

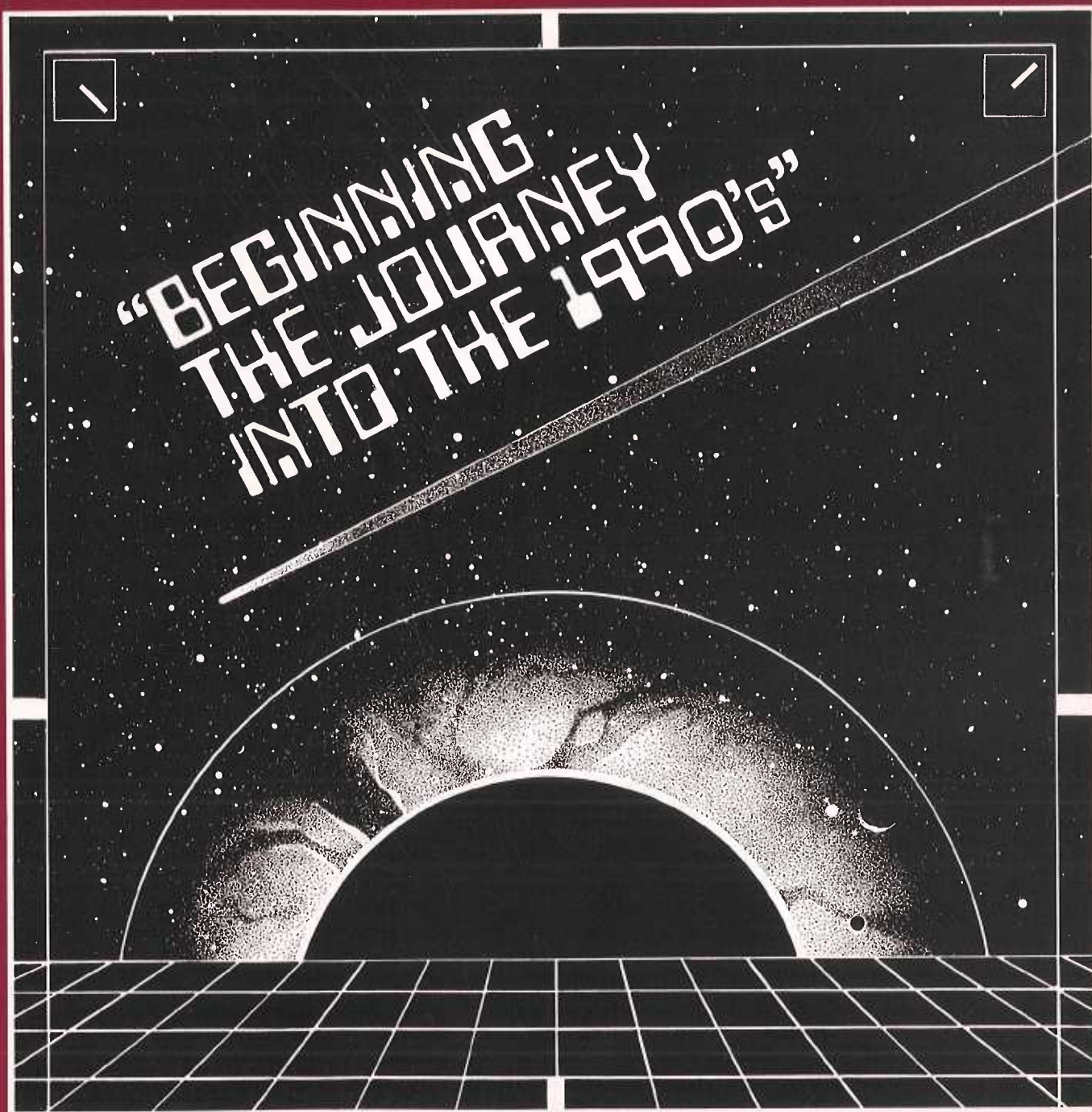
Vol. 16, No. 2 February 1986

the ALMACAN

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



An International Association of Professionals in Employee Assistance Programs



15TH ANNUAL MEETING • 1986 CALL FOR PAPERS

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The Annual Meeting Program Committee met on January 13 to ferret through the myriad of EAP issues for the most pertinent. We direct you, with pen in hand, to turn to our special Call for Papers section. Now is the time to bid for a speaking engagement at ALMACA's 15th Annual Meeting!

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Halley's Comet passes only once in a lifetime, and the untrained eye might miss it. With the theme "Beginning the Journey Into the 1990s," ALMACA's 15th Annual Meeting will be a harbinger for creative, new EAP strategies oriented toward the future, and you won't want to miss it. Our educational component will foster an understanding of the rapidly changing workplace. Get in on the action by responding to our Call for Papers!

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FROM THE EXECUTIVE DIRECTOR

Thomas J. Delaney

When the business news reporters recently compiled their year-end summaries, most emphasized that 1985 will be remembered for the mergers and acquisitions; those that occurred, those that did not, and those that were planned but not yet consummated.

A number of the corporations which merged had EAPs, and the labor, management and contract administrators involved in those programs had to deal with this modern-day industrial fact of life.

MERGERS & ACQUISITIONS

EAP providers themselves are participating in mergers and acquisitions, and it looks like these will be increasingly significant in 1986. They will involve the merging of one or more independent EAP providers, the acquisition of one or more providers by other providers, and the buying out of EAP providers by other companies that previously have not been in the EAP field. One of the more interesting developments involving buy outs relates to insurance companies. For years, many of us in the EAP field have expected property, casualty, liability and health insurance companies to recognize the value of EAPs in reducing their risk. With the need to market their products more aggressively and maintain their competitiveness, as well as discovering that EAPs are an effective loss-control mechanism, some insurance companies are starting or acquiring EAP services.

It is not only the insurance companies which are shopping. In my January, 1985 column, I wrote about the "vertical integration" of EAP, whereby health care providers (such as hospitals) offer EAP services. This phenomenon continues, and hospitals are shopping for EAPs.

The health care industry itself is undergoing tremendous changes (in case you had not noticed). Individual hospitals are being acquired or affiliating

with chains. The chains are experimenting with various components such as providing hospices, acquiring medical schools and creating their own health insurance plans. Adding EAPs fits some of their plans. Of course, if an EAP provider is acquired by a hospital chain (or anyone else, for that matter), there is no guarantee of continued support. As the parent company experiments with how to best compete in the volatile health care industry, the EAP will be subject to further business conditions and corporate politics.

What does this mean for the ALMACA membership? The changes impact the in-house provider as well as the outside agency. As administrator of an in-house program, an ALMACA member may find that a contractor for a subgroup of the company has been acquired by another EAP provider, or by a health care chain. The outside provider may be approached by corporate representatives to discuss a buy out. They may find that one of their clients suddenly owns an EAP provider. They may find that a referral agency has acquired an EAP component.

AGGRESSIVE ADVERTISING

Does this all mean that the smaller, independent EAP provider is going the way of the Dodo Bird? Emphatically not. As we all know, there is plenty of potential need for all. I believe that the aggressive advertising by the alcoholism treatment chains has been a big help to everyone involved in alcoholism treatment, including the small, independent treatment centers, and the alcoholics and their families. By the same token, national and regional advertising by the expanding EAP chains will increase the awareness of labor and management leaders about EAPs, as well as the general public. This will lead to more organizations being interested in developing EAPs.

With the emergence of a wider variety of EAP providers—large and small,

freestanding or affiliate, nationwide or single-community—the in-house coordinator who purchases services is going to have to become a sophisticated shopper. The buyer will have to ask more than how much and how often. The question of what and how will become more important. A variety of EAP contractors means that there is one to meet every organizational need, but the organization has to know what their own needs are.

Evaluation of EAP efforts will help the in-house coordinator determine if the service being purchased continues to meet the needs of the organization. This refers not only to the EAP contractor, providing the service that it is under contract to provide, but to the in-house coordinator, who is aware of his or her organization's changing needs, as well as the responsibility to renegotiate the contract to address those needs.

NEW VS. OLD MODELS

The "pure" OPC consulting model was for an outside expert to come in, assess the EAP needs of an organization, design an EAP program, help implement it, and then quietly pull up stakes to do the same with another work organization. It evolved as many consultants stayed on to administer the EAP on a contractual basis. The setting changed as NIAAA encouraged its comprehensive alcoholism treatment center grantees to do community outreach and education for the industries in their communities. We now have large national contractors, consultants who direct EAPs only, while others provide short-time clinical health services, along with the EAP. My guess is that all the old models will stay, and there will be more new models. That means there is room for all, but not necessarily means that all will survive. Ones that keep an eye on the new developments and decide how to position themselves will, as in most businesses, stand a better chance of survival. □

ONE MEMBER'S VIEW

EAP/Physician Communication: A Problem?

by Linda Hay Crawford, M.Ed.
Administrator, Alcoholism and Drug Abuse Detoxification and Evaluation Program
and William E. Flynn, M.D.
Director, Alcohol and Drug Services
Georgetown Medical Center
Washington, D.C.

In the course of the assessment process, EAP practitioners may on occasion consider contacting their clients' personal physicians. Often, an employee referred to the EAP states that he or she is already undergoing treatment or therapy.



Linda Crawford Why bother contacting the physician at all? As EAP professionals, physicians have information on their patients — our clients — which may be needed for an accurate assessment. Paying a phone call is also common courtesy. Furthermore, it may be necessary to ascertain whether that physician is part of the problem or, otherwise, wants to be of assistance.

Often, it is this mixed agenda which can make such calls awkward and nonproductive. If a client is already in a physician's care, the EAP professional immediately may be suspect of either the patient's genuine participation in that care or the care's effectiveness.

Over the last several months, we have informally taken a survey of EAP practitioners in their approaches to physicians, and their attitudes toward them. Several practitioners no longer bother calling their clients' doctors, or put it off until absolutely necessary. Others report being chastised for

interfering with the patient-physician relationship, or having received complaint letters suggesting they may be practicing medicine without a license.

Most EAP practitioners report mixed results in interfacing with physicians, primarily due to the lack of knowledge by both parties on the other's cultures and roles. It has become clear, however, that with the proliferation and acceptance of EAPs, our impact is reverberating throughout the health care profession. The intervention mechanism whereby EAPs identify faltering workers and motivate them toward treatment in earlier stages of their illnesses poses a challenge to the physician culture and practice.

On June 1 and December 11, 1985, we gathered a circle of individuals in

the D.C. area to discuss these concerns, identify where the specific conflicts lie, and develop interim guidelines for constructive communication. We hope that our suggestions (see box), promote mutual understanding between the EAP and medical professional.

the D.C. area to discuss these concerns, identify where the specific conflicts lie, and develop interim guidelines for constructive communication. We hope that our suggestions (see box), promote mutual understanding between the EAP and medical professional.

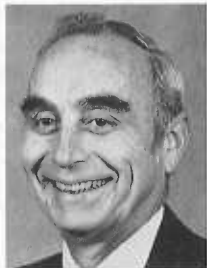
ISSUES OF CONFLICT

The immediate issues which we identified as creating conflict are:

- a lack of knowledge and understanding of each other's cultures or methods of practice.
- the proactive approach of EAPs versus the traditional, nonconfrontive approach by physicians.
- the questioning by physicians of the EAP practitioner's skills and train-

Suggested Guidelines for Communicating with Physicians

1. Avoid being confrontational with physicians. It is EAP's nature and scope of practice to be confrontational. It is not the practice of the physician, who will immediately resist this approach.
2. Present your observations or conclusions as preliminary, allowing the physician to participate in the final conclusions, as opposed to initially confronting him with your final conclusion, which he can only meekly accept or oppose.
3. Make it clear that you are not practicing medicine without a license. Physicians listen for non-physicians to do this and are threatened by someone extending into physician boundaries.
4. While calling a physician, use the experience of your company in dealing with impaired employees and the authority given to the EAP in stating your case.
5. Don't patronize.
6. Recognize the M.D.'s role and try to include him or her in planning.
7. Recognize your client's tendency to split you and the physician, and liability in allowing that to happen.
8. Be cognizant of your own past negative experiences with physicians, and the hostility that may result, so it does not interfere with your objectivity.
9. Give your credentials and experience.
10. Encourage the utilization of other M.D.'s for second medical opinions.
11. Involve your client so that he prepares the physician for your call, and underscore the importance of that call.



William Flynn

ing, especially in regard to alcoholism and drug abuse, and vice versa.

- the problem of EAP practitioners crossing boundaries and practicing medicine without a license. Assessment is often presented as diagnosis to physicians.
- the mixed agenda by EAPs on whom they serve, i.e., the employer as well as the client. Often, if job performance doesn't improve, the employee leaves his employment and the relationship with the EAP practitioner is ended, while a physician serves the patient alone and has responsibility for that individual's long-term care.
- time constraints of EAP professionals to move quickly and effectively toward selecting a specific treatment option, while a physician tends to take more time in pursuing slower, more cautious options.
- the reluctance of physicians to discuss patient care with non-physicians. Many of us have experienced physician refusal to return phone calls. The lack of a collegial attitude by physicians adds to resistance by EAPs to include them.

As difficult as it is sometimes to account for a physician's role in the assessment and subsequent referral of the EAP client, it is a necessary step which in the long run may be most beneficial to the troubled individual. Physicians can reinforce the patient's treatment efforts and provide long-term follow-up.

MESHING OF ROLES

At Georgetown Medical Center, we have the unique ability to foster the meshing of the EAP and physician roles. We serve several EAPs through our services and teach our medical students about EAPs. Through the senior medical student clerkship in psychiatry on the Alcohol and Drug Unit, a student is assigned a patient and an EAP coordinator. Based on the guidelines which have evolved out of

our experience, we believe it is a primary opportunity for EAP professionals and medical students to interface, and we believe the kind of program which must proliferate in order to augment mutual understanding.

A more meticulous review of the physician-EAP relationship is in the best interest of our field. EAP practitioners are different than other health professionals and should strive toward special working accommodations. Our immediate suggestion is to organize workshops and seminars on this topic, involving both EAP and medical organizations. Perhaps ALMACA chapters are an appropriate forum for discussion. We hope you will contact us if you are interested in this issue, and strive for more communication and constructive action. □

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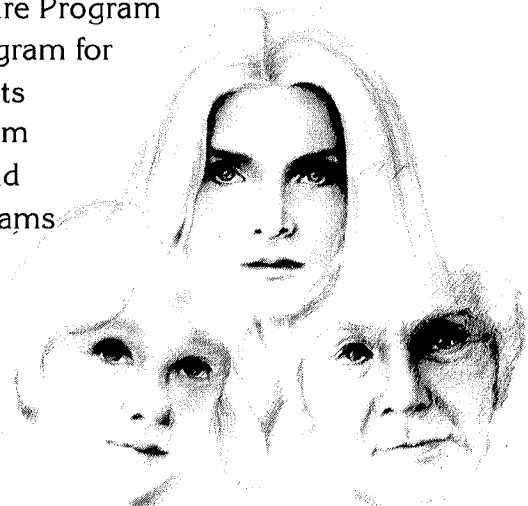
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UPDATE ON CREDENTIALING

Chapter Presidents Respond

by Judi Laws
ALMACA Credentialing Specialist

On the Credentialing Time Line (January *ALMACAN*), Tasks 1-5b have been completed. To summarize, they involved selecting a committee, identifying potential vendors, soliciting chapter president views, and developing an RFP. As we revise the RFP, we are being guided by input from the Ad Hoc Credentialing Committee (see box, next page), and by the responses we received from the chapter presidents on key credentialing issues. (See Table 1)

Since *THE ALMACAN* is the primary medium for the ALMACA Office to disseminate information to each and every member, this month's coverage will report the views of chapter presidents who responded to our query on key credentialing issues. Being on a very tight timetable, we knew that chapter presidents would not have time to present these issues at chapter meetings. Therefore, in order to help us shape the RFP, during late December, Tom Delaney asked chapter presidents for their individual opinions on seven issues. A rating scale appeared at the end of each of the following statements.

1) Levels of Credentialing—The chapter submissions from the credential workshop packets indicated that the majority (14 of 25 chapters) favored one level of credential, initially—that of senior professional. After there has been time to see whether having only one is adequate, consideration may be given to adding other levels. Indicate whether you agree that there should be one initial level of credentialing.

2) Credentialing Specialties—While recognizing the variety of EAP work settings and job requirements, chapter submissions from the credentialing workshop packets favored *one* generic credential, initially (for administrators, consultants, labor, management). It would attest to the fact that credentialed EAPs everywhere possessed the

27 competencies (listed in the October *ALMACAN*) which have been approved by the Board as the basis for the EAP credential. Indicate whether you favor one general EAP credential.

3) Renewal of Credential—In order to insure continuing competence after initial certification, most professions have a requirement for renewal of the credential. Because new knowledge about employee problems and solutions is coming to light every day, it is essential that EAP professionals demonstrate their state-of-the-art competence every two to five years, by meeting some type of renewal requirements, e.g., CEUs, award of academic degree with EAP specialty, reexamination, academic teaching, on-the-job program innovations, etc. Indicate whether you agree that the EAP credential should be periodically renewed.

4) Experience

a. Do you agree that eligibility for a senior EAP credential should require a *minimum* of at least three years of full-time, or six years of half-time work?

b. Must this experience for a senior EAP credential have included *all* 27 of the Board-approved competencies?

c. Would you agree that volunteer activities, internships, and academic

degrees cannot be substituted for some minimal length of experience?

5) Education—There should be *no* academic degree required for credential applicants. However, *some* degrees (to be determined at a later date) may be substituted for *some* but not all of the work experience requirements. Do you agree that there should be no required academic degree at this time?

6) Substitution of Other Professions' Exams—Some certification bodies allow those who have passed written exams in allied professions to be exempt from test-taking. Akin to interstate reciprocity agreements, this would permit, for example, CACs, MDs, ACSWs, etc., to forego sitting the ALMACA exam, *provided* the applicant meets *all* experience and other requirements. Do you agree that ALMACA should explore and consider this kind of substitution for test-taking?

7) Grandfathering—There are several ways of insuring fair treatment of all applicants, while requiring each to take a written exam. One option is to use the grandfathers as the field test participants whereby no pass/fail scores are given; once the test is validated and pass/fail scores set, subsequent applicants must achieve a

CHAPTER PRESIDENTS' RESPONSES

Table 1

Critical Issue	Number of Responses				
	SA	A	N	D	SD
1. One Level	7	14	0	6	3
2. One Credential	6	19	0	2	3
3. Credential Renewal	14	14	0	2	0
4. Experiential Requirements					
a. Three-year minimum	6	19	1	3	1
b. All 27 competencies	4	10	2	13	1
c. No substitutions	5	12	0	10	2
5. Education: No degree	7	15	4	2	2
6. Substitution Examinations	6	8	0	9	7
7. Grandfathering					
a. Some test exemptions	6	20	0	3	1
b. No test exemptions	0	4	0	14	3

SA = Strongly Agree; A = Agree; N = Neutral;
D = Disagree; SD = Strongly Disagree

passing score. Another option is to award a one-year provisional credential to those meeting certain requirements; at some time during that year, the candidate must pass a written exam in order to acquire a full, face-value credential. A third option is to assign a weight of, perhaps, 30% to the written exam, with the other 70% of the credentialing evaluation allocated to such factors as work experience, references, exemplary contributions to the EAP field, etc. Please indicate the degree to which you agree with these two statements.

a. ALMACA should require that every credential applicant take a written exam, provided some exemption option (such as those listed above) be established.

b. ALMACA should require that every credential applicant pass a written exam; no test exemption should be available.

Thirty chapter presidents responded—10 from the Eastern Region, 10 Central, five Southern, and five Western. Aggregate figures on their responses are shown on Table 1.

Board Credentialing Decisions

At the Board of Directors meeting on November 11, ALMACA President Jack Hennessy and Executive Director Tom Delaney were asked to develop two or more credentialing procedures for consideration at the March 25 Board meeting. They were instructed to obtain "appropriate Board participation" in drawing up these proposals. In order to secure wide Board and regional input, Jack exercised the authority that Article VI, Section 3 of the ALMACA Bylaws provides him and appointed an Ad Hoc Credentialing Committee for this purpose. The committee members are:

Gary Atkins (Chairperson), ALMACA Vice President-Operations, Sunnyvale, CA.
Jesse Bernstein, President, Greater Detroit ALMACA Chapter, Ann Arbor, MI.

Tamara Cagney, Chairperson, Program Managers Committee, Oakland, CA.

George Cobbs, Chairperson, Labor Committee, San Francisco, CA.

Terrence Cowan, Chairperson, THE ALMACAN Advisory Committee, Austin, TX.

Richard Groepper, founder of the Georgia ALMACA Chapter, Atlanta, GA.

Edgar Marchesini, Chairperson, Special Projects Committee, New York, NY.

Carol Nigut, representing the Illinois Chapter, Chicago, IL.

Donald Phillips, Chairperson, Education and Training Committee, Washington, D.C.

Riley Regan, Chairperson, Standards Committee, Trenton, NJ.

Peter Schweitzer, President, New York City Chapter, East Elmhurst, NY.

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WOMEN'S ISSUES

Women, Alcohol and the Workplace (Part II)

By Ann D. Clark, Ph.D. and
Stephanie S. Covington, Ph.D.

The first part of this two-part series was published on page 8 of the January *ALMACAN*.

The first article in this series summarized issues and factors contributing to drinking among women in the workplace. Findings based partly on our survey of 100 women confirmed that the workplace contributes to inappropriate drinking patterns in women by creating pressure to drink, providing unhealthy role models, and by either informally sanctioning or simply ignoring such behavior.

But the question remains, "How can this problem be solved?" The previous article outlined the factors, both subtle and obvious, that contribute to problem drinking among working women. This article provides strategies for enhancing the EAP's ability to meet the special needs of female employees.

Because men and women have different life and job experiences, they each demand specially designed intervention programs or efforts to assist them in getting help. Women historically have used health services more than men—not because they are "sicker" or "needier," but because they are more willing to seek help. Therefore, it is ap-

propriate for the EAP to reach out to women employees.

To begin with, it is important to be aware of the attitudes of the employer and the EAP coordinator toward working women. Too often, because women are overrepresented in low-skill, low-pay jobs, employers feel it is easier to replace them than to help them. Certainly, society's double-standard toward women's alcohol and drug usage filters into the workplace. This results not only in a more negative attitude toward their drinking, but nonsupport when help or treatment is sought. To work at optimum level, an effective EAP coordinator must be sensitive to and knowledgeable about the special needs of women.

PREVENTION

The EAP can foster a culture of "options"—clear messages that drinking is *never* required in any social working situation. Prevention efforts can be greatly enhanced by gaining the support of top management and labor organizations. A corporate image that connotes sobriety as the norm and respected in the work environment can be promoted through policy statements that discourage drinking by supervisory personnel during lunch hours or at company-sponsored events.

IDENTIFICATION

The EAP can develop early identification programs to help supervisors and employees detect the onset and progression of alcoholism and other forms of chemical dependency in women. Often the symptoms described or the problems presented by women disguise the real issue of chemical dependency. For example, an addiction problem may manifest itself as absenteeism, depression or physical illness. The EAP must be alert to the fact that the job performance model, which is a primary assessment tool, may not be an accurate indicator for women. Since many women, more often than men, are overskilled for the jobs they hold, it is possible for them to work at less than peak performance due to an addiction problem and still meet the job's performance criteria.

Further, the role of the male supervisor in overprotecting the female employee has been well documented. The EAP can educate supervisors to use intervention to assist—not conceal.

EDUCATION AND REFERRAL

The EAP needs to provide educational and outreach programs and materials specifically designed for women. Examples include a series of

Firsthand Comments on Alcoholism and Work

Perhaps the best description of the relationship between alcohol and work is presented in these statements by working women:

"It's hard to juggle everything. I come home, throw a load of laundry in while the kids are helping get their own dinner. I'm going to school part-time and my ex-husband isn't much help. I don't have any family to help. I feel so alone and tired, and it just helps sometimes to sit down with a couple of glasses of wine and forget it all."

"I think having a drink is okay to unwind after work, although it isn't always easy to stop after one. A lot of times how much I drink depends on job stress and on whether someone else is drinking with me. Alcoholism does run in my family and that does worry me sometimes. I like to go out after work with other people. Sometimes that has gotten me into trouble."

"I don't think I have a problem, but sometimes I wonder. I know I'm not as sharp at work sometimes as I should be. Other times I'd like to ask someone about it, but no one seems to talk about drinking—except the guys that brag. I mean, women . . . they don't seem to discuss it. But I think it's beginning to be a problem for me."

appeals to women who are at risk of alcohol problems, publications showing positive images of women and using female subjects and pronouns, and publicity of resources specifically geared to women's needs.

In addition, women often are reluctant to confide in male counselors. Consequently, a program that effectively meets women's needs should make female counseling staff available at both the intervention and treatment stages. Each EAP should develop a network of well-established referrals for female clients.

Educational programs could include general information on chemical dependency—i.e., stages, symptoms and recent research on genetic predisposition. Special emphasis should be placed on the interactive effects of alcohol on other problems that affect women. Four significant areas of concern are stress, physiologically related factors such as PMS, depression and eating disorders.

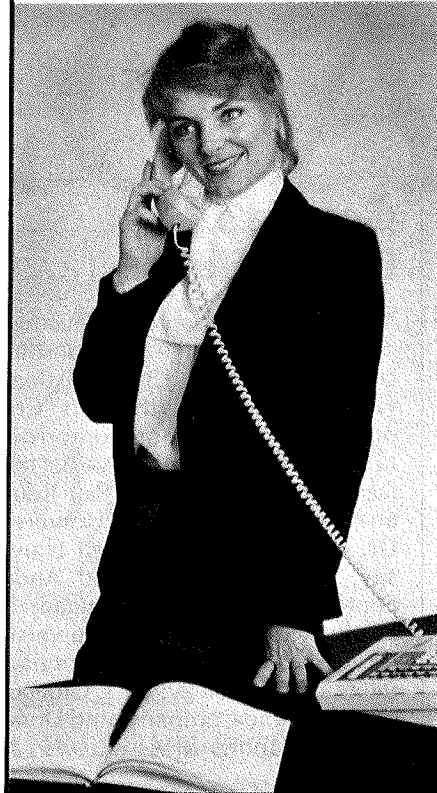
The EAP can expand education to include stress reduction programs emphasizing alternative ways of coping with pressure. Ultimately, however, employers will need to alleviate the sources of stress in the workplace by providing more frequent and equitable employment opportunities for women.

RESEARCH

More research and data collection by EAPs, training institutions and health professionals are needed. Such data include not only information on drinking patterns of women, but on such correlated concerns as the impact of stress, family problems and working conditions. Certainly the efficacy of intervention strategies and prevention programs must be further evaluated.

By educating themselves and focusing on the special needs of women, EAPs can become responsive to women's lives—a tool that women can use in healing themselves. □

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REGIONS AND CHAPTERS

Western New England Symposium

"Networking for People and Profit," the theme of the fourth annual Western New England ALMACA Symposium will be held on April 16 at the Sheraton Inn in West Springfield, Massachusetts.

Five workshops are planned for attendees and include: Establishing an EAP: How it Works; EAPs: Who Makes Up the Network?; Labor/Management Working Together, or Do They?; Employee Alcoholism: The Total Picture; and Confidentiality & Legal Issues.

For further information contact: Collette J. Ross, 47 Mayfair Street, E. Longmeadow, MA 01028, (413) 525-4655.

Metrolina Training Seminar

The seventh annual Metrolina ALMACA Training Seminar will be held March 20-21 at the University of North Carolina at Charlotte College of Business Administration. The theme will be "1986: Preparation for Credentialing."

ALMACA Credentialing Specialist Judi Laws will be featured at the banquet and discuss recent credentialing developments, and the plenary session will feature syndicated cartoonist Doug Marlette of the *Charlotte Observer*, whose speech is titled "Cartooning! Unmodifiable Behavior." Seminar speakers will include: Alisse C. Camazine, Attorney, Clayton, MO; Jim Roth, President, Behavioral-Medical Resources, Inc., Tempe, AZ; Bette Ann Weinstein, President, Motivational Programs and Training, Bethesda, MD; Don Phillips, President, COPE, Inc., Washington, D.C.

For more information contact: Karen P. Harkey, Metrolina EAP, Conference Publicity Chairperson, 100 Billingsley Rd., Charlotte, NC 28211; (704) 376-7465.

Georgia's 11th EAP Institute

The Georgia Chapter is once again cosponsoring the EAP Institute, scheduled for May 18-23 in Atlanta, Georgia. This year's theme is "Competency: Training for Tomorrow." Included on the impressive list of 29 faculty members are: Drs. Paul Roman and Terry Blum, Tulane University; Dr. Harrison Trice, Cornell University; Drs. John Erfurt and Andrea Foote, University of Michigan; Dr. Bradley Googins, Boston University; Dr. C. Howard Grimes, Georgia Institute of Technology; Dick Groepper, Crawford and Company; and Donald Sandin, Sandin & Associates, and others.

A report of last year's conference was published on page 27 of the July 1985 *ALMACAN*. For more information on the 1986 program contact: Dept. of Continuing Education-R, Georgia Institute of Technology, Atlanta, GA 30332-0385; (404) 894-2400.

New Chapter Officers

NORTH TEXAS CHAPTER

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Vice President, **Mary Hubbard**, APFA, Euless

Secretary, **Johnie Qualls**, City of Dallas, Dallas

Treasurer, **Wright L. Carlisle**, Atchison, Topeka & Santa Fe Railroad, Fort Worth

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CENTRAL AND WESTERN NEW YORK CHAPTER

President, **Joe DiMaria**, Employee Health Referral Systems, Rochester

Vice President, **Kay Johnson**, EAP of Rochester, Rochester
Secretary/Treasurer, **Bob Conway**, Conway Associates, Inc., Rochester

HURON VALLEY (MICHIGAN) CHAPTER

Vice President, **Keith Bruhnsen**, University of Michigan, Ann Arbor

Secretary, **Kathy Klykylo**, Personal Performance Consultants, Southfield
Bruhnsen and Klykylo are filling vacancies on the chapter executive committee.

COLUMBIA RIVER CHAPTER

President, **Gregory Lee**, St. Vincent Hospital, Portland, OR

Vice President, **Michael Dinius**, Health Systems Services, Vancouver, WA

Secretary, **Lynn McClenahan**, Consultant, Portland, OR

Treasurer, **Ray McDonald**, CH₂M Hill, Portland, OR

HUDSON VALLEY CHAPTER

President, **Marcia E. Nagle**, Longview Associates, Inc., Mt. Kisco, NY

Vice President, **Edward King**, King Consultants, Inc., Greenwich, CT

Secretary, **William E. Kirtsos**, Westchester/Putnam Counties EAP Consortium, White Plains, NY

Treasurer, **William O'Brien**, White Plains, NY

1986 Regional Conferences

Central Region—Columbus, OH, May 5-6.

Eastern Region—Buffalo, NY, June 8-11. Contact: Ed Carter at (716) 885-0701.

Western Region—San Diego, CA, March 26-28. Contact: Sharon Rhodes at (619) 571-1698.

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Special Projects Committee Report on Treatment-Based EAPs

by Edgar P. Marchesini, Chairperson

Early last year, the Executive Committee asked the Chairperson of the Special Projects Committee to conduct a study of hospital-based EAPs to identify the scope of their roles, activities and services, and to determine their impact on consulting services and in-house EAPs.

The Executive Committee was concerned because there had been several heated exchanges published in *THE ALMACAN* (September 1984, December 1984, February 1985) between private consultants and treatment representatives concerning conflict of interest. Some consultants felt that a conflict situation existed when hospital-based EAPs referred their clients' employees and dependents to their own treatment facilities.

The implication was that patients would be referred primarily to inpatient treatment when other less-costly options might be more beneficial to their needs.

Treatment advocates responded indignantly to these allegations. One respondent stated that the focus of the Special Project Committee's study was all wrong, "that it implied that the link between health care providers and EAPs is a real blight that threatens to destroy the EAP field itself." They vehemently denied any conflict of interest, pointing out that as professionals their referrals were made on the basis of patients' needs. They also reminded the committee that a conflict of interest also exists whenever an EAP administrator (work-based or treatment-based) or consultant makes a referral which is not in the best interest of the patient.

Also, several respondents informed the Special Projects Committee that the focus on hospital-based EAPs was too narrow, that we should also include other treatment entities such as community mental health centers, family service agencies, private therapy groups, drug and alcoholism clinics, and individuals in private clinical practice. The committee accepted this suggestion and decided to include these additions under the caption of treatment-based or hospital-based EAPs.

Following an evaluation of the early opinions and comments, the Special Projects Committee decided to broaden the study to include the roles, activities and services of private consultants and work-based EAPs. From an ethical point of view, this approach seemed more equitable than singling out one group (treatment-based EAPs) for scrutiny.

In order to obtain some "feel" of the ethical aspects of the issues, the Special Projects Committee carefully prepared several essay-type questions which were sent to key people in ALMACA to get their views. These included: Members of the Board; Consultants-Private and Government; Treatment and Work-Based EAP Administrators; Chapters (contacted by Regional Vice-Presidents); NIAAA; and Hospital management corporation executives

I wish I could say that the number of replies we received was overwhelming, but that would be an exaggeration. The overall response, although statistically small, was large enough to identify the positions of the various groups on the issues.

ESSAY QUESTION RESPONSES

In the following section, I will analyze and summarize the responses to the essay questions and comment, when appropriate, on minority replies that I feel deserve consideration.

Does a conflict of interest exist when an EAP administrator or counselor receives payment or other consideration for referring employees to specific treatment facilities?

There was unanimous agreement that if such payments were blatantly "kickbacks" that they were unethical, and should be referred to the Ethics Committee for appropriate action.

Another common area of agreement was that all referrals should be determined on the basis of what is in the best interest of the patient.

With regard to conflict of interest, the majority opinion was that it is unethical to receive such payment. However, a

few respondents commented that it is acceptable if all parties involved were aware and did not object to the remuneration plan.

The primary concern of industry people was that even the most ethical individuals could be tempted to prioritize referrals when a personal reward was involved. The extreme viewpoint was that payments of any kind were unethical and unprofessional.

Do you feel that private consultants should receive payment or other consideration for referring clients' employees exclusively to hospitals or freestanding facilities they represent contractually?

The majority opinion was the same as the first question. In other words, a conflict of interest exists whenever the remuneration supercedes the needs of the patient.

In a few cases, consultants indicated that they avoided any taint of self-interest by referring clients' employees to treatment facilities other than those they represented.

Does a conflict of interest exist when a hospital offers EAP services free to corporate, union and government organizations for the purpose of obtaining their treatment referrals?

The majority opinion was that it was appropriate for hospitals to offer EAP services as long as the purpose was not primarily to fill beds. Respondents recognized that it was traditional for hospitals and health care organizations to offer public education in all areas of health care and maintenance.

A smaller group indicated that the potential for conflict of interest exists whenever EAP services are provided, regardless of the provider's affiliation. The resolution suggested was to judge each case by its adherence to predetermined assessment and referral criteria. I am sure that this suggestion was well-intended; however, realistically, I don't see how such a monitoring system could be implemented.

Can an EAP offer treatment to employees and, if so, under what circumstances?

Most respondents did not feel that EAPs should offer treatment. The consensus was that the main focus of an EAP is on assessment, referral and short-term counseling, as long as the staff is professionally qualified to handle it. In addition, it was felt that an effective EAP should also provide supervisory training and employee education to raise the level of awareness about behavioral-medical and related problems.

The majority defined short-term counseling as six (6) sessions

SPECIAL PROJECTS COMMITTEE MEMBERS—Edgar Marchesini (Chairperson), Manager, Employee Advisory Services, Metropolitan Insurance, New York, NY; Michael J. O'Brien, Director, Longview Associates, Inc., White Plains, NY; and Thomas P. O'Connor, Administrator, Rehabilitation Services, Boston Edison Company, Boston, MA.

"It was generally accepted that hospitals could offer EAP services to corporate and government organizations."

or less. All agreed that long-term counseling is a treatment function. Some cautioned against short-term counseling/therapy, because they felt it could lead to a closed system that would seriously limit the patient's freedom of choice of other treatment modalities. Despite these reservations, it seemed to be generally accepted that a substantial number of EAPs offered some degree of treatment. This applies to those operated by consultants as well as work-based in-house and treatment-based programs.

Would you prefer EAPs to be work-based, i.e., in-house programs or programs managed by private consultants?

Treatment and work-based EAP personnel differed on which system is best. A few misunderstood the question interpreting it to mean that we were comparing the merits of in-house company programs vs. programs administered by private consultants.

Consultants and corporate/union EAP administrators favored work-based programs, because they felt that treatment-based programs triggered ethical questions concerning conflict of interest. Treatment-based EAP administrators and health providers stated that the answer was to choose a program that best met the needs of the target employee population.

If you answered yes to the previous question, then what, in your opinion, is the main focus of an EAP?

This question was largely covered above. Most respondents agreed that the main focus of an EAP is the assessment and referral functions.

A few mentioned that containing health care costs and monitoring the quality of medical care were also important functions of EAP administrators.

Under what circumstances can a hospital-based EAP offer EAP services to corporate and government organizations?

As indicated in the third question, it was generally accepted that hospitals could offer EAP services to these organizations. However, there were conditions laid down by some respondents, such as:

1. the provision that they furnish the government or corporation with a monthly statistical report detailing where employees were referred for medical treatment.
2. only if there are no work-based EAPs or consortiums available to employees in the area.
3. the EAP must be separated from the treatment component of the hospital so that it can make independent deci-

sions about referrals.

4. operation under the same circumstances as a private consultant—a contractual agreement between two parties.
5. as long as there is no requirement, stated or implicit, to use the treatment center's resources, and the EAP is staffed by competent EAP personnel, it can offer these services.

In which of the following problem areas should a "broad-brush" EAP furnish assessment and referral assistance: Alcoholism; Drug Abuse; Emotional and Mental; Stress Management; Retirement Planning; Health and Fitness; Cardiovascular Risk Reduction; Blood Pressure Control; Smoking Cessation; and Accident Prevention.

There were two extreme groups which responded. One, representing occupational alcoholism and drug abuse, generally favored concentrating on the first four items. The other, largely representing newer EAPs and health care providers supported including most items under the EAP umbrella.

Despite these strong opinions, I think we all recognize that the scope of our programs is not decided by us. It is usually made by top union and corporate management jointly in labor-mgt., EAPs, and by the CEOs in management programs. The best we can do is to influence that decision by establishing credibility within the organization.

Is there any danger that new health care delivery systems (HMOs and PPOs, etc.) which are becoming increasingly popular with cost-conscious business and industry, will replace EAPs?

The majority did not feel that these new health care delivery systems would replace EAPs. However, they did feel that they would have an impact on EAPs because:

1. EAP personnel will have to know more about these systems, especially with regard to cost savings and quality of care.
2. with the rapid growth of HMOs and PPOs, EAPs certainly face the possibility of becoming a service offered by these new systems.
3. as these new health care delivery systems proliferate, the EAP administrator's role will become more proactive and preventative rather than reactive, as it has been in the past. S/he will have to develop closer relationships with these forms of health care that stress primary prevention.

The minority opinion was that there was no danger at all, because EAPs are not part of the health care delivery opinion. One comment was that "you are comparing apples and oranges." A final comment was "if it happens, it's our own fault."

SUMMARY

Generally, respondents felt that payments or other considerations for referrals were unethical. Some scrupulous consultants and treatment-based EAP administrators insisted

"There was a sharp difference of opinion about the problem areas that should be serviced by an EAP."

that, as a matter of conscience, they did not ever make referrals to treatment facilities they represented contractually.

All participants in the study (consultants, corporate and union EAP personnel, treatment providers) agreed that patients should only be referred to health care resources that best met their needs. They were opposed to any system or procedure which precluded other treatment alternatives, i.e., closed systems.

There was also unanimous agreement on the purpose and major functions of an EAP. They all agreed that an EAP should not provide long-term therapy, but could offer short-term counseling/therapy if the staff was professionally qualified to furnish this service. There was a sharp difference of opinion about the problem areas that should be serviced by an EAP, and the majority did not feel that the new health care delivery systems posed a threat to EAPs.

This study has taught us that internal conflicts can be counter-productive and divisive, if they are not settled quickly. ALMACA can remedy this situation by providing a forum where such issues can be fully discussed, where everyone concerned can express her/his opinion, and where the resolution of problems can be reached in an atmosphere of fairness and reason.

In this study, the original focus was on conflict of interest. Upon further examination, the Special Projects Committee learned that it was a broader issue that concerned all segments of the membership. We learned, too, that in any profession or association, there will be unpleasant situations where individuals violate ethical rules, and that these individuals can be from any special interest group (consultants, EAP personnel, treatment professionals, etc.).

After carefully considering the facts, the committee feels that ALMACA's Code of Ethics adequately covers these situations (see Code items 3, 4, 9 and 11), and recommends that the *Procedures For Review of Member Conduct* be utilized in those cases where members are in violation of ALMACA's Bylaws and Code of Ethics. To further emphasize the importance of professional conduct, we suggest that the ALMACA application and renewal forms include a consent provision to be signed by applicants. This addition will simply state that s/he consents to be bound by ALMACA's Code of Ethics.

In closing, the Committee would like to state that the members of ALMACA are decent, hardworking practitioners who are dedicated to helping people in a humane and unselfish manner. They understand the value of integrity and the need for ethical standards in our profession. We feel certain that they will accept the committee's recommendation as a further endorsement of ALMACA's Code of Ethics. □

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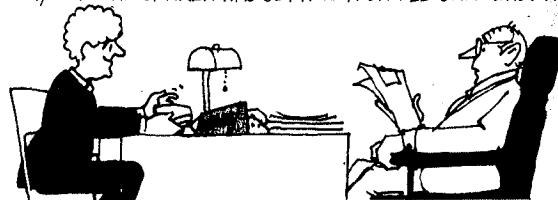
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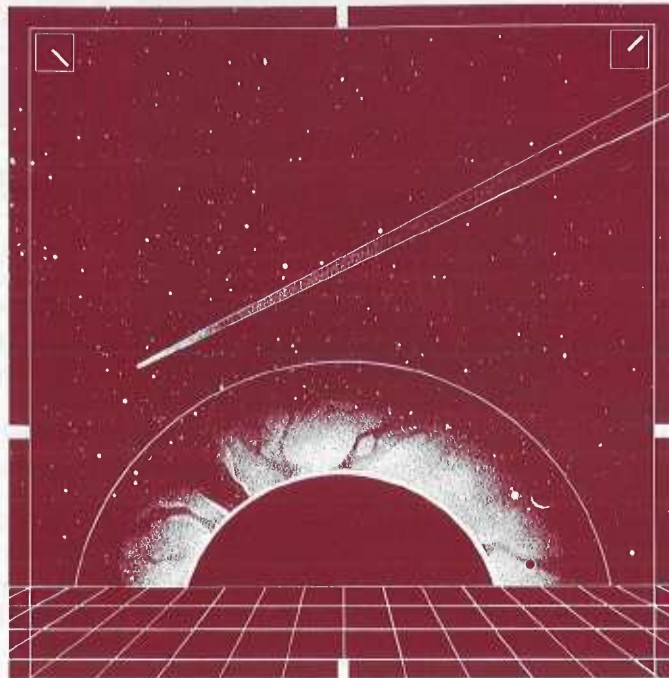
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ANNUAL
MEETING



1986
CALL FOR
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“BEGINNING THE JOURNEY INTO THE 1990s”

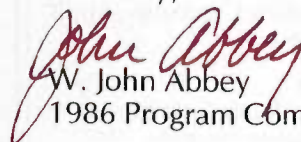
Dear fellow ALMACANs:

Much has changed in the EAP field over the years. For the past several decades we have, and continue to, revolutionize the workplace. Although occupational alcoholism remains central to the EAP concept, our field has grown in ways that demand new perspectives if we are to continue to meet the needs of labor and management, employee and union member.

The 1986 Program Committee has decided to begin the journey into the 1990s and beyond by taking a hard look at the obstacles and concerns in the delivery of EAP services in today's world of shrinking resources, conflicting demands, and need for greater understanding of the human condition in the workplace.

We hope that ALMACA's Annual Meetings will continue to be *the* forum for professional development of EAPs. Let us not be caught "sitting on our hands," but rather join in creating an exciting and stimulating program that will serve in continuing to revolutionize the workplace.

Sincerely,



W. John Abbey
1986 Program Committee Chair

15TH ANNUAL MEETING

15th ALMACA Annual Meeting

Hyatt Regency Dallas
Dallas, Texas
November 2-November 6, 1986

Submission deadline for Abstracts

April 4, 1986

Mail to: Judith O. Evans
ALMACA, Inc.
1800 N. Kent Street
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Arlington, VA 22209

Submission of Abstracts (175-200 words)

Each workshop is followed by a series of statements or questions which were designed to help you arrive at a decision about the content of your proposed presentation. In your submission you should attempt, if possible, to explicitly describe how your presentation would address these statements or questions.

Please indicate for which workshop your abstract is being submitted by entering the workshop letter and number in the space provided. If it is not included, your abstract will be returned for the additional information.

The submission package *must include* the following:

- twenty-five (25) copies of the abstract using the form provided on page 20.
- two (2) copies of the vitae of the author and presenter (if different), including current and other significant employment, academic institutions attended, degrees received, and papers presented or published. This information is required in the awarding of CEUs.

Review of Abstracts

In reviewing all submissions, the Program Committee will give first



consideration to those abstracts which most closely respond to the suggested workshop content.

In addition, the Committee will attempt to limit the total number of presenters in each workshop to three. This will provide participants with the opportunity to seek answers to the questions raised from the presentations. Abstract submissions should be written on the premise that each speaker will have the floor for no more than 30 minutes.

Special Note

If your abstract is accepted for presentation, you will be requested to provide printed material, a minimum of 150 copies, for distribution to workshop participants.

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1986 CALL FOR PAPERS

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TRACK A NEW EAP PERSPECTIVES

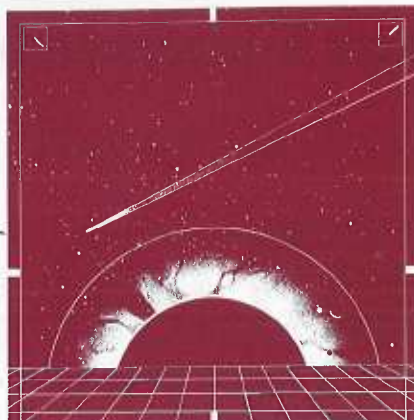
WORKSHOP A-1 Choosing and Monitoring EAP Vendors

- what does the company need?
- what are they?
- how do you find them?
- picking a vendor
- what do they sell?
- negotiating the contract
- monitoring the contractor

WORKSHOP A-2 Changing Roles of Internal EAPs

- from direct service to contract
- combining internal and external EAP services
- who manages the program?
- defining the limits
- EAPs and the 80s
- changing corporate attitudes
- the organization as a client

15TH ANNUAL MEETING



1986 CALL FOR PAPERS

WORKSHOP A-3 Wellness, Health Promotion and Counseling; What Happened to Job Performance?

- protecting the performance model
- all things to all people?
- what happened to alcoholism?
- obtaining visibility
- do EAPs provide therapy?
- what is motivational counseling?

TRACK B LEGAL

WORKSHOP B-1 Malpractice/Confidentiality/ Legal Liability

- pros and cons of malpractice insurance
- confidentiality for the EAP practitioner
- legal liability at the workplace
- EAP confidentiality and the supervisor
- how confidential are EAPs?
- confidentiality and ethics

WORKSHOP B-2 Arbitration/Litigation

- update on current legal trends
- arbitration and EAPs
- arbitration: labor vs. management
- arbitration/litigation: what has changed?
- EAPs and the legal department; friends or foes?

WORKSHOP B-3 Drug Screening/Fitness for Duty

- drug screening and the EAPs
- preemployment drug screening
- drug screening for cause
- random drug testing
- drug screening: friend or foe in the EAP?

- what is determining fitness for duty?
- the EAP and fitness for duty
- fitness for duty: safety vs. confidentiality
- legal issues raised by drug and alcohol abuse in the workplace

TRACK C ORGANIZATIONAL SURVIVAL

WORKSHOP C-1 Organizational Dynamics and the EAP

- internal networking/consultation
- the corporate culture—games our parents never taught us
- managing change in the organization

WORKSHOP C-2 Joint Labor-Management Programs: Is There a Future?

- have unions been sold down the river?
- who has controlling interest?
- how have they changed?
- are they a benefit?
- trends in labor-management programs

WORKSHOP C-3 Marketing Internal or External EAPs to the Employee and Employer

- how to develop an EAP marketing plan
- how to implement and maintain an EAP

- revitalizing the EAP
- identifying the key organizational components
- selling the reluctant employer
- marketing as a continuous activity
- training for the trainers

TRACK D CURRENT ISSUES

WORKSHOP D-1 Ethical Dilemmas

- conflict of interest
- organizational demands creating conflict
- organizational reinterpretation of the EAP role
- should we sell them what they need or what they want?
- what is the cost of a free lunch?
- paper programs
- pricing

WORKSHOP D-2 Health Care Benefits

- HMOs
- PPOs
- DRGs
- pre-admission certification
- gatekeeping
- concurrent review
- making the system meet EAP needs
- health care benefits—cost-containment strategies
- the EAP & health care benefits—the future

WORKSHOP D-3 AIDS

- company policies/procedures
- myths and fears in the workplace
- understanding AIDS in the workplace
- AIDS resources
- safety and confidentiality issues
- testing for AIDS

ABSTRACT SUBMISSION FORM

This is the *author's* form. It must be filled out completely and returned to ALMACA.

Abstract submitted for workshop (letter and number): _____

Author/s (List principal author first): _____

Workshop Presenter/s (List job title, company or affiliation, address and phone number): _____

Permission to publish (signature): _____

I will _____ will not _____ be providing printed material for distribution to workshop participants.

Abstract (175-200 word minimum)

(Continue on another sheet of paper, if necessary)

Helping the Recovering Cocaine Addict with Job Reentry

by Dr. Larry Kroll

By admitting that he was addicted to cocaine and entering treatment, John R., a semiskilled worker in the automotive industry, took a giant step toward recovery. Upon graduation from the program, though, John faced a challenge just as formidable—staying clean after job reentry.

Upon returning to work, many recovering addicts face continuous reminders of their cocaine use and the likelihood of pressure from cocaine buddies they work with to use again. This precarious situation requires considerable attention, skill and cooperation by employers, EAPs, treatment programs, and in many cases such as John's, unions.

Cocaine use is a prevalent workplace problem, whether it involves recreational use by assembly-line workers or business executives who "snort a line" to close a business deal. Regular users now constitute 1% of the workforce. Resultant problems appear most frequently in young adults (18-25) and mid-adults (26-34)¹, traditionally America's most productive workers. The 1985 University of Michigan Survey of U.S. high school seniors shows significant increases in usage, suggesting more prevalent use by the next generation



ABOUT THE AUTHOR—Dr. Larry Kroll is clinical director of the Lifeline program at the Louis A. Weiss Memorial Hospital in Chicago, Illinois. He has treated substance abuse patients for 15 years and was active in developing the certification program for Drug Abuse Counselors for the State of Illinois.

"Reentry can be smoothed by encouraging (an addicted employee) to hook up with another recovering worker."

of workers. Researchers say this rate of use will increase substantially in coming years; in 1976, 10% of high school seniors reported trying cocaine, but a follow-up questionnaire found that nearly 40% had tried it by age 27.²

PROGRESSIVE COCAINE USE

An examination of the progressive nature of cocaine use and addiction, and how a worker's reentry into the workplace is handled, holds valuable insights for employers victimized by cocaine abuse. Many users are introduced to cocaine over an afterwork beer with friends. A pusher will often use the persuasive argument that, "It gives you a nice high, you can't get addicted to it, and you can even drink more with it." Typically, new users will socialize more with other users, and may be lined up with a dealer within a short period of time.

Returning to our case study, the progression of cocaine use and addiction frequently occurs like this. After a few nice highs in his early progression with cocaine, John R. became aware of fellow users in his plant. He sought them out at work and at parties, and within six months of first ex-

perimentation, was integrated into a network of users at his plant. The group was a loose coalition, united by the added thrill of clandestine meetings.

In the next six months, John found the thrill was turning to desperation, although he denied it. He could no longer afford his \$300 per week—and growing—habit on his wages, and his credit rating had bottomed out. (The average cocaine habit is reportedly \$33,000 per year.³)

After increases in productivity during the first few months of on-the-job use, his job output declined. spurts of frenetic activity led to mistakes and production losses. Angry outbursts stunned coworkers and resulted in his first confrontation with his supervisor. Physically, John had become gaunt, his eyes were ringed with fatigue, and his complexion was pasty.

John was also developing a new behavior pattern—he was frequently tardy or absent on the day after payday. He would binge after cashing his check, snorting coke continuously for 12 or more hours, and then crash in exhaustion.

His erratic attendance and continued errors on the production line led to another confrontation with his supervisor. In this case, the benefit of an EAP referral led to proper treatment for his addiction, although a parallel situation in another plant might have resulted in termination.

FOLLOW-UP AFTER TREATMENT

Proper assessment and referral by the EAP practitioner is tantamount to the first step of recovery. However, regular follow-up after job reentry is vital, because pressure exerted

“... there is more fiction than fact in cocaine's association with economic success.”

on the worker to use cocaine again is likely to be strong. It is helpful to ask him the following questions:

- Are you going to feel pressure from coworkers when you return to work?
- Are you going to feel like an outcast? (Many addicts are eager to please others and find it difficult to resist becoming part of the cocaine “clique” again.)
- Is there any way we can help you with other job-related stress?

His answers can alert the EAP professional to possible pitfalls.

Reentry can be smoothed by encouraging him to hook up with another recovering person at work. The support gained by taking coffee or lunch breaks with someone who has “been there” is invaluable. An EAP practitioner should encourage him to attend self-help groups at the company and assist his supervisor in accommodating this activity in his regular schedule.

To help him avoid contact with his old drug-using clique, it may be necessary to change shifts or departments—a move that requires cooperation between the union and management, when applicable, so that the action adheres to organizational guidelines. He may require special exemption from union rules.

NCDAI Publications on Cocaine and Other Drug Abuse

The following are materials available through the National Clearinghouse for Drug Abuse Information

PREVENTION/EDUCATION MATERIALS

General Information

Cocaine Addiction—It Costs Too Much
Drug Information Flyer Series: Cocaine

SCIENTIFIC/TECHNICAL MATERIALS

Research Issues Series

Issue 7, Drugs and Addict Lifestyles
Issue 29, Drugs and the Family

Research Monograph Series

Monograph 25, Behavioral Analysis and Treatment of Substance Abuse
Monograph 35, Demographic Trends and Drug Abuse, 1980-1995

Monograph 50, Cocaine: Pharmacology, Effects, and Treatment of Abuse

Monograph 61, Cocaine Use in America: Epidemiologic and Clinical Perspectives

Special Reports

Developing an Occupational Drug Abuse Program
Employer's Guide to the Employment of Former Drug and Alcohol Abusers

Highlights from the National Survey on Drug Abuse, 1982

Inhalant Use and Treatment

WHERE TO WRITE

Single copies of these publications are available at no cost and may be obtained by writing to:

NCDAI, P.O. Box 416

Kensington, Maryland 20795

Allow three to four weeks for delivery.