EMPLOYEE ASSISTANCE PROGRAMS IN MANAGED CARE

NORMAN WINEGAR

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ABOUT THE AUTHOR

Norman Winegar, LCSW, CEAP, has over 23 years of experience in the EAP and behavioral health care fields, both as a practitioner and an administrator. He is the author of three previous books concerning the managed behavioral health care field. Currently Vice President of Clinical Services for Magellan Behavioral Health, Mr. Winegar directed CIGNA Behavioral Health's employee assistance program and has held a variety of positions in the managed care industry. A frequent trainer, he is a licensed employee assistance professional and a licensed alcohol and drug abuse counselor.

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Chapter 1

A Service for the Twenty-First-Century Workplace

This morning Teresa awoke to discover that a personal crisis is about to complicate her life—one that will test this single mother's substantial problem-solving skills and her resilient emotional resources. It involves all aspects of Teresa's life that are important to her—family, job, finances, and self-esteem. It's an all too familiar crisis, but one that seems to escalate with each reoccurrence.

This time the crisis is especially anxiety provoking, for she fears that it will cost her her job. Only two months ago, when the crisis last occurred, Teresa's supervisor called her into her office. The supervisor, Ms. Oliveras, said she really liked Teresa and wanted to help but didn't know how, and besides it wasn't her job. Her job was only to see that the office functions smoothly, the work gets done, and customers get served. She said that Teresa wasn't helping and was in fact becoming a problem and a hindrance. Reliable attendance was what the company demanded first and foremost. She warned Teresa not to let this problem cause her to miss work again. She even wrote the warning down and handed a copy of the note to Teresa.

Teresa's mind races. If she loses her job and misses even a single paycheck, she will fail to meet her mortgage payment. She will surely lose her newly purchased home for which she has worked so hard and which means so much. Her ex-husband's hateful prediction that she'd fall on her face if left on her own would come true. And then what will happen to her two small children?

Teresa's crisis is a common one in America, for Teresa is a member of the sizable, ever-growing minority of employed parents, about one in five, who is single and experiencing a child care crisis (Bond et al., 1998, p. 30). Her child care arrangements have failed again, and she is not sure how to find other responsible caregivers for her two preschool-age children on such short notice. Without child care she cannot go to work. Her only option may be to miss part or all of the workday to resolve the problem, at least temporarily. For Teresa, as with other American parents, disruption in child care services is a common problem, happening, on average, about once every three months (Bond et al., 1998, p. 51). For a single, working mother with

limited resources, however, this seemingly small crisis may well escalate into a major, destructive, life-changing event.

Dennis is leaving his primary care physician's (PCP) office again. This time his complaint was about his headaches, which are becoming increasingly worse. His doctor ordered some tests this time, and Dennis is thinking about having to explain to his boss that he'll need to take another morning off this Friday. He is not looking forward to that conversation.

This office visit with Dr. Jefferson was different from the others Dennis has had recently. The doctor seemed to take more time with him. He asked a lot of what Dennis thought were personal, not medical, questions. Dr. Jefferson seemed especially interested in how Dennis was taking the medications prescribed for him about six months ago for depression. He emphasized to Dennis that these medications had to be taken exactly as prescribed. Dennis told him that he'd never been very good at taking medicine, while wondering to himself what any of this had to do with his headaches.

Though he doesn't feel well enough, as his headache has returned, Dennis returns to work. He is a technician for a cable television company and, when he's feeling well, spends most of his time in the field installing new cable service and repairing problem equipment. Although he dreads it, he knows he needs to see his supervisor to turn in the excuse he received from Dr. Jefferson, and to tell him he'll need another morning off for the tests the doctor ordered. His relationship with his supervisor, Mr. Hardy, has not been good lately. He even thinks Mr. Hardy is a little afraid of him now, after the big argument they had two weeks ago. He believes Mr. Hardy is assigning too many of the difficult assignments to him instead of the newcomers, as it used to be. In fact, Dennis feels a lot of people at work who used to be his friends are now acting strangely toward him.

When Dennis finally arrives at Mr. Hardy's office, his boss seems particularly ill at ease. His supervisor tells Dennis that he's been dreading this discussion for months. He makes a quick call, and in from an adjacent office step the company's security guard and Mr. Jensen, the human resource manager who hired Dennis seven years ago. Mr. Hardy explains to Dennis that his employment is being terminated, effective immediately. He and Mr. Jensen explain that Dennis's attendance has faltered, the quality of his work has declined, and his temper and irritability have disrupted his co-workers and managers. They point out that he's been warned before about the need to change but has not done so. Everyone feels badly about this, but since the merger, the company can no longer tolerate people not functioning efficiently. They tell Dennis that he's had his chance, and the company cannot be responsible for resolving whatever problem he's having. After he signs some forms, the guard will escort him off the property. His belongings from his locker are already in a box in the adjoining office.

Dennis is stunned and bewildered. He does not seem to have the energy to get angry. He remembers some talks with the supervisor about his work, but he never thought he was in danger of losing his job. Then again, Dennis has felt unhappy a lot in the past couple of years and many things have seemed a little unreal.

Though often unrecognized by family, friends, co-workers, and professionals, Dennis's situation is common. One in five Americans experiences a substance abuse or mental health disorder over the course of a lifetime (Von Korff and Simon, 1996, p. 162). Dennis suffers from clinical depression, one of the nation's most common behavioral disorders, with an affliction rate of 6 to 8 percent of all primary care outpatients (U.S. Department of Health and Human Services [DHHS], 1993, p. 2).

About half of those who experience a behavioral disorder impacting their social and occupational functioning never seek any treatment (Narrow et al., 1993, p. 95), and Dennis receives care through his PCP, not a behavioral care specialist. Studies have shown that of the half who seek care for diagnosable behavioral conditions, about half receive treatment only from a general physician, and that as much as 70 percent of all psychotropic medications and 80 percent of antidepressants are prescribed by general physicians (Strosahl, 1994, p. 177). Unfortunately for Dennis, his depression has not responded to the particular treatment prescribed by his physician. His work has evidenced a pattern of deterioration for months, but workplace efforts to intervene have been unsuccessful. Now, in addition to his depressive disorder and somatic complaints, Dennis is confronted with numerous psychosocial stressors associated with his newfound status as unemployed. His tenuous relationship with his treatment provider, Dr. Jefferson, will be disrupted by his loss of employment. Dennis will join America's ranks of the uninsured. Untreated, his behavioral disorder will worsen, exacerbated by financial and family problems that develop as a consequence of losing his job.

Teresa and Dennis have something in common—both of their dilemmas could have been effectively addressed by an employee assistance program (EAP). An EAP could have assisted Teresa in finding reliable child care and helped Dennis to identify his depressive condition early in its progression and to obtain effective treatment before his job performance resulted in termination. Neither of their employers offered such a service, making them part of the estimated 58 percent of American businesses employing fifty or more workers who do not offer such a benefit to their workforces (Oss and Clary, 1998). Yet thousands of American employers do offer such services (see Table 1.1),

TABLE 1.1. National Prevalence of EAPs by Size of Work Site

Number of Employees	Number of Work Sites	Percent of Work Sites Offering EAPs	Percent of Employees with Access to EAPs
All work sites	162,800	32.9	55.3
Under 100	61,600	20.9	21.0
100-249	66,000	33.2	34.0
250-999	29,000	48.4	51.8
1,000 or more	6,200	76.1	82.3

Source: Adapted from Oss, M.E. and Clary, J. (1998). EAPs Are Evolving to Meet Changing Employer Needs. *Open Minds* 12(1), p. 5.

and their numbers are growing, representing one of the few expanding markets for early intervention counseling and consultation services.

Businesses offer EAPs, not for purely humanitarian reasons, but instead out of a recognition of the prevalence of psychosocial problems in society, as well as an awareness of their negative impact on employee productivity and employer health care costs. In the face of fierce competition in the global marketplace, many businesses have embraced EAPs as a tool to extend their competitive ability. The awareness that a counseling-oriented tool can help employers' bottom line by assisting workers to remain healthy and productive has been one of the least publicized changes in American business in the past decade. To thousands of workers aided by EAPs and those professionals and students in counseling fields, it may be one of the most significant changes.

Employers need to ensure early identification and effective treatment intervention for workers experiencing behavioral disorders for three reasons. First, behavioral disorders are very common, affecting about one in five Americans. Second, behavioral disorders create functional disabilities that impact both social and occupational functioning; this reduces worker productivity and indirectly creates higher social costs that are borne by employers in the form of taxes. Third, behavioral disorders can escalate, thereby increasing health care costs if left undetected and untreated in their earlier stages. Adopted from Von Korff and Simon (1996, p. 162), the three most prevalent psycho-

logical disorders among presenting primary care patients most likely to be members of the workforce are

- alcohol abuse,
- major depression, and
- generalized anxiety disorder.

BACKGROUND

It is useful to think of EAPs as products. They may be sold and delivered by a range of entities, from solo practitioners offering relatively modest counseling services to international behavioral care companies offering an entire EAP product line. In sharp contrast to managed behavioral care products, health maintenance organizations (HMOs), and other health care systems, EAPs are largely unregulated. Though their goals remain consistent, their functions, features, and forms continue to change according to the forces of the marketplace. No one standard model exists. In fact, EAP suppliers compete fiercely for the millions of dollars in EAP contracts awarded annually by private businesses and the federal government. Each supplier promotes the virtues and features of its own EAP products. We will later examine how EAPs are marketed, and throughout this book we will use this concept of the EAP as a product.

EAPs have an unlikely and uniquely American origin. Their development over the past century is a testimony to the changes in America's attitudes toward psychosocial problems. The origin of EAPs lies in the temperance movement of the late nineteenth and early twentieth centuries. These popular initiatives preached the evils of alcohol and the merits of change and redemption. Although they approached the enormous and complex social problem of alcohol abuse from a mainly moral perspective, these efforts brought the problem and its consequences to the nation's attention. Inspired by this, a handful of progressive American businesses responded by establishing fledgling counseling programs within their business operations. These services were closely allied with early occupational medicine physicians and were often housed in these settings. They were usually staffed by social workers, and by the 1920s, the most common environment for the professional practice of social work was occupa-

tional settings. Social work today continues be highly represented in EAP practice. The goal of these pre–Alcoholics Anonymous, occupationally based counseling services was primarily to assist alcohol abusers and their families in an era long before the development of the social services infrastructure we are accustomed to today.

Although the Great Depression of the 1930s diminished the number and impact of these early efforts to offer professional psychosocial assistance in the workplace, World War II, with its emphasis on maximum productivity and worker safety, helped resurrect early EAP efforts; again the focus was assisting problem drinkers. The emergence of the Alcoholics Anonymous self-help group in the 1930s demonstrated the growing awareness in American of the notion of problem drinking as a treatable, medical condition—not a purely moral problem. This illness had a new name: *alcoholism.* A new term emerged for the workplace-based programs to assist problem drinkers—occupational alcoholism programs (OAPs)—and this term persisted into the 1970s. Kaiser Shipbuilding, owned by industrialist Henry Kaiser who also pioneered one of America's first HMOs, was a World War II era business that sponsored such services. Other heavy manufacturers, including Kodak and Allis-Chambers, also sponsored early OAPs. When peace and prosperity returned in the 1950s, the business need for OAPs seemed to decline.

By the 1970s, Americans once again were focused on the impact on society of alcohol and drug abuse, now termed chemical dependency or substance abuse. Americans were also more aware and accepting of the notion of emotional or psychiatric disorders as illnesses. Treatment of these problems through newly developed psychotropic medications and through new counseling and psychotherapy approaches also gained acceptance. OAPs evolved into so-called "broad-brush" programs, or EAPs aimed at assisting employees, and their family members, who might be experiencing a *broad* range of problems that might impact worker productivity. Large commercial EAPs, selling services to multiple employers, emerged onto the business scene in the 1970s, led by Human Affairs International.

The managed care revolution that changed the behavioral care delivery system in the 1980s was the next driver of change in EAP products. This dynamic laid much of the foundation for EAP products at the beginning of the twenty-first century.

EAPs TODAY

How do we know an EAP when we see one today? What are its distinguishing features if it is indeed shaped by market forces in a managed-care-dominated environment? Two useful definitions help us answer this question.

The first definition is from one of the seminal figures in the EAP field, Dale Masi.* Masi offers a useful description of the essential components of EAPs in a paper prepared for the U.S. Center for Mental Health Services.

First she defines an EAP as a

> professional assessment, referral, and/or short-term counseling service offered to employees with alcohol, drug, or other mental health problems that may be affecting their jobs. Employees are either self-referred or referred by supervisors. EAP services . . . include managerial/supervisor consultations; supervisory and union steward trainings; employee orientations; childcare and eldercare referral services; critical incident stress debriefings; workplace violence prevention; and employee education. Eligible clients often include family members of employees, significant others, and retirees. (1998, p. 1)

Today's EAPs involve more than the services described in the previous definition. In fact, Masi describes sixteen elements of current EAP services.

1. *Policy statement.* This document describes the purpose of the program, its scope, mandate, and the roles of personnel involved in its functioning. Policy statements are vital documents, for they represent an organization's endorsement of the program. Without such a statement, EAP's role is unclear and its effectiveness within the workplace is hampered.

2. *Toll-free telephone access, twenty-four hours per day, seven days per week.* EAPs offer access to professional counselors, not nec-

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*Dale Masi, DSW, is a professor at the University of Maryland at Baltimore's Graduate School of Social Work and a researcher of EAPs' effectiveness. At the University of Maryland she developed one of the few formal training programs in the EAP field. The Graduate School of Social Work offers a Master of Social Work degree with a specialization Certificate in EAP Studies.

essarily for "telecounseling," but for referrals and crisis intervention, if needed. Increasing numbers of EAP consumers have access to, and the ability to obtain referrals from, counselors via their EAP's Internet capabilities. They can also access community organizations, self-help groups, and screening tools using this and other information technology.

3. *Assessment and referral.* Without an accurate assessment, treatment services for psychosocial problems can be ineffective and inefficient. Assessments for problems of a clinical nature are best done in a face-to-face setting with a licensed professional and can usually be achieved in one or two visits. Many clinical concerns may be resolved in this environment, as clients sometimes expect advice, clarification, information, or validation, not the initiation of a course of psychotherapy. Assessment of nonclinical problems such as elder care or child care concerns lends itself more appropriately to telephonic assessment. The term *referral* in this context concerns the resources recommended by the EAP staff to the client for resolution of the identified problem. EAP companies contract with networks of professionals called affiliates, or providers in managed care terminology, who assess EAP clients in professional offices or clinics. Some EAPs offer face-to-face assessment and referral services at the work site if the employer so chooses.

4. *Short-term counseling.* Masi notes that some EAPs offer short-term counseling, focused on a central theme and lasting four to eight visits. She explains that with the advent of managed behavioral care, an EAP with eight counseling visits is sometimes more generous than the health plans provided by the employer. In this manner, some employers who desire aggressive case management in their medical and behavioral care benefits to manage costs may still provide an easily accessed, relatively generous short-term counseling benefit. By providing an EAP through a direct purchase from a supplier, these employers gain much greater control over the administration of counseling services than is available to them when purchasing counseling services for patients (employees and dependents) enrolled in HMOs or other managed care organizations (MCOs).

5. *Other client services.* In this grouping, Masi includes the nonclinical services directed toward clients that have become typical of EAPs. These include child care, elder care, legal information, consul-