MARCH/APRIL 1999 • VOLUME 29 • NO. 2 • WWW.EAP-ASSOCIATION.COM

EAP ASSOCIATION

Exchange

The Magazine of the Employee Assistance Professionals Association

Providing EAP Services

A Menu Of Choices

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Suitable for Large Groups

External:
Off-Site Delivery Available

Internal/External Combination:
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Providing Professional Intervention

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Sharing Costs & Benefits

INSIDE: 1999 EAPA AWARDS/NOMINATIONS CRITERIA

SEE PAGES 16 & 43

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About the Author

Sandra Nye received her JD from De Paul University College of Law in 1982 and her MSW from Loyola University School of Social Work in 1974. Ms. Nye is principal of the Chicago law firm of Nye and Associates, Ltd., concentrating in law related to human service delivery and family law. She is author of three editions of the *Employee Assistance Law Answer Book,* and of numerous articles and chapters on legal issues in human service delivery.

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Front Desk

This month's issue was coordinated by EAPA Exchange *Advisory Committee Chair John Maynard*

Join the Team!

As the newly appointed chair of the *EAPA Exchange* Advisory Committee, I want to thank those EAPA members who have provided such able guidance and leadership to our magazine in the past. The *Exchange* carries valuable—often vital—information to our members, and it plays an important role in reminding us of our roots, while introducing us to new ideas and challenges.

The Advisory Committee sets the editorial tone and direction for the *Exchange*. I expect it to be a lively, hard-working, and rewarding committee. I invite those members who would like to be part of this group during the next two years, as well as those who have ideas for articles, issues to cover, etc., to contact me by e-mail at johnmaynard@midlife-mastery.com or by phone at 303-444-6300.

Now, a look at this issue. In the past several years, we have produced much information on the ways that EAPs are serving their clients. In this issue, we take a look at current methods of delivering EAP services. Internal, external, combined internal/external, peer-based — each was selected to meet the specific needs of the work force and the work organization.

Turn to page 8 for "Providing EAP Services: A Menu of Choices" and read a series of articles from EAPA members who describe why and how their organizations have chosen specific EAP delivery systems. Also in this issue are the results of a survey performed by our own Internal EAP Managers Committee.

The second part of an excerpt from *The Employee Assistance Handbook*, edited by EAPA member James M. Oher, starts on page 20. The article was written by Drs. Jeffrey Kahn and Seth Aidinoff and gives a comprehensive outline of mental health issues to consider when assessing a client.

Thank you to EAPA member Ken Collins for his new column, "Constructive Confrontation," which will examine how new EAP design and service ideas fit or conflict with the field's long-established principles and practices, such as the EAP core technology. We welcome your feedback on this new column or any other article or feature of the *Exchange*.

Sincerely,

John Maynard

John Maynard, Ph.D., CEAP
Chair, *EAPA Exchange* Advisory Committee

Coming in the next issue:

Acquisition/Mergers & Organizational Change

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President's Page

What They Don't Know Can Hurt Us

by Gregory P. DeLapp, CEAP

GREGORY DELAPP, CEAP
EAPA President

In the life history of any given business entity or group, there are projects undertaken with real enthusiasm, and which hold great promise for understanding, direction, and accomplishment. We all have shelves full of such completed project reports. EAPA is no different.

One such EAPA project and completed report is known as the "LaScola Study," which EAPA funded to explore how EAPs are understood and viewed from the perspective of key labor and management decision makers. These are the decision makers who have authority over employee assistance programs, not those who work directly in the EAP. It is, in its most basic form, a survey of the customer and/or purchaser of the EAP service.

While we gave tremendous thanks to the EAPA members who dedicated their time and effort to complete this undertaking, and to WellPoint Health Networks and WellPoint Behavioral Health for their financial support of this project, whatever came of all this effort and financial backing? A dusty cover on a lonely shelf?

The other day, I dusted off the cover and re-read the LaScola Study (it was a slow day at work). By the close of page one, I had recalled that the study provided considerable insight regarding the factors considered when establishing an EAP, the perception of EAP contributions to business objectives, future directions for EAPs from the decision maker's perspective, thoughts on managing/evaluating EAPs, and the general perception of EA professionals and EAPA as an information resource organization. The LaScola Study is so full of information that it makes for compelling reading. How could *this* report get dusty?

The previous fate of the LaScola Study is symptomatic of approaches we have taken over the years at EAPA: not using the valuable information we already have in our possession, and not dealing with the reality of our marketplace. Let me explain.

If we're not understood on the workplace level, then we're not understood as a profession. Again, not good.

The LaScola Study confirmed that EAPs are entrenched in the American workplace (the study did not venture into issues of an international scope), and that both labor and management view EAPs as practical and appreciated. The responding decision makers also confirmed that they do not pay very close attention to their EAP, nor do they have a real deep understanding of it. That's a problem in my book. By extension, the survey respondents viewed EAPA as an unknown entity.

The LaScola Study gives EAPA an impetus for developing our marketing strategy. Our first challenge will be to address the fact that EAPs are highly thought of but not understood. Lack of understanding could prove to be fatal to an EAP, as some of members will attest. The study also noted that EAPs are considered inexpensive. This is good. The term "inexpensive" is relative, however, to the current business conditions (and expenses) of the survey respondents. This is not good.

If the decision makers and purchasers of employee assistance services don't understand EAPs, there is a risk that these same people won't understand the inherent problems when an EAP service is configured to be overtly clinical, primarily work-life oriented, or any number of hybrids. If we're not understood on the workplace level, then we're not understood as a profession. Again, not good.

The response to these dilemmas, as historic EAPA activity would indicate, is to talk about how awful this is, to blame each other for allowing the dilemma to develop, and to attack our own members who look, sound, or are representative of the EAP hybrids in question. Why do we do this to

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The *EAP Association Exchange* (ISSN 1085-0856) is published bimonthly for $20 per year (from the $115 membership fee) by the Employee Assistance Professionals Association, 2101 Wilson Boulevard, Suite 500, Arlington, VA 22201-3062. Postage for periodicals is paid at Arlington, VA and other offices. POSTMASTER: Send address changes to the *EAP Association Exchange*, 2101 Wilson Boulevard, Arlington, VA 22201-3062.

From the COO

Members Respond to Needs Assessment

by Sylvia Straub, Chief Operating Officer

SYLVIA STRAUB
Chief Operating Officer

Nearly 27 percent of U.S.-based EAPA members responded to the first biannual Needs Assessment Survey that was mailed in January. Early results indicate that 75 percent of members are satisfied or very satisfied with EAPA, and some 86 percent indicate that they intend to renew their memberships. A full report of survey findings and winners of the drawings will be published with the May/June issue of the *EAPA Exchange*. Canadian and International region members will be surveyed in the near future.

EAPA's Invite Is High

A number of organizations have contacted EAPA to indicate their desire to work with the Association on a number of issues:

- The North American Partnership for Responsible Hospitality invited us to a local meeting where they provided information about employee assistance and introduced EAPA to issues affecting restaurants, hotels, and other groups in the hospitality industry.
- The President's Committee on Employment of People with Disabilities has invited EAPA to its meetings. Chair of the committee is former U.S. Senator Tony Coelho.
- The American Psychological Association invited EAPA to a conference entitled "Work, Stress, and Health '99: Organization of Work in a Global Economy." The conference was held March 11-13 in Baltimore, MD.
- The National Education Association's division of Healthy Professionals and Quality Performance wants to work with EAPA to get the word out to its members that EAPs are an important resource in dealing with stress, a problem that seriously affects a large portion of U.S. teachers.
- The Society for Human Resource Management has contacted EAPA to identify speakers for its annual conference.
- The Office of National Drug Control Policy invited EAPA to a series of meetings, one of which included a coalition of organizations, to determine how we might work together to bring information and education about drug abuse prevention to parents in the workplace.
- Sheila Macdonald and I have been meeting with staff of the U.S. Chamber of Commerce to develop plans for providing EAP and drug-free workplace programs to a greater number of small businesses.

On the Road Again

EAPA's traveling exhibit booth is on the road again this spring. EAPA will exhibit at the National Managed Health Care Congress in Atlanta this March. In April, the booth travels to New Orleans for the 1999 Academy of Occupational Health Conference. EAPA's exhibit program, which is funded by Eli Lilly Company, has reached thousands of mental health and human resources professionals who might not otherwise have learned about employee assistance. EAPA's booth has one panel devoted to the Employee Telephone Assistance Program (ETAP), which screens for depression and now alcoholism. It's important to know that ETAP is not a telephone EAP; rather, it is a screening tool intended to encourage those who may have these problems to seek help from an EAP.

Technology, Technology, Technology

EAPA President Greg DeLapp has spoken frequently about the importance of technology in our personal and professional lives. EAPA is currently updating its database system so that we will be able to record and retrieve information from integrated files. The system has a number of new features that our present system does not have, including the ability to handle inventories, and speaker and exhibit information for our annual conference. This project is being managed by Finance Department Director Sheree Clayton-Thomas; she is assisted by George Figliozzi, who is executive assistant to me and the Board, manager of information and office systems, and Web master. George has reported that EAPA's Web site (www.eap-association.com) receives more than 250,000 hits each month from more than 5,000 distinct visitors. His work for EAPA's Web site includes development of "authenticated pages" (a members-only section), chat rooms, and much more. Stay tuned.

Committees Are an Association's Mainstay

EAPA has some 29 committees on the books as well as task forces that work

on specific issues and then disband when their work is done. These committees and task forces are essential in providing the Board of Directors with well-reasoned recommendations on a variety of professional issues and frequently with products that address some of these issues. The committee chairs and members are sometimes unsung heroes who do yeomen's (and women's) work for the Association. I'd like to extend my thanks and that of the staff to committee chairs and members for the splendid work they do. I also invite you to check out the Web site for the list of EAPA committees and chairs. Most members have e-mail, and perhaps they would like to send a word of appreciation to these chairs and their committee members.

A Sincere Apology

The staff and I are mortified when mistakes are made, and I'd like to publicly apologize to the EAPA UAW members for omitting their union's name in the list of sponsors that appeared in the January/February 1999 *EAPA Exchange*. The UAW, teaming with Ford, GM, and Chrysler Daimler, have been generous and frequent sponsors of EAPA's annual conferences. The good news is that this gives me the chance to reiterate how much we appreciate their support of EAPA!

Finally... my own professional association, the American Society of Association Executives, published information on EAPA and employee assistance in the February 1999 issue of its magazine, *Association Management*. The information was part of a larger article on benefits that are important to employees in the association world.

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President's Page

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ourselves? Why are we not capitalizing on the strengths we have? Why are we not promoting our value to the marketplace? Why are we not demonstrating the utility and value we can bring to bear to the challenges of today's workplace?

We can begin by actively working with groups such as the U.S. Chamber of Commerce who want EAPA to assist them in reaching the vast array of small employers they represent all over the USA.

We can begin by actively pursuing promising relationships with the Office of National Drug Control Policy, the Society for Human Resource Management and other associations, a variety of substance abuse coalitions, Eli Lilly and Company, Pfizer, ALCOA, and other employers willing to work with us to promote mutual interests.

We can begin by acting on the promise of development in the international arena.

We can begin by working with labor to align EA service with the emerging trends in employee needs.

And, clearly, it is time to openly and directly work with the managed behavioral healthcare industry and the emerging work/life industry on mutual interests, of which there are many. The days of dealing with these two groups like pit bulls *is over*. We will never be understood and properly valued by key labor and management decision makers if our efforts are constantly directed at what we are not, rather than promoting what we are and how we can contribute to the challenges of today's workplace. We can't do that if our energy, resources, and membership talents are expended on pointing blame and wallowing in the "ain't it awfuls."

EAPA members are being boxed out of service contracts and employment. While there are natural shifts in workplace environments that may contribute to that reality, it is unconscionable to think that we have done this to ourselves, too.

In response, there are many initiatives by your Board of Directors to be more inclusive, to reach out to the many communities we interact with, to get us a seat at the workplace decision making table, and to hear from you directly. We have tremendous talent within our ranks. We have good information available to us. We have employer and labor entities interested in EAPA. We have other associations ready to work with us. The question is are we ready to step up to the challenge of really defining our role? Are we ready to be understood?

The dusty cover on the LaScola Study has been lifted. Membership survey information is rolling in. The talents of many, many members have been positioned to move EAPA forward. I'm ready to use the information we have to go after the reality of our marketplace. How about you?

Gregory Delapp can be reached at gdelapp@cartech.com.

EAP ASSOCIATION **Exchange**

1999 EDITORIAL CALENDAR

May/June	Acquisitions/Mergers & Organizational Change
July/August	Policy Violations and Grievances: How to Handle Workplace Offenders
September/October	Public Policy Issues for EAPs (Annual Conference Issue)
November/December	A Look at EAPs within Managed Care Organizations

Providing EAP Services

A Menu of Choices

With each issue, the EAPA Exchange strives to keep EAPA members informed of the many ways that employee assistance programs are serving the needs of diverse clients. In this issue, we give you a brief look at the types of EAPs various companies have implemented. Internal, external, internal/external, member assistance programs, peer assistance programs, EAP combined with work-family program—each model was selected to serve the special needs of the work force.

Internal EAPs allow EA professionals to interact with employees and management on a regular basis. External EAPs are generally less involved with the daily corporate bureaucracy. Combined internal/external EAPs are the growing trend for large companies with staff in multi-state locations. Member assistance programs are a vital part of a healthy labor organization. Peer assistance programs make seeking help easier for those who discuss their EAP issues with colleagues from their profession. Combined EAP/work-family programs want to provide one-stop service to employees with multiple needs. All are examples of how today's work world is making employee assistance available.

The following information is based on interviews conducted by Kay Springer, EAPA Exchange *editor.*

Conoco

Internal EAP

For many years, Conoco, a Texas-based oil company with approximately 15,000 employees worldwide (8,000 based in the U.S.), had only one person on staff providing EAP-related services to employees. Then, from 1987 to 1988, employee mental health and substance abuse expenses increased by 14 percent. In January 1990, Conoco introduced an internal EAP, and charged the staff with managing the escalating mental health expenses. The internal EAP is available to all U.S.-based employees and expatriates. Conoco also provides external EAP services to employees and their families living in the United Kingdom, Venezuela, Canada, Asia, and Trinidad. In the near future, the company expects to make employee assistance available worldwide to all of their employees.

Why did Conoco choose an internal EAP? According to Dixie Wilson, senior staff consultant, "The biggest benefit of an internal EAP is the opportunity to interact with employees and management on a regular basis. We can attend meetings, work on committees, and talk informally. This allows our staff to develop trust and strong working relationships with our business partners and has strengthened our position as consultants to the organization. In addition, an internal EAP is more responsive to the organization's safety needs, including workplace accidents, injuries, threats of violence, and critical incidents."

In a recent interview, Wilson explained that they developed a standard assessment-referral-follow-up EAP model, with a primary focus on overseeing use of the company's managed care benefits. "Our policy has been to expand treatment options and to offer alternatives to in-patient care," she said. We provide limited management of outpatient cases because they have already chosen a cost-effective approach. We focus our energies on the long-term and more difficult cases."

Conoco's introduction of an internal EAP has brought the employees and the employer many benefits. "Our internal surveys show that the employees are pleased with our services," said Wilson. "In the first year of operation, we reduced mental health costs by $3 million dollars. Over a period of six years, we have reduced costs by $19 million."

Wilson also noted that overall utilization of Conoco's entire medical system has decreased by 59 percent since the EAP was introduced. "We like to think we contributed to that success as well," she said.

* If your EAP model is not described here, please consider describing it in a future article for the *EAPA Exchange.* Contact the editor at 703-522-6272, ext. 308.

Wilson pointed out that a company needs a minimum of 3,000 employees before an internal EAP could become cost-effective. She also noted there are two areas to manage carefully to ensure the internal EAP's viability. "Because the counselors are employees of the company," she said, "it is imperative to ensure confidentiality." If the employees view EAP as too closely aligned with management, they may not trust the program. In addition, it is important to carefully manage the boundaries with other groups, such as human resources and organizational development staff, to prevent turf issues."

Wilson pointed out that Conoco's internal EAP has created many valuable organizational linkages, especially with middle management. These linkages, in addition to the cost benefits, have made an internal EAP an excellent choice for Conoco.

Employee Counseling of Indiana

External EAP

by Phil Hess, CEAP

Though it started as a hospital-based EAP, Employee Counseling of Indiana became a separate, for-profit external EAP in 1978. Today, we serve a wide variety of clients, such as school employees, factory workers, local newspaper staff, hospital workers, municipal bus system employees—everyone from entry-level blue collar workers to top-level management executives.

My earlier career as an internal EA professional gave me first-hand experience with the constant uphill battle to obtain sufficient resources for an EAP. Through my contacts in ALMACA/EAPA, I joined forces with another external provider to develop this external EAP.

There are many pluses and minuses to any EAP model a company selects, but I believe some of biggest benefits to the external model are maximum independence and minimum bureaucracy. While working closely with diverse client populations, we can make decisions quickly regarding access to EAP appointments, consultation, crisis intervention, training, and organizational development activities. We have an excellent affiliate network of seasoned and multidisciplinary professionals with whom we coordinate and provide EAP services to companies throughout the country.

Depending on the size and scope of the organization we serve, we align our services with staff in human resources, risk management, safety, security, collective bargaining, labor/employee relations, management, and medical departments. If we do not reach at least one department representative within the entire organization, we feel we are not demonstrating the value of the EAP. Over the years, we have dramatically increased our consultations within our client organizations.

In any EAP, issues pertaining to resistance, control, and ownership within the client company have a big impact on how easily and effectively we can provide EAP services. We found it was extremely important to recognize our own capabilities and limitations. We have learned that as long as our values match the operational, financial, ethical, and legal values of the client company, there is potential to do business together. In retrospect, we encountered difficulties when we compromised our standards to placate a customer.

From the employee-client's standpoint, an external EAP setting has pluses and minuses. EAP confidentiality is always a pivotal issue for employees. We have found that individuals concerned about protecting their confidentiality will most likely feel that way, regardless of whether the EAP is delivered in an internal or external setting. Because an external EAP is not involved in the company politics that an internal EAP may encounter, we can appear to be more objective. On the other hand, we don't have the advantage of seeing on a daily basis the things that go on within the client organization, as internal EAP staff do.

Other examples of perceived negative aspects come from those individuals seeking EAP services in hopes of receiving free counseling or treatment services. In addition, managers and supervisors who want the EAP to "fix" their employee problems may come to the external EAP with unrealistic and false expectations. We try to manage expectations of our services by continuously evaluating and reviewing EAP activity. We meet periodically with key personnel and consumers to discuss various needs, concerns, and strategies, while clarifying expectations. If left unmonitored, these issues can become distorted over time, causing situations to escalate and leaving us to react to them rather than manage them.

Of course, there are many benefits to the external model. We have been able to respond quickly and efficiently to customer requests, develop professional and business relationships over time with our customers, customize services to employer needs, including reviewing what may not be working well and making appropriate changes in a timely manner.

In those companies that truly integrate the core technology into their EAP, we have been able to keep better track of program utilization and healthcare costs, especially mental health and substance abuse services. In addition, we have learned how to serve our customers and continue to explore ways to demonstrate outcomes to current and prospective customers.

Phil Hess, external programs director for the EAP Association, is employed by Employee Counseling of Indiana, an external EAP in Indianapolis, Indiana. He also owns Midwest Workplace Consultants.

Johnson & Johnson

Internal/External Combination

by Tom Baker, CEAP

In 1978, Johnson & Johnson, a diversified and decentralized family of healthcare companies with more than 35,000 employees in the U.S., established an internal EAP that provided traditional EAP services to employees and family members. In 1993, J&J started a combination internal/external EAP after an extensive program study indicated that the combination model would improve our ability to provide professional and cost-effective services.

Approximately half of our employees who reside within the greater New Jersey region receive EAP services from J&J's five full-time and one part-time EA professionals. Our external EAP provider offers EAP services to the remaining J&J employees residing outside the New Jersey region. This combination model allows J&J to provide 24-hour coverage and prompt response to all of our domestic employees, regardless of where they are located. In addition, in 1996, our external provider, ValueOptions, instituted telephonic EAP services for our expatriate employees located throughout the world.

This partnership model has largely eliminated the problems one might expect to find when serving such a diverse employee population in myriad locations. The initial formation of our partnership was, of course, not without some initial problems. Clarifying expectations and dealing with certain "turf" issues virtually eliminated the problems. The end result was an EAP that is stronger, more effective, and more cost-effective than the previous internal-only model.

Both employer and employee have benefited from this combined EAP model. Our EAP can provide rapid response and professional attention to all of our employees and their immediate family members. We offer a national list of screened, licensed providers whenever a referral is necessary. And this combination model has significantly improved access for both employees and family members by maintaining on-site access supplemented by off-site services.

Preliminary evidence suggests that we have both curtailed costs associated with the EAP and improved its effectiveness, reach, and quality of services. Gathering and disseminating data (such as utilization rates, types of problems encountered, training sessions, etc.) have improved markedly since we instituted this model.

In 1992, the EAP cost $59 per employee. In 1998, we reduced that expense to $43 per employee, thus lowering costs by 27 percent. At the same time, our point-of-service satisfaction surveys indicate that persons using the program reported a consistently high level of satisfaction.

J&J's EAP is one part of our Health and Wellness organization, which also includes Occupational Medicine, Disability Management, and Wellness. We think our combination EAP is an effective program that offers superior services to our employees. By offering both training and elements of the traditional EAP core technology, we have been both proactive and responsive to our employees' needs. We believe our EAP helps J&J meet the obligations set forth in our Credo: To, in every way, provide the very best for our employees.

Tom Baker, CEAP, D.Min., CACD, is a senior consultant with the Johnson & Johnson EAP, based in New Brunswick, New Jersey.

The State of Colorado

Peer Assistance Models

Nurses. The first to adopt the peer assistance model in Colorado was an entrepreneurial group of registered nurses and licensed practical nurses working with the support of the Colorado Nurses' Association House of Delegates, who passed a 1984 resolution to support the development of a statewide peer employee assistance program. Since 1983, this group of registered nurses and licensed practical nurses had been studying the lack of peer support for nurses who had substance abuse problems and who often dealt with licensure sanction. "Bonnie Forquer, who was then an ALMACA leader, was the driving force for the implementation of this EAP model," according to EAPA member Elizabeth Pace, MSM, RN, CEAP, executive director of Peer Assistance Services, Inc.

"Although volunteers had been helping these nurses," said Pace, "we felt it would be impractical to rely upon volunteers on a long-term basis. For that reason, we turned to the EAP model where we found a tried-and-true method of early intervention and a body of knowledge with defined skills and services," she said. She explained that the EAP professional business model provided the structure they needed as well as the nonprofit status they wanted so they could obtain funding from outside sources.

"Another big plus," said Pace, "was that the program was distinct from our professional association, a feature that increased the likelihood that nurses would use the program." The peer EAP is available to all nurses, including those who, because of drug diversion in the workplace, have been disciplined or terminated and cannot access their own EAP. This peer assistance program has expertise in licensing and regulatory issues that are affected when a licensed healthcare professional has substance abuse or mental health problems.

After 15 years of service, the biggest challenges include funding and increasing program awareness. Over the years, funding sources have included federal block prevention/intervention dollars, foundations grants, fees-for-service, private fundraising, and professional service contracts with regulatory agencies that are funded by license fees. Regarding utilization, Pace said, "We are still trying to get

the word out about this program. We know we're still only seeing a fraction of nurses who need help."

In closing, Pace explained, "Substance abuse and related problems occur in nurses at the same rate as the rest of the population, but nurses often encounter certain barriers that prevent them from getting the help they need. Peer assistance offers nurses an excellent intervention strategy to receive confidential assistance and rehabilitation support. In addition, it provides a mechanism that helps ensure the nurse's ability to practice safely."

Physicians. Colorado's Physician Health Program, formed in 1986, offers assessment, monitoring, and support services to another segment of the work force that has problems. "Physicians are trained to put their patients first," said Yvonne Garber, interim executive director at CPHP, "and to attend to the healthcare issues of others before themselves. They often feel ashamed to ask for help or believe they should be able to treat themselves."

CPHP's peer assistance model, based on the concept of doctors helping doctors, was started by several parties—a major malpractice insurance carrier, the Denver Medical Society, and Dr. Stephen Dilts, the program's medical director. Most funding is provided through a fee attached to annual renewal fees for the physician's medical license in the state of Colorado. The Colorado Board of Medical Examiners oversees the program's contract. CPHP offers services to all licensed physicians and physician assistants in the state. Other types of financial support comes in the form of contributions from hospital systems, managed care systems, and others.

In addition to peer assistance, CPHP provides ongoing documentation for physician-clients to hospitals, where they have privileges, as well as to credentialing groups, the board of Medical Examiners, and employers. "We provide our clients a safe place for receiving help with personal problems and monitor them in their treatment so they may continue to practice medicine safely," said Garber. "If CPHP is aware that a physician is at risk, CPHP has the responsibility to consider patient safety when making decisions."

Most cases are self-referred and referrals by colleagues are counted as self-referrals. The Board of Medical Examiners, hospitals, and other workplaces may refer clients as well. Medical directors and clinicians at CPHP provide education and consultation to workplaces on a regular basis to improve early intervention and prevention.

Like most members of today's work force, physician-clients most frequently seek help with stress and depression. Treating physicians for alcohol or drug misuse is different for this audience because they are exposed to regulated substances in their everyday work. Part of their treatment includes learning how to be around these drugs when they return to work.

Typical treatment plans include individualized outpatient plans as well as a traditional 28-30 day regime. For more severe problems, such as dual diagnosis, the physician may be referred for three to four months to an inpatient setting. Treatment is determined by appropriate clinical recommendations, not by the physician's medical insurance coverage. CPHP believes this, in part, is the reason for the many successful outcomes.

"Most important," said Garber, "is for our clients at CPHP to feel trust in our staff. We must connect well with our clients and help them learn to become patients who take good care of themselves and address their own health issues. CPHP regards its mission as extremely important to physicians, physician assistants, and the Colorado community."

Attorneys. The most recent peer assistance model in Colorado was designed five years ago for attorneys. According to Les Crispelle, executive director of the Colorado Lawyers Health Program, malpractice insurance carriers for attorneys provided the initial impetus and funding for this peer assistance program. "The insurance companies recognized that early intervention prevented malpractice suits and reduced the number of grievance violations," says Crispelle. More recent funding, however, has come from the Colorado Supreme Court, which began supporting the program after the Court started following some attorneys on probation.

"If an attorney get in trouble because of a substance abuse or mental health issue," notes Crispelle, "the Court refers the case to us. In the past the Court had been disciplining these people in accordance with Court rules. Now the Court is being more compassionate because its members have seen the benefits of getting the attorneys into treatment."

Like many others of this type, this program offers peer assistance through a traditional assessment-and-referral EAP model. While more than half of the clients are self-referrals, this program will take calls from anyone, including a family member, judge, or coworker, who sees that the

ABA Provides Lawyers Assistance Program to Members

Since 1973, members of the American Bar Association (ABA) in California have been benefiting from a lawyers assistance program (LAP). In 1988, the ABA developed a Commission on LAPs, which oversees these programs in all 50 states and every province in Canada. The ABA service is free. In providing a clearinghouse function for LAPs, the ABA offers the following functions:

- keeps information on services provided through the programs
- monitors program activity, tracking which programs offer broad brush EAP or strictly substance abuse support
- tracks program funding information
- conducts an annual national workshop

For more information, contact Donna Spilis, 312-988-5359.

attorney is not acting normally. The program includes group discussions for attorneys who have problems with mental health issues, substance abuse, or HIV/AIDS.

Despite the many successes, there are some drawbacks to this EAP model. "We have no control over what kind of insurance our clients carry," says Crispelle. "Their providers could be anywhere and offer anything." Often, those attorneys who have substance abuse problems may be cutting costs by no longer carrying health insurance. In a big state such as Colorado, which largely subscribes to managed care plans, there is little access to residential in-patient treatment. In addition, Crispelle noted there are no supervisory referrals. "The closest thing to a supervisory referral is when the Court sends someone to us."

Crispelle pointed out that a subtle approach works best with his potential clients. When making presentations about the peer assistance program to state bar associations or at legal seminars, he tells the audience how to help an alcoholic client or friend, and then hopes that they will get the message for themselves. With more than five years of steady referrals, the approach seems to be working.

Labor Union Reaches "the Unreachable" Through Peer Assistance Program

by George Maltezos, CEAP, LCPC, and Mark Stone, Psy.D.

The International Brotherhood of Electrical Workers (IBEW), Local 701, had a successful external EAP, or member assistance program (MAP), in operation from 1987 until October 1992, when the members voted to implement an internal MAP. Our trustees felt we needed a more personal approach and that an in-house MAP would provide even higher quality EAP services. It proved to be a successful move, particularly because our EA professionals monitored what managed care benefits our plan would provide. Utilization rates improved, healthcare costs plummeted, and members were basically pleased with the program.

Our prevailing union mentality—members helping members—is truly a credo we follow. That's what it's all about. We believe that when members respond to treatment, everyone benefits. The worker gains control over a problem. The worker's family is united. Colleagues work in safety.

But what happens if a worker does not face up to a problem because of denial or failure of friends and relatives to confront the person about the problem? IBEW, Local 701, faced this problem and our solution was to create yet another aspect of employee assistance that has touched the lives of even our most difficult-to-reach members. In 1997, we formed a peer group assistance program, after a model first developed by Bill Sonnenstahl at Cornell University.

Recognizing that people learn most of their behavior, such as smoking and drinking, from their friends, colleagues, and peers, we decided to use that same approach to help members "unlearn" their problem behavior with alcohol. That approach has proven useful to so many persons who have turned to AA to control their addiction to alcohol. In the same way, we formed the peer group assistance program to get union members working with other union members who have not faced up to their drinking problems.

The recommended first step was to conduct an intervention with the problem drinker, but much planning and training first had to take place. Working together is a fundamental part of the training. Extensive planning is essential, as is careful selection of those who form the intervention team.

Peer group members are trained to focus on coworkers who have denied their problem to the point that their alcoholic behavior has prevailed, despite all efforts on their part or their family and friends to bring about change. They work specifically with the "hard-core" alcoholics. No intervention occurs unless the probability for success is reasonably assured and much training takes place to prepare for the intervention.

We formed three peer group teams with six or seven people on each team. We then put them through a five-day training program where they learned to understand the problem of alcoholism, as well as how to address problems associated with alcoholism, how to conduct an intervention, and how to address the mechanisms of denial and resistance.

Five days of training is only the beginning. The peer group continues to meet regularly for additional training and mutual support. Two of the most important training components are showing respect for the individual and maintaining confidentiality. Peer members are advised not to work individually. They meet as a group to plan and determine their course of action. In addition, they plan follow-up support to ensure the success of an intervention that has already taken place.

Peer group members join the team with differing views regarding alcohol consumption. Some have recovered from a drinking problem, some are social drinkers, and some do not drink at all. All share the common concern that drinking to excess serves no one beneficially and that the welfare of the member and the family as well as the safety of the coworkers are critical.

Because there are only a few members with extreme problems, the number of peer group interventions appears small. From 12 interventions by the peer group, seven members have successfully entered treatment, where they continue successfully addressing their drinking problems. We consider them seven success stories. Even one successful intervention can be beneficial to our MAP because it stops an out-of-control problem and allows the member to return to successful employment.

Together, union MAP and peer group assistance have contributed to expanded member utilization (from four percent to eight percent since we developed an internal MAP), decreased healthcare costs, and improved member satisfaction. We believe these services have contributed to the overall well-being of our union membership.

George Maltezos, CEAP, LCPC, is the director of the Member Assistance Program of Local #701 IBEW, DuPage County, Illinois. Mark Stone, Psy.D., is a clinical psychologist and consultant/trainer to the program.

Lincoln EAP

External EAP Consortium

by Kris Brennan, CEAP

Editor's Note: External EAPs are beneficial to companies that don't want or can't afford to hire an on-staff EA professional. Another type of external EAP—the EAP consortium—allows companies to share the expenses of an EAP.

The Lincoln EAP's origins began with the Lincoln Council on Alcoholism and Drugs, Inc. In the early 1970s, these local business leaders began the Business Assistance Group, which employed a network of volunteers to identify and counsel workers who had drinking problems.

In 1974, the Council received a grant from the National Institute on Alcoholism and Alcohol Abuse (NIAAA) to develop a comprehensive, broad brush employee assistance program, now known as the Lincoln EAP. The grant helped the Lincoln EAP develop a consortium model to serve small- and medium-sized businesses. Today, the Lincoln EAP has grown into a private, nonprofit EAP service center providing comprehensive services to businesses, local government offices, and educational institutions.

Because the majority of employers in Lincoln run small- or medium-sized companies, the Lincoln EAP makes high-quality EAP services available and affordable to private and public companies that are unable to establish their own EAP.

Starting an EAP consortium is always challenging because it requires a group of companies to work together to make the EAP financially feasible. In our formative years, we created a partnership with our member companies; they shared in our vision, were committed to our success, and assisted in our growth. We own our long-term financial viability to our member companies' belief in the value of EAP and in our particular service model as a way to meet their needs.

EAP work in a consortium can be more challenging for several reasons. For example, many small companies do not have a human resources department or policies and procedures. They also tend to rely on the EAP for a variety of organizational development and intervention issues. Family-owned businesses add their own set of personal dynamics. In general, EA professionals in an EAP consortium need to offer more supportive and consultative assistance to supplement the HR issues and supervisory skills of the client-company.

As an external EAP model, we usually try to work with staff in the HR department. We also try to integrate with safety, medical, benefits, and training staff, if they exist.

Our most recent cost/benefit analysis shows that our companies are realizing a $4 to $6 return for every $1 invested in EAP services. We believe the many other types of benefits for this EAP consortium include:

- comprehensive, cost-effective EAP services;
- an individually tailored approach to each company we serve, regardless of size;
- assistance in dealing with troubled employees;
- help in retaining valuable employees;
- assistance to supervisors and managers in how to deal effectively with employees;
- information on emerging workplace trends and resources;
- consulting, coaching, and training in communication and problem-solving skills.

We focus on the worksite, rather than clinical, issues, and we have gained a strong foothold in this area.

One drawback of being a free-standing EAP is that we have no other resources to offset our fees. Client-companies have to pay what it actually costs us to deliver our services, which can be a competitive disadvantage when competing with other EAPs connected to hospitals, insurers, etc. We have to work hard to find a balance between offering cutting-edge, high-quality, and responsive service and not pricing ourselves out of the market.

In recent years, we have started serving clients throughout the U.S. Using the lessons we learned in Lincoln, we have established effective, hands-on services at all of our sites. As we celebrate our 25th anniversary, we believe that we have made lasting contributions to the quality of work life in the Lincoln, Nebraska, business community as well as other parts of the country.

Kris Brennan is executive director of the Lincoln, Nebraska EAP, Inc., the oldest EAP consortium in the U.S.

Integrating EAPs with Work-Life Programs

A New Way to "Have It All"

by Larry Bussey

In 1996, three groups—the EAR employee assistance program, owned by Ceridian; Employee Assistance Associates; and The Partnership Group, a leading work-life services provider—formed Ceridian Performance Partners. The goal of the new organization was to create a truly integrated EAP/work-life service, which would make it possible for employees to call just one number for any work or life issue and receive the broadest possible range of services and assistance.

Before forming the new corporation, EAR had worked with various work-life vendors to provide our customers with a seamless EAP/work-life offering. We felt we needed to go beyond "seamless" and set out to form an entirely new entity. One important reason for making this change is that a client's needs do not divide neatly along the line that exists between the EAP and work-life fields. A person frequently has dependent care needs that are inextricably tied up with broader family, work, or personal problems. Seamless service makes it possible to coordinate the delivery of a variety of EAP and work-life services. It does not, however, truly integrate the issue identification, assessment, and problem solving that take place when assisting the client. The seam may be invisible to the client, but it still exists.

Moving from seamless to integrated was a new process. In the new Ceridian Performance Partners, it soon became apparent that EAP and work-life cultures are quite different. Do EAP counselors always look for clinical issues behind every straightforward request for information or referrals? Do work-life counselors offer dependent care referrals and educational packets as the solution to every problem? These different cultures have frequently shaped client expectations. EAP clients generally value the time that the EA professional invests in consulting with them on their problem or concern. Often, work-life clients have already identified their need and want a quick and efficient response to their request for referrals or information. The task of creating an integrated service required developing a broader and more integrated understanding of the counselor's role.

The EAR program (now Ceridian Performance Partners) has always relied on immediate telephone access to counselors as a key means of delivering service to clients. In this model, the telephone is not just a point of entry to whatever services a client might need. The telephone counselor acts as an active case manager, coordinating the delivery of whatever services a client requires. This is true even if a client is referred to an in-person affiliate counselor for services.

In practice, this model of service delivery has led to the development of a distinctive role for Ceridian Performance Partners' telephone counselors. They frequently act as supportive "coaches" to clients. They use their clinical expertise not only to assess the client's situation and make appropriate referrals, but also to help the client be an informed consumer of clinical services and other resources.

It is not unusual for a client to begin a call by saying, "I need to see a counselor." After some exploration, the counselor may help the client recognize that some other type of service or support would be more helpful. Then, in the role of a case manager or "coach," the counselor provides ongoing motivational support and encouragement to the client.

This model of service delivery, with its distinctive role for the telephone counselor, provided a foundation for building an integrated EAP/work-life service. Counselors were already used to addressing a broad range of issues and coordinating a wide variety of services. With an EAP/work-life service, the range of issues and variety of services would only be wider!

The theory sounded simple. When it was put into practice, there were significant challenges that tested the model. What follows is a summary of the challenges, described from an EAP perspective. Colleagues who came from the work-life side experienced the mirror image of what's described here.

It's Not Just about Assessment.

EAP clinicians rightly assume that helping people understand their situation is a core job function. In an integrated EAP/work-life service, such assessment is not always appropriate or necessary. Clients frequently have a clear understanding of their needs when they call, making additional assessment redundant. The difficulty, of course, is in distinguishing between clients who *actually* know what they need, and clients who *think* they know what they need. (EAP clinicians frequently deal with the latter type of client!) With the integrated service, counselors learned to take extra care at the beginning of the call to clarify, and in some instances, negotiate expectations for the interaction. Frequently that required explaining that a few basic screening questions are included in interactions with all clients. At the same time, counselors had to learn that not every caller needed a "coach"; some just needed resources.

Empowering or Caretaking?

Some EAP counselors became frustrated with clients who not only knew what they needed, but then expected the counselor to provide it for them: "I need some information on travel options in Mexico." Clinicians are used to helping people be more self-reliant and resourceful. Counselors had to resist the urge to send such callers to the local library. They had to broaden their understanding of empowering and providing. They are not mutually exclusive. The aim of empowering is to help people reclaim responsibilities that belong to them, but that they have lost control of. The goal of providing a service or resource is to give people additional time to spend on matters that are more important to them. Coaches do not go into the game to play for their players. At the same time, they may handle many extraneous responsibilities that would distract their players from the game.

Does an integrated Service Dilute the Clinical Challenge for Counselors?

Initially, some counselors felt that their interactions would be less clinically challenging. It was not unusual for counselors to say, "I did not go to graduate school to help people find pet sitters!" It is true that counselors are dealing with more everyday requests. Overall, however, their interactions with clients are more complex. When a client calls an EAP, the ground rules are generally understood. Clinician and client both have a general idea of what kinds of things one calls an EAP for, and what to expect from the service. With an integrated service, those ground rules no longer exist. They have to be reinvented with every call. By expanding the scope of topics and services that clients call about, the clinical issues become more, rather than less, challenging.

How Do You Support the Information Needs of Counselors?

How far can you expand the range of topics and services without spreading counselors too thin? The service delivery model assumes that one case manager coordinates all services. Is that realistic? Counselors do not have to do it all, but they do need to know what questions to ask to make sure the client gets the right services. Typically, this issue is addressed through training. Well-trained EAP clinicians, using just their head and their gut, know what questions to ask. A simple template designed to ensure that key topics are covered is generally all that's needed to keep them on track. Training and simple prompts are not enough to support counselors in delivering an integrated service. Ceridian Performance Partners built a new case management system that is a sophisticated information management tool for counselors. The system is being continually refined to provide more and better information to them.

Moving from seamless to integrated is a process. The issues described above are ongoing challenges. At the same time, members of our counseling staff have become some of the strongest believers in this model. They feel a new kind of empowerment. They recognize that they are finally able to work with the whole person. They value having the tools and resources to do whatever makes sense to help a client. They recognize that the coaching/case management role, which has been such an important part or our service delivery model, is precisely the role they continue to fulfill.

Recently a counselor spoke with a caller who was having problems at work and with her fiancé. The counselor was able to use her counseling/coaching skills to help the client better understand and work through some of these problems. During the course of the conversation the counselor also learned that the client was very frustrated by her inability to find a place to hold their wedding reception. The counselor told her our research team would find her some options. The client was thrilled with the service. The counselor was left to wonder whether she was satisfied because of the counseling, or our ability to locate a reception hall, or the fact that we could do it all. Whatever the reason, the counselor knew she had more ways to help clients than she has ever had before.

Larry Bussey, CEAP, is director of communications for Ceridian Performance Partners. He joined Ceridian in 1992 and worked for three years as a counselor on the overnight shift. From there, he moved into supervision and management. Larry was responsible for developing the Ceridian Performance Partners' integrated service delivery capabilities.

New Chapter-Level Awards Program Will Provide Local Recognition for Depression in the Workplace

A new program will give EAPA chapters the opportunity to present their own award to a company in their community that has shown support for employees with symptoms of depression. The chapter-level awards program will become part of the Annual National Public Education Campaign on Clinical Depression Award, which is been given annually to one national company. Funding for this new awards program is being provided by Eli Lilly and Company. EAPA headquarters staff will work with EAPA chapter officers to determine criteria for the award.

Look for more details on this awards program in special chapter mailings and future issues of the *EAPA Exchange*.

INTERNATIONAL EAP ASSOCIATION
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MINUTES OF THE JANUARY 1999 BOARD OF DIRECTORS MEETING

The Board of Directors met on January 21, 1999 via teleconference. The meeting was called to order at 3:06 p.m. (eastern time) and the minutes of the last meeting were corrected to show Judy Braun as present on the previous teleconference. The minutes were approved as amended.

The Board was updated on the progress of several committees including Awards, Diversity, Behavioral Risk Management, Internal Program Managers, External EA Providers, Finance, Small Business, and the Managed Care Task Force. The Executive Committee reported on progress with their charges and President DeLapp reported on his efforts on the Work/Life Task Force. The Special and Regional Directors then followed with reports on their activities.

The spring Board meeting was scheduled for April 30 to May 2, 1999, at the Maritime Institute in Baltimore. Board members were encouraged to make their travel arrangements promptly.

Legislative and Public Policy Director Sheila Macdonald gave a comprehensive update on the upcoming Public Policy Conference.

Chief Operating Officer Sylvia Straub followed with a review of the Needs Assessment Survey.

The meeting was adjourned at 4:40 p.m. (eastern time).

Nominations for EAPA Board of Directors

The following positions on the EAPA Board of Directors are now open for nominations: Labor Director; External EA Providers Director; and Regional Directors for the Canadian, Mid-Atlantic, North Central, Pacific, and Southwest Regions. The nominations period is open from January 1 through April 30, 1999. Elected candidates will serve from 1999 to 2001. The elected officers will assume office at the EAPA Annual Conference in Orlando, Florida, in October 1999. All candidates must be voting members of EAPA. Elected officers may not serve in a position for more than two consecutive terms.

The process for nominating members to elected positions in EAPA **has changed.** Nominations shall be submitted in writing by two voting members to the Nominations Committee. Nominations must be postmarked by **April 30, 1999** and mailed to the Nominations Committee, EAPA, 2101 Wilson Blvd., Suite 500, Arlington, Virginia 22201-3062 OR faxed to George Figliozzi, Board Assistant, at 703-522-4585 by close of business on April 30, 1999. For more information, contact George at 703-522-6272, extension 314.

Regional Directors must live in the region which they would represent; the persons nominating a Regional Director must also live in the region to be represented. Regional Directors must be CEAPs, voting members in good standing for at least four years immediately preceding nomination, and must be willing and able to attend scheduled meetings of the Board and Association.

Special Directors: Labor and External EA Providers. The Labor Director must work in a labor EAP and be a member of a labor union. The External EA Providers Director must work in an external EAP. Special Directors must be CEAPs, voting members in good standing for at least four years immediately preceding nomination, and must be willing and able to attend scheduled meetings of the Board and Association. All EAPA members vote for Special Directors.

For further information, contact the EAP Association, 2101 Wilson Blvd., Suite 500, Arlington, VA 22201; (phone) 703-522-6272, (fax) 703-522-4585; (e-mail): eapamain@aol.com

Living with Grief at Work, at School, at Worship

The sixth annual National Bereavement Teleconference, will be broadcast on Wednesday, April 14, 1:30 p.m. to 4:00 p.m. (eastern time). Hospice Foundation of America offers this live-via-satellite program, as well as accompanying support materials, free of charge as a public service. The teleconference will be moderated by Cokie Roberts of ABC News and will feature a distinguished panel of experts. Follow-up materials include a companion book of articles and resources. EAPA is listed as an organization to contact for further information on workplace support. For further information or to find a teleconference site in your area, call 202-638-5419.

Dignity and Diversity at Work: The Key to Competitive Advantage

by Martin Crawley

This is the second of a two-part international conference report on dignity and diversity in the workplace.

In September 1998, a two-day conference sponsored by the EAP Institute of Waterford, Ireland, focused on the issues of dignity and diversity in the workplace as a key to business survival in an increasingly competitive global economy. Twelve speakers addressed attendees at the conference, which was held in Dublin, and covered a range of topics, including problems arising from increasing immigration to Ireland, managing diverse work populations, increasing the opportunities for female workers to participate in corporate management, and controlling and preventing workplace sexual harassment, among others. Conference speakers offered their insights into these problems and discussed solutions that they had helped initiate through their own individual work experiences.

Increase in Immigration

Peter Flood, equality executive with the employers' group, the Irish Business and Employer Confederation (IBEC) of Dublin, warned that racial discrimination will become a feature of the workplace in Ireland, given the steep rise in immigration over the last three years alone. The number of work permits issued have risen by 20 percent in each of the last three years, he said, presenting Irish businesses with an issue they have not before had to deal with, but which is commonplace in other parts of Europe. Given that the demand for labor is not being met by

supply in Ireland, particularly in the information technology (IT) sector, Flood said it is important that Ireland avoid acquiring an international reputation that suggests foreigners are not welcome there. Such a reputation would make it significantly more difficult for Irish companies to recruit skilled workers from abroad.

Recognizing Individual Value

Turning away from the law, Alison McCloskey, manager of group diversity of the Ulster Bank Group, defined diversity as a management style that recognizes and values the different contributions individuals make to an organization. The differences are not only those that are narrow and visible, such as gender and color. They are also wide and sometimes invisible and include religion, culture, personality, disability, marital and family status, sexual orientation, and educational background.

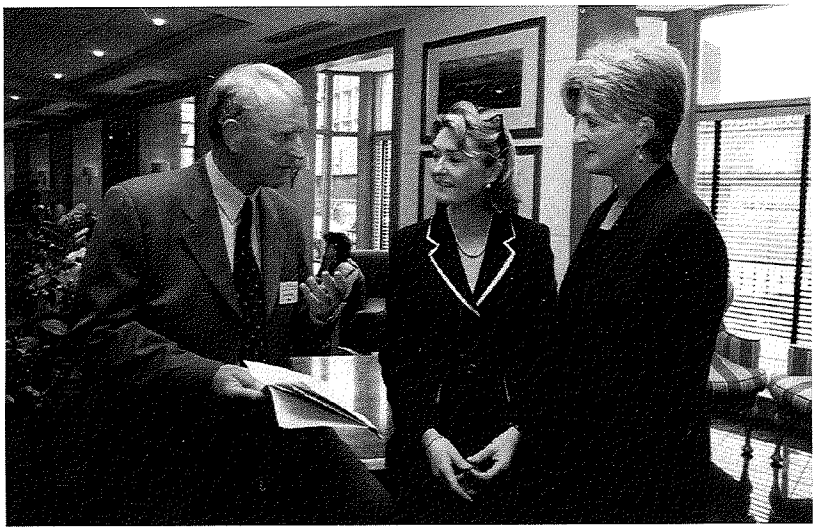
The successful management of diversity, she said, helps combat stereotyping, harassment, and undignified behavior with the introduction of policies that account for both the company's organizational needs and the staff's personal needs. These values and policies should be aimed at encouraging diversity within the work force in order to maximize use of the skills, abilities, and richness of all employees.

According to McCloskey, many companies now realize the damaging impact that harassment can have in the workplace, not only in terms of reputation risk but in terms of staff morale, performance, and, ultimately, on the bottom line: profits. "Organizations cannot afford the damage that can result in respect of [their] ongoing "license to operate," she said.

From her experience with the preparation and implementation of the Ulster Bank's "Dignity at Work" policy, McCloskey stressed that, first, an employer's approach to harassment must be consistent. Second, all senior managers, not just human resource personnel, must be involved and the resulting policy must be supported by documentation. She said her bank wanted to create a culture where everyone knows that harassment is unacceptable and takes ownership to ensure that it will not be tolerated in the organization.

Belief System

Sheena Clohessy of Clohessy Consulting led discussion on the idea of creating a culture that accommodates dignity rather than punishes those that trans-



Maurice Quinlan, Conference Director, (Ireland) discussing the conference program with Marie Therese Fitzgerald, Eurocontrol (Belgium) and Pat Graham, EAP Consultant, Solutions, (Scotland) during the annual EAP Institute conference, "Dignity at Work–Adding Value to Employee Contribution."

gress a rule. Using the example of a severe sexual harassment case, which was strongly denied by an otherwise reputable employer, she asked whether sexual harassment was the product of an environment or the product of poor behavior that can be attributed to individuals.

For example, when a woman who had been harassed refused to accept that it was just a "prank that went wrong" (as argued by the company in Court), she was regarded as not adhering to society's accepted view of women as caring, understanding, and nurturing and indeed of men as independent, economic providers, decisive, and less feeling.

Clohessy said it was unlikely that the woman's company deliberately chose to misinterpret the motivation of its employee. "However, when you operate out of a set of beliefs that are supported within your environment, it is possible to seriously misjudge the effect of your behavior on another person. The fact that you didn't intend to do so does not mitigate the damage." For Clohessy, it is not just a matter of legislation, but the belief system in a company surrounding such legislation.

"If an existing environment creates the behavior and there is an inability to bring your thinking beyond your own value system, then the potential for repetition is a real one," she warned. That was how this particular employer was capable of viewing the legislation as a vehicle of defense for its position and not as a guideline that would enable it to handle the situation. "It attempted to manage the situation," she explained. But what it really required was a leader to challenge a set of values that were inappropriate, values that were already enshrined in existing legislation. The result did not add value either to the employee contribution or to the company as a whole. Presently and for the future, businesses operate in a world of increased diversity. The challenge is to examine paradigms constantly and question their effectiveness and legitimacy.

Lee Richards, human resources manager of Akzo Nobel Organon Ireland, detailed a number of initiatives that his company implemented to overcome the lack of opportunities for women to progress and develop within the company. Akzo Nobel Organon Company employs 700 workers in Ireland, of which 65 percent are women whose average age is 25. An equality audit found that a traditional view of women's role in society as well as physical barriers (for example, shift work and manual handling) had reduced promotional opportunities for women. The company initiated an awareness campaign, starting at the top. It introduced new recruitment and selection procedures, eliminated the physical barriers, and encouraged women to apply for non-traditional jobs. The new initiative also included building on successful role models, providing training and work experience opportunities, managing development programs, introducing flexible working arrangements, reinforcing activities to ensure equality as an organizational value, and adopting a harassment/bullying policy.

The results, Richards told the conference, increased the participation rate for women in senior management in the company from 0 percent in 1988 to 43 percent in 1998. In the same 10-year period, the participation rate of female workers in the professional/ supervisory level rose from 26 percent to 48 percent, in the technical/craft area from 12 percent to 52 percent, and in the semi-skilled from 0 percent to 44 percent.

Reconciling Work and Family

Akzo Nobel Organon also produced a complementary plan to reconcile work and family responsibilities. This included flexible working arrangements such as flextime, job-sharing, reduced or part-time working, annualized hours, and home-based work. It introduced leave arrangements that provided for flexible timing of leave, including maternity and adoptive leave, parental leave, compassionate leave, leave of absence, emergency leave, and career breaks. It also introduced a workplace crèche (day care center) childcare support/ allowance, EA programs, and access to counseling.

"Legislation alone can have only limited success," Richards said. "Equality and other 'people' issues must be a core value in the culture of the organization and these initiatives must be compatible with the business/management systems." A systematic approach is essential to achieve and sustain change, he added, as are education and development activities, and reinforcement of company policies through complementary supportive practices.

Johanna Fullerton, a partner with Pearn Kandola, occupational psychologists, discussed how her group concentrates on testing the success of various company initiatives to manage diversity. She explained her company's so-called MOSAIC model to see how diversity is being managed as follows: Does an organization have "Mission" and values, "Objective" processes and systems for selection, a "Skilled" work force that is

aware and fair, "Active" flexible working systems, "Individual" focus, and a "Culture" that empowers its workers?

Paula Carey of the Irish Congress of Trades Union (ICTU) told the conference the unemployment rate among those with disabilities stands between 70 percent and 80 percent. She emphasized that the concept of assistance must underpin the employment of people with disabilities. The introduction of legal obligation, under the Employment Equality Act of 1998, while changing the dynamic that currently prevails between employer and employees, should in no way undermine the goodwill that currently exists among many employers. Gina Quin, chief executive of Gandon Enterprises Ltd., told the conference how her company provides sheltered work for those with disabilities. Gandon is comprised of seven different companies, all of which are run on a commercial basis, Quin added, noting that they employ a 50/50 mix of both persons with and without disabilities. Employment has risen from 200 in 1994 to 360 today, with a total turnover across the seven companies of £11 million.

Majority of Absences Due to Stress

Tom Cox, professor of organizational psychology at the University of Nottingham in the United Kingdom, urged employers to develop strategies to deal with work stress through the application of a risk management paradigm focused on true prevention at the organizational level. He warned, however, that the risk management approach needs to be balanced by enhanced support and rehabilitation for those employees who, despite their organization's best efforts, experience stress. Fin O'Hara, manager of EAP, health, and stress audits of the UK-based health insurance company, BUPA, said that Confederation of Business and Industry (CBI) figures in Britain indicate that 54 percent of sickness absence is stress-related. He said organizations that maximize the contributions of their personnel will emerge successful in this era of increasingly fierce global competition.

The effective management of health in the workplace can reduce such sickness absence and its associated direct and indirect costs, O'Hara said, as well as lowering the cost of litigation, ill health retirement, employee liability insurance, and private medical benefits provision.

Conference papers are available for purchase at $95 per set. Please contact Claire Rowell, EAP Institute, 143, Barrack Street, Waterford, Ireland. Tel: (051) 855733; International tel. +353-51-855733. Fax: (051) 879626; International fax + 353-51-879626.

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Occupational Psychiatry and the Employee Assistance Program

PART TWO

by Jeffrey P. Kahn, M.D., and Seth Aidinoff, M.D.

The following material is the second of a three-part excerpt from, The Employee Assistance Handbook, *edited by EAPA member James M.Oher. Part II of this excerpt discusses assessing a client's psychiatric history and examines the most common types of psychiatric disorders. (Copyright © 1999 by John Wiley & Sons. All rights reserved. Reprinted by permission of the publisher John Wiley & Sons, Inc. To order a copy of the book, call 1-800-225-5945 or visit Wiley's home page @ www.wiley.com.)*

PSYCHIATRIC HISTORY

Current problems are often related to past problems. It is helpful to know if the employee has ever had counseling, psychiatric consultation, or psychiatric hospitalization in the past, and for what reasons. In particular, it is important to know about past and present mental health diagnoses.

Although the list of possible psychiatric disorders is long, there are only a few common psychiatric diagnoses. A presenting complaint of stress or depression is common to most of these diagnoses, and an acute stressor may exacerbate almost any psychiatric disorder. Although most of the categories of psychiatric disorders are outlined below, it is worth remembering that anxiety disorders, mood disorders, and substance abuse are the most prevalent of the disorders described. Thus, recognition and treatment of these disorders should be given the highest priority. Some other diagnoses, although less common, are also especially important to recognize.

Anxiety Disorders

Anxiety disorders refer to the group of disorders whose primary symptom complex includes prominent anxiety. These disorders appear commonly in the workplace and are often exacerbated by workplace stressors. On outward appearance, many employees with anxiety disorders will appear merely tense or sad, or show little clear evidence of anxiety at all. Others may exhibit concrete symptoms such as phobias (panic disorder), stage fright (social phobia), or hoarding (obsessive-compulsive disorder). Whenever anyone has significant anxiety for more than a short period of time, there is usually an underlying anxiety disorder. Although benzodiazepines (like diazepam), or buspirone (a non-benzodiazepine, non-addicting, antianxiety medication) can seem useful for symptomatic anxiety, they will have little effect on the underlying anxiety disorder. Identification of anxiety disorders and other diagnoses allows prompt consideration of appropriate medication strategies to combine with psychotherapy. There are several common anxiety disorders.

Panic Disorder. Panic disorder is characterized by recurrent and unexpected panic attacks. Panic attacks are defined by *DSM-IV (Diagnostic and Statistical Manual of Mental Disorders, 4th ed.)* as "a discrete period of intense fear or discomfort" during which at least four of the specified physical or emotional symptoms are present. Symptoms include palpitations, sweating, trembling, shortness of breath, a choking feeling, chest pain, nausea, abdominal pain, lightheadedness, derealization, fear of going crazy, fear of dying, numbness, and chills or hot flashes. Panic disorder is often associated with fears or phobias of driving, flying, enclosed spaces, or even of leaving the house (agoraphobia).

Panic disorder responds well to treatment with tricyclic antidepressants. The selective serotonin reuptake inhibitor (SSRI) antidepressants are less reliably effective for panic disorder, and some other antidepressants have little direct antipanic effect. Choice of antipanic medication is often determined by side-effect profile, as described below. Most important, antidepressants can cause an initial

increase in anxiety, with relief of symptoms only coming after three or four weeks. This can sometimes be appropriately dealt with by concurrent short-term dosing with clonazepam.

Clonazepam and alprazolam are considered effective antipanic agents. Because clonazepam has a longer half-life, it has a lower abuse and withdrawal potential than alprazolam. It is not clear that any other benzodiazepines have specific antipanic properties. Because of its ease of use, rapid onset, and low side-effect profile, many clinicians advocate the use of clonazepam for long-term treatment of many panic disorder patients. However, in view of the potential for addiction, noncompliance, and abuse, caution is advised. Special care should be taken in patients who have a history of substance abuse. Abrupt discontinuation of any benzodiazepine can produce dangerous withdrawal syndromes, as well as exacerbation of the treated symptoms. Psychotherapeutic issues in panic disorder may include overcoming phobias, dealing with separation or loss, medication compliance, and relationship problems. With appropriate treatment, panic attacks will usually go into full remission in a month or less. At that point, there will be gradual improvement in phobias, anxiety, and other symptoms.

Social Phobia. Social phobia is persistent anxiety about situations where there is a fear of social scrutiny. Common social phobic situations include meeting new people (shyness) and public speaking (stage fright). Fear of embarrassing oneself is a central symptom, commonly accompanied by racing heart and sweating. Unlike abrupt onset panic attacks, social anxiety has a more gradual onset. Symptoms can be severe enough to cause significant social and occupational limitations. Some employees have learned how to endure social anxiety without avoiding the feared situation. Although the anxiety remains distressing, it can also help to hone some speaking and social skills.

Social phobia is generally responsive to SSRI antidepressants, with therapeutic benefits starting to appear after some three to six weeks at an effective dose. Beta-blockers (such as propranolol or atenolol) can be used to relieve physical symptoms just before a speech or presentation. Psychotherapeutic issues commonly include public speaking fears, shyness, and feelings of social isolation. Cognitive-behavioral approaches use systematic desensitization and other approaches to reduce avoidant behavior. Psychotherapy works best in combination with medication.

Obsessive-Compulsive Disorder. Obsessive-compulsive disorder (OCD) is a syndrome of obsessions or compulsions (or both) that cause significant distress, or that interfere with social or occupational functioning. Obsessions are persistent and unwanted thoughts that can be about orderliness, religion, anger, nonsensical, and other thoughts. Compulsions are repetitive behaviors in response to an obsession or to a set of stereotyped rules. Examples include counting, cleaning (handwashing), checking (stove, lights, locks), and hoarding. Compulsions are often intended to neutralize obsessive thoughts, and can consume vast amounts of time. Overly perfectionist, slow, or rigid job performance can suggest OCD.

Effective OCD treatment includes medication and psychotherapy. Medications that can be effective include the SSRI antidepressants and clomipramine. Doses are typically much higher than for depression, and the full medication benefit may not occur for several months. Medication effect can be further improved with the addition of a second medication to enhance the effect of the first. Optimal treatment includes cognitive-behavioral approaches to address obsessions and compulsions, and interpersonal approaches to understand issues of anger and control, ingrained behaviors, and family dynamics.

Traumatic Stress Disorders. These disorders are included among the anxiety disorders in *DSM-IV*. They occur in response to the observation or experience of an emotionally traumatic event outside the range of ordinary experience. Post-traumatic stress disorder (PTSD) is characterized by persistent re-experiencing of the traumatic event through memories, dreams, flashbacks, or hallucinations, with consequent distress and decreased functioning. Apparent PTSD may often reflect exacerbation of longer-term anxiety or mood disorders. Acute stress disorder refers to short-term dysfunction (less than four weeks) marked by derealization and other symptoms similar to those experienced with PTSD. Some clinicians have suggested that these stress disorders typically occur in people with pre-existing anxiety or depressive disorders, and that they are often associated with legal or entitlement claims.

Treatment of traumatic stress disorders typically involves diagnosis and medication management of component anxiety and depressive disorders (e.g., panic disorder or major depression). Concurrent psychotherapy focuses on the details and effects of the stressful event, other family and work issues, and returning to normal functioning. Group psychotherapy may focus on issues of understanding and overcoming the traumatic event. Prognosis is variable, with many employees having a full recovery. Others may have ongoing symptomatic or entitlement issues.

Mood Disorders

Mood disorders refer to the group of syndromes where dysregulation of mood is the most prominent symptom. Mood disorders are common and generally responsive to treatment. There are several common mood disorders that present in the workplace.

Major Depression. Major depression is marked by the presence of severely depressed mood, often accompanied by diminished pleasure, sleep changes, appetite changes, psychomotor changes, fatigue, memory or concentration difficulties, suicidal thoughts, feelings of hopelessness, and feelings of worthlessness or guilt. It is important to remember that most cases of depression do not include all of these symptoms. However, the presence of any of these symptoms is an indication for a full evaluation for depressive

symptoms. It is also useful to remember that major depression may first present without a complaint of mood disturbance. However, the presence of other depressive symptoms should trigger a closer evaluation for depression. Major depression is often comorbid with panic disorder.

Mood disorders are responsive to specific treatment. Antidepressant treatment and appropriate psychotherapy are the cornerstones of most treatment of depressive disorders. Antidepressants must be prescribed in an effective dose and continued for at least three to six weeks before a response can be expected. The choice of antidepressant should largely be determined by the side-effect profile, the medication cost, and concurrent medical considerations. Tricyclic antidepressants (desipramine, imipramine, nortryptilene, and others) are generally lowest in cost, and are unsurpassed in efficacy for major depression. Tricyclics do have a side-effect profile that includes anticholinergic effects such as dry mouth, constipation, and orthostasis. In addition, the cardiac arrythmogenic effects of the tricyclics make them contraindicated in most cases of heart block.

The newer selective serotonin reuptake inhibitors (SSRIs, such as fluoxetine, paroxetine, sertraline, and fluvoxamine) are just about as effective, and have a more limited side-effect profile that makes them a more common choice. Even so, SSRIs have been noted to cause uncomfortable agitation, nausea, and appetite or energy changes that may be unacceptable to the patient. In addition, sexual side effects of the SSRIs (decreased libido, delayed or retrograde ejaculation) can be problematic. Other useful antidepressants include buproprion and trazodone. Benzodiazepines or other sleep medications may help with insomnia until an antidepressant can begin working.

Dysthymic Disorder and Atypical Depression. Dysthymic disorder refers to a long-term (at least two years) presence of consistently depressed mood, with neurovegetative signs, that does not meet the full criteria for major depression. Many employees with dysthymic disorder may actually suffer from the long-term atypical depression subtype. This common diagnosis reflects depressed but reactive mood, increased desire for sleep, increased appetite, decreased energy (sometimes feeling physically heavy in arms or legs), and a chronic pattern of heightened sensitivity to interpersonal rejection. Chronic atypical depression is often comorbid with panic disorder or acute major depression. The SSRIs are the preferred treatment for treating atypical depression. They have the advantage of treating major depression as well, but offer unreliable relief of panic disorder.

Psychotherapeutic issues in depression may include grief, loss, hopelessness, and frustration. Careful attention should be paid to suicide risk, especially around the time of medication response. Hospitalization may be indicated for major depression when there are questions of poor self-care, treatment noncompliance, or suicidal risk.

Bipolar Disorders. Bipolar disorders (for example, manic depression) refer to a group of mood disorders characterized by marked fluctuations in mood, including the presence of periods of mania or significantly elevated mood. All employees evaluated for depression should be questioned about a history of manic or hypomanic episodes. Manic symptoms may include persistent elevated, expansive, or irritable mood, grandiosity, decreased sleep, fast speech, psychomotor agitation, or abnormally increased activity (spending, sexual, other). Manic episodes are also often accompanied by psychotic symptoms. Primary medications for bipolar disorder include lithium, carbamazepine, and valproic acid. Medication compliance is often a major focus of psychotherapy. Although the prognosis for control of manic and depressive episodes is excellent, there can still be infrequent manic breakthroughs.

Adjustment Disorders

Adjustment Disorder with Anxiety. Adjustment disorder with anxiety (not a formal anxiety disorder in *DSM-IV*) requires the presence of an identifiable major stressor in the three months preceding onset of marked distress or diminished functioning. A diagnosis of adjustment disorder with anxiety should be made only after specifically establishing the absence of all other anxiety disorders.

Adjustment Disorder with Depressed Mood. Adjustment disorder with depression (not a formal mood disorder in *DSM-IV*) reflects the presence of a recent specific major life stressor and consequent depressed mood. A diagnosis of adjustment disorder with depressed mood should be made only after specifically establishing the absence of all other mood disorders.

Substance Abuse/Dependence

Substance abuse and dependence are common disorders that present frequently in the workplace. The clinician must be aware of signs and symptoms of common drugs of abuse and should be aware of the drugs of choice in the local geographic or socioeconomic environment. Every employee presenting with an emotional complaint should be asked about alcohol abuse/dependence.

Substance Abuse. The cardinal feature of substance abuse is maladaptive behavior (continued use despite adverse consequences). Adverse consequences may include failure to fulfill role obligations, legal problems, exposure to hazardous situations, or recurrent social or interpersonal problems.

Substance Dependence. Substance dependence indicates substance abuse with the additional presence of the following phenomena (three of the following phenomena are required by DSM-IV to make a diagnosis of dependence): tolerance, withdrawal phenomena, greater than intended use, persistent efforts to cut down, a great deal of time spent in substance-abuse-related activities, and neglect of other activities.

Substance Withdrawal. Withdrawal phenomena with marked physical or psychological phenomena are common with all major drugs of abuse. Evidence of physical withdrawal indicates a need for immediate medical attention.

Substance Abuse/Dependence. All clinicians should have some familiarity with the basics of the diagnosis and treatment of substance abuse even if they do not treat substance abusers themselves. Treatment of the substance abuser requires identification of the problem and decision of the employee to receive treatment, detoxification, rehabilitation, and relapse prevention. The successful treatment of substance abuse requires choosing appropriately among a wide variety of treatment modalities. Inpatient or structured outpatient treatment may be indicated. Medication (naltrexone, sleep medication, antidepressant medication, antianxiety medication) may be helpful for relapse prevention and treatment of comorbid symptoms. Psychotherapy (individual, group, family) may be indicated. Involvement in an AA model self-help group is almost always appropriate.

Psychotic Disorders

Psychotic disorders are characterized by prominent and generally persistent psychotic symptoms including delusions, hallucinations, or paranoia. When these symptoms appear in the workplace setting, they are often secondary to major depression, bipolar, or substance-abuse disorders. Employees may appear eccentric, preoccupied, withdrawn, or out of control. Primary psychotic disorders such as schizophrenia are less likely to have their first presentation in the workplace setting. As noted above, the presence of any psychotic symptoms is an indication for immediate evaluation by a clinician skilled and comfortable in evaluating psychotic symptoms.

Treatment of schizophrenia usually starts with an antipsychotic medication. Such older medications as chlorpromazine and haloperidol are being replaced by newer antipsychotics such as risperidone and olanzepine. These newer "atypical" antipsychotics offer improved benefit with significantly fewer side effects. Medication often includes antidepressant or antipanic medication as well. Psychotherapy is largely supportive at first, though many patients benefit from group psychotherapy and more involved individual therapy. It is important to remember that psychotic symptoms are generally responsive to antipsychotic medication these days.

Personality Disorders

Every individual has recognizable personality traits and styles. Those personal styles generally have both advantages and disadvantages. Personality disorders, though, are rigid and exaggerated personality styles that generally interfere with relationships and functioning. A poor fit between personality and job function or organizational structure can

be a major source of stress in the workplace. This poor fit may be detrimental to the individual or the organization. Although a full discussion of personality disorders is beyond the scope of this article, some attention to personality issues is always warranted in the evaluation of an emotional complaint. Personality disorders are often associated with diagnosable anxiety and mood disorders. The categories of personality disorders recognized by *DSM-IV* include paranoid, schizoid, schizotypal, antisocial, borderline, histrionic, narcissistic, avoidant, dependent, and obsessive-compulsive.

In general, personality disorders are most responsive to psychotherapy. However, medication can be used to promptly treat comorbid syndromes while psychotherapy is initiated. Medication treatment of concurrent anxiety and mood disorders will typically reduce personality rigidity and allow psychotherapy to work faster and more easily.

Malingering/Factitious Disorder

No discussion of workplace mental health complaints is complete without some attention to fabricated symptoms. Feigned symptoms may be deliberate or unwitting. Symptoms may be intentionally produced in the presence of external incentives (malingering), or without any external incentives (factitious disorder, where the goal is to seek a sick role). Symptoms may be physical or psychological.

Careful evaluation for malingering or factitious disorder is indicated when symptoms are inconsistent with likely diagnostic categories, where legal and entitlement issues are involved, and where there appears to be noncompliance with full evaluation. Importantly, fabricated symptoms can coexist with genuine psychiatric disorders.

Malingering (feigning symptoms for external benefit) is not an emotional disorder and does not generally respond to psychotherapy or medication. Factitious disorder (feigning symptoms without external benefit in order to be considered ill) is an emotional disorder that may be treatable with appropriate psychotherapy.

Stress Complaints without Underlying Physical or Psychiatric Disease

Emotional complaints (either physical or psychological) may also be present without apparent underlying physical or psychiatric illness. This should prompt another review of the history and differential diagnosis. The presence of limited or inconsistent symptoms that still do not meet criteria for any of the above disorders may nonetheless require symptomatic treatment.

When psychological symptoms of stress are present without a diagnosable psychiatric disorder, symptomatic treatment is indicated. Antianxiety medications are often useful for brief or intermittent treatment of anxiety. Antidepressant medications are not indicated for the treatment of depressed mood in the absence of any of the above psychiatric diagnoses. Brief supportive psychotherapy is also frequently useful in the treatment of anxiety or depressed mood in the absence of the diagnosis of a psychiatric disorder.

MENTAL STATUS EXAMINATION

The mental status examination (MSE) supplements the employee's psychiatric history in the same way that a physical examination complements an employee's medical history. A detailed MSE might include specific questions or tests about memory, abstraction, concentration, orientation, knowledge, suicidal and violent thoughts, and self-reported mood. Perhaps most importantly, though, the MSE includes careful observation about affect (observed emotion), anxiety, judgment, self-awareness, behavior, personal interaction, thought process, and speech content.

References are available from the authors.

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In the May issue of the **EAPA Exchange,** *the third and concluding part of this article will discuss the differential diagnosis, recognizing when conditions require immediate psychiatric referral, considering non-urgent psychiatric referrals, therapeutic approaches to treatment, workplace and family interventions, workplace prevention, and independent medical evaluations.*

Licensed Mental Health Professionals Needed for May 5, National Anxiety Disorders Screening Day

If you are a licensed mental health professional and would like to learn more about participating in the upcoming National Anxiety Disorders Screening Day, scheduled for May 5, 1999, call Mary Guardino or Jeanine Christiana at Freedom from Fear, 718-351-1717; (e-mail) fffnadsd@aol.com

New Document Offers Assistance with Creating a Living Will

"Five Wishes," a document first used in the state of Florida in 1997 by individuals who wanted to set up a legal living will is now available for free on the Internet at www.agingwithdignity.org; also available by mail for $4 (to cover postage and handling) from Aging with Dignity, P.O. Box 1661, Tallahassee, Florida 32302-1661.

In Memory of Our EAPA Friends Who Passed Away

EAPA Emeritus Member **Hal Davidson** died in October 1998. Davidson received Emeritus Membership status in 1993 for his guiding and stabilizing influence with the EAPA Alabama Chapter. In his 1993 letter of recommendation to emeritus status for Davidson, Larry Robinson wrote, "Hal was always willing and ready to help with any request or assignment that was asked of him. He was the first to volunteer whenever a volunteer was needed."


Tom O'Connor

Tom O'Connor, who served as EAPA president from 1982 to 1984 and held several Board positions before then, died on October 20, 1998. O'Connor designed and implemented the occupational alcoholism program at Boston Edison Company in 1963. He was also executive director of the Arch Foundation, which sponsors the Gavin Halfway and Three Quarters houses, as well as board member and secretary of the Archdiocese of Boston's recovery program for priests.

Dick Bickerton, who served as both EAPA member and EAPA staff person, died in February 1999. EAPA Mid-Atlantic Regional Director Dorothy Blum, EAPA member Jim O'Hair, and EAPA COO Sylvia Straub represented EAPA at his funeral in Virginia.

Bickerton received a Special Recognition Award from EAPA in 1997 to honor his contributions as the first manager of the ALMACA Clearinghouse, which was later renamed the EAPA Resource Center. Bickerton had also been very active in the EAPA Small Business Committee.


Dick Bickerton


Geraldine O. Delaney

Geraldine O. Delaney, who, in 1957, founded Alina Lodge, a treatment center for addiction, died on August 9, 1998. Former EAPA President Jack Hennessy represented EAPA at her funeral service.

While becoming one of the most successful female executives in U.S. healthcare, Mrs. "D" spiraled deeper into her own addiction. She eventually recovered with the help of Bill Wilson, his wife Lois, and the 12-step programs. She went on to develop a "no nonsense treatment program for those "reluctant to recover."

Internationally known, Mrs. "D" was counselor to the Office of Economic Opportunities; on the advisory board of the U.S. Alcohol, Drug Abuse, and Mental Health Administration; and a frequent lecturer and trainer at the Rutgers School of Alcohol Studies. Mrs. "D" recognized that families of addicts needed education to support family recovery. She started one of the first residential family programs in the country and was often quoted as saying, "I've heard a family member undo in five minutes what has taken us five months to achieve."

(Our thanks to Mark J. Schottinger, executive director of Little Hill-Alina Lodge, for sharing information about Mrs. "D" with EAPA.)

Constructive Confrontation

Three Generations and Still Counting

by Ken Collins

A couple of weeks ago, I got a call from John Riley, EAP manager at Chevron. "Ken", he said, "We lost a friend yesterday. Sully Sullivan passed away." I got to know Sully during my years at Chevron, where he established their first EAP nearly 30 years ago. Like a proud parent, he would call every now and then to check up on the program. Sully was a charter member of EAPA, serving as its first vice president and then succeeding Frank Huddleston as its second president.

It's an open question whether the EAP model developed by Sully, Frank Huddleston, and the others who met for the first time in April 1971 at the Los Angeles National Council on Alcoholism offices (to establish the Association of Labor-Management Administrators and Consultants on Alcoholism) will survive. While more and more companies are purchasing EAPs, the number of internally staffed and/or managed programs keeps dropping. It's not merely that companies are blindly following one another in a rush to outsource whatever is not "core business." The disturbing fact is that the EAP core technology that ties the EAP function to the workplace is disappearing, along with the internal model. I recognize that this may not be true for labor programs or educational institutions or for regional programs serving local industries. Among the large employers, quite a few of whom have had internal programs since the early 1970s, the pattern is clear. My purpose for writing this column, which will appear on a regular basis in the *Exchange,* is to examine what is changing in the EAP world and to assess what these changes mean.

First Generation Values

Many, if not most, of the older EAPs were begun and staffed by recovering people. People like Sully Sullivan got involved with EAPs, having already established deep roots in their companies. (Incredible as it may seem today, there was a time when you hired on in your youth, worked your way up, and retired from the very same organization.) Sully and others from his generation brought to their work what can best be called "communitarian" values, flowing from their personal involvement in the recovering community. Their mission, (and it could truly be called a "mission"), was to prevent alcoholism from reaching its fatal conclusion by using the threat of job loss to break through denial. Some, like Sully, had actually spent time in their company's marketing function and were gifted at selling others on their ideas. Many of this first generation knew their company's culture and how to effectively promote their programs within their organizations. These programs got off the ground not only because their champions understood the corporate culture, but also because they could actively draw upon the trust they had previously established with executive-level management.

Second Generation Values

Many programs, like Sully's, began with occupational alcoholism, but expanded their scope within a few years to include various psychological, personal, and relationship issues. In becoming broad brush, these programs continued to encourage supervisors to refer employees with job performance issues. Yet, as program coverage widened, EAPs came to be seen more as employee benefits and less as a means of preventing personal problems from interfering with work performance. As EAPs expanded, positions for mental health professionals opened up in large numbers. This second generation of EA professionals, with master's degrees in social work and family counseling or doctorates in psychology, brought with them clinical skills to identify depression, anxiety, and post-traumatic stress. They placed equal emphasis on stress reduction sessions for employees alongside of supervisor training. Their caseloads reflected the transition from alcoholism to family and psychological problems as primary issues. While utilization rates climbed out of single-digit figures, self-referrals began increasingly to dwarf the number of supervisor referrals. During this era, EAPs became increasingly involved with policy considerations related to sexual harassment, workplace violence, benefits design, and compliance with federal regulations. These inroads into the organization represented a level of integration that was far broader than what was achieved by the first generation, although not nearly as deep.

Third Generation Values

In the early 1990s, the field shifted again. EAPs at Chevron and other