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The magazine of the Employee Assistance Professionals Association

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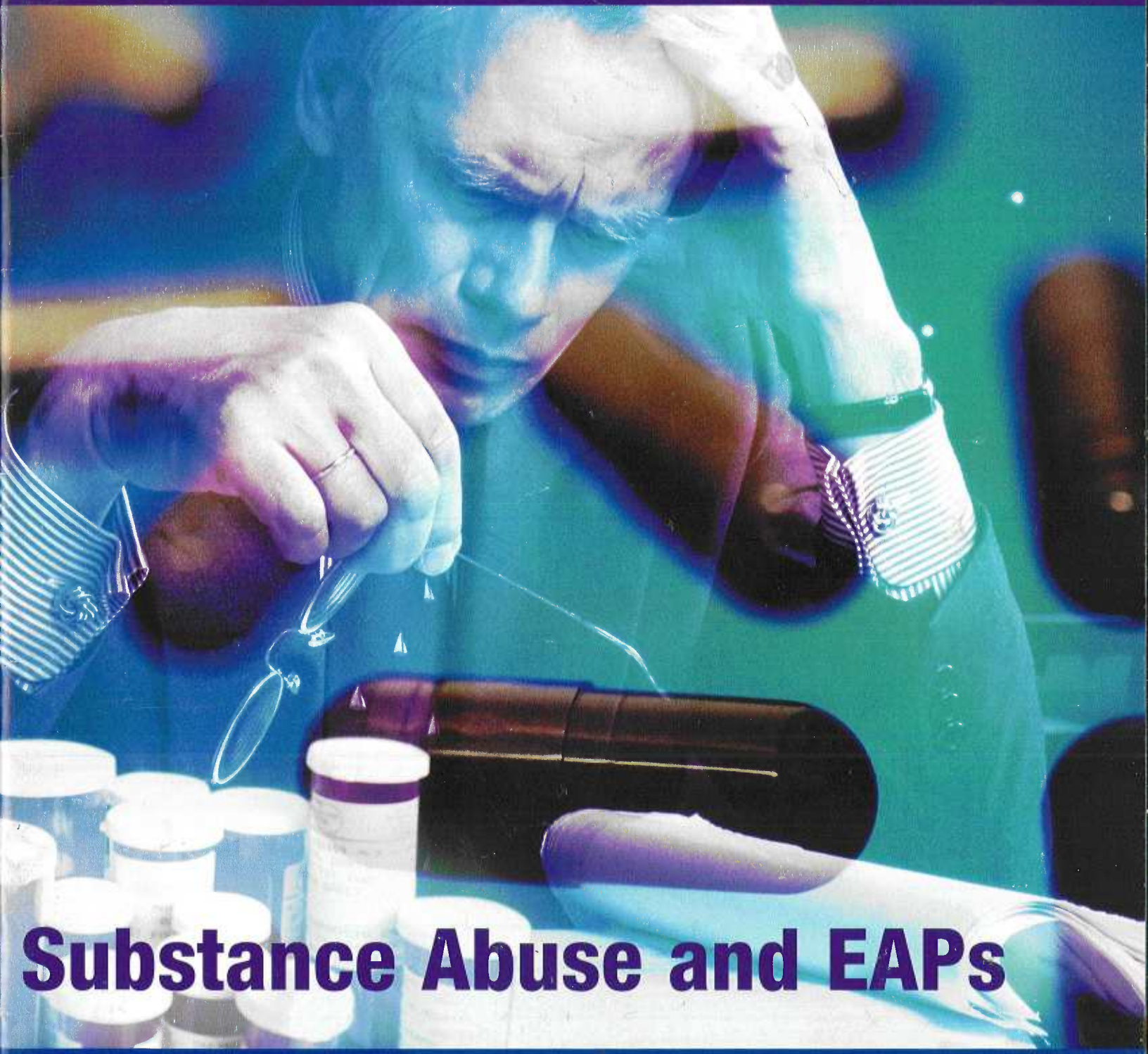

Substance Abuse and EAPs

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INTERNATIONAL EAP ASSOCIATION

Employee Assistance Professionals Association

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Evaluation of a Peer Support Program to Reduce Substance Abuse Within a Large Manufacturing Company

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Analyses of drug-testing results, benefits utilization patterns, and other variables failed to show statistically significant advantages to implementing peer support programs, but given their low cost, they merit further study.

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Our Foundation and Our Opportunity

Maria Hartley

by Maria Hartley, LEAP

Any discussion of the employee assistance industry and its impact on the workplace must begin with substance abuse, particularly alcohol addiction. The development and proliferation of EAPs coincided with employers' growing interest in reducing the impact of alcohol abuse on workers' productivity and performance. Identifying employees with alcohol problems and providing them with appropriate assessment and referral services became the foundation upon which EA professionals built today's broad-brush programs that address issues ranging from depression and stress to financial and legal problems to child and elder care.

All too often, however, the discussion about employee assistance neglects to mention the important role substance abuse plays today and will continue to play in our future. As the theme articles in this issue of the *Journal* make clear, combating substance abuse offers an opportunity—make that several opportunities—to enhance our skill sets, leverage new markets, and position ourselves as workplace experts on behavioral issues that affect the bottom line.

Such opportunities reflect evolving attitudes and policies toward substance abuse and especially alcohol abuse. Although employers' initial interest in addressing substance abuse stemmed from workers' drinking behaviors and their impact on workplace performance, alcohol eventually began to seem benign in comparison to more addictive (and illegal) substances, including cocaine, heroin, and marijuana. The grounding of the *Exxon Valdez* in Alaska's Prince William Sound in 1989 returned alcohol to the spotlight and prompted the passage of federal legislation in 1991 mandating drug testing for transportation employees in safety-sensitive positions. That law, and the recent enactment of various state and local bans on cigarette smoking in commercial establishments, suggests that the use of alcohol, nicotine, and other addictive substances is now seen as a public safety issue rather than simply a workplace performance matter.

This shift in perception has created new opportunities for EAP providers to utilize their unique knowledge of substance abuse issues to the benefit of both employers and employees. As the articles beginning on page 20 explain, EA professionals can provide substance abuse professional (SAP) services to help work organizations meet the demands of the Department of Transportation drug-testing requirements. They also can work with impaired professional programs (IPPs) to ensure that doctors, lawyers, and others subject to disciplinary action by state licensing boards receive proper treatment, thereby minimizing the risks to patients and clients (not to mention employers). They can encourage employees to adopt wellness-oriented lifestyles to decrease the possibility of relapse, and they can help employers alter workplace cultures that tolerate and even encourage substance abuse.

Excited as I am about these articles, I am equally if not more pleased that this issue contains a Research Report, our first in more than a year. The report discusses the experience of a large employer in implementing peer assistance programs at several sites. I encourage you to read the report and let me or any other member of the Communication Advisory Subcommittee know whether you find it helpful.

Finally, be sure to read the feature articles on how women are faring in the EA industry and how EA professionals can partner with disability management specialists to reduce the incidence of presenteeism. And don't miss John Maynard's "View from Here" column on being proactive in identifying new opportunities to prove our value to the workplace. John expands the definition of substance abuse to include abuse of food, which can lead to obesity and then to a host of other problems that impede workplace productivity.

I hope this issue of the *Journal* spurs all of us to take a fresh look at substance abuse and consider the role it plays in our businesses. Let's build on our knowledge of abuse and addiction and make the most of new opportunities awaiting us. ■

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To promote the highest standards of practice and the continuing development of employee assistance professionals and programs.

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Research papers for the *Journal of Employee Assistance* Research Report should be sent to Research Committee, EAPA, 4350 N. Fairfax Dr., Suite 410, Arlington, VA 22203. Send five copies and omit any identifying information (name, address, etc.) from each copy. For more information, contact Dan Hughes, Research Committee chairman, at (212) 241-8937.

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Presenteeism: Taking an Integrated Approach

By integrating the efforts of disability management and employee assistance programs, employers can form a solid foundation for an early-return-to-work program that reduces the impact of presenteeism.

by Marybeth Stevens, M.S., CDMS, CCM, CRC, and Norman Hursh, Sc.D, CRC, CVE

A supervisor notices that a valuable longtime employee has missed several project deadlines, appears distracted, and has begun arriving late to work and leaving early. Another employee, recently diagnosed with diabetes, has returned to work after taking a short-term disability leave of absence but is having difficulty coping with the effects of the illness on her life. A third employee harbors lingering feelings of anger about an on-the-job injury that are interfering with his successful return to work and is also struggling to care for an aging parent recently diagnosed with Alzheimer's disease.

These employees are exhibiting "symptoms" of presenteeism, a term used to describe the phenomenon of employees showing up for work but not performing to their full potential. Although presenteeism is familiar to many employers as a concept, it is still considered the next frontier among workplace issues, and relatively few work organizations—mostly large employers—are taking steps to address it (see "The Presenteeism Mindset").

Presenteeism shifts the focus of employers, human resources professionals, and others interested in workforce performance from employees who take unscheduled absences from work (a problem known as absenteeism) to employees who are present but not as productive as they could be. There are many drivers of presenteeism, including (but not limited to) chronic health issues or episodic illness, difficulty returning to work after an illness or injury, personal or family problems, and child care or elder care needs.

To address presenteeism and its multiple causes, some employers are making use of their workplace benefits, including disability management and employee assistance programs (see "An Integrated Approach to Presenteeism"). As this article will discuss, an integrated approach to combating presenteeism leverages the strengths of multiple programs to address the physical, mental, emotional, vocational, and practical needs of employees.

AN EMERGING AWARENESS

On the surface, employee presenteeism may not appear to be a serious problem. From an employer's perspective, having an employee on the job would seem preferable to having him or her miss work due to an unscheduled absence, whether from illness, injury, or other cause. In addition, the impact of presenteeism is difficult to gauge on a case-by-case basis—unlike disability cases such as workers' compensation claims, which are easier to measure in terms of cost of benefits and duration of time off.

Nonetheless, research indicates that presenteeism can have a significant effect on productivity and on a work organization's bottom line. Wayne D. Burton, M.D., employee wellness and productivity executive for JP Morgan Chase, says that presenteeism is estimated to account for two-thirds of total direct and indirect costs (such as lost productivity) stemming from medical care, absenteeism, short- and long-term disability, and presenteeism. The remaining factors together account for about one-third.

A small but growing number of employers are beginning to consider presenteeism from the perspective of performance and productivity management. They are starting to ask themselves a question: When my employees are not able to focus on their tasks and responsibilities, when they are distracted by problems and concerns, when the quality and consistency of their work suffers, what is the impact on my company's performance and productivity?

"The awareness is beginning to emerge at all levels," says Ronald Loeppke, M.D., chief health officer and senior vice president of integrated solutions for CorSolutions Inc. "What we have seen is that the 'C-suite' level in the company—the executive team—does grab onto this issue of managing total cost by recognizing the business value of health in the workforce."

A GLOBAL APPROACH

Disability managers and EA professionals can play a major role in helping companies understand the importance of addressing presenteeism and utilize existing tools and services more effectively to help improve employee produc-

Marybeth Stevens is immediate past chair and Norman Hursh is chair-elect of the Certification of Disability Management Specialists Commission (CDMSC), the only nationally accredited organization that certifies disability management specialists. Ms. Stevens is also the delivery leader of Workplace Absence and Disability Management Programs for General Electric. Dr. Hursh is an associate professor in the Rehabilitation Services Department of the Sargent College of Health and Rehabilitation Sciences at Boston University.

tivity. Disability managers know the importance of early-return-to-work programs that help ill and injured employees transition back to the workplace. Employee assistance professionals, meanwhile, understand the value of addressing the emotional, mental health, and work/life needs of employees.

By integrating their separate but complementary perspectives, disability management and EA professionals can develop a global solution to both absenteeism and presenteeism. Indeed, disability management and employee assistance professionals are at the heart of a team approach that can also encompass the wellness, work/life balance, and human resources functions and meet the needs of supervisors and managers as well as employees. Adopting a global view of health, wellness, and productivity enables companies to begin breaking down the "silos" of medical and pharmacy benefits, disability management, employee assistance, and wellness and work/life programs.

"There is a tremendous opportunity if the head of health benefits, the head of the EAP, the head of disability, and/or the corporate medical director would aggregate this information and begin to show the business case of why an integrated health solution is critical to the bottom line of the company," Loeppke says. "Then, executives would really 'get it,' if they don't already. In fact, I have had corporate executives ask why their people have not brought this total cost perspective and the business value of integrated health strategies to their attention. The opportunity is ripe for those within organizations to bring this forward to their executive teams."

Traditionally, EAPs have focused on non-disability-related issues like personal or family problems and work/life concerns, such as child care and elder care referrals. The EAP often operates separately from disability management, which focuses on returning employees to work after an illness or injury. Disability management and employee assistance programs, whether internal or provided by third parties, usually do not integrate their services very much, and direct referrals between programs are often difficult because of confidentiality issues.

Many employers view their EAPs, disability management programs, and other workplace benefits separately, but in so doing they fail to recognize the complementary strategies underlying them. This can be seen most clearly, perhaps, in the link between returning an employee to work after an absence (whether covered by workers' compensation or short-term disability) and addressing any lingering presenteeism/ productivity issues.

By involving EAPs in early-return-to-work programs, employers may see increases in their medical and pharmacy costs.

Some companies may be successful in developing early-return-to-work programs for employees who suffer occupational or non-occupational illnesses or injuries. They may not enjoy as much success, however, administering the necessary follow-up activities, including monitoring returning employees to ensure they are adjusting emotionally and psychologically to the workplace. Offering various types of support, include counseling through the EAP, can help early-return-to-work programs achieve more productive outcomes.

IMPROVING EAP UTILIZATION

Clearly, using an integrated benefits approach to assist employees who have been off work and are transitioning back into the workplace is one way employers can target presenteeism and show significant gains in productivity. Such an approach can also help companies increase utilization of their EAPs.

Carol A. Harnett, assistant vice president and national practice leader of group disability and life practice for The Hartford, says employers generally expect 4-6 percent of their employees to use the EAP each year. Some studies, however, indicate that utilization is typically lower, around 1-2 percent annually. By involving EAPs in early-return-to-work programs, employers may see increases in their medical and pharmacy costs. While employers might consider this a negative development, Harnett believes it is a positive turn of events.

"When you have good utilization of your EAP, it means your employees are dealing with their issues, particularly depression and anxiety disorders, which are two of the main things we see," she says. "As workers visit their doctors and take their medications, medical/ pharmacy costs may go up a little bit, but the hope is that this will change the presenteeism problem. If employees deal with issues appropriately, they will not leave the workplace. They'll be at their jobs and they'll be more productive."

To increase EAP utilization, companies should make sure that employees and supervisors alike understand how the program operates, the benefits it provides, and the fact that it is free and confidential. Supervisors can be an important source of referrals to EAPs for employees who exhibit signs of stress or presenteeism problems. At the same time, supervisors themselves may need EAP support as they face the pressures of maintaining and/or increasing the productivity of their units and managing employees, including those who are coming back to work after an absence.

"Companies may spend a week giving two-hour training sessions each day on new software that may affect productivity by a certain amount," says David Whitehouse, M.D., M.B.A., corporate medical director of CIGNA Behavioral Health. "Yet when it comes to employees understanding how to use their benefits, which are at least of equal importance to productivity as new software, how much time do they spend training them how to use it? Usually, it's minimal."

In addition, as employers look at integrating EAPs with wellness and, increasingly, disability management programs, there is an even greater opportunity to help employees access these services, both for practical concerns and for

emotional/behavioral reasons. For example, an employee who has been on disability leave may be physically ready to return to work, but child care may have become an issue in the interim. Another employee may be seeking information about nursing homes for an elderly parent living in another state and may also need emotional support to deal with his or her feelings surrounding this issue.

ELEMENTS IN PLACE

The first step in addressing presenteeism is to realize that the problem exists in all companies. Chronic illness, disability, personal/family problems, and other issues can diminish the productivity of the most highly trained, experienced, and valued employees. By understanding that work and life issues are inextricably linked, employers can offer resources to their employees and assist them in being as productive as possible.

The elements of an effective presenteeism strategy may already be in place through existing benefits and programs. Many companies have EAPs, work/life initiatives, and wellness, prevention, and disability management programs. What's required, however, is a team approach.

Loeppke advises not to tackle presenteeism through a sole source but rather through a corporate health team that spans health benefits, disability management, employee assistance, behavioral health, occupational health, health promotion, and wellness. "Bring it together so that the executive team will see there is a dialogue and an interest in an integrated approach," he says.

As an integrated approach is developed, companies will begin to understand that there is no hard boundary between disability management, employee absence, and productivity/presenteeism. "You can't see where disability ends or presenteeism begins," Burton says. "It's a continuum."

Presenteeism strategies begin with the acknowledgement that work/life issues can affect the performance of even valued employees. With this understanding, employers can explore workplace strategies that can help employees come back to work, stay at work and be as productive as possible. ■

The Presenteeism Mindset

Presenteeism is currently beyond the scope of focus of many employers, who typically are more concerned about employees who are absent than those who are on the job.

"Most definitely there is the buy-in from the very large employers, but we don't see interest yet from the middle market and the small companies," says Carol A. Harnett, assistant vice president and national practice leader for group disability and life at The Hartford. "Some of those employers are still struggling with whether absenteeism is really an issue."

There may be another underlying reason why presenteeism isn't capturing the attention of employers. Although some research indicates presenteeism is a major drain on workplace productivity, presenteeism requires companies to look at employees from the perspective of human capital, a valuable asset in which to invest not only training but also resources to develop and maintain productivity.

"You really have to place a value on the employees and their being fully healthy and productive," says David Whitehouse, M.D., M.B.A., corporate medical director at CIGNA Behavioral Health. "This is another approach to performance management that says, 'If you are functioning at 75 percent, I can give you support to get you to 100 percent.'"

An Integrated Approach to Presenteeism

At JP Morgan Chase, disability management and EAP professionals work side-by-side to handle the company's internally managed short-term disability program, focusing on both physical and mental health issues, depending upon the employee's needs.

"The partnership between the EAP and short-term disability management was one I set up over 20 years ago," says Wayne Burton, M.D., employee wellness and productivity executive for JP Morgan Chase. "We realized that not only is a significant portion of our short-term disability caseload related directly to mental health, but in many short-term disability cases, mental health issues are in part a co-morbidity. Someone starts out having a heart attack, but we know that a large percentage of people who suffer heart attacks have depression afterwards."

If the co-morbidity (or secondary medical condition) of depression is not diagnosed and addressed, the employee is far more likely to be away from work longer on disability leave. If the employee does return to work, the underlying depression may result in another absence or short-term disability, as well as presenteeism issues when he/she is on the job. By integrating disability management and EAP, however, JP Morgan Chase is able to assign the right professional—whether an occupational health nurse or a registered nurse who specializes in mental health nursing—to manage the employee's case.

"Rather than mental health being carved out, if the mental health profession would work part and parcel with physical medicine, then a person could be treated in total," says Daniel J. Conti, Ph.D., first vice president and EAP manager for JP Morgan Chase. "We have nurses who are professionals in case management and know how to introduce the idea of behavioral medicine, to help employees take some steps to live in a healthier way and learn how they can manage their emotions to do better with their physical conditions. In the vast majority of cases, it's done very easily and is seen as a source of additional support. Pushback from employees isn't an issue here, and it's a free and confidential service."

Gender Discrimination in Employee Assistance?

Although EAPs often help employers and employees address gender discrimination issues, it is debatable whether the industry is better than many other professions in opening doors for women leaders.

by Erin Gilbert

A woman in the United States can take advantage of an astounding array of vocational opportunities. She may seek employment as a television producer, frantically organizing stories for the evening news. She can progress through the ranks of a law firm or medical practice. She may work as a traveling land surveyor, on the road for weeks at a time and coming home once every two or three months.

With this vast array of choices available, it would seem that gender discrimination would be nearly absent from the workplace. Yet evidence suggests the opposite—that gender discrimination in the workplace is alive and flourishing. The facts are familiar and compelling. On average, women make $0.72 for every $1.00 earned by men in equal positions with similar experience.[1] Women remain concentrated in "pink collar" jobs such as health care support, personal care, and administrative support,[2] and head only two of the 500 largest businesses in the United States.[3]

Perhaps as a means of avoiding possible gender discrimination, some women are choosing to become entrepreneurs rather than work for others. From 1997 to 2002, the number of women-owned businesses in the United States grew by 14.3 percent.[4] Evidence indicates, however, that ownership opportunities are not immune to the impact of gender discrimination, nor is the recent growth in women's businesses as significant as it may appear. Women may lack invaluable business networks and the necessary capital to finance their businesses. Further, many of these women-owned businesses are established as sole proprietorships and thus have no paid employees.[5]

EAPs often help individual or corporate clients confront gender discrimination, so the EA field should recognize the importance of eliminating gender discrimination. Thus, an examination of how women are faring within the field is relevant. To determine the degree of gender discrimination present within the field, this article will explore the topics of female entrepreneurship and female leadership. Interviews with women who are leaders in the industry will provide insight and nuance into these topics.

EXAMINING THE OPPORTUNITIES

Opportunities for entrepreneurial women exist in the EAP industry, as the six interviewees made clear by describing the ways they established their own EA enterprises. Mary Vasquez, president and chief executive of VMC Behavioral Healthcare Services, started her company after she was awarded federal funding to encourage the growth of EAPs in her area. The funds proved to be instrumental in developing her initial contracts. When Dale Masi, president and chief executive of Masi Research Consultants, began working with IBM, the company provided some upfront funding and requested that she start her own business. Lucy López-Roig, president and CEO of Lucy López-Roig and Associates, was contacted by the secretary of health in Puerto Rico when the country's government was seeking individuals to establish EAPs.

But what about leadership opportunities for women? Research by Smith suggests that women are more likely to have job authority in industries composed mostly of females.[6] The EAP field would seem to fit this description. Although the Employee Assistance Professionals Association (EAPA) does not specifically track the gender of its members, the organization acknowledges that the majority of its members are women. While EAPA membership is not necessarily indicative of the exact percentage of women and men in the industry, for the purposes of discussion it may be assumed that the EA profession is divided in a similar manner.

Thus, one might imagine that women would hold some job authority within EAP firms. Magellan Health Services, ComPsych Corporation, ValueOptions, United Behavioral Health, Cigna Behavioral Health, MHN, Inc. and APS Healthcare are giants in the EA industry. Yet not one of these seven companies is led by a woman.

In a profession populated mainly by women, why do men hold the majority of leadership positions? Dale Masi noted that the presence of male "networks," such as exclusive clubs, certain alumni groups, and sporting engagements, aids many businessmen. Similarly, Kristine Brennan, executive director of Continuum, observed that formal and informal mentoring frequently occurs

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among men. She believes that males are taught about leadership as children and are brought into the fold of leaders by other men as they grow to adulthood. Because both leadership skills and mentoring relationships are essential to successful individuals, men are conferred many advantages by this arrangement.

ORIGINS OF EMPLOYEE ASSISTANCE

When asked whether they feel the EAP profession has supported them during their careers, the six interviewees gave a range of responses. One rejected the idea that employee assistance has been especially friendly to women, observing that most EAP companies are led by men. Another interviewee seemed startled by that comment and instead praised the field's supportive nature, which she associated with the presence of so many female social workers performing EAP work. Brennan took the middle ground, noting that while the profession has accepted women, more men are assuming leadership positions as larger firms purchase smaller ones.

The origins of employee assistance and current trends in the industry suggest possible explanations for such diverse responses. Though employee assistance is closely associated with and related to social work, the two industries stand in marked contrast to each other. Social work began as and remains a pink collar field, characterized by small agencies and private practitioners and lacking the corporate/small business dichotomy present in the EAP industry. Employee assistance, on the other hand, evolved from occupational alcoholism programs, which were staffed predominantly by male recovering alcoholics.

The "second generation" of EA professionals included many trained counselors, a change that brought more women into employee assistance. Now, as the profession enters its third generation, the trend is toward consolidation, with larger companies purchasing smaller ones. Depending on when they entered the profession and the jobs they have performed, women may hold different opinions on the nature of employee assistance—as a pink collar industry comprising mostly female counselors and social workers, or a male-dominated business with corporate consolidation decreasing female entrepreneurial and management opportunities.

What can the EA profession do to increase the number of female entrepreneurs and leaders? Brennan suggested that successful female EA professionals have a responsibility to mentor other women as they begin their careers, even though women entering the profession today do not confront the barriers faced by previous generations. Masi believes that EAPA and EASNA (the Employee Assistance Society of North America) should sponsor programs on the subject, such as a workshop featuring a panel of successful women from the EA field.

Dawn Motovidlak, president and chief executive of Business Health Services, observed that as more women enter the overall workforce and compete with men for executive positions, many of them are realizing that the fastest way to these positions may be to start new businesses. She believes EAPs can be instrumental in minimizing the difference between the numbers of male and female business owners and leaders by providing work/life services to client companies and emphasizing (to both women and men) the need to balance work and family responsibilities.

BRIEFCASE AND BROOM

These and other methods may prove helpful in increasing the number of female entrepreneurs and leaders in the EAP industry. Many women, however, carry "double loads" that are not likely to be alleviated solely by the provision of equal opportunities in the workplace. In the United States, nearly three of every four women with children under the age of 18 were employed in 2002.[7] In addition to their jobs, these mothers are performing the majority of caregiving duties within the home and family.[8]

The burden of home and family duties frequently creates disadvantages for women in the workplace. For example, a woman may work only part time because of her responsibilities rather than work full time and be penalized or fired when she requires time off to care for sick children or elders. The EAP industry, like social work, offers an assortment of jobs that may be appealing for those with caregiving responsibilities, such as affiliate positions or part-time work at call centers. Unlike social work, however, employee assistance includes large corporations with many traditionally structured full-time positions. In this way, the industry may be viewed as less accommodating toward women than social work.

Owning an EAP firm may allow more flexibility than other jobs, though the double duty of employment and caregiving may remain. Brenda Blair, president of Blair Consulting, found that she could work late at night if she was otherwise engaged with family obligations during the day. Mary Vasquez agreed, noting that it is easier to balance traditional female roles with a career when one is the business owner. Indeed, she realized that her family could be a valuable source of assistance. During a particularly hectic time, she awakened her husband and three sons to help finalize a proposal.

These and other comments and insights from these successful individuals indicate that intelligent, capable women can succeed in the EAP industry. As the industry evolves, however, it remains to be determined whether it will provide opportunities for women to launch their careers and businesses or continue its current trend toward consolidation and male leadership of large firms. ■

Notes

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Evaluation of a Peer Support Program to Reduce Substance Abuse Within a Large Manufacturing Company

Jeffrey N. Thompson, M.D., M.P.H., Kelly B. Kyes, Ph.D., Allen D. Cheadle, Ph.D., Charles H. Bombardier, Ph.D., Robert Jacobsen, Karen Sorenson, Paula Stewart, and Steve Hill

ABSTRACT

Substance abuse in the workforce represents a significant problem for employers and employees. One promising prevention and early intervention strategy is a peer support program.

This paper describes a prospective cohort study designed to test the impact of a worksite peer support program on (1) mental health and EAP utilization, (2) substance abuse and worksite safety statistics, (3) health benefit utilization and costs, and (4) productivity. The study was conducted at a large manufacturing company and included 8 intervention worksites and 14 matched control sites. Outcome measures included drug use (from employer drug-testing results), substance abuse benefit utilization, overall health-care costs, workers' compensation claims, and use of short- and long-term disability leave.

None of the worksite-level analyses of the outcome variables produced statistically significant results, and in only one case was the difference in pre-/post-change outcomes statistically significant between groups when using an employee-level analysis (short-term disability days increased significantly in the control group compared to the intervention group). Despite the negative results, peer helper programs merit further study given their relatively low cost and ability to build on the natural trust workers have in their respected peers.

KEY WORDS: Peer support, substance abuse, health care, employee assistance program (EAP).

Introduction

Substance abuse in the workforce represents a significant problem for employers and employees. Of the $1.85 billion in estimated economic costs of alcohol abuse in the United States, 70 percent (or $1.34 billion) is attributable to lost productivity (Harwood 2000). Substance abuse affects safety, productivity, absenteeism, and turnover in the workplace (Harwood, Fountain, and Livermore 1998).

Estimates of illicit substance abuse in the public sector and among different industries vary widely, ranging from 3 percent in the service industries to more than 20 percent in the mining and construction industries (Bureau of Labor Statistics 1989). One survey found that 9 percent of employees and 12 percent of applicants tested positive for some illicit substance (Bureau of Labor Statistics 1989).

However, simply identifying and treating or removing persons with frank substance diagnoses cannot address the effects of substance abuse in the workplace. This is because the negative effects of alcohol abuse on workplace performance usually are not attributable to people with alcohol dependence (Mangione, Howland, and Lee 1998). Most are due to occasional abuse, such as drinking at work or hangover effects from episodic binge drinking at night. Such drinking behavior is unlikely to be detected by traditional for-cause screening or to come to the attention of EAPs. In addition, substance abuse is related to worksite culture, such as attitudes toward drinking, workplace policies, the accessibility of alcohol, the degree of worker autonomy, and workers' sense of control (Ames and Janes 1992; Trice and Sonnenstuhl 1988).

Data concerning employment outcomes for workers who use illicit substances often show conflicting results. One prospective study examined the relationship between pre-employment drug testing and subsequent employment outcomes. New hires testing positive for pre-employment drug use were followed over time and found to be associated with higher adverse employment outcomes, including higher turnover rates and more accidents, injuries, and disciplinary actions than those with negative pre-employment test results (Zwerling 1990). However, the magnitude of the differences between groups was small (relative risk <2). In a similar study, no relationship was found between drug use and job performance (Zwerling 1990).

Drug testing after occupational injury is practiced widely in the transportation industry, but little is known about the association between illicit substance use and occupational

injury in other occupations (Zwerling 1993). One report suggests that alcohol and prescription drugs are a more frequent factor in workplace fatalities than are illicit substances (Lewis and Cooper 1989).

Results from a recent corporate drinking survey show that the answer is not as simple as identifying workers with diagnosable substance abuse problems. In that study, three in five incidents of workplace tardiness, absenteeism, and poor performance were caused by alcohol use in light to moderate drinkers (Mangione 1998).

To address more effectively the problem of substance abuse in the workplace, strategies are needed to change workplace culture, detect hazardous substance use earlier, and provide interventions that penetrate the organization more broadly. One promising prevention and early intervention strategy is a peer support program. Peer support programs got their start in schools and among other adolescent populations. While some programs focused simply on coalescing peer influence, more complex programs involved teaching communication and persuasion skills to peer helpers (McAlister 1980). A meta-analysis of outcome results from 143 adolescent prevention programs concluded that peer programs were superior to other interventions (Tolber 1986).

Various industries have begun to harness the influence of peer support to help manage substance abuse problems. The railroad industry, for one, has a long history of using peer intervention programs (e.g., Operation Red Block, Union Pacific; Operation Stop, Burlington Northern). Union Pacific has attributed a number of perceived benefits to peer intervention programs (Eichler 1988), including reduced workplace substance use or abuse, decreased tolerance of substance use by other workers in the workplace, increased effectiveness of supervisory personnel, improved union-management relations, enhanced safety, fewer personal injuries, reduced utilization of medical benefits, decreased workplace accident investigations, and less money spent on legal proceedings.

The American Flight Attendants Association (AFAA) also uses peer helpers, who are trained to refer their fellow union members to EAP services. The AFAA reports that 3.6 percent of its members used EAP services from 1983 to 1985. Of those, more than 30 percent were referred by peer helpers and 17 percent by supervisors, while 51 percent were self-referrals (American Flight Attendants Association 1997).

In the only controlled trial of workplace peer support intervention, 3M used peer support along with supervisor training and employee education programs to reduce substance use, risky behaviors, and negative consequences of alcohol use at work (Stoltzfus and Benson 1994). Self-report data collected from one experimental and one control site revealed less alcohol consumption and fewer negative consequences of alcohol use at work among members of the experimental group. The authors concluded that employee participation and ownership of the program might have helped change the normative culture of workplace alcohol use.

Study Overview

In 1996, management of a large manufacturing firm wanted to strengthen the company's substance abuse efforts and implemented a pilot peer support program at three locations. The primary goal of the program was to offer voluntary prevention and early intervention services to reduce employee impairment arising from substance abuse, workplace stress, family stress, and similar causes. At the core of the program were a group of employees called peer helpers who were trained to listen to and assess co-workers' needs and recommend appropriate referrals to the EAP before there was an effect on workplace performance. Training focused on listening and support skills as well as understanding and promoting EAP services.

The estimated costs of a program with 10 peer helpers totaled approximately $22,000 for start-up and implementation and $11,000 for annual maintenance (Table 1). Estimated costs associated with employees losing time from their regular jobs, based on a 10-person design team and 10 peer helpers, totaled roughly $18,000.

Methods

Research design. The peer support program was evaluated using a community-based prevention design. Sites were selected for participation based on a pre-selected group of criteria. Sites agreeing to participate, called self-selected intervention sites, were matched with comparable control sites. The self-selected sites comprised the "community" in which peer support services were provided. (A randomized selection of sites was not possible due to conflicting business needs of the company; instead, a hierarchically matched control group was selected for each intervention site.)

Selection process. The peer helper program was implemented in a large manufacturing company with diverse plants located in 46 states as well as an international division. Total employment at the company in 1998 was 32,000. Eight worksites with some 2,000 employees participated in the peer support program.

Worksites were invited to self-select using the following criteria:

- Non-intrusive but supportive management, union, and human resources representatives;
- A strong and involved EAP;
- Adequate and dedicated developmental resources;
- Use of "teaming" systems (i.e., employees are empowered to exercise greater decision-making authority);
- A trusting work environment; and
- A stable work environment (e.g., labor bargaining activity).

Control sites were chosen based on characteristics most

likely to influence or confound the outcomes associated with the peer support program and/or utilization of a managed health care delivery system. Matching of control sites with self-selected sites was based on union status, product line, geographic region, site size, ethnicity of the worksite, and manufacturer environment.

Once a site accepted program implementation, a design team of management, human resources, union, and employee representatives was tasked to tailor and communicate the program to the worksite. Peer helpers were chosen by one of three strategies: (1) nomination by co-workers, (2) conscription by the union, or (3) self-nomination. Nomination by a co-worker appeared to result in faster program start-up in that peer helpers were identified more quickly, had already been functioning as informal "helpers" in the workplace, and often had a history of keeping co-workers' confidences.

Training of peer helpers. Training of peer helpers occurred in a two-day program conducted by two EAP counselors with the assistance of the onsite EAP counselor. A one-day follow-up training was conducted after three months, followed by annual one-day refresher training. All training focused on developing active listening skills, reflective paraphrasing, explaining how to give and receive feedback, and role-playing. Peer helper interventions were both passive (when a co-worker sought assistance from a peer helper) and active (when a peer helper contacted a co-worker with a concern). Peer helpers received supervision in monthly or quarterly meetings with the onsite EAP counselor.

The program began with three pilot sites in mid-1997; three programs started in 1998 and two in 1999. The sites ranged in size from 120 to 470 full-time employees (FTEs), with 8 to 23 peer helpers (comprising 3.0 to 10.8 percent of the workforce) per site. The number of peer helpers depended largely on the physical size of the plant and the number of work shifts.

Sample. Across all sites, just over 80 percent of the employees were male, and roughly three-quarters were Caucasian. The average age was slightly older than 40 years and average tenure about 12 years in both groups. Nineteen percent of employees in the intervention group and 11 percent in the control group belonged to unions. There were no statistically significant differences between the intervention and control groups on control variables (Table 2).

Outcome measures and research hypotheses. The effect of the peer support program was evaluated using outcome indicators available in administrative databases. We expected that the presence of a peer support network in the workplace would result in lower rates of positive random and for-cause drug tests. We also predicted that the peer support program would result in lower rates of substance abuse and mental health treatment utilization, lower cost per covered life for substance abuse treatment, and lower workers' compensation-related medical and time-loss payments.

Statistical testing. The analysis of quantitative dependent variables was conducted using the worksite as the unit of analysis. Pre-intervention data were aggregated at the worksite level and converted to an annual rate per employee (for example, the average annual cost of mental health benefits per employee). Post-intervention data were then aggregated in a similar way and a change score computed (post-intervention minus pre-intervention).

Unpaired T-tests were conducted to test for the significance

Table 1 **Costs of Peer Helper Program: Program Implementation and Maintenance Costs**

Start-up and Implementation Costs		Maintenance Costs	
Design/training meeting (includes meeting room, food and travel)	$4,200	Design/training meeting (includes meeting room, food and travel)	$2,340
Two trainers (includes transportation, meals and training)	$10,300	One trainer (includes transportation, meals and training)	$4,160
Communications (includes materials, mailings and contractors)	$2,650	Communications (includes materials, mailings and contractors)	$2,650
EAP costs for design meeting	$4,800	EAP costs for maintenance phase	$1,600
Peer helper recognition costs	$500	Peer helper recognition costs	$500
Total	**$22,450**	**Total**	**$11,250**

of the difference in change scores between intervention and comparison groups. A sensitivity analysis was conducted with and without large cases to test and adjust for non-parametric outcomes. We found no differences in reported outcomes with and without large cases.

Validity of the intervention. The project included a substantial process evaluation to measure the extent to which the peer support intervention was implemented (effect size and dose effect) and to identify lessons that might be applied to future efforts. Levels of peer helper and EAP activity (e.g., number of contacts and referrals) were tracked using quarterly reports obtained from the peer support program coordinators and EAP administrators. In addition, the corporate drug testing coordinator conducted key informant interviews. Finally, three study team members independently ranked the peer support programs on a number of dimensions, including management support of program, degree of buy-in by employees, employee knowledge of the program, strength/cohesiveness of the peer helper team, and the overall quality of the program.

Results

Process findings. The number of peer helper contacts at each intervention worksite ranged from 30 to 156 per quarter, for a rate of 11 to 87 contacts per 100 employees per quarter. The number of EAP contacts was substantially lower, ranging from 6 to 36 per quarter, for a contact rate of 4 to 10 per 100 employees per quarter. The problems encountered most frequently by peer helpers were related to work and marriage/family, with about 17 peer helper contacts per 100 employees.

Table 2 **Demographic Characteristics of Intervention and Control Groups**

Characteristic	Intervention	Control
# of worksites	8	14
# of full-time employees	1,837	3,047
% of male employees	80.7	81.8
% Caucasian	77.1	73.5
% Black	15.5	22.9
% Hispanic	6.3	2.4
% Asian/Pacific Islander	0.3	0.4
% Native American	0.8	0.8
% union members	19.1	11.2
% married	77.2	72.7
Mean age in years	39.6	40.2
Mean years tenure	9.0	8.8

NOTE: No significant differences were found between intervention and control on any of the variables shown.

Structured interviews were conducted with key informants at seven of the intervention sites. Regarding program focus, the vast majority of respondents said the purpose of the program was to provide an additional avenue of support for employees with problems. When asked to identify key areas of need for the peer support program to address, respondents overwhelmingly cited work stress resulting from a variety of factors, including downsizing, work system changes, new product lines, and layoffs.

The individual structured interview ratings revealed three clear groupings of the intervention worksites: (1) a high-rated group (two sites) with an overall average ranking of 4.7 (on a 5-point scale) and a quality rating of 5.0; (2) an intermediate group (three sites) with an overall average ranking of 3.5 and a quality rating of 4.0; and (3) a low-rated group (two sites) with an overall average ranking of 2.2 and a quality rating of 2.0. This grouping of programs into three levels, based on the ratings, roughly confirmed the results from the key informant interviews.

Respondents at the high- and intermediate-rated sites reported respect for the peer helpers, a belief that interactions with peer helpers were confidential, and increasing trust and confidence in the program over time. The two low-rated sites reported a lack of stakeholder commitment, lack of ownership, and ineffective program coordination.

Outcome findings. None of the worksite-level analyses of the outcome variables produced statistically significant results, and in only one case was the difference in the pre-/post-change statistically significant between groups when using an employee-level analysis (short-term disability days increased significantly in the control group compared to the intervention group,.

In most other instances, the modal pattern was a decline in both the intervention and control groups. For example, substance abuse treatment costs per employee per year declined from $2.36 to $0.36 in the intervention group and from $22.24 to $1.56 in the control group. An exception to the downward trend in expenditures was mental health treatment costs in the intervention group, which increased from $11.84 to $27.88. Positive test rates from random drug testing declined from 2.8 percent to 0.7 percent in the intervention group and from 3.3 percent to 0.5 percent in the control group. Changes in random drug-testing rates were driven primarily by one intervention site.

Table 3 **Outcome indicators**

Outcome variable	Peer Helper Sites		Control Sites	
	Pre-	Post-	Pre-	Post-
	N = 3		N = 4 (random) N=5 (for cause)	
Random drug testing[1]	2.8 percent (812 tests)	0.7 percent (716 tests)	3.3 percent (314 tests)	0.5 percent (158 tests)
For-cause drug testing	2.7 percent (70 tests)	0.0 percent (34 tests)	1.5 percent (40 tests)	2.2 percent (20 tests)
Health benefits (cost per covered life)[2]	N = 6		N = 13	
Substance abuse treatment	$2.36	$0.36	$22.24	$1.56
Mental health treatment	$11.84	$27.88	$17.88	$10.72
Other medical treatment	$1,054.48	$692.20	$1,217.92	$1,189.32
Workers' compensation (per FTE)[3]	N = 6		N = 13	
Cost of workers' compensation claims	$173.60	$117.44	$209.12	$79.16
Short-term disability (per 100 FTE)[4]	N = 6		N =13	
Number of STD claims	6.0	4.0	8.4	8.0
STD disability days	164.0	126.8	236.0	233.6

NOTES: None of the pre-/post-changes differed significantly between intervention and control sites.
[1] Percent of tested employees with a positive test result
[2] Average of quarterly costs per covered employee for the indicated category, at an annual rate
[3] Average of quarterly costs per full-time employee, at an annual rate
[4] Number of claims and days per 100 full-time employees

Discussion

As with other community-level studies, this study included relatively few units of analysis and, consequently, has limited statistical power. This problem was compounded by our inability to obtain data (e.g., EAP and health benefit utilization data) from some of the sites. Therefore, it is difficult to say whether the peer support programs had no impact on outcomes or whether we were unable to detect the impact given the limited number of sites in the study.

However, while the study was inconclusive in terms of the main quantitative outcome analyses, we think there are sound business reasons to consider implementing peer helper interventions based on the qualitative results. The peer helpers were able to reach a larger percentage of the workforce than the EAP. We believe this reflects the capacity of the peer helpers to detect incipient problems and intervene earlier in the process of problem development. The qualitative data suggest that peer helpers are seen as a highly acceptable, available, and respected alternative source of support for workers within a large manufacturing company.

The study had several important limitations. Despite considerable effort, we were unable to compile data during several quarters, especially EAP and peer activity data. The worksite staff responsible for reporting the data had many competing priorities and few incentives to complete data forms or comply with research needs. Health benefits data were impossible to obtain from several insurers due to federal standards restricting the release of mental health and substance abuse information.

We had planned to conduct an employee survey and considered assessing several possible outcomes, such as perceptions of the program and actual drinking behavior. Ultimately, we abandoned these plans due to concerns about the confidentiality of the data, the intrusiveness of directly surveying workers, and fears that these factors might damage the nascent support workers had for the peer program.

Recommendations

For businesses considering peer helper programs, our experience underscores the importance of soliciting buy-in from key stakeholders, including management and union leadership, even before the commencement of the program. A major corollary of this principle is to ensure confidentiality in the peer helper relationship. Workers' confidence in the program seemed to depend on whether they felt they could trust peer helpers with personal information. Respect for and trust in peer helpers may have hinged on how peer helpers were chosen. Nominations of peer helpers by co-workers appeared to be the most effective means of selection in terms of ensuring respect and trust.

For researchers interested in studying peer helper programs in workplace settings, we have a number of recommendations. First, do not underestimate the speed and power of large-scale market forces and business changes—such as revising health benefits programs, increasing employee access to health care provider networks, and switching EAP providers—to influence key outcome variables. These secular changes in health care utilization may have overshadowed any smaller impact the peer helper program had on health benefits or other quantitative outcome data. Dependent variables and the time frame for outcome analyses should be based in part on anticipated changes in the health care market. Longer periods of study may be necessary to allow for maturity of the program and effect size.

Conclusion

Substance use and abuse in the workplace are important and costly problems that probably are not addressed adequately by drug testing and professional help (e.g., by EAPs). Peer helper programs have been used to address psychosocial and substance abuse problems in schools as well as in a number of industries. Peer helping also aligns with a workforce trend of teaming systems and worker empowerment to improve the overall workplace culture.

Our attempt at implementing peer helper programs within a large manufacturing company was reasonably successful at six of eight sites. However, the goal of demonstrating the efficacy of peer helpers was not met due to a variety of methodological limitations, operational challenges, and secular changes in the health care financing landscape.

Peer helper programs remain attractive for their relatively low cost, the ability of peers to broadly penetrate the workforce, and because they build upon the natural trust that develops between workers. Peer helper programs merit further study, especially in conjunction with programs designed to make grassroots changes in workplace culture regarding alcohol and drug use.

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Substance Abuse and EAPs

Forming Effective Alliances with IPPs

By working closely with impaired professional programs, EAPs can help health care practitioners receive the substance abuse treatment they need, thus improving the care their patients receive.

by Stanley L. Denton, LCSW, CEAP, and Martha E. Brown, M.D.

Nancy Smith, a nurse, completed the substance abuse treatment program to which her employee assistance program (EAP) had referred her six months earlier. It was now time for her to renew her nursing license. She completed her renewal application and indicated she had been treated for alcoholism. One month later, she was informed by the nursing board's impaired professional program (IPP) she would have to resubmit to an evaluation of their choosing, with possible additional treatment.

John Brown, a doctor, had a long history of substance abuse. He informed his supervisor of his problems and was referred to the medical board's IPP. Two months later he returned to work, but nothing was said about the referral to the IPP. The following year, one of his patients died, and the patient's family filed a malpractice suit.

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During the investigation, Dr. Brown's treatment for substance abuse came to light. It was noted that the hospital's administrators had not referred him to the EAP, nor did they have any official documentation of the referral to the IPP. In addition, the hospital had not attempted to monitor his treatment compliance. Had the administrators referred Dr. Brown to the EAP and monitored his compliance, they would have discovered he had failed multiple drug screens and also been diagnosed with bipolar disorder. The patient's family filed suit against the hospital for neglect employment, along with the malpractice suit.

EMPHASIZING RISK MANAGEMENT

Alcohol use, abuse, and dependency impose a heavy burden on society. The costs for health care secondary to alcohol and substance abuse treatment, as well as for losses stemming from reduced workplace productivity, premature death, crime, and legal problems, number in the billions of dollars.[1] Workplace productivity losses alone are estimated to cost the United States $89.5 billion per year.[2] In addition, two million American workers report being victimized each year by workplace violence, costing employers billions of dollars.[3]

Behavioral risk management has become a major concern for both health care professional licensing boards as well as the health care industry in general. Multiple studies indicate many health care professionals are at risk of developing, or already are experiencing, substance abuse and dependency problems. McAuliffe and others, for example, reported that 59 percent of physicians had used psychoactive drugs in their lives, while one in four had abused prescription drugs and one in ten currently use drugs regularly.[4] Brown and others report that much remains to be done for the health care profession to both recognize and provide treatment for impaired health care professionals.[5]

A growing number of health care licensing boards are responding to substance abuse problems among health care professionals by establishing IPPs, while the health care industry is developing various internal programs. The impetus for these programs varies: The concern for public safety, for example, has pushed many licensing boards to increase the role they play in monitoring the treatment and care provided by their licensed professionals. While public safety is certainly a major concern, there are other issues that need to be considered, including increased litigation, liability risks, and costs resulting from the presence of impaired professionals in the workforce.

These issues have driven the development of many corporate risk management programs. Although the development of IPPs and internal risk management programs have run along parallel lines, limited attention has been paid to the need of these programs to interface and work together to meet the objectives of both. A primary challenge facing the health care industry and IPPs is to provide services that complement one another while also ensuring the professional's needs are met.

Employee assistance programs are in a unique position to interface between the workplace and the IPP, filling the gap in providing services and sharing information. Additionally, the EAP can moni-

tor the effectiveness of the IPP as well as the quality and type of services provided to the health care professional. It is with these concepts in mind that we offer the following guidelines for the effective interfacing of EAPs and IPPs.

FINDING COMMON GROUND

For EAPs and IPPs to interface effectively, they must resolve issues pertaining to intervention, referral, return to work and fitness for duty, disciplinary action, and monitoring of aftercare treatment. An effective collaborative effort requires the programs to broaden the scope of their intervention processes, extend their referrals to include one another, and coordinate their evaluation, treatment, and return-to-work plans.

Communication. The EAP and IPP need to establish a formal line of communication that goes beyond simply becoming acquainted with each other's programs. A protocol needs to be established so that each program communicates with the other throughout the intervention, treatment, and case management phases. Information that is shared can be invaluable in improving the quality of the assessment, ensuring that adequate treatment is received, evaluating return-to-work restrictions, and monitoring the case. All of these benefits contribute to the safety of the overall workplace as well as that of the health care professional.

Common ground. It is important for the EAP and IPP to establish common ground on treatment philosophy, treatment providers, costs for treatment, and drug-testing procedures. This will prevent health care professionals from having to undergo repeated evaluations and treatment, reduce the need for services that are not covered by insurance providers, and ensure the best outcome possible. The EAP can help the employer reduce health care costs by identifying needed changes in insurance coverage and ensuring the provider list meets the requirements of the IPP. In addition, the EAP can assist in the return-to-work process by modifying work schedules (to enable the individual to attend treatment) and offering needed supervision.

Licensed health care professionals have unique treatment needs related to confidentiality, time schedules, and specialized care that need to be addressed. These issues often pose distinct challenges for treatment providers. IPPs are in an excellent position to evaluate the effectiveness of treatment providers who serve their licensed professionals.

Supervisory dual referral. Collaborative interventions and referrals have several advantages for both the IPP and the EAP. The control that an IPP wields over the health care professional's license is a critical motivation for impaired professionals in denial. A mutually-agreed-upon recommendation not only sends a strong message to the impaired health care professional, it also adds support to each program when these cases go to court or in front of a licensing board.

Collaboration in the areas of intervention, referral, return to work, disciplinary action, and monitoring of aftercare treatment is imperative.

Although EAPs often are not directly responsible for referring health care professionals to IPPs, they are in an excellent position to educate workplace supervisors and administrators and staff of the IPPs in their state. The requirements for reporting an impaired or potentially impaired health care professional to licensing boards run the gamut, from no reporting obligation in some states to mandatory reporting in others. Additionally, given that IPP policies vary from profession to profession and state to state, EAPs can be invaluable in helping new employees from other states obtain services required by the IPP in their new state.

Drug testing. Many IPPs and health care facilities have mandatory drug testing programs. Procedures to share drug test results can be established to prevent duplicate testing. This reduces the cost to the company and/or the individual.

IPPs and EAPs often test for more than the so-called "DOT 5" (marijuana, cocaine, amphetamines, opiates, and PCP). In health care settings it typically is necessary to test for several controlled substances, given the easy access many health care professionals have to controlled substances. The Department of Transportation (DOT) has developed drug-testing standards that have stood the test of the legal system. Following these standards as closely as possible minimizes the possibility of lawsuits and/or reversals of drug-testing results.

While many workplaces and most IPPs follow the DOT guidelines, some do not. To avoid ending up in court without a defense, accept only drug test results that meet your program standards. Before you agree to share drug test results, ask the following questions:

1. Are DOT guidelines being followed, except possibly for the number and/or type of drugs being tested for? If not, why not?
2. What is the collection process?
3. Is a chain of custody used?
4. What laboratory is used?
5. What types of screening tests are performed?
6. What drugs are targeted by the test?
7. Are positive test results being confirmed through gas mass spectrometry (GC/MS)?
8. Is there a Medical Review Officer? If so, do all positives go through the MRO?
9. What is the random selection process for monitoring?
10. How often are health care professionals tested for drugs?
11. How soon after receiving notification of the need to undergo drug testing must a health care professional be tested?
12. What is the process for dealing with prescriptions for controlled substances written by "helpful colleagues" or received through "doctor shopping?"
13. What is the process for appealing drug test results, and what is the health care professional's status during the appeal process?

14. Is the EAP notified when an appeal is taking place?

The EAP can serve multiple roles in the drug-testing process, including interpreting the significance of positive or negative tests. The EAP also can (1) facilitate communications with a firm's substance abuse professional, (2) ensure that drug panels include the drug(s) the health care professional is known to abuse and those readily available to him/her at work, and (3) help develop a "stand down" procedure for health care professionals whose positive drug test results are being appealed.

Policies and procedures. EA professionals should sit down with IPP representatives in their states and compare policies and procedures. Significant elements to review include the following:

1. Is there a return-to-work or fitness-for-duty policy? Do these policies and procedures complement one another, or do they conflict?
2. With respect to the Americans with Disabilities Act (ADA), what is the policy if a health care professional needs the employer to make reasonable accommodations so s/he can perform essential job functions? The IPP is in an excellent position to assist the EAP in gathering the needed documentation that will help the professional. The EAP, on the other hand, can serve as an internal advocate for reasonable accommodations or employee benefits.
3. Are procedures in place for coordinating return-to-work plans and making any needed modifications for the work setting? If treatment is ongoing, are recommendations concerning the work setting listed as part of the treatment plan?
4. If both the EAP and IPP have return-to-work contracts with the impaired professional, do they support one another or impose conflicting requirements? Is there a procedure for the two programs to share this information with each other?
5. What plans are in place for monitoring treatment compliance? What is the protocol for sharing information and procedures should the health care professional fail to comply with the treatment program?

SUPPORTING PROPER TREATMENT

When patient safety is at issue, the margin for error is minimal and the liability risks are great. Multiple problems can arise in case of a failure to establish a formal relationship between a health care workplace setting, the EAP, treatment providers, and the IPP. These problems include duplication of services, competing or conflicting treatment recommendations, missed information, inadequate case management, and risks to patients and employees.

Employee assistance programs and impaired professional programs are in a unique position to form an alliance to support proper treatment of health care professionals and ensure their safe return to work. Collaboration in the areas of intervention, referral, return to work, disciplinary action, and monitoring of aftercare treatment is imperative. This alliance will improve the effectiveness of their respective programs, enhance the quality of care for the identified health care professional, and reduce the liability risk for all. ■

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SAP Services: A Natural Extension of EAPs

Providing substance abuse professional services can make EA professionals better aware of the trends and treatments in the substance abuse area and increase their value to employers and employees alike.

by Sue Tignor, LSW, CEAP, Richard Hoernemann, LPC, CEAP, and Linda Lindsey, LPC, CEAP

The provision of substance abuse professional (SAP) services is an ideal growth opportunity for a "best practice" employee assistance program. SAP services are, after all, a natural extension of what our profession has been doing since its inception (with some modifications).

Long before drug-testing legislation had even been considered by federal and state legislatures, employers had identified substance abuse as a workplace issue and established EAPs to address it. Prior to World War II, businesses like Ford Motor Company had begun to focus on the negative effects of alcohol abuse on family life and workplace productivity. During the war, as worker shortages developed, employers sought outside assistance (e.g., the Yale Plan for Business and Industry, a forerunner of EAPs) to further address the impact of alcohol on personal and work lives. Later, as more workplaces became unionized and EAPs began to proliferate, termination ceased being the preferred method for addressing declining work performance stemming from alcoholism. More recently, the rise of Alcoholics Anonymous and other 12-step programs, treatment centers, and social welfare programs influenced the development of a new perspective on alcohol abuse, one that emphasizes recovery and return to work.

As these developments progressed, EAPs established themselves as workplace substance abuse experts and began to partner with key organizational players. These partnerships have enabled EAPs to exert significant influence on workers' health and wellness, workplace productivity, and business costs, all of which are inextricably linked. Having evolved from "helpers" performing one-to-one counseling in the background to sitting at the boardroom table where policy decisions are made, we are now in a pivotal position to educate employers about sound practices that affect what most of them agree is their most valuable resource—their employees.

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INHERENT LIABILITY

About 75 percent of substance abusers are employed, and employers are painfully aware of both the obvious and hidden costs of their behaviors—increased absenteeism, lower productivity, higher accident rates, greater utilization of sick leave, and so on. Health care providers estimate that anywhere from 20 to 40 percent of all general hospital admissions can trace their complications to an untreated addiction, significantly contributing to the escalating costs of health care footed (largely) by employers.

It is well documented that EAPs can help lower these costs, both by identifying substance abuse early and by improving treatment outcomes. Positive treatment outcomes facilitated by EAPs have been reported by firms such as Gillette, Ramada, Warner, Marsh and McLennan, Tropicana, Southern Edison, and Sawyer Gas. Employers consistently document at least a 3:1 return for every dollar invested in an EAP, and it is this ratio and similar outcomes that support and promote our role as productivity experts in the workplace.

Assuming the role of an SAP can position an EAP to provide an even better return on an employer's investment and broaden the professional expertise of an EA practitioner, but it's a challenging task that entails new risks and responsibilities. Although EAPs are ideally positioned to assume the additional responsibilities of SAP work, they should do so only with a clear understanding of the differences between EA and SAP functions and the inherent liability in blending the two. The EA professional historically has had a clearly defined role, the basis of which is the confidential, therapeutic relationship with the employee. With the assumption of the SAP role, however, that relationship is subject to different constraints and responsibilities.

As a substance abuse professional, you are an advocate for neither the employer nor the employee. Your function is to protect the public interest in safety.

The U.S. Department of Transportation's regulations pertaining to drug and alcohol testing of employees in the transportation industry couldn't be more clear about this. As a substance abuse professional, you are an advocate for neither the employer nor the employee. Your function is to protect the public

interest in safety by professionally evaluating the employee and recommending appropriate education/treatment, follow-up tests, and aftercare.

In the traditional employee assistance role, a recommendation for treatment is based on whether the employee's presenting symptoms meet diagnostic criteria for abuse or dependence. In the SAP role, however, there may be overriding safety concerns that warrant a recommendation for treatment even if the standard diagnostic criteria for abuse or dependence are not fully met.

To fulfill the role of a SAP, the EA professional must thoroughly understand 49 CFR (Code of Federal Regulations) Part 40, the federal rules governing drug and alcohol testing of employees in the transportation industry, and particularly the subparts relevant to the role of the SAP. The initial implementation of DOT rules did not require that SAPs be trained, but the rules revisions that took effect in August 2001 now require extensive training, the successful completion of an exam, and the acquisition of 12 continuing education units (CEUs) every three years to maintain eligibility to perform SAP/DOT work.

TASKS THAT ENTAIL RISKS

Our firm's internal EAP experience with second-chance agreements spans 15 years. Because of our understanding of the supports that are in place, the contract requirement, and our role, we achieve an 80 percent success rate of retaining employees referred for alcohol/drug policy violations. We have a clear understanding that the safety of everyone in our company (in the health care field) is the foremost consideration and that a drug-free workplace is ultimately in the best interest of all patients, employees, and visitors. This understanding has created a win-win situation for all and applies to the provision of SAP services to other employers.

Administrators of more risk-adverse EAPs will contend that the liability concerns are too great to provide SAP services, but we submit that our daily work is loaded with tasks that entail risk. EA professionals commonly find themselves making decisions when conducting ADA (Americans with Disabilities Act), child and elder abuse, and violent risk assessments. Additionally, we conduct critical incident stress debriefings and advise companies in the aftermath of threats and trauma.

Much of the liability risks facing EAPs conducting SAP work stems from the EA professional's failure to fully understand the SAP's role. For example, the EA professional who misunderstands the Department of Transportation's return-to-duty process might easily be drawn into conducting a fitness-for-duty evaluation, but doing so goes beyond the SAP's role as specified in the DOT rules and increases liability risk. DOT regulations require the *employer* to determine whether the employee should be returned to the job. SAPs can minimize their liability by basing their recommendations on the employee's compliance with the prescribed treatment plan and by avoiding speculation about the prognosis for continued recovery.

Not surprisingly, we've found that the term "substance abuse professional" is used quite loosely. In addition to those who have taken the training and passed the qualifying exam, there are many people functioning as "non-DOT" SAPs. People in this role perform similar functions in that they assess presenting symptoms, make recommendations for further services, conduct case management duties, and generate plans for ongoing, unannounced testing.

The employees they're working with, however, may or may not perform safety-sensitive duties and are not in positions affected by DOT regulations. Their employer typically is enforcing a drug-free workplace policy which mandates that an employee who tests positive be assessed by a SAP before returning to duty. These "non-DOT" SAPs also provide drug-free education for supervisors and employees.

EXTENDING OUR REACH

As EA professionals we must ask ourselves: Do we really want to relinquish SAP work to, say, psychologists and social workers? Based on our experience, we believe SAP services are a good fit for EAPs. The U.S. Department of Transportation apparently agrees: In establishing minimum qualifications to become a SAP, the department recognized the certified employee assistance professional (CEAP) credential.

But because there are other credentials that qualify one to become a SAP, it may be erroneous to conclude that EA professionals are providing the majority of SAP services. Though there is probably no accurate tally available of the percentage of SAP services being provided by EA professionals, it is significant to note that many of the providers registered on SAPlists.com, for example, are private practitioners.

EAPs that perform SAP duties become much more aware of current trends and treatments in substance abuse, which ultimately translates into providing higher-quality substance abuse services. Extending our reach to provide SAP services only strengthens our effectiveness and positions us to intervene against substance abuse where the greatest opportunity exists: the workplace. ■