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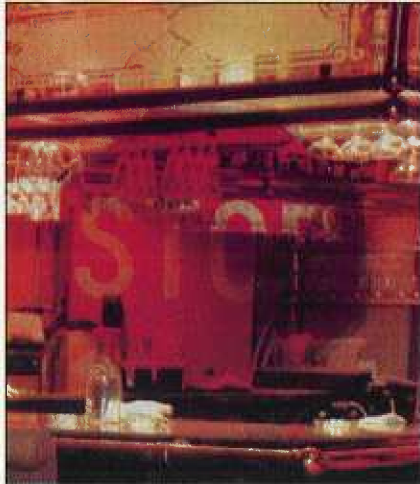

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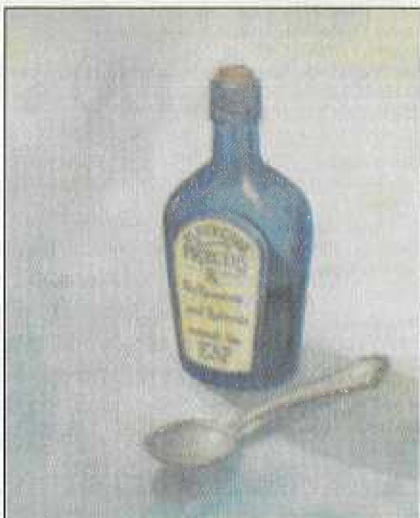

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COMMENTARY

Preparing For Changes

On the one hand, the message from corporate America is clear: We are tuned in to our workers' needs; we offer flextime; we are "family-friendly;" and we have work-family managers on the payroll.

But let me ask you, has your worklife changed much? Last year, in a nationwide survey of 875 workplaces, two-thirds of companies answered no when asked if they might *ever* offer child- or eldercare. The 1992 Society of Human Resource Management study of more than 1,000 companies noted two-thirds were not at all involved in eldercare—even though eldercare demands are expected to affect as much as 44 percent of all workers by the late 1990s.

Is dependent care happening in the workplace or not? The literature answers it this way: A handful of companies are family friendly, such as Corning Inc., Xerox, American Express, IBM, US West, Aetna, Johnson & Johnson, UNUM and Nations Bank Corp.

Why don't more workplaces climb on board? Most work-family research shows that child- or eldercare problems raise absenteeism and lead to work disruptions, higher turnover and increased stress. Dana Friedman, co-president of the Family and Work Institute, has research that says about half of female employees and one-third of male employees say childcare responsibilities interfere with their work. Other studies from the institute show that 25 percent of those surveyed changed jobs, quit or became self-employed because of their eldercare duties. About one-third were tardy, left early or were absent because of dependent care responsibilities.

So why don't more companies have dependent care?

Some say because the programs don't work that well. A recent *Wall Street Journal* report on work/family services noted that research on childcare centers was mixed. Of five studies that used companies administrative data (rather than employee opinions), two studies found corporate childcare reduced absenteeism and three studies found it reduced turnover. "One thing is clear," the story said, "corporate childcare centers yield favorable publicity."

Are these programs truly just window dressing, put there to be good corporate publicity? Some say yes. But as EAPs, we know how important the connection is between work and family. We know stressors in one area affect other areas. What we need to do is to tie these programs to the bottom line. We must be able to show CEOs and middle managers alike that these programs help productivity. Not only that, we have a much larger task if we choose to undertake it. We need to work to change the corporate culture in many of our workplaces. The corporate culture rewards the worker who comes early and stays late, the worker who keeps his personal life away from the job and his feelings to himself. We need to address this culture and prove, with hard data, that taking care of self and family positively enhances the bottom line.

Please stop by and see us at the EAPA convention in Anaheim. We will be showcasing our 1994 Editorial Calendar there.

Chip Drotos

J.Chip Drotos, CEAP
Associate Publisher

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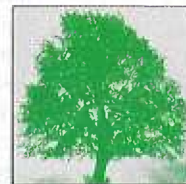

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Motivating Members to Stop

EAPs, Peers Are Partners Between Request and Referral

By Claire Aschner, CSW, CEAP

EAP counselors are often the first professionals to hear an employee express concern about drug and alcohol use and identify its relationship to other problems the employee is experiencing. The client, whether a voluntary or mandatory referral and whether on an initial or repeat visit, connects with the EAP at a critical point. What transpires between the request for help and the referral for treatment can have a major impact on the client and his or her eventual commitment to treatment and recovery. It is at this pivotal juncture that the EAP counselor can influence clients to more fully understand and accept their problems and consider a plan of action.

Especially in this time of managed care and greater accountability for use of benefits, it is essential to provide services that will promote proper and effective use. A pretreatment process that informs, educates and enhances motivation maximizes the probability that the client comes prepared and committed to treatment and recovery.

About seven years ago, the Personal Service Unit of District Council 37 (a New York City labor union) developed an innovative service to specifically assist chemically dependent members at the stage between the request for help and the referral for treatment.

This article will discuss this service provided through "motivation groups." It will explain why they were developed and how they are run. As one of the rotating group leaders, the author will be writing from the perspective of firsthand experiences with these groups.

District Council 37, a part of the American Federation of State, County and Municipal Employees, is composed of nonuniformed employees of the City of New York (excluding teachers). The Personal Service Unit (PSU) is a twenty-one-year-old members' assistance program under the auspices of the Health and Security Plan. PSU is a broad-brush EAP available to all covered union members and their dependents.

A DIFFERENT APPROACH. Members who wanted help with chemical dependency prob-

lems would call or come to PSU to schedule an appointment with a social worker. Often many of these members would not show up for their appointments. This tied up social workers' time and prevented or delayed access to services for other members. To address this problem, An approach using groups was developed. Many EAP's were increasingly and creatively using groups to address a variety of issues. Instead of giving each member requesting help an individual appointment with a social worker, a group was formed to be led by a social worker. The use of motivation groups not only provided greater program efficiency but had major clinical advantages as well.

All members who request help from PSU gain access to our services through contact with our screening unit. The screening unit's purpose is to provide an assessment to determine the nature of the service needed, which varies from providing information and referral to short-term counseling with a PSU social worker. Therefore, a great deal of information is gathered by the screener.

When the problem is chemical dependency, additional information is elicited, such as substances used, for how long, how much, how often, a treatment and family history of substance abuse, support systems, psychiatric problems, impact on the job and what is prompting the current request for help. All members requesting help for chemical dependency in the current week are assigned to a motivation group meeting the following week. Only those members in an acute state of physiological withdrawal or who have major psychiatric problems inappropriate for a group would be excluded and given an individual appointment.

MOTIVATION GROUPS. Motivation groups meet for three 90-minute sessions under the leadership of a PSU social worker. After the group process is completed, the group leader becomes the case manager for each member and is responsible for monitoring the member's treatment and recovery. The member's attendance at these three group sessions, whether enthusiastically or reluctantly, indicates some acceptance of the problem and some willingness to devote time and energy to explore ways to get help.

Although, as in any group, each motivation group has its unique personality depending on its composition, size, level of interaction among members and the leader's style, the groups do have similarities in terms of the tasks that need to be accomplished. In the beginning, members are reminded of the dates and times of subsequent meetings and confidentiality is stressed.

Members are told the primary purpose of the group: to provide a bridge between the request for treatment and the implementation of the treatment plan. The members are asked what they personally would like to get out of attending the group.

The group setting is conducive to having members express themselves because the group starts out with two major commonalities: The group members are all members of the same union and they are all drug or alcohol users. Union members naturally gather to talk in groups. Meetings with union representatives and shop stewards often occur in groups where working conditions, problems and grievances are discussed. There is also the sense that the union is on the member's side; a natural alliance exists for providing help. The other commonality, that all the members in the group have requested help for chemical dependency, serves to diminish the shame and guilt of self-disclosure, which could be heightened in a one-on-one session.

The group's purpose is multidimensional. Further assessment is done within the group and an individualized treatment plan is developed for each member. Education about chemical dependency is provided. Through interaction with the leader and other group members, each member is influenced to move forward on his or her own continuum from a place where treatment is requested and contemplated to a place where a plan of action is considered and can be implemented. Through this process, motivation for recovery is enhanced and group members are readied for treatment.

Baruch and Gallagly (1989) discuss the advantages of a group experience with alcoholics, called "whether-or-not groups" in which "clients explore whether or not they are alcoholic and whether or not they need treatment." They contend that alcoholics who are honestly sharing their positive and negative feelings in the treatment process are more likely to be engaged in treatment and also are more likely to receive lasting help.

REASONS AND EXPECTATIONS. Members' reasons for wanting treatment vary, as do their expectations about it.

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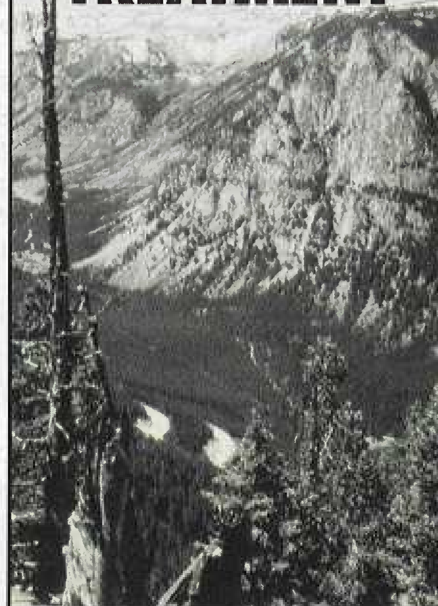

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continued from page 7

Some are propelled by job-jeopardy issues—the behavior related to drug and alcohol dependency may have affected job performance in several ways, the most common problems being poor attendance and tardiness. The request for help may be to avoid disciplinary action by documenting involvement in treatment. Others may be seeking help because they are being pressured by a family member who is fed up with their drug use and its consequences. The group members are encouraged to talk about their personal reasons for having asked for help. As they talk to each other, they confront and challenge each other. For example, Tom may say to John," If you're trying to get clean for your wife, forget it. That's what I did last time and I was only able to stay clean for a while. Now I'm here for me." This may cause John to reflect and reconsider.

Most members are suffering from a combination of problems, losses and potential losses. These problems include financial hardship and massive debt, loss of housing or threatened eviction, damaged or broken relationships, impaired health, legal or criminal problems, shame and low self-esteem. Drug use has become their dysfunctional coping mechanism. Often they attribute drug use to having problems rather than seeing that problems are caused and exacerbated by their drug use.

FOCUS ON ESCAPE. Tony, a clerical worker in his mid-forties, told the group he had been drinking too much because of a recent divorce. After listening and sharing in the group, he said he realized he was no different from the other group members who were dependent on crack or other drugs. He was surprised to learn and accept that he had a serious problem with alcohol that could eventually cost him his job. Tony decided he did not want to continue drinking to mask his frustration with his current life state.

Members' expectations of treatment also vary. Some wish for a way to reduce drug use but still get high occasionally and may fantasize about developing a strategy to minimize consequences rather than control or cease use and abuse. Group members respond to each other and promote reality testing.

Many members come to the group saying, "I just want to go away." This expectation may be based on a friend's experience or their own prior experience.

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Frequently, there may be no concept of the "where, what happens at the "away" or what will happen when they return. The focus is on escape. This expectation can make the leader feel like a travel agent and can create a lot of frustration in the member who does not need inpatient treatment. When inpatient treatment is indicated, whether detox or rehabilitation, it is presented as a prelude to continuing treatment, not an entity in itself. It is one thing to stay off drugs in a hospital setting, but another to return to work and stressors and maintain recovery. This is clarified and reinforced.

A MIXED BAG. The group is almost always a mixture of members who have previously been in treatment and those who have not. Those members with prior treatment experience are able to share experiences and answer questions from those who are new to treatment. The "experienced" can consider what went wrong and what they will do differently this time. In this way, relapse is introduced as a normal, though not necessary, part of the recovery process for some people, and relapse triggers can be identified. Members are taught about the abstinence violation effect, the difference between a slip and a relapse, and how to prevent a slip from becoming a relapse.

What is often identified as a relapse trigger is the thought "I can stop on my own; I don't need to go to treatment." Sharing a relapse experience, Jane told the group she needed to test whether one "hit" could really hurt her. She felt so ashamed about "picking up" that she stopped going to treatment and started using heavily again.

Members are encouraged to share other thoughts related to their chemical dependency and related to treatment. We look at the difference between thoughts that would promote staying in treatment and recovery, and thoughts that would promote continued drug use. When members learn to identify and distinguish between positive and negative thoughts and are shown that negative thoughts do not need to lead to negative behavior, but can be challenged, they are given a skill which can make them feel they have more choice and control.

Each group member is asked to talk about his or her drug use from the first use to the present and the perceived consequences. Group members can identify and empathize with each other's experiences. Members sometimes challenge each other when they sense denial or minimalization or provide support for each other. They might provide solutions to a particular problem, such as how to handle picking up one's paycheck without picking up drugs.

This may be the first time some group members have publicly discussed their drug use and its associated problems in a setting conducive to recovery. This is a major contrast from discussions with their drug-using associates who would stress only the benefits of continued use. Most members do not have any social contact with non-drug users. In the process of talking about their drug use and its related problems in a supportive environment, members can move to the point of owning their problems regardless of the initial

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reason they sought help. The process that takes place parallels the process of doing Step One in 12-Step self-help groups and forms a natural lead into introducing the part these programs play in recovery.

THE SUPPORT NETWORK. The social worker introduces and stresses the need for a sober support network as part of any successful recovery program. Information about Narcotics Anonymous (NA) and Alcoholics Anonymous (AA) groups is provided and meeting schedules are distributed.

Group members who have previously been involved in self-help groups share their experiences. The group leader asks the group members to attend an NA or AA meeting near where they work or live between the first and second motivation group meetings. An alternative with which I've recently experimented is taking the entire group to a nearby meeting. I find this approach more effective and use it whenever scheduling permits. It ensures that everyone (including myself) will attend the same meeting. Often members will not attend a meeting on their own, either because they are apprehensive or because some obstacle, such as lack of childcare, prevents them from attending. When we go together, we can all share our impressions at the next motivation group meeting. Members are often moved by the warmth with which they are greeted. They can identify with the person who is presenting and the struggles to maintain sobriety.

Group members sometimes question the necessity for 12-Step programs in recovery. I answer honestly that although recovery is possible without it, the members I have worked with who have had a successful recovery incorporated self-help into their recovery program.

It is expected that there will be a great deal of ambivalence regarding the recovery process. It is important that ambivalence be accepted as normal and necessary at this stage of the help-seeking process. If the worker labels it as resistance and denial, and confronts the member too soon, the stage may be set for a power struggle. The very essence of having this process between the request for assistance and the referral for treatment is to begin to allow the ambivalence to be expressed and worked on. The members must struggle within themselves to accept that they have a problem. If the sought-after treatment is provided too soon, before a foundation is laid and before it is truly understood and wanted, it may be rejected.

Similarly, EAP counselors may feel pressured by the job where the main interest is to get the person fixed as soon as possible and back to work. If they move too fast, opportunities will be missed to assist the client properly. The result may be rejection of the treatment plan or acceptance with minimal commitment and eventual noncompliance. For an excellent discussion about how to distinguish between the precontemplation stage, the contemplation stage and the action stage, and effective interventions in each stage, see "Motivational Interviewing" (Miller and Rollnick).

Recovery is dealt with honestly and realistically. This is important because in

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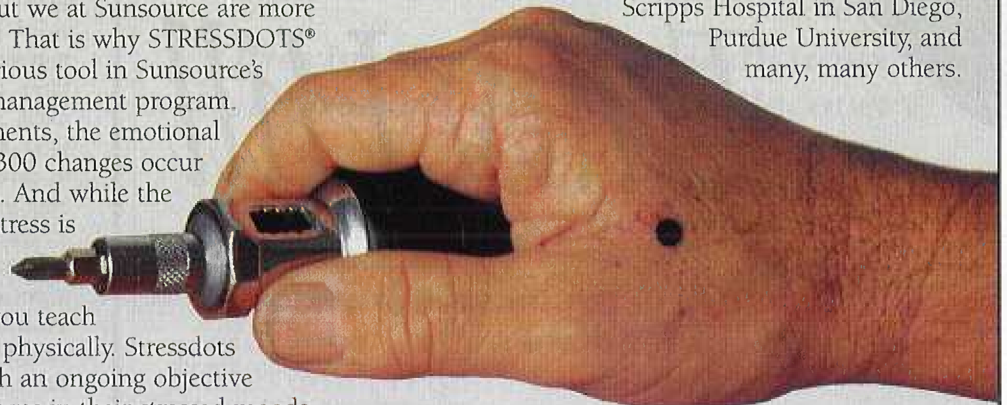

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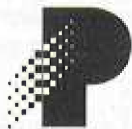

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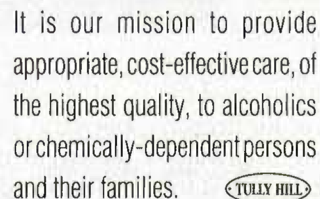

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the short term, giving up mind-altering chemicals can be experienced as a major deprivation physiologically, psychologically and socially. Also, the problems the addiction was masking may feel overwhelming. In the short term, discomfort is increased. I tell the members that giving up drugs may initially feel like putting out a house on fire. The destruction has stopped, but all you see is a destroyed house surrounded by ashes. Recovery is the process of rebuilding the house, and that can be a long and difficult task. In the long run, gains and benefits will be experienced. Clients need to know that early recovery can be frustrating, but sticking with it brings rewards.

PARTNERS IN MOTIVATION. A level of closeness and support often develops among the members over the three-session period. They sometimes become as concerned about each other's problems as they are about their own. They share experiences, learn from each other and encourage each other. Moreover, they become partners with the counselor in the motivation-enhancing process. In the last session, they evaluate their experience in the group and terminate. Some may start treatment together at the same facility, and this is often experienced as a benefit.

A relationship with the group leader is maintained for treatment monitoring and trouble-shooting. Documentation is provided for those in job jeopardy. Letters requesting medical leaves are provided for those members requiring inpatient treatment. Short-term disability is available for those members who do not have sick time to cover their absence from work. These built-in supports help the member get the treatment that is needed.

In addition, in most cases, the employer is not informed that the member is being treated for chemical dependency. The only exception to this would be if the member has signed a stipulation to inform the employer of his treatment. The member has to sign a form for the social worker to release information or maintain contact with the treating facility in order to monitor treatment progress.

Motivation groups have many advantages for both group members and group leaders. First, it is a more efficient process than individual assessment and treatment planning. Second, it provides the information and the readiness for the road to

recovery from a professional and from other members. Any traveler would benefit from having guidance and information before a trip to an unknown destination. Information about what to take, the language, the currency, the climate, the cost and the culture help prepare the traveler for the trip. A traveler on the road to recovery benefits from having this information as well. The briefing about the disease and treatment of chemical dependency provided by the motivation group and the the opportunity to express doubts and fears and ponder one's capability of achieving abstinence enhance the possibility of making the journey and staying on course.

THE COUNSELOR'S ROLE. The counselor's role of providing information and leading the way within the context of the group can provide the opportunity for creativity and challenge. When appropriate, role playing, brain-storming and a whole range of techniques appropriate to the moment can be used.

The leader must create an atmosphere of caring, concern, respect and safety in order for anything to be accomplished. But the counselor does not have sole responsibility for what happens in the group. The responsibility for enhancing motivation and preparing members for treatment comes about through an alliance formed with the leader and the group members.

The motivation group or pretreatment process may be transferable to other settings—most easily, to other union programs. There may be some settings where doing pretreatment in a group may be incompatible with the culture. In those cases, some of the strategies employed in the group can be used in individual work before the client is referred to treatment.

Treatment programs can also initially place clients in groups to decide about recovery separate from other patients who have a deeper commitment to abstinence and recovery. These newcomers who are testing themselves and treatment will not have a negative effect on more advanced patients and can be integrated with them when they are ready. Allowing more time and process between the request for assistance and the beginning of treatment can help strengthen the client's understanding of his or her problem and enhance commitment to treatment.

Bibliography available on request.

Aschner is a counselor for the Personal Service Unit D-37 in New York City.

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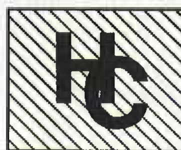

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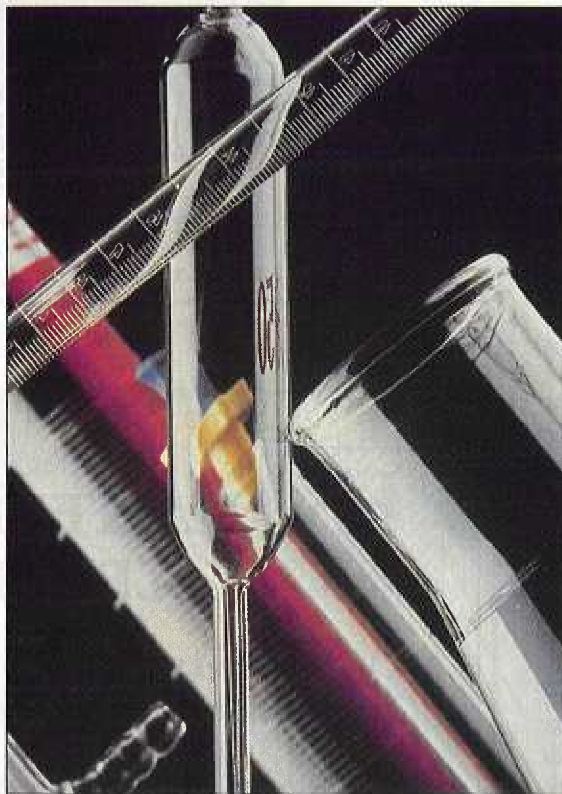
Drug Testing: Labor And Liability

Unions Should Take a Second Look at Drug Testing Responsibilities

By William J. Judge, JD, LLM

No one can deny drug and alcohol use at work poses a safety risk. There is, however, great debate in union worksites over who is responsible for ensuring workplace safety and taking steps to limit the risks from drug or alcohol use. For years unions have been reluctant to become involved and many have fought the steps taken to address the problem (e.g., drug testing). But, unions are being increasingly criticized for not recognizing their responsibility to protect members from problems caused by drug and alcohol use at work.

Increased drug and alcohol testing and the unions' part in training and referring members for work is forcing many to re-examine the union role.



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At a recent seminar on drug testing, a business agent for a local union vehemently denied he had, or should have, responsibility for his members' drug or alcohol use. He believed such matters are either private or the employer's responsibility. But, when questioned further, he indicated his local union operates a referral system through which it qualifies and assigns individuals to work for area contractors. The following discussion then took place:

Q: If one of your members whom you assigned is tested for drugs by a contractor and tests positive, (assuming no challenge to the result) what do you do?

A: His name is placed back on the referral list.

Q: Do you refer him for counseling?

A: No. That's his private business.

Q: Before he is reassigned is he required to have a negative drug test?

A: No. We are opposed to drug testing.

Q: Aren't you concerned about referring him out again unless he has received counseling and has a negative test?

A:I have no choice but to refer him out. I can't force him to go to counseling, and I won't test him.

These responses are far from novel. With limited exception, union officials either ignore the problem of drug and alcohol use among their members or they feel powerless to take any steps to address the problem. Some fail to react because they believe there can be no legal recourse against them. But that is changing. Union officials who fail to recognize this fact put themselves, their members, their union and the public at risk.

The purpose of this article is to highlight the risks and to propose some steps that can be taken to limit these risks. It is sincerely hoped that these steps can be taken without being forced by the courts.

THE RISKS. While certain strides have been made since 1985 in reducing the use of illicit drugs and alcohol in this country, drug and alcohol use at work remains a serious safety and health risk. The most recent studies exploring the link between drug use and workplace injuries found that those testing positive for marijuana in pre-employment tests had 55% more accidents and 85% more injuries than those testing negative. Those testing positive for cocaine experienced 85% more injuries at work than those who were negative. Those who deny the link between drug or alcohol use and workplace safety invite disaster.

Many union officials believe they are immune from liability in such cases. They are not. Over the past 20 years, union officials have become increasingly exposed to liability stemming from injuries suffered by members at work. At least one author, Professor Lorraine Schmall, believes unions should be held liable for workplace injuries as a consequence of their failure to adequately represent the membership. According to Schmall, "Intuition and a sense of fairness dictate that a union's 'duty of fair representation' should also include the obligation to discover, bargain over and attempt to remedy workplace hazards."

The belief that unions are immune from liability arises from a number of court decisions which essentially found that holding union officials liable for their mistakes would upset the delicate balance between federal labor law and unions. That sentiment is changing. Unions, especially those operating work referral systems, will come under increasing attack for injuries that result from those referrals.

WHOSE DUTY? To whom does the union owe a duty to improve safety? Certainly a union owes such a duty to its members. This obligation is threefold. First, the union owes a duty to protect non-using members from those who use drugs and alcohol at work. Second, the union owes at least a moral duty, if not a prudent business obligation, to those members in need of counseling. Finally, those members who test positive for prohibited-substance use must be vigorously and competently represented in the grievance process.

The union is also obligated to the employers with whom they bargain. If the union operates a referral system, isn't an employer who uses members' services entitled to rely upon the union to ensure, to the extent possible, that the individuals referred are fit and capable of safely performing the tasks assigned? Denying the problem or refusing to face the related issues could result in an unfair labor charge for refusal to bargain in good faith.

Although legally tenuous, it could be argued the union owes a duty to the public to take steps to ensure the safety of the workplace. Anyone who is injured by a member who is found to be positive for drugs or alcohol will certainly sue the union and its officials and, if successful, could place the assets of the local union in jeopardy.

The prospects of a lawsuit arising out of an injury to a co-member or to a foreseeable injury to a member of the public points to the duty owed by union officials to the local union. Failure to take reasonable steps to limit the risk of member drug or alcohol use could bankrupt the local. The drain on the local's assets can be seen not only as a result of lawsuits (legal fees and damage awards) on the health and welfare funds, but also in the loss of members who need help. If they cannot get the help they need, they will eventually lose their jobs and not be able to support the activities of the local union.

LIMITING THE RISK. To limit the risks drug and/or alcohol using members may pose, union officials may consider the following:

- Address philosophical concerns about the subject.
- Develop a procedure for confronting a member with a problem.
- Carefully select appropriate healthcare providers.
- Keep current on the legal issues in this area.
- Know the terms of the current collective bargaining agreement.
- Be prepared to grieve all appropriate drug test results.

Perhaps the biggest hurdle to overcome in limiting the risks posed by union members' drug and alcohol use is confronting

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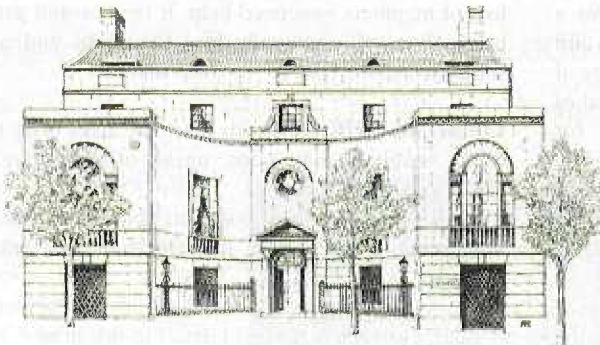

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LIABILITY

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the philosophical reality that unions do not wish to become involved in the private affairs of members. Certainly that position is understandable. But, the reality is that the private lives of their members are, at least to a certain extent, subject to scrutiny. If union officials continue to ignore this reality, they could find themselves defending their actions, or failure to act, before twelve jurors.

Limiting the risk of drug and alcohol use at work does not require a total philosophical metamorphosis. In fact, all that is necessary is to do what most union members expect—provide adequate representation. What can be done? Start by recognizing that members are experiencing problems with drugs and/or alcohol. Union officials must establish procedures for confronting the member who needs help.

The membership may have to decide the scope of authority to be given to the business agent or officers to accomplish this task. Confrontation without some form of penalty for refusal to correct the harmful behavior (e.g., refusal to reassign until the member agrees to seek appropriate healthcare) is useless. The failure to develop such procedures simply allows the member to continue the harmful activity that puts the union at risk.

Protocol for confrontation assumes the union has some form of members assistance program or at least an approved list of competent healthcare providers. A union official should not confront a member with his or her problem without some place to refer that member for professional help.

With an appropriate healthcare referral system in place, the union can then develop rules that prohibit the inclusion of anyone with a drug and/or alcohol problem from being reassigned until certain rehabilitation criteria have been met. Simply put, a member that has tested positive does not get reassigned until he or she has a negative test result and has been released by his or her treatment provider to perform the assigned tasks. Many unions have successfully employed this procedure.

There is no substitute for being prepared to respond to these issues. To do so, the union official must remain abreast of changes in the law that could affect his conduct. That doesn't mean you have to be a lawyer to perform your

tasks, but you need to develop reliable resources that can supply advice on your responsibilities in this ever-changing area.

Most of what you will need to know is likely contained in your collective bargaining agreement. All union officials that will be addressing these issues must have a good working knowledge of the current agreement, the local's by-laws and the union's constitution.

The union that assists a member in confronting a drug or alcohol problem does not abdicate its responsibility to vigorously represent members who have been disciplined for an alcohol or drug-related violation of an employer's rules.

In fact, the fastest way for a union to be accused of failing to adequately represent a member is by presenting an incompetent defense or no defense at all in such cases. Too often union officials feel the issues are too complex or scientific, but simple education and preparation can help them avoid most of the current criticism.

THE OMNIBUS ACT

Q: What are the compliance dates?

A: The following are the applicable compliance dates:

** December 15, 1992: Regulations issued in *Federal Register*;

** April 14, 1993: Comment Period Closes;

** September 1993: Final Rules anticipated;

** September 1994 (OR ONE YEAR FROM DATE OF FINAL RULE): Compliance by large employers (50 or more subject to testing);

** September 1995 (OR ONE YEAR FROM DATE OF FINAL RULE): Compliance by all other employers.

OMNIBUS QUESTIONS.

Q: When will employees be tested for alcohol?

A: The required testing events are the same with alcohol as with controlled substances. Alcohol testing will be required for:

1. pre-employment/pre-use in covered function;

2. where there is reasonable suspicion of use;

3. following an accident or "incident"; and

4. on a random basis.

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Setting The Standards

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If individuals who have been confirmed positive are retained as employees, they cannot return to their safety-sensitive functions until they have a negative "return-to-duty" alcohol test. The employer must then subject these employees to random "follow-up" tests for at least 12 months.

Q: What is a positive alcohol test?

A: As proposed, anyone with a breath test result between .02 and .04 cannot be allowed to perform a safety-sensitive function for 24 hours. But that person cannot be disciplined under the Department of Transportation's (DOT) authority.

Q: What happens if an employee refuses to take a breath test?

A: Refusal is prohibited. Essentially, it is the same as having a result that is equal to or greater than .04. Therefore, any employees who refuse may not be used in safety-sensitive positions until they comply. Disciplinary consequences of refusal are not dictated by the rules.

Q: If employees test positive must they be terminated?

A: That depends upon the policy of the employer or the agreement between the employer and employee, if one exists. DOT does not make employment decisions for regulated employers. Therefore, DOT would never issue a rule that says you must terminate someone. DOT does have the authority to limit access to regulated positions and determine to whom a license is issued. DOT can, for example, impose a one-year driving ban on any individual who refuses to submit to a required test.

There is nothing in the proposed rules that prohibits an employer from firing someone who tests positive. Employees will have to negotiate the employment consequences of a positive result.

Q: I've been told an employer cannot fire someone who tests positive because to do so violates the Americans With Disabilities Act. Is this true?

A: Not necessarily. If an individual is fired for testing positive for the prohibited use of alcohol, the ADA will probably not protect him or her. The ADA may protect an employee from discrimination if that employee is allowed to seek and does successfully complete treatment for alcoholism.

Title I of the ADA provides that an employer "may prohibit the use of drugs and alcohol in the workplace, may require employees not be under the influence of alcohol or engaging in the illegal use of drugs in the workplace and may require employees to conform to the requirements of the Drug Free Workplace Act" and DOT's rules. Anyone "currently engaged" in the use of illegal drugs is "not a qualified individual with a disability." Those who test positive for the use of alcohol will not be protected unless they can show they are "disabled by alcoholism."

Many issues related to drug or alcohol testing and the impact of the ADA are yet to be answered. EA

William J. Judge, J.D., LL.M. River Forest, IL

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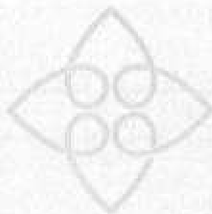

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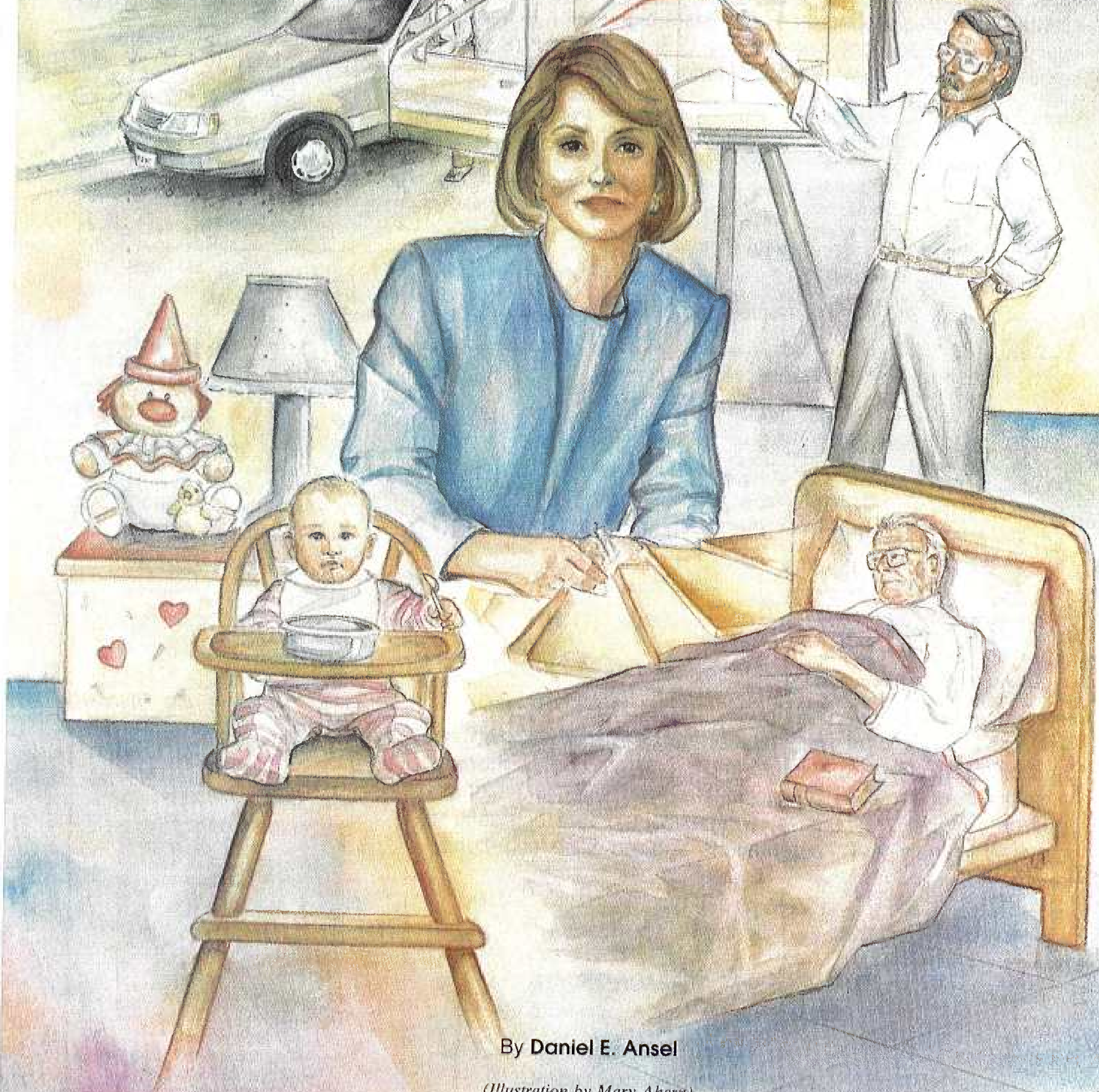
An EAP Opportunity: Work/Family Programs

Work/Family Coordination Targeted As Added Value To EAP



By **Daniel E. Ansel**

(Illustration by Mary Ahern)

EAPs seeking to increase the value of their services need to recognize that work/family programs represent an opportunity, not a threat. However, for those EAPs who hesitate, many will find themselves in the same position they have with managed care—other entities are controlling their destinies.

According to the Hudson Institute Workforce 2000 and The Family Diversity Project, in the year 2000, the typical employee group will be older (average age 39), more culturally diverse (20 percent nonwhite, 23 percent immigrant), more female (47 percent), and more encumbered by responsibility—household duties, children, eldercare, continuing education and retirement planning. This will result in work/family issues increasingly taking center stage as women and men alike look for ways of managing demands at work while taking care of increasingly complicated family issues.

EAP OPPORTUNITY. This creates an excellent opportunity for EAPs to strategically position themselves within the corporate structure to manage these services because they already deal with many of these issues on a daily basis. *Employee Benefit News* reported in the June 1992 issue that a survey by the Families and Work Institute of 188 major corporations showed 87 percent plan to do something about work/family issues in the future and 68 percent say demand for work/family benefits is rising. Additionally, half the senior managers responding to a recent survey by International Foundation of Employee Benefit Plans consider work/family benefits to be more important than they were as recently as 1990.

In fact, many major companies have identified work/family issues as one of the primary keys to long-term success and are assessing strategies to develop organized, well-defined work/family management programs. The forward-looking EAP needs to act.

"We believe to attract and retain the best talent and to be an employer of choice, we needed to create a structure to coordinate work/family issues," says Paula Bills, Director of Employee Services for Nabisco Foods. "This is a people friendly company; we want to recognize diversity of lifestyles, and we want to be proactive in addressing work/family issues."

Other corporations such as IBM, Aetna, Campbell's, Johnson & Johnson, Procter & Gamble and AT&T are actively designing programs to address work/family issues, a fact that has not gone unnoticed by some EAPs. "We are involved in an ongoing process of evaluating services to assist our employees in managing personal and family concerns," says Ed Berte, manager of employee assistance at Procter and Gamble. "How to structure and organize these services is taking on increased importance and my expectation is this will continue for the foreseeable future."

As is often the case, these corporate opinion leaders will create models for providing work/family services and thus increase expectations for all employers to address this need in some comprehensive way. The movement is likened in some ways to the emergence and growth of employee assistance programs themselves. What began as a management tool to increase productivity has grown to be one standard by which potential employees evaluate companies. Work/family services may determine which company is most concerned for and sensitive to common issues they must cope with in their daily lives.

The challenge of getting started in planning a corporation's strategy to address work/family concerns necessitates a systematic approach and most EAPs have the knowledge and skills to facilitate this. Many companies have work/family-style programs in place, but they lack a systems approach to the management and delivery of care, said Brad Googins, director of the Center on Work and Family at Boston University.

A well-designed system is essential to providing a solid base and structure for the program. For example, as some EAPs have discovered, one pitfall companies should avoid is loosely building their program around a personality. A program built around a personality always will be vulnerable if that personality leaves. The program built around a system will maintain continuity, integration and direction—key elements of success.

EAP POSITIONING. The EAP's first step is to position itself to manage a work/family system by determining a company's intent in providing these serv-

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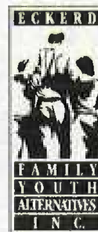

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ices. This intent should drive all decisions regarding the design and implementation of the system. Several key reasons to implement work/family benefits include: recruitment, productivity, employee retention, union pressure and desired image of being a progressive, employee-sensitive company. Once the intent is defined, the EAP can work with the company and begin to design a system that will achieve the objectives set forth.

"The EAP took the lead in anchoring these services," says Ray Johnson, senior manager of employee assistance services for the Bank of Montreal, "and the systems put in place continue to develop."

Four clearly defined components of a successful system that EAPs have experience conducting are: planning, promotion/education, operations and evaluation/outcomes.

PLANNING. Once appropriately positioned to to pursue work/family management, the EAP's next step is to determine who to involve from the company. The choices depend primarily on the size of the company and what areas of expertise are available for input. Areas to consider including are: personnel, communications/public relations, credit union, training and those areas that handle benefits, medical and wellness services. Of course, labor needs to be represented in those companies with unions. (Even though this program is a direct function of the company, it may be valuable to get comments from community representatives such as United Way and insurance carriers.)

Once key personnel have been selected, the EAP should help the group decide collectively which work/family issues will be addressed now or in the future. With those issues delineated, the group should assess existing programs to determine the strength of the foundation on which they can begin to build.

The final step in the planning phase is for the EAP to lead the development of a focused three-to-five-year plan. This process should include: reviewing applicable policies and procedures, assessing organizational structure, reviewing the current corporate strategic plan and conducting some basic research to determine demographic makeup of one's employee base, both now and how it will be in the

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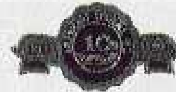

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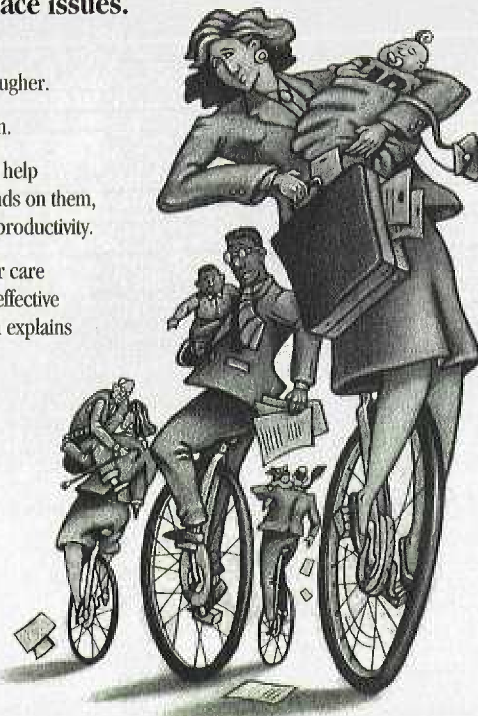

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future. One also should address consumer preference and needs and assess what resources, both internal and external, are or will be available. The EAP can then assist the company to create a targeted strategic plan, setting goals and establishing priorities. (Total quality management tools, including K.J. Affinity, interrelationship diagrams, radar charts and tree diagrams, can be very useful.)

PROMOTION. As all EAPs know, a well-coordinated promotion and employee education program is of vital importance if the company is to maximize the benefits of the services and enhance employees' perception of its worth. The EAP can assist the company in viewing its employees as consumers or customers and sell them on the program and how it will benefit them and their families physically and emotionally, and, in the long run, financially.

"It is amazing to see organizations who have a number of work/family programs in place, but their employees see no integration or comprehensive program, just pieces," says Googins. Obviously the EAP needs to keep top management informed and in turn, supportive. Supervisors need to be educated and trained, equipping them with the message that a partnership must exist between employers' needs and family demands.

Finally, the EAP needs to promote the program to the company's employees and family members. The promotional plan should be ongoing and long range, continually emphasizing benefits and how those benefits translate into compensation for the employee. "It is important that a company send a clear message to its employees that it cares and is responsive," says Ray Johnston, senior EAP manager for the Bank of Montreal. "Without a strong promotional program in place the message never gets through."

OPERATIONS. There are a variety of ways to coordinate the programs and deliver the services, presenting the real opportunity for proactive EAPs. Many companies are putting in place programs either internally developed or contracted for with no central planning, contract management or principal entity for over-

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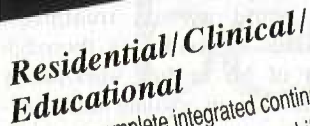

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