

Employers and the Value of Treating Substance Abuse: A Recommendation Concerning Faith-Based Programs

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Although most are inclined to think of health primarily in terms of physiology, society, as a whole, has come to perceive health status in terms that extend beyond the tangible aspects of existence. The physiological effects produced by stress, for example, have caused the realization that the concept of health encompasses matters related to the mind and emotions as well. So, too, have the consequences engendered by alcohol and drug addictions caused many to consider health in more than merely physical terms. This broader view is not lost on employers, who, perhaps more directly than any other group, have experienced first hand the economic costs associated with alcohol and drug addiction by employees.

The plague of substance abuse and addiction so pervades the culture that it has been widely recognized as a matter worthy of research and public discourse. According to a study conducted by the federal Substance Abuse and Mental Health Services Administration in 1999, 105 million people in the United States over the age of 12 reported current use of alcohol (Substance Abuse and Mental Health Services Administration, 1999). Of these persons, 10.4 million were under the age of 21, and 8.1 million were estimated to be addicted to alcohol. The study also found that 14.8 million people reported current use of an illicit drug, on which 3.6 million were dependent. Overall, the study found that 10.3 million persons in the United States were dependent on either alcohol or illicit drugs in 1999. The White House Office of National Drug Control Policy reported similar results from another study ("Fact Sheet: Drug Data Summary," 2003).

The pervasive problem of substance abuse and addiction adversely affects society in several ways: It challenges public safety, burdens the national conscience, and consumes resources. Both the White House Office of National Drug Control Policy and the National

Employers bear the most direct economic burden associated with addictive behaviors by employees. Because employers most readily quantify addiction cost, they have an identifiable financial incentive to eliminate or minimize this problem. Employers collectively wield the economic power necessary to compel a candid identification of the most efficacious treatment modality for addictive behavior, which preliminary evidence suggests might be found in faith-based programs. Addiction has become so pervasive that the debate over the relative efficacies of faith-based, as opposed to conventional, psychiatric-based programs should be resolved. By identifying and providing health insurance coverage for the most effective of these modalities, employers would have the opportunity to enhance their competitive posture by curbing the effect of addiction on profitability.

Mental Health Association (NMHA) have found a strong correlation between substance abuse and crime (Office of National Drug Control Policy, 2003). More specifically, employers have found that addiction exacts significant economic costs on a firm and compromises its competitive position in the marketplace. Individual consumers, too, have come to intuitively understand that those costs are somehow embedded in the price paid for goods and services. Yet, without regard to the lens through which one might view the matter, a common thread emerges: The price paid for addiction, whether stated in economic or personal terms, is great. For example, the National Institute on Drug Abuse and National Institute on Alcohol Abuse and Alcoholism have reported that alcohol and other drug addiction approached a total economic cost of \$276.3 billion in 1995 and noted that these costs ultimately result in higher taxes and increased consumer prices (NIDA/NIAAA, 1998).

Key Words

alcohol and drug addiction
faith-based programs
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Employers are the most well-placed constituency to lead the nation in the effort to address the problem of alcohol and drug addiction. Because employers bear the most direct economic burden of these disorders, they can most readily quantify the cost posed by them. For this reason, employers have a specifically identifiable financial incentive to find a solution to this problem, which society, in general, finds too nebulous to grasp. Moreover, by wielding their combined economic power as purchasers of healthcare, employers can drive the market forces that will allow the most efficacious treatment modalities for addictive behavior to be identified.

Preliminary data indicate that this efficacy might be found in faith-based programs that concentrate on the spiritual dimension of addiction. Yet these nontraditional treatment modalities, which typically do not provide medical care, medical detoxification, or medical withdrawal services, are now obstructed by an array of contractual, legal, and regulatory barriers. Here, too, employers may bring a collective weight to bear on these obstacles that individual consumers cannot surmount.

The purposes of this article are twofold: (a) to remind employers of the economic value they will find in providing health benefits to cover the cost of treating alcohol and drug addictions, and, (b) to encourage employers to press for further study of faith-based addiction recovery programs as a viable means of treatment. The authors submit that employers are best situated to lead efforts to find a consensus concerning the most effective means of treatment, thereby bringing about changes that will benefit both their competitive posture in the market and society.

Employer Cost

Alcohol and drug addiction is a prevalent *societal* problem that inevitably crosses over to the workplace. Studies indicate more than two-thirds of illegal drug users in the United States are employed and 12% of workers have consumed at least 5 alcoholic drinks per day within the past 30 days (Atkinson, 2001). Moreover, 12% of workplace disabilities in the United States have been attributed to alcohol and drug abuse (Mental Health Trends, 2003). All levels of the corporate structure are affected, and a majority of firms have indicated that

employee drug and alcohol addiction poses significant operational concerns (Wah, 1998). Although the most readily identified problems are absenteeism and diminished productivity, the negative consequences of addiction taint the spectrum of vital workplace measures. For example, the evidence indicates that substance abusers (Strazewski, 2001)

- are 16 times more likely to be absent from work than their coworkers.
- perform at a level that reflects only two-thirds of their potential.
- cause 40% of industrial accidents and fatalities.
- are five times more likely to injure themselves on the job than nonhabituated workers.
- incur four times the medical costs as their peers and use benefits eight times more often than nonabusers.
- account for more than 40% of employee thefts.

These problems pose significant costs to employers. In fact, each substance abusing employee costs approximately \$7,000 per year (Strazewski, 2001), aggregating about \$200 billion annually to American businesses (Wah, 1998). According to Mark Derbyshire, a director of behavioral health, "If you're paying someone \$30,000 a year, you're only getting \$15,000 to \$18,000 worth of work out of that person. Multiply that by the number of employees experiencing problems, and you quickly realize you're losing a bundle" (Atkinson, 2001, p. 43).

The financial costs associated with addictive behaviors will become of even greater concern to businesses for two related reasons. First, the prevalence of addiction is progressing at a remarkable rate in the United States (Institute for Research, Education and Training in Addictions, 2003). Second, there exists a steady and incremental move in the state legislatures and in the United States Congress toward some form of statutory mandate for parity in physical and mental health insurance coverage (Jacobi, 2003).

Some versions of parity embrace an all-or-nothing approach, which would create a true dilemma for employers (Jacobi, 2003). These proposals would mandate that all private insurance plans cover treatment for both physical and mental illnesses and require parity in the terms and conditions of such coverage. By forcing employers to choose between providing

no health insurance at all or selecting a private plan that provides a full range of coverage (including mental health benefits), the full parity approach would be asking employers to make a difficult choice. The former arguably would weaken their position vis-à-vis other firms in the labor market, and the latter might expose them to higher health insurance premiums—although it has been suggested that any increase in insurance costs would be minimal (Kirschstein, 2000; Sturm, Zhang, & Schoenbaum, 1999).

It is, of course, possible that any eventual parity legislation would exempt employers who adopt their own self-insured plans (Jacobi, 2003). Such employers might decide to exclude mental health coverage from the scope of their plans for any number of reasons. For example, perceptions concerning the indeterminate nature of mental illness itself have sometimes led employers to forego coverage for mental health conditions out of a concern that they would be paying for “treatment” related not to symptoms of a true illness, but to an employee’s unhappiness in life circumstances, such as personal dissatisfaction in a relationship with a supervisor or a spouse (Jacobi).

These suspicions, although perhaps valid in certain contexts, arguably are less relevant for employees who engage in the sort of treatable behavior that manifests itself in readily quantifiable economic terms, such as drug or alcohol addiction. Moreover, employers who summarily dismiss the plight of addicted workers do so at their own expense. Quite simply, those who forego coverage for treating addicted employees will burden themselves with a compromised workforce whose best efforts are diverted to a competing passion and also expose themselves to potential legal problems associated with terminating an employee who falls into a protected class. The issue, therefore, is how employers might address the underlying problem in the most cost-effective manner.

Economic Benefits of Providing Substance Abuse Treatment

Statistics concerning the economic costs of addiction and its pervasive nature among the U.S. labor force suggest that employers must deal with the problem. Although termination might seem to be the simplest and most obvious solution, it could be the least viable option for a variety of reasons. An employer who

replaces a terminated worker inevitably faces the same statistical probability of hiring a new employee with similar problems with addiction. Although employers might be able to reduce this potential by adopting a pre-employment drug-screening program, they would still risk hiring a person predisposed to alcohol abuse, which accounts for most of the substance abuse in the United States (Substance Abuse and Mental Health Services Administration, 1999). They also would face the risk of hiring a person who becomes dependent on alcohol or drugs *after* being hired. Moreover, by terminating an employee, an employer incurs the significant cost of training another worker.

Finally, employers cannot readily replace the experience and continuity some employees bring to the firm. In short, certain employees are either indispensable or simply too costly to replace.

These factors alone provide ample incentive for employers to seek treatment for workers bound by addictive behavior patterns. The practicality of this incentive is fortified by evidence that suggests improvements in the job-related performance of workers who successfully complete a substance abuse program. According to the Federal Alcohol, Drug Abuse, and Mental Health Association, the return of investment of Employee Assistance Programs used to treat employee addiction and mental health problems is estimated at eight to one; savings are produced by fewer accidents, less employee theft, reduced training and hiring costs, higher morale, and greater job efficiency (Goldstein, 1997). Similarly, Barbara M. Levine of Hewitt Associates, a highly regarded human resource consulting firm, suggests that to the extent organizations can intercede and place employees into treatment programs early, worker productivity and absenteeism rates will be positively influenced (Fitzsimons, 1992). Moreover, alcoholics and drug addicts who have not undergone treatment have been found to incur twice the healthcare costs of those who have been treated (NMHA, 2002). Finally, a 1996 study by the President’s Commission on Model State Drug Laws determined that every dollar spent treating substance abusers yielded \$10 in overall corporate savings (Reynolds, 1998).

In short, logic suggests that employers might find in these studies—all of which

involved traditional, non-faith-based treatment programs—a financial incentive to provide addiction recovery for their employees who are dependent on alcohol or drugs. The economic value of such programs does not appear to be at issue. Rather, viewing the matter solely from a financial perspective, the most significant concern is the identification of the most efficacious treatment methodology. Preliminary data suggest that faith-based programs might offer this efficacy, thereby enabling employers to compound the economic value already found in the world of secular addiction treatment.

Secular Versus Faith-Based Recovery Programs

Although the medical community has long relied on psychiatric therapy and treatment for substance abusers, religious organizations have quietly operated their own parallel system for more than 40 years (e.g., the first of such programs, Teen Challenge, was founded in 1958 in Brooklyn by Reverend David Wilkerson). These faith-based programs have largely gone unnoticed by healthcare professionals and health insurers. Yet, preliminary studies show them to be markedly more successful than secular programs.

According to the National Center for Neighborhood Enterprise (NCNE), a not-for-profit, nonreligious organization devoted to addressing a wide variety of societal problems, including substance abuse, the traditional psychiatric-based programs tend to exhibit initial success rates of between 6% and 13% (NCNE, 1998). In contrast with their traditional counterparts, several faith-based programs have achieved success in 60% to 80% of their cases (see www.ncne.com/). For example, a survey of Teen Challenge of Chatanooga—a faith-based program—indicated that 88% of program graduates required no additional treatment after completing the program, 67% refrained completely from the use of narcotics, marijuana, alcohol and cigarettes, 72% continued their education upon completion of the program, 75% were employed, and 67% attended church regularly (NIDA, 2004). Victory Fellowship—a faith-based program in San Antonio, TX—claims similar results (NCNE, 1998, p. 21). Studies have shown even more pronounced differences between faith-based and secular

programs in terms of recidivism rates (NCNE, 1998, p. 6).

This prominent divergence in results between psychiatric and faith-based programs has been attributed to a fundamental difference not only in the approach taken to treatment, but also in the goals set for patients. In particular, faith-based programs question the focus psychiatric programs place on rehabilitation, which seeks to modify behavior patterns that might return when a client re-enters the environment that initially created his or her addiction. Although the NMHA found that secular treatment programs are effective in treating drug addiction, it noted that addiction is an often chronic disorder that requires continued and repeated treatment episodes (McLellan, Lewis, O'Brien, & Kleber, 2000). In contrast with the emphasis secular programs place on behavioral modification, faith-based programs seek to produce a lifelong transformation by engendering a value shift that provides patients with a fulfilling life that transcends the power of temptation. Interestingly, while logic might suggest that such a program would be most plausible for patients who are predisposed to a spiritual strategy, NCNE has found that a majority of successful faith-based clients previously held hostile or skeptical views of religion and spirituality (NCNE, 1998, pp. 4–5).

Faith-based programs also are considerably less costly than their secular counterparts. Whereas the average secular program costs between \$300 and \$600 per day, anecdotal evidence suggests that faith-based programs cost less than 10% of that amount (NCNE, 1998, pp. 9, 42, 54).

It is ironic, in the face of this evidence, that health insurers tend to cover only treatment provided by secular programs. This seeming anomaly in the financing of addiction recovery treatment is to some extent derived from various state regulatory schemes that inherently favor traditional psychiatric programs over faith-based ones.

Therefore, it is no surprise that health insurers customarily tie their obligation to pay for medical care to the provider's compliance with state law licensing requirements. In this way, insurance companies have tried to limit their payments to healthcare providers who possess the minimum competence to render the service for which they claim compensation. Consistent with this objective, which

emerged in the context of conventional medical care, insurers who provide addiction-recovery benefits customarily limit their coverage to programs that satisfy the sometimes rigid state law licensing requirements and counselor-to-patient ratios that govern traditional medicine-oriented, psychiatric-based modalities.

Faith-based programs tend to be frustrated by these constraints. Unlike their secular counterparts, faith-based providers typically employ as drug counselors recovering addicts who, though lacking the academic degrees necessary for licensure or certification by the state as a physician or counselor, have firsthand experience in the entangling web of addiction and the process of being freed from the grip of compulsion (U.S. Office of Technology Assessment, 1994). They likewise find their efforts inhibited by state-mandated counselor-to-patient ratios geared toward the dynamics of the traditional model (NCNE, 1998, p. 65).

Faith-based providers acknowledge that these rules might have a logical basis when applied to the traditional programs for which they were designed. Yet they argue that the prevailing legal and regulatory scheme is simply problematic in the context of interventions that employ a completely different methodology. Moreover, they contend that the law arbitrarily encumbers them with unnecessary operating costs.

State governments are beginning to understand the validity of these points. In 1997, for example, the Texas legislature exempted faith-based programs from such rules (SB 1070/HB 2481). Florida, too, recognizes that faith-based programs should be subject to a different set of guidelines (Section 9, Florida Statute 397.082). Authorities in other states, however, span the spectrum in their responses to faith-based interventions, ranging from allowing them to operate with a “wink and a nod” to insisting that they operate in strict compliance with the law (NCNE, 1998, pp. 65–79).

Employer Recommendations

In 1997, NCNE convened a roundtable of faith-based treatment providers, legal and research scholars, and drug treatment officials from five states with a view toward shifting the paradigm of drug and alcohol treatment in the United States. The resulting discussion led to a number of recommendations for action by

both the public and private sectors to improve the efficacy of treatment programs. Among them were the following:

- the exemption of faith-based programs from state licensing laws that are geared toward conventional therapeutic programs
- the granting of credit by the states for spiritual training and counseling methodologies as an alternative to the academic standards that apply to traditional programs
- the exemption of faith-based programs from counselor-to-patient ratios that are relevant only to the conventional medical treatment model
- the removal of legal and contractual barriers to third-party payment for faith-based services (NCNE, 1998, pp. 81–85).

Preliminary data suggest that these proposals might be well-grounded. Although the existing evidence is more than anecdotal, it has not been subjected to the level of scrutiny that many academicians demand. In light of the importance of the issue to both employers and society at large and recognizing the controversy that inevitably attends the discussion of matters related to faith and religion, the authors recommend that additional research be undertaken to more specifically identify the correlation between faith and addiction recovery. In short, the resolution of the debate concerning the relative efficacies of traditional and faith-based addiction treatment is vital to society’s collective well-being. To embark on an expansive and impartial inquiry to accurately and objectively identify which of these alternative treatment modalities is, in fact, most effective was the goal of this study.

The authors believe two factors should work together to invigorate this debate within the corporate community: the incidence of addictive disorders among employees in the United States, and the economic self-interest employers have in the productivity of their workforces. Accordingly, the authors recommend that employers undertake a careful review of the existing studies to compare faith-based and secular treatment programs and encourage additional studies to resolve any remaining questions concerning their relative efficacies. Such studies might compare a number of programs of the traditional model with

a variety of different faith-based programs—including programs offered by different religious groups.

Should employers conclude from these efforts that faith-based programs are significantly more effective than their secular counterparts, the authors would further recommend that faith-based programs be considered as a vehicle to restore compromised employees to their full potential, and that employers actively lobby for changes in the legal and contractual environments that shape the manner in which these programs are operated and financed. In addition to pursuing changes in the various state legislatures, for example, employers might consider pressing for more flexible health insurance coverage guidelines that would embrace faith-based remedies. To the extent insurers continue to incorporate traditional license-based regulatory constraints into their contractual models, they inadvertently could be shifting resources away from the most effective means of treatment.

Conclusion

From a societal perspective, the sheer extent of the addiction problem among the population makes it imperative that it is addressed. The authors believe two facts point to employers as the sensible choice to support, if not lead, the nation in doing so.

First, logic suggests that employers should be driven by their own economic self-interest to address the consequences of addiction in the workplace. Because employers directly bear the most significant economic costs associated with addiction in the labor force, they can best quantify the problem in monetary terms. This ability also gives employers a more immediate incentive to address addiction in the most cost-efficient manner.

Second, by virtue of the relationship that exists between an employer and an employee whose abilities have been compromised by addiction, and in light of the economic pressures employers bring to bear on the health insurance market and on treatment providers, it is arguable that employers have the ability to most efficiently structure and control the manner in which the problem is addressed. Quite simply, because employers largely drive the demand side of this equation, they are uniquely situated to help us, as

a society, find the most efficacious solution to addiction.

Finally, the preliminary evidence concerning both the cost advantages of faith-based programs and their efficacy over the more traditional, secular programs should be sufficient to initiate a discussion among employers about the comparative value of these treatment options. Although the corporate world has long shared a collective concern with addiction, the business community has been reluctant to address it. To the extent this reticence has stemmed from questions about the long-term benefits and the tremendous cost associated with the traditional psychiatric-based addiction recovery programs, the authors conclude that they should be compelled by the experience of faith-based programs to revisit the issue.

References

- Atkinson, W. (2001). EAPs: Investments, not costs. *Textile World*, 151(5), 42–44.
- Goldstein, T.F. (1997). Employee assistance programs. *Journal of Compensation and Benefits*, 13(2), 23–27.
- Institute for Research, Education and Training in Addictions. *Addiction treatment: When knowing the facts can help*. (2003). Retrieved January 3, 2004, from www.ireta.org/budget/facts_can_help.doc
- Jacobi, J.V. (2003). Parity and difference: The value of parity legislation for the seriously mentally ill. *American Journal of Law & Medicine*, 29, 185–201.
- McLellan, A.T., Lewis, D.C., O'Brien, C.P., & Kleber, H.D. (2000). Drug dependence: A chronic medical illness and implications for treatment, insurance and outcome evaluations. *Journal of the American Medical Association*, 284(13), 1689–1695.
- Mental health trends. (2003). *Workplace visions* (Society for Human Resource Management Research Report), 2 (3).
- National Center for Neighborhood Enterprise (NCNE) policy monograph. (1998). *Outcry from the Alamo: Ending the hostility toward faith-based drug treatment*. Washington, D.C. Retrieved February 11, 2004, from www.ncne.com/linkpage.cfm?webpage_id=88&category_id=14, or 202/518-6500
- National Institute on Drug Abuse (NIDA) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA). (1998). *The economic costs of drug and alcohol abuse in the U.S.* Retrieved February 11, 2004, from www.nida.nih.gov/economiccosts/Chapter1.html#1.10
- National Institute on Drug Abuse. (NIDA). *National Institute on Drug Abuse Report*. Retrieved February 11, 2004, from http://www.teenchallenge.com/index.cfm?studiesID=2&doc_ID=170
- National Mental Health Association. (2002). *Substance abuse insurance parity: A guide for advocates*. Retrieved February 11, 2004 from www.nmha.org/state/parity/SAParity.pdf
- Office of National Drug Control Policy. (2003). *Fact sheet: Drug data summary*. Retrieved February 11, 2004, from www.whitehousedrugpolicy.gov/pdf/drug_data_sum.pdf
- Reynolds, L. (1998). Mental health parity. *HR Focus*, 75(6), 8.

- Strazewski, L. (2001). Facing facts about workplace substance abuse. *Rough Notes*, 144 (5), 114–118.
- Sturm, R., Zhang, W., & Schoenbaum, M. (1999). How expensive are unlimited substance abuse benefits under managed care? *Journal of Behavioral Health Services and Research*, 26(2), 203–210.
- Substance Abuse and Mental Health Services Administration. (1999). *Annual national household survey*. Rockville, MD. Retrieved February 11, 2004, from <http://www.samhsa.gov/news/newsreleases/000831nrhousehold.htm>
- U.S. Department of Health and Human Services, National Institutes of Health, National Institute of Mental Health. Kirschstein, R.L. (2000). *Insurance parity for mental health: Cost, access, and quality*. Final report to Congress by the National Advisory Mental Health Council. Rockville, MD. Retrieved February 11, 2004, from www.nimh.nih.gov/parity/paritypdf.pdf
- U.S. Office of Technology Assessment. (1994). *Technologies for understanding and preventing substance abuse and addiction*. Shaffer Library of Drug Policy. Retrieved February 11, 2004, from www.druglibrary.org/schaffer/library/studies/ota/Otatoc.htm
- Wah, L. (1998). Treatment vs. termination. *Management Review*, 87(4), 8.

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