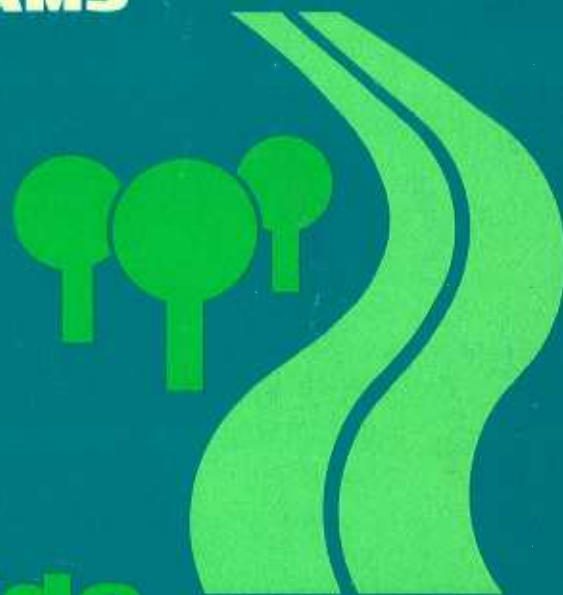

**EMPLOYEE
ASSISTANCE
PROGRAMS**



**A Guide
To Community
Resource
Development**

**Muriel Gray, Ph.D. LCSW, CAC
Daniel Lanier Jr., DSW, ACSW**

MIKE WEBB

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TM

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PREFACE

This handbook is designed to assist individuals entering employee assistance work with minimal prior experience or training in the field. It is specifically designed for the employee assistance worker who is working with little direct professional guidance.

The purpose of this handbook is to present the most basic ways of collecting and analyzing information in order to identify and evaluate existing community resources.

INTRODUCTION

The relationship between employee assistance programs and community resources is interdependent. The success of one is, to a great extent, dependent upon the success of the other.

The success of any (employee) assistance work is in part based upon the availability of resources in the community because they provide the necessary treatment or service. It is senseless to start a program if there are not community resources to sustain it.

Once you have determined that the available community resources are in general, adequate and appropriate, it will be necessary to systematically identify and collect information about these resources.

Part I of this manual offers suggestions on finding community resources. Part II gives an overview of treatment facilities, psychotherapists, and psychotherapies. And finally, Part III gives suggestions and ideas on evaluating community resources.

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PART I

**Finding
Community
Resources**

FINDING COMMUNITY RESOURCES

Mental Health/Alcoholism/Drug Treatment Facilities

As a consumer of resources you will find that specific community resources are not always readily available when you need them. On the other hand, you may identify several resources for which you have little use at a given time. Because you will probably identify specific resources at various times — often when you least expect to find them — it will be important to contain and organize this information when you get it. The best way to contain this information is to have a place to keep it. In the absence of a file cabinet, a large loose-leaf binder with pocket dividers is an excellent place to store brochures, jot down notes, keep evaluations, blank referral forms, etc.

Step I — Purchase large-loose leaf binder with pocket dividers.

The advantage of the pocket dividers in the loose-leaf binder is to aid in organizing the community resources by categories of services.

Step II — Define possible areas of assistance and categorize the notebook accordingly.

Some ideas of assistance categories include:

I. Alcohol/Drug

A. Diagnostic and referral service

B. Treatment

1. Detoxification
2. Inpatient (Primary & Extended Care)
3. Outpatient
4. Transitional houses
5. Intensive day treatment
6. Individual alcohol/drug counselors
7. Monitored antabuse/methadone

C. Support groups

1. AA, Al-Anon, Women for Sobriety, etc.
2. NA (Narcotics Anonymous)
3. FA (Families Anonymous)
4. Aftercare groups
5. Alumni groups
6. Recovery, Inc.

II. Marital/Family/Relationship Problems

A. Diagnostic and referral service

B. Treatment/counseling

1. Family
2. Marital/couples
3. Parenting classes/groups
4. Individual private psychotherapists
5. Sexual dysfunction counseling

C. Safe Houses/Foster Homes

1. Youth — run away
2. Adult — battered
3. Child abuse

III. Education/Career

A. Diagnostic and referral service

1. Mental retardation
2. Learning disabilities
3. Tutors
4. Special schools/continuing education

B. Skills/Aptitude/Interest Assessment, etc.

C. Career Counseling/Training

IV. Health (*Medical/Dental*)

A. Diagnostic and referral service

B. Types of treatment

1. Holistic
2. Weight control
3. Pregnancy difficulties
4. Private practitioners
 - a. wellness/preventative
 - b. natural/osteopathic
 - c. other specialities, etc.

V. Other Psychological Treatment

- A. Diagnostic and referral service
- B. General psychotherapy treatment issues
 1. Life transition
 - a. adult
 - b. youth
 2. Sexuality counseling
 3. Stress/Management
 4. Conscious raising groups, assertiveness training, etc.
 5. Depression, affective-disorders
 6. Grief counseling
- C. Types of treatment
 1. Individual short term supportive counseling
 2. Individual long term psychotherapy
 3. Group therapy
 4. Self-help groups
- D. Other counseling
 1. Debt, credit, etc.
 2. Legal

You have now accomplished the first two steps in community resource development — 1) a means of collecting community resource information and 2) a system of organizing community resource information.

You are now ready for the next step which involves contacting other professionals in the community.

Step III — Contact your professional organizations:

- ALMACA/Association of Labor Management Administrators and Consultants on Alcoholism
- AEAPP/Association of Employee Assistance Program Practitioners
- EASNA/Employee Assistance Society of North America
(Find and join your local community mental health association, psychological association, social work association, professional counseling association, etc.)

Do not wait for an emergency to arise to call your professional organization. (However, they are an excellent resource in an emergency.) Call your local ALMACA or AEAPP chapter now. ALMACA has a nationwide membership directory which will be invaluable in your EAP work. In addition to asking about the directory, ask when and where the monthly meeting will be held and the scheduled topic. Call another EAP representative and invite him/her to go with you. If that is not possible, go alone. Then, be prepared to meet a friendly, informed group of people.

If you have not already guessed, ALMACA and AEAPP meetings are quite informative. Each month a different treatment/professional issue is presented by a member practitioner. Feel free to join in the discussion. On the other hand, if you are in the middle of an emergency when you call an ALMACA or AEAPP member (i.e., you needed a resource yesterday), ask them about the local facilities they use for specific problems. If the problem is unique, (i.e., deaf, black, female, teenage alcoholic) ask to be referred to a member who has worked with such a population.

These professional organizations are in fact, cost-effective for continuing education-type seminars each month. Speaking of cost — membership in your local ALMACA chapter is based upon your national membership. So join the national and local organization, and attend your local chapter meetings. Membership in AEAPP is local. First go as an interested guest to both and decide about membership afterwards.

EASNA is an international society of employee assistance specialists who are primarily concerned with education, quality assurance, career development and research issues. Unlike the other professional associations, EASNA does not have local chapters. However, membership includes anyone who has an interest in employee assistance programs. For membership information, call the toll-free directory assistance.

Step IV — Call local businesses/corporations that have employee assistance programs and ask the EAP personnel about local facilities/practitioners they use.

Step V — Check the yellow pages in your phone book. The yellow pages list a cross-section of facilities and private practitioners in general categories. Not an ideal way, but this is a good source for determining the availability of resource. It is a good starting point, a way to get “assistance category” ideas. **Do not make referrals directly from the yellow pages!**

Another way to find community resources is to contact the appropriate (or inappropriate) professional association for assistance. Check your loose-leaf binder categories. There probably is a professional association for each general category. If you knew the name of the professional association, you would only have to find them in the phone book and call. But, you do not have the foggiest idea of the name they use! Well, here's a clue.

Step VI — Check the white pages in your phone book under "National," "Association of," "American," — "your state's name," etc. For example, refer to the general categories listed under Step II.

Alcohol —

- "National" Council on Alcoholism
- "National" Black Alcoholism Council

Mental/Family —

- "Association of" Marriage and Family Therapists
- "Association of" Mental Health Specialists
- (Your State) Mental Health Association
- National Association of Social Workers
- National Association of Clinical Social Workers
- National Association of Black Social Workers
- American Psychological Association
- American Psychiatric Association

Education/Career —

- American Personnel and Guidance Association
- Association for Retarded Citizens
- American Foundation for Autistic Children

Legal —

- Association of Trial Lawyers
- American Bar Association (predominantly white)
- National Bar Association (predominantly black)

Health/Dental —

- American Diabetes Association
- American Cancer Association
- American Medical Association (predominantly white)
- National Medical Association (predominantly black)
- American Dental Association (predominantly white)
- National Dental Association (predominantly black)

Other Psychological —

- Association of Black Psychologists
- Association of Black Psychiatrists

Even though locating resources this way is difficult, sometimes there is no choice. It is super-sleuth detective work. However, the national professional associations will refer you to their members in your area or to a local service directory. If there is a need, you can reverse the process. For example, on one occasion, one of the authors read an article in a professional magazine and wanted to contact the writer. The only clue of identification was her name. But, it was gathered through her writing that she was either a psychologist, social worker, or sociologist. Therefore, a call was made to APA (American Psychological Association) membership. It was explained that there was a need to contact this person and they were asked to check their membership roster.

She was a member: APA provided her work phone number, address, and place of employment (3,000 miles away). She was called and gladly provided the information requested.

Step VII — Call state and local community agencies/organizations for service directories:

1. Hospitals
2. Department of social services
3. Chamber of Commerce, Kiwanis, Urban League, etc.
4. Business organizations
5. Local radio or TV station managers or public service managers. (*The suggestion may seem far-fetched but all stations are required by law to provide a community needs assessment for their public affairs programming.*)
6. Churches
7. Colleges, universities, etc.
8. United Way

Step VIII — Read your local newspaper. You will discover all sorts of information related to self-help groups, mental health clinics, new programs, etc.

Now that you have been inundated with names of various treatment facilities, all you need is a troubled employee . . . right? Wrong!

DIAGNOSTIC AND REFERRALS/ PRIVATE PRACTITIONERS

At this point, it becomes incumbent to identify a professional who can diagnose/assess the employee's problem/condition and can suggest the appropriate treatment approach — i.e., individual psychotherapy, alcoholism treatment, etc. This person is called a Diagnostic & Referral Resource.

It could be that you already have a list of individual and group practitioners to provide this service. If not, use the same steps you used for finding the treatment facilities. In other words, call your professional organization, friends, EAP contacts, specialists working in treatment facilities and other professionals you have met. This time you are looking for the names and addresses of individual/group practitioners who are professionally trained in various mental health areas in addition to chemical dependency.

Step IX — Make a list of individual/group practitioners. But first, are you wondering what a group practitioner is?

Well, "group practitioners" can be described in numerous ways but for our purposes, we will describe the "ideal situation." It would be a collection of individuals who work together to provide various employee assistance services. If each partner has an area of expertise, the group probably will be able to diagnose and make recommendations for innumerable problems. If you cannot find the "ideal," try to find several practitioners who have general practices and up-to-date knowledge of alcoholism and other drug problems. When you find a good Diagnostic and Referral (D&R), ask them to recommend others in the field, both local and in different cities. Share this information with other EAP coordinators.

Step X — Talk to colleagues, friends, etc., and read your community newspapers.

Another method of identifying resources in your area or in an unfamiliar area can be colleagues and associates. Many are human service professionals who have had a personal experience/knowledge of com-

munity resources. Do not hesitate to ask other EAP coordinators whom they have used and ask their opinion.

Your primary task of finding community resources has been accomplished.

SUMMARY

Finding

- Step I — Purchase Loose-leaf Binder with Pocket Dividers
- Step II — Define Possible Areas of Assistance and Categorize the Notebook Accordingly
- Step III — Contact and Join Your Professional Organizations
- Step IV — Call Other Corporate/Agency EAPs
- Step V — Check the Yellow Pages in Your Phone Book
- Step VI — Check the White Pages in Your Phone Book
- Step VII — Call State, Local, Community Agencies/Organizations
- Step VIII — Read Your Local Newspaper
- Step IX — Make a List of Private Practitioners
- Step X — Talk to Colleagues, Friends, etc.

PART II

Treatment Facilities Psychotherapies Psychotherapists

INTRODUCTION

It is crucial to know that which you are evaluating. Too often, competent employee assistance program workers, who happen not to be formally trained, feel uncomfortable evaluating human service agencies/professionals who have been formally trained. The feeling sometimes gets in the way of the evaluation process. Basic knowledge regarding program, psychotherapy and psychotherapist differences might aid in facilitating an effective and objective evaluation. Because there are many different treatment approaches and psychotherapies, this overview has been prepared to simplify your evaluation tasks.

ALCOHOLISM/DRUG TREATMENT

I. Detoxification

Withdrawal from alcohol/drugs can be fatal. Therefore, some patients must be monitored closely for serious medical complications. Inpatient medical detoxification is usually recommended for patients who might enter acute withdrawal. Such patients have severe shakes and other nervous system dysfunctions. On the other hand, some patients display slight or moderate symptoms. These patients are not likely to enter into serious withdrawal. Detoxification may be either on an inpatient or an outpatient basis (depending on the patient and the severity of the withdrawal symptoms).

II. Inpatient Treatment Program

Some alcoholism/drug patients respond to treatment best by being admitted to a hospital, a separate alcoholism clinic, or a transition house. Most of these treatments have fully-developed programs which emphasize detoxification and other medical treatment if necessary; basic alcoholism education; group counseling; participation in AA, NA; family counseling; aftercare planning; alumni groups, etc. In these cases, hospitalization is viewed as a therapeutic intervention, with reliance on education and strong group identification.

III. Outpatient Treatment Program

Some alcoholism/drug patients are treated in outpatient settings. That is, they are not admitted to a hospital, clinic, etc. overnight. As an outpatient, treatment can be carried out by professionals and non-professionals simultaneously. The therapeutic approaches used during treatment are the same as those used in inpatient programs, although the intensity might vary. One of the advantages of this type of program is that the patients' family-work life need not be completely disrupted. On the other hand, abstinence from alcohol/drugs is more difficult to enforce and reinforce. Motivation and stage of illness might very well be a determining factor in selecting this type of treatment program.

IV. Extended Treatment Programs

The transitional house provides shelter, food and a well-structured living environment where everyone assumes a responsible day-to-day

share. Some of the larger programs have a graduated series of programs — a quarter-way house, a half-way house and a three-quarter way house. These programs provide degrees of external support to the recovering person. Usually many of the staff at a transitional house are recovering. Abstinence from any drug is a strictly enforced requirement.

PSYCHOTHERAPIES

This overview covers basic general psychotherapeutic approaches.

Short-term Individual Psychotherapy

This approach is most useful for the presenting problem induced by some specific event or situation (death in a family, divorce, physical illness, job promotion, move to a new home). Any situation — even good news — can sometimes produce an upset. In these cases, the goal of the therapist is to iron out the problem as quickly as possible. It usually requires only a few visits.

Long-term Individual Psychotherapy

This approach is used for problems or concerns not necessarily caused by a specific life-event. Instead, it is most useful for problems related to lingering inner conflict and anxiety. The goal of the therapist is to identify the cause of the problem and to help develop new behaviors and reactions to the problem. This may take many months or years — depending on the problem.

Family Therapy

This method of treatment involves the whole family. The family is interviewed and participates in therapy sessions in order to determine the cause of a problem. Perhaps a son needs to share activities with his father who is unavailable in the evenings. A mother may be spending a lot of time worrying about things that could be less of a problem if she could see them from a different perspective. The goal of the therapist is to help the family members see each other in a new light in order to change the way they react toward one another. Depending on the nature of the family problems, this procedure may require a few visits, or many visits.

Group Therapy

Group therapy takes place when a small group of people meet to discuss their individual problems. The role of the therapist is to guide the conversations, offer advice and point out things the group members might otherwise miss. Therapy groups may be formed to focus on specific problems, or to focus on specific types of people and problems they may have. Perhaps a group of single mothers want to meet regularly with a therapist to discuss their problems. It may be a recently divorced group meeting with a therapist to discuss issues specifically related to adjusting to new times.

Play Therapy

Play therapy usually is used with a child who has a problem. The goal of the child therapist is to determine the basis of the child's difficulty. Play is a child's form of communication, so this therapy works well with young children. For example, not all problems of bed wetting, emotional withdrawal etc. are signs of emotional disturbance. However, sometimes these behaviors do signal a need for help.

This overview was presented to acquaint you with the general psychotherapies. Now we will take a look at the various people trained to provide psychotherapy.

PSYCHOTHERAPISTS

Psychiatrists

Psychiatrists are medical doctors who specialize in mental illness. In addition to psychotherapy, this person can also prescribe medications.

Clinical Psychologists

Clinical psychologists are professionally trained individuals who specialize in testing and psychotherapy.

Clinical Social Workers

Clinical social workers are professionally trained individuals who are skilled in the treatment of mental illness and family problems, and also trained in mental health management and administration.

While there are other professional disciplines trained in psychotherapy, this overview includes those most often reimbursed by insurance companies and third-party providers.

All psychotherapists perform therapy. In addition to psychotherapy, the psychiatrist (who is always an M.D.) can legally dispense medication. The psychologist (clinical or educational) can also administer psychotherapy and interpret psychological/cognitive tests. Clinical social workers perform basic psychotherapy.

It should not be said that one group is more effective than the other; however, it can be said that generally one group might be more/less appropriate than the other. It can also be said that generally one group might be more/less expensive than the other — and rightfully so. If the nature of an emotional problem requires medication and psychotherapy, or if there are medical complications, a psychiatrist/M.D. is definitely needed. If the problem seems to require basic “psychotherapy only,” there is no need to pay for the service of dispensing medicine when it will probably not be used. Generally speaking, differences in fees, however, will be determined by treatment over and above general psychotherapy, and by regional locality. Therefore, a psychotherapist (Master of Social Work) in New York City might charge the same fee as a psychiatrist in Cheyenne, Wyoming.

Interestingly, most of these fees are set within county/state insurance company reimbursement scales. They are not solely set by the psychotherapist.

It is this added knowledge which will help you speak more easily with the human service professionals you will encounter.

PART III

Evaluating Community Resources

INTRODUCTION

Assessment of the quality of resources is an important responsibility associated with being a consumer of community resources. A bad resource is worthless.

Evaluation is very difficult because of the complexity and the number of variables involved. On the other hand, evaluation is crucial in the assistance process.

This section of the handbook will detail the basic steps in a systematic approach to resource assessment. For our purposes, the resources have been categorized as:

1. Alcoholism/Drug Treatment/Mental Health Facilities
2. Individual/Group Private Practitioners
3. Other Needed Services

EVALUATING COMMUNITY RESOURCES

Now that you have found and categorized the community resources, it is important to determine their usefulness. Up to now, most of the work has been research. It is time to do an on-site evaluation.

Alcoholism/Drug Treatment/Mental Health Facilities

Step I — Phone each facility.

At this stage, call a facility on your list. Identify yourself by name and explain your affiliation with the EAP and the work you are doing. Ask to:

1. Make an appointment to meet with someone regarding the services which the facility offers; and
2. Receive brochures and literature on the facility. (It is helpful to receive the literature before visiting the facility.)

Your evaluation starts with that phone call. Keep your notebook and Community Resource Record forms handy!

Step II — Begin to complete the Community Resource Record form. (Appendix A)

If you identify yourself as being with an EAP and if you are asked "What is an EAP?", it tells you they have probably not worked with EAPs before. This is not a strike against them. On the contrary, it tells you that when you meet with them, you will clearly have to explain the EAP role and your expectations of the treatment facility. Do not forget to ask for their facility literature. You will want this information for some idea of what to expect when you visit the facility. Nothing is worse than being caught off-guard and distracted by relatively superficial things. This is a lesson often learned the hard way. For example, one of the authors visited an alcohol treatment facility with what we would describe as an appearance and decorum that was extravagant and intimidating. Needless to say, there was such preoccupation with the appearance that a number of important questions were left unasked and therefore, resulted in telephone calls to get needed information.

Literature in advance of your visit will give you an opportunity to formulate questions. This is especially helpful if it is an unfamiliar service. (Most of us are more familiar with certain types of services than others.)

Step III — Visit each facility with another EAP team member whenever possible.

Step IV — Continue to fill out the Community Resource Record form.

Be sure to take the community Resource Record form with you. Do not be embarrassed to complete this form during your visit. As a matter of fact, when you fill out this form you are performing and emphasizing to the facility, one of your employee assistance responsibilities — evaluation of community resources. Besides, no one expects you to remember all the information. Even if you could remember everything, there is another reason for using the form:

Filling in the form suggests to others that you are systematically collecting information in order to make an informed decision as a consumer. It is important to subtly remind yourself and others that your job depends upon appropriate and accurate choices. This is why evaluation is essential.

You are at the facility and you are filling in the form. You look at the form and it looks like a foreign language to you. What in the world is “medical model,” “Gestalt orientation,” “paradoxical intervention,” etc? How do you find out without appearing completely ignorant?

First of all, it is important to have the language explained (even if you think you understand) because so much of the “language” is used differently by different individuals. Asking them for an explanation, therefore, does not imply ignorance; rather it indicates that you are aware of the nuances of the field.

Step V — Ask for clarification of terms.

One may ask in this way: “I’ve heard _____ described in various ways. Could you elaborate on your use of the term (concept)? Would you give me an example of how you use _____?”

To this point, most of the focus probably has been on the services/programs which are unique to that facility/service. Do not forget to find out everything you can that would be relevant to your particular type of

employees. Ask about flexible scheduling of appointments, child-care considerations, special population groups, age range, sex, racial composition, etc. Then make sure you:

Step VI — Tour the facility.

While touring, expect to evaluate it on different levels — subjective and objective. It is a crucial point and the process gets complicated.

Step VII — Make note of the subjective assessment.

You are completing a process, the evaluation, that began with your phone call to the facility. If you received a brochure (before visiting), you probably had some “hunches” and impressions about the place. While discussing and touring the facility, you probably had even more intuitive feelings. Do not ignore these feelings. Use them! Notice: We did not say rely on them. Rather use them to alert you to your own prejudices. Now that you are aware of your bias (toward or against), “check” these out through an objective procedure.

Step VIII — Objectively test any subjective assessment.

For example, you visit a treatment facility and have the feeling that their treatment schedule is not as structured as you were led to believe. If this is the case, check it out by noting the time; a few minutes later, ask to see the day’s activity schedule. If the activity you observe is inconsistent with the schedule, your intuition was probably right and substantiated by objective data. On the other hand, if the activity you observe is consistent with the schedule and you still have an “uncomfortable feeling,” look for more objective data.

If this feeling persists, do not rule out the possibility of personality or personal value differences.

On the other hand, do not forget to be alert to your intuitive feelings about a facility seemingly doing everything right. Make sure you check out these feelings with objective data, too. Remember, the example we gave you of that physically impressive facility? Unfortunately, the treatment program was not as impressive.

Step IX — Objectively evaluate each facility.

The most objective evaluations will be the result of the information you get from your contact with, or your use of, the facility, and the information you get from those who have actually used the facility. Ideally,

you will be visiting the facility with another EAP team-member or community resource consumer. This will provide more feedback (and interpretations) upon which to base your evaluations. You will be using the following evaluation tools. However, short of this ideal, the following criteria is close to a foolproof formula.

Community Resource Record Form — (See Appendix A)

This form highlights the general areas to be considered in the evaluation. It is concise and can easily be completed while you are touring the facility. And it is general enough to be used both for mental health and drug/alcohol treatment facilities.

Assessment of Alcoholism Treatment Center Form

This detailed form (developed by ALMACA) is intended for alcohol/drug treatment facilities. However, its length makes it unwieldy to use during the actual site visits. Therefore, review this form before visiting the facility. Then jot down any questions on the Community Resource Record Form you think might be relevant. Call ALMACA and request this form. Ask facilities to fill it out and mail it to you.

Referral Resource Questionnaire — (See Appendix B)

This questionnaire is designed for mental health and EAP individual/group, private practitioners. It is convenient because it can be mailed to each person on your list; this way, the practitioners initially will screen themselves. Only those interested in working with your EAP will return the questionnaire. After that, you have to start "the phone and visit routine."

The procedure for evaluating individual/group practitioners is similar to that used for evaluating facilities. The major difference is that in this instance you are assessing an *individual's* right, qualifications and competence to offer a recognized service.

Because the emphasis is on the practitioner, it is important to obtain information about the individual.

"Finding" the practitioners is very time-consuming. Similarly, determining competence can be very difficult. Luckily, you do not have to determine competence alone. Educational institutions, professional certification and licensing boards, professional associations, and colleagues can be a tremendous help. They "vouch" for the individual by granting a

particular degree, certificate, license, membership and "friendship," respectively.

Step X — Refer to "Criteria for Evaluation Resources" in the upcoming section.

CRITERIA FOR EVALUATING COMMUNITY RESOURCES

There are a number of important criteria for evaluating and planning the use of treatment facilities. Some criteria remain applicable regardless of whether the facility is a freestanding inpatient treatment program, an outpatient facility, a hospital-based facility, or a group of practitioners who have united as a rather loose-knit confederation of "associates." These criteria are not necessarily listed in order of importance. However, each item listed should be evaluated and given serious consideration during the selection process.

1. The Facility's "Track Record"

The facility's "track record" is one of the most important criterion to be considered. One can start with such basics as the length of time they have been in business. It does not mean that a relatively new treatment facility cannot also be good or provide excellent service. However, it is more difficult to evaluate the service of new facilities. When a dilemma of this sort exists, one must rely more heavily on the other criteria to be discussed.

An indication of the facility's "track record" can be obtained from a variety of sources. One can begin the evaluation process merely by asking the treatment personnel. However, one should not rely too heavily on just the glowing response the treatment facility personnel are likely to provide. A more objective indication of the facility's "track record" can be obtained from the experience of those who have used it and from data and information the facility is able and/or willing to make available. An assessment of the facility's "track record" can also be conducted (in part) through recovering patients who have had experience with the facility (with appropriate safeguards for protecting the patient's confidentiality, of course).

There may be good treatment facilities which have not operated long enough to establish a "track record." However, one can begin to get indications of the type of facility it is from the first group of patients who complete their program, and the attitude of the facility's staff towards the treatment of chemical dependency and employee assistance program personnel.

A staff which is approachable, open, friendly and warm does not in and of itself denote competence. It does, however, indicate that the staff is more likely to feel confident about themselves and have less to fear of an evaluation process. Such a staff is also more likely to be open and receptive to tailoring and amending programs to fit the patient's needs than one which is rigid, immobile and adamantly set against change. In other words, they are more likely to tailor their program to fit the needs of their patients rather than to mold the patients to their program. Such information may be used in conjunction with other criteria until the facility has sufficient time to develop its "track record."

A facility's success rate, or lack thereof, can also be considered along with its "track record." Although success rate, in and of itself, can be a misleading criterion. Therefore, one must be careful about what is being measured. When using success rate as a criterion of measurement one must be careful to examine data closely — to ask the right question to ascertain if successful treatment includes all patients admitted to the facility or just selected patients: those who remain for the entire course of treatment; those admitted for the first time only; those selected after a rigorous screening process; only those responding to the follow-up questionnaire; only those with certain diagnoses.

These are but a few of the questions to which one should be alert when asking a treatment facility about its success rate. Of particular importance, it should be asked: What happens to relapse patients? How are repeaters counted? Are chemically-dependent patients given a psychiatric diagnosis when they have had multiple admissions to the same treatment facility for chemical dependency? In what way are patients who have multiple admissions treated differently from those with a single admission? Is a patient with multiple admissions handled statistically as a "success" or as a treatment "failure"? What length of time is used by the facility in follow-up to determine treatment success? When a treatment facility uses statistical data to support its success, is it willing to allow a study and comparison with other available statistical data? Again, there should be adequate precautions to safeguard the confidentiality of patients.

Some of these listed questions may sound elementary and redundant. However, the authors are aware of a treatment facility whose statistical data indicated that it had a higher successful recovery rate than similar treatment facilities in the area. Yet it became known, only after extensive conversations with staff, that the facility seldom admits the same patient

twice for chemical dependency and never admits the same patient a third time for the treatment. If a patient being treated for chemical dependency has a relapse a short time after discharge and requires readmission, the patient is admitted to the treatment facility's psychiatric service and given a psychiatric diagnosis. After this practice was related to the authors, it was verified through the examination of medical records. When asked about this practice (with supporting records) the admissions' director readily admitted it. The justification was that the patient did not have a good recovery in the first two admissions so they obviously had a psychiatric disorder. There they need admission to the facility's psychiatric services for a longer period than that which was customary for the chemical abuse treatment service. However, it was determined that the treatment regimen of the psychiatric service was identical to that which the patient had received on the chemical abuse treatment service — only longer. One should therefore, be sure to ask the right questions when inquiring from a treatment facility about its success rate. And, their reply is to be used as criteria for determining the facility's "track record."

2. Alcoholism, Drug Addiction and Other Forms of Chemical Dependency Should Be Regarded as Primary Diseases.

Many mental health practitioners, therapists, clinicians, and treatment facilities do not regard alcoholism, drug addiction, and other forms of chemical dependency as primary diseases. They consider them secondary to an underlying personality disorder, the results of moral weakness, or other behavioral medical conditions.

Considerable experience has shown that active alcoholics and those who experience other forms of chemical dependency but are treated for a form of personality disorder rather than for alcoholism, have not obtained lasting sobriety. Conversely, there have been numerous experiences when it has been necessary to treat the alcoholism and help the individual obtain sobriety, before it was possible to treat any underlying physical or mental problem. It, therefore, is very important for success that: 1.) the primary treatment be conducted in a facility and by practitioners who have a philosophy that alcoholism and other chemical dependencies are primary diseases which are treatable and 2.) that the patient share some of the responsibility for successful treatment outcome.

The support for other forms of drug addiction and chemical dependency as a primary disease is not as prevalent as it is for alcoholism. However, other forms of chemical dependency share enough similarity,

and physical and emotional characteristics that addictionologists consider them in the same category for purposes of classification and treatment as the disease of alcoholism.

3. Early during the Treatment Process, Patients Should Be Made Free of Psychotropic Drugs.

In the treatment of substance abuse and dependency disorders, alcohol is considered a drug. In the treatment of dependency disorders alcohol is classified as a mind-altering drug, with valium, librium, quaaludes, miltown and other psychotropic drugs. Alcohol and psychotropic drugs are just as dangerous and life-threatening to the patient as barbituates, cocaine and heroin. This does not include the use of anti-psychotic drugs such as thorazine, prolizon, trilafon, stelazine, and meelartil. One of the primary goals of treatment of patients with dependency disorders is to make the patient free of mind-altering drugs.

Detoxification, a medical procedure, should be done under medical supervision. It is acceptable medical practice to use tranquilizing medication to gradually reduce the body's dependency on drugs during the detoxification process. However, early in the treatment process, the patient should be expected to be free of mind-altering and mood-changing chemicals. Patients who are treated for dependency disorders and who have required a period of detoxification should not be expected, therefore, to return to their families or return to their employer with a requirement/expectation that they will continue to use alcohol and/or psychotropic medication.

Needless to say, psychotropic medication, mind-altering drugs and antipsychotic medication does not include disulfiram (antabuse, Ro-Disulfiram). Antabuse is frequently used as an adjunct to the treatment of alcoholism. It is usually prescribed during the acute-treatment phase of care, immediately following detoxification. Antabuse should be prescribed by a licensed practicing physician who has examined the patient and who is familiar with his/her medical history. Like other prescribed medication, antabuse should be taken under medical supervision with periodic examination of the patient by the prescribing physician.

4. Families (or Significant Others) Are Encouraged to Participate in the Treatment Program.

Alcoholism and other forms of chemical dependency should be treated as family diseases. The goals and philosophy of the treatment facilities should be those which encourage the active participation of the family

members (or significant others). In the active, untreated chemically dependent person, family members may suffer emotionally, psychologically, and sometimes physically as much as the active practicing substance abuser or chemically dependent person. The family members do not automatically get better as a result of the substance-abuser or chemically dependent person getting treatment. The quality of the treatment facility can be measured by the extent to which it allows and in fact, encourages the family (or significant other) to become an active participating member in the treatment process of the substance-abuser or chemically dependent person.

Active family participation in the treatment and recovery process is necessary in order to help make them aware of their role in the recovery of the primary patient. Participation in the recovery process by family members is also necessary in order to help them to be able to set appropriate limits, and appropriate and realistic expectations about the recovering substance abuser.

More and more treatment facilities recognize the importance of spouses and other significant family members participation in the recovery process. Some residential treatment facilities now have special arrangements and accommodations for spouses to spend the final week or last few days at the treatment facility with the primary patient. The provision of these special facilities by residential care centers is essentially a very strong statement about the importance of spouses in the recovery of the primary patient.

5. The Treatment Facility Should Actively Prepare Patients Against Relapse Prior to Discharge.

Another criterion on which the treatment facility can be assessed and evaluated is the extent to which it actively prepares patients for relapse prior to their discharge. The primary role and responsibility of the treatment facility is to provide treatment and care for patients who are in acute states of physical, emotional, and mental distress and suffering from the disease of alcoholism and other forms of chemical dependency. A part of that responsibility during the acute phase of treatment is both to help patients to remain in a state of recovery and to be able to recognize the signs and symptoms of the onset of a relapse. The staff should also prepare patients to avoid a relapse once they recognize the signs of the onset of this phenomenon.

The dynamics of relapse should be made known to the patient immediately after the detoxification phase and during the acute phase of treatment. It should also be a part of other programs, such as day-care treatment programs and intensive outpatient treatment programs which provide care for addictive disorders. The extent to which the treatment facility prepares patients for relapse should be a very important assessment criterion during the evaluation process.

6. The Facility Should Have Adequate Provisions for Care of Acute Medical Problems (Not Necessarily on the Same Premises).

Another criterion by which a treatment facility can be evaluated is the manner in which it has made provisions for the care of patients with acute medical problems. Many chemically-dependent people arrive at treatment facilities in an acute stage of physical distress. It is often necessary to provide treatment for these accompanying physical disorders while the patient undergoes detoxification, and during the acute treatment phase of chemical dependency. Alcoholism and other forms of chemical dependency are chronic progressive diseases. As a result of their chronicity, it is not unusual for the newly hospitalized, chemically-dependent patient to be suffering from some degree of pancreatitis, hypertension, esophageal varices, hepatitis, alcoholic psychosis, liver damage, or form of brain damage. These are in addition to such things as contusions, abrasions, cuts, simple and compound fractures, and malnutrition. The treatment facility does not need a completely equipped and fully-staffed intensive care unit. It should, however, be prepared to treat routine emergencies, and should have an agreement with a nearby general medical acute care treatment facility (with the necessary transportation arrangements) which can care for those emergencies that the chemically dependent treatment facility is not prepared to handle. The extent to which staff is knowledgeable and familiar with these procedures is another indication of the quality-of-care provided by the chemically dependent treatment facility. This criterion should be included in the evaluation and assessment of the facility.

7. The Extent to Which the Facility Will Help to Expedite Patient's Entry into the Treatment Program.

One of the ways which a treatment facility can be evaluated and assessed is the extent to which it is willing to tailor its program to meet the needs and sensitivities of individual patients and/or clients while main-

taining the integrity of its program and the dignity and confidentiality of the program participants.

This can be evaluated by the treatment facility's advance contact with the prospective patient/client once appropriate identification has been made. Advance information should be provided about such things as financial arrangements, method of payment, anticipated length of treatment (if known), and the rules and procedures, expectations and responsibilities to the patient. A personal copy of the latter should be provided the patient.

Many patients are now seeking treatment for chemical dependency, personal problems, mental and emotional disorders via assistance from employee assistance programs and/or company occupational programs. The caliber and reputation of the treatment facility can be greatly enhanced by working cooperatively with employee assistance program personnel.

Other ways a treatment facility can expedite the patient's entry into treatment is by making its treatment philosophy overtly known, not only to its patient population, but to its potential client community as well. A particular treatment specialty should be made known, e.g. care for individuals who are considered chronic and have already had several in-patient admissions for the treatment of chemical dependency — or if the facility only treats certain age groups, e.g. young adults between the age of 18 and 30, etc. Conversely, it should be known if the facility has a philosophy of not working with a particular type of patient, i.e. individuals who are poly-addicted, or patients who have had three or more hospitalizations for the treatment of chemical dependency within the past year. One of the most important but often overlooked criterion is the availability of staff to talk with potential patients and, if necessary, to encourage treatment.

8. The Facility Should Meet Local and/or State Standards for Licensure and Accreditation for the Treatment of Alcoholism and Drug Addiction (or be in the process).

Localities and states have established criteria and procedures to ensure quality of service and level of care. The most widely recognized accreditation is that of the Joint Commission for the Accreditation of Hospitals (JCAH). However, facilities must also be licensed by their locality/state.

Each state has a governmental body to license treatment facilities in addition to JCAH. In other words, licenses and accreditation assure the public that the facility has met minimum standards for providing services to chemically-dependent patients. Licenses and accreditation do not ensure the quality of service, they do, however, ensure that the minimum standards have been met in order to qualify for reimbursement from major insurance companies.

9. Staff Should Meet Minimum Education/Training Qualifications.

Each profession has its own criteria by which to judge its members. Individual professional competence is measured by educational attainment, professional affiliations, and license and certification.

Educational attainment generally refers to formal degrees and certifications for attendance of specialized courses, seminars and workshops. It also includes education resulting from one's personal recovery experiences.

Professional affiliations and memberships are also measures of qualifications. They accept as members those who meet specific criteria. Membership in a professional association does not ensure level of competency. It does, however, indicate that specific standards have been met.

Licensure and certification test competence. They are measures of qualifications established by a governmental organization in conjunction with a professional organization. State licensure and certification ensures that the individual has met prerequisite standards for practicing a profession in that state. At this time, not all states have licensure requirements for chemical-dependency practitioners.

Unlike educational attainment and professional affiliations, licensure and certifications indicate level of competence as established by a licensing/certifying body.

If one is not sure of credentials/qualifications — ask! However, many individuals display diplomas/certificates on their walls. Also feel free to ask questions like — “Where did you receive your chemical dependency experience? What kind of training do you have? etc.”

10. Staff Should Possess Certain Personal Characteristics.

In order for treatment to be effective a certain rapport between client and treatment practitioner must be established. It requires that practitioners be capable of displaying warmth and compassion. They must

also be open and able to encourage client openness. The practitioner must also be capable of being supportive and friendly, and possess other human qualities which make for a trusting environment for personal growth and recovery.

Treatment facility staff should be able to display an awareness and an understanding of all aspects of therapeutic interviewing when communicating with clients.

Therapeutic interviews consist of the content, the process and relational aspects. The content denotes what is said during the interview. The process is concerned not only with what is said, but how information is conveyed. The relational aspect is concerned with those things which the counselor does to establish trust, understanding and a good working relationship with the client, i.e. posture, gestures, movements, attentiveness, or other similar behaviors.

11. An Appropriate Aftercare Plan Will Be Set Up and It Will Be Accessible to the EAP Representative.

After care usually takes place after the chemically-dependent patient has returned to work, although aftercare plans are made in the acute treatment phase of care. It is a broad concept which includes the details of continued treatment and discharge summaries. Aftercare is really the continuum of care. It is that phase of treatment which begins after the acute phase of treatment has been completed.

The purpose of aftercare is to assist in the recovery process by supporting abstinence and by monitoring for possible relapse symptoms to ensure the patient's abstinence and extended recovery. Aftercare is one of the components in the treatment process. It is the prescribed extended treatment which follows primary treatment. The aftercare program should be formulated by the client, the EAP counselor and a designated counselor from the acute care treatment facility. It should be based on the supportive needs of the clients.

Treatment facilities should be able to respond to a variety of aftercare needs for at least one year, preferably two. Some of these needs include, but are not limited to, self-help fellowship group attendance (i.e. AA/NA), sobriety support (aftercare) groups held at the treatment facility, alumni group meetings, family groups/counseling etc. It is desirable to have a two-year documented history of the recovering persons participating in the aftercare program. During this time, the treatment facility should be expected to keep the EAP counselor informed of the clients' activities in the aftercare process. That is, the treatment facility should

inform the EAP counselor about attendance at aftercare meetings, concerns of possible relapse, need for more intensive treatment, or other things which might threaten recovery and interfere with treatment progress.

12. Visits by EAP and Supervisors Should Be Encouraged.

Continuity of treatment is important in recovery; therefore, visits by the EAP/worksite representative should be welcomed. The EAP counselor is the case manager and is therefore an important part of the treatment team. Encouragement of visits by the EAP/supervisor is an important way of acknowledging this EAP philosophy. On the other hand, the treatment facility has an obligation to respect the confidentiality of other clients. Consequently, visits should be encouraged that will not conflict with treatment and/or confidentiality.

13. Communication Is an Important Role.

Continuous communication with an EAP is an important part of treatment. The treatment facility should be prepared to communicate with the EAP about issues which fall into three general categories: 1) referral expectations, 2) clinical/treatment issues and 3) administrative issues. An example of referral expectations would include EAP notification of client arrival within a specified time. An example of clinical issues would include client involvement in treatment and periodic reports regarding treatment progress and/or any major changes in treatment plans. As a matter of fact, most EAP counselors should be a part of major changes in treatment plans. An example of administrative issues would include discharge plans, back-to-work considerations, and/or time requirements for aftercare participation.

14. There Should Be a Formal Continuing Educational Program for Staff and Periodic Attendance at Local/National/Regional Workshops, Conferences, and/or Seminars by Staff.

The chemical-dependency field is continuously evolving and developing. Therefore, treatment facilities should make provisions for staff members to learn about and participate in educational programs which will allow them to stay abreast of state-of-the-art developments in treatment. This objective can be accomplished by in-service training, participation in community/national seminars, conferences, and/or courses

at local universities/colleges. When touring facilities, look for recent certificates/diplomas, etc. Also feel free to inquire.

15. The Treatment Facility Must Urge and Make Provisions for Patients' Use of Community Self-help Groups (AA, AL-ANON, etc.) as Part of Follow-up and Long-term Care.

Long-term recovery is associated with individuals who attend self-help fellowship meetings several times a week in the early stages of recovery. Therefore, the treatment facility should arrange for clients to become actively involved in self-help groups as a foundation in treatment and recovery.

16. The Facility Should Provide an Opportunity for Patients to Return for Refresher/Retreats (i.e. Weekend Get-togethers).

More and more facilities are recognizing the importance of retreats and refresher courses for alumni. Through such courses, they acknowledge the importance of reinforcing the fundamentals of a good recovery program and supporting a sober lifestyle. The facility should have an alumni group which meets periodically.

17. The Facility Should Use a Holistic Treatment Approach.

The treatment facility should be prepared to address a patient's problems in addition to chemical dependency. Most chemically-dependent clients have family, marital, legal, financial, etc., problems. These problems must be addressed as a secondary problem, a threat to sobriety in primary treatment, and reflected in the aftercare treatment plan.

This criteria is not all inclusive. They do, however, provide an excellent guide for assessing and evaluating treatment facilities and resources. As you become more experienced, you may expand these criteria to fit your particular needs.

SUMMARY

Evaluating

- Step I — Phone Each Facility
- Step II — Begin to Complete Community Resource Record Form
- Step III — Visit Each Facility
- Step IV — Continue to Complete Community Resource Record Form
- Step V — Ask for Clarification of Terms
- Step VI — Tour the Facility
- Step VII — Make Subjective Assessment
- Step VIII — Objectively Test Subjective Assessment
- Step IX — Objectively Evaluate Each Facility/Practitioner
- Step X — Refer to "Criteria for Evaluating Resources"

CRITERIA FOR EVALUATING ALCOHOLISM AND DRUG ABUSE TREATMENT FACILITIES

1. The Facility's "Track Record."
2. Alcoholism, Drug Addiction and Other Forms of Chemical Dependency Should be Regarded as Primary Diseases.
3. Early During the Treatment Process, Patients Should be Made Free of Psychotropic Drugs.
4. Families (or Significant Others) Are Encouraged to Participate in the Treatment Program.
5. The Treatment Facility Should Actively Prepare Patients Against Relapse Prior to Discharge.
6. The Facility Should Have Adequate Provisions for Care of Acute Medical Problems (Not Necessarily on the Same Premises).
7. The Extent to Which the Facility Will Help to Expedite Patient's Entry into the Treatment Program.
8. The Facility Should Meet Local and/or State Standards for Licensure and Accreditation for the Treatment of Alcoholism and Drug Addiction (or be in the process).
9. Staff Should Meet Minimum Education/Training Qualifications
10. Staff Should Possess Certain Personal Characteristics
11. An Appropriate Aftercare Plan Will Be Set Up and It Will Be Accessible to the EAP Representative.
12. Visits by EAP and Supervisors Should be Encouraged.
13. Communication Is An Important Role.
14. There Should Be a Formal Continuing Educational Program for Staff and Periodic Attendance at Local/National/Regional Workshops, Conferences, and/or Seminars by Staff.
15. The Treatment Facility Must Urge and Make Provisions for Patients' Use of Community Self-Help Groups (AA, AL-ANON, etc.) as Part of Follow-up and Long-term Care.
16. The Facility Should Provide an Opportunity for Patients to Return for Refresher/Retreats (i.e. Weekend Get-togethers).
17. The Facility Should Use a Holistic Treatment Approach.

APPENDIX A

COMMUNITY RESOURCE RECORD FORM

Name _____ Phone _____

Address _____

_____ Hours _____

Contact Person _____

Type of Service _____

Description of Program/Service

Treatment Theory

Program Staff (full/part time, background, degree, experience, etc.)

Accreditation/Licensure

Medical Services (detox available, separate detox program, physicians available etc.)

Type of Client

Special Emphasis/Services

Limitations of Referral

Describe Aftercare/Follow-up

Service/Treatment Cost

Referral Procedures

Clinical Impressions and Other Comments

APPENDIX B

THE REFERRAL RESOURCE LETTER AND REFERRAL RESOURCE QUESTIONNAIRE

The _____ Employee Assistance Program is a multi-service program which provides assessment, referral and follow-up service for _____ employees. While we provide assistance for a variety of problems, we anticipate that many of the problems will require the services of mental health professionals. For this reason, we are presently compiling a resource file of agencies and practitioners (private/group) who will be in a position to work with our clients.

In order to compile our resource listing and make appropriate referrals, we are presently contacting practitioners who might be interested in receiving referrals from our program and who might have appropriate expertise to work with our clients. We are enclosing a questionnaire to provide us information about the nature of your practice. If you would be interested in being included in our resources file, please fill out the enclosed questionnaire and return it to:

We realize that the questionnaire is lengthy and rigorous, but it will be very helpful to us if you will be as thorough as possible.

If you have any questions, I'll be happy to speak with you about our program.

Sincerely,

REFERRAL RESOURCE QUESTIONNAIRE

MENTAL HEALTH PROFESSIONALS

Please complete this form as thoroughly as possible. You are encouraged to attach your curriculum vitae and any brochures or other information you may have regarding your practice. If your's is a partnership or group practice, a questionnaire should be completed for each *practitioner*. please contact _____ for additional copies of this form if necessary.

Please return the completed questionnaire within three weeks to:

I. Identifying Data

- a. Name of practitioner _____
- b. Office address _____
- c. Telephone number of practice _____
- d. Other telephone numbers where you may be reached _____
- e. Group or corporate name, if applicable _____

II. Practice Data

- a. Discipline (check one or more as appropriate)
Psychologist____ Psychiatrist____ Social Worker____ Minister____
Other (please specify) _____
- b. Practice is (check one) full time____ part time____
- c. If part-time, please list days and hours of operation _____
- d. Please describe the nature of your practice as completely as possible, including *types of patients and patient groups* with which you deal (children, adolescents, adults, individuals, couples, families, etc.) Make note of *treatment approaches* and modalities (analytic, behaviorist, etc., hypnosis, biofeedback). Please feel free to include any other information about your practice; append additional sheets as needed.

- e. Please describe fee structure _____

- f. Please describe eligibility for and participation in third-party payment programs _____

- g. Do you carry malpractice insurance? Yes _____ No _____

III. Professional Training

- a. List degree or degrees which qualify you for professional practice, and schools attended: _____

- b. Please list and describe all other major coursework, workshops, institutes, continuing education programs, and specialized clinical supervision which you have received and which you feel contributes to your professional competence. _____

IV. Professional Experience

Please list all relevant professional experience other than current practice, including any current employment. Please include dates, and indicate specialization regarding types of clients, types of problems dealt with, and therapeutic modalities employed. _____

V. Affiliations and References

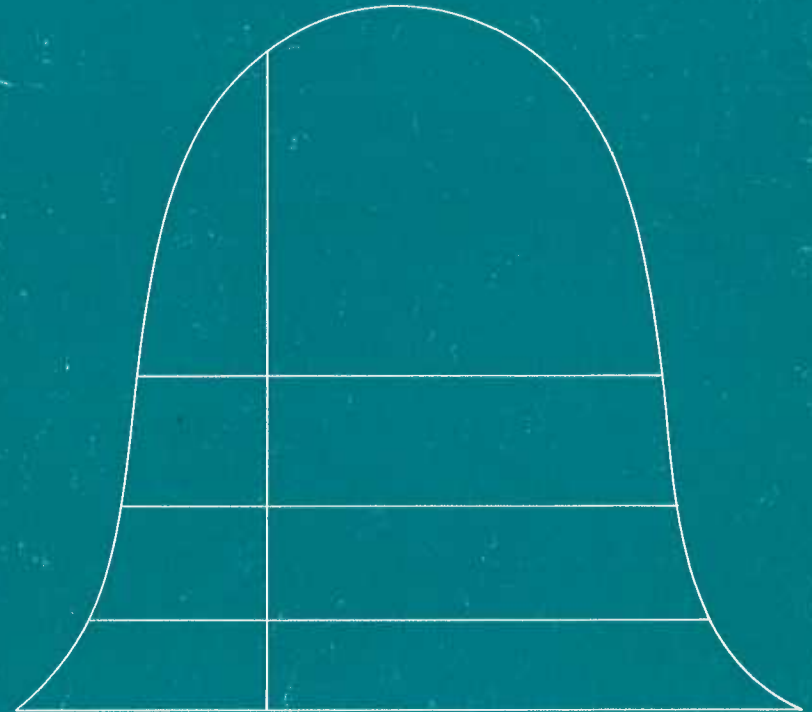
- a. If applicable for your discipline, list license number _____

- b. Please list all professional *certifications* which you hold _____

- c. Please all professional organizations of which you are a member other than those providing certification _____

- d. Please list names and addresses of three references from the professional community _____

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Problems

Other Employees Who Benefit from
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