

WHITE PAPER:

PROJECT 95 –BROADBRUSH: Lessons for Today

a brief history of contemporary EAP

by Jim Wrich

Pinehurst. Forty-five years ago, two representatives from each state traveled to Pinehurst, North Carolina to participate in a three-week training program that was to ultimately change the landscape of workplaces in America and around the world. In time, this disparate group came to be known as “The Thundering 100”.

They were called upon to meet a challenge which had long vexed medical professionals, corporate managers, and the criminal justice system. It had ruined millions of families and careers, created consternation in the workplace, swelled jail cells and hospital emergency rooms and left lasting scars on both the individuals who were afflicted and their loved ones. The challenge was to intervene earlier in the progression of alcoholism. That meant not waiting until an alcoholic had gone all the way to the bottom of the heap, through hospitals, jails and mental institutions. They would be trained to recognize the earlier, subtler signs and symptoms to trigger an intervention while the alcoholic still had a job, a family and some modicum of self-respect. The setting would not be the streets or courtrooms but the workplace.

One recovering man. Several years earlier a terminally ill alcoholic truck driver in Iowa, in the depths of despair was slumped down in his bathtub with water up to his throat and the barrel of a loaded pistol in his mouth. For reasons not entirely understood, he decided to give life one more chance. After finding God and A.A. he went on to ultimately serve three terms as Iowa’s Governor and one term in the US Senate. As a recovering alcoholic, Harold Hughes became a bigger than life figure. While only a freshman Senator, he was the prime mover in establishing the Comprehensive Alcohol Abuse and Alcoholism Treatment and Rehabilitation Act of 1970 -- Public Law 91-616. Known as the Hughes Act it established The National Institute on Alcohol Abuse and Alcoholism (NIAAA). In the following session he shepherded PL 92-255 through congress to create the National Institute on Drug Abuse (NIDA).

NIAAA: bringing it together. The training at Pinehurst was part of a grand scheme launched by NIAAA to earlier identify alcoholics nationally. By then research was confirming the incidence and prevalence of the problem in the general population, its enormous public costs and its wide swath of personal and family destruction. In contrast to this bleak picture, there was a growing belief among a small group of pioneer treatment providers and recovering alcoholics that recovery was not only possible but likely if the disease was treated earlier and as a *primary* illness using a multi-disciplinary approach that addressed its physical, emotional and spiritual dimensions.

Developed in the 1960s by Dan Anderson, PhD. and Nelson Bradley, MD while both were working at Wilmar State Hospital in Minnesota, this approach later became known as the Minnesota Model of addictions treatment. It departed from typical treatment practice at that time which was largely based on false assumptions. Each of the major disciplines had their own take on alcoholism and how to treat it:

- The psychological approach saw alcoholism as a symptom of a deeper underlying disorder needing to be addressed first before the alcoholism could be successfully treated.
- The medical approach subscribed to the disease concept provided there was tissue damage, such as cirrhosis of the liver or brain damage.

- The social work model viewed alcoholism as the result of sociological conditions – poor parenting, bad environment, and other factors – all of which were largely beyond the ability of either the patient or therapist to change.
- Finally, there was the psychiatric approach which for all practical purposes viewed alcoholism as a valium deficiency.

All of these methods mistook the effects of the disease for its causes while seeing the alcoholism as second or third in importance behind whatever disorder the practitioner had been personally trained to treat. And that disorder was never alcoholism.

The multi-disciplinary treatment of addiction. By 1972 outcome data from Hazelden and other treatment programs began to accumulate on the multi-disciplinary approach that reinforced long held anecdotal information from members of Alcoholics Anonymous: recovery was possible and the right kind of intervention worked. The Minnesota Model utilized all of the essential professional disciplines organized in a coherent protocol. It focused first on alcoholism as a chronic, primary disease and second on the medical, psychiatric, psychological, spiritual, and sociological features which attended it. It also recognized that some people had what would later be termed a comorbid disorder – two or more primary illnesses which exacerbated each other, each of which needed to be addressed if recovery from the others was to be fully realized. When acute medical and psychiatric conditions were present, they were addressed beforehand to avoid a crisis and better enable the patient to respond to the alcoholism treatment protocol.

This protocol translated into a new kind of treatment team that included medical staff, a psychologist, a clinical social worker, a clergy. Most notably, the leader of the treatment unit itself -- was a recovering alcoholic who had been trained in effective counselling techniques and who through first-hand experience was intimately familiar with the ways alcoholics could deceive themselves and others in order to continue drinking. Anderson and Bradley recognized the critical importance of modeling recovery and knew that the experience of a recovering person could not be replicated in a classroom.

From the streets to the workplace. Prior to Pinehurst, NIAAA had put together a crack team of professionals and lay people who really understood the disease of alcoholism and how alcoholics were accessing both A.A. and formal treatment. Self-proclaimed as “The Dirty Thirty” one member was Don Godwin who was to become the Chief of the Occupational Programs Branch of NIAAA. In the forward to my first publication “Project 95-Broadbrush”, he wrote:

“The statistics are staggering and, sadly, the increased number of people becoming afflicted each year exceeds the number...who begin a recovery program for the first time.” He continued, “Unfortunately, A.A. and other programs have no choice but to deal with people who have reached the acute stages of the illness because our current system takes so long to identify the problem. The reason...is that fewer than five percent of the alcoholic population fit the skid-row derelict stereotype which is the current image the general public has of an alcoholic.”

He went on to say that the employment setting offered a new approach which could provide the earlier identification so badly needed. The premise was that only five percent of alcoholics were on skid-row, the other 95% were in the workplace, thus the term “Project 95.” More important was the belief that by the time someone had lost their family, health, job and often their freedom, they had largely lost their motivation to stop drinking even if they realized it was slowly killing them.

Of all the referral resources – family, friends, clergy, medical professionals, therapists, courts – far and away the one which “The Dirty Thirty” considered most promising was the employer. For starters, the last

thing an alcoholic wanted to lose was his job because it not only represented the last vestige of self-respect but provided the money needed to continue to drink. Moreover, the disease had often progressed to the point that there were serious money problems. With the prospect of getting fired, the idea of quitting drinking became more palatable and the involvement of a recovering person in the workplace helped light the lamp of hope.

The employer, on the other hand, had a vested interest that other institutions such as courts and churches did not have – the bottom line. As the research rolled in, the impact of alcoholism on corporate profit was stunning. On the level where the work was performed, enlightened managers and their union counterparts had long recognized that a small percentage of employees were causing the preponderance of their headaches. Usually excessive drinking was involved and customary disciplinary measures seldom yielded a permanent solution. Most importantly, the structured characteristics of the workplace provided defined boundaries which employees without personal problems could work within, but which alcoholics found increasingly difficult to navigate.

So there we were at Pinehurst, roughly one hundred of us. NIAAA offered Single State Agencies created by the Hughes Act grants of \$50,000 per year to fund two Occupational Program Consultants, one for the private sector and the other for the public employers. About half of us were recovering alcoholics who knew a lot about alcoholism and little about anything else while the other half were professionally trained—nurses, clinical social workers, psychologists, MAs in counseling, medical doctors -- who knew a lot about a wide range of personal problems but very little about alcoholism.

Getting acquainted. At first, there was competition and suspicion with each group enamored of its own rectitude and painfully eager to teach the other what it absolutely knew they needed to know. This was especially true of the recovering folks, of which I was one. It may have been the only place on earth where a group of drunks could feel superior to professionals and we were enjoying our moment. When we had been in the throes of our disease, many of us had personally experienced the futile efforts of professionals untrained in alcoholism. We were true believers: We knew that we knew! And we certainly knew that they didn't know. On the other hand, some of the professionals had trouble fathoming how anyone could even dream of sending an unpolished motley crew like us out to meet captains of industry.

Fortunately, we had a splendid leader who saved us from ourselves. A silver-haired father figure who was the Acting Chief of the Occupational Programs Branch of NIAAA, Will Foster, was a recovering alcoholic himself and read the scene perfectly. A few days into the training, he addressed "... the alxies in the room ..." at a plenary session. Noting our "... superiority complex ..." and using biological terms that had no medical significance, he told us to knock it off. He told us that we were experts only about our own recovery. With greater refinement, he also told the professionals to learn from the alxies because, theories aside, we had "... been there ..." They needed what we had to offer – our experience, strength and hope -- and above all our commitment. And, no course of study could impart that to them.

There is nothing like a good shot of humility to clarify things and engender appreciation for the views of others. We jelled as a group and the divisions evaporated. Together, we developed the quiet sense of urgency that is felt by recovering people who know what the end will be for the suffering alcoholic who struggles in a downward cycle trying to use their own unaided will to reduce the consequences of their disease. We couldn't be casual about alcoholism – untreated a tragic end was inevitable. At the same time, as a group we broadened and deepened our awareness of the many psychiatric and social factors that would affect our main objective to not just get a person on the road to recovery but to keep them there. This would require dedication and a depth of study that went beyond any narrow, personal anecdotal experiences.

Above all, we needed to be professional, and we had great instructors from labor, industry and the field of alcoholism who pointed us in the right direction. Looking back, we were giving each other the best we had of ourselves. By the time we completed our formal NIAAA training 18 months later in New Orleans, we had become so close that we didn't want it to end. So we formed OPCA – the Occupational Programs Consultants Association – which met as a group for many years thereafter at the annual EAPA convention.

The challenges and the excitement. In the months and years that followed we addressed many crucial questions all the while sharing what we were learning through direct experience. Paul Roman, a young Ph.D. from Tulane University, followed our progress from the beginning and developed what was to become the CORE technology for the field. It was ultimately incorporated into the program standards of both professional associations, EASNA and EAPA. In 1972, led by Maryland and Minnesota, state legislatures began to mandate treatment of alcoholism, drug addiction and mental health issues. Until then, insurance companies refused to cover “mental and nervous disorders” and alcoholism was one. And in 1974, the Joint Commission on Accreditation of Hospitals promulgated alcoholism treatment standards which brought respectability to the treatment field.

Alcoholism only or something more. The first major issue we wrestled with at Pinehurst and throughout the 1970's was the type of program we would promote. A number of companies had tried with varying degrees of success to address workplace alcoholism by training first line supervisors in the signs and symptoms of the disease, using them to intervene directly and to refer those whom they thought were alcoholics to an in house recovering AA member. Pioneered by companies such as Dupont and Eastman Kodak, which had experienced the remarkable transformation AA could make in a person's life, this approach was known as a “Straight Alcohol Identification Program.”

As time passed, it became apparent that while dramatically helping some alcoholics there were problems with this strategy. First, supervisors were hard to train and it didn't last long. It wasn't a natural part of their function as managers. They did not have occasion to use what they had learned often enough to get good at it. Not wanting to “accuse” someone of being alcoholic, they usually waited until late stage symptoms emerged. Then, in spite of the training, the decision to intervene was largely subjective and its implementation was inconsistent. Supervisors with strong religious beliefs regarding drinking might see a problem everywhere, while those who had a drinking problem themselves did not see it anywhere. Of equal importance, even though alcoholism afflicts employees from top to bottom in an organization, no one above the first line supervisory level was ever identified. First line supervisors simply do not confront senior executives on personal matters. Finally, threatening to fire someone because of a medical condition was illegal and led to the possibility of a lawsuit or union unrest.

Eventually the strategy moved towards identifying job performance and attendance problems and using these as the trigger to refer people. We thought supervisors would be comfortable in an area consistent with their natural role. More than anything, the appearance of a “witch hunt” could be avoided. Referred to as the Job Performance Alcohol Identification Program, it too was fraught with problems. Supervisors were admonished not to diagnose alcoholism or even discuss it but to stick strictly to job performance. But, the person to whom they were to refer the employee was an alcoholism paraprofessional. Moreover, it didn't take into account that not all employees with performance problems suffered from alcoholism – in fact, at least half did not. But there was another alternative presented to the OPCs at Pinehurst.

An enduring model. The Mineral Mining Division of Kennecott Copper Company in Ogden, Utah had pioneered a different approach. With a program called Insight headed up by Otto Jones, they focused strictly on job performance but the referral was made to Otto, who was a licensed clinical social worker and had deep knowledge of alcoholism. Supervisors focused on job performance and attendance and if regular

disciplinary measures failed to correct the situation they referred the employee to the Insight program. Then Jones made a differential diagnosis and referred the employee to appropriate care in the community. By not affixing an alcoholism label on the program it didn't carry the stigma of previous workplace efforts. Otto found that about half the time the problem was alcoholism but with the rest of the participants it was some other disorder. However, utilization was so much higher than in the straight alcoholism programs that in absolute numbers, Insight was reaching more alcoholics.

Equally important, Otto wanted to know what difference Insight was making to the company. The overall improvement was stunning: a 52% reduction in absenteeism, a 74.6% decrease in weekly indemnity expense, and a 55.4% decrease in medical surgical costs. A few participants got worse and some stayed the same but a significant majority -- 77% -- improved across the board. The savings added up to several times the cost of the program. Years later when I was Director of the EAP at United Airlines (UAL) we found similar results and while about 40% of the participants had a substance use disorder, they accounted for the lion's share of cost savings. Our benefit to cost ratio for the program overall computed to a 7 to 1 over 5 years based on pre-post absenteeism alone.

Without discarding the Job Performance Focused Alcohol Identification approach, NIAAA advocated for the Broadbrush approach as well. OPCs were encouraged to propose whichever concept an employer was willing to adopt. Overall, Broadbrush emerged as the solid favorite. But it didn't happen without a prolonged battle within the field - the Executive Director of National Council on Alcoholism lead the charges against the Broadbrush approach. In short, he didn't like the name and didn't believe it would identify alcoholics. But, behind the scenes others at NCA supported the concept, Ross Von Weigand among them. When I asked him about titling my first book "The Employee Assistance Program" he said, "It won't turn anyone on, but it won't turn anyone off, either." The name stuck.

Accountability. During the course of our training from NIAAA, we tackled other thorny issues, the most important of which was how we would know whether or not we were really doing any good, not only for the individual but for their employers and unions. The two major markers were recovery and participant utilization, which we referred to as penetration. We kept it simple. If 10% of the workforce suffered from alcoholism, we asked how long it should take to identify and refer a number equivalent to that population at risk. At that time the US economy was largely industrial and turnover was much lower than it is in today's predominantly service sector economy. So we informally thought the period should be about 5 to 7 years, resulting in an annual penetration rate of 1.5% to 2.0% per year for alcoholism referrals.

In Broadbrush programs we assumed that mental health and family problems also affected about 10% of the workforce so another 1.5% to 2.0% should be added to the utilization rate. Thus, many of us adopted a first-time annual employee utilization rate of 3% to 4% as a benchmark. This computed to about 30 to 40 first time employee referrals per year per 1000 employees, with 15 to 20 being assessed alcoholic. In addition, we believed a significant number of family members should be served. Turning to recovery, the Hazelden data indicated that a 50% benchmark first time continuous recovery rate after one year with improvement in life functioning and life style was a safe expectation for employed alcoholics and many of us adopted that as a goal. Later Norm Hoffman, PhD. began an illustrious career at CATOR, an addiction treatment outcomes research firm in St. Paul, Minnesota. He developed a data base of 75,000 adults and 11,000 adolescents which continued to show that recovery was likely in a majority of cases if the right type, length and level of treatment was provided.

It took a while longer to empirically document the benefits for employers but eventually Benefit to Cost Analysis were developed. Until then the Insight data was the gold standard for many of us as we traveled our states talking to corporate and union leaders. Equally important were the positive anecdotal reports

from supervisors and union reps along with a reduction in grievances and labor unrest. These satisfied even some of the most conservative managers as the Thundering Hundred implemented programs around the country.

We also thought it was important to declare what a Broadbrush program was *not*. It wasn't industrial social work, industrial psychology or industrial medicine. It wasn't a treatment program or in-house AA. It was neither a place to coddle poor performers or to trigger punishment. Persuasion not coercion was the key. The earliest definition of what Broadbrush was "... a labor-management control system designed to earlier identify problem employees when their problems impair job performance and motivate them to receive assistance to resolve the problem." As time passed this definition was refined and methods were developed to attract and assist employees before their problems adversely affected their performance.

The heart of the program: A and R. Finally, and most importantly, was the role and function of the person to whom employees with problems would be referred. With straight alcohol identification and referral programs the answer was easy: Usually it was a recovering alcoholic trained in motivational interviewing. But, in Broadbrush programs the role and credentials were more complex. Someone who knew how to identify and refer alcoholics was still essential, but they also needed to have sufficient familiarity with a host of other mental health, family and concrete issues to make an accurate assessment and an appropriate referral. Technically, they needed to professionally perform three tasks:

- 1.) accurately assess a broad range of issues distinguishing between presenting and primary disorders,
- 2.) bring the issues forth to the attention of the participant in a way that didn't cause them to run out of the room, and
- 3.) persuade participants to take action that they would not have been able to take on their own, without resorting to illegal leverage tactics by threatening their job if they didn't comply.

One task we did not believe they should do was the treatment itself. We did not believe a single therapist could be competent to treat all of the disorders a Broadbrush program would attract. Moreover, if they got bogged down in delivering the direct care, we were concerned that they would not have time to handle new participants or the all-important follow-up and continuing care, which for chronic issues could include weekly sessions for a period of time.

We initially referred to them as Motivational Interviewers and later Assessment and Referral (A and R) resources. Very few professionals and virtually no recovering people were ready made for this role. While several dozen had emerged from the original Thundering 100 and the following group of NIAAA trainees, these numbers were miniscule in comparison to the hundreds and then thousands of workplaces that would eventually develop what were to become known as Employee Assistance Programs.

Mountains and valleys. By 1975, we were riding high. Dozens of Fortune 500 companies were installing programs, insurance coverage was increasing, testimonials abounded, and positive data was accumulating. One might have believed that Broadbrush programs would always be a source of help for large numbers of alcoholics and other addicted people given their original objective, the support of NIAAA as the principal funding source, the initial makeup of the OPC group, the name of the field's first professional association (The Association of Labor and Management Administrators and Consultants on Alcoholism-ALMACA), and the fact that some of the most compelling BCR data was based on the recovery of alcoholics. Unfortunately, a number of conditions and events evolved over the years that militated to the contrary.

Many great in-house Broadbrush programs – by then known as EAPs -- did emerge such as those at Burlington Northern Railway, Bank of Montreal, Amoco and United Airlines and a group that became known as the Employee Assistance Roundtable. But as the years passed such programs became fewer and farther between and the alcoholism focus was all but lost in many of them.

Over the years, I have completed performance audits of dozens of EAPs. In some the rate of Substance Use Disorder (SUD) referrals is where we as OPCs thought it should be, about 1.5% to 2.0% of the employee population per year, first time participants. But in many programs the penetration into the alcoholism population had fallen to less than the incidence of the problem in the general population, barely one-fourth of the standard we had set for ourselves in the mid-70s. Yet, the disease certainly hasn't disappeared. Since Don Cahalan's landmark study, "American Drinking Practices" in 1967 through present day studies published by NIAAA, the rate of alcoholism and other drug disorders has remained at about 9 percent, or 1 in 11 in the general population, with men being higher than women. So, the question is, "What happened?"

The evolution of the Insight program provides a striking picture of what was to occur in the EAP profession. Ever the entrepreneur, Otto Jones created a company, Human Affairs International (HAI), and began providing Insight to other employers on a contract basis. Starting small, the company grew as the EAP concept caught on around the country and by the mid 1980's HAI was providing services to some of America's largest companies. The need for competent assessment and referral staff surged. The problem was that few of them had Otto's skills as both a clinical social worker *and* an expert in recognizing and intervening in alcoholism. Otto preferred MSW's but like virtually all other health professionals, few had been trained in addictions and virtually none in the A and R function. In the beginning, Otto himself trained them. But when HAI grew into a national organization it had to contract with hundreds and then thousands of MSWs and other professionals nation-wide in order to demonstrate to prospective customers that it had a sufficient national network to service their multi-state workforces. Otto couldn't train them all.

Filling a gap and creating an industry. In the meantime, a couple of bright young innovators, Carl Tisone and Richard Hellan in St. Louis formed PPC Worldwide Service in 1975, which became the world's largest commercial EAP provider. Recognizing how few companies had adequate mental health benefits, PPC offered a unique approach in which their own contracted EAP counselors would provide brief therapy to employees. In essence, those charged with assessing and referring were doing the treatment themselves. Since some employers had more extensive mental health benefits than others, PPC provided service options based on numbers of EAP sessions ranging from 3 to 10. This was a great model for some problems such as financial, legal, family and marital for which brief therapy was appropriate. But, because brief therapy isn't generally suitable for most chronic issues including addictions, PPC's policy was to refer participants with those issues to outside addiction treatment resources unaffiliated with PPC.

As national EAP referral networks were formed many individual A and Rs served multiple providers. Very few had the kind of training necessary to recognize and refer employees with alcohol problems. Instead, standard practice began to focus on the presenting problems, such as the marital, family and financial issues which can be caused by addiction. But, addiction itself was not generally addressed unless presented, which was rare. Experience has shown that A and Rs must be trained in how to effectively inquire about addiction to break through the denial inherent in the condition. This starts by asking *every* referral about their personal and family background regarding drinking and drug use patterns.

Other commercial EAP providers sprang up. Some addictions treatment centers that had been receiving referrals from in-house EAPs staffed largely by recovering alcoholics decided to get into the EAP business themselves so they could channel referrals into their own treatment programs. Many EAP professionals considered this to be a conflict of interest that could compromise the integrity of the A and R process. The

most logical group to protest would have been ALMACA, the field's only professional association at the time. But ALMACA itself had a conflict. Always strapped for money, a major source of its income was its annual conferences where most of the exhibitors and many attendees were sponsored by treatment centers. I recall having commented to Tom Delaney, who was the Executive Director of ALMACA, that I feared we would someday find that half of the EAPs were owned by treatment organizations trying to put everyone into inpatient treatment while the other half would be owned by insurance companies trying to keep everyone out. By the mid 1980's most employees that had access to an EAP worked for employers that had contracted for service with a commercial provider.

It's gotta be easier than that. There were exceptions to the commercial or external EAPs as they were called. At UAL in 1978 we developed an in-house service that was widely recognized by ALMACA and others as one of the premier programs in the field. About 40% of the referrals were for alcoholism and other drug issues. Many organizations sought our consultation. But, when we described the arduous 3-year task to implement the program for 50,000 employees, including 160 two-and-one-half hour training sessions for 4000 key management personnel up through and including the CEO, most EAP inquirers opted for the "turn-key" service of a large commercial provider. Soliciting proposals and managing a contract was much easier than the hands-on implementation and management required of a Director of a large in-house program and it involved little direct hiring of A and R staff or key employee orientation and training. But, unfortunately, the Assessment and Referral resources were largely untrained in addictions.

With rare exceptions, such as Dr. Dale Masi's program at the University of Maryland, schools of social work, psychology and medicine taught virtually nothing about alcoholism and drug addiction. And they certainly did not teach students how to intervene in the way an A and R needed to in order to function effectively. At UAL we found that in filling one A and R position, it was necessary to interview on average 10 candidates, and getting those 10 required weeding through more than 50 resumes. The worst fears of the OPCs and organizations such as NCA were beginning to be realized. Literally thousands of therapists untrained in alcoholism and effective assessment and referral techniques were becoming the heart of the EAP world.

Trouble brewing in paradise. Compounding the problem, the field of addictions treatment was coming under attack. Free-standing residential programs like Hazelden and the Caron Foundation (Chit Chat Farms) charged between \$75 and \$100 per day for treatment, or \$2000 to \$3000 for a 30 day stay. However, the hospital based programs were charging about \$250 per day and addictions treatment suddenly became a god-send for hospital administrators. The "Baby Boom" had been followed by a "Baby Bust" and hospitals all around the country had empty maternity wards. An enterprising organization, Comp Care, stepped up to solve two problems: the increasing numbers of empty hospital beds and the insufficient numbers of alcoholism treatment services. They developed a "turn-key" addiction treatment program that they sold to hospitals for \$65 per bed per month, including staffing, the treatment protocol, training, supplies and profit. Within 3 months a hospital could have a fully operational addictions treatment program that might otherwise take a year or more to develop. Equally important, they could sell a service that cost \$65 a day for \$250 to \$300. And, because they were a hospital, insurance companies readily paid the tab while often denying reimbursement to the free-standing residential programs.

As the commercial EAP industry developed, commercial addictions treatment chains also sprang up. In addition to Comp Care, companies such as Parkside Medical Services developed national chains of rehab programs using the Lutheran General program founded by Dr. Bradley in Park Ridge, Illinois as the model. But these companies could not develop new treatment programs fast enough to dominate the industry so they bought up existing freestanding programs and by 1988 grew to more than 2000 beds nationally. In the

acquisition process layers of bureaucracy were added to what had been reasonably priced services, driving up the cost of care without necessarily adding value or improving outcomes. To their credit, some conducted outcome evaluations on their patients but the results at \$8,000 were about the same as Hazelden had found under Dan Anderson in the early 1970s before it had been accredited by JCHA and was charging only \$28 per day.

By the late 1980s many larger employers had become self-insured and the benefit managers who had become more directly responsible for containing costs were not happy with the price escalation. With very few reasonably priced free-standing programs still in existence after all the mergers and acquisitions, typical residential addiction treatment costs passed the \$10,000 mark and a few soared over \$30,000. Benefits managers rebelled. Today, many cost double that amount. In the meantime, residential recovery centers such as the Retreat in Wayzata, Minnesota, are getting comparable outcomes for \$5,000 to \$7,000.

For years overall health care costs had been increasing at 2 to 3 times the rate of inflation and represented an ever-increasing share of the Gross Domestic Product. In 1985, our firm began comparing health care costs to corporate profits and by 1988 the total net income of the Fortune 500 Industrials was eclipsed by their employee health care expenses. Many group insurance plans had only recently begun covering treatment of addictions and mental health and, with a baseline of near zero, quite naturally these claims increased at the fastest rate. They represented the low hanging fruit for the cost cutters. Benefit managers began to realize that health insurance companies had a vested interest in cost escalation because their administrative expense and profit margins were pegged as a percentage of claims. Many had already enlisted Health Maintenance Organizations (HMOs) which assumed the risk at a fixed, multi-year fee. But an HMO's scope was limited to medical-surgical care, and unlike alcoholics or those suffering from depression, beneficiaries complained loudly when the service they needed was cut back.

The new treatment boss. In the early 1990s a counterpart to medical HMOs came on the scene which carved-out mental health and addiction treatment: the Managed Behavioral Health Organization (MBHO). They too accepted contracts at risk. Studying a company's claims data, they calculated the total cost for mental health and addictions, agreed to a firm fixed priced contract at roughly 70% and took over the assessment and treatment. With one of the most expensive components being the standard 30 day residential care for addictions, our own retrospective audits disclosed a non-random pattern of denial of treatment for alcoholism and drug addiction. In one case, a large employer was on a path to spending 10% of its total employee health care costs, or \$20 million, over the following two years for mental health and addictions treatment. The MBHO accepted a contract for \$14 million and proceeded to spend a little over \$5 million for actual care and virtually no one in a group of 50,000 was referred to residential or inpatient chemical dependency treatment. The outcry from the unions and employees led some employers to conduct audits but most were satisfied to weather the storm of criticism and enjoy the short-term gains.

For a period, EAPs and MBHOs competed directly in the workplace, with the MBHO vetoing EAP referral decisions. But that ultimately went by the boards. In building their businesses, MBHOs accelerated growth by rapidly acquiring commercial EAPs, securing their customers and upselling them managed behavioral health products at a much greater cost *but* with the promise of reducing the overall mental health expenditures. Two of the largest commercial EAP firms—Human Affairs International and PPC were swallowed up along with several others. In justifying denial of care practices the MBHO's touted studies that purported to prove that outpatient care was as effective as residential care for addictions treatment. This wasn't what the research of Hoffman and others showed but it was welcome news to benefit managers and independent practitioners.

It was true that few alcoholics needed 30 days in an acute care hospital. More typically, at UAL we found that about 40% of participants suffering from addiction needed primary residential care. Unless there was a serious co-morbid physical or psychiatric issue, the free-standing programs were at least as effective and cost less than half as much. Of the remaining 60%, intensive out patient, small group therapy, one-to-one counseling, and sometimes just AA alone secured excellent outcomes: 72% first time recovery for ground employees; 84% for flight attendants; and better than 90% for pilots and senior management. These recovery rates were far above average and began by providing the right care the first time. Beyond that, the intensity and length of the continuing recovery protocol and family involvement accounted for most of the difference in these outcome rates from the norm. Unfortunately, valid outcome data in the fields of both EAP and treatment began to shrink to nearly nothing as the MBHO's took over. The principal measurement was cost reduction, not recovery, and they certainly achieved that goal largely through denial of appropriate care as the percentage of health care costs represented by substance use disorders and mental health was cut by more than half.

This stuff should be easy, too. Compounding the issue further was the Reagan Administration's response to the growing concern about illegal drug use. At a political rally Nancy Reagan picked up on a placard held by a young school girl that proclaimed, "Just Say No!" When the Reagan Administration turned it into a national mantra ostensibly to fight addiction, both the disease and its treatment were trivialized. It led many to wonder whether treatment was even necessary to begin with. Going further and stressing the need for drug testing the clock was turned back even more. The message was clear: "Use will power to solve your alcohol or drug problem and if you don't our drug testing will weed you out." Employers were in a bind: if an employee caused harm or injury in the workplace while under the influence of drugs, the absence of a drug testing program could be used against the company in a liability suit.

Not only easy, but it's gotta be cheap. Staffing an EAP with A and R professionals who did face-to-face interviews represented a price to employers that generally ranged from \$1.50 to \$3.00 per employee per month, less than 1% of the cost of health care benefits at that time. At UAL the preponderance of our assessments were face-to-face but because about 10% of our employees worked in remote areas we also needed to conduct some assessments over the phone. Our data showed that about three times as many telephone referrals came back to the program within a year for a different problem than was the case with the face-to-face participants, and a disproportionate number of these re-entries turned out to be chemically dependent.

In the 1990's the "Telephone Model EAP" became popular. One large commercial EAP service built a major part of its business through acquisitions of local and regional EAP providers who conducted face-to-face interviews. After an acquisition, they went to the customers and offered to reduce the price by 50% to 70%, and then converted the A and R process to a telephone model which yielded much greater profits than the face-to-face model. Referrals for alcohol and drugs became even more rare. Being able to read body language is important in differentiating the primary from the secondary issues. Because addiction will seldom be the presenting issue, it can be difficult to recognize even when the person is sitting in front of the A and R. Over the phone, chances are diminished more. However, when an HR manager was led to believe they could have something at \$8 to \$10 per year per employee instead of \$20 to \$30, it seemed like a no-brainer. Besides, no one was keeping score when it came to penetration and recovery rates.

And, here we are. There has been an ebb and flow with what EAPs became and they did not all end up the same. Some still do outcomes, follow professional standards and have good utilization rates for addiction. Some try to be "everything to everyone" and have lost sight of the purpose for which EAPs were

established. Others are little more than casual counseling for an array of issues that endear the staff to employees but do not tangibly address the tough issues people face, especially addictions.

It would be easy to simply criticize these developments, especially the monetization of EAPs and treatment. But the truth is, the evolution of EAPs has been like any other movement with a mix of positive and negative results. Today, upwards of 200 million Americans have access to assistance through EAPs that didn't exist when the "Thundering 100" first gathered in 1972. Millions have received help that they would otherwise not have had if not for an EAP. It is highly doubtful this could ever have happened by serially implementing in-house programs. And while far more alcoholics and drug addicts could have been helped, and perhaps should have been had there been better training of staff and fewer compromises in program design and objectives, the fact is that on balance the results have been significant.

So, what's next? The current leaders in the EAP field, especially EAPA and EASNA, need to decide whether or not addiction is still important. If so, then there are lessons to be learned and the following might be considered:

- Until health education institutions, especially schools of medicine and social work, get serious about addiction and include comprehensive instruction for their students in how to recognize the disorder and effectively refer patients for a professional assessment and treatment, late stage identification will continue to be the norm and the personal and public costs will continue to mount unabated.
- Until insurance companies acknowledge that effective recovery can be delivered by free-standing recovery programs at less than \$7,000 for four weeks, and reimburse for it, treatment costs will continue to escalate beyond anyone's ability to pay.
- Since very few health professionals are ready made for the A and R position appropriate training is essential. If an A and R cannot distinguish between an early to middle stage alcoholic who shows signs of depression due to ingesting a depressant drug and someone who is clinically depressed and just drinking too much, they cannot competently do the job.
- Unless EAP practitioners are trained to effectively inquire about alcohol and drug use with every referral, assess addiction, bring it to the attention of the afflicted and their families, and refer them to the most appropriate care, the penetration rates for addiction will continue languish at a level that makes a positive benefit to cost ratio nearly impossible.
- In moving the needle to improve a person's life and safeguard the employer's vested interest, the industry standards need to be enforced by employers, audited by qualified representatives of either EASNA or EAPA, and an honest outcome evaluation system must be part of any EAP.
- Finally, the words of Dan Anderson many years ago still hold true:

"You have to love alcoholics in order to work effectively with them."

Some EAP personnel are capable of this love, others are not. An honest self-assessment is required.

Addiction is more than just a code in the DSM. Now as in 1972, it is a killer that ruins lives, exacerbates a host of other health disorders, fills prison cells, and robs society of its greatest treasure -- a fully realized human life. But, as millions of recovering people will attest, it can be successfully addressed.

The A and R position is more than just a job that offers a clinician a chance to work for an important employer instead of a non-profit social service agency. It is heart of a life-saving workplace system that can be as lonely as it is rewarding.

An EAP is more than just another feel-good HR program. It is often the best hope an employee or family member has of breaking free from a life-destroying condition.

We need not regret the past nor wish to shut the door on it. But, neither does it help to exaggerate our achievements. As always, we need to honestly reflect on where we are, what we have done, who we are, and what will be required of us to do better going forward. Millions are still out there and they need us.

END.