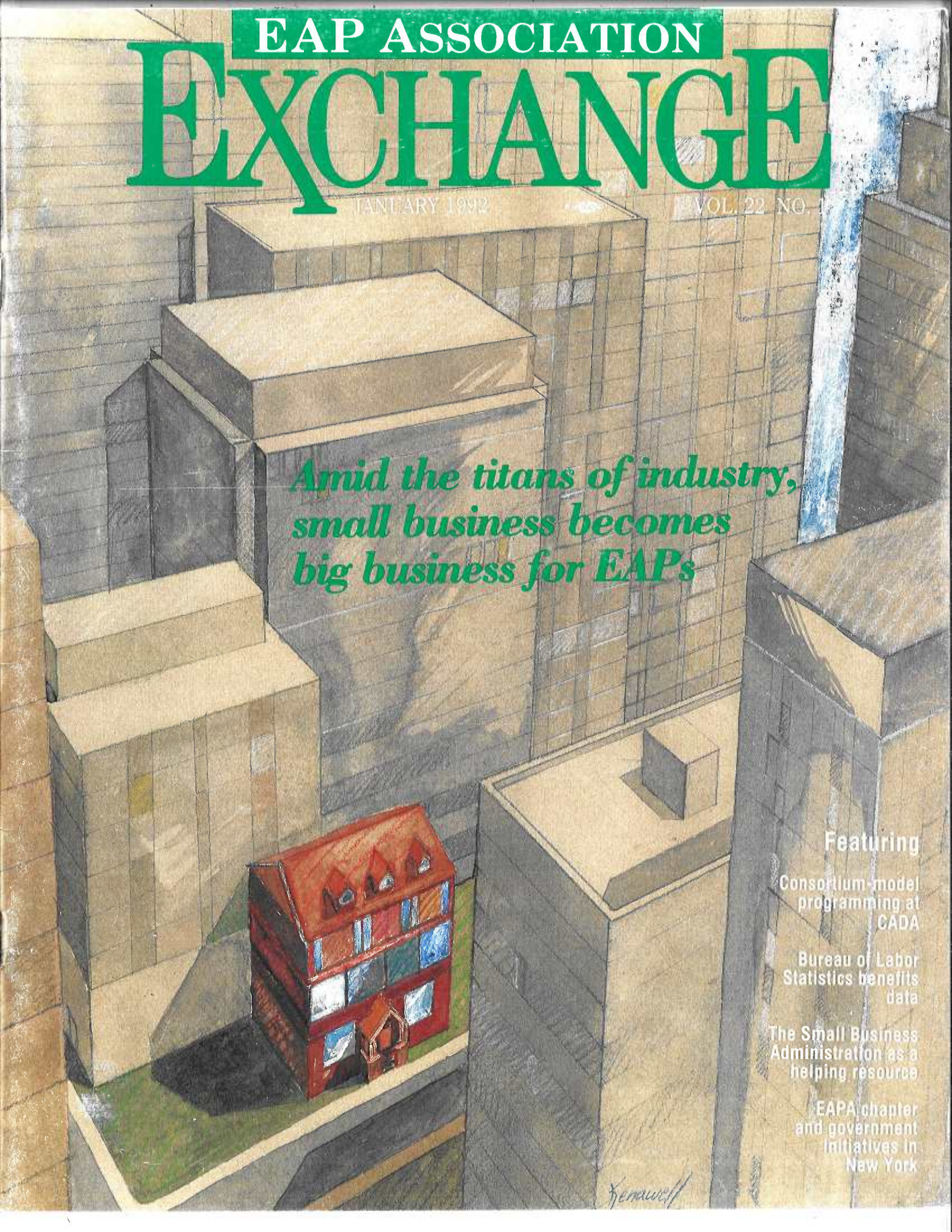
EAP ASSOCIATION

EXCHANGE

JANUARY 1992 VOL. 22 NO. 1



Amid the titans of industry, small business becomes big business for EAPs

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Bureau of Labor Statistics benefits data

The Small Business Administration as a helping resource

EAPA chapter and government initiatives in New York

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EDITOR'S COMMENT

Small Titans

SOMEWHERE in the halls of fine art hangs an illustration portraying a subaqueous food chain. It shows a fish being devoured by a larger fish, which is being devoured by a larger fish, which is being devoured by the largest fish. The largest fish, upon closer inspection, is actually a pack of small fish. It makes a powerful visual message that small organisms, of little consequence individually, can be great forces to be reckoned with *en masse*.

Small businesses are the same way. For more than 20 years running, EAPs have been successful at marketing and providing services to larger and, to a lesser degree, mid-size employers. But what about the other 90% of businesses? Harnessing this economically powerful but more elusive clientele requires more creativity, innovation and energy, as many of the more traditional strategies are inappropriate, or inefficient due to the lack of large, centralized worker populations.

Our feature coverage is packed with information and ideas. The first article is about an EAP consortium that developed by the Corporation Against Drug Abuse in Washington, D.C. The Bureau of Labor Statistics gives a statistical overview of the prevalence of mental health and substance abuse benefits among small employers. The Small Business Administration then describes its efforts to provide anti-substance abuse programming for small employers and stresses its availability to EAPs as a helping resource. Finally, a recent small business conference by the EAPA New York City Chapter is reported on, as are promotional activities of New York's Division of Alcoholism & Alcohol Abuse.

EAPA MEMBERS are given an introduction to the association's new Executive Director, Michael Benjamin, on page 5. Benjamin, who interviewed with the Board of Directors during the National Conference in St. Louis, joins EAPA from the National Association of Counties. In next month's issue, the *Exchange* will provide more up-close-and-personal coverage of the person who now fills the big shoes at EAPA headquarters.

THE BUSINESS PAGE continues the *Exchange*'s coverage of managed behavioral health care with an article by Charla Parker on making spreadsheet calculations for staffing and funding an expanded program. Discussions will continue in February, with feature coverage on managed behavioral health care.

Threats and opportunities abound for EAPs in 1992. You can continue to count on the *Exchange* to bring you concise, accurate and innovative reporting on current developments in the EAP field, as well as the latest EAPA-related news. It's just one of many benefits of membership in EAPA, and we're glad you're along for the ride!

Rudy M. Yandrick

PUBLISHED BY:
The Employee Assistance Professionals Association, Inc.
4601 N. Fairfax Drive
Suite 1001
Arlington, VA 22203
Telephone (703) 522-6272

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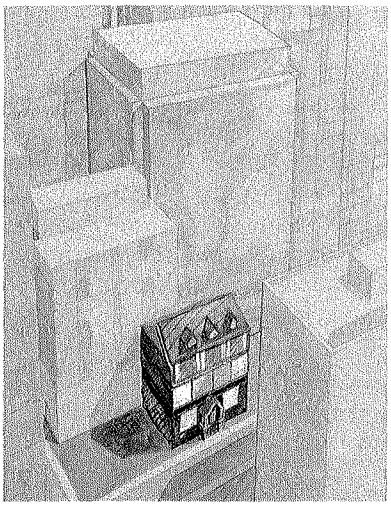
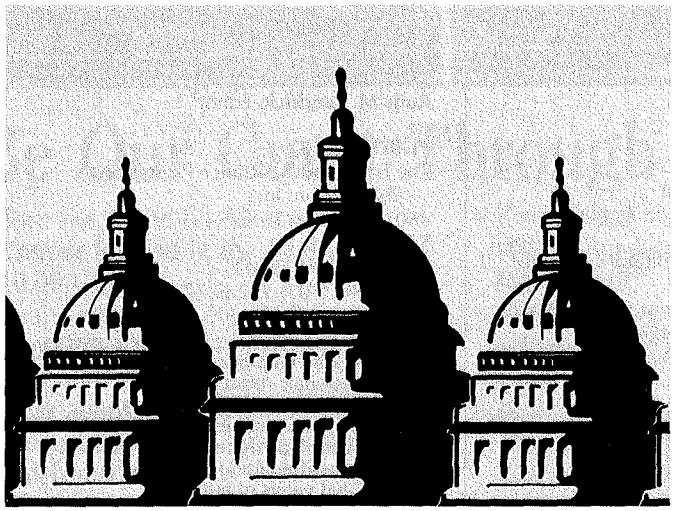


SMALL BUSINESS EAP DEVELOPMENT

DEPARTMENTS



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SPECIAL MEMORANDUM

Benjamin Named as EAPA Executive Director

Six long months of anticipation are over. EAPA's extensive search process for replacing EAPA's outgoing Executive Director, Tom Delaney, has ended with the appointment of a successor. Michael L. Benjamin will stride into EAPA's Arlington, VA headquarters for the first time on January 13 as the association's new chief operating officer.

Benjamin comes to EAPA from the National Association of Counties (NACo), where he worked since October 1989 as associate legislative director for human services and education. In that capacity, he advised county officials on the development of human services and education policy through a steering-committee process and represented that policy to the federal government, Congress, and other organizations. He worked with the Administration and Congress to overcome legislative and regulatory barriers to implementation of such programs as welfare reform, the JOBS program, child care, the food stamp program, and others.

From 1986-89, Benjamin he was responsible for the overall performance of a three-year contract NACo had with the National Institute of Mental Health (NIMH). The project provided technical assistance to county governments impacted by the farm crisis, mentally ill in jails and the criminal justice system, and with substance abuse problems of young chronically mentally ill adults.

His tenure at NACo began in 1974, when he was hired as director of the NACo Research Foundation Alcoholism and Alcohol Abuse Program. From 1977 to 1981 he was assigned to NIMH from NACo under the Intergovernmental Personnel Act of 1970 to serve, variously, as community support consultant, acting executive secretary and health scientist administrator.

He moved from the metropolitan Washington, DC area to Portland, OR to become executive director of the North/Northeast Community Mental Health Center from 1981-85 and president of Michael Benjamin & Associates from 1985-88. At Benjamin & Associates, he provided consultation, training, fact-finding, problem-solving, project-management, planning (program and financial), and related services to individuals, groups and organizations. A special focus was directed to organizations serving minority clients. From 1964-74, he held jobs in various locations as job developer and clinical placement director, lecturer in psychiatry, research project administrator, director of research & evaluation for a drug abuse training institute, a developer of drug education programs, public health advisor, and teacher of German.

Benjamin graduated from Yale University in 1972 with a master of public health degree while majoring in mental health administration. He graduated from Texas Southern University in 1964 with a bachelor of arts degree in psychology and a minor in German.

Among his honors, Benjamin was given the Outstanding Young Men of America Award in 1975, Drug Dependency Institute Fellowship from NIMH in 1970-72, and Charles Young American Legion Scholarship in 1959-60.

Benjamin is knowledgeable about EAP issues, which have been a part of his professional training. He has broad experience working with boards of directors and, while at NACo, he worked as a lobbyist and managed an annually held national meeting of over 1,000 participants.

EAPA's Search Committee conducted its proceedings from the standpoint that the position of EAPA Executive Director is the most influential job in the EAP field. The committee received hundreds of resumes from talented, qualified professionals with experience in association management and employee assistance, and culled through mountains of parchment for the most highly qualified individuals. EAPA is fortunate to have acquired the services of someone of such distinguished character and achievement. In the February *Exchange*, EAPA members will meet Michael Benjamin from a more personal side. Be looking for our coverage!

EAPA's new Executive Director, Michael Benjamin (l), has been welcomed to the association by the person he succeeds, Tom Delaney. Delaney has cordially briefed Benjamin on issues important to EAPA and the EAP field, providing for a smooth transition.

Board Meets During 20th National Conference

For members of EAPA's Board of Directors, the 20th National Conference in St. Louis meant hustling from one meeting or workshop to the next, often trying to juggle conflicting schedules. The Board engaged in a long interview process of three final candidates for EAPA's Executive Director position. The Executive Committee met with each candidate for an hour on the mornings of November 10, 11 and 12, and the Board met with each candidate for three hours afterward. The final selection occurred during the Board meeting on November 13.

The selection process has resulted in an offer of employment extended to, and accepted by, Michael Benjamin. (Please see the related article about Benjamin on page 5.)

Other Board action included the following:

• The draft of a strategic plan for EAPA was presented to the Board by Brad Googins, cochair of the *ad hoc* Strategic Planning Committee. Comments have since been submitted to EAPA headquarters from Board members. Refinements to the initial draft will be made by committee, and an updated draft will be considered by the Board when it deliberates for two or three days at the spring Board meeting to work toward a final document.

• EAPA's Board appointments are made on rotating three-year terms, and President Dan Lanier named the following people to the Board:

• **Irene Simonetti** was named chair of the Advisory Committee to the *Exchange*, replacing Claire Fleming.

• **George Cobbs** was named chair of the Bylaws Committee, replacing Jim Roth.

• **Gary Maltbia** was named chair of the Ethnic & Cultural Concerns Committee, replacing John Hooks.

• **Jack McCabe** was named chair of the Labor Committee, replacing Thom Murgitroyde.

• **Tamara Cagney** was reappointed as chair of the Standards Committee.

• **Ron Finch** was named chair of the *ad hoc* Benefits Committee, replacing Sally Lipscomb. (This is not a Board position.)

• **Jane Ollendorff** completed her term as chair of the Annual Meeting Site Selection Committee. Under EAPA's new Bylaws, this committee is defunct, so a successor will not be named.

• A new chair was elected by the Employee Assistance Certification Commission, **Terry Cowan,** to replace outgoing chair Sandra Turner. Three new commissioners—**Carmen Abbott, Mark Cohen and James Martin**—were named by President Dan Lanier.

[Due to the holidays, the *Exchange* was unable to obtain biographical information on all of the appointees. Be looking in the February issue for more information on the new Board members, and the new EACC chair and commissioners.]

• Sandra Turner presented the Education & Training Committee report on behalf of chairperson Muriel Gray. She discussed a "vision" of the committee for an Education and Training Resource Center and development of an EAP training program and related publications. President Lanier asked the committee to continue to develop ideas and formulate proposals, and to submit a report at the spring meeting. No formal action was taken.

• Sandra Turner also submitted a report for the EACC as its outgoing chair. She requested that the EACC work with EAPA legal counsel to draft a procedure by which the EACC can act on ethical issues brought before EAPA and the EACC simultaneously. President Lanier directed the EACC to proceed.

• Standards Committee chair Tamara Cagney raised the issue of whether EAPA's legal definition of EAP should be revised. President Lanier directed that a subcommittee be created to discuss it further.

The Board approved the Professional Guidelines, the second stage of the Standards process, submitted by the committee. Another motion was approved to provide a copy of the Guidelines to each EAPA member at cost, to make a discount available to chapters for bulk purchases, and to include an additional charge for non-EAPA members wishing to buy the Professional Guidelines.

The committee is also working on an EAP nomenclature. A subcommittee is presently working on the development of program evaluation guidelines. [Refer to page 10 of the November 1990 *Exchange* for a graphic presentation of the Standards process.]

• The Board commended EAPA headquarters staff for its work in contributing to the success of the 20th National Conference.

• Reports were also made by each of the regional representatives. Of particular note, in the Canadian Region's report (made by Carolyn Stark on behalf of chairperson Brenda Broughton), Canada has been gradually increasing its membership, which now stands at 110. The region has formed a Coast Task Force to continue recruiting new members. Also, the Canadian members in attendance at the 20th National Conference expressed their pleasure at the quality of the workshops.

The spring Board meeting will tentatively be held in mid-May at a site to be determined.

The 21st National Conference "Call for Papers" will appear in the *Exchange* next month. Be looking for it!

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CONCURRENT WORKSHOPS continued

- ❑ **EAPA-129** **"ALCOHOLISM: PROBLEMS, PROGRESS, PROMISE"** John Wallace, Ph.D.
- ❑ **EAPA-130** **"DISCUSSION OF THE U.S. POST OFFICE DRUG SCREENING PROJECT"** - Jacques Normand, Ph.D.
- ❑ **EAPA-131** **"CULTURAL DIVERSITY"** - Celina Pagani-Tousignant
- ❑ **EAPA-132-A** **"BENEFIT DESIGN - ITS IMPACT ON THE EXTERNAL EAP" - PART I** Greer M. Kabb, CD, MA, CEAP; Linda Havlin
- ❑ **EAPA-132-B** **"BENEFIT DESIGN - ITS IMPACT ON THE EXTERNAL EAP" - PART II** Greer M. Kabb, CD, MA, CEAP; Linda Havlin
- ❑ **EAPA-133-A** **"SELF HELP GROUPS" - PART I** Nancy Carlson, NCSAC, II
- ❑ **EAPA-133-B** **"SELF HELP GROUPS" - PART II** Nancy Carlson, NCSAC, II
- ❑ **EAPA-134-A** **"HOW TREATMENT PROVIDERS CAN WORK EFFECTIVELY WITH MANAGED CARE" - PART I** Monica E. Oss; May Welch
- ❑ **EAPA-134-B** **"HOW TREATMENT PROVIDERS CAN WORK EFFECTIVELY WITH MANAGED CARE" - PART II** Monica E. Oss; May Welch
- ❑ **EAPA-135-A** **"A DISCUSSION OF THE CORE TECHNOLOGIES OF EAP AND WELLNESS" - PART I** John C. Erfurt; Andrea Foote, Ph.D.; Betty Reddy
- ❑ **EAPA-135-B** **"A DISCUSSION OF THE CORE TECHNOLOGIES OF EAP AND WELLNESS" - PART II** John C. Erfurt; Andrea Foote, Ph.D.; Betty Reddy
- ❑ **EAPA-136-A** **"DRUG SCREENING AND COMPULSORY REFERRALS" - PART I** Sue Curtain, MS, CEAP; Robert R. Ramsey; Dr. Chris Taylor
- ❑ **EAPA-136-B** **"DRUG SCREENING AND COMPULSORY REFERRALS" - PART II** Sue Curtain, MS, CEAP; Robert R. Ramsey; Dr. Chris Taylor

CONCURRENT WORKSHOPS continued

- ❑ **EAPA-137** **"LINKING NEW DEVELOPMENTS IN HUMAN RESOURCES WITH EAPs: LIFE CYCLE PLANNING"** - Victor Barocas
- ❑ **EAPA-138-A** **"IMPROVING QUALITY FOR EAP CHANGE AND GROWTH"-PART I** Arthur J. McLaughlin; John M. Marurer, Jr.; Bonnie J. Rack-Wildner, William J. Shanahan, Ph.D., CEAP
- ❑ **EAPA-138-B** **"IMPROVING QUALITY FOR EAP CHANGE AND GROWTH"-PART II** Arthur J. McLaughlin; John M. Marurer, Jr.; Bonnie J. Rack-Wildner, William J. Shanahan, Ph.D., CEAP
- ❑ **EAPA-139** **"DIAGNOSTIC & TREATMENT STRATEGIES FOR BORDERLINE PERSONALITY DISORDER"** - Michael Langley, Ph.D.
- ❑ **EAPA-140** **"EAP AND BENEFITS"** - William Filstead, Ph.D.; Will Turner
- ❑ **EAPA-141** **"AMERICAN WITH DISABILITIES ACT"** - Brian Lawton, Ph.D., CEAP
- ❑ **EAPA-142-A** **"MANAGING FOR QUALITY – BEHAVIORAL HEALTH PURCHASERS PERSPECTIVE" - PART I** Edward Stetzer; Gail Rosselot, RNC, MPH; James M. Oher, CEAP
- ❑ **EAPA-142-B** **"MANAGING FOR QUALITY – BEHAVIORAL HEALTH PURCHASERS PERSPECTIVE" - PART II** Edward Stetzer; Gail Rosselot, RNC, MPH; James M. Oher, CEAP
- ❑ **EAPA-143** **"CULTURAL DIVERSITY AND COMMUNITY RELATIONS"** Dr. Mabel Tinjacá
- ❑ **EAPA-144-A** **"INNOVATIONS IN CD TREATMENT" - PART I** Jeffrey Smith, M.D.; Martha A. Morrison, M.D.; Michael Ratcliff
- ❑ **EAPA-144-B** **"INNOVATIONS IN CD TREATMENT" - PART II** Jeffrey Smith, M.D.; Martha A. Morrison, M.D.; Michael Ratcliff
- ❑ **EAPA-145-A** **"UNDERSTANDING ORGANIZATIONAL AND DEMOGRAPHIC INFLUENCES ON EAP CASELOAD" - PART I** Neil B. Colan, Ed.D.; Rob Schneider, Ed.D.; Linda Little, Ph.D.; Lawrence Gerstein, Ph.D.; Chelle Dainas, Ph.D.
- ❑ **EAPA-145-B** **"UNDERSTANDING ORGANIZATIONAL AND DEMOGRAPHIC INFLUENCES ON EAP CASELOAD" - PART II** Neil B. Colan, Ed.D.; Rob Schneider, Ed.D.; Linda Little, Ph.D.; Lawrence Gerstein, Ph.D.; Chelle Dainas, Ph.D.

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- ❑ **EAPA-101-B** **"EAP AS CARE MANAGER" - PART II** Paul W. Heck, M.Ed., CEAP; Donald W. Magruder, CEAP; Linda Tally
- ❑ **EAPA-102** **"MENTAL HEALTH ADDICTION AND AFTER CARE"** Charla Rasmussen-Scarbrough, MS, CEAP; Jacqueline Harrigan, CEAP
- ❑ **EAPA-103-A** **"SUCCESSFUL COCAINE TREATMENT – FACT OR FICTION" - PART I** J. Randall Webber, MPH; Barbara Eisenstadt, Ed.D.
- ❑ **EAPA-103-B** **"SUCCESSFUL COCAINE TREATMENT – FACT OR FICTION" - PART II** J. Randall Webber, MPH; Barbara Eisenstadt, Ed.D.
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- ❑ **EAPA-104-B** **"A PEER REVIEW METHOD OF MAKING QUALITATIVE JUDGMENTS REGARDING EAP PERFORMANCE: THE FLORIDA PROGRAM CERTIFICATION PROJECT" - PART II** Teddy M. Kemp, CEAP; Tamara Cagney, BSN, MA, CEAP; Sharon Amatetti, MPH
- ❑ **EAPA-105-A** **"EAP EVALUATION" - PART I** John Maynard, Ph.D., CEAP; Brenda Blair, CEAP
- ❑ **EAPA-105-B** **"EAP EVALUATION" - PART II** John Maynard, Ph.D., CEAP; Brenda Blair, CEAP
- ❑ **EAPA-106** **"A DYNAMIC APPROACH TO MARKETING EAPs TO SMALL BUSINESSES"** - Susan A. Berger, Ed.D.; Elena M. Brown, MA, CEAP
- ❑ **EAPA-107-A** **"MANAGING PROVIDERS SERVICE" - PART I** Dorothy B. North, CEAP; Charla Parker, MAP, CEAP
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- ❑ **EAPA-112** **"INNOVATION IN JOINT LABOR-MANAGMENT PROGRAMS"** - Charles Grantham, BS, MBA; John H. Lucas, Jr., BA, MS
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- ❑ **EAPA-113-B** **"SEXUAL TRAUMA: MISDIAGNOSED & OVER HOSPITALIZED" - PART II** Jeanne Rigaud, MS, NCADC
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- ❑ **EAPA-118** **"DOES INPATIENT TREATMENT MAKE A DIFFERENCE"** Diana Walsh, Ph.D.; Ralph Hingson, Sc.D.; Daniel M. Merrigan, Ed.D.
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- ❑ **EAPA-119-B** **"EAPs THAT HAVE MET THE CHALLENGE OF SERVING THE SMALL BUSINESS CLIENT" - PART II** Donna Abernethy; Dan McGinnis, MHS, CEAP; Marian Roser, MS, CEAP
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- ❑ **EAPA-123-B** **"EVOLUTION OF THE EAP INTO MANAGED CARE" - PART II** Richard T. Hellan, CEAP; John J. Dolan, CEAP
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- ❑ **EAPA-125** **"CD TREATMENT – STATE OF THE INDUSTRY"** Patrice M. Muchowski, ScD.
- ❑ **EAPA-126-A** **"BENEFITS DESIGN FROM THREE PERSPECTIVES" - PART I** Hal Levister; John Riley; Don Sanderson
- ❑ **EAPA-126-B** **"BENEFITS DESIGN FROM THREE PERSPECTIVES" - PART II** Hal Levister; John Riley; Don Sanderson
- ❑ **EAPA-127** **"QUALITY IMPROVEMENT IN BEHAVIORAL HEALTH DELIVERY"** Dr. David Zarchin, Ph.D.; David Noone, Ph.D.
- ❑ **EAPA-128** **"PARTNERSHIP FOR COST EFFECTIVE MENTAL HEALTH SERVICES"** - William H. Kyles, MA, MPA; Rachel Goldman, MA

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ASAM Holds Roundtable, Hennessy Attends

The American Society of Addiction Medicine is engaged in ongoing development and implementation of its recently published *ASAM Patient Placement Criteria for the Treatment of Psychoactive Substance Use Disorders,* a document which has received the formal endorsement of EAPA's Board of Directors. Toward this end, ASAM sponsored an invitational roundtable discussion on November 18-19 in Arlington, VA. Jack Hennessy, chair of EAPA's Treatment Committee, attended on EAPA's behalf.

One goal, according to Dr. James F. Callahan, executive vice president of ASAM, was to initiate consensus development among providers, corporations, government officials and other policy makers about clinical criteria for placement of alcohol and other drug-dependent patients. A second goal was to elicit comments from participants on the *Patient Placement Criteria* and the steps ASAM plans to take to implement and evaluate the document.

Among the organizations represented at the roundtable were:

- CHAMPUS.
- American Psychological Association.
- Joint Commission for Accreditation of Health Care Organizations.
- Office for Treatment Improvement.
- Washington Business Group on Health.
- National Council on Alcoholism and Other Drug Dependencies.
- National Association of Addiction Treatment Providers.
- Legal Action Center.
- American Psychiatric Association.
- American Nurses Association.
- National Association of Alcoholism and Drug Abuse Counselors.
- Agency for Health Care Policy and Research.
- National Institute on Drug Abuse.
- American Association for Partial Hospitalization.
- American Medical Peer Review Association.
- Blue Cross/Blue Shield Association.

Dr. James F. Callahan

- Office of National Drug Control Policy.

Dr. Callahan notes that the conference was stimulating, thought-provoking, educational, candid, conciliatory and consensus-minded. Although it was not an explicit objective of ASAM to seek endorsement of the *Criteria,* many participants agreed that a desirable goal is to develop one national set of criteria which can be presented for acceptance to employers, purchasers and providers of treatment. The barriers to achieving this type of consensus document were identified and strategies were discussed to move all "stakeholders" in the *Criteria* to a criteria-development process that is inclusive, research-based and field data-based.

ASAM, a national medical society of 3,500 physicians, will continue to be among the organizations taking a leadership role in developing, implementing and evaluating a single set of criteria that can be used by all persons involved in patient-placement and cost-of-care decisions.

UPDATE ON CERTIFICATION

Happy Endings, New Beginnings

Nineteen ninety-one was a year of very good fortune for the Employee Assistance Certification Commission (EACC). At the close of the year, Professional Testing Corporation had just given its 10th examination on behalf of the EACC. There were (and still are) 4,603 Certified Employee Assistance Professionals (CEAPs), 57% of whom are also members of EAPA.

After nine new appointments by EAPA president Dan Lanier late the prior year, the majority of commissioners completed their first full year of service to the EACC in 1991. They brought with them fresh perspectives and more heterogeneity in terms of professional experience, ethnicity and culture, which is helping to keep the EAP profession on par with relevant social and workplace developments. Additionally, the EACC, under outgoing chair Sandra Turner, implemented a variety of changes to assure that CEAP candidates understand and have fulfilled certification requirements and to streamline the recertification process.

NEW CONCERNS IN 1992

The EACC is ambitiously continuing its drive toward excellence in 1992. This month, CEAPs receive correspondence explaining their certification status and how last year's changes affect them personally. CEAPs who have not yet received their letter should contact the EACC office (c/o EAPA) to ensure that their address is current.

A challenge for the EACC in 1992 relates to a requirement implemented last year that all CEAP candidates complete a "Verification of Experience" form showing that the candidate has fulfilled the 3 years/3,000 hours requirement. On the EACC's agenda will be establishment of criteria to clarify which work experiences are EAP-specific for purposes of exam eligibility.

Why is this verification-process essential? Many people perform functions that are considered a part of EAP practice, such as clinical tasks found in Content Areas 5 and 6, but they may not perform them in the workplace environment nor perform other tasks found in Content Areas 3 and 4. In other cases, many people in counseling and treatment settings receive client referrals from EAPs, but the nature of their work is different from that described in the EAP Scope of Practice. For example, a person with the title of "EAP Coordinator" may work for a freestanding treatment facility to coordinate the referral of clients, but this is vastly different from the role and responsibilities of an "EAP Coordinator" in the workplace from where assessments and referrals are made.

Call PTC for questions about the CEAP Exam

The EACC office receives a steady stream of general questions about the CEAP exam. More often than not, they are referred to Professional Testing Corporation (PTC), which administers the CEAP exam. The EACC office urges people with questions of this variety to contact PTC directly, in New York City, at (212) 852-0401.

The EACC anticipates committing more resources to differentiating between people who are, in fact, practicing EAP, and those who are not. It plans to take a tougher line enforcing other policies, as well, which has the potential to lead to some decertifications.

The EACC is also establishing new and better ways to communicate with CEAPs. One of them is publication of a new bimonthly newsletter for CEAPs called *CEAP STANDARD*. It will further people's understanding of the benefits and responsibilities of being a Certified Employee Assistance Professional and keep them current on new developments. The first issue will be off the press at the beginning of the EACC's fiscal year in July.

Last but not least for 1992, EACC has a new chair, Terry Cowan, and two new commissioners. Please turn to page seven for more on the changes and additions. Terry will be communicating regularly with EAPA members and CEAPs throughout the year.

Nineteen ninety-two holds great promise for building new relationships between the EACC and EAP professionals. As CEAP membership tops 5,000 for the first time this year, the EACC is committed to furthering its goal of making Certified Employee Assistance Professional the universally recognized designation among decision makers in business, labor and government.

EAPA's Subject Search Catalog

Updated for the 1990s

EAPA is keeping apace with an EAP profession on the move and has fine-tuned its popular Subject Search Catalog. The new listings, shown in the menu below, are consistent with the newly revised Content Areas that constitute the CEAP Scope of Practice. Subject searches consist of a collection of journal articles, book chapters, brochures, pamphlets, ect. which provide informtion in a given topic.

Here's how to order: Mark the boxes to the left of the titles you want. Make a check payable to "EAPA" for the total amount of your order, based on the prices shown to the right of each title. Mail the form with your check or purchase order to: EAPA, 4601 N. Fairfax Drive, Suite 1001, Arlington, VA 22203.

Advance payment is required, but telephone orders will be accepted if they are billed to American Express, Master Card or Visa. Telephone: (703) 522-6272.

TITLE **PRICE**

Work Organizations

- ☐ Cultural Diversity 14.00
- ☐ Labor/Management Programs 17.00

Human Resource Management

- ☐ Benefits Overview/Manager's Guide 14.00
- ☐ Benefits/MH, CD 9.00
- ☐ Career Development/Competencies . 22.00
- ☐ COBRA 9.00
- ☐ ERISA 9.00
- ☐ Fitness for Duty 24.00
- ☐ Insurance/Health Care Utilization 18.00
- ☐ Job Loss 16.00
- ☐ Knox-Keene 6.00
- ☐ Law: Anti-Drug Abuse Act (summary) 6.00
- ☐ Law: Drug-Free Workplace Act 6.00
- ☐ Law: Duty to Warn 10.00
- ☐ Law: Privacy Act 7.00
- ☐ Legalization 7.00
- ☐ Managed Care/Alternative Therapies 5.00
- ☐ Managed Care/Cost Containment 11.00
- ☐ Managed Care/HMOs, PPOs 18.00
- ☐ Managed Care/Overview 7.00
- ☐ Managed Care Utilization 7.00
- ☐ Work and Family: Child Care 15.00
- ☐ Work and Family: Eldercare 6.00
- ☐ Work-Site Wellness/Health Promotion 26.00

EAP Policy and Administration

- ☐ Confidentiality 9.00
- ☐ Contracting: Pricing and Services 10.00
- ☐ Cost-Benefit Analysis/ Effectiveness 42.00
- ☐ Cost Containment 19.00
- ☐ EAP History 9.00
- ☐ EAP Internal/External 6.00
- ☐ EAP Models and Essential Ingredients 22.00
- ☐ EAP Models and Influences 34.00
- ☐ EAP Overview 14.00
- ☐ EAPs and Small Businesses/ Consortia 9.00
- ☐ Ethics 10.00
- ☐ Evaluation Benchmarks 39.00
- ☐ Managed Care/EAP Perspective 6.00
- ☐ Marketing 9.00
- ☐ Needs Assessment 7.00
- ☐ Policy 16.00
- ☐ Supervisory Programming 18.00
- ☐ Traning of EAP Practitioners 12.00
- ☐ Utilization 18.00

EAP Direct Services

- ☐ Case Load/Case Management 10.00
- ☐ Critical Incident Stress Debriefing 50.00
- ☐ EAP/Chemical Dependency Assessment 15.00
- ☐ EAP Referral Process 14.00
- ☐ Prevention 16.00

Chemical Dependency and Other Addictions

- ☐ Aftercare/Relapse Prevention 14.00
- ☐ Co-Dependency 7.00
- ☐ Drug Testing Bibliography 4.00
- ☐ Drug Testing Cost-Benefit Analysis 4.00
- ☐ Drug Testing/EAP Perspective 9.00
- ☐ Drug Testing Overview 21.00
- ☐ Employer Anti-Drug Programs 9.00
- ☐ Women and Chemical Dependency . 14.00

Personal and Psychological Problems

- ☐ AIDS and the Workplace 20.00
- ☐ Physically Challenged 19.00
- ☐ Stress: Job-Related 19.00
- ☐ Work and Family: General 12.00

Also of interest

- ☐ Audiovisual Reviews 27.00
- ☐ EAPs in Higher Education 11.00
- ☐ EAP Program Forms 14.00
- ☐ EAP Salaries 5.00
- ☐ EAPs in School Systems 11.00
- ☐ Troubled Health Care Providers 10.00
- ☐ Troubled Professionals/ Executives 11.00

Special Offering

- ☐ Fact Sheets (complete sets only) 15.00

Topics: Absenteeism, consumption, dollar impact/workplace use, drug-free workplace regulations, EAP response, employer investment in EAPs, four most prevalent workplace drugs, impact/job-performance measures, incidence/prevalence, positive consequences of EAPs, termination vs. treatment, Workforce 2000

Cost of Searches $ _____

Non-EAPA members add *50%* surcharge _____

Sub-Total $ _____

Virginia Residents add 4.5% sales tax _____

TOTAL $ _____

YOUR NAME _____

Membership Category _____

Organization _____

ON THE LABOR FRONT

Getting the Word Out

by Jack McCabe
Sheet Metal Workers' International Association, and
Chair, EAPA Labor Committee

It was a pleasure and an honor to be appointed by President Dan Lanier as the new chair of EAPA's Labor Committee. There is a great deal that organized labor members can do to help further the objectives of EAPA, advance the EAP field, and promote EAPs within our own unions. My deepest ambition over the next three years is to succeed at encouraging more labor people in the EAP field to speak out and write about their accomplishments and practices, and about labor philosophies. In other words, I'd like us to become more conscientious about generating good PR.

This is a simple matter of making it a priority to contribute articles to magazines in the EAP field such as *EAPA Exchange*, speak at conferences, and write for our unions' internal publications. For example, the Sheet Metal Workers publishes an eight-page monthly tabloid, *Focus on Funds*. It runs columns from our various departments, including National Benefit Funds, National Training Fund, National Energy Management Institute, and others. With the help of our internal communications staff, we write a monthly EAP column, also.

In the December issue, our column ran a testimonial by a member of SMWIA's Houston-based local who overcame a personal substance abuse problem through our local EAP affiliate. The member described how he lost control of his substance abuse problem, approached his supervisor about it, and was referred to the Workers Assistance Program of Texas. He was then sent to an intensive outpatient program, which he successfully completed. He is in recovery today. The member divulged his name in the article because he was sincere about encouraging others with problems to self-refer to the program for help before they lose control of their situations.

An EAP (or MAP) can't buy better publicity than that, and we have all helped union members like him. Whether it is a testimonial from a brother or sister or an article about problems for which the EAP can help or about miscellaneous other activities the EAP is involved in, it's all publicity that helps to accomplish the objectives of our programs.

I would also like to see the *Exchange* used more often as a means by which labor members can communicate with each other. Instead of using the "On the Labor Front" column to run testimonials—which would be like preaching to the converted—I would like to see more articles about innovations in labor program development, such as the one in last Month's *Exchange* about the Laborers' International Union MAP. This column can also be used to bring labor members up to speed on current events, such as a recent strategy session held at the George Meany Center about workplace substance abuse which will run in next month's issue.

Labor has been a cornerstone of ALMACA and EAPA since the association's formation nearly 21 years ago, and it's up to all of us to help keep labor on the front line. Any EAPA member with news that s/he thinks is of interest to labor is invited to contact the *Exchange* through EAPA headquarters or to correspond with me directly. My address is 1750 New York Avenue, NW, Washington, DC 20006-5386.

In other business, I received a letter from EAPA Western Region Representative Jim Lehman recently. He described how labor is helping the Colorado Chapter in very practical ways. Here is an excerpt from his letter.

Labor's participation in EAPA has always been a mainstay of the association. In many regions such as the Western Region, Labor's participation has been very slight. The Colorado Chapter has been taking steps to correct that situation. At the present time, the Colorado Chapter meets in UFCW Local #7 Union Hall for their monthly meetings. The chapter has a UAW member on its executive committee, its checks are printed by a union printer, and it banks at the union bank in Denver. The Colorado Chapter can be used as a model for other chapters to get more labor involvement at the local level.

I wholeheartedly encourage EAPA chapters and labor members to work together for mutual benefit, such as the Colorado Chapter is doing. This is what labor unions and, for that matter, professional associations, are all about.

Jack R. McCabe

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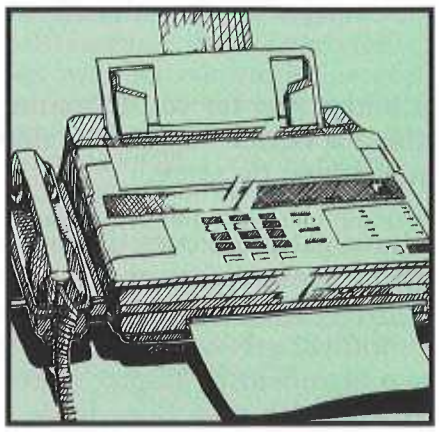
Atchison, Norton Augusta, Mission Wichita	Cushing Ardmore	Boonville	Parker	Alliance O'Neill Lincoln	Chandler	Cheyenne

E & T Survey Shows Member Preferences

The June 1991 issue of the *Exchange* ran a FAXback Survey on the education & training preferences of members. Fifty-six responses were received. The questions concerned the Content Area(s) in which members would most like to have training available, the format that training should take, and the relative importance they assign to various types of education & training.

Of the 56 respondents:

- 37 were CEAPs.
- 48 were individual members.
- 27 were from private/for-profit organizations, 11 were from private/nonprofit organizations, 8 were from state-government organizations, and the balance were from other types of organizations.
- 26 worked primarily in internal



EAPs as administrator, manager or coordinator; 11 worked primarily as program consultant, manager or service provider (external EAP); 11 worked primarily as EAP counselor; 2 as marketing representative; and 1 as therapist.

Members were asked to rank the six Content Areas, in order of preference from most important to least important, as the focus on which training should be available. The overall rank of each Content Area was determined in this way: total responses for most-important were multiplied by a value of 6; total next-to-most-important responses were multiplied by a value of five; and so forth down to least-important, in which total responses were multiplied by a value of one. Then the six numbers were added up for an overall score for each Content Area.

The Content Area receiving highest ranking overall was **Content Area 4**—EAP Direct Services. (CA4 was ranked *most-important* by 23 people.)

- Second: **Content Area 3**—EAP Policy & Administration. (CA3 was ranked *most-important* by 22 people.)
- Third: **Content Area 5**—Chemical Dependency and Other Addictions.
- Fourth: **Content Area 1**—Work Organizations.
- Fifth: **Content Area 2**—Human Resource Management.
- Sixth: **Content Area 6**—Personal and Psychological Problems. (CA6 was cited as *least-important* by 18 respondents.)

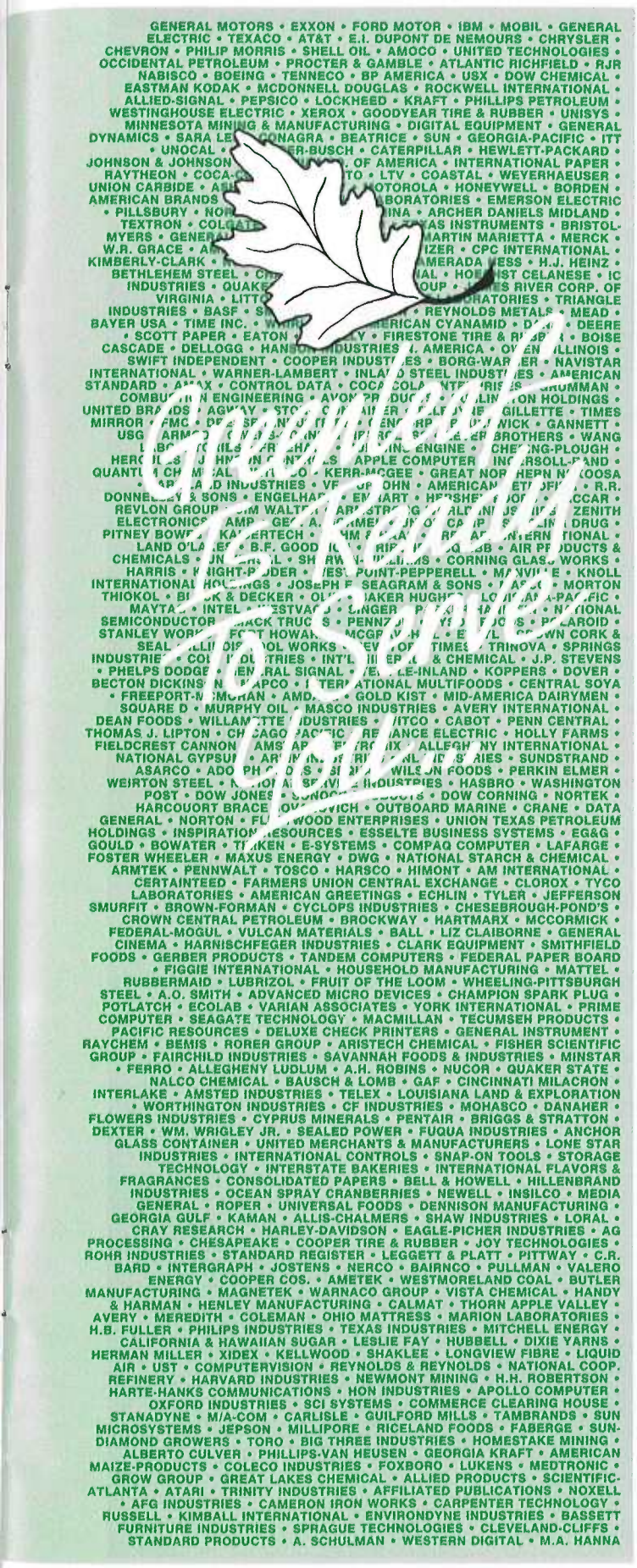
A similar formula was used to rank respondents' preferences for nine types of education & training, in which each type was rated from most-important to least-important. There were nine categories presented for ranking in this FAXback query. The highest-rated type of education & training cited by respondents was **Chapter or local conferences/seminars/courses**. Thirteen respondents ranked it as *most-important.*

- Second: **Regional conferences/seminars/courses.**
- Third: **Non-credit seminars (PDH-approved) of up to two days in duration.**
- Fourth: **National conferences/seminars/courses.**
- Fifth: **Non-credit seminars (PDH-approved) longer than two days.**
- Sixth: **Off-campus college credit courses leading to a degree.**
- Seventh: **On-campus college credit courses which lead to a degree.**
- Eighth: **On-campus college credit courses which are not degree-oriented.**
- Ninth: **Off-campus college credit courses which are no degree oriented.**

Respondents also rated the formats in which they would like training to be provided. (More than one format could be selected.) The formats, along with the number of times each was cited, was as follows:

- Seminars (42).
- Videotapes (33).
- University-based courses (30).
- Self-study guides (28).

These results, along with other survey data and information, are being used by the Education & Training Committee to create professional-development plans for EAPA. The *Exchange* appreciates members' response to the June FAXback Survey and others that are published periodically.



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A Novel Experiment in Consortium-Model Programming at CADA

BY SUSAN A. BERGER, ED. D. AND ELENA BROWN

One of the progressive grassroots organizations to emerge from the drug-free workplace movement in the United States is the Corporation Against Drug Abuse (CADA). CADA is firmly committed to EAPs as a primary means of helping employers respond to problems related to substance abuse in the workplace. In fact, it has established a project called the Washington Employer Resource Consortium (WERC) to provide EAP services to a segment of the business community largely unserved in the Capital area—small employers.[1]

CADA's decision to proceed with a consortium was based on research data derived from a survey of area small employers it undertook in 1990.[2] The purpose of the survey was to learn about the experiences of small businesses in providing substance abuse programs and related health insurance benefits to employees. Among the findings were these:

- Out of a stratified sample of 4,100 small employers significant percentage of employers required to comply with the Drug-Free Workplace Act—36%—had no substance abuse policy. The lack of a policy, it bears mentioning, is in violation of federal law.
- The overwhelming majority of respondents agreed that substance abuse is a national problem.
- The majority of small employers surveyed provided health insurance for their employees. Sixty percent (60%) of these employers covered most of their employees with traditional indemnity coverage.
- Data revealed that substance abuse treatment did not appear to be a standard part of their health plans.
- The majority of respondents said they would consider joint purchasing for health insurance, and about 50% would consider joint purchasing for mental health/substance abuse coverage.

To help small businesses solve their problems in addressing substance-abuse and health-benefit problems, in June 1991 CADA announced the creation of WERC to enable small employers in the region to purchase quality, cost-effective EAP and related services.

Small employers are a unique breed of business. The survey showed they have five significant characteristics. They are:

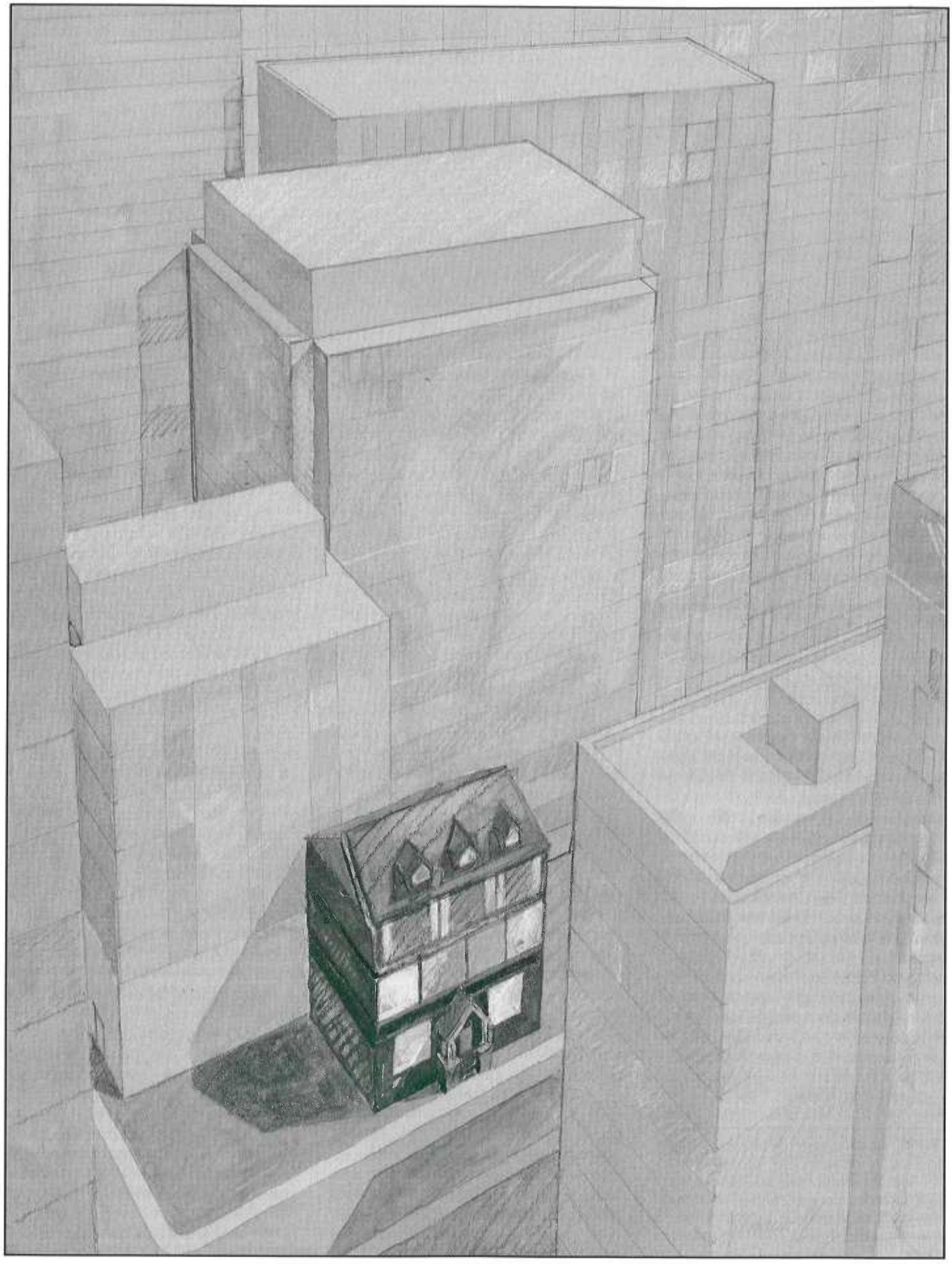
- **Diversity.** Small firms are highly diverse, representing many different industries, sizes and organizational cultures.
- **Resource scarcity.** Ninety-five percent (95%) of all small employers have fewer than 100 employees and, therefore, have a scarcity of time, staff and disposable money.
- **Lack of expertise.** Smaller firms often lack in-house human resource expertise to identify and contract for EAPs and other specialized programs to meet their staff development needs.
- **Need for simplicity.** They require user-friendly information and easily accessible services.
- **Dispersion.** Since they are geographically dispersed, they can be more efficiently reached through industry and trade associations than through individual contact.

In spite of their diversity and geographical dispersion, they need to be aggregated into a larger group to create economies of scale in order to

[1] CADA was one of 25 drug-free workplace programs highlighted in the article "State Initiatives Take the Drug-Free Workplace from Washington, D.C. to Main Street USA," which ran in the November 1990 issue of the *Exchange*, pp. 18-23. CADA is a nonprofit corporation that has received financial support for the WERC project from the Robert Wood Johnson Foundation. Implementation funding has been provided to the consortium, although continuing operations will be financed by fees derived from participants in the consortium.

CADA's members are employers of all sizes and, because of the Corporation's high visibility in the Washington, DC business community, provides substantial outreach for WERC.

[2] The survey was conducted by the independent consulting firm of Arthur Andersen & Co., in conjunction with CADA.



WERC SERVICES

Benefits of Membership

- Technical consultation
- Informational seminars
- Quarterly newsletter
- Comprehensive library
- Networking opportunities
- Membership directory
- Referrals to related services

Drug Testing

- Specimen collection sites
- Analysis & confirmation
- Medical review of results
- Choice of panels of drugs
- Confidential reporting

Employee Assistance Services

- Consultation on policy & program development
- Supervisory & management training
- Employee education
- Client case management
  - 24-hour crisis line
  - 3 counseling sessions
  - Monitoring & reporting
- Assessment, referral and follow up

Managed Mental Health Benefits

- Coverage for mental health, alcohol and substance abuse treatment (carve out) including Inpatient, Outpatient and Alternative Treatment
- 24-hour telephone referral service
- Assistance in arranging care
- Review and approval of appropriate care
- Coordination of benefits payment

reduce per-capita costs to levels comparable to those of large employers. At the same time, they need flexible services which can be purchased on an incremental basis as the needs are recognized and funds become available. Furthermore, small businesses need a great deal of education and assistance to understand drug-free workplace issues and to select responsive services.

INNOVATIONS

WERC's model of service delivery departs from many traditional EAP consortia by incorporating the following features, tailored for small businesses.

• **Membership benefits.** Unlike traditional EAP consortia, small businesses may join WERC for a nominal annual membership fee and immediately have access to the professional expertise they require to assist in identifying needs and resources. Prior to purchasing any EAP or other services, members of WERC receive an "organizational audit" to review their substance abuse policies and programs, health benefits and employee characteristics. WERC staff then recommends appropriate services and a plan to educate them about workplace issues. By doing so, WERC provides the services and simultaneously promotes EAPs.[3]

• **Unbundled services.** Because of the scarcity of resources and frequent lack of human resource expertise, small businesses have a greater immediate need for the "front-end" services—policy consultation, manager and supervisor training and employee education—that support EAP utilization. In fact, many small companies may not initially desire EAP services, but do want help in developing a policy or educating their employees about the dangers of drug abuse. Therefore, these EAP components may be purchased separately even before a decision to implement an EAP has been made.

These services are also provided as part of a comprehensive EAP package that includes clinical case management (assessment, referral and follow up) for a wide variety of personal problems. The option to purchase services separately allows flexibility and the chance for employers to do what they feel they can afford at any particular time. Although our goal is to promote the full EAP package, CADA believes that first engaging employers "where they're at" is an effective strategy to accomplish it. Initially, this may mean helping small companies through policy development and education. The benefits of implementing an EAP—which may not be initially apparent to the employer—often come later.

• **Aggregated training and education.** In order to create efficiency, training and education often involve aggregating several small companies into one group program, in a convenient central location. These are promoted as networking opportunities as well, which many small employers seek, since they and their staffs often feel isolated. In addition, because small firms often lack human resources departments, WERC plans seminars and conferences on industry trends for health and mental health issues, as well as training on management issues, as requested by its members.

The employee-education and supervisor-training seminars are held approximately monthly for audiences of no more than 50 people. They are usually held at locations where space is provided by work organizations on CADA's Board of Directors.

• **EAP preferred provider network.** In response to the geographical and cultural diversity of area small businesses, WERC selected four EAP providers who serve as "preferred providers." These firms were selected through an extensive proposal-evaluation process to assure member companies of a consistent level of quality services. Companies are assigned to the provider which best meeds their needs, and WERC has negotiated favorable rates. By including several providers in a network, WERC has established a team to work cooperatively in planning and implementing the EAP for consortium members.

• **Division of labor.** A unique feature of this model is that the four EAP firms providing services are responsible only for case management and not the other front-end components of the EAP package. In this way, WERC can support the role of EAPs as gatekeepers and allow them to focus on assuring appropriate referral and utilization of treatment resources, consistent with trends in managing benefits costs effectively. This arrangement also helps keep the costs of the EAP services down, because the

[3] WERC's staff consists of a full-time project director, a full-time EAP professional, a full-time administrative assistant, a part-time finance manager, and several part-time consultants providing services related to employee assistance, training and marketing.

provider responsibilities have been reduced and supplemented by WERC staff.

• **Monitoring and evaluation.** WERC's EAP providers will play an active role in monitoring, data collection and evaluation as the program develops. Four Washington-area EAP firms are used, which are: Employee Assistance Service, Inc.; Enhance EAP, of Alexandria Hospital; Employee Assistance Program Services, of Montgomery General Hospital, Inc; and Sheppard Pratt Hospital EAP. Data on referrals, treatment resources, utilization, patterns, relapse and return to work will be shared and evaluated as a team to identify ways to be more effective case managers. By doing so, WERC hopes to show how EAPs fit into the larger health care delivery system for management of mental-health and substance-abuse problems.

• **Additional services.** While all of the above adaptations are intended to better respond to the needs of small employers, our market research also indicated that these businesses want and need technical assistance in several other areas related to providing a drug-free workplace. For example, many of these businesses are government contractors and have to conform to drug-testing requirements. They need consultation on the appropriate type of program needed to comply with regulations, as well as advice on how to write their policies and what, if any, liability issues they should be aware of in planning and implementing phases. These are highly specialized areas requiring knowledge and expertise about substance abuse in the workplace that are provided by professional WERC staff.

In addition, WERC members can benefit from economies of scale in the purchase of drug-testing services. By negotiating with a selected NIDA-approved laboratory, WERC will soon offer savings to its members who wish to perform preemployment, periodic, post-accident and probable-cause testing. WERC-contracted services will include various panels of drugs specifically designed to identify the drugs of abuse most prevalent in the employed population, convenient specimen collection sites and the services of an independent medical review officer.

"...program development is based on research about small businesses that has enabled WERC to aggregate small, independent companies into a heterogeneous group..."

• **Community education and outreach.** WERC's innovative programs and approach rely heavily on a marketing strategy which provides for continuing education about the problems of substance abuse in the workplace, the ways it can affect the productivity and profitability of the small business, and the testimonials of those small employers who are "true believers" in EAPs and other drug-free workplace programs. WERC has engaged a core group of business leaders to promote membership and works with a variety of trade and professional associations to provide outreach and education to their members.

MANAGED CARE SERVICES

WERC's model recognizes that EAPs and drug testing are two types of detection and early-intervention programs. However, our initial study showed that many small employers inadequate mental health/substance abuse benefits to cover the cost of treatment recommended for people who have been identified through these programs. Therefore, WERC has contracted with a managed mental health plan to provide specialized substance abuse treatment as an adjunct benefits program to the EAP. By doing so, we have developed an integrated continuum of services.

In WERC's model, the EAP focuses on client needs through assessment and referral. If the EAP is indeed an effective gatekeeper, it also manages utilization of resources, matching the client's needs with the appropriate facility and services. Implicitly, this function affects benefits costs and, ultimately, employer costs. Additional cost effectiveness is achieved through the managed mental health plan covering treatment. The plan utilizes a management information system to measure efficiency and assure appropriate utilization of services.

THE CHALLENGE CONTINUES

The consortium's program development is based on research about small businesses that has enabled WERC to aggregate small, independent companies into a heterogeneous group with the leverage to negotiate with insurers, EAP providers and drug-testing labs for competitive rates and high-quality benefits programs.

WERC has learned that in the best of times, EAPs have had to overcome denial, lack of information and knowledge, and resistance to paying for what many employers believe is a secondary benefit with little proven cost-benefit. With a recession continuing for the near future, with cutbacks and layoffs, these are not the best of times. Survival requires creativity, innovation, adaptability and patience. WERC's model is, in some respects, an experiment in using new ways of promoting a valuable service to small employers. The continuing challenge is to, first, get them to acknowledge the value of the service and, second, to act on it.

SUSAN A. BERGER, ED.D. is vice president of workplace programs for CADA. She is responsible for policy and program development for drug testing, EAPs and managed health care. Dr. Berger also directs a project grant from the Robert Wood Johnson Foundation to develop and test new approaches for providing drug-free workplace programs for small employers.

ELENA BROWN, CEAP is director of program operations for CADA's newly established Washington Employer Resource Consortium. She performs organizational audits and program/policy consultations and oversees the delivery of training/education and EAP services to small employers. Brown is also treasurer of the EAPA Washington, DC Chapter.

Small group health insurance reform bills compared

SIDE-BY-SIDE COMPARISONS PROVIDE INSIGHTS, ANALYSIS

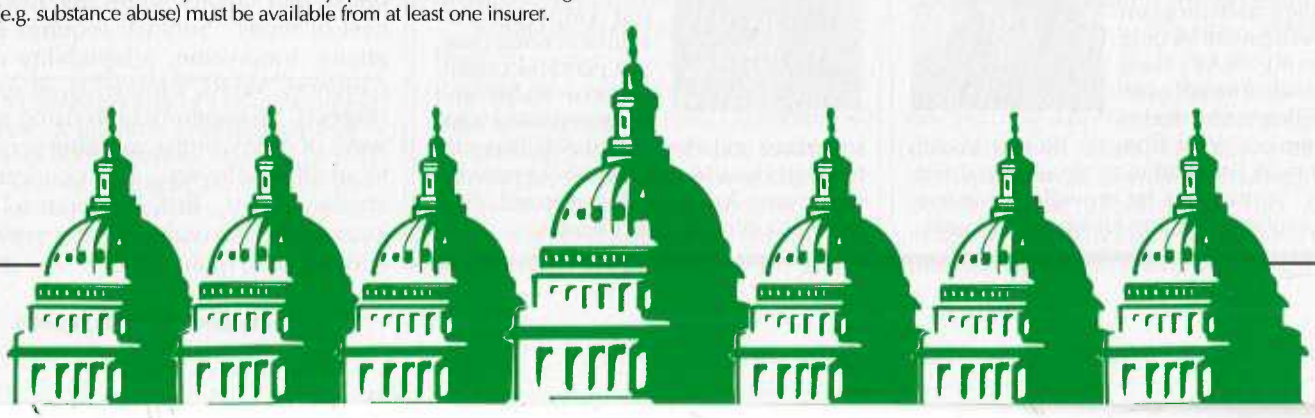
In the *Exchange*'s continuing coverage of health care reform legislation this month, three bills containing health care insurance reform measures for small business are compared below. Side-by-side comparisons are made for: H.R. 2535, The Pepper Commission Health Care Access and Reform Act of 1991, introduced by Rep. Henry Waxman (D-CA); H.R. 3626, The Health Insurance Reform and Cost Containment Act of 1991, introduced by Rep. Dan Rostenkowski (D-IL); and S. 1872, The Better Access to Affordable Health Care Act of 1991, introduced by Sen. Lloyd Bensten (D-TX).

Essentially, these bills only require that health insurance coverages be extended to small employers according to certain restrictions, explained below. They don't, for instance, specify pooling arrangements by which the coverage would be provided. However, passage of any of the bills may necessitate pooling arrangements in order to extend coverages.

In December, the push for small group health insurance reform was given some momentum when a presidential commission recommended action on this issue, along with health insurance for school-age children and the proliferation of malpractice lawsuits.

Provision	Pepper Comm.	Rostenkowski	Bentsen
Application	All small employer plans must meet "basic standard"	Insurers must offer the "standard" plan to all small employers	Insurers must offer the "standard" plan and the "basic" plan to all small employers
Small group defined	1-100 employees	2-50 employees	2-50 employees
State insurance mandates	Preempted for all small employers	Preempted for the "standard" plan only	Preempted for the "standard" and "basic" plans
Enrollment	Guarantee issue* All employer plans	Guarantee issue* All small employer plans	Guarantee availability* States can choose from several models "Standard" and "basic" plans intended to be guaranteed available

* "Guarantee issue" means that if an insurer offers a health plan to one employer, it must be offered to all employers (or else a segment of employers, such as small employers, as specified in the bill). "Guarantee availability" means that any specialized kind of coverage (e.g. substance abuse) must be available from at least one insurer.



Provision	Pepper Comm.	Rostenkowski	Bentsen
Guarantee eligibility	All employer plans	All small employer plans	All small employer plans
Benefit design	**"Basic"** plan covers: inpatient mental health 45 days/year outpatient mental health 25 visits/year with special 50% coinsurance unlimited hospital care unlimited physician care unlimited diagnostic tests preventive/prenatal/well child $250/$500 deductible 20% coinsurance for most services no cost sharing for preventive care $3,000 limit on cost sharing	**"Standard"** plan covers: inpatient mental health 190 day/lifetime in freestanding psychiatric hospital outpatient mental health; unlimited visits with special 50% coinsurance (per Medicare) 90 days inpatient per spell of illness; 60-day lifetime reserve unlimited hospital services for children unlimited physician care unlimited diagnostic tests preventive/prenatal/well child $250/$500 deductible Medicare coinsurance for most services no cost sharing for preventive care no coinsurance for inpatient pediatric services $2,500/$3,000 limit on cost sharing	**"Standard"** plan covers: inpatient mental health 45 days/year outpatient mental health; 20 visits/year with special 50% coinsurance unlimited hospital care unlimited physician care unlimited diagnostic tests preventive/prenatal/well child $400/$700 deductible, or 1%/2% of wages 20% coinsurance for most services no cost sharing for preventive care $3,000 or 10% of wages limit on cost sharing **"Basic"** plan covers hospital care, physician services, diagnostic tests, and preventive services. Amount, scope and duration unspecified; cost sharing unspecified.
Promotion of managed care	Federal certification of managed care/UR Federal standards preempt state laws regulating managed care/UR	N/A	Federal certification of managed care/UR Federal standards preempt state laws regulating managed care/UR
Maximum premium variation	1.32:1	2:1	Not limited
State mandates	Preempted for all small employers	Preempted for the "standard" plan only	Preempted for the "standard" and "basic" plans only

STATUS OF BILLS: At the *Exchange*'s deadline, no action was taken by Congress on any of the three bills. All have been referred to appropriate committees. Action is expected during 1992 on small group health insurance reform, health care affordability and affordability, and national health care. **NOTE:** In addition to those listed above, other provisions by which the bills vary include preexisting conditions, rating by health status, rating by demographic factors, age/sex, industry, geography, limits across blocks, and renewals.

OSHA issues rules protect workers from AIDS and hepititis

The Department of Labor's Occupational Safety and Health Administration (OSHA) issued rules on December 2 which would protect workers from infection by AIDS or hepatitis virus. The rules, which singled out the offices of doctors, dentists, hospitals, funeral parlors and firehouses, require employers to provide workers with training, protecting, clothing, puncture-proof recepticles for contaminated supplies and, in the case of hepatitis, vaccination against the virus. In announcing the new rule, Assistant Secretary of Labor Gerald F. Scannell stated that although previous rulings required protective devices, there was little compliance.

The new rules will be more strictly enforced. The annual estimated cost for employers is $1,100 for a doctor's office and $872 for a dentist's office. The ruling will go into effect in March 1992. OSHA predicts that the regulations will prevent 200 deaths and 9,200 blood-borne infections a year. *Anyone wanting a copy of the standards should contact: OSHA Office of Publications, U.S. Department of Labor, Room N3101, 200 Constitution Avenue, NW, Washington, DC 20210; (202) 523-9667.*

In other news, the Centers for Disease Control (CDC) recently announced it is dropping its plan to list procedures that health workers, infected with the AIDS virus, should not perform. According to a *New York Times* report, the draft guidelines from CDC suggest the emphasis will be on identifying—on a case-by-case basis—infected health workers who do not meet standards of infection control or whose stamina or mental state makes them unfit to practice. Local panels will determine whether individual workers are fit to perform particular invasive procedures.

Proceedings of EAPA's legislative and Public Policy Conference will appear in the March issue!

President Bush meets with small business group on HC reform

On December 13, President Bush met with small business leaders from four groups to hear about their ideas on health care reform. The groups were Cleveland's Council of Smaller Enterprises (COSE), Cleveland Health Quality Choice, Florida Health Access Inc., and Custom Care, an insurance program sponsored by Prudential and Southwestern Bell. COSE is a coalition of 10,000 small businesses that has succeeded at keeping insurance costs low.

The meeting was President Bush's first with outside groups on health care reform. He is expected to comment on health care reform during his State of the Union address on January 28.

National Institute on Mental Health announces managed care grant program

The U.S. Department of Health and Human Services is developing a new program entitled "Research on Managed Mental Health Care." Grant applications are being accepted for a projected start date of July 1, 1992. Applications may seek funding for up to five years.

The announcement includes the following areas of interest:

- Access to and provision of mental health care in managed care settings by patients with various types of mental disorders
- Comparisons of access to mental health care under managed care systems and other types of systems
- Availability and effectiveness of different treatment modalities under managed care, as compared to other systems
- Quality of mental health care delivered in managed care systems, as compared with other systems
- Patient outcomes in managed care systems, as compared to other systems
- Provider-patient relationships in a managed mental health care program
- Financial impact of managed care on patient, mental health providers and payoers
- Methodological studies linking the measurement of services provided under managed care systems with clinical outcomes and costs
- Changing roles of mental health providers under various types of managed care arrangements
- Appropriateness, use and effects of clinical criteria in mental health utilization review programs

For more information, contact: Paul Widem, Chief, or Agnes Rupp, Ph.D., Mental Health Economics Research Program, National Institute of Mental Health, 5600 Fishers Lane, Room 18C-14, Rockville, MD 20857; (301) 443-4233.

Assuring Adequate Benefits is First Hurdle for Small-Employer EAP Services

EEAP professionals know that half the battle in providing effective EAP services is to assure that client organizations have adequate benefits coverages and limits to pay for necessary counseling or treatment. The Bureau of Labor Statistics, a part of the U.S. Department of Labor, has released new data in a 99-page bulletin entitled "Employee Benefits in Small Private Establishments, 1990."

As the chart at right shows, small establishments, defined as work organizations with fewer than 100 employees, provide benefits to employees less frequently than do larger establishments. Of particular concern to EAPs, medical benefits (shown highlighted) are often lacking. This suggests that EAP firms wanting to serve small employers may have an extra hurdle to cross by convincing employers to enhance their health plans *before* actually selling EAP services. (Comparable data, by the way, were not available on the *adequacy* of benefits between small and larger employers. One could speculate that they would yield additional discrepancies.)

The chart below shows various medical benefits provided by small employers. Most benefit plans provide mental health, alcohol abuse and drug abuse treatment benefits, although they were generally subject to much higher

BENEFIT PLANS

Percent of full-time employees participating in benefit plans

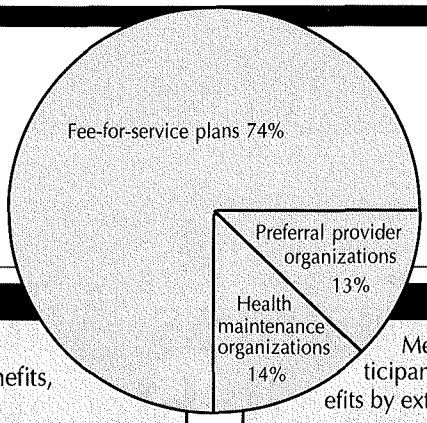
Benefit	Small Establishments, 1990	Medium and Large Establishments, 1989
Paid holidays	84%	97%
Paid vacations	88	97
Unpaid maternity leave	17	37
Medical care	69	92
Life insurance	64	94
Retirement plan	42	81

MEDICAL CARE BENEFITS

Percent of full-time participants by coverage for selected categories of care, small establishments, 1990

Category of medical care	Care provided					Care not provided
	All	Covered in full	Subject to internal limits only	Subject to overall limits only	Subject to internal and overall limits	
Hospital room and board	100	13	3	57	26	-
Hospitalization—miscellaneous services	100	13	3	58	26	-
Extended care facility	83	4	12	12	54	17
Home health care	79	14	7	16	42	21
Hospice	51	4	5	20	22	49
Surgery						
Inpatient	100	23	0.5	69	7	-
Outpatient	100	27	0.5	64	8	-
Physician visits						
In hospital	100	16	0.5	71	13	-
Office	100	5	11	76	7	0.5
Disagnostic X-ray and laboratory	100	21	1	67	11	-
Prescription drugs—nonhospital	96	2	20	64	10	4
Mental health care						
In hospital	98	1	17	8	72	2
Outpatient	96	0.5	17	1	77	4
Alcohol abuse treatment						
Inpatient detoxification	97	5	13	14	64	3
Inpatient rehabilitation	78	1	11	7	59	22
Outpatient rehabilitation	72	1	14	4	53	28
Drug abuse treatment						
Inpatient detoxification	94	5	13	12	63	6
Inpatient rehabilitation	73	1	11	4	57	27
Outpatient rehabilitation	68	1	13	3	51	32

■ **Internal limits** apply to individual categories of care, e.g. separate limits or benefits for hospitalization. Limits may be set in terms of dollar ceilings on benefits, coinsurance, or as deductible or copayments. ■ **Overall limits** are expressed only in terms of total benefits payable under the plan, rather than for individual categories of care. ■ Where 0.5% is shown, the actual percentage is actuall less than 0.5%, but more than 0.0%. ■ **Detoxification** is defined as the systematic use of medication and other methods under medical supervision to reduce or eliminate the effects of substance abuse. ■ **Rehabilitation** is designed to alter abusive behavior in patients once they are free of acute physical and mental complications.



Medical care benefits: Percent of full-time participants by type of fee arrangement, small establishments, 1990

MENTAL HEALTH

Medical care benefits: Percent of full-time participants in plans with mental health benefits, 1990

Coverage limitation	Hospital care	Outpatient care
With coverage	98	97
Covered the same as other illnesses	12	1
Subject to separate limitations	85	95
Limit on days	47	35
per year	44	34
per confinement	3	0.5
per lifetime	1	0.5
Limit on dollars	55	77
per day	0.5	28
per year	17	54
per lifetime	47	-
Coinsurance limit	14	63
Ceiling on out-of-pocket expenses does not apply	26	55
Separate copayment or deductible	3	9
Without coverage	2	3

ALCOHOL ABUSE

Medical care benefits: Percent of full-time participants in plans with alcohol abuse treatment benefits by extent of benefits, small establishments, 1990

Coverage limitation	Inpatient detoxification	Inpatient detoxification	Outpatient care
With coverage	99	80	74
Covered the same as other diseases	28	11	6
Subject to separate limitations	72	69	68
Limit on days	46	44	25
per year	36	36	22
per confinement	7	5	0.5
per lifetime	6	8	3
Limit on dollars	39	39	50
per day	1	1	13
per year	14	14	33
per lifetime	30	30	27
Lower coinsurance rate	11	11	28
Ceiling on out-of-pocket expenses does not apply	18	18	28
Separate copayment or deductible	2	2	5
Without coverage	1	20	26

internal and overall coverage limits than other forms of medical care.

The BLS data also show that separate deductibles for various medical benefits were common, as were higher deductibles. The average annual deductible in 1990 for participants in plans with overall limits was $197. Also, four out of five participants in plans with overall deductibles had to meet both individual and family deductibles. Most commonly, family deductibles were equal to two or three times the individual deductibles.

The pie chart shows that most employees working for small employers are covered by traditional fee-for-service plans. Comparable data were not available for larger employers.

The other two charts above show benefit coverages and limitations for mental health and alcohol abuse treatment. (The data on drug abuse treatment are very similar to those of alcohol abuse treatment, and therefore are not reprinted in this brief article.) It is striking that the vast majority of coverage for treatment of these illnesses was separate from other illnesses. Further, plan coverages for alcohol-abuse and drug-abuse treatment tended to favor inpatient care.

For mental health coverage, plans commonly limited the duration of hospital stays (often to 30 or 60 days per year, compared to 120, 365 or unlimited days for other illnesses), and sometimes imposed a separate, lower, maximum on covered hospital expenses (such as a lifetime maximum of $50,000). For alcohol abuse and drug abuse treatment, plans were also more restrictive than other illnesses. Limitations most commonly included restrictions on the number of days of inpatient hospital care per year, the number of outpatient visits per year, reduced coinsurance levels for outpatient treatment, and maximum dollar amounts per year or per lifetime. A typical limitation on inpatient care was 30 days per year. Similarly, outpatient care might have been restricted to 20 or 30 visits per year. Dollar maximums were often combined between inpatient and outpatient care, with $50,000 per lifetime a common limit. Finally, limitations on days and dollars were often combined for alcohol and drug abuse care.

The BLS study also took note of utilization-review activities, although no accompanying charts are shown here. BLS notes that most managed care programs consist of preadmission reviews for nonemergency and nonmaternity care, concurrent reviews for hospitalizations, discharge planning for transferral to other health care settings, and second surgical opinions. One-fourth of fee-for-service participants had their care subject to UR, compared to three-tenths of PPO participants.

Persons wanting to order the BLS bulletin "Employee Benefits in Small Private Establishments, 1990" (Bulletin 2388) can do so by calling BLS's Chicago office at (312) 353-0614. The charge is $5.