

MANAGED MENTAL HEALTH CARE

ADMINISTRATIVE
AND
CLINICAL ISSUES

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Employee Assistance Programs

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Employee Assistance Programs (EAPs) were introduced in the 1940s at Kemper Insurance, Eastman Kodak, and the DuPont Corporation. These programs were initiated not by the companies themselves, but through the efforts of employees who were recovering from alcoholism. These employees went to upper-level management stating that if their supervisors had confronted their job performance problems earlier and had been less understanding about their "problem," they could have broken the denial of their illness earlier, thereby saving the companies thousands of dollars in lost productivity as well as improving the employees' health and happiness. These employees asked to be able to start programs to help their fellow workers whom they knew had similar problems. The rationale for having the program in the workplace was based on the recovered workers' claim that the threat of losing their jobs was leverage to motivate alcoholic patients who had jobs into accepting treatment (Masi 1982).

These early programs were called Occupational Alcoholism (OA) programs and dealt strictly with the alcoholic employee. In that model, supervisors were trained to look for symptoms of alcoholism and to confront the employee with those symptoms. The employee was then expected to see an alcoholism counselor (a recovering alcoholic) within the company for treatment of this addiction or run the risk of losing his or her job.

Such programs continued, but they were not developed to a great extent until the passage of the Hughes Act (Public Law 91-616 1970).

Senator Harold Hughes, a recovering alcoholic, testified in the U.S. Senate on behalf of separate legislation for alcoholism. The Hughes Act mandated the establishment of the National Institute on Alcoholism and Alcohol Abuse (NIAAA) as separate from the National Institute of Mental Health (NIMH). This Act also mandated the establishment of an Occupational Branch for the NIAAA that granted funds to each state to hire two Occupational Program Consultants (OPCs). These consultants developed programs in the private and public sectors (Masi 1982).

The Hughes Act also mandated the development of programs for the prevention, treatment, and rehabilitation of federal employees with alcohol and drug problems. (One of us [D. A. Masi] was privileged to direct the model Employee Counseling Services [ECS] for the federal government in the office of the Secretary of the U.S. Department of Health and Human Services from 1979 to 1984.)

Another major development occurred in 1971, when a group of individuals in the field came together in Los Angeles to develop an organization called the Association of Labor-Management Administrators and Consultants on Alcoholism (ALMACA). It was developed as a nonprofit international organization of practitioners involved in occupational alcoholism programming and employee assistance programming. This organization continues to serve as the professional body for the OA/EAP practitioner (Masi 1984); in 1989, it changed its name to Employee Assistance Program Association (EAPA).

Other legislative action serving to promote awareness of the need for OA/EAPs was the Rehabilitation Act of 1973 (Office of Personnel Management 1979). Section 504 guarantees the rights of handicapped people. The implications for the workplace are that employers must offer reasonable accommodation to employees with handicapping conditions. The U.S. Attorney General has defined alcoholism and drug addiction as handicapping conditions (National Institute on Alcohol Abuse and Alcoholism 1976).

Meanwhile, changes began to occur in the area of occupational programs as practitioners began to report that programs that included other types of employee problems, as well as alcoholism, were more effective and tended to avoid the stigma associated with OA programs. Also, it was becoming harder to justify turning away employees who needed assistance in other areas besides alcoholism. The evolution of this new, broader model was the birth of the Employee Assistance Program (EAP).

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The EAP's scope included other problem areas such as marriage, emotional, and financial problems. It also had a focus on a supervisory referral to the program based on observation of poor job performance rather than on a diagnosis of alcoholism. Because it usually utilized untrained staff members who were recovering from alcoholism, the OA model often referred employees out for treatment of problems other than alcoholism. Today, however, this practice is changing with the influx of mental health professionals into the EAP field. Most EAP programs currently are operated by outside contractors and offer members 6 to 8 counseling sessions by mental health professionals.

EAPs as "Managed Systems"

In recent years, "quality of work life" has become a term used to describe values some believe have long been pushed aside by industrial societies. These values relate to the quality of human experience in the world of work. Structures for new benefits have developed to ensure and promote this quality of life. At the same time, there is considerable concern about the ways and means of increasing industrial productivity in the face of international competition and the increased shortage of skilled, educated workers.

Currently these dual concerns are converging and focusing attention on the relationship between quality of work life and productivity. EAPs have been developed in acknowledgment of that relationship. The employee assistance movement addresses the interconnections between work problems and personal/family life conflicts and the resulting effects of stress and strain on workplace productivity.

The OA/EAP saved the company money, because employees whose alcoholism went untreated used up leave and health benefits and had more frequent accidents. This was a unique benefit of the EAPs, which made them distinct from traditional counseling services. In recent years, EAPs have operated from a systems perspective and have evolved to assess and modify more broadly "troubled" behaviors. Although problems are now addressed more holistically, the basic emphasis remains on improving work performance and lowering the costs associated with workers' problems.

Program components and procedures vary, depending on whether the program is developed by the company staff in the medical or human resources department or by outside contractors. EAP models

have developed to meet the growing needs of a wide variety of companies. The major program types are the in-house model, the out-of-house model, the consortium model, and the affiliate model.

- ◆ *In-house model.* In this model the entire assistance staff is employed by the company. The company directly supervises the program's personnel, sets policies, and designs all procedures. It could be housed physically in the company or located in offices away from the company.
- ◆ *Out-of-house model.* In this model the company contracts with a vendor to provide an employee assistance staff and services. This model usually provides 8 counseling sessions to an employee. The company sets and agrees to specific policies and procedures for the EAP contract that the vendor must follow. The vendor might provide services in its offices, the company's offices, or a combination of both. One pattern that has emerged with this model is that there are fewer referrals to community providers for treatment and counseling.
- ◆ *Consortium model.* In this model several companies pool their resources to develop a collaborative program at one location to maximize individual resources. Generally, this model works best for companies with fewer than 2,000 employees. Services are shared and provided in one central office, although separate supervisor training programs can be offered.
- ◆ *Affiliate model.* In this model a contracted EAP vendor subcontracts with a local professional when there is neither sufficient clientele nor employees to warrant hiring full-time staff. The vendor can then reach employees in a company location in which the vendor might not have an office. Usually this model is used in conjunction with one that involves paid staff (Masi and Friedland 1988).

Today most EAPs are staffed with social workers or individuals with master's-level education and training. Psychologists with doctorates, for the most part, make up the affiliate/subcontractor group. Future directions show this continuing, with more emphasis on hiring licensed clinicians. Internal programs are often staffed by employees who are recovering from alcoholism, some of whom have gone back to school and obtained graduate degrees. However, the self-identified alcoholic individual in the EAP field is less visible as the mental health professionals in EAPs increase in number.

Ingredients of Effective EAPs

EAPs should include the following ingredients to be effective:

1. A policy statement that includes the purpose of the program;
2. Organizational and legal mandates;
3. The roles and responsibilities of various personnel, especially managers, in the organization and procedures;
4. Staffing with mental health professionals who have at least 2 years' training and experience in treatment of alcoholism and addiction;
5. Confidential record-keeping in accordance with federal alcohol and drug regulations issued in 1987 by the U.S. Department of Health and Human Services;
6. Union support;
7. Supervisory training in problem identification and proper referral techniques;
8. Employee outreach and education; and
9. Sensitivity to special populations in the work force.

Criteria used to measure the success of outcomes vary considerably, and few rigid scientific studies support many of the claims of EAPs. There is considerable concern in the employee assistance field that as staffing patterns change to include more licensed professionals and fewer recovering employees, less attention is being paid to treatment of addictions. A relationship appears to exist between contracted programs (employing fewer recovering staff) and a lower number of alcohol and drug cases treated by the EAP.

EAPs have traditionally been confined to providing information and assessing performance problems of employees and referring them to appropriate community resources for treatment. Many EAPs are now able to offer their own short-term treatment/counseling sessions, because they have added professional staff who can provide the same services as referral agencies. EAPs reduce a company's health benefit utilization by providing counseling services in a contained environment. The provision of such counseling services made it a natural development for EAPs to move into providing managed mental health care.

EAPs and HMOs

Most American corporations offer health maintenance organizations (HMOs) as part of their benefit plan. HMOs and EAPs are similar in that they are both funded through a prepaid per capita system rather than a fee-for-service system. They both attempt to manage care so as to contain costs and use limited resources to provide care to a population. To do this, they usually use a specified panel of providers, and specified referral sources, which act as gatekeepers to mental health and substance abuse services. Both types of organizations train and supervise their staffs and have standards for clinician performance and quality of care.

However, there are several important differences between EAPs and HMOs:

- ◆ HMOs offer medical as well as mental health and substance abuse services. This means that HMOs can offer more comprehensive treatment of serious mental illnesses and provide coordination between medical, psychiatric, and addictions care (to provide alcohol detoxification, for instance). EAPs offer a variety of social and vocational services (child care, elder care) that are less focused exclusively on health.
- ◆ HMOs are insurance companies as well as service providers. This means that the HMO is financially at risk for *all* health services needed by its members. The EAP is responsible only to provide those services specified in its contract or scope of operations. This means that if an HMO clinician decides that a patient needs hospital care, day treatment, or continued counseling, the HMO must cover the costs within its benefit package, even if it does not directly provide these services.
- ◆ HMOs provide mental health or substance abuse care to patients referred by themselves or their primary physicians. This care is totally separate from the work environment. Clients of EAPs are often referred by their supervisors, and care is provided in the context of the work environment. This means there are different guidelines for confidentiality in the two systems, and different ways in which work and work performance are included and used in counseling.
- ◆ HMO service is provided in a medical or clinic setting. EAP service is provided on-site in the workplace, or as close to it as possible. It

is most often under the auspices of the personnel department, rather than a medical department.

- ◆ HMOs are usually available to families of subscribing members. Many EAPs are not available to family members.
- ◆ HMOs and EAPs have different historic traditions. Although both arose from the efforts of organized labor, HMOs were traditionally medical institutions, employing professional clinical staff. EAPs were begun by recovering employees who were not professionally trained.

These differences may lead to clashes in the two systems when it becomes necessary for them to work together. Because HMOs are increasingly prevalent as a dominant form of employee health insurance, an EAP is often faced with a referral to an HMO for hospital services or continued counseling.

When working with an HMO member, the EAP counselors must approach the work much differently than with a privately insured employee. With a privately insured employee, the EAP counselor is the sole decision maker regarding disposition of the patient's case. If the counselor decides to admit the patient to a hospital, he or she also decides which hospital to admit to (traditionally, a fixed length-of-stay 28-day program). The aftercare is also provided, post-hospitalization, by the EAP counselor.

When working with an HMO member, the EAP counselor usually has to call the primary care provider for a mental health referral so he or she can speak to a substance abuse counselor regarding the case. The HMO counselor would then ask to do his or her own evaluation. This is often seen as a delay tactic by the EAP counselor. Even if the HMO counselor did not need to do a face-to-face evaluation and did an immediate phone screening, the two clinicians might disagree on disposition of the patient's case (i.e., need for hospitalization). The EAP counselor might see this as a denial of substance abuse services and would react accordingly, whereas the HMO counselor might believe that reaction to be inappropriate and intrusive.

Even when there is agreement to hospitalize a patient, there can be disagreement over which treatment facility to use and for how long. Once the patient is in treatment, neither clinician would believe there was a collaborative effort.

There are several reasons why this HMO/EAP interface is difficult to maintain.

1. *Clash in gatekeeping role.* Because both the EAP and the HMO clinicians believe their job is to make the appropriate clinical match between a patient's/employee's needs and available resources, there are two people doing the same job. The EAP clinician sees no need for the HMO clinician's evaluation, because he or she has already completed that piece of work. Meanwhile, the HMO clinician wonders why the EAP clinician is asking for a particular treatment, because the evaluation has not yet been done.
2. *Clash in preferred providers.* EAP counselors often wish to refer patients to the inpatient substance abuse programs with which they are most familiar. Because EAPs do not have to cover the costs of such programs, they sometimes prefer traditional 28-day programs. Although EAP counselors do not have contracts with these facilities, this resource network represents *their* preferred providers. The HMOs usually use short-term inpatient detoxification programs, or outpatient detoxification, as well as rehabilitation programs with shorter lengths of stay. These represent their preferred providers. They usually have contracts with each and work closely with in-house utilization review programs. Often preferred providers of an EAP and an HMO are mutually exclusive.
3. *Lack of communication.* Because EAPs and HMOs are different systems, with differing costs, traditions, and objectives, it is often difficult for clinicians in these systems to collaborate in treatment planning. There is limited literature on efforts by EAPs and HMOs to grapple with these problems and work together (Fallon and Lenney 1987; Lee 1988).

The Harvard Community Health Plan, a Boston-based staff model HMO, recently conducted a 6-month pilot project with an EAP for a large municipal employer. During these 6 months, the 5 senior EAP counselors could admit patients directly to the HMO's contracted short-term, in-hospital detoxification unit without prior approval by the HMO. The EAP counselors would be able to phone the unit, 24 hours a day, 7 days a week, and if the unit staff thought it was appropriate, the member would be immediately accepted for admission. The HMO also brought in a clinical liaison to work with the hospital staff and meet every one of the members admitted through this system. Once stabilized, the patient would meet with the liaison to determine any additional treatment. Admission criteria were written up and agreed on by the HMO and the EAP.

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Through follow-up phone conversations, the EAP counselors reported being greatly relieved at the ease they had in admitting the HMO members for in-hospital treatment. They were now allowed to act as gatekeeper for urgent substance abuse cases and referred appropriate patients. During the 6 months, the program generated 13 admissions, which represents about 5% of the year's detoxification admissions. It is difficult to determine how many of these patients would have been admitted if prior approval had been required, but it is clear that the admissions represented some additional cost to the HMO.

However, at 3- and 6-month review meetings, the atmosphere between EAP and HMO was totally changed. There was a sense of collaboration that never before existed. For the first time, the HMO and the EAP counselors thought they had worked together to accomplish a difficult goal.

Problems between the EAP and the HMO still remain, but because the project was so successful, the HMO developed a 24-hour telecommunications system that connects *all* their employer groups to an immediate phone screening service.

EAPs and Health Promotion

Some EAPs market health promotion activities. This must be considered carefully, because there is a real difference between health promotion and counseling assistance for employees with problems. Though they are not contradictory systems, the expertise each needs is not the same. An example is the U.S. Department of Health and Human Services, which placed health promotion and education in the Office of Public Health and its EAP in the Office of Personnel. Table 20-1 may simplify the differences between the two (Behrens 1983).

Utilization of EAPs

It is estimated that 18% of the members of any work force are affected by personal problems that can affect job performance. Of the entire work force, 12% have alcohol- and drug-related problems, and 6% have emotional problems.

The numbers of employees seen in the EAP are generally expressed in terms of a penetration rate that is a measure of the extent to which a program is reaching its target employee population. It is

Table 20-1. Distinctions between Health Promotion Programs and Employee Assistance Programs

<u>Health Promotion Programs</u>	<u>Employee Assistance Programs</u>
Strictly voluntary.	Uses coercion and threat of job loss as stimuli for seeking assistance.
Deals with healthy employees.	Deals with employees with personal problems.
Aimed at all employees and often deals with employees in groups.	Focuses on individual employees.
Concentrates on all types of health education, along with other life-style topics.	Involved with diagnosis and treatment of alcohol- and drug-addicted employees.

derived by dividing the number of employees seen by the total employee population. A typical penetration rate for the first year of an EAP is between 4% and 6%, which is expected to stay approximately the same from year to year, as long as it is a new 4% to 6% of the employee population that is being reached. Statistically, the demographic proportions existing in the company population at large should be reflected in the demographics of the EAP clientele. The philosophy of the EAP is to try to reach all groups in the company's work force. In fact, employee outreach and education is aggressively performed by EAP staff.

Executives are often underrepresented in these statistics. Minorities and women may also be over- or underrepresented in program statistics. If an EAP is not representative of the employee population at large, charges of singling out employee groups may be made, which greatly undermines a program.

Future Trends and Issues

Certain major trends, both in the organization of employee assistance services and in the larger social and economic picture, have implications for the future of EAPs.

There are four factors that will have a direct impact on EAPs as they continue to prosper:

1. The role of EAPs in managed mental health;
2. The focus on drug abuse in the workplace;

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3. The increasing number of persons with or affected by AIDS; and
4. The need for quality management by objective third parties.

At one end of the managed mental health continuum, EAPs are becoming the HMOs of mental health services. Increasingly, companies request that an EAP provide up to eight counseling sessions for an employee. As a result, the EAP is able to facilitate problem resolution without referring the client. Thus the client avoids use of health care benefits while receiving *bona fide* professional assistance.

However, if the EAP emphasizes short-term general mental health services, it may dilute its mandate of reaching the addicted employee.

Both public- and private-sector employers are seeking to combat drug abuse in the workplace. Drug testing is currently receiving the most attention. The American Management Association in its research report *Drug Abuse: The Workplace Issues* (1987) stated, "There has been a rapid increase in the number of companies testing [for drugs], and the trend will continue. . . . EAPs will be increasingly called upon for assistance as companies attempt to develop policies on drug testing and related issues" (p. 10).

EAPs may also contribute to an emphasis on rehabilitation in combating drug abuse (Masi 1987). This is evidenced in the Federal Executive Order of September 15, 1986, "The Drug Free Federal Workplace," which states, "Agencies shall initiate action to discipline any employee who is found to use illegal drugs, provided that such action is not required for an employee who . . . obtains counseling or rehabilitation through an employee assistance program" (p. 176).

Increasingly, employers are having to address the issue of AIDS in the workplace. The EAP could take the lead in assisting companies to address this highly sensitive issue by providing a number of services. For example, short-term EAP counseling can be made available to employees who are HIV positive. EAP intervention in the workplace would include ongoing education on AIDS, supportive counseling to co-workers and supervisors of persons with AIDS or who are HIV positive, and facilitating implementation of the company's policy on AIDS. Education on AIDS will be the key means of intervention, and the EAP should not wait to begin this effort only after an employee who is HIV positive or who has AIDS is identified within a company. Education efforts may include counseling family, friends, and co-workers in how to better understand the employee's needs and how to cope with the problems presented by the disease on a day-to-day basis. An-

other large group of employees whom the EAP could assist would be those who have family members or significant others with AIDS or who are HIV positive (Masi and Montgomery 1987).

As programs develop over time, a critical need will be for evaluation by objective third parties. Knowing that at this time there is no regulatory body for EAPs, company attorneys are asking that there be some built-in protection for the companies they represent. Third-party clinical evaluation will be necessary to protect both client and company. Companies are being asked to justify the cost of programs. Thus, the trend toward evaluating from a cost-effective dimension will also grow.

References

- American Management Association: Drug Abuse: The Workplace Issues. New York, AMACOM, 1987
- Behrens R: The distinction between health promotion programs and employee assistance programs. Lecture to DHHS EAP Administrators in Employee Counseling Service Units Directors at a workshop, Washington, DC, February 14, 1983
- The Drug Free Federal Workplace. Washington, DC, Federal Executive Order, September 15, 1986
- Fallon AB, Lenney JR: EAPs and HMOs: the genesis of a new partnership. EAP Digest 7(4):29-32, 1987
- Lee FC: EAPs and managed care: a blurring of the line. EAP Digest 8(5):20, 1988
- Masi DA: Human Services in Industry. Lexington, MA, Lexington Books, 1982, pp 74-75
- Masi DA: Designing Employee Assistance Programs. New York, AMACOM, 1984, p 14
- Masi DA: The Drug-Free Workplace. Washington, DC, Bureau of National Affairs, 1987
- Masi DA, Friedland SJ: EAP actions and options. Personnel Journal, June 1988, pp 63-64
- Masi DA, Montgomery P: Future directions for EAPs. ALMACAN 17(3):20-21, 1987
- National Institute on Alcohol Abuse and Alcoholism: Rights of alcoholics under federal law: advisory memorandum from the Ad Hoc Forum on Occupational Alcoholism convened by the Occupational Branch of NIAAA. Washington, DC, National Institutes of Health, Fall 1976, p 3

Office of Personnel Management: Handbook of selected placement of persons with physical and mental handicaps in federal and civil service employment (Document 125-11-3). Washington, DC, U.S. Government Printing Office, March 1979

Public Law 91-616 (42 U.S.C. 4582): Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970, 3 August 1970

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