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# Listening to History: Lessons for the EAP/Managed Care Field[1]

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## Introduction

The twentieth century witnessed the rise of occupational alcoholism programs, the explosive growth and evolution of these programs into employee assistance programs (EAPs), and the more recent evolution of many EAPs into managed behavioral health care organizations. Like the addiction treatment industry with which it is historically linked, the EAP field is confronted with unparalleled threats and opportunities. This paper recounts three episodes in the history of addiction treatment and recovery in America and reflects on what these episodes might teach us about the vulnerabilities and challenges facing the EAP/managed care field. The presentation is intended as a platform for reflection about the roots, evolution, and future of a field that is undergoing rapid transformations in its mission and character.

## Three Episodes in History

Our first episode is drawn from the history of alcoholic mutual aid societies in America. There many such societies organized by and for alcoholics between the late 1700s and the early 20th century. There were the Native American temperance societies, the Washingtonians, the fraternal temperance societies, the reform (ribbon) clubs, the Ollapod Club, the Keeley Leagues, the Business Men's

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Moderation Society, the United Order of Ex-Boozers, and the Jacoby Club. None of these organizations outlasted their founding generation.

When Alcoholics Anonymous emerged out of the Oxford Group in the late 1930s, it had little more prospects for survival than did its predecessors. AA faced threats of professionalization and commercialization--Bill Wilson's offer of employment to work as a lay therapist at Towns Hospital. Explosive growth--from less than 100 members in 1939 to 8,000 in 1941--threatened to overwhelm and dilute AA's program of recovery. (Members of a new AA group in Richmond, Virginia, for example, regularly drank beer at their meetings.) There was dissension over plans for AA missionaries and AA hospitals and the operation of AA clubhouses. Local AA groups struggled with the inclusion of women and African Americans. Jealousies abounded over who could speak for AA. There were even rumors that AA was a scam to make AA's co-founders rich. Issues of ego, money, property, and sex threatened to tear AA apart. By all accounts, this self-described "neurotic fellowship" should have shared the premature death of its predecessors. We will explore what sources of resiliency prevented that demise and what those sources have to teach us today.

For our second episode, we will visit the rise of addiction treatment during the second half of the 19th century. An elaborate network of medically-oriented inebriate asylums, religiously-oriented inebriate homes, private addiction treatment franchises, and proprietary bottled addiction cures rose in the second half of the 19th century. In 1895, the future of addiction treatment could not have looked brighter. Significant strides had been made to destigmatize alcoholism and other addictions via a well articulated disease concept of inebriety. The American Association for the Study and Cure of Inebriety was celebrating its 25th anniversary. The *Journal of Inebriety* was about to enter its 20th year of publication. Care for inebriates was emerging as a legitimate specialty within medicine and religion. Treatment institutions were growing in number, and the proprietary home cures were reporting record profits. All seemed bright, and yet within 25 years this multi-branched field of addiction treatment had all but disappeared from the American landscape. We will try to identify the sources of this demise and what this chapter in history has to teach us today.

For our third episode we will visit the modern field of addiction treatment and one particular treatment system known as Parkside. The roots of Parkside can be traced to Dr. Nelson Bradley, Dr. Jean Rossi and Rev. John Keller who took what they had learned at Willmar State Hospital (and from Pioneer House and Hazelden) in Minnesota and refined that model within Lutheran General Hospital in Park Ridge, Illinois. In 1980, a plan was implemented to replicate this

successful alcoholism treatment program throughout the country via a newly created entity, Parkside Medical Services (PMS). PMS went on to become the largest provider of addiction treatment services in America: 100 separate treatment sites, more than 2,000 inpatient beds, 2,500 staff, and annual revenues of more than $220 million.

Addiction treatment institutions, including many treatment franchises like PMS, grew almost explosively during the late 1970s into the mid-1980s, but then began to encounter threats to their existence. If there was one organization that should have survived the turbulence of this period, it was Parkside. It had bright and long-tenured addiction treatment professionals and deep roots in the mainstream Minnesota Model of chemical dependency treatment. It should have survived, but it didn't. By the end of 1993, Parkside as a Lutheran-affiliated national network of addiction treatment centers had collapsed. We will explore some of the factors that contributed to Parkside's demise.

From the above three episodes in the history of addiction treatment and recovery in America, eight lessons will be identified that can help assure that the EAP field does not share the fate that befell many addiction treatment institutions in the in the 1890s and Parkside in the 1990s. In trying to apply these lessons to the EAP field, it is important to acknowledge the difficulty in talking with any clarity about an "EAP field" or an "EAP/Managed Care field." A growing variety of organizational configurations and rapidly expanding service menus are stretching the boundaries of the term *Employee Assistance Program* and making it difficult to make sweeping statements about what EAPs are and how they are evolving. But this rapid transformation in the character of EAPs is itself part of the story we will explore.

## 1. Monitoring and Shaping the Social, Economic and Political Ecosystem

The first lesson suggested from our three episodes in history is the importance of rigorously monitoring the ecosystem that constitutes a field's operating environment. America's first network of addiction treatment programs fell in part because of dramatic shifts in the social, economic and political climate within which they had been birthed. The medicalized view of inebriety--the proposition that inebriety was a treatable disease--began to fade in the late 1890s within a growing climate of therapeutic pessimism. A redefinition of addiction in moral and criminal terms led to a bold new social strategy: let the existing inebriates die off and prevent the creation of new inebriates by prohibiting the non-medical sale of alcohol and other addictive drugs. State and federal prohibition

laws temporarily dried up the demand for addiction treatment services, and prohibition advocates discouraged the continuation of the financial support that had sustained addiction treatment institutions for more than a half a century.

The effects of this political shift were further magnified by several simultaneous and equally unanticipated economic depressions. Widespread economic distress forced a rapid reallocation of private and public funds away from inebriate asylums and toward what were perceived as more important personal and community needs. Many inebriate homes and asylums simply did not see these environmental changes coming quickly enough to position themselves for survival. In a similar manner, errors in reading the external environment prevented Parkside from recognizing the fundamental changes that were transforming addiction treatment in the United States. At a time when most addiction treatment leaders were recognizing that the days of inpatient addiction treatment were numbered, Parkside's leaders pursued an aggressive expansionist strategy of purchasing inpatient treatment programs. When inpatient census plummeted across the country, Parkside collapsed under the weight of its own size and debt.

AA also faced political and economic threats in the Wet-Dry polarization of post-Repeal America. Several organizations interested in alcohol problems during this period collapsed from lack of financial support because they were seen as too wet by Drys and too dry by Wets. The Council for Moderation, the National Committee on Alcohol Hygiene, and the Research Council on Problems of Alcohol were among the casualties of AA's organizational peers in the 1930s and 1940s. AA's solution to this potential entrapment in political turmoil and financial dependence was reflected in two fundamental decisions. The first was to take a position of uncompromising neutrality on all outside social and political issues. The second was to minimize its financial needs by pledging itself to corporate poverty and economic self-reliance. The decisions that contributed to AA's survival emerged out of AA's own internal turmoil and out of AA's recognition of the environmental threats to its existence.

So what implications can be drawn from all of this for our current situation? First, it is important to point out that challenges to the modern addiction treatment and EAP fields have unfolded within the most robust economy in American history. We must ask ourselves the question: How would we fare if there was a sudden economic downturn that forced difficult choices in the allocation of public and corporate resources? The addiction treatment and EAP/managed care industries are vulnerable to any precipitous economic decline, but vulnerable for different reasons.

Addiction treatment institutions are vulnerable because of a broader cultural shift in the perception of addiction and addiction treatment. As happened in the late 19tn century, we are again shifting from medical to moral and criminal models of viewing those addicted to alcohol and other drugs. Therapeutic pessimism is again on the rise as treatment is increasingly cast as a place where bad, irresponsible people are coddled and protected from the consequences of their behavior. The ideological foundations for treatment and the treatment system's claim to cultural ownership of alcohol and other drug problems is weakening.

EAPs are vulnerable because of a fundamental change in the relationship between organizations and their employees. The day is passing when company presidents saw themselves as the paternalistic heads of their own organizational families--a day in which employers and employees were bound by an implicit covenant of mutual loyalty. Today, employees are more likely to be viewed as replaceable commodities whose potential risks/costs to the company must be actively managed. When workers get so redefined, the organizational culture that birthed industrial alcoholism programs and EAPs is in danger of crumbling.

The grass roots movement that birthed industrial alcoholism programs is all but gone and needs to get rebirthed if addiction treatment and addiction-inclusive EAP's are to sustain their viability as cultural institutions. That survival hinges on the re-instillation of four simple messages that birthed the rise of a modern alcoholism movement in the 1940s: 1) The alcoholic is a sick person, 2) The alcoholic can be helped, 3) The alcoholic is worth helping, and 4) Alcoholism is a public health problem worthy of public resources.

I believe that the EAP field needs to participate in the rebuilding of this grass roots recovery movement and renew its relationship with employees in general and organized labor, in particular. To do that, we must move back into full partnership with recovering people in our local communities. We need to help re-instill the cultural belief in the potential for permanent recovery. Many members of our field who are in personal recovery have come to mask that history behind an expanding array of professional credentials. The time has come for those among us in recovery to climb back out of the closet and reassert that permanent recovery from alcoholism and other addictions is not only possible but a living reality, the best evidence of which is our own transformed lives.

It is not enough to simply monitor threats and opportunities in the external social, political and economic environment. We must counter the growing sense that the field is being shaped almost exclusively by outside forces. We must shed our chameleon-like character, define who we are and where we are going, and then pursue that identity and vision through a rebirth of professional and social

activism. None of us would be here today if it were not for the Marty Manns, the Lefty Hendersons, the Harold Hughes, the Will Fosters. They and many more unnamed heroes spent decades of their lives as activists creating fields now threatened by professional passivity. We need a new generation of activists.

**2. Singularity of Purpose**

The second lesson to be drawn from our historical vignettes is that we must not lose touch with our founding mission. Organizations operating within turbulent environments often encounter diversions from their primary missionBdiversions that are frequently masked as golden opportunities. Many 19th century alcoholic mutual aid societies lost their sustaining passion (their focus on the alcoholic) when they got caught up in broader political agendas of the temperance movement. Nineteenth century inebriate asylums and many of their 20th century counterparts became similarly diverted when they moved beyond into activities far beyond the boundaries of their founding missions.

AA avoided the threat of such diversions through Bill Wilson's almost single-handed advocacy of what members at the time referred to as "Bill's damned traditions." The Twelve Traditions saved (and continue to save) AA from self-destruction by detailing a core set of values and operational principles to manage the dangers of distraction. As a field and as individual organizations, we have yet to evolve such a clear delineation and utilization of our core mission and values. Their creation and use would dramatically enhance our future resilience as a field.

We have seen the mission of the EAP field get redefined in ever-extending concentric circles: from occupational alcoholism programs, to employee assistance programs, to drug free workplace programs, to managed behavioral health organizations, to "work-life" programs. The privatization of EAPs via the shift from internal company-operated to external vendor-operated programs has been marked by a shift from a service orientation to a sales orientation. Profit and proprietary self-interest have emerged as potential sources of corruption of EAP clinical decision-making processes.

The Drug Free Workplace Movement brought a new level of invasiveness and coerciveness to many EAPs, shifting their focus from one of personal recovery for occupationally impaired *addicts* to one of apprehension, containment, control, and punishment of *drug using* employees. EA professionals in many companies became perceived more as behavioral police than professional helpers.

The metamorphosis of EAPs into managed behavioral health organizations with a primary focus on risk management and cost containment marks the latest

shift in the redefinition of the EAP "client" from the corporate employee to the corporation. We now have a most unusual situation: the short term profits of EAP organizations and the organizations for whom they work are suddenly linked to denying or rationing rather than maximizing services to employees. The field of employee assistance needs, for technical accuracy, to be renamed the "employer assistance" field in order to reflect the field's redefinition of its primary client.

Organizations within turbulent operating environments are often confronted with the need to adapt rapidly or become extinct, but it is important that we filter our strategies of financial survival through our mission. A lesson from both the inebriate asylums and Parkside is that strategies of financial support that work in the short term may not work in the long term and may weaken the long term integrity of a professional endeavor. We must be very careful that we don't financially survive in terms of our institutions and our personal careers only to discover that we have become something else--that the field that it took decades to build is gone while its institutions and its workers have changed their essential mission and character. We must be very careful not to justify our existence solely based on cost savings, only to later discover that we achieved such savings not by managing care but by altering the quality and access to care.

The question, "What is the future of EAP?" needs to be answered not as a question about the future of EAP as a profitable market, the future of EAP organizations, or the future of career opportunities within EAP. The question that calls for an answer is, "What is the future of the need and the vision out of which EAP was born?" History suggests that professional disciplines that do not remain cognizant of their core reason for being do so at their own peril. Such cognizance can come by achieving broad consensus in answering four questions:

1. What is our **primary** purpose for being?
2. If we have more than one purpose, are these multiple purposes mutually compatible? (Are there any inherent conflicts through which pursuing one purpose fundamentally compromises our ability to pursue another defined purpose?)
3. When one purpose is in conflict with another, which will take precedence?
4. What core values will help us determine when we say "yes" and when we say "no" to EAP-related service and business opportunities?

We all need to revisit our organizational missions and participate in some serious discussion of who and what we are and who and what we are not. Once that vision is clear, we must let this recrystallized mission drive decision-making at

all levels within our organizations.

### 3. The Divergent Dangers of Isolation and Absorption

Mutual aid societies and addiction treatment organizations have long faced twin threats related to boundary transactions with their operating environments. These organizations often faced demise either from isolating themselves from their professional, political and social environments or by being co-opted and absorbed into these environments.

Organizations whose missions involve them with stigmatized issues and stigmatized groups of people have a long history of becoming what I have described as "closed incestuous systems." Such systems can rise to remarkable levels of achievement only to stagnate and then implode. The first medically-oriented addiction treatment institution in the United States--The New York State Inebriate Asylum in Binghamton, New York--self-destructed from precisely such a process and many of its historical progeny have suffered similar fates.

Many addiction treatment providers of the 1980s no longer exist today. Some of these organizations lacked any defining membrane to separate and protect themselves from a rapidly evolving behavioral health care environment. They expanded their identities from alcoholism to addiction to behavioral health or behavioral medicine, only to be gobbled up by more powerful forces within their operating environments. This is a death masked in the process of rapid growth, diversification, loss of identity, loss of passion, and, finally, closure or absorption.

EAPs at both of these poles will not survive the next decade. Those isolationist EAPs will be swept away by forces they didn't see, let alone understand. Those EAPs that chase unlimited market opportunities or are gobbled up in serial mergers may discover somewhere in this process that they have survived as managers of behavioral health services but that they have lost their souls in the process.

There are two related issues within this theme of dilution, diversion, and absorption that are worthy of discussion: 1) the changing status of the alcoholic within the EAP field, and 2) the rapid integration of EAP into broader behavioral health organizations.

The EAP field is rooted historically in the industrial and occupational alcoholism programs that rose up in the early and mid-20th century. When the window of opportunity presented itself for these programs to move towards a broadbrush model, it was done with two rationales: 1) that a broader range of services with a less stigmatized label would result in even larger numbers of

alcoholic employees receiving help, and 2) that this broader service would extend the benefits of this program to a wider population of employees with problems other than alcoholism. The second of these anticipated benefits has been achieved, but as the field's mission has moved outward in ever-widening circles, there are real questions about the degree to which EAPs are now fulfilling their core historical mission of returning alcohol-impaired workers to full health and productivity.

In my more than three decade career, I have witnessed a rise in the expertise in EAP practitioners regarding problems other than addiction, but a deterioration of the ability of EAP practitioners to recognize alcohol and other drug-related problems and to effectively intervene in these problems. What was supposed to be an extension of services beyond the alcoholic is in many quarters turning into a transfer of focus to other areas. As the EAP environment has expanded its embrace to encompass all employees, it has become a less friendly place for the impaired alcoholic.

If we survive as organizations at the sacrifice of our founding mission; then we will have recreated the conditions--the unmet needs--out of which the field was originally born. We will have come full circle and will need to rebirth ourselves. I envision a day in the coming century when enlightened employers will tire of losing some of their best workers to the ravages of alcoholism and will call for a program to intervene in the lives of these employees. Perhaps such a program could go by a name fitting to its form and function: perhaps we could call these new programs *occupational alcoholism programs*. We must maintain fidelity to the field's founding mission by reasserting addiction knowledge and expertise as a central and critical core of EAP services.

The current epidemic of organizational mergers within addiction treatment and EAP is part of a broader shift in the character of American organizations. Such merger frenzy is underway in all sectors of the American economy. It is also, more specifically, part of the current movement out of categorical segregation in health and human services toward cross-disciplinary service integration. As a result of these changes, we are seeing fewer but larger organizations in these arenas, and we are seeing core service of addiction treatment and EAP fields shrink at the same time there is dramatic growth in new and peripheral services. The danger in this trend is that whole arenas of professional endeavor could disappear clouded in the illusion of continued service availability. The names may still be there, services could theoretically exist on paper, while the reality is that the core services that took decades to build could be gone.

History tells us that much can be lost in these integration frenzies. Mergers

of addiction treatment and psychiatric units in hospitals, for example, have all too often been more analogous to hostile takeovers than carefully planned integrations. I regularly visit such units following such so-called mergers and I am hard pressed to find the core addiction treatment technology that once existed there. This is a death masked in the rhetoric of service integration. I think a major challenge entering the new century will be that of maintaining a core identity for the addiction and EAP fields amidst what will be an unquestionable wave of service integration initiatives.

There is also an implied business assumption within this frenzy of mergers of behavioral health organizations that bigger is better and safer. This assumption has yet to be tested over time. We have yet to determine which of these many new EA configurations best serves the needs of individual employees and their families. We must ask ourselves what is being lost in this frenzy to affiliate and merge and be careful that responsiveness to local needs and tastes will not be sacrificed by homogenizing EAP services into the professional equivalent of fast food franchises.

## 4. Toward a Definition of Core Clinical Technology

Inebriate asylums fell in part because of poorly defined clinical technology--no unifying theory, no codification of treatment methods, and a preference for anecdotal case study as opposed to the use of scientific methods to test theories and evaluate treatment methods. The inebriate asylums possessed clinical folklore but not a science of addiction treatment. When they were suddenly put under a cultural microscope as a result of broader political and economic forces, they had no scientific data that they could use to justify their existence.

The modern fields of addiction treatment and EAP have likewise advanced more by ideological proclamation than by science. But scientific research is beginning to play an increasing role in the evaluation of our services. As we progress, we need to continually define our core technologies and use rigorous methods of evaluation to determine what those technologies are and are not capable of achieving (and defining with whom that technology does and does not work). If it turns out that we have no defensible technology, then there is no justification for the field's future. If on the other hand, as I suspect, the research confirms that this technology works with some employees but not others, then we must vigorously work to bridge the gap between this clinical research and our clinical practice--a process that will inevitably focus on the sharper delineation of clinical subpopulations, improved intervention matching, and the continual

expansion and refinement of service menus.

## 5. Continua of Care

The 19th century inebriate asylum's struggle to compete with inebriate homes and proprietary addiction cure institutes was due in part to the asylum's fixation on a single modality--long-term (1-4 years) institutional care. This made it difficult to compete with the much shorter, less restrictive, and less costly modalities of their competitors and assured that the asylums would see only those addicts in the latest stages of deterioration. The modern addiction treatment field has been similarly prone to modality biases that have been increasingly challenged by research findings that confirm: the existence of multiple etiological pathways for addictive disorders, the presence of multiple clinical subpopulations, the need for rigorous assessment and carefully differentiated treatment interventions, and the existence of multiple styles and long term pathways of recovery.

Clinical research confirms the need for community-based continua of services spanning primary prevention through various levels of primary treatment and sustaining care. It has taken more than a century for the addiction field to construct and implement this notion of differential diagnosis and the strategic use of a continuum of care for each client. The backlash against the one-size fits all (28-day inpatient) "Minnesota Model" of addiction treatment threatens to erode this emerging concept of continuum of care and replace it with a one-size fits all low-dose outpatient therapy intervention. We must carefully protect and elevate this continuum of care concept. We are increasingly treating chronic diseases characterized by remission and relapse that unfold within still poorly understood developmental stages of recovery. The issue is not only that different EAP consumers need different types of treatment, but that the same person often requires different types of treatment during different stages of his or her addiction/recovery careers.

Welfare reform initiatives and the current trend toward full employment have contributed to the growing numbers of multiple problem clients/families seeking and being referred for EAP and addiction treatment services. This new generation of clients who present with multiple problems of great acuity and chronicity and with numerous personal and environmental obstacles to stable recovery are often not amenable to the brief outpatient therapies that are becoming the prescriptive norm for everyone seeking EAP/behavioral health services. Only a continuum of care can respond to these changing needs. We must continue to champion this concept. Multiple episodes of low dose therapies that meet cost-

containment goals in the short run may not do so in the long-run and our rush to unquestionably embrace these brief interventions may create a backlash that could threaten the future existence of both the EAP and addiction treatment fields. Such brief interventions should be embraced as part of a continuum of care, not as financial or clinical panaceas.

We must continue to generate outcome data to evaluate elements within this continuum of care at the same time we need to be cautious about a political setup in which we are given decreasing resources to work with clients presenting with greater problem chronicity and intensity. When evaluation studies then confirm that low dose treatments have minimal impact in either inciting personal recovery for most of these clients or reducing their long term social costs, the inevitable outcome will be the conclusion that treatment doesn't work and the extrusion of these individuals from the workforce. Such a conclusion could lead to the abandonment of workplace counseling, diminished support for community-based treatment, and the emergence of more coercive and punitive interventions into the lives of those who fail to respond to brief outpatient therapy. We need as a field to be able to look back in future years and say that we spoke out about such issues and that we refused to be part of such processes.

## 6. Ethical Vulnerability

Ethical abuses within 19th and early 20th century inebriate homes and asylums hurt their image with the public and contributed to the erosion of support for their continued existence. Those ethical breaches included unethical marketing practices (particularly claims of excessive cure rates), corruption in the award of contracts (particularly to trustees and family members), the financial exploitation of patients/families, unsanitary conditions and improper care, excessive use of restraints and solitary confinement, cruel and immoral treatment of patients by attendants, and charges that an inordinate percentage of the financial resources were being devoted to support the extravagant lifestyles of the superintendents. Public exposés did great damage to these institutions and the field=s image was further damaged when many of the proprietary cures were revealed to contain alcohol, opium, morphine and cocaine.

The addiction treatment field has been similarly hurt in the past decade by exposés of personal and institutional shortcomings. There is little doubt that the aggressive managed care that is decreasing accessibility and altering the character of addiction treatment in the U.S. grew out of abuses within the treatment industry itself: inappropriate admissions and re-admissions; inappropriate lengths of stays;

excessive fees, and unethical marketing practices, to name just a few.

The EAP field is moving into a period of heightened ethical vulnerability. These vulnerabilities, which have historically focused on clinical issues, include innumerable ethical complexities involved in the field's business practices: issues involved in the sale, acquisition, and merger of EAP providers; the duality and inherent conflicts in simultaneously provided EAP and managed care services; unethical marketing and sales tactics, including lowball bids for EAP contracts that inevitably lead to service erosion; the troublesome relationship between profit margins and the duration and intensity of service utilization (profit-driven rationing of care); excessive profit margins; misrepresentation of utilization rates; "free" EAP services (the illusion of EAP linked to a 1-800-Tape Recorder or a 1-800-Say No@ hotline); vendor contracting and referral practices; lack of geographically accessible referral sources; the replacement of comprehensive employee behavioral health benefits with low-dose EAP services, and the movement of EA practitioners into areas far beyond their education, training and experience. Conflicts of interests and conflicts of loyalties abound in the emerging EA environment.

We now have a window of opportunity to prevent the ethical abuses that could spawn a backlash against EAP in the coming decade. To avoid this backlash, we need to get ourselves ethically re-centered. I think we can do that by enhancing our ethical sensitivities in light of this changing environment, creating or updating organizational codes of professional practice, and by exerting greater disciplinary control over those in our profession who violate the boundaries of ethical practice. The ethical standards development within the EAP field that has to date focused primarily on clinical ethics needs to be expanded to encompass a rigorous scrutiny of ethical issues and potential ethical standards related to the field's business practices.

## 7. Leadership Challenges

Developing fields (and organizations) face three fundamental leadership challenges: 1) surviving the character foibles of their charismatic founders, 2) managing the transition between the creators and the sustainers, and 3) implementing long term structures for leadership development and leadership succession.

Very few addiction-related mutual aid societies have outlived their founding generation, and the history of addiction treatment is replete with stories of institutions achieving great acclaim only to fall into disrepute behind the fall from grace of their charismatic leader. John Hawkins, John Gough, and other key

leaders within the Washington Movement contributed to the demise of this movement by pursuing their own career agendas as paid temperance lecturers. Reform clubs sprang up in the 1870s around local charismatic leaders, sustained themselves for years, and then quietly died out alongside the relocation or death of these local leaders. The man most responsible for the founding of inebriate asylums in America--Dr. Edward Turner--created such animosity within his own organization and in his professional peer relationships that he was expelled from his own facility and precluded from membership in the first professional association of the field that he himself had helped create. Most of the leaders of 19th century inebriate asylums and homes birthed these organization, maintained them for years, and then collectively retired or died without cultivating new leaders to take their places. The environmental threats to this field were significant in the early 20th century, but in many ways this field died as much from old age as from these external threats.

AA used its Steps, Traditions, and the sanction of "group conscience" to minimize the ability of AA to be mortally wounded by the character defects of its leaders. AA took a minimalist approach to organizational structure, chose not to place its founders in positions of centralized power, defined a core set of principles through which all organizational decisions were to be filtered, decentralized decision making within the lowest level of the organization, and created constantly rotating cycles of leadership.

Today many of the remaining founding leaders within the addiction treatment and EAP fields are poised to leave in mass within the next decade. This rapid bleeding out of the history and professional culture of these fields poses a significant threat to their future. This situation calls for: 1) the development of leadership succession plans inside individual agencies and for the field as a whole, 2) the development of mechanisms and rituals through which we can honor the service of these exiting leaders and capture their experience in ways that can be passed on to new generations of workers, and 3) the creation of one or more leadership institutes to prepare tomorrow's leaders within the EAP and treatment arenas.

## 8. Unity and Statecraft

Perhaps the saddest element of the story of America's first network of addiction treatment providers is the lack of certainty regarding the field's death. We know that the last issue of the *Journal of Inebriety* was published in 1914, but the exact time of the demise of the American Association for the Study and Cure of

Inebriety is unknown--sometime in the 1920s. It is noteworthy that no one remained who cared enough to document the collapse of a field that had provided addiction treatment in America for more than sixty years. Two final factors that contributed to the demise of that field was the lack of unity of the field (bitter debates raged for years between competing branches) and the lack of statespeople who could speak for the field out of a reputation of unquestionable honesty and integrity.

I think a lesson of this period is that we must come together and find a way to speak with one voice. We need strong advocacy organizations that can guide the long-term evolution of the field and protect the integrity of the field from internal and external challenges. We need statespeople whose pronouncements about the needs of employees and their families transcend issues of personal and institutional self-interest. We need statespeople who have the courage to make decisions that are based more on principles than popularity or profitability. We need statespeople who are viewed by all as truthtellers and not hustlers pursuing their own personal or institutional agendas.

## The Lessons of History

In closing, let me recap what I think are the eight historical challenges that I believe are important in shaping the future of the EAP field.

1. We must rigorously monitor the social, political and economic ecosystem within which we operate and sustain an activist stance in shaping social, economic and political agendas that support hope-infusing interventions into the lives of impaired workers.

2. We must not be diverted from our primary purpose. We must sustain fidelity to our historical mission.

3. We must monitor our boundary transactions with the extra-professional environment in order to avoid the threats of isolation and implosion on the one hand and dilution and absorption on the other.

4. We must define core clinical and management technologies and practice only within the boundaries of that technology.

5. We must continue to construct continua of care that can respond to behavioral

health problems of varied intensity, complexity and duration.

6. We must find ways to elevate the level of our ethical practices, both in the business arena and the clinical arena.

7. We must find ways to survive the character flaws of our charismatic founders. We must implement strategies of leadership development and succession that will allow us to survive our founding generations with our mission intact.

8. We must come together, rise above our parochial personal and institutional interests, and find a way to speak as one voice. We must find the courage to be truthtellers.

## A Personal Note

As I interact with EAP professionals in my travels around the country, it is clear that this is a time of great strain. Many EAP professionals report that it is getting harder and harder to draw personal satisfaction from their day-to-day duties. The transition from company counselor to fiscal gatekeeper and contracts manager has not been an easy one for many. Some are taking an activist stance to more positively shape the future of their organizations and the field. They are trying to re-seed their organizations and the broader field with what they believe are our most important core values. Others are practicing a policy of self-containment--creating pockets of hope within which they can actualize the historical values that originally drew them to EAP. Still others are exiting the field in search of arenas that offer greater levels of personal and professional satisfaction. What all three of these groups share is the experience of strain in trying to reconcile their own personal and professional values with those they encounter within our evolving field.

In this time of great strain, I think we can sustain ourselves through the same four daily rituals that have long been the hallmark of addiction recovery. We need to find *centering rituals* that provide us time alone to set aside distractions and help us "keep our eyes on the prize"--keep ourselves focused on what is most important within this thing called EAP. We need time to reflect, meditate, pray and stay focused. We need *mirroring rituals* through which we can interact with like-minded spirits for mutual support. The worst threats of this period we need to face together, not in isolation. We need regular *acts of self-repair* to heal ourselves and

our most intimate relationships. We must guard against the danger of carrying light to others while leaving our own homes in darkness. Finally, we need to cultivate unpaid *acts of service* in our communities--acts that help affirm the nobility of public service and remind us of why we chose to devote our lives to helping others.

The future health and vitality of our field will only be as strong as the health of our individual service organizations and the health of each of us. I have completed more than thirty years of involvement with these imperfect instruments we call intervention and treatment but I pass this milestone still believing that at their best these instruments can transform individuals, families, organizations and communities. It is that power that is the soul of our field, that power that can nurture each of us and our organizations, and, if the field should lose its way, that power that will have to be rediscovered in the future. I wish each of you and your organizations godspeed on your journey into that future.