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September/October 1998

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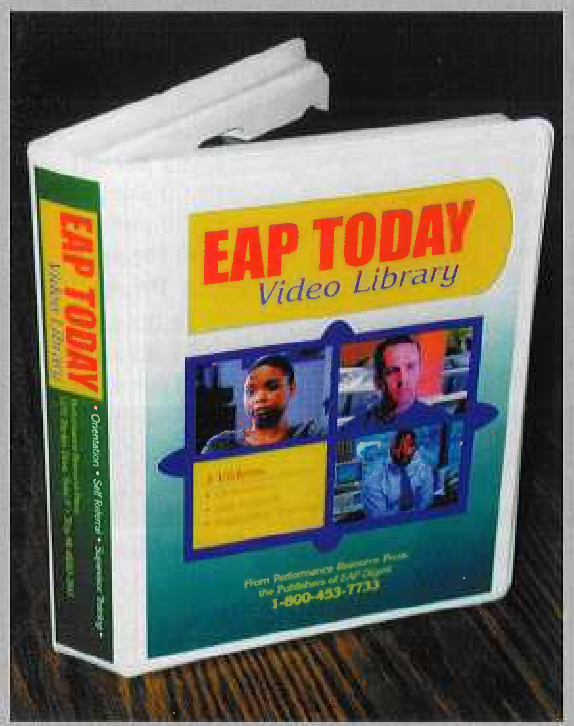

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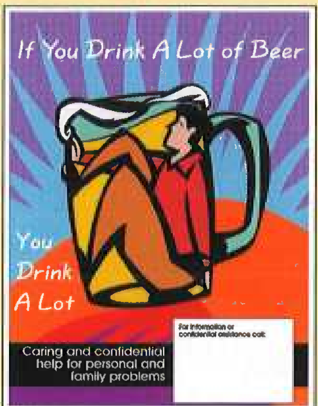

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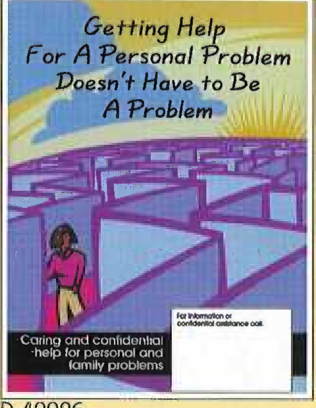

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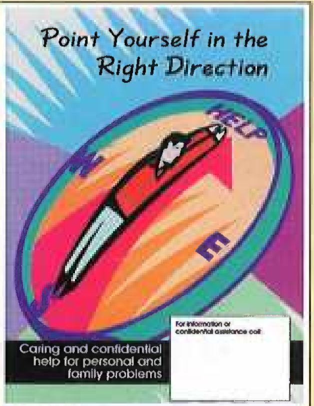

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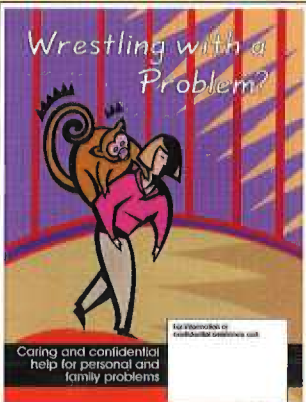

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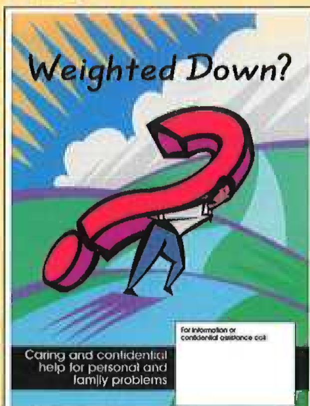

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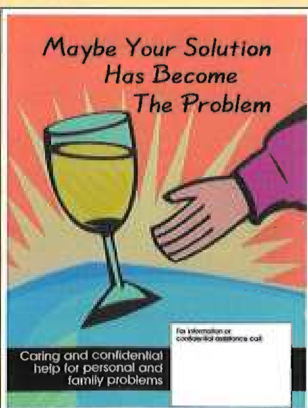

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The Voice of Employee Assistance Programs

Vol. 18 Issue 6 September/October 1998

COVER STORY

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MEASURING OUTCOMES

Do Clients Get Better?

It's a question customers have a right to ask. Consider using any of these client self-report tools to help find the answer.

By K. Jeff Fladen

PLUS...

7 Beyond Symbols in this issue's *In House*

Legislation proposing parity for substance abuse treatment will likely pass. But true parity can only be achieved if the forces that have dismantled the nation's substance abuse treatment system are put in check.

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By Rick Selvik, LICSW, CEAP, and David Bingaman, LCSW, CEAP

24 The ABCs of the ADA

By the very nature of their work, EAP professionals are finding themselves more involved in matters regarding the Americans with Disabilities Act. Here's a primer on the act with some helpful steps to limiting EAP exposure.

By Roger Wapner, PhD, CEAP

27 The Status of EAPs in Higher Education

Compared to private sector employers, universities and colleges have been slow to develop EAPs and few have a formal drug testing program. Read about these and other developments on the higher education front.
By Mark J. Minelli, PhD, Richard W. Davenport, PhD, Robert L. DeBruin, PhD, and Sarah Campbell, RN, CS ANP

34 Ultrarapid Opioid Detox *in Close Up*

A new approach to treating heroin addiction has a remarkable success rate, say the treatment professionals who practice it. But few in the medical community are as optimistic.
By Brent Chartier

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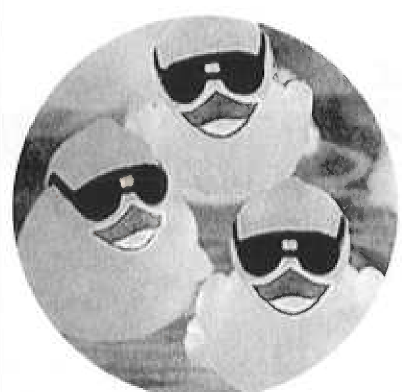

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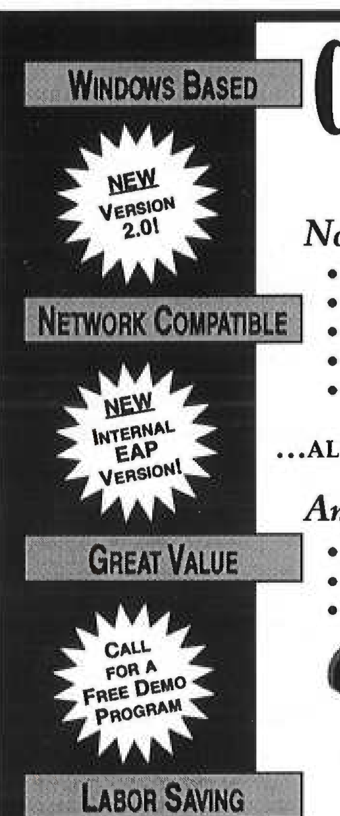

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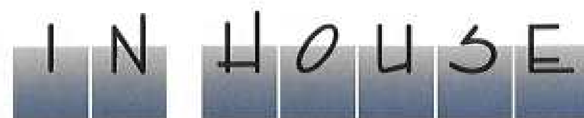

Beyond Symbols

The Substance Abuse Treatment Parity Act may look good on paper, but parity in practice is what's needed.

With mental health parity now law, it's likely that the Substance Abuse Treatment Parity Act now before Congress will soon pass.

Big deal. The act addresses none of the forces that have effectively dismantled the nation's substance abuse treatment system in recent years.

In fact, the act will likely become more famous for what it *doesn't* do than for what it *does*. It *doesn't* require companies to provide substance abuse coverage. It *doesn't* create a more expedient system for handling appeals from patients who've been denied care. It *doesn't* require managed care firms to disclose how they decide who gets care. And it *doesn't* ensure that people who need substance abuse treatment will get the care they need.

Language from a National Association of Alcoholism and Drug Abuse Counselors (NAADAC) fact sheet makes it clear that the act is little more than a symbolic gesture to both patients *('Congress feels your pain')* and the substance abuse treatment field *('Your contributions really do matter, really')*: "This bill does not mandate substance abuse coverage. Group health plans are not required to provide any substance abuse treatment benefits. Employers may use medical necessity criteria."

Well, enough with the symbolism. The substance abuse treatment industry has been the healthcare community's lost child for far too long. Facts prove that alcohol and other drug addiction is the costliest health problem facing our nation. Facts prove that no part of a company is immune to the influence of addiction. And facts prove that addiction treatment works.

George T. Watkins
Publisher
EAP Digest

I ask you to join me in supporting parity for substance abuse treatment as a first step, but by far not the only step in ensuring that substance abuse treatment gets the respect it deserves. We also must advocate passage of laws that require health plans to cover the full continuum of treatment services at levels on par with coverage for medical and surgical benefits; that require all physicians and healthcare and criminal justice professionals to receive training on addiction, its signs and symptoms, and its treatment; that require the managed care industry to reveal how patient placement is determined so that purchasers and consumers can make an informed choice; and that require state insurance commissioners to monitor managed care practices and establish boards of review to expedite patient and therapist appeals.

I urge everyone reading this to become actively involved. For updates on the substance abuse parity legislation, phone NAADAC at 703-741-7686 or visit their Web site at www.naadac.org/legis.htm. Other good resources are Join Together (617-437-1500 or www.jointogether.org), which advocates sound public policy on substance-abuse related issues, and The Henry J. Kaiser Family Foundation (202-347-5270 or www.kff.org), which regularly issues health policy reports related to managed care practices. ■

Publisher,
George T. Watkins

MARKETPLACE

■ Toshiba American Medical Systems is the latest company to offer **WellCall** services to employees. The San Francisco-based WellCall provides preventive and complementary healthcare education, counseling and referral services. (Phil Siegel, 415-333-1650)

■ Mired in the perception that it provides only legal services in the Midwest, Midwest Legal Services has changed its name to **ARAG Group**. In addition to being the largest administrator of employer-sponsored legal plans, the company offers financial guidance, tax advice and other services to employers. (800-888-4184 or 515-246-1200)

■ **COMMANDisability** is a new short- and long-term managed disability product offered by Trans-General Life Insurance Co. of Pittsburgh. The program relies on RN case managers who apply managed care protocols to employees on disability leave. Call 800-328-5433 or 412-544-1000.

■ The Berkeley, California-based **Pathmakers** has purchased six outpatient clinics in the Denver/Colorado Springs area. Pathmakers has provided behavioral care services to northern California communities since 1982. (Tim Harrall, 510-704-2452)

■ **Human Affairs International** (HAI) will provide EAP services to the 65,000 employees and dependents of R.R. Donnelley & Sons, the world's largest printer. Also, **Magellan Behavioral Health**, which owns HAI, has been selected to provide managed behavioral care services to the more than 200,000 members of the Farmington, Conn.-based ConnectiCare. With contracts serving more than 62 million people, Magellan is the nation's largest managed behavioral care company. (Erin Somers, Magellan, 410-964-1593)

■ Atlanta-based **Charter Behavioral Health Systems** (CBHS) has announced it will purchase five psychiatric hospitals and the contract management business of **Ramsay Health Care** of Coral Gables, Fla. The five hospitals are located in Houma, La., Conway, SC, Mesa, Ariz., and DeSoto and San Antonio, Texas. (Donna Wood, CBHS, 678-297-4440) ■

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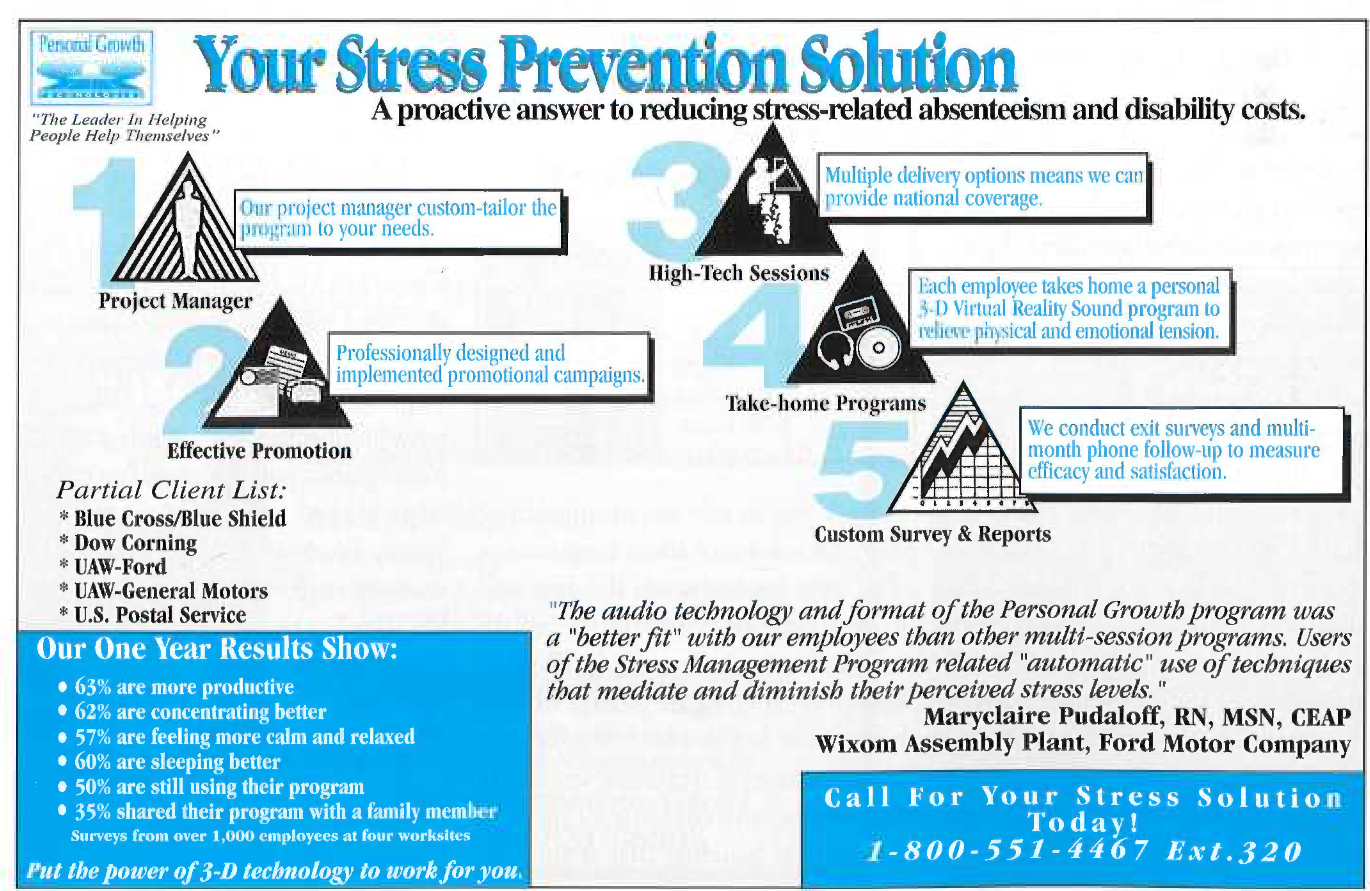

Reader Service Card #6

TRANSITIONS

■ **Thomas W. Kozlowski, PhD,** former director of operations for behavioral health care services at the Joint Commission on Accreditation of Healthcare Organizations, has been named director of quality management at PacifiCare Behavioral Health of Laguna Hills, Calif. Kozlowski will oversee PacifiCare's National Committee for Quality Assurance activities.

■ A corporate restructuring has led to several staff changes at Pioneer Behavioral Health of Peabody, Mass. **Robert Boswell,** formerly executive vice president, has been named senior vice president. **Michael Cornelison,** formerly regional director of operations, has been promoted to executive vice president of operations. Also, **Lowell Foster** has been appointed to the new position of executive vice president, managed care. He had been president of MedOne Health Plan, a Columbia/HCA subsidiary.

■ **Jim Rascati** has joined ETP Inc. of E. Hartford, Conn. as marketing director. He had served as director of EAP for NovaMed Corp. and as vice president of marketing for Green Spring Health Services. ETP is a health and human resource development firm with both corporate and military clients.

Jim Rascati

■ **Zohreh Y. Yamin** has been named executive director of Montana Community Partners, a public sector division of Magellan Behavioral Health. She had served as director of clinical operations and programs for MBC of Iowa.

■ Minneapolis-based Health Risk Management (HRM) has added two senior executives to its staff. **Gerald Osband, MD,** has been named executive vice president and corporate medical director, and **Julia Campion** has been named vice president of managed care consulting. Both Osband and Campion will be working with one of HRM's key market segments, at-risk HMOs. ■

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About the Author

Sandra Nye received her JD from De Paul University College of Law in 1982 and her MSW from Loyola University School of Social Work in 1974. Ms. Nye is principal of the Chicago law firm of Nye and Associates, Ltd., concentrating in law related to human service delivery and family law. She is author of three editions of the *Employee Assistance Law Answer Book*, and of numerous articles and chapters on legal issues in human service delivery.

Reader Service Card #7

Survey Shows Employees Reluctant to Use Work/Life Benefits

Most employees rank work/life benefits about as important as health insurance, but almost half of the employees responding to an Intracorp and Gallup Organization survey hadn't used a work/life benefit in the past year. That's because many don't believe these services are confidential, don't believe their managers are supportive and don't want to be chided for using benefits that may mean more work for their co-workers. "Companies may offer work/life programs, but they're not making them easy to use," says the Gallup's Robert Schussel. "And employees feel that using these benefits might jeopardize their job or advancement opportunities." Companies that encourage use of their work/life benefits tended to have healthier, more satisfied employees, according to the survey. And employee satisfaction rose with the number of work/life benefits offered. The most frequently used work/life benefits are flex-time (used by 30 percent of employees); family leave (18 percent) and long-term-care insurance (17 percent). Child care resource and referral (4 percent), on-site day care (2 percent) and elder care resource and referral services (2 percent) were the least used. (Intracorp, 800-345-1075)

Health Plan Rates May Rocket in 1999

Healthcare purchasers may have to dig deeper into their pocketbooks next year. Watson Wyatt, a consulting firm, predicts double-digit price hikes for all but HMO and point-of-service health plans. The reasons: an aging population is driving utilization up; the public is demanding more expensive lifestyle drugs, such as Viagra, the male impotency pill; HMO share prices and earnings have been hit hard on Wall Street, leading executives to be more dollar conscious; managed care discounting has reached saturation in some markets; and technological advances have made it more expensive to do business. EAP marketers might take advantage of the situation by educating employers on the cost-offset benefits of having an EAP. (Solutions, 6/98)

Prepare to Be Accredited, Advises EASNA VP

External EAP providers from the United States should do like many of their Canadian counterparts and begin preparing for program accreditation through the Employee Assistance Society of North America (EASNA), advises Barbara Marsden, LISW, CEAP, EASNA's first vice president and EAP manager for Genesis Health System in Davenport, Iowa (program accreditation should not be confused with peer certification through the Employee Assistance Certification Commission or professional licensure, which is being considered in many states). Marsden chairs EASNA's Committee on Accreditation. She believes stateside EAP vendors will start seeking program accreditation because of the sale of the Canadian EAP vendor, CHC, to the Columbia, Md.-based Green Spring Health Services earlier this year. "CHC is already accredited. But now that Green Spring has a majority interest in CHC, Green Spring will have to apply for accreditation when CHC is up for renewal in 2000," she says. And that should start a wave of accreditation requests from EAP vendors competing with Green Spring in the United States. Accreditation has caught on in Canada because Canadian companies often hire consultants to head-up their EAP selection process, and Marsden says most consultants prefer EASNA accreditation in their selection criteria. EASNA has offered accreditation since 1990. Since that time, 96 EAP providers — two-thirds of them from Canada — have applied for accreditation. For more information on accreditation, contact either EASNA at 312-644-0828 or Marsden at 319-421-3660.

Investigation Finds Doctors Profit from Rights to Grow Tobacco

A cross-check of people holding federal rights to grow tobacco with medical rosters shows more than 760 doctors and other healthcare workers own rights to grow more than 7 million pounds of tobacco — enough to keep 264,000 people on a two-pack-a-day habit for a year. "To own and farm and produce tobacco as a doctor sends a resoundingly wrong message," says Arthur Caplan, a University of Pennsylvania medical ethicist. Few of the people who hold the growing rights actually grow tobacco themselves. Most lease their rights to family members or sharecroppers for a profit, according to an Associated Press investigation. The cross-check found growing rights were held by all types of doctors, including family practitioners, psychiatrists, oncologists and surgeons. One doctor was a regional medical director for the American Cancer Society. Another wrote health tips for a local newspaper. (Associated Press, 6/29/98)

Safety and the Telecommuter's Workspace

Employers have yet to receive firm guidance from either OSHA or the states as to what they can and cannot do to ensure that a telecommuter's home workspace meets the same safety standards as the commercial workplace. Then how can employers lessen their exposure? That very question was addressed in the spring issue of Safe Workplace. Of course the best way to root out hazards in a telecommuter's home is by physical inspection of the area, but that practice raises issues about violation of privacy and perhaps even harassment. The article recommends giving employees reasonable notice that their workspace will be inspected at a certain time. There's also the question about which injuries are compensable. For example, say a telecommuter is assaulted in his or her home workspace. Is this workplace violence? It's a question that awaits an answer from either OSHA, workers' comp boards or the courts.

Test for Alcoholism Claims to Be the Most Accurate Ever Developed

Researchers at the University of North Carolina's Bowles Center for Alcohol Studies have developed a test for alcoholism that they claim is 85 percent accurate. That would make it the most accurate ever developed. Interestingly, the test isn't at all high tech and has little in common with our current understanding of the disease. Writing in a recent Alcoholism: Clinical and Experimental Research, the UNC researchers say two indicators — a sweet tooth and a particular personality trait — accurately predicted alcoholism in 85 percent of 78 men tested. To learn if they had a sweet tooth, subjects were asked about the types and frequency of desserts they ate. As for the personality trait, researchers say subjects who tested positive for alcoholism appeared, in simple terms, to love what they feared most. They gave the example of someone "who might love to sky dive, but is afraid to go on an airplane." (Join Together)

APA's New Online Journal Debates Antidepressant, Placebo Effect

It was a tennis match of words: The American Psychological Association (APA) unveiled the first article in its peer-reviewed, electronic journal Treatment & Prevention, and professionals from all over the country volleyed back their responses. In the article, "Listening to Prozac but Hearing Placebo: A Meta-Analysis of Antidepressant Medication," researchers Irving Kirsch, PhD, of the University of Connecticut and Guy Sapirstein, PhD, of Westwood Lodge Hospital, Needham, Mass., reviewed 19 studies to determine whether antidepressants work because patients want them to or because they corrected a patient's chemistry. Their conclusions: Fully 75 percent of the beneficial effects of antidepressants can be traced to the placebo affect — antidepressants work because patients believe they will. After the online article appeared, researchers from across the country responded almost immediately. A Columbia University researcher found fault with almost every aspect of the article. A Carnegie Mellon University psychologist called it seriously flawed and oversimplified. Visit the journal at the APA's Website, www.apa.org. If the first Treatment & Prevention is any indication, future issues should make for lively reading. (APA, 202-336-5700)

Fellowships To Help Reduce Stigma of Mental Illness

In addition to their work with Habitat for Humanity, former President and First Lady Jimmy and Rosalynn Carter have adopted mental illness as a service project. The Atlanta-based center named in their honor is both a think-tank and advocate for improved public policy for mentally ill people and their loved ones. The center recently awarded $10,000 fellowships to five journalists to encourage accurate coverage of mental health issues and to discourage stereotypical language and images that perpetuate stigma and discrimination against the mentally ill, says Dr. John Gates, director of the center's mental health program. The fellowships were awarded to a New York radio producer investigating cultural barriers to getting mental health care; to a US News & World Report senior writer investigating the impact of managed care plans on long-term psychological therapy; to a public radio correspondent studying employment and education challenges among the mentally ill; and to two freelance writers, one investigating mental illness and aging, and one looking into how Abraham Lincoln coped with depression. For more information on the fellowships or The Carter Center, call 404-420-5126.

Call this Condom A Money Saver

Condoms help prevent pregnancy and the spread of some diseases. But can they keep credit card spending to a minimum? A condom developed by the National Center for Financial Education (NCFE) can. Users place their credit cards in the NCFE's condom, which is actually an envelope with warnings printed on both sides about the dangers of frivolous spending. NCFE also sells a credit card warning sticker. Both the condoms and stickers can be used as part of an EAP training on budgeting or financial management. For pricing and ordering information, contact NCFE at 619-232-8811 or write NCFE Credit Protection, PO Box 34070, San Diego, CA 92163-4070.

ODDS & ENDS

TOP 5 The most common reasons employees give for a positive drug test — and why they're wrong.

1. *"I've been using ibuprofen."* Reality: Someone taking ibuprofen will not test positive for marijuana use because tests can distinguish between the two.
2. *"The test is wrong. I don't do drugs."* Reality: Government-certified testing labs and collection sites follow a strict, three-step testing process. False test positives are extremely rare.
3. *"You must have tested the wrong urine."* Reality: The procedures used by government-certified are as strict as those used by the courts to secure evidence.
4. *"I've been eating hemp-based foods."* Reality: Eating hemp burgers, hemp chocolates or other hemp-based products will not trigger a positive test.
5. *"I was at a party where people smoked marijuana, but I didn't."* Studies show that it's highly improbable that someone could ingest enough second-hand marijuana smoke to fail a drug test.

Source: Beth Lindamood, senior analyst, Great American Insurance Companies, Cincinnati, Ohio, 1-888-788-4242.

EAP PROFESSIONAL

Federal agency seeking an Employee Workplace Intervention Analyst to administer the Employee Assistance Program at its facility located in Southeastern Michigan. This individual will provide management with information and feedback on program activities and develop recommendations to improve and increase management and employee support for the program.

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A Generation at Risk

Study finds that twice as many youths as adults have a serious gambling problem.

As more municipalities turn to casinos and other forms of gambling to increase revenues and liven up abandoned downtown areas, more and more people are gambling. Unfortunately, something more than revenues are increasing. A recent study shows that for every adult with a serious gambling problem, two young people struggle with the same issue.

Researchers who conducted one of the largest studies ever on the gambling habits of young people concluded that developing a gambling addiction is a greater threat to young people than developing an addiction to any drug, including tobacco.

University of Minnesota researchers surveyed 122,000 students to determine that between five and eight percent of 6th, 9th and 12th graders have a serious gambling problem compared with one to three percent of adults. Researchers also found that boys gamble more than girls, older youths more than younger ones, and ethnic minorities more than whites. Antisocial behavior, being male and frequent alcohol use increases the likelihood of the frequency of gambling.

Youths who are pathological gamblers were more likely to have parents with gambling problems, to be engaging in illegal activities and to have suicidal thoughts. Young males prefer gambling with sports lottery tickets and betting pools while young females prefer lottery tickets and bingo.

"With gambling becoming more accessible in U.S. society and having the first generation of youth be exposed to this widespread access, it will be important to be able to intervene in children's and adolescent's lives before the activity can develop into a problem behavior," say researchers.

(American Psychological Association, 202-336-5700)

NOTABLY

Availability of an EAP is listed as one of the nine best disability management practices in a report prepared by the Washington Business Group on Health and the Watson Wyatt Worldwide consulting firm. Other best practices include an examination by a medical specialist, labor's cooperation and supervisor/manager training. (Watson Wyatt, 800-243-1349)

For every $1 Americans put into equity funds, they gamble $2 on state lotteries, casinos and other forms of legal gambling. (*Money*, 7/98)

Americans spend $8.6 billion a year on psychotropic medications (drugs that have a special action on the mind). Doctors write about 208 million prescriptions for psychotropics each year. Roughly one-quarter of these are written by psychiatrists, the rest by family doctors, internists or other physicians. (*The Wall Street Journal*, 4/10/98)

Drug-testing giant SmithKline Beecham reviewed the results of 5 million drug tests to determine whether drug use is higher among employees in urban or rural areas. Surprisingly, rural areas such as southwestern Tennessee, western Indiana and northwestern Florida had test-positive rates of 8 to 16 percent, more than twice the 4 to 6 percent test-positive rates for large metropolitan areas like New York, Philadelphia and Los Angeles. Perhaps just as surprising, Miami, a city long considered as a hub for illegal drug trafficking, had test-positive rates averaging 3 percent. (Join Together)

The Internet is growing in popularity within HR circles. Almost all (95 percent) HR managers currently using the Internet to describe employee benefits plan to put even more HR information online in the future, according to a survey from the International Foundation of Employee Benefit Plans. HR departments use online technology to display health plan information (66 percent), employee manuals (48 percent) and pension/retirement plan information (47 percent). Almost 65 percent of HR managers surveyed have been online for less than a year. (International Foundation of Employee Benefit Plans, 888-334-3327, option 4)

Do you have clients who are fathers with a chronic health problem? Then be sure to ask how their children are doing in school, say researchers from the University of Florida College of Health Professions. Researchers have found that children whose fathers have a chronic condition have more behavioral problems than their peers — even peers whose mothers have a chronic health problem. (UF, 352-392-2844)

Here's an argument for early intervention: Two-thirds of the psychiatric patients surveyed say they waited four years before they sought treatment. (Global Alliance of Mental Illness Advocacy Networks, 718-351-1717)

Financial and retirement planning education top the list of employee benefits businesses have targeted for expansion in the coming year, according to a survey conducted by *Employee Benefit News (EBN)* and the Hay Group. Hewitt Associates estimates that the number of employers offering group financial planning services will triple by the year 2000 to more than 27 percent of all employers. CIGNA asked new employees to rank the benefits most important to them. The company's retirement plan placed first (67 percent) followed by medical benefits (58 percent), vacation time (39 percent) and a flexible work schedule (39 percent). (Sources: ARAG Group, 515-246-1200; CIGNA, 215-761-8573; *EBN*, 212-765-5311)

In satisfaction surveys conducted with 140 patients who were counseled by a therapist over a live video hook-up, 100 either agreed or strongly agreed that they could talk to their therapist by video as well as they could in person. Only 22 patients said the video camera made them feel self-conscious. (*Behavioral Disease Management Report*, June 1998)

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Reader Service Card #8

FURTHERMORE . . .

✔Diversity management, preventing sexual harassment and legal issues in business are among the more than 800 seminars available through PBS The Business Channel. Seminars are offered by satellite or over the Internet. EAP professionals interested in enhancing their training efforts through PBS The Business Channel are encouraged to call 888-822-8229 or visit www.PBSbusinesschannel.com on the Internet.

✔The American Psychiatric Association has developed a half-hour video to aid in the self-management of clients diagnosed with schizophrenia. *Critical Connections* uses case histories and testimonies to stress that patients should accept their illness, commit to therapy and stay on their medication regimen. The video is free for the asking. Send requests on company letterhead to APA, Division of Public Affairs, 1400 K St., NW, Washington, DC 20005; or fax to 202-682-6255.

✔Trainer's Tools Online, located on the Dartnell Corporation's Website (www.dartnellcorp.com), offers visitors free activities, articles and assessments to enhance their skills and the value of their trainings. The site also displays information on hundreds of books, newsletters, videos, tapes and workbooks available through the company.

✔The Gallup School of Management offers seminars based on the many hundreds of Gallup Organization surveys conducted over the past 30 years. Seminars are designed for executives from both the public and private sectors and center on such business fundamentals as employee productivity and attitudes and organizational development. For a course catalog, call 800-228-8592 or 402-486-6406 or write The Gallup School of Management, 47 Hulfish St., Princeton, NJ 08542.

✔EAP professionals may be interested in four specialty sections of the American Public Health Association (APHA) — Alcohol/Tobacco and Other Drugs, Disability, Mental Health and Occupational Health and Safety. Each section publishes a newsletter and keeps members current in other ways, and section membership is included with the annual $125 APHA membership fee. All APHA members receive conference discounts and two monthly publications, the *American Journal of Public Health* and *The Nation's Health*. For information, call 202-789-5600 or write APHA, 1015 15th St., NW, Washington, DC 20005-2605. ■

Reader Service Card #9

NCADD Intervention Network Goes Regional

Service Update

The National Council on Alcoholism and Drug Dependence's (NCADD's) Intervention Network has opened 8 regional offices. Anyone seeking intervention services for an alcohol or other drug dependent person is encouraged to contact the regional office covering their state. Professionals interested in providing intervention services should call 212-206-6770, ext. 14, for more information.

Region 1 (Ariz., Calif., Hawaii, Nev., Ore., Utah, Wash.): 805-963-1433
Region 2 (Ark., Colo., Kan., La., N.M., Okla., Texas): 713-520-5502
Region 3 (Ala., Fla., Ga., Miss., N.C., S.C., Tenn.): 404-351-1800
Region 4 (Conn., Maine, Mass., N.H., N.Y., R.I., Vt.): 212-252-7001
Region 5 (Del., District of Columbia, Md., N.J., Pa., Va.): 215-345-6644
Region 6 (Ind., Ky., Mich., Ohio, W.Va.): 216-431-4131
Region 7 (Idaho, Ill., Iowa., Minn., Mo., Mont., Neb., N.D., S.D., Wis., Wyo.): 414-475-2363
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HEALTH SENTRY™

Volume 11, Issue 4

CRYING

There's an unwritten code about crying at work. Here's what to do if you find yourself tearful on the clock.

Have you ever cried at work? Maybe a boss or co-worker's criticism hit hard and you started to cry. Or the pressure was on, you were close to deadline, you just didn't think you could make it and the tears just started to roll.

Crying is nothing to be ashamed of. It's normal, natural, even healthy. However, the stigma attached to tearfulness and unwritten workplace codes may make us feel embarrassed or uncomfortable when it happens. Someone who cries at work may be viewed as weak, unstable or unbusinesslike. In fact, fully three-quarters of the employees who responded to a national survey said work is "not the place to let your emotions show" and that crying at work "should be done in private."

But that may be easier said than done. For instance, crying is a normal part of the grieving process. Someone who lost a loved one or who is going through divorce may tear up at any time—late at night, during work, after something that reminds him or her of the loss, whenever. In fact, people who don't allow themselves to grieve normally risk other problems, including depression and some physical ailments.

Crying is also associated with stress (see article at right). Deadlines, quotas, an impending layoff or department restructuring—today's workplaces are demanding and stressful. In response, some people may experience what one EAP counselor called "spontaneous tearfulness"—crying for no apparent reason.

Whatever the reason, if crying at work makes you uncomfortable, consider the following.

- If you feel tearful in the presence of others, excuse yourself. You don't have to give a reason, just say you're upset and would like to talk about it later.

ABOUT THOSE TEARS

- If you feel that you might cry, try to relax by breathing deeply or thinking about something other than what's causing your tearfulness.
- Tearfulness sometimes follows criticism. If you've had trouble with criticism before, talk to your employee assistance program for help in developing more constructive ways to handle it.
- If there's no apparent cause for your tearfulness, it may be a sign of something else. Professional counseling may help you to take better control of your emotions. Contact your employee assistance program.

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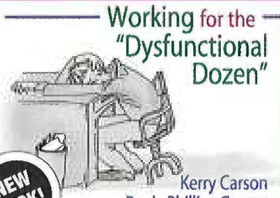

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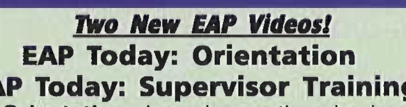

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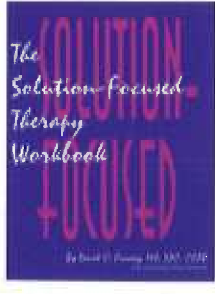

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MEASURING OUTCOMES

Do Clients Get Better?

By K. Jeff Fladen

Several outcome tools can be used to prove how effective EAPs are in helping employees get better

"Do employees get better after they've seen you?"

It's a question purchasers have a right to ask their EAP vendor. Too bad most vendors are tongue-tied when it comes to an answer. They may point to a few testimonies taken from client satisfaction surveys, but two or ten or a dozen success stories hardly represent all employees who've come to the EAP. Besides, most satisfaction surveys ask service related questions, not whether and to what extent a client's life was changed as a result of his/her participation in the EAP.

A vendor might then turn to any number of tables or charts it collects as a normal part of its reporting function — utilization rates, number of sessions provided, types of problems treated, etc. — to answer the question. But describing what an EAP does isn't the same as answering whether clients improve.

A determined vendor might pull out all the stops, producing elaborate analyses of accident and absentee rates, employee turnover and healthcare utilization. But so many other variables can impact these measures, like economic downturns, changes in attendance and disciplinary policies, that it may be impossible to ascribe any of their effectiveness to the EAP. Besides, access to this data may be difficult or impossible for external vendors to access.

As to whether employees get better as a result of their participation in the EAP, a good source of information is the employees themselves. Fortunately, EAP professionals have at their disposal a number of client self-report outcome tools to gather and evaluate this information. These tools have the added advantage of being easy to use and easy to apply both to the clinical and administrative aspects of the EAP. For EAPs that aren't using these tools, it might pay to investigate their usefulness.

ABOUT CLIENT OUTCOME TOOLS

Client outcome tools, such as the BASIS 32, SCL-90, HSQ, BSI, and the OQ-45 (see sidebar at right), consist of anywhere from 10 to 90 questions (shorter questionnaires may be preferred as they're easier to complete, which may lessen client resistance). These tools typically use a Likiert scale where clients report their level of agreement with statements such as "I feel irritable" or "I tend to blame myself for things." Ratings for each question are tabulated and, in the case of some tools, broken down into categories such as depression, anxiety or other measures of interpersonal functioning. (Note: For an outcome tool to be valid and reliable, it must be studied in a clinical trial where questionnaires are repeated over time to a group receiving treatment *and* to a matched, control

THE TOOLS

Information on where to order any of the five outcome tools discussed in this article follows:

Brief Symptom Inventory—BSI
NCS Assessments
PO Box 14126
Minneapolis, MN 55440
Phone: 800-627-7271, ext. 5151

Behavioral and Symptom Identification Scale—Basis 32
McLean Medical Center
115 Mill St
Belmont, MA 02178
Phone: 617-885-2432

Health Status Questionnaire—HSQ
The Psychological Corporation
800-228-0752 or
Health Outcomes Institute
2001 Killebrew Dr Suite 122
Bloomington, MN 55425
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OQ-45
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Symptom Checklist 90-R (SCL-90)
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group that is not receiving any clinical intervention.)

In an EAP setting, these tools are usually given to clients before the first session, after the last session and at one or more intervals during the course of care. Scores are then entered into a database so that they can be compiled any number of ways, such as by EAP account, clinician or both. Comparing a client's before and after score provides an overview of the client's progress in treatment. Compiling several before and after scores provides an accurate depiction of overall rate of improvement — or deterioration — for a group of clients. Improved client scores mean improved life functioning which, by extension, leads to improved job performance and productivity.

Self-report outcome tools can be incorporated into an EAP practice any number of ways. Reviewing a client's before-session score can help an EAP professional make the most efficient use of session time. Used between sessions, it can signal the need to refer the client to a more appropriate avenue of assistance. Should a client drop out of treatment, his/her self-report scores, in addition to clinical observations, could signal the need to use other interventions, such as contact with a supervisor or family member (provided authorizations have been granted) when there's a risk of dangerous behavior.

When a sufficient number of before and after scores have been gathered, they can be used in several ways to benefit the EAP. Compiling scores by EAP contract can be helpful for both program planning and account management purposes. An account manager can discuss with an employer the average level of client distress at the beginning of EAP participation and at termination. If employees from one company show significantly more distress before seeking assistance from the EAP than employees from other contracts, this may suggest the need for interventions to get clients into care sooner. Also, scores can be broken down to indicate the average beginning and ending scores of clients whose cases were resolved within the EAP versus those clients referred outside for treatment.

CLINICAL EFFICACY

For programs that provide short-term counseling, these scores can also be used as part of a professional's clinical supervision. Using average before and after scores for a group of counselors as a benchmark, one counselor's scores can be compared to the entire group. This kind of analysis can help in determining clinical staff development activities. (Note of caution: There simply is not enough experience with these tools

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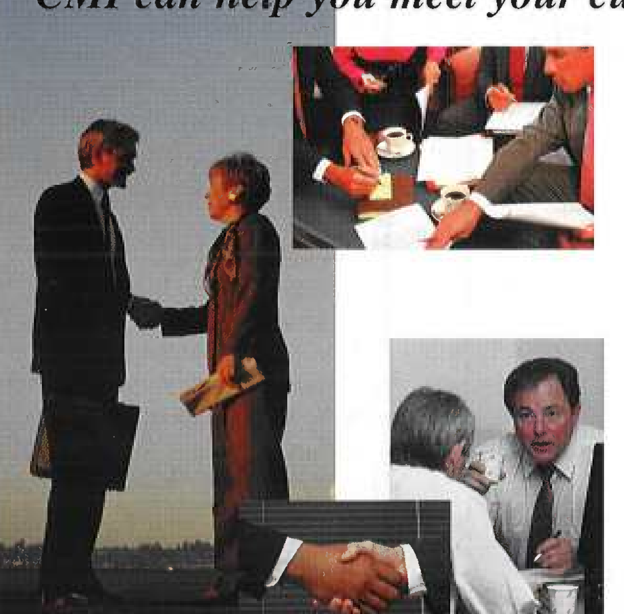

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to use them as the only indicator of counselor competency. Without statistical expertise, it is unclear how many cases are needed to draw clear conclusions about a clinician. However, scores may be used with other criteria, such as case reviews and the timely submission of reports, to determine a counselor's competency.)

Another possible clinical use is to determine when to refer an employee for mental health counseling. The lack of an improvement in a client's self-report may indicate the need for a referral, perhaps for a medication evaluation or more specialized or in depth therapy.

For EAP professionals working with managed care organizations (MCOs) or large healthcare systems, outcome tools can be used by quality improvement teams to improve clinical effectiveness. In some settings, these tools can be used to compare different theoretical approaches such as cognitive-behavioral psychology and solution-focused therapy.

These tools also resolve a number of issues related to working with affiliates. For instance, no one can accurately assess the quality of a clinical practice simply by examining degrees and licenses. As networks become regional and national, such tools will help EAP managers feel confident in the clinicians that see their clients.

While some professionals clamor about the need for further research into the reliability, validity and usefulness of client self-report outcome tools, their application in EAP practice seems clear. Such tools can help direct treatment, determine clinical efficacy and, of course, answer the question, "Do employees get better after they've seen you?" ■

K. Jeff Fladen is the EAP manager at Union County Behavioral Health Care Partners Marysville, Ohio, and owner of Paradigm Consulting and Counseling. He can be reached at 937-229-7485 or at paradigm@erinet.com

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EAP Outcomes

From the Client's Point of View

Most clients of this EAP report that they do get better.

By Rick Selvik, LICSW, CEAP, and David Bingaman, LCSW, CEAP

Four developments are fueling interest in behavioral healthcare outcomes.[1] The first of these is the managed behavioral healthcare industry's shift in recent years from focusing on cost cutting to balancing costs with quality care. Another development is the growing consumer interest in healthcare. Consumers demand value, which is leading to hospital and provider "report cards" issued by third-party government agencies and non-profit organizations. The third development centers around the information revolution. Paper-and pencil client reports have been replaced with electronic systems that allow for immediate data analysis for both consumers and providers. The fourth development involves the transformation of American businesses to "learning organizations."[2] Organizations have come to expect clinical outcomes, utilization data and other evaluative measures for use in their continuous quality improvement processes.

The EAP community is interested in client outcomes as well. Outcomes are usually measured by comparing a client's health status before s/he receives services to his/her health status after services are rendered. Positive outcomes spell cost savings to employers. At a time when employers are beginning to realize that the indirect costs of diseases and health problems are perhaps greater than the direct costs of healthcare, providers who can prove their value are the ones most likely to remain in business.[3]

To determine the value of its services, the EAP administered by Federal Occupational Health (FOH), a division of the United States Department of Health and Human Services, collects data on the health status of employees who use the program. The health status measures used by FOH are the same measures recommended by the Health Outcomes Institute and InterStudy, two healthcare consulting firms that advocate assessing, tracking and analyzing outcomes as a result of health treatment interventions.[4] FOH's goal is to learn if employees get better and become more productive after using the EAP.[5]

METHOD

The FOH EAP serves more than 1.2 million government employees and their family members. Employees come from more than 400 different agencies representing a variety of occupations, from criminal justice and transportation employees, to scientific researchers. More than 300 EAP counselors (a formal job title) nationwide see clients. The vast majority (96 percent) of clients are seen in face-to-face counseling sessions. Controlling for single-session, management referred cases, clients average between four and five sessions with the EAP.

EAP counselors are responsible for collecting reliable outcome data to demonstrate the value of their services.[6] To assist in this task, all EAP counselors are connected to an EAP information system (EAPIS), which also includes productivity, data management and report writing functions. For the purposes of outcomes measurement, EAPIS includes four pre- and post-health status questions, an absenteeism question, and a score from the Global Assessment of Functioning (GAF) Scale from the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV).*

Counselors ask the four health status questions and the absenteeism question at case opening and at case closing. (Questions are asked only if the counselor believes it is clinically appropriate.) The GAF score is determined by the EAP counselor at case opening and again at case closing.

During the 18-month period from January 1997 through June 1998, 105,167 individuals contacted the EAP (this is an actual figure representing employees or dependents who contacted the EAP, not the number of calls placed). About one third of these contacts (34,853) were either management consultations, medical department referrals, family consultations or individuals who did not follow through on an EAP counselor's recommendation to come in for a first session. The remaining 70,314 contacts led to a case opening, meaning that the individual met with an EAP counselor in a face-to-face session (with the exception of the 4 percent of cases opened by phone). Of the cases opened, 56,466 were closed (the remaining 13,848 cases are still on active status). The following are the before and after health status results of 16,055 closed cases, approximately 28 percent of all closed cases.[7]

RESULTS

EAP intervention led to client improvement across six outcome measures — productivity as it is affected by the client's physical and emotional health, work relationships, health, attendance and global assessment of functioning (see questions and results, page 23).

PRODUCTIVITY

As affected by physical health: At case opening, 12 percent of clients reported that in the four weeks before they came to the EAP, they experienced "quite a bit" of difficulty in doing their work or other regular, daily activities or "could not do their daily work" as a result of their physical health. At case closing, only 5 percent of clients reported this level of difficulty, a 58 percent reduction.

As affected by emotional health: At case opening, 27 percent of the clients reported that in the four weeks before they came to the EAP, they experienced "quite a bit" of difficulty or "extreme" difficulty in doing their work or other regular daily activities as a result of their emotional problems (such as feeling depressed or anxious). At case closing, only 8 percent of clients reported this level of difficulty, a 70 percent reduction.

WORK RELATIONSHIPS

At case opening, 28 percent of clients reported that in the four weeks before they came to the EAP, their physical or emotional problems interfered with their normal interactions with coworkers, family, friends or neighbors. At case closing, only 8 percent of clients reported this level of difficulty, a 71 percent reduction.

HEALTH

Clients also were asked about their perception of their health status. At case closing, the number of clients reporting that their health was either "fair" or "poor" declined by more than 33 percent over case-opening scores.

ATTENDANCE

Clients reported at case opening that they had been unexpectedly absent or tardy an average of 2.15 days in the 30 days prior to using the EAP. At case closing, clients reported being absent or tardy an average of .97 days in the previous 30.

GLOBAL ASSESSMENT OF FUNCTIONING

Counselors also assess a client's level of functioning using the Global Assessment of Functioning (GAF) Scale. Average client GAF scores improved from 65.89 to 71.93 (out of 100) from case opening to closing.

COMMENT

At least two methodological issues may be raised regarding these findings, the first of which involves how the data was gathered. Some researchers fall on the side of sampling. Others say all clients should be surveyed. While arguments can favor either side, most clinical managers agree it is easier to survey all clients rather than, for example, one of every five.[8]

There also may be some question about the client records used. As mentioned, 70,314 EAP cases were opened in the 18-month period beginning January 1997. Slightly more than two thirds of these cases (56,466) were closed over this same period (the remaining cases are still on active status). This analysis used before and after health status information from 16,055 of the total number of closed cases. When these 16,055 cases were compared with the full 56,466 cases available, both groups were found to have similar demographic profiles.

The next step in the outcomes process will be to incorporate these outcomes with the results from client satisfaction surveys, demographic data, clinical assessment data and the types of interventions used. Comparing health status before and after treatment with assessment and intervention information will demonstrate which interventions work best with each client type.[9] This may then point to the need to include more disorder-specific or multidimensional assessments within EAPIS.

Of course the overall challenge will be to provide FOH customers with cost savings information directly tied to outcomes. This information may be ex-

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trapolated from studies showing that the rate of health-related job loss is about 10 times higher for people in the bottom one-fourth of the physical health status scale than for those in the top one-fourth.[10] To date, about 10 percent of EAP clients served by FOH at case opening are in the bottom one-fourth of the physical health status scale. At case closing, this health status rate dropped to 5 percent, a 50 percent reduction in possible health-related job loss costs, according to these other studies. Given time and additional data, this information may offer organizations solid evidence of the benefits of the EAP both to clients and their own bottom line. ■

Rick Selvik, LICSW, CEAP, an EAP consultant for FOH, has 17 years experience in healthcare. For FOH, he consults on EAPIS, participates in account management/sales, develops continuous quality improvement measures and oversees the production of customer and management reports. ***David Bingaman, LCSW, CEAP,*** *EAP Manager for FOH, has 23 years experience in the substance abuse treatment and EAP fields. He currently manages an EAP that serves 870,000 public employees and their family members. Direct correspondence to Federal Occupational Health, 13th Floor, 105 W. Adams, Chicago IL 60603-6206; phone 312-886-4215; or e-mail at selvikr@aol.com or dbingaman@foh.dhhs.gov.*

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Health Status Questions and Results

Federal Occupational Health EAP clients participating in this study were asked five questions relating to their productivity, work relationships, health and absenteeism. The questions are posed by EAP counselors at case opening and again at case closing. The Global Assessment of Functioning score is determined by EAP counselors at the time a case is opened and when it is closed.

PRODUCTIVITY

(as affected by physical health)

"During the last four weeks, how much difficulty did you have doing your work or other regular daily activities as a result of your physical health?"

	Pre	Post
None at all	54%	63%
A little bit	19	22
Some	15	10
Quite a bit	10	4
Could not do daily work	2	1

PRODUCTIVITY

(as affected by mental health)

"During the last four weeks, to what extent have you accomplished less than you would like in your work or other daily activities as a result of emotional problems (such as feeling depressed or anxious)?"

	Pre	Post
None at all	21%	41%
Slightly	27	37
Moderately	25	14
Quite a bit	22	7
Extremely	5	1

WORK RELATIONSHIPS

"During the last four weeks, to what extent have your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors or groups?"

	Pre	Post
None at all	22%	43%
Slightly	25	35
Moderately	25	14
Quite a bit	22	7
Extremely	6	1

HEALTH

"In general, would you say your health is…"

	Pre	Post
Excellent	18%	21%
Very good	32	35
Good	35	34
Fair	12	8
Poor	3	2

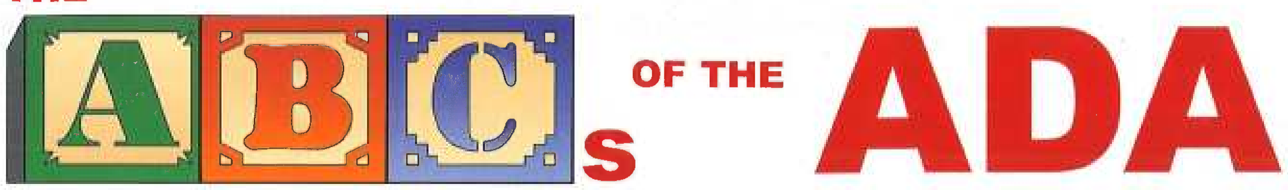
ATTENDANCE

"How many days have you been unexpectedly absent or tardy in the last 30 days?"

	Pre	Post
Average days absent	2.15%	.97%

GLOBAL ASSESSMENT OF FUNCTIONING

	Pre	Post
Average GAF score	65.89%	71.93%



The ABCs of the ADA

A primer on the Americans with Disabilities Act for EAP professionals.

By Roger Wapner, PhD, CEAP

Recent court cases relating to the Americans with Disabilities Act (ADA) have kept the ADA a fresh topic among HR circles. EAP professionals should be equally interested in these court rulings and clarifications for a number of reasons. First, the two types of employees most likely to file an ADA claim — those who face separation and those who've been denied accommodation — are quite frequently also EAP clients. Also, an EAP may be called upon to assist employees who claim to be disabled but who don't qualify for ADA protection. There's also the expectation on the part of many employers that an EAP will proactively deal with their problem employees, thereby heading off disability claims — although it's also true that an EAP professional's diagnosis may be cause for a disability claim. Finally, both internal and external EAPs may be listed as defendants when employees file suit under the ADA.

For EAP professionals new to the ADA arena, this article offers a broad overview of the ADA with some recommended steps to limit exposure to an ADA claim. But be forewarned: This article isn't the cookie-cutter, ADA problem solver so many companies are searching for. There is no step-by-step manual, no one-accommodation-fits-all ADA machine, and the time spent searching for one is energy wasted. With expert counsel, the path your organization will take to implementing ADA processes will be tempered by the amount of risk and exposure you or your organization is prepared to face.

Reader Service Card #23

Terms and Definitions

The ADA prohibits employment discrimination against "qualified individuals with disabilities." Qualified individuals are those who meet the knowledge, skills, abilities, education and other job-related requirements of a position they either hold or desire to hold or who, with or without reasonable accommodation, can perform the essential functions of a job.

The employer determines whether an employee is ADA eligible — not an employee or an employee's attorney or a doctor or therapist. (However, it is good practice for an employer to consult with a doctor or therapist.) Employees who are not satisfied with their employer's decision may sue, in which case the court will determine eligibility.

It's important that employers apply the procedures they use to determine eligibility equally to all employees who claim disability. Of course all steps in this process should be documented, especially any opinions or reports from medical staff, and the process should involve the employee as much as possible. Documenting the company's ADA processes with the employee is one of the most important aspects of reducing risk.

The following criteria are used to determine whether an employee is eligible for protection under the ADA:

- The employee must be disabled within the meaning of the ADA. The ADA defines *disability* as (1) a physi-