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SOLUTIONS TO THE PROBLEMS
JANUARY 1994
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SOLUTIONS TO THE PROBLEMS

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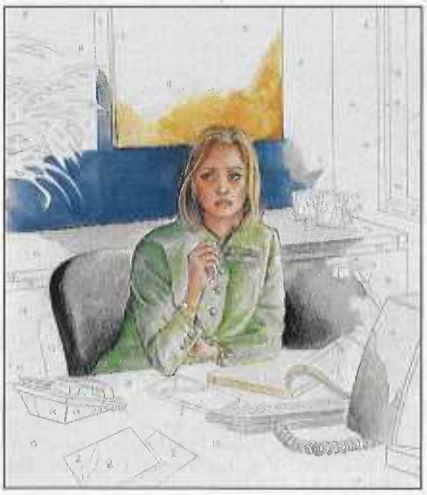

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Cover Photography by Joe Griffin, Sports equipment courtesy of The "Out" House, Waco, Texas

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Surviving the Cut

Survivor Syndrome May Sabotage Downsizing Objectives

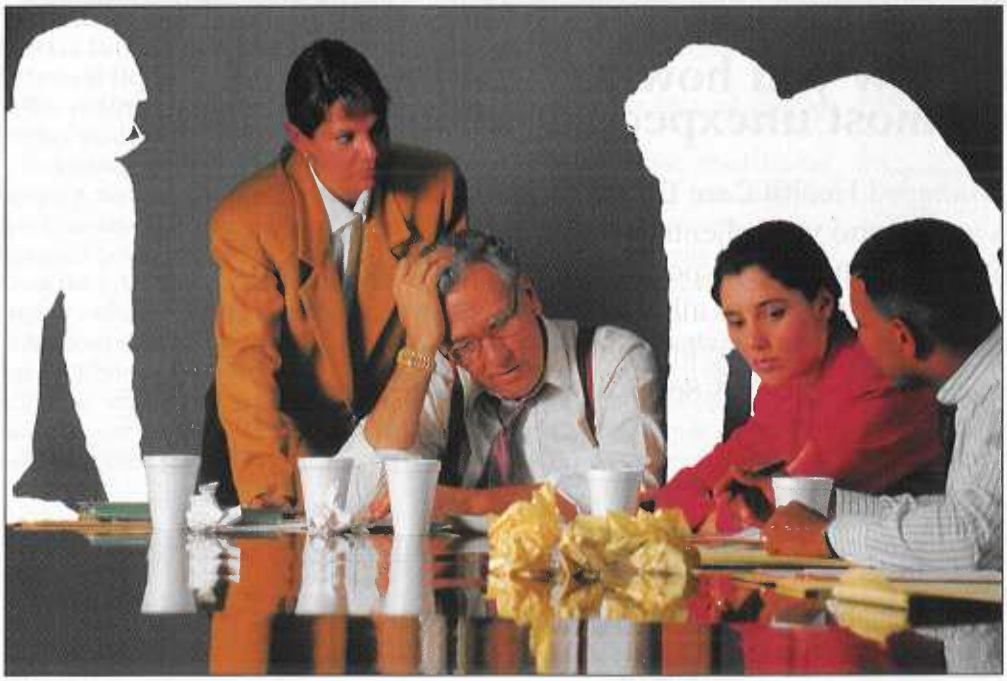
By R.O. (Bob) Fournier, MSOD

Downsizing, as we all know by now, has become the number one business strategy in North America for the 1990s. The word "downsize" does not even exist in any dictionary that I can find, but we certainly know what it means in layperson's terms—layoffs for tens of thousands of people across the country. It is a disastrous strategy for individuals, families and communities. It also speaks volumes about our continuing attempts to "buy" our way out of situations that we managed our way into over the past 30 to 40 years.

During that period between the 1950s and the end of the 1970s, North American organizations got fat with human resources and, as a result, they became less efficient and less effective. The quality movement in Japan showed us that we could not move large organizations fast enough in new directions to recapture the marketplace. The stage was set for downsizing and its traumatic effects.

As with any change story, downsizing has two sides to its implementation. The first side concerns those employees who have been selected to leave the organization primarily for "performance-based" reasons; or by seniority in the case of hourly-paid, unionized groups; or in some cases, simply because a certain type of work can be contracted out at a significantly reduced cost to the organization.

The other side of downsizing is coping with "survivor syndrome." The survivors face many difficult challenges in the future, and the organizations they work in are generally unprepared and ill-equipped for the negative effects of downsizing on the workers who remain. Managers have little or no experience in this area. Most are so wrapped up in the activities related to moving people out of the organization and reshuffling work that still needs to be done that they simply are unable to attend to the needs and concerns of those who are still there.



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THE SYNDROME. *Relief.* The survivor syndrome, in my experience, occurs in stages over time. The first stage is, obviously relief that "we" survived the cut. For unionized employees, this is often known well in advance since seniority most often dictates who stays and who is to be laid off. In the case of professional and administrative staff, however, performance, personality, sponsorship and seniority are taken into account in the decision-making process. The different approaches used for these two groups are reflected in the amount of relief displayed by the survivors. This relief is almost always accompanied by a corresponding increase in productivity by all remaining employees across the organization.

Guilt. Relief is short-lived as the second stage of grief and guilt sets in. In almost every case of downsizing, the employees who survived have friends or colleagues whom they know and respect, who have been laid off in the exercise. The survivors feel sorry that these friends and colleagues were forced to leave the organization through no fault of their own and worry about their welfare. Although they are powerless to change the fate of these people, if layoffs are stretched out over a lengthy period, the survivors will eventually avoid those who are leaving. This is often caused by the survivors' personal feelings of guilt that the others are leaving and they are staying. "Why him, and not me?" or "Why her and not Jane?" are common questions asked during this stage.

Anger. The third stage is one marked by anger at the organization's management for:

- not managing effectively to avert these measures;

• not accepting full responsibility for the organization's woes;
• choosing a downsizing strategy as a cop-out for poor decisions in the past; and
• not having the guts to remove the real poor performers from the organization when the opportunity presented itself.

This anger has a tendency to distract employees from their tasks and causes an increase in stress and a deterioration of relationships between subordinates and their superiors, as well as between peers. In extreme cases this can lead to incidents, and in heavy industries may eventually result in unsafe conditions and injuries. I have known organizations where anger and stress were still active many years after the downsizing had been completed.

Organizations and managers who do not see, or choose to ignore, the effects of downsizing on the surviving workforce are likely to be in for some very unpleasant surprises down the road. As the stages unfold and recycle, productivity will eventually drop off as people get tired of attempting to maintain unusually high energy levels. Absenteeism and short-term illness increases will result as fatigue sets in. Employees feel overworked, understaffed and unsupported by management.

If the organization falters in its attempts to maintain lower costs and high outputs with often significantly reduced human resources, the survivors will almost certainly begin to experience all of the feelings that came with the pre-downsizing era. Fear, uncertainty and waiting for the other shoe to drop will once again become the norm; and if left unchecked, they may well result in a self-fulfilling prophecy of another downsizing episode.

Renewal. There is a fourth stage in this whole process—that of renewal. This stage occurs when the new organization begins to stabilize and order replaces chaos. The organization has usually worked through most of the issues associated with the downsizing and begins to renew its energy; and the survivors become more focused on their goals and objectives.

In this stage, the organization is capable of achieving and maintaining more effective levels of real performance and productivity. Organizational life is less hectic and hurried, and much more synergistic as individuals and groups work together in harmony, not forgetting but setting aside the pain of downsizing and getting on with their new realities. It is difficult to determine how many organizations actually reach this level of stability.

One organization I worked with underwent a series of downsizings beginning in 1982 and ending (or has it?) in 1990. In 1993, the survivors were still struggling with all of the three stages, and there appears to be no end in sight for them. (This particular organization underwent three down-

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sizings in eight years, and at present—three years later—is still in the midst of one.) Part of the problem is that they are in a stable, but low-growth market, and each time they downsize their profits rise dramatically for a short period of time. Unfortunately that rise is not sustainable, and the specter of more downsizing looms over their heads.

It is even more unfortunate that their managers are driven only by quarterly reports and stock market analyses, both powerful motivators. I will not be surprised if this organization simply downsizes itself out of existence.

EAPS AND THE SYNDROME. Employee assistance professionals are uniquely placed in organizations to help managers and employees address the four stages of the syndrome. In their work, particularly if they adopt the role I defined in "Navigating a New Role: EAPs and Teams at Work" (*EmployeeAssistance,* August 1993), EAPs can track the health of the organization over time and alert it to potential problems. In addition, they should be able to sense changes in the organization's pulse. Those changes are often subtle but discernible to trained observers who know what they are looking for inside the system, as well as where to look for problems.

In one organization I worked with, we were able to predict when and where problems would occur by simply collecting data anonymously as the downsizing approached. A team of managers, union representatives, and professional and administrative staff working together with the data were able to design preventive strategies for implementation as the downsizing unfolded on schedule. These strategies not only reduced some of the negative effects of the experience on the survivors, but actually created an esprit de corps which carried the organization through the difficult times with a much more positive attitude than expected. In the long term, this work served as a springboard for a healthy culture that was capable of competing more effectively than ever before in its market sector.

The EAP's counseling role is even more crucial during the downsizing activity and not only with their usual clients. Managers at all levels of the organization will require informal, if not formal, counseling as they work through the various stages with individuals and groups on a daily basis.

As with any change of this nature, you will find that people can one day be relieved, the next day angry and the next day relieved again—this results in increased stress among managers and union leaders, and they are in need of counseling to understand and depersonalize these events. They also need advice from reliable sources on how to manage the organization through the transition with stability, and help individuals and groups that display a variety of mixed reactions to the downsizing activity. That advice is only credible from a third party with an unjaundiced view of the organization. The sole objective is to help the organization through the turbulent times.

UNIQUE OPPORTUNITY. Downsizing affords a unique opportunity for the organization to examine its "people systems"; but managers and human resource professionals may have little time and no resources to expend on this activity as they work on the more visible issues associated with moving people out of or around the organization.

EAPs may not have a lot of disposable time available during this period either, but it is worth finding the time to get a good sense of how, or whether, existing systems will fit in the new organization. Will they help or hinder stability? Will they induce collaboration or competition among the remaining employees? Will the systems have value-added effects or simply frustrate the workforce? Do we need to eliminate some systems altogether or replace them?

Almost all organizations miss this opportunity only to regret it later as the survivors rebel against outdated people systems. Those systems may also have contributed to some of the organization's malaise and its inability to compete as well as it should have in the past. If that is the case, then there is a high probability that it will do so again in the future and erode any short-term gains realized by downsizing.

As an objective third party, EAPs

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This course is especially valuable to:

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- **April 27-28, Roosevelt Hotel, Manhatten, NY**
- **November 16-17, Back Bay Hilton, Boston, MA**

To register or receive a training brochure contact:
Employee Assistance Professionals Association, Inc.
2101 Wilson Blvd., Suite 500, Arlington, VA 22201; phone (703) 522-6272; fax (703) 522-4585

6 DATES & LOCATIONS

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have three things in their favor:
1. Credibility built through being seen as helpful.
2. The trust of managers and employees alike. (A word of caution here—trust is your greatest asset, but the most fragile and, therefore, easiest to lose.)
3. What I call the license to ask dumb questions.

These characteristics will help EAPs collect accurate data from which to develop effective recommendations for action, particularly those management will require.

OBJECTIVITY. I have mentioned objectivity more than once in this article because the organization in a downsizing mode is emotionally changed and requires third party helpers to maintain an appearance of non-involvement while being involved. You must not only be objective in word and deed but you must be viewed to be this way by all members of the organization if your work is to be effective.

Those of us in EA and OD who have been involved in these situations will attest to the fact that this is an extremely difficult role to play. I have, in the course of my work in this area formed many opinions about what should and should not be done; and internally, at least, these 'parent tapes' have played loudly and emotionally for me.

I have on occasion formed judgments and have been humanly guilty of some very strong feelings about how an organization treats people, particularly the survivors throughout the downsizing and beyond. During those moments I had to remind myself, or be reminded by the significant others in my life, that:

- I am an advocate for the organization in the change process.
- I may be the only person in the organization to whom people at all levels can turn to for support by way of listening and communicating problems in a non-threatening way.
- When I am not objective, I am less effective in a critical role.
- No one got up on the wrong side of the bed one morning and decided to go to the office and fire hundreds or thousands of people. That decision is never made by one person, nor is it made without a great deal of painful deliberation.
- These are unusual circumstances, causing abnormal behaviors to be displayed.
- The organization is out of sync with its normal operating mode, and I can contribute to creating some semblance of stability through timely and helpful interventions.

These reminders have always been invaluable to me in my work with downsizing organizations, and they are outstanding advice for anyone who chooses to step into the fray.

THE ADVOCACY ROLE. Finally, I offer some advice for anyone who chooses to play the helper role in downsizing. First, remember that you have chosen an advocacy role for positive change in the process—as futile as it may seem to be at times. This should define how you act and work during this time.

Second, the organization may reject recommendations and advice that you propose. Remember the emotional state the organization is in and be assured that most logical managers and unions will act differently based on your interventions—it may not be exactly what you propose, but they will act.

Third, I have sometimes found it useful to work by the adage that says "It is easier to ask for forgiveness than to receive permission." At times you may see things that require immediate intervention, but you are uncertain as to whether you have the approval to act on them. In those cases, I suggest you act on the data in front of you, and on your instincts. Most often I have found that I responded to a need that the person or organization was simply unable to communicate in ways that it customarily would under normal conditions. Part of the third party role is to create clarity from watching the chaos.

Fourth, don't expect a lot of thanks for your interventions, either during or after the change process, and don't take rejection of your good advice and counsel personally. Organizations, for some obvious and not so obvious reasons, want and need to believe that all good ideas are developed internally and not by some "outsider" who couldn't possibly understand what is going on because he or she is not "one of us." Your sense of

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FIVE LEVELS OF CARE MAKE ONE IMPORTANT DIFFERENCE. COST CONTAINMENT.

Detoxification Treatment Program

The average length of stay in the Sub-acute program is five days. The Sub-acute level of care necessitates the highest level of medical monitoring. Twenty-four hour-a-day nursing with a 1:3 patient ratio is standard. One-on-one, twenty-four hour-a-day visual monitoring is provided by the nursing staff to patients requiring this level of care.

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A multidisciplinary treatment team consisting of the Medical Director, Addictionologist, Psychologist, Nutritionist, Nurse, Master's-level Therapist and an Addictions Counselor review all the findings and develop each patient's specific treatment plan. Each patient works with this treatment team throughout their inpatient stay so that their specific treatment goals are achieved. The treatment team meets a minimum of once per week to evaluate the patient's progress.

Partial Hospitalization

A multilevel outpatient program consistent with an Addiction Medicine model. Patients are assigned to a level within the overall program, based on medical necessity and which best meets their needs. All services are conducted by full-time professionals under the leadership of our Medical Directors, our Board Certified Psychiatrist and our Addictionologist.

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This program serves patients who are stable enough to continue their work during the day, and who can be involved in intensive evening sessions. A patient-specific treatment plan is developed in conjunction with the primary treatment team. This strategy has dramatically reduced the number of patients dropping out of treatment during the transfer from one level of care to another.

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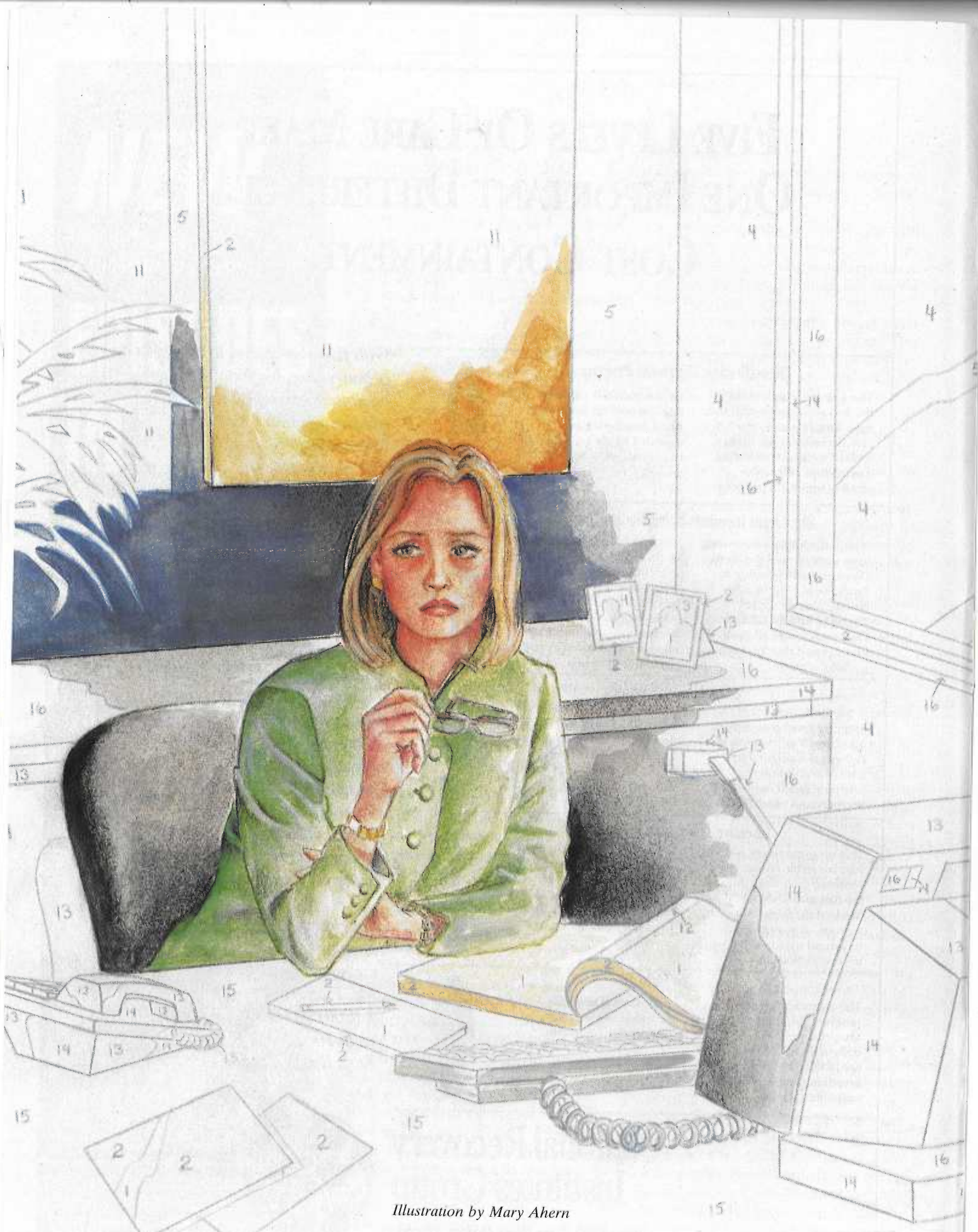

Illustration by Mary Ahern

Unfinished Recovery

Partial-Fix Treatment Strategies Miss Multiple Diagnosis

By Cardwell C. Nuckols, PhD, and John T. Gohman II, DPA

Many employee assistance professionals remember the days when the following was true:

- You identified an employee with alcoholism or drug dependence;
- You referred them to treatment;
- The employee returned to work with a recovery plan; and
- The insurance company paid the bill—few questions asked!

We recall treatment centers during the 1970s with no marketing staff or waiting lists and a staff-to-patient ratio of 1-to-3 or 1-to-4. Patients entered treatment with two kids, a spouse, good insurance, a supportive environment and a past history of responsible living. No one had even heard of medical review, precertification and many other terms used today.

Now, many EAPs pray for those days, hoping to see one more 45- year-old alcoholic with an intact family.

A SICKER POPULATION. Today it seems we are seeing a sicker population of patients than ever before. There are three variables at the heart of this problem. They include:

1. Early Onset of Drug and Alcohol Use. Children of the 1950s and 1960s had their mood altering alcohol or drug experience between the ages of 13 and 14. Later generations now entering the work force may have initiated use at ages as young as 8 or 9 years old. The average age of onset for high risk adolescents is 10 years old to 11 years old.

Disruption of the crucial development period at 11 years old to 13 years old causes serious difficulties. This is the time of great social and cognitive progress. Many of these individuals display poor social skills relying almost exclusively on anger or withdrawal to solve problems. Cognitively, they are stuck in a concrete stage of development. Between the ages of 11 and 13, the adolescent progresses to a formal stage, developing the important skills of conceptualization, problem solving and abstraction.

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Early onset of use often is associated with an individual who has poor social and cognitive skills and may seem somewhat narcissistic and anti-social. Skills necessary for both workplace production and recovery are often ill-developed.

2. Stronger Drugs. In the last two decades, the drugs on the market have become more addictive, both physically and psychologically; and addiction occurs quite rapidly. Most employee assistance professionals have struggled with crack-addicted employees. It appears that crack will continue to be popular in the 1990s, but heroin is staging a comeback. Even the marijuana smoked today is two times to four times stronger than that smoked in the 1960s and 1970s.

Add to the strength of the drug the fact that these drugs can be and often are smoked. Taking the drug via the pulmonary route gets the substance to the brain twice as fast as sticking a needle in a vein.

Adverse Environments. Over the past three decades, there has been expanded concern about the consequences of children growing up in alcoholic or other adverse family environments.

From a relapse perspective, the loss of family values, combined with drug subculture street values, creates a deadly combination. The lack of positive male and female role models and a supportive recovery environment hampers recovery attempts. Many neighborhoods are more conducive to relapse than recovery.

THE DILEMMA. We are treating a population with more complicated problems. More pathology is being diagnosed than ever before. However, as sicker patients are admitted, another trend is developing: Treatment stays are briefer and case loads are larger, exacerbating the problem. "Sicker clients" should call for more help and a greater intensity of treatment, but this is not necessarily happening. The following two cases illustrate this dilemma.

Case I: A 28-year-old male employed by the city was admitted for detoxification only. He recently relapsed on crack cocaine and alcohol after 40 days of abstinence post-treatment.

The patient has a long-standing history of chemical abuse and dependency. Initial use consisted of marijuana and alcohol at age nine. Consumption of mood-altering substances has been consistent with a brief interruption after the last treatment episode.

This individual lives in a part of the city known for gang involvement and drug dealing. He has had difficulty maintaining abstinence-based contracts. His brother, who resides in the same household, is a gang member who sells and uses crack.

This patient's case is further compromised by extraordinarily estranged relationships with people. He has a past psychiatric history of bipolar disorder. The patient reported that he started having "mood swings" in his early 20s. He was diagnosed as having bipolar disorder in 1989 and was started on lithium. He continues to take this medication with frequent interruptions.

Case Analysis: This patient was certified for a seven-day hospital stay with 12 outpatient visits. Although this would allow for acute stabilization and development of a recovery plan, many relapse issues remained.

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WHY SHOULD YOU REFER HEAD-INJURED PEDIATRIC PATIENTS TO CUMBERLAND HOSPITAL?

Cumberland Specializes in Child & Adolescent Care

Each year some 200 pediatric patients ages 2–22 are admitted to Cumberland Hospital for Children and Adolescents. Being able to interact with their peers gives them a valuable social and psychological advantage in their road to recovery.

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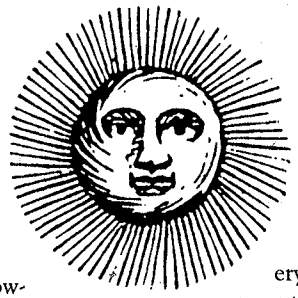
And, because recreation is an important part of head injury therapy, Cumberland makes sure its patients spend time in creative play, exercise and recreational therapy—on the playground and in the gym. At Cumberland kids can still be kids.

Cumberland Has Successful Experience Treating Head-Injuries

Cumberland is a JCAHO-accredited hospital, with eight years' experience treating patients with all levels of head injuries. This table shows the percentage of patients admitted to Cumberland at each RLA level during the past three years:

RLA Level 1	2.0%
RLA Level 2	45.0%
RLA Level 3	16.8%
RLA Level 4	15.7%
RLA Level 5	5.3%
RLA Level 6	5.2%
RLA Level 7	6.3%
RLA Level 8	3.2%



In addition, Cumberland has the experience treating young patients with many types of head injuries. This table shows the percentage of patients admitted with head injuries resulting from the following causes:

Automobile accident	44.0%
Pedestrian accident	15.2%
Bicycle accident	8.2%
ATV accident	5.3%
Skateboard	2.1%
All others	30.4%

Cumberland's Staff

Because Cumberland is a hospital, and not just a rehab center, you can be confident that treatment is delivered by licensed rehabilitation professionals and other accredited hospital staff, all under the direction of an admitting physician. All physicians on Cumberland's admitting staff are board-certified in their specialty, and dedicated to the treatment of head-injured patients, The staff includes Donald A. Taylor, M.D., *Pediatric Neurologist*, Michael J. Decker, M.D., *Physiatrist*, Daniel N. Davidow, M.D., *Pediatrician*, and James E. Sellman, M.D., *Pediatric Psychiatrist*.

Cumberland Hospital's Quiet Country Setting

Cumberland Hospital is located on a quiet, college-like campus that spans some 1,200 acres, just a few miles from Colonial Williamsburg and Jamestown. Healthy, outdoor activities—such as walking, hiking, and fishing—all available right here on the Cumberland campus are part of our comprehensive rehabilitation program.

Here, patients and their families can escape the hectic pace of everyday life and refocus their lives on the rehabilitation process.

At dawn and dusk, deer can often be seen grazing at the edge of the woods around the hospital, and flocks of Canada geese stop by to feed and rest on their journeys North and South.

Cumberland Patients Recover

Cumberland has a proven record of successful treatment and recovery with head-injured patients. In a recent study conducted jointly with the Medical College of Virginia Hospitals, of 36 patients at RLA 4 or below who were admitted to Cumberland within 180 days post-injury, 22 made substantial improvement of two or more levels on the RLA scale, while 9 of the remaining 14 patients improved by one RLA level. In the same study, it was noted that 10 of 16 patients admitted 180 days post-injury in a vegetative state improved by two or more levels on the RLA scale.

Cumberland Knows You Want Only the Best for Your Patients

When so much is at stake in the life of a young patient, we know you won't settle for anything less. Cumberland Hospital is ready to answer your questions or to admit your next referral.

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1-800-368-3472

Cumberland Hospital for Children and Adolescents
New Kent, Virginia

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Because of early onset of use and adverse environmental conditions, this patient lacks social and cognitive skills necessary for successful recovery. His need for continuous (one year plus) clinical guidance and support (halfway house, transitional facility, etc.) is evident.

The fact that he is addicted to crack cocaine also negatively impacts his opportunity for recovery. The drug, the environment and the lack of social skills require longer term supportive or surrogate approaches. If he has short-term support, the odds are less than 10 percent that he can stay abstinent.

Case II: This is a 32-year-old female who was referred for short-term (12 sessions) outpatient treatment due to progressive worsening of chemical dependency and a history of accidents on the job. She has no history of treatment.

For the past seven years, this patient has used benzodiazepines at two to three times the therapeutic dose. Her condition has worsened over the past two years as her use of alcohol has escalated to five or six drinks per day.

The patient reported that over the past four to five years, she developed a strong craving for food and started bingeing on a daily basis. Her weight increased to over 200 pounds. During the past year, she has tried several fad diets and resorted to the use of laxatives. Her weight dropped 72 pounds in five to six months.

She complains of symptoms of depression and has had one incident of overdose on tranquilizers approximately one year ago.

The patient is currently married to a man she describes as "abusive." This is the third marriage for this individual. She also claims to be an incest survivor.

Case Analysis: An adverse environment may be the single most common cause of relapse. This patient's current home situation, as well as her past history of familial trauma, make her an extremely poor candidate for short-term outpatient success.

Also, the combination of benzodiazepine and alcohol withdrawal can be hazardous without close medical supervision.

It certainly would appear that the possibility of clinical depression and self-destructive behavior along with the drug and eating disorders should mandate a more medical and intensive approach.

GAINS AND LOSSES. In years past, both of these cases—and thousands like them—would be immediately referred to an inpatient detoxification and rehabilitation hospital setting. The length of stay would probably have been twenty-one to twenty-eight days with a one year continuing care outpatient follow-up. Even at that length of stay, many of the family-related issues of relapse (e.g., incest trauma) would not have been addressed.

As we gain in technology, we seem to lose in treatment intensity. We know more about the integration of psychiatry, family, and trauma treatment, but how do we implement it? For both the EAP and the clinical specialist, this issue has become a frustrating one. More problems, more technology, but less time and less staff.

We can only predict that with current trends the field of treatment might revert to the chronic medical model of 30 years ago. Addictions treatment is becoming a patchwork stabilization job with increasing incidence of relapse and more profound medical pathology.

Tailoring treatment to a patient's individual needs is necessary. Admission and discharge criteria for every level of care is critical. Still, cost containment is imperative; not everyone needs 28 days or months of treatment. On the other hand, many will only become sicker if less restrictive approaches are the only formula.

Employee assistance and treatment professionals are the ones who should be making decisions based on multidisciplinary assessments regarding acuity and need for continuing stay—not someone who has never seen nor had a relationship with the individual.

Companies who are investing in reducing stay as a way to financially support their existence are making admission and length of stay decisions. This somehow seems like an overreaction to the earlier lack of controls placed on admission and length of stay. Somewhere in the middle lies the answer. Can we develop standards of care that best serve the patient and not just the financial well-being of the provider, monitoring agency or insurer? EA

Nuckols is president of Cardwell C. Nuckols & Associates in Apopica, Fla., and Gohman is executive director of Glenbeigh Health Sources, also in Florida.

Workplace Due Process: The EA Contribution

By Paul M. Roman, PhD

From my vantage point, the EA field is in growing turmoil as we move into 1994. Increasingly fierce competition is found within the EA field itself and between EA workers and those in emergent peripheral areas, such as managed care and behavioral health. Entrepreneurialism seems to have achieved dominance over professionalism.

In the face of this apparent turmoil, "the center can hold" if the EA field recognizes it is not a healthcare delivery system. Instead, it is a mechanism for the resolution of a quite wide range of problem situations in the workplace.

MORE ON THE CORE. The problems that are dealt with through EA technology are centered around employee behavior problems. However, EA workers seem busily engaged in fragmenting their work arena and talking themselves out of becoming a valued profession in the workplace. Many EA workers, along with many of their leaders, are convinced that clinical skills and activities are the centerpiece of their activities.

In today's cultural context, such an identity only encourages tighter supervision and scrutiny, cost concerns and questions about whether the EA function is actually promoting rather than reducing healthcare utilization.

If EA workers could recognize their work is not primarily clinical, they would have a firm base upon which to build claims for how EA work adds value to a range of existing organizational functions. This message has been heard in many quarters, but the field's leadership seems drawn, like moths to a flame, to the intrigue of impending disaster and disintegration of the field.

DUE PROCESS FUNCTION. Central among the key functions of EA activity is the provision of due process to problem employees, their supervisors and their work peers. In their obsession with the details of clinical diagnosis, many EA workers never understand how problem employees are viewed in the broader workplace context.

In many settings and situations, the troubled employee or the troubled relationships between employees and their supervisors are seen as powder kegs ready to blow. The blowup is often not the worst part, or the greatest fear of management. The bigger problem is the litigation that can follow the blowup.

Litigation is not only legal action against the workplace brought to bear by employees who believe they have been mistreated, it is also action that occurs internally in the workplace in the form of complaints, grievances, mediation and arbitration.

Whether initiated internally, externally, or both, litigation is very expensive for the workplace. It not only may lead to costly awards for those who are found to have been wronged, but it takes a great deal of time away from many employees' work.

It is also a typically demoralizing process. Litigation places conflict in a very strong spotlight. It makes people take sides, and causes anxiety and distress. The impact on morale generally affects productivity and turnover.

CONFLICT MANAGEMENT. If EA services are adequately and appropriately accessible in the workplace, they can offer a great deal in terms of avoiding both internal and external litigation.

One of the oldest advantages of EA work is its value in reducing the use of the formal grievance process in unionized settings. Typically the employee with behavior problems is an asset to neither labor nor management. Neither side is going to "win" in the internal litigation process if the individual's problem continues to affect his or her work.

The impact of EA presence on formal grievance reduction was observed across a wide range of unionized settings. These data were particularly important because they were generated in settings where unions would be especially alert to mechanisms that would inappropriately circumvent the agreed-upon grievance procedure, or which would attempt through clinical processes to turn legitimate grievances into medical symptoms.

Early EA work clearly had an impact on grievances that were centered around troubled employees. Indeed, it was the observation of these conflict resolutions that frequently cemented the foundation of "jointness" between labor and management around the ownership of the EAP in many of these unionized settings.

Beyond the reduction of formal grievances, EAPs can also be vital in providing counsel and advice to supervisors or work peers who find themselves in conflict with subordinates or colleagues. There are similar situations where supervisors or co-workers are simply bewildered by certain employee behaviors and need some guidance. In many such instances, problems are resolved by talking them through; and there needs to be a little consideration for anyone going to any kind of treatment.

ACCESSIBLE AND CREDIBLE. Of course, the counseling and advisory function can work only if EA services are visible and readily accessible to supervi-

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sors. Many of the today's EAPs have no workplace presence because their only function is to act as a clinical funnel into treatment settings. Although a supervisor might access these services over the phone or by visiting some downtown office, this is not likely.

Supervisory consultation is also limited by the extent to which the EA worker is knowledgeable about the workplace. Many EA workers have no management, supervisory or union backgrounds. Furthermore, in many instances EA workers are assigned to provide services to multiple sites where they will have little opportunity to gain enough familiarity to provide effective supervisory or peer consultation.

Probably most important is the extent to which people in a particular workplace perceive that an EA worker possesses adequate workplace knowledge to be of help to them. If there is minimal presence in the workplace by EA specialists, the less likely it is that they will be viewed as credible sources of consultation. Further, an identity as a "shrink" will lengthen this social distance even more, regardless of how "present" the EA worker happens to be.

PERCEPTIONS OF JUSTICE. It is important to observe that people have provided effective help to others since the beginning of time, long before the invention of EA work. Further, it is possible that effective help can be provided in workplaces without the presence of an EA program.

The significance of a formal program however is substantial. It allows for equity of treatment for all employees. Further, it eliminates the need to develop or reinvent a strategy for dealing with problem employees every time a new situation arises. Finally, a policy-based program has a life of its own, beyond the individuals who initiate it or who are crucial in providing support for its implementation.

A formal program is part of the mechanisms of bureaucratic organization that were discussed in a recent column. The purpose behind putting things in writing and diffusing the written documents to all affected parties (the essence of a "policy") is to assure fairness and to maximize the likelihood that everyone will be offered the same opportunities if such is necessary.

Consistent use of an EA policy is an excellent means for avoiding many forms of litigation, to say nothing of conflict reduction and resolution. It is important to note that in many court cases, the offering of EA services to problem employees has been judged an adequate opportunity for problem employees to seek the help necessary to bring their performance back up to par. In other words, employees with claims that they were unjustly disciplined or dismissed because of behavioral-medical problems have frequently had those claims denied if there is evidence that they were offered the opportunity to use EA services.

These examples of due process and conflict management demonstrate the critical value of EA work, independent of clinical expertise or treatment utilization. This description also demonstrates that it is crucial for EA work to be integrated into workplace functioning in order for the due process and conflict management benefits to be realized. EA

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

In Pursuit of the Right Questions

By Jim Francek

Downsizing, rightsizing, outsourcing, redeployment, restructering, relocation, realignment, reengineering—over the last ten years the world of work has created a new language. All of these factors have impinged directly on the employee assistance profession.

THE CONTEXT. The context that surrounded the early development of EA included prosperity, growth, expansionism, stability in the home and at work, and long-term employment. Employees often worked for large organizations that viewed them as assets and sought to develop loyalty and seniority. People who surfaced with addiction problems were often tolerated for extensive periods of time. The seeds of occupational alcoholism efforts were born out of direct experience with the success of 12-Step efforts.

As more and more companies developed programs, people working as EA professionals were seen as "experts" by other department professionals, who expected them to "fix the dysfunctional person," so he or she could be productive. The goal was to retain trained personnel. After all, training and retraining are costly.

During the 1980s, the context changed dramatically. Driven by large groups of stockholders—often keyed to pension funds—companies in an unregulated environment became the unlucky targets of those who would turn a fast profit. Undervalued companies found themselves targets of leveraged buy-outs, takeovers, mergers, redistributions of assets and sales of liabilities. Considerable technological changes were beginning to make it possible to do a lot more with far fewer people.

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EAPA Refutes Study's Claims

Research sponsored by the National Intitute on Drug Abuse (NIDA) and carried out by the National Research Council (NRC) reported that there was limited scientific evidence to prove a causative link between lower substance abuse in the workplace and the use of workplace drug testing.

Bradley K. Googins, PhD, part of the NRC committee, said many misinterpreted the findings to be an attack on the effectiveness of EAP interventions.

EAPA's chief operating office, Michael L. Benjamin, was quick to point out the McDonnell Douglas study findings that included a 5-to-1 return on investment in their EAP program. This study also mentioned higher productivity, fewer absences from work and fewer accidents. These results were considered conservative because they did not include replacement labor costs, recruiting and training costs, and excess benefits costs.

The research committee indicated EAPs concentrated more on finding new cases, devoting insufficient time to prevention of relapse. They also reported that follow-up was nearly non-existent or limited to one or two visits.

Benjamin responded by noting the emphasis of managed care on getting chemically dependent workers into treatment. He said long-term involvement under national health reform would allow EAPs to refocus on aftercare as well.

Study Estimates Depression Costs

In the latest study researching the cost of depression in the United States, economists at the Massachusetts Institute of Technology and the Analysis Group estimated the total related spending at $43.7 billion per year.

The study, published in the *Journal of Clinical Psychiatry,* includes one aspect absent in the most recent study by Dorothy Rice at the University of California, which estimated the cost at $30.4 billion. A $12 billion price tag for lost productivity at work accounts for the increased estimate. Until the MIT study, researchers only accounted for losses related to lost work days, hospitalization, lost income from suicides, outpatient care and drugs.

Economists estimated a 20-percent loss in productivity for days when those suffering from depression were at work. Joseph Caldwell, a Charleston, W.Va. lawyer, told *The Wall Street Journal* that while depressed he completed about 50 percent of a usual day's work.

Although Paul Greenberg, the study's lead author, admits the study includes less than perfect estimates, he also says it succeeds in communicating that mental illnesses are approaching the magnitude of physical illnesses in their cost to society—a fact that mental health advocates embrace as they continue to push for an increase in mental health benefits in healthcare reform.

The National Institute of Mental Health research estimates an 80-percent to 90-percent success rate in the treatment of depression. Unfortunately, only one in three sufferers ever seeks treatment.

EAPA Conference Headlines Managed Care, Added Value

EAPs, exhibitors, presenters and other addiction professionals gathered to grapple with the challenge of integrating with managed care and adding value to EA skills at the 1993 EAPA Conference held in Anaheim Nov. 13 to 17.

Keynote speaker, the Honorable Joseph H. Califano, Jr., president and COB for the Center on Addiction and Substance Abuse, spoke on CASA's efforts to fight America's drug problems. Califano said the disintegration of the family is part of the plague of alcoholism and drug abuse that is targeting teen-agers and even younger children. He noted the dearth in funds allocated to research chemical dependency—due in part to a general skepticism about treatment efficacy.

He pointed to the importance of early identification and indicated those who are in the ideal position to make an early identification are nurses and doctors in emergency rooms, judges and teachers.

For EA professionals who have been buffeted with voices of doom, Califano had positive words on EAPs being essential to implementing a turnaround.

He said CASA has a major role to inform society of the cost of substance abuse, and especially to move it into mainstream medical acceptance.

Califano ended with a warning: A

successful campaign has to deal with all aspects of the drug and addiction phenomenon—supply, prevention and treatment. "The real enemy is fragmentation of our efforts," he said.

A wealth of speakers presented the issue of added value from their own particular areas of expertise. Referring to the environmental niche established by a core technology, some pointed out that if the environment changes and professionals don't adapt, their services will become obsolete.

EA Profession Among 20 Best Job Opportunities

Social work, and more specifically, EAPs are popping up everywhere and they offer one of the 20 best employment opportunities for the future, according to a *U.S. News and World Report* survey.

Of the Fortune 500 companies, over 90 percent operate EAPs for their employees, either as a referral service or for personal counseling. Metropolitan areas offer the most opportunities in the field, according to the survey. EA professionals may earn from a $20,000 entry-level salary to a $50,000 top-level salary.

One of the extra benefits EA professionals encountered in their field, according to the survey, was the variety of people they work with, helping keep the work experience interesting. At the same time, survey response suggested aspects of the profession, such as dealing with work/family issues, may make the separation of work and home more difficult.

For training, the individuals need a bachelor's degree, and a master's degree in social work. Also, they are encouraged to take the Certified Employee Assistance Professional exam after working for three years.

Violence In Workplace Is On The Upswing

Thirty-two percent of 479 human resource professionals responding to a survey by the Society for Human Resource Management (SHRM) reported at least one act of violence in their workplace since 1989, a trend which experts predict will continue.

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More than half of those reporting violence indicated between two to five acts of violence occured in the past five years. According to SHRM President Michael R. Losey, that fact indicates violence in the workplace is a significant problem that is getting worse.

Fistfights and other physical altercations accounted for nearly 75 percent of the violence reported, while shootings accounted for an alarming 17 percent. Other violence included stabbings, sexual assault and use of explosives.

Programs Win NCADD Approval

The National Council on Alcoholism and Drug Dependence (NCADD) presented two affiliates with awards for their development of programs that address the treatment of college students and women.

The Nebraska and the Colorado affiliates received their awards and explained their programs at the Conference of Affiliates in Charlotte in October.

According to a report by NCADD, the programs addressed the complexity of treating patients of different ages and genders.

The Nebraska affiliate received a Meritorious Award for Life II Nebraska Collegiate Alcohol Abuse Prevention Project. The program uses three curricula to educate students on risk reduction, acute alcohol intoxication and the link between alcohol use and AIDS in a non-judgemental atmospere. The project provides Nebraska campuses with a common approach and over 10,000 people have been trained in Life II concepts.

The Denver affiliate received a Commendation Award for "Women and Addiction: Healing and Recovery in the 90s," a conference that educated participants in the unique needs and treatment of women by connecting with community agencies.

Coverage For Unwed Partners Stirs Controversy

Apple Computer faced losing a $750,000 tax break when three of the five county commissioners in Williamson County, Texas voted against the breaks because of Apple's benefit policy that covers the unmarried partners of its employees.

According to *The New York Times*, at the county meeting after the announcment of the tax breaks, one spectator argued that the county (located outside of Austin) had not been founded on principles condoning live-in lovers or homosexuality. County Commissioner David S. Hays, who previously stated the county should not interfere with the policies of a private company, changed his mind and joined two other commissioners in rejecting the tax abatement. Hays said he feared he would be tagged as one who brought homosexuality into the county.

In response to the county's initial rejection, Apple officials said the company would begin looking for a new location for their complex.

In continued negotiations, the commission reversed its prior rejection and came to an agreement with Apple.

The complex will bring an estimated $300 million and 1500 or more jobs into the area over several years. Apple officials said their policy is based not only on ecomonics, but also on prinicple.

Targeting Intervention

Evaluating Health Promotion, Focusing Resources

By Carole K. McMichael

Joe Griffen Photography

If your employees' rigorous workday routines translate into pounding keyboards and walking the 1k between file cabinet and desk, they might become frequent participants in wellness programs for high risk workers, or they might not. What you know about evaluating health promotion programs may make the difference. What you know about the trends of wellness under healthcare reform may help shape employee behavior in the workforce of tomorrow.

Employee Assistance interviewed Ron Z. Goetzel, PhD, executive director of Data Analysis and Evaluation Services for Johnson & Johnson Inc. in Washington, D.C., on how to evaluate successful wellness promotions.

EA: Where do wellness programs fit into a corporate structure?

GOETZEL: Wellness promotion has become much more central to the overall strategic business objectives of companies, and also much more well-integrated with other human resource functions, such as EAP, occupational health and safety, and organizational development and quality.

EA: What range of activities might be classified as wellness programs?

GOETZEL: Wellness promotion can involve identification and management of a whole range of high risk conditions, using programs such as: blood-pressure and cholesterol screening; smoking cessation; stress management; exercise and fitness; nutrition planning; motor vehicle and home safety education; alcohol and drug abuse identification; ergonomics problem screening; AIDS education; consumerism; and pregnancy education. We are beginning to see an expansion into disease management, dealing with employees with acute diseases as well as chronic conditions, such as diabetes or arthritis, to help them better manage those conditions and get back to work more quickly.

Health promotion is moving toward behavioral modification programs and ways in which they can merge behavioral, pharmaceutical or therapeutic inventions—getting better compliance. For example, in the area of diabetes, programs could determine how to get people to more closely monitor their diets and blood-sugar levels, and make appropriate intervention efforts.

EA: What should an EAP or HR department do when they want to approach management about implementing some kind of wellness program?

GOETZEL: They need to gather the evidence that such a

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program actually is effective. You start by outlining the objectives of the program. There are a number of different objective categories—one may be increased awareness of one's health and healthcare issues and proper management of one's health. Another may be behavior changes that are fairly easy to measure, such as smoking rates, seat belt usage and exercise and blood pressure levels. Management of healthcare costs may be another objective. Human resources outcomes could include things such as lower absenteeism, reduced workers' compensation and disability claims, improved productivity and reduced turnover.

Think through what kind of elements would help you achieve your objectives. You can provide evidence of how these programs have been able to impact the objectives at other sites and organizations, and you might actually do some baseline measurements within your organization to see how much these things are costing you and to what extent they can be related to lifestyle behaviors and characteristics of the population.

Examine the mechanisms now in place that can help you do baseline measurement. For example, take your medical claims experience and isolate what proportion of that experience is attributable to behaviors, habits or characteristics of a population. How much of it is something that is truly modifiable and could result in reduced utilization and cost?

EA: How important is it to have a timetable as part of the planning stage?
GOETZEL: You may want to have a general timetable initially; and if management agrees, you go to the nitty-gritty details of what is going to happen month by month. A general timetable is helpful in terms of the kinds of things you think you can achieve in a 12-month period, 24-month period and 36-month period—what are the anticipated goals of the program, coupled with anticipated outcomes? Once you have a buy in, you present the approximate level of investment that will be needed, followed by the details of what that pays for in terms of programs and interventions.

EA: What variation is there in evaluating wellness programs?
GOETZEL: There is a great deal of variation in terms of measuring outcomes, starting with the very inexpensive, straightforward customer survey that includes issues related to morale, self-reported productivity and health improvement. As you want to become more rigorous in your evaluation, you may work with the scientific community to do one of the best types of studies—one that has random groups versus intervention-control groups.

EA: Doesn't that have a long time frame?
GOETZEL: Not really. You can test the effectiveness of a program to manage blood pressure or cholesterol in a 12-month period. Economic outcomes usually do need a longer time frame to work. Also common is the before-and-after type of design, where you essen-

tially hope to see improvements in the key measures.

Health measures are the easiest to track and the ones we have the most control over. However, if the EAP is trying to say the program has an impact on productivity, measures will depend upon what access the organization has to the data, how valid the data are and what individual motivation influences those factors. If the EAP has done anything comparable for EAP functions, they may already be familiar with mechanisms that measure productivity.

Two related measures that are often evaluated are absenteeism rates and disability rates. On absenteeism there are actually some very good studies. We have just done a study ourselves on this, showing participants in health promotion programs over time report lower rates of absenteeism than non-participants.

EA: How would you define a successful wellness promotion?

GOETZEL: There would be high awareness, along with high participation—especially among the highest risk populations. Health would be defined in terms of health improvement, risk reduction and behavior change. Success would be defined in terms of satisfaction with the program and its component parts, and improvement in attitudes, morale and esprit de corps.

Financially, it would be defined as improved healthcare utilization and cost. Look at reduced absenteeism, reduced turnover, reduced workers' compensation and disability experience, and improved productivity.

EA: If a company has a limited budget, can they do much in this area?

GOETZEL: There are more expensive and less expensive evaluations. My general rule is to devote about 10 percent of the program budget to evaluation.

EA: Do most companies go to someone outside the company to determine the outcome?

Goetzel: Yes, typically the persons running the program are not experts in the area of research and management.

EA: Is there a simple software program that can help the non-experts?

GOETZEL: Not that I am aware of.

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However, there are different survey programs that allow you to develop the survey instruments. There are also programs that will allow you to track participation and health improvements over time and programs for analysis of medical claims data, and different aspects of measurement.

The first step in most good evaluations is figuring out what question you are trying to answer, and why is it important to answer it. Typically, most insurance reports give you tons of data on every physician who has ever treated any of your clients, and all kinds of statistics that are totally useless because you do not know what to do with them. That is why you need an expert to help you figure out how to get to the information you need by yourself, choose commercial software, select tools and systems to gather the data and create something special.

EA: You mean people write an individualized program for their company and then work off of that?
GOETZEL: Yes, but anyone can program or load a spreadsheet or data base program to get statistics. The hard part is understanding and knowing what you need and why, and knowing what is the best way and a valid way of getting to that answer. There are a lot of invalid ways to get those answers and unfortunately, there is a lot of research out there that is quite poor.

EA: What are some of the invalid ways, the stumbling blocks?
GOETZEL: One common way is to misuse statistics. For example, a study looks at the number of people who are at high risk at the beginning of a program and then, after some kind of intervention is provided for them, reports back, purely by numbers, twelve months later that many fewer people are at high risk.

There are several factors affecting changes in statistics. One might be people dropping out of programs. If you start off with 100 people at high risk, come back 12 months later and report back that 20 of the 25 people you were able to round up had improved, that does not mean you have an 80 percent success rate.

In this example, there are actually two major problems—first, you did not have a good follow-up rate, and second, there is a regression to the mean, which means if you start off with people who are at extreme values, they will gravitate to average values. That is not true for everything; for example, for smoking or even weight problems, people's scores do not move toward the mean, but with things like blood pressure and cholesterol, you may get people with extreme scores and nothing more than testing them will bring their scores down to average values.

In doing medical claims analysis or even absenteeism rate analysis, often people do not control for other factors that can influence the intervention—including shifts in demographics of the population. Company healthcare costs may have gone down because a workforce that had started off with very old employees, who have all retired, is now composed primarily of very young people. In another scenario, healthcare costs may have gone down because everybody was with the HMO; and now they have all gone to the indemnity plan, introducing a whole category of healthier people into the risk pool.

EA: Why is there so much trouble with how to do research?
GOETZEL: There is a body of expertise out there, but relatively few researchers have gone into the corporate arena where they are needed.

EA: Don't most businesses have some kind of outcome measuring mechanisms in place, if not in the people field, in the production field?
GOETZEL: They are usually financial performance measures, which are standard, performed by accountants and finance professionals. They focus on how much money is brought in, what expenses are and how much profit or loss the project is experiencing, but the process for measuring bottom lines is different than for evaluating an intervention program.

EA: Are there any areas of wellness promotion that are more effective? Are there certain types of wellness projects that do not seem to come up with good figures?
GOETZEL: The industry is moving toward a much more targeted intervention strategy. In other words, rather than giving everyone in the population the same program at the same level of

intensity right now, the direction has been in focusing resources on those people who need it the most—those at highest risk and those who could most benefit from an intervention program. Instead of spending $100 for every employee, you would spend $300 on some and $10 on others. So it is a focused allocation of resources based upon employees' needs and their readiness to change.

The other major change in technology is a much greater incorporation of psychosocial dimensions in behavior-change technology. Rather than assuming that everyone is at the same level of readiness, there is initially an assessment drawn to determine how ready and how motivated each individual is to change his or her behavior. You have a different intervention for employees who really are not very motivated versus those people who are very motivated.

A good program does not give all employees the same things regardless of where they are. It is a given in psychosocial literature, but it has not been so in behavior literature. All smokers would get the same packet of information regardless of where they were. Now fortunately, there is much better technology to identify precisely where people are.

EA: Are there a lot more screening devices?

GOETZEL: Yes, both screening and intervention programs. Johnson & Johnson has a program called Pathway To Change that is based upon 15 years of research with tens of thousands of people. It identifies not only where people are in their readiness to change but also provides interventions directed at each stage of change. Those who are ready to take action will get a much different message than those who are just thinking about it.

EA: What do you see in the area of future trends?

GOETZEL: One trend views the problem from the corporate perspective. Employers are going to continue looking at managing healthcare costs. Depending upon where healthcare reform ends up, it may not be a significant issue for them. Everyone is under the same umbrella of experience rating. It could be the government's problem or the

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regional alliance's problem to manage costs rather than the employer's.

I think there is going to be a much greater linkage between benefit design and health promotion programs, where people will be rewarded for efforts at health improvements. I think there will be greater partnerships across human resource areas including the EAP, medical, health, safety and training benefits.

Focus is on prevention and aftercare. They may not solve healthcare problems, but they are significant factors. Other trends? There is going to be a much greater emphasis on the relationship between health and work. In other words, people will be viewed as more valuable commodities and resources. There is going to be an appreciation that the healthy workplace brings about healthy workers, both physically and psychologically. The two will not be as divorced as they are now. Wellness professionals and EAPs will be treating the organization as much as the individuals in the organization.

EA: In wellness promotions, do you find there is a difference between upper management participation and the rest of the company?
GOETZEL: Successful wellness programs need senior management participation to work; it has got to come from the top down as most innovations do. It cannot be senior management saying, "We don't believe in this, but if you really want to do it, go ahead; still, you've got to be on the job." The CEO on down need to be participating and encouraging middle managers and other managers to participate. In many cases, it is easier to get higher level personnel (who have greater flexibility in their schedules) to participate than lower level personnel.

EA: Is there any move toward integrating wellness programs or promotions with workers compensation aftercare?
GOETZEL: Yes. We all know people who have had heart attacks and six weeks later they are on the job smoking and working until midnight, waiting for the second heart attack to occur; so you want to have follow-up programs that are behavioral in nature—not just treating the disease, but treating the person.

EA: Has anyone addressed the problem of the legal liabilities of wellness programs?
GOETZEL: You have got to get supervision management and have safety features in a facility.

EA: Wouldn't that be too costly for many companies?
GOETZEL: Not if you weigh the benefits against the costs. What you want to do, if possible, is create a health promotion center to be a focal point of health issues for the organization; and do more than just provide equipment, but educate people on things that are related to fitness. Just having a fitness center alone is insufficient if you are trying to impact the health and well-being of the high risk population. You may be better off spending your money on a walking track and some educational program that will achieve the same result.

EA: Have there been any objections from unions, especially with the screening involved in wellness programs?
GOETZEL: Typically, unions love health promotion programs because they see them as a way of improving their health and well-being that is being offered by the company. Generally, it is seen as a very positive benefit. The screening piece of it has to be handled very carefully, so that it is not the company conducting the screening and collecting the data. If a company acted on data in a negative fashion, that would kill the program very quickly.

Generally, a third party vendor does the screenings, and if the data are to be given back to the company, there is informed consent from employees. They know the medical department or EAP will have access to the information, and allow them to have access. Most often companies prefer a third party handle the screenings and interventions.

EA: Any final advice?
GOETZEL: I think it is in the interest of EAPs and HR personnel to work synergistically with health promotions. We are trying to move away from a body-part type of mentality toward a whole person, global mentality. What happens above the shoulders is, if not more important, as important in terms of the individual's health and well-being as what happens below the shoulders. EA

Dual Commitment

Coordinating EAP and Wellness

By Hal Steiger, PhD

The employee assistance field has come a long way since its origins in occupational alcoholism. EAP professionals now provide a wide range of services for a variety of personal problems that affect employees and their families. Broad brush programs continue to evolve, as long-term counseling and case management are beginning to be added to the traditional services of assessment and referral.

The evolution of the EAP field parallels changes in the way mental health and substance abuse services are organized, funded and delivered. The emphasis on managed care has tended to focus EAP efforts on either coordination with a company's preferred providers or advocating for its clients when those provider systems are deficient. Thus the current emphasis in EAP work is either direct delivery of services or assuring that employees and dependents get appropriate care after a referral has been made. In this climate, educational services designed to prevent future difficulties may take a back seat to the more urgent task of treating current problems.

COOPERATIVE MODEL. At Honeywell's corporate EAP, wellness, health promotion and prevention programs have a prominent place alongside the focus on appropriate treatment. Using an integrated health services model, EAP and health promotion programs work cooperatively to deliver services aimed at promoting healthy behavior, identifying individuals at risk for illness and lowering measurable risk factors. Both programs share a common vision, are supported by the same administrative structure and are shaped by the same core values, which include a holistic integration of body, mind and spirit, a focus on prevention and a commitment to cooperation across program boundaries.

The ability to join efforts with a strong health promotion-wellness program provides unique opportunities. The health promotion program uses EAP staff to deliver psycho-educational seminars, lead support groups and provide healthcare customer education classes. The EAP uses the health promotion professionals to add specific sessions on exercise, nutrition and ergonomics to its traditional stress management classes and for case-specific referrals. In addition, because EAP services are linked to health promotion and wellness, it is possible to deliver programs that address broader organizational issues without appearing to step outside the EAP's charter. EAP efforts to support organizational health and wellness include sessions on organizational change, organizational stress and organizational self-esteem.

The following are examples of the type of interdepartmental cooperation possible when an EAP and health promotion program work together.

EAP Contributions to Health Promotion. The "anchor" prevention program offered by the corporate office health services department is the "Life $avers" program. Life $avers is a comprehensive health incentive program that recognizes and rewards employees who practice healthy behaviors. It also provides encouragement and support for employees with health challenges while they pursue opportunities to improve their health status. The program focuses on (1) heart disease risk factors, (2) breast, cervical, and colon cancers, (3) self-care and healthcare consumer skills, and (4) managing healthcare.

The EAP offers an important health education seminar as part of the consumer education component of the program. The "Staying Mentally Healthy" class covers definitions and criteria for mental health and information on mental illness, substance abuse, anxiety disorders and mood disorders, such as depression. In addition, employees are helped to understand how to best use their managed care providers. Because adolescent mental health problems can be acute and costly, a special focus of the class includes early warning signs of adolescent problems and information on treatment and community resources. Hundreds of employees have taken this class and given it very favorable evaluations.

In addition, the health promotion program sponsors noon-hour seminars on topics related to mental health. Classes include positive parenting, balancing work and family, sexual harassment awareness and prevention, depression, coping with difficult people, stress management, and how to thrive in the midst of corporate change.

Several topics have been presented in series format and have included video series such as John Bradshaw's "The Family" and Bill Moyers' "Healing and the Mind," followed by EAP-led discussions. Also, an EAP counselor with a background in the psychosocial dimensions of weight problems leads a weight management support group to help employees succeed at dietary and lifestyle changes related to weight loss and maintenance.

Health Promotion Program Contributions to EAP. As companies face the challenges of doing more with less, stress levels are bound to increase. EA professionals are aware of the increase in stress-related problems brought in by individual employees. In addition, specific departments may experience high stress levels as a result of organizational change, increased work load or diminished resources.

The EAP provides individual counseling for stress management, and also designs and delivers customized programs for various groups in the organization that are experiencing difficulty with increased stress levels. After meeting with management and departmental representatives, the EAP designs a specific cluster of classes and activities to meet that depart-

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During the last decade, our economy has experienced a globalization. The subsequent falling away of a national-boundaries base and the redistribution of manufacturing to the wide corners of the world have both created prosperity in some parts of the world and destroyed the economic base in others. At the same time, the speed of life at work and at home has accelerated to incredible levels.

Faxes, modems, Wizard, voice mail, E-mail, laptop computers, cellular phones, Newton, cablevision, virtual reality—these are just some of the technological advancesthat didn't exist a short time ago. All of these developments have created the possibility of "virtual organizations." Virtual organizations are dependent on the availability of "just-in-time" workers. It is no coincidence that the largest single employer in our country after the government is Manpower Inc. What does this mean to those who work in the EA field? It means *the context has changed.*

THE CUSTOMER. One of the key concepts of the quality movement is "focus on the customer," but exactly who is the customer of EA efforts? If you asked an old-timer, he'd say the operational supervisor, who needs his work unit to produce. If you asked a group worker, it would be the system. If you asked a clinician, it would be the individual in need. And if you asked the manager of managed care, she'd say it's the benefits department.

The Achilles' heel of the EA field is that it does not have consensus about exactly who its customer is. As a result, we as a group come off as unfocused, undisciplined and tenuous at best. Insofar as we do not have a clear picture of who our customer is, we fail to tie directly into the business strategy of our host organization.

We have seen that modest efforts have helped a copper mine evolve into a company with the largest EA delivery system in the world. We have seen it acquired by one of the major insurance providers as a marketing strategy. And now, as that insurance company presses to develop managed care, we are seeing it shed all of its seasoned EA professionals, replacing them with "managed care" experts.

This, of course, makes perfect sense when you are an insurance company that must make a profit to survive. Managed care is here to stay and will continue to draw "experts" to it, but its customers are the benefits department of the organization, not managers. My only concern is that these experts still call themselves an employee assistance program.

Who exactly is the customer of EA efforts? What does this customer expect from the provider? Our customers have changed. They no longer need large numbers of employees to do their work. They would prefer a relationship that allows maximum flexibility. How will EA strategies respond to this preference?

CONVERSATIONS. When change takes place, conversations reveal fear, loss or insecurity. Some conversations are full of anger, aggression, and fault-finding. Some focus on lack of energy and uncertainty. If this field is to continue, we need conversations that uncover the possibilities. We need to be talking about the assets of our profession. We need to work with our customers to define expectations.

If we come to our organizations as experts, our conversations may be directive, closed and isolationist. If we approach our work organizations as consultants—our conversations would tend to be more open-ended, engaging and evolutionary.

What is absolutely true is that if our work is not directly related to the business strategy of our work organization, then we will not be around long! If we are not connected to the work organization's business strategy, then maybe we don't deserve to be there. Do you know your company's business plan for the next year?

THE CHALLENGE. As I see it, the EA field needs to answer four questions rather quickly:

- Who are our customers?
- What are our customers' expectations of us?
- How do we know that we are meeting our customers' expectations?
- What is the long-term consequence of an EA effort that is disconnected from the business strategy of its host organization?

As is my tradition, I welcome your calls and comments.

Francek is head of Organization Resizing Practice with King Chapman Broussard & Gallagher in New York. He can be reached at EmployeeAssistance, P.O. Box 2573, Waco, TX 76702 or with King Chapman Broussard & Gallagher, The Kent Bldg., 161 East 42nd St., New York, NY 10017.

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