAN and
direct mailing to
ALMACA members

	<i>Cut-off date</i>	<i>Effective date of insurance</i>
March	<i>April 15</i>	May 15
June	July 15	August 15
September	October 15	November 15
December	January 15	February 15

THIS CEAP POLICY IS AVAILABLE IN BOTH THE UNITED STATES AND CANADA.

(2) Each employee or family member will be informed fully as to the scope of and limitations on confidential communications elicited during the assessment, referral and treatment process.

(3) Such information received in the course of and for the purpose of assessment, referral or treatment will not be disclosed without written consent except when such failure to disclose would likely result in imminent threat of serious bodily harm to self or others; or as otherwise required by law.

Thus, unauthorized disclosure is prohibited unless "... failure to disclose would likely result in imminent threat of serious bodily harm to self or others; or as otherwise required by law."

Finally, the CEAP is obligated to conduct him- or her- self in a manner that places employee protection foremost.³

The CEAP will recognize that the relationship between the EAP provider and the employer is based on trust, confidence and respect for the employee's legal rights. As such, the CEAP will:

(1) not discriminate in assessment and referral on the basis of race, religion, age, national origin, physical handicap, gender or sexual preference.

(2) make full disclosure of the functions and purposes of the Employee Assistance Program as well as any affiliation with a proposed therapist or treatment program.

(3) not give or receive financial consideration for referring employees to particular therapists or treatment programs.

(4) not engage in sexual conduct with clients.

(5) not act in any manner to compromise a professional relationship.

In summary, the duties of a CEAP are derived from the definition of EAP, coupled with the ethical constraints of the EACC Code of Professional Conduct.

EXPECTANCY OF CLAIMS

Generally, in the EAP practice, the risk of claims frequency and claims severity is very low. The likelihood of being sued is slim and, even if suit is brought, the damages are not likely to be high. As a result, if the scope of practice is specifically limited to EAP functions, one can offer comprehensive and affordable insurance protection. If, however, one must include health care or mental health care functions within the scope of practice, the population to be covered is expanded to include potential claims of higher frequency and of greater severity. Not only would the premiums be substantially higher, the insurance program

would not be providing the appropriate kind of risk protection given the functions of an EAP professional. For this reason, the CEAP Professional Liability Insurance Program is not assigned for and does not cover physicians, social workers, psychologists or nurses in the practice of these professions.

CALCULATING PREMIUMS

In negotiating this new insurance program, our goal was to provide CEAPs adequate insurance protection at affordable prices. Given the low frequency and severity of claims, the coverage limits are high. The fact that the policy is *occurrence* rather than *claims made*, it offers additional protection. Moreover, representation costs (i.e. lawyers) are provided over and above coverage limits. Finally, there are no deductibles.

In conclusion, ALMACA is pleased to offer the CEAP a unique professional liability insurance program specifically tailored to meet his or her needs.

REFERENCES

¹ *Public Policy: Legal Definition of EAP, THE ALMACAN*, May 1988, page 11.

² "The EACC Code of Professional Conduct for Certified Employee Assistance Professionals" (Sec. II, A 1-3), *THE ALMACAN*, Dec 1988, p. 20.

³ *Id.* at Sec. II, F, p. 21. □

Your job is on the line...



...if you have an addicted employee. Your business pays the cost of absenteeism, lateness, sloppy work and accidents. Eagleville Hospital's Program for Employed Persons (PEP) offers short-term, intensive alcohol and drug treatment and twelve weekly sessions of aftercare to help your employees and your business.



100 Eagleville Road
Eagleville, PA 19408
(215)539-6000
out of state, 1-800-255-2019

CEAP

**Professional
Liability
Insurance
Program**



APPLICATION FORM

1 NAME _____
ADDRESS _____
CITY _____ STATE _____ ZIP _____
IS ABOVE ADDRESS OFFICE OR HOME? _____
PHONE: (Office) _____ (Home) _____

2 Are you a member in good standing of ALMACA?
YES _____ NO _____

3 Professional degrees and training, licenses, certifications

4 Current position and professional activities

5 Estimate annual number of:
assessment & referrals _____
counseling sessions _____
other (specify) _____

6 Annual income derived from
employee assistance practice
19_____ \$ _____
19_____ \$ _____

7 Current professional liability carrier (if any):

8 Have you ever been declined for professional liability insurance coverage? _____
If yes, explain. _____

9 Have you had any professional liability lawsuits and/or claims brought against you in the last five (5) years? _____ If yes, explain on a separate sheet of paper.

10 _____
SIGNATURE OF APPLICANT DATE

SIGNING THIS FORM AND TENDERING THE PREMIUM DOES NOT BIND THE APPLICANT NOR THE COMPANY/UNDERWRITER TO COMPLETE THE INSURANCE COVERAGE. IF THE INSURANCE IS EFFECTED, FAILURE TO RESPOND CORRECTLY TO THE QUESTIONS CONTAINED HEREIN MAY RESULT IN VOIDING OF THE COVERAGE.

THIS APPLICATION MUST BE COMPLETED IN FULL. IF A QUESTION DOES NOT PERTAIN TO YOU, PLEASE ENTER "N/A". THE APPLICATION MUST BE SIGNED. THE DEADLINE FOR RECEIPT OF THE APPLICATION IS APRIL 15, 1989.

The cost of this liability insurance policy is \$185.
Checks are payable to "Treiber/Van Wagner."

Return to: Treiber/Van Wagner, Inc.
69 East Jericho Turnpike
P.O. Box 341
Mineola, NY 11501
Questions? Call (516) 746-1515.

INFORMATION ABOUT ALMACA'S PROFESSIONAL LIABILITY INSURANCE POLICY FOR CERTIFIED EMPLOYEE ASSISTANCE PROFESSIONALS (CEAPs)

This special program has been created to meet the professional liability insurance needs of Certified Employee Assistance Professionals who are members of National ALMACA. It provides the broadest available professional liability protection for CEAPs at very competitive rates. The program is underwritten by J.J. Negley Associates, a firm expert in the field of professional liability. Treiber-Van Wagner, Inc. is the program administrator.

POLICY COVERAGE FEATURES

PROFESSIONAL LIABILITY

- ▶ Limit of liability:
 - \$1,000,000 per claim
 - \$2,000,000 master policy aggregate
- ▶ This coverage is for individual CEAPs
- ▶ Occurrence form
- ▶ Defense costs in addition to the limit
- ▶ No deductibles

ANNUAL COST

- ▶ \$160 premium
- ▶ \$25 nonrefundable administrative fee

UNDERWRITER

For over 25 years, J.J. Negley associates has acted as an underwriting manager, providing a stable insurance market for health and social-service agencies. Negley Associates specializes in mental health, alcohol and drug rehabilitation and is a recognized expert in the field. Scottsdale Insurance Company is the carrier and is rated A+ by Best's, regarded as the insurance industry's best rating company.

PLAN ADMINISTRATOR AND CONTACT

This plan is administered by Treiber/Van Wagner, Inc., 69 East Jericho Turnpike, P.O. Box 341, Mineola, NY 11501; (516) 746-1515.

ELIGIBILITY

This insurance program is available only to Certified Employee Assistance Professionals who are members of National ALMACA and meet the program's requirements. The policy provides professional liability protection for individual CEAPs. It is not designed for and does not cover physicians, social workers, psychologists or nurses in the practice of their professions.

Drug-Free Workplace Regulations Released

The interim final rule on the Drug-Free Workplace Act was issued by the Office of Management and Budget on January 31. The final rule will become effective on March 18. Here are some pertinent details of the Act contained in the interim final rule, which is now in effect.

- Statute requires that all *federal contractors* who receive a contract in excess of \$25,000 certify to the federal agency that it will provide a drug-free workplace. All *grantees* are to certify to the federal agency that it will maintain a drug-free workplace.
- A drug-free workplace, as defined by the regulations, is one at which the employees of the contractor or grantee are prohibited from the unlawful manufacture, possession, distribution, dispensation or use of a controlled substance. *The drug-free workplace requirements were published in THE ALMACAN on page 11 of the December issue and page 13 of the February issue.*
- Criminal activities by employees that occur *off* the work site are not covered under the regulations.
- The statute is violated if:
 - the contractor or grantee submits false certification.

STATUTE VS. REGULATION

With the implementation of new laws, such as the Drug-Free Workplace Act, some aspects are enforceable by "statute" and others by "regulation."

A **statute** is the public law itself. In the case of the Drug-Free Workplace Act, it is Title V, Subtitle D of P.L. 100-690 (known as the "Anti-Drug Abuse Act").

A **regulation** is that which has been written by a regulatory agency, usually the Office of Management and Budget, which further defines or clarifies the statute. A regulation cannot "rewrite" the law.

- the contractor or grantee fails to comply with the certification.

- a substantial number of employees have been convicted of criminal drug statutes occurring on the work site, which indicates that the employer has failed to make a good-faith effort to provide a drug-free workplace.

- Contractors or grantees who violate the statute, as determined by the federal agency, shall be subject to suspension in payments, termination of the contract or grant, or debarment from any contract or award from any federal agency, not to exceed five years.

- The regulation defines "grant" to cover block grants and entitlement grant programs. The regulation further defines "grant" to include only direct assistance from a federal agency to a grantee.

- The regulation cuts off coverage at the first entity that receives the assistance, and *excludes* subgrantees. For example a single state agency that receives a block grant from ADAMHA must, as the grantee, comply with the Drug-Free Workplace Act. When this money is passed on by the state agency to a local employer—in effect, the subgrantee—the local employer is not required to come into compliance with the Drug-Free Workplace Act provisions.

- Other exclusions to the Drug-Free Workplace Act are:

- Medicare third-party payments to hospitals, since this transfer of money is not made via a procurement contract or grant. However, hospitals that do have procurement contracts or grants must comply.

- banks and other financial institutions that sell U.S. Treasury bonds. However, the institutions that have procurement contracts or grants must comply.

- procurement contracts awarded by the U.S. Postal Service.

- Existing contracts and grants which are substantially modified on or after March 18 will be required to comply.

- Contractors or grantees performing

work in federal facilities are required to comply.

- Drug testing is *not* a requirement of the statute.

Although the final rule takes effect on March 18, the comment period does not end until April 3. A statement will be issued afterward which provides clarification of aspects of the Act which were previously unclear.

FAA Releases Airline Drug Testing Regs

A heavily publicized crash of two trains in Chase, Maryland in 1987, from which the engineer at fault tested positive for marijuana, precipitated the Department of Transportation's requirement that all of its agencies establish anti-drug programs for their personnel.

On November 21, 1988, the Federal Aviation Administration (FAA) released regulations stating that airlines are required to establish drug-testing programs, as well as implement EAPs, which must provide education and training on drug use for employees and supervisors. According to the regulation, each airline carrier must submit its anti-drug plan to the FAA by April 20 and begin testing within 120 days of FAA's approval of the plan.

The plan's highlights include these items:

- Carriers must conduct random drug testing for 50% or more of its safety-related employees per year.

- Covered employees will primarily be those in safety-sensitive positions.

- The substances to be tested for will include marijuana, cocaine, opiates, PCP and amphetamines.

- Carriers must establish EAPs for their employees.

- Carriers cannot hire job applicants who fail the preemployment drug test.
- Carriers must remove from service any incumbent employee who tests positive.

In its final rule making, the FAA dropped a proposed requirement for a mandatory, one-time rehabilitation for employees who test positive, and carriers will retain their traditional right to discharge employees who test positive.

The Final Rule, which appeared in the *Federal Register* on November 21, requires that employers conduct pre-employment, periodic and random testing, and testing based on reasonable cause.

The specific language in the regulations related to EAPs is this:

VIII. Employee Assistance Program.

The employer shall provide an EAP for employees. The employer may establish the EAP as a part of its internal personnel services or the employer may contract with an entity that will provide EAP services to an employee. Each EAP must include education and training on drug use for employees and training for supervisors making determinations for testing of employees based on reasonable cause.

A. *EAP education program.* Each EAP education program must include at least the following elements: display and distribution of informational material; display and distribution of a community service hot-line telephone number for employee assistance; and display and distribution of the employer's policy regarding drug use in the workplace.

B. *EAP training program.* Each employer shall implement a reasonable program of initial training for employees. The employee training program must include at least the following elements: The effects and consequences of drug use on personal health, safety, and work environment; the manifestations and behavioral cues that may indicate drug use and abuse; and documentation on training given to employees and employer's supervisory personnel. The employer's supervisory personnel who will determine when an employee is subject to testing based on reasonable cause shall receive specific training on the specific, contemporaneous physical, behavioral, and performance indicators of probable drug use in addition to the training specified above. The employer shall ensure that supervisors who will make reasonable cause determinations receive at least 60 minutes of initial training. The employer shall implement a reasonable recurrent training program for supervisory personnel making reasonable cause de-

terminations during subsequent years. The employer shall identify the employee and supervisor EAP training in the employer's drug testing plan submitted to the FAA for approval.

Two interesting aspects of the final

rule are that there is no mandatory referral to the EAP in the event of a positive test, and that no EAP role is specified beyond the education and training requirements stated above. □

A NEW AND BETTER WAY TO SCREEN FOR CHEMICAL DEPENDENCY

SUBSTANCE ABUSE SUBTLE SCREENING INVENTORY

The **ACCURATE** way to identify abusers—
over 90% validity.

DEFENDABLE scientifically—
for insurance and courts.

Bypass **DENIAL**— abusers cannot
conceal problems.

OTHER FEATURES:

- **SUBSCALES**—
codependency
denial

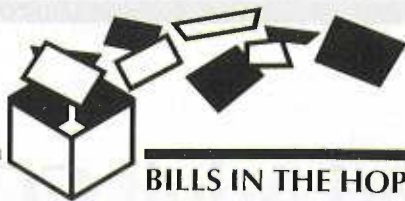
- **BRIEF**—
10 minutes to take
1 minute to score

- **ECONOMICAL**—
less than \$1.00 per person

- **PRACTICAL**—
can be used by any EAP

The
S.A.S.S.I.
INSTITUTE

4403 Trailridge Road
Bloomington, Indiana 47408
Telephone (812) 333-6434



BILLS IN THE HOPPER

This is the first installment of a monthly column that reviews the pertinent legislation under consideration by Congress and state legislatures. This month's column highlights federal legislation only, although bills that are brought to ALMACA's attention through our public policy campaign will be summarized in a similar manner in future issues.

SUBJECT: HEALTH INSURANCE

H.R. 16

SPONSOR: Rep. John Dingell, no cosponsors

INTRODUCED: January 3, 1989

HIGHLIGHTS: The bill would provide a program of national health insurance.

STATUS: Referred to the House Committee on Energy and Commerce.

H.R. 210 and H.R. 216

SPONSOR: Rep. Rose Marie Oakar, both have 14 cosponsors

INTRODUCED: January 3, 1989

HIGHLIGHTS: H.R. 210 would provide for a demonstration project relating to treatment for drug abuse and alcohol abuse under the health benefits program for federal employees. H.R. 216 would increase the government contribution rate under the federal employee health benefit provisions of title 5 of the U.S. Code, extend coverage for employees who are separated due to reductions in force, require insurance carriers to obtain reinsurance or stop-loss in insurance (or to otherwise demonstrate financial responsibility), and assure adequate mental health benefit levels and otherwise limit benefit reductions.

STATUS: Both have been referred to the House Committee on Post Office and Civil Service.

A BILL NUMBER NOT AVAILABLE AT PRESS TIME

SPONSOR: Rep. James Florio

INTRODUCED: March 1, 1989

HIGHLIGHTS: This bill would require employers to provide minimal drug and alcohol abuse treatment coverage. It is virtually identical to the bill introduced at the end of the last Congress, which was reported on in the December 1988 issue of *THE ALMACAN*, page 13.

STATUS: Referred to the House Energy and Commerce Committee.

SUBJECT: VETERANS ADMINISTRATION, MENTAL HEALTH SERVICES

S. 86

SPONSOR: Sen. Alan Cranston, 5 cosponsors

INTRODUCED: January 25, 1989

HIGHLIGHTS: The bill would improve the capability of the Department of Veterans Affairs health-care facilities to provide the most effective and appropriate services possible to veterans suffering from mental illness, especially conditions which are service-related, through the designation of up to five of its facilities as centers of mental illness research, education, and clinical activities.

STATUS: Referred to the Senate Committee on Veterans.

SUBJECT: CLINICAL SOCIAL WORKERS

S. 118

SPONSOR: Sen. Daniel Inouye, one cosponsor

INTRODUCED: January 25, 1989

HIGHLIGHTS: The bill would provide coverage of clinical social workers' services when provided on-site at a community mental health center or off-site as part of a treatment plan.

STATUS: Referred to the Senate Committee on Finance.



palm is a nonprofit corporation who's main activity is sponsoring workshops on the issues of chemical dependency at the workplace.

palm is not a membership organization. Participants include representatives from labor, management and the health care field. Each chapter is administered by representatives from the local community under the supervision of the national PALM Board of Directors.

palm workshops are designed to provide practical information, not theory. They offer actual application of techniques that have proven effective in dealing with chemical dependency at the workplace.

palm workshops are held monthly at locations throughout the country. For information about your nearest chapter, please call or write to our national office.

PROBLEMS OF ALCOHOLISM IN LABOR AND MANAGEMENT, INC.

DBA: PALM

2130 West Ninth Street

Room 103

Los Angeles, CA 90006

Telephone (213) 738-PALM

Joy W. Ellis, Executive Director
Douglas K. Maguire, President

Chemically Dependent and Adult COA Women in Recovery

PART 1

by Patricia A. Pape, ACSW and SCAC

This article, which will be presented in two parts, is excerpted from the author's presentation "CD/ACOA Women in Recovery" before the 39th conference of the Alcohol and Drug Problems Association in Charlotte, North Carolina on September 27, 1988.

Part 2 will appear in the April issue.

Since ancient times, women who have alcoholism or are chemically dependent have been the victims of extreme stigma and stereotyping. An old Romulus law decreed that women who engaged in adultery and drinking could be sentenced to death. Society still associates the two, only instead of death, female alcoholics today are often sentenced to rejection, disgust, labeling, misdiagnosis, prejudice and sometimes apathy or indifference. Society today often verbalizes an intellectual acceptance of alcoholism and the disease concept, while rejecting those who suffer from it. Perhaps this is why many women, when they are having problems with alcohol, turn to the use of more acceptable and respectable "drugs"—legitimately prescribed medications.

For women, the stigma of the disease is a triple stigma, and often a barrier to her being identified and getting the treatment she needs. First, there is the general stigma of the disease of alcoholism. Despite the acceptance in 1956 of alcoholism as a disease by the American Medical Association, many people today figure an alcoholic drinks because of choice and moral weakness. The second stigma comes from the fact that the moral standards for women are often higher than those

for men. To "drink like a man" and occasionally get drunk is often viewed as humorous; a woman who is drunk is viewed with disgust. Women are defined as the nurturers and caretakers of society; placed on a "pedestal" that in turn supports isolation; and as mothers, face ultimate disgrace. The third stigma relates to the continued association of drinking and sexual promiscuity. In reality, the research indicates that female alcoholics have decreased sexual desire; that what actually increases is their chance of being sexually victimized because they are considered acceptable targets for male aggression.

Because women are raised and socialized in the same society and with the same values as everyone else, they are acutely aware of the stigma—and in fact they turn it against them-

selves, creating two of the major issues with which they must deal in their recovery: guilt and shame.

A majority of these women who have the disease of alcoholism grew up in families where one or both parents were alcoholics. As children of alcoholics, they incurred two things: first, an increased risk of genetically inheriting the disease (research indicates a 50% chance of becoming alcoholic with one alcoholic parent, a 95% chance with two alcoholic parents) and, secondly, the suffering of a great many emotional problems from being raised in an alcoholic family. Children of alcoholics develop an inability to trust, an extremely high need to control, an inability to identify or express their feelings or their needs and an excessive sense of being responsible for those around them.

Children of alcoholics tend to become and/or marry alcoholics. Nine times out of 10, a daughter of an alcoholic father will marry an alcoholic man. Alcoholic women in general tend to marry alcoholic men. Thus, if a woman is both alcoholic and an adult child of an alcoholic parent, her chances of being married to, or in a relationship with, an alcoholic increases dramatically.

PATRICIA PAPE is president of Pape & Associates, a Wheaton, Illinois-based business consulting firm which specializes in the design, implementation and monitoring of comprehensive EAPs. She has an extensive background as a therapist, with special expertise in family therapy, alcoholism, interpersonal communications and EAPs. Her education includes a master of social work degree from George Williams College, Downers Grove, Illinois (1979) and a bachelor of arts in sociology from Northwestern University, Evanston, Illinois (1962).



TWO-YEAR TREATMENT MODEL

The two-year treatment model presented in this paper attempts to address both the issues of the recovering alcoholic female and the issues of the adult child of an alcoholic.

Many treatment models look at a two-year treatment, aftercare and fol-

low-up plan. This length of time is consistent with the research done on PAWS—the Past Acute Withdrawal Syndrome—which can last from 6 months to two years. It is the time period when the risk of relapse is highest. There are predictable symptoms of PAWS, which recovering alcoholics need to be aware of and learn to cope with and to compensate for. Some of these predictable symptoms are: short-term memory problems, inability to concentrate for long periods of time, and neurological augmentation and mood swings.

Research on the treatment of female alcoholism presents evidence of the value of all-female treatment groups that address the specific needs of women during early recovery. This also prevents them from taking on their usual roles and behaviors that they do with men—passivity, non-assertiveness, care-taking—and allows them to talk about issues they might not feel free to talk about in the presence of men—physical and sexual abuse, incest or rape, and other sexual issues in their relationships with men. The issues of sexual preference and being lesbian would appear to need addressing in yet another group specifically for gay alcoholic women, as many of the gay women are uncomfortable talking about these issues in a heterosexual women's group.

Dr. Sheila Blume (1988) stresses the need for a thorough assessment and diagnosis prior to any kind of treatment. Because women tend to exhibit more physiological problems than men, a good physical—including a gynecological examination and a pregnancy test for sexually active women is extremely important.

There needs to be a thorough alcohol and drug history, because so many women have a history of the use of tranquilizers, barbiturates, sedatives and amphetamines in addition to alcohol. The treatment staff needs to be alert to any delayed withdrawal symptoms from other sedatives—par-

ticulary the benzodiazepines—which are longer-acting than alcohol. In diagnosing women, it is important not to focus on the quantity of alcohol consumed (women tend to drink less than men), but rather on the chemical use patterns and also the effects on both personality and personal functioning.

Someone trained in both alcoholism and psychiatry needs to do a thorough differential diagnosis to determine if there is primary alcoholism (most patients have this diagnosis) or secondary alcoholism (the presence of a pre-

“Three, six, nine, 12, 18 and 24 months are periods of highest risk, and it only makes sense to structure treatment to be inclusive of these time periods.”

existing, diagnosable psychopathological state or a state which develops during prolonged abstinence). In females, depression, anxiety disorders (panic disorders or agoraphobia are the most common) and eating disorders often coexist with the alcoholism. In the case of dual diagnosis, the psychological problems are usually secondary to the alcoholism. And always, treatment must begin by addressing the alcoholism and the goal of total abstinence from all mood-altering chemicals.

Some of the major issues women bring into treatment are: low self-esteem, dependency, identity confusion, guilt and shame from the stigma, socialization related to their role as nurturers of others, inability to identify and express their own feelings (especially anger), inability to identify their own needs and get them met, and such practical problems as employment, child care, housing and finances. They often have the unrealistic expectation that others should know and meet their

needs without their having to ask, because this is what they have done for others. Most women have been isolated for years and would prefer not to be part of a group. In addition, they often don't like or trust other women and have a particular resistance to a women's group—professional or AA. They sometimes state that they find it easier to relate to men than to women.

The research indicates that women gain a great deal of value from both structure and from education. Treatment programs need to build in structure and provide a variety of forms of education—audiovisual with discussion, reading materials and continued education in groups.

Involving family and significant others from the beginning of treatment is crucial. It is even more important in the treatment of women than men. Part of the reason for this is the priority women have placed on relationships and also the centrality of their roles of wife and mother to their own identity. The entire family—everyone who lives in the home, including the young children—needs to be involved in treatment.

Before looking at the issues, themes, special needs and goals of the women in treatment, I'd like to address three questions: Why two years? Why just women? Why ACOA?

There are three main reasons for the two-year time frame. The first is related to the research on the Post-Acute Withdrawal Syndrome (PAWS). According to Terence Gorski (1988), PAWS is the number one cause of relapse during early recovery. The symptoms are predictable and last anywhere from 6 to 24 months, depending on how long and to what degree and combinations a person used alcohol and other drugs. Three, six, nine, 12, 18 and 24 months are periods of highest risk of relapse, and it only makes sense to structure treatment to be inclusive of these time periods. Secondly, surveys done by AA indicate that people who stay active in AA for two years—getting a sponsor and work-

ing the steps—have about an 80-85% chance of lifelong sobriety. Third, the research on grief and loss—which is central to the treatment of both chemical dependency and ACOA issues—suggests that two years is about minimal to complete the grief work involved in major losses in life.

DISEASE PROGRESSES DIFFERENTLY

Why just women? Again, the research indicates that the disease progresses both differently and more quickly in women and also that women have special needs—particularly in early recovery. Women appear to enter treatment with lower self-esteem than men. They have more guilt (a woman, wife or mother “should not” be an alcoholic!) and shame because of their “lack of control” over having this disease. They have suffered more loss—both real and psychological—and been the object of more societal stigma and stereotyping. In co-educational therapy groups, women often take on their old roles—as caretakers and nurturers of men, more passive about speaking up and getting their needs met—and there is more sexual acting out and focus on the men, rather than on their own recovery. Finally, there are issues such as physical and sexual abuse, being raped or survivors of incest that women will not initially talk about in co-educational groups. Since 75-80% of chemically dependent women face these circumstances, it appears necessary to offer them the best opportunity in early recovery to work on them.

Why ACOA? Eighty percent of the chemically dependent women with whom I have worked have one or both parents who are alcoholic. Also, relationships are traditionally the number one concern for women, and ACOA treatment is all about relationships. The profile of an ACOA—inability to express feelings or get needs met, fear of taking risks or responsibility

for oneself, lack of trust in the world, people-pleasing, existing for others, overextended because of an inability to say “no,” and ambivalence about relationships (approach-avoidance behaviors)—is the description of women’s issues! The degree of damage to the ACOA woman is greater than that of a non-ACOA woman but the themes are the same. Because the ACOA groups are co-educational, the opportunity to learn and practice new behaviors toward men is available during the second year of treatment. Hopefully by this time women have been able to enhance their self-esteem and begin to establish their own identity apart from men. They are ready to move on from stances of victimization and learned helplessness to taking re-

sponsibility for themselves and making choices.

In summary, this treatment is “the best of both worlds”—a year with only women to lay the foundation for lifelong sobriety and a year with both men and women to learn and practice new behaviors toward both.

REFERENCE

Blume, Sheila B., M.D. *Alcohol/Drug Dependent Women*. Johnson Institute, 1988. □

BODY, MIND, and SPIRIT Together they make life whole.

When substance abuse shatters lives, The Oxford Network of Care can help people through the process of restoring work, family and social roles.

Medically supervised detoxification, residential and outpatient care, and intensive day and evening programs focus on the goal of total health and wellbeing.

Locations throughout southeastern Michigan including residential programs in the Detroit area at The Oxford Institute and St. John Hospital-Macomb Center, and at Hilton Head Island, South Carolina.

For more information, call The Oxford Network of Care where experts in chemical dependency care for body, mind, and spirit.

Our newest facility located at Hilton Head Island is now open.

(313) 628-0500 outside Michigan
1-800-548-0670 in Michigan
(803) 681-4004 in South Carolina



**The Oxford
Network of Care**

*Southeastern Michigan
and South Carolina*

IN MEMORIAM

OAP Pioneer John Norris Dies

Every now and then we are reminded how far back the legacy of the EAP field goes. Such is the case when one of its great leaders from prior decades passes away.

Dr. John Norris, who died in New London, New Hampshire on January 13 at age 85 of congestive heart failure, practiced basic EAP work for the Eastman Kodak Company as far back as the 1930s.

After becoming associate medical director in 1937, he helped alcoholic employees by using constructive coercion, the classic worker intervention strategy that remains one of the core technologies of EAP work. Using job jeopardy as leverage, and with the support and help of an employee's supervisor, Dr. Norris earned a reputation for saving careers by getting trou-

bled individuals into treatment and the Alcoholics Anonymous network. He referred to alcoholism as a disease as far back as 30 years ago and understood its denial patterns, particularly when employees feigned other medical problems to explain their absenteeism and poor work performance.

Shortly before his death, he recalled those interventions during an interview with the *Boston Globe*. "I saw we had a tremendous advantage in that we could use the employee situation to break through the characteristic denial of alcoholism," he said. "It's harder to argue with your boss than with your wife. We could confront the alcoholic with the reality that he'd be fired if he didn't do something about his alcohol problem. Then we'd give him the facts of the disease. We didn't tell him how to take care of his problem, but I'd bring in one of the recovering AA's, someone with good, solid sobriety, to talk to him, offer to take him to meetings. In two-thirds or three-quarters of these cases, we had success."

WORK FOR KODAK, AA

Dr. Norris became medical director at Kodak in Rochester, New York in 1943 and retired to New London, Massachusetts, in 1969. Like many of the early occupational alcoholism programmers, he had a strong affiliation with AA. He was a nonalcoholic member of AA's General Service Board from 1954 to 1978, joining at the personal request of Bill Wilson, who cofounded AA in 1935. He was the board's chairman from 1961 to 1978. One of the highlights of his life came in 1973 when he went to the White House to give President Nixon the 1,000,000th copy of AA's Big Book.

"Dr. Norris was a gentle, loving person, very caring," one of his recovering colleagues on the AA board recently told the *Boston Globe*. "He had a great feel for the spiritual aspects of AA. Dr. Norris was a peacemaker. He brought people together. He kept AA



Dr. John Norris

on track, so it wouldn't get entangled in money or politics."

Dr. Norris was born in Dorchester, MA in 1903. He graduated from Dartmouth College, and McGill University in Montreal, Canada, and set up a private practice in 1933 until joining Kodak.

After retiring, he helped to found hospice and home health care agencies in New Hampshire's Kearsarge Valley. While in Rochester, NY, he was president of the Monroe County medical society from 1950-51. He was also chairman of the state's Advisory Committee on Alcoholism, an appointee of Governor Nelson Rockefeller. Later, he became chairman of the North Conway Institute of Boston, an ecumenical organization for education on alcoholism and other drug addictions.

Dr. Norris received numerous awards throughout his career. Among them were: ALMACA's Special Recognition Award; Rochester Academy of Medicine's highest honor, the Albert David Kaiser medal; the National Council on Alcoholism's Gold Key Award; the medal of the American Medical Society on Alcoholism; and the President's Citation from the Medical Society of the State of New York and the Health Association of Rochester. The John L. Norris Clinic at Rochester State Hospital was also named in honor of his achievements.

Dr. Norris is survived by his wife, Eleanor, three sons and four grandchildren. A service was held for him on January 21 in New London. □

MANAGEMENT TRAINING FOR
EMPLOYEE ASSISTANCE PROGRAMS

THE DRYDEN FILE II

© MCMLXXXVIII Motivision, Ltd.

UPDATED WITH NEW FACES, NEW
SETTINGS AND A NEW ENDING.

24 Minutes

Available on 16mm Color Film
and Video Tape (all formats).

Previews \$25 U.S.

Deductible Upon Purchase

Purchase Price \$495 U.S.

Plus Shipping

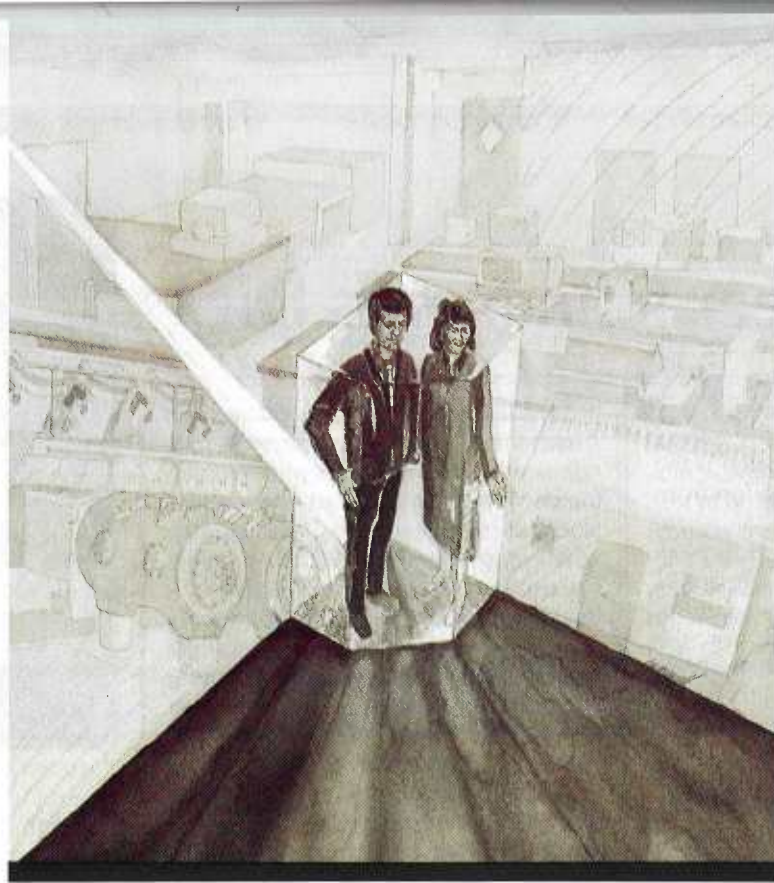
Motivision, Ltd.

2 Beechwood Road

Hartsdale, N.Y. 10530

Call (914) 684-0110

ALSO ASK FOR A COURTESY PREVIEW OF
"EAP-AT YOUR SERVICE!" TO ENCOURAGE
SELF-REFERRALS. LENGTH: 8 MINUTES.



Preferred Provider Organizations:

A Historical Perspective, Legal Considerations, and Special Issues

by Laura S. Altman, Ph.D.

Preferred provider organizations (PPOs) are one of the most recent approaches to health care cost containment. A PPO is an intermediary health care delivery system of selected providers who meet certain professional standards and often pay a fee to join as part of the application process. PPOs contract with employers, insurance carriers or third-party administrators for their network of providers to offer services to subscribers of a defined group.

PPOs differ, in two basic ways, from health maintenance organizations

(HMOs) and independent practice organizations (IPAs). First, they reimburse providers on a fee-for-service basis and, second, they offer subscribers the freedom to use a designated (i.e. "preferred") provider or a nonparticipating provider. Subscribers are channelled toward preferred providers through reduced cost-sharing (which in some cases may be waived altogether), but may select to use a nonparticipating provider at greater out-of-pocket cost.

Cost savings in PPOs are accomplished in three ways: negotiated or

discounted fees paid to participating providers, the use of "select" or efficient providers, and through utilization review. There is disagreement about what constitutes a PPO. Some self-described PPOs have exclusive provider panels with no option of partial reimbursement for nonpanel providers, and others may use a capitated, prepaid reimbursement. This adds confusion to the term "PPO," as PPOs are generally thought to have the two distinguishing features, the freedom-of-choice option and fee-for-service reimbursement.

In the mental health field, PPOs are relatively new. Those that do exist are of two kinds: the multi-service PPOs, offering mental health care as one of several services; and the mental health specialty PPO, providing mental health services only.¹

HISTORICAL PERSPECTIVE

According to Dr. Joan Trauner of the University of California Institute of Health Policy², several factors have contributed to the development and growth of preferred provider arrangements. These are: historical precedents, escalating health care costs, competition between providers, and state and federal responses to cost escalation.

HISTORICAL DEVELOPMENT

Historically, negotiated fee-for-service health care is not a new idea. In the early 1900s, according to Trauner, "contract medicine" was a practice whereby certain physicians agreed to provide less-expensive medical services to members of specific fraternal or employee groups. In 1939, California Physicians' Service (Blue Shield) was the first to offer discounted medical services. Participating physicians agreed to accept their reimbursement as payment in full for certain categories of patients. Now, the Blue Shield reimbursement rate system is widely accepted.

The PPO concept was first facilitated and later threatened by multiple employer trusts (METs). In her 1983 paper Trauner discussed how the federal Employee Retirement Security Act, implemented in 1975, permitted the establishment of METs, which were unregulated associations of small employers. The law allowed METs to institute their own health and welfare benefits plans. Insurers and third-party administrators marketed discounted benefits plans to METs by selectively contracting with providers. Many METs failed, largely due to lack of insurance, leaving large unpaid medical

bills. Subsequent federal legislation has enabled states to better regulate METs, but few PPOs that were started because of them were able to survive.

ESCALATING HEALTH CARE COSTS

The second well-documented factor that has contributed to PPO development is health care cost escalation. In the 30 years between 1950 and 1980, health care costs rose from 4.4% of the gross national product (GNP) to 9.8%.³ What is of even more concern is that during this time period the growth rate of health care expenditures was 30% higher than the growth rate of the GNP.⁴ Unions and the business community—both of whom pay the major portion of health insurance premiums—are also concerned. In 1983, employers reported that 24% of corporate profits, after taxes, were spent on health care.⁵

Of particular interest to the EAP community is mental health cost escalation. Although few data are available to compare the growth rates of costs for general and mental health care, it is generally assumed that mental health costs have escalated at an even greater rate.⁶ There are special problems in mental health, not found in other types of health care, that have contributed to this and have impeded cost-containment efforts. Psychotherapy can be provided by one of several types of practitioners, and there are many recognized professional disciplines. Several mental health treatments are available, but a lack of consensus among professionals exists about which are the most effective. Diversity of professional opinion abounds on some very basic issues, including the appropriate duration of treatment for specific problems, the definition of a successful treatment outcome, and universally accepted indicators for psychiatric and substance-abuse hospitalization or residential treatment.

PRO-COMPETITIVE PUBLIC POLICY

The third major impetus to PPO de-

velopment was public policy. Pro-competition policy emerged early in the 1970s, when it became evident that regulation alone could not adequately keep health care costs in check. In 1973, federal legislation required large employers to offer HMO plans as an alternative to traditional insurance benefits. During the past 15 years, the number of HMOs and IPAs has greatly increased (National HMO Consensus, Interstudy, 1986). These organizations introduced competition into health care. Particularly in areas where there was a large supply of health professionals and/or hospital overbedding, providers began to seek ways to increase referrals and retain clients. One alternative facing professionals was to work for an HMO, but such an arrangement involved a loss of autonomy. Joining other prepaid practices, such as IPAs, required the professional to assume some financial risk. PPOs presented a solution requiring little, if any, loss of autonomy, and seldom involved financial risk.

A model for PPOs was provided by the State of California in response to high Medicaid costs. In 1982, California initiated selective hospital contracting for MediCal patients. A second California bill was enacted that allowed for private purchasers of health care to contract selectively with providers at alternative rates.

On the federal level, a bill concerning preferred provider health care was introduced in 1983 by Rep. Ron Wyden and 13 cosponsors. This PPO-enabling legislation focused on overriding restrictive state legislation that prohibited contracting between health care providers and purchasers. Currently, Congress has not adopted this or further PPO-enabling legislation, as the majority of states have already removed barriers to their formation. (See Chart 1, next page.)

LEGAL CONSIDERATIONS AND BARRIERS TO PPO DEVELOPMENT

State and federal PPO facilitating laws

STATE LEGAL REQUIREMENTS FOR PPOs: APPLICATION OF PREEXISTING PROVISIONS, JUNE 1986

Prior restrictions ^a	PPOs not permitted	PPOs permitted	Undetermined
Enabling statutes:	Georgia ^b	Informal interpretation:	Appears positive:
California	Montana	Arizona	Alabama
Florida	Ohio ^c	Colorado	Alaska
Illinois		Massachusetts	Connecticut
Iowa		Missouri	Delaware
Kansas		New Jersey	Oklahoma
Louisiana		New York	Rhode Island
Maine		Tennessee	South Carolina
Maryland			West Virginia
Michigan		Other legislation:	
Minnesota		Nevada	Possible conflict:
Nebraska			Mississippi
New Hampshire			New Mexico
North Carolina			North Dakota
Oregon			Vermont
Pennsylvania			No opinion:
Utah			Hawaii
Virginia			Idaho
Wisconsin			South Dakota
Wyoming			Washington, D.C.
Formal regulation:			
Arkansas			
Texas			
(Kentucky) ^d			

^a Statutes in these states had been interpreted or perceived to prohibit certain essential features of a PPO. These states have now adopted enabling statutes or regulations to overcome the obstacles.

^b Commercial insurers only.

^c Health service corporations only.

^d Kentucky is in the process of adopting regulations.

SOURCE: RAND CORPORATION REPORT, 1987.

are generally viewed as a pro-competitive strategy to reduce health care costs. Ironically, however, PPOs are sometimes criticized on the grounds that they promote anti-competitive practices by establishing an elite panel that freezes out nonparticipants and places restraints on trade. Various guides prepared for developing PPOs reflect a concern for possible antitrust violations. The PPOs most vulnerable to litigation are those that are provider-sponsored organizations with a large share of the professional community.⁷ Setting fees by these PPOs most clearly resembled "horizontal price-fixing," in which potential competitors agree among themselves on price and other matters. This practice was ruled illegal in the 1982 Supreme Court Case *Arizona v. Maricopa Medical Society*.

Smaller, more exclusive PPOs, are not as concerned about antitrust litigation,

but they face other obstacles. In some states, medical societies have lobbied against pro-PPO laws in order to reduce the potential competitive threat that PPOs might pose. This effort was successful in Utah, and PPO-facilitating legislation was defeated. However, Utah is one of the states that has recently adopted PPO-enabling statutes.

Some providers or sponsors may be inhibited from establishing PPOs because of their concerns about the utilization review process these organizations use. Gurvitz has argued that premature termination or denial of treatment due to utilization review decisions may place panel providers at higher risk for malpractice lawsuits.⁸ In California, in fact, standard malpractice insurance does not provide protection for lawsuits stemming from utilization review, and special additional coverage is usually obtained by reviewers.

Another important consideration for all utilization-review systems are the special confidentiality requirements of mental-health and substance-abuse records.⁹

PPO MODELS AND SPONSORSHIP

Although there is considerable diversity among PPO models, all appear to have a panel of selected providers, which may or may not include hospitals. Some PPOs select providers on the basis of quality-of-care indicators (e.g. certification, licensure) and/or efficiency.¹⁰ Some PPOs require providers to pay an initial fee, ranging from a nominal amount to up to \$2,000. Other PPOs do not use a listing fee; rather, they charge an annual fee ranging from \$100 to \$400.¹¹

One of three groups usually sponsors a PPO:

- an insurer or third-party administrator.
- a primary purchaser of health care, i.e. union or employer.
- a group of providers.

Sponsorship by an insurance carrier or TPA is the most prevalent model. In these, the PPO enters into agreements with selected providers who reduce their usual and customary fee per unit of service by a certain percentage, and then brokers the services of these providers to large purchasers of health care.

In purchaser-sponsored PPOs, self-insured employers or unions take the initiative and can help with the development of the provider network. Provider-sponsored organizations are those initiated by hospitals, physicians or specialty providers. They, too, broker their services, develop a network of individuals and hospitals, then market their services to payors of health care.

Panel providers' services may be fully covered, while subscribers pay 20% for other providers' charges.¹¹ Fees are established (e.g. set or contracted) in advance by the PPO or can be negotiated, but are generally discounted, at an average of 15 to 20 percent lower than market rates.¹²

MENTAL HEALTH AND SUBSTANCE ABUSE

A key feature of PPOs is the emphasis on appropriate length and place of treatment, through strict utilization review. For mental health, utilization review must counteract the effects of two aspects of PPOs that would otherwise tend to increase length of treatment and, hence, costs. First, few PPOs offer financial incentives to providers to reduce utilization . . . and providers are unlikely to change their practice style without financial risk. Second, the reduced cost-sharing that PPOs provide for subscribers is apt to increase the demand for mental health services.¹³

Gurevitz⁸ points out some of the difficulties that PPOs can pose for psychiatry. In particular, he notes the importance of the use of triage by psychiatric specialists to avert complications caused by treatment delays. He is also concerned about a health care system that encourages the use of nonphysician providers and that emphasizes cost containment.

PPOs that offer mental health services have mainly relied on psychiatrists and psychologists. An increasing number of panels, however, especially



LAURA ALTMAN, Ph.D. recently received her doctoral degree from Brandeis University in Waltham, MA. She is in private practice and provides consulting services on managed mental

health/substance abuse care. Previously, she was the clinical director of a mental health agency.

Dr. Altman's article is based on research conducted for her doctoral dissertation "Psychologist Participation in PPOs: Factors That Influence the Decision to Join."

the mental health PPOs, are beginning to include master-level therapists with specialty expertise, such as marriage/family substance-abuse skills.^{14,1}

A wide range of mental-health and substance-abuse services can be found in PPOs. Not all contracts, however, offer all of the services as a benefit to their subscribers. Most PPOs provide outpatient care and inpatient psychiatric services. Many also offer substance abuse treatment. The areas where the most diversity has been found to occur is in the "specialty" services such as day/evening treatment, home health care and residential programs for chemically dependent adolescents and adults. Some PPOs have been found to exclude marriage counseling, educational testing, treatment for learning disabilities, obesity and children's behavior problems.¹

From the EAP professional's perspective, exclusions such as the above are a major barrier. Nevertheless, there are areas where PPOs appear to have promise. Because most panel providers are carefully screened, they are experienced professionals with the types of credentials that are used as quality indicators. In addition, most providers join a PPO in order to increase referrals. EAP clinicians, as a potential referral source, should be most well-received, with timely access for their clients. Finally, in this era of escalating costs for mental health care—with cost containment efforts for mental health being so problematic—PPOs may provide a means to interrupt the spiraling escalation of costs without dramatically reducing benefits for care.

FOOTNOTES

¹ Altman, Laura S., Frisman, Linda K., "Preferred Provider Organizations and Mental Health Care." *Hospital and Community Psychiatry*. Vol. 38, April, 1987.

² Trauner, J.B., "Preferred Provider Organizations: The California Experiment." (Unpublished paper). Institute of Health

Policy Studies, University of California, San Francisco; 1983.

³ Segal, Martin E. Company. "Preferred Provider Organizations: Can They Help To Stem Rising Costs?" *Newsletter 28*: 1984.

⁴ Luft, Harold S., Trauner, Joan B., *The Operations and Performance of Health Maintenance Organizations: A Synthesis of Findings From Health Services Research*. Institute for Health Policy Studies, University of California, San Francisco, 1981.

⁵ Herzlinger R., Schwartz J. "How Companies Tackle Health Care Costs: Part I." *Harvard Business Review*, July-August 1985.

⁶ Dickey B., Frisman, L.K., McGuire, T.G., "Cost-effective Mental Health Care: Implications for Policy and Research." (Unpublished paper.) Health Policy Center, Brandeis University, 1985.

⁷ Gabel, Jon, Ermann, Dan, "Preferred Provider Organizations: Performance, Problems, and Promise." *Health Affairs*, Vol. 4(1), Spring 1985.

⁸ Gurevitz, H., "Psychiatry and Preferred Provider Organizations." *Psychiatric Annals*, 1984.

⁹ Weller, C.D., "Legal Issues for PPOs." Paper presented to the Pew Associates Conference. Florida; February, 1985.

¹⁰ Rothenberg, F., "PPOs: Critical Elements in Their Design." *Health Care Financial Management*. October, 1983.

¹¹ O'Connor, M.L., "Preferred Provider Organizations: A Market Approach to Health Care Competition." *Hospital Forum*. November/December, 1982.

¹² Schoer, D., Taylor, E., "A Survey of Preferred Provider Organizations." *Hospitals*. March, 1984.

¹³ de Lissovoy, G., Rice, T., Ermann, D., Gabel, J., "Preferred Provider Organizations: Today's Models and Tomorrow's Prospects." *Inquiry*. Vol. 23, Spring 1986.

¹⁴ Marshall, M.H., Schlusel, M.E., Seay, J.D., "Subspecialty and New Market PPOs and ADS." (Unpublished paper.) The National Health Lawyers Association, Conference on PPOs and Other Alternative Delivery Systems. Washington, D.C., September, 1984. □