Journal of
Employee Assistance

The magazine of the Employee Assistance Professionals Association

VOL. 39 NO. 2 • 2ND QUARTER 2009

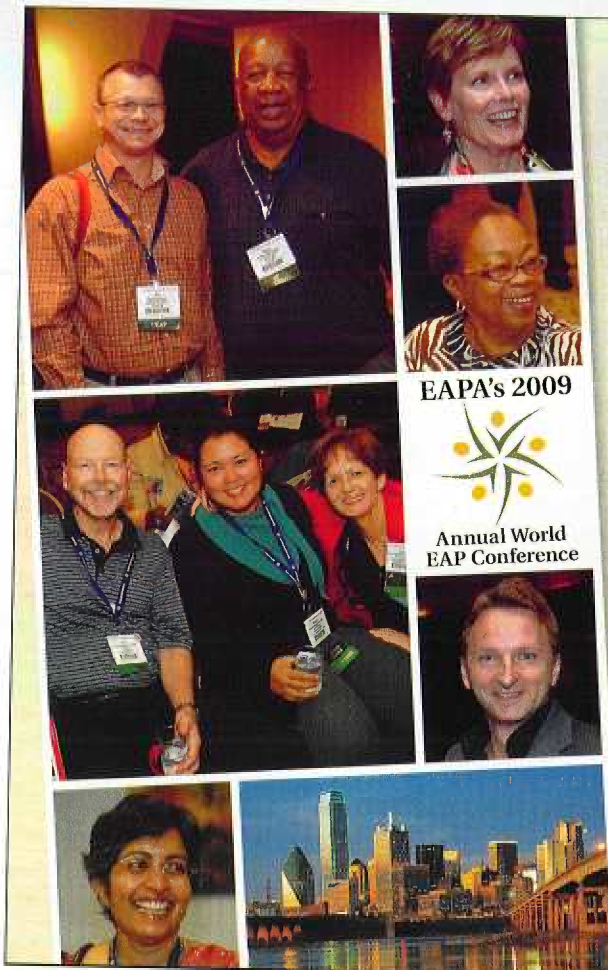
The Changing Nature and Future of EAPs

Also inside:

Diabetes and Aging in the Workplace

Sex and Love Addiction on the Internet

Employee Assistance Professionals Association



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The Changing Nature and Future of EAPS 12
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by Marcia Draheim, RN, CDE, and Sandra Drozdz Burke, Ph.D., RN, CDE, BC-ADM
An understanding of diabetes and its relationship to aging can help EAPs better assist employees with the disease and encourage healthy behaviors among those who are susceptible to it.

Recovering from Workplace Traumatic Events 10
by Pat Burton, M.S.W.; Jeff Gorter, M.S.W., CAC; and Rich Paul, M.S.W., CEAP
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Navigating in the Winds of Uncertainty 16
by R. Michael Westbay, LISW, ACSW and Gabrielle F. Sarfaty, M.A., PMHC, NBCC
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Sexual Health and the EA Professional 18
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Sex and Love Addiction on the Internet 21
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"There is no 'one size fits all' playbook for the unthinkable. For example, a crisis plan based on the assumption of terrorist activity or a natural disaster (as so many recent plans have been) will prove ineffective for providing guidance or structure following an event such as a mass shooting."

"Recovering from Workplace Traumatic Events," page 10

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The Courage to Change the Things We Can

Maria Lund

by Maria Lund, LEAP

With all the uncertainty lately about the economy, unemployment, and national and world affairs, I've been thinking about the Serenity Prayer:

God grant me the serenity to accept the things I cannot change; the courage to change the things I can; and the wisdom to know the difference.

At times like this, it may seem there's not much we can change—that we're at the mercy of forces we may not completely understand, much less control. But in fact there's a lot we can change if we focus on core values and strengths and summon our courage and conviction.

For example, we can take stock of the vast array of information—both about what's working and what isn't—that times of transformation offer. We can seek training to help sharpen our basic skills. We can attend professional meetings and network with colleagues to share ideas. We can review our internal systems and procedures to make sure they're up to date and consistent with best practices. We can scan the changing horizon for options and risks we hadn't considered in the past. And we can make an extra effort to reach out to our clients—the employees, managers, and corporate leaders we serve—to identify any concerns or opportunities we may be overlooking.

These are the lessons I draw from the articles in this issue of the *Journal*. From Pat Burton, Jeff Gorter, and Rich Paul's tips on preparing for and responding to crises to Marcia Draheim and Sandra Burke's piece about assisting workers with diabetes, the message is clear—change, whether sudden and powerful or gradual and barely noticeable, is a certainty. The only uncertainty is whether and how we will prepare for and respond to change.

This has been true of the EAP field since its inception, as the interviews with four EA professionals on pages 12-15 make clear. Arlene Darick, one of the interviewees, put it this way: "The needs of the workforce have changed dramatically from the days when substance abuse was the primary presenting issue. Listening to your customers' needs and developing programs to assist them can contribute to your EAP's success and retention, especially during severe economic downturns."

So, consider using the current uncertainty to your advantage. Make improvements to your program, your services, your capabilities and your methods—the things you can change. Accept the fact that new challenges and opportunities will arise, and that you cannot foresee or prepare for all of them. Resolve to be the best professional you can be, to be open to the important truths that changes often bring.

Being the best you can be requires keeping current on workplace trends and developments, and this issue of the *Journal* addresses some prominent ones: sex addiction, diabetes (especially among older workers, who are becoming more numerous), and sexual health. This issue also contains a thought-provoking letter from Charlie Williams, who takes up the call issued by Joel Bennett and Mark Attridge in the 4th quarter 2008 issue to add a preventive health component to the EAP Core Technology. Charlie is the second person to comment on that article (Patricia Herlihy did so in the 1st quarter 2009 issue), so it clearly is a topic that deserves attention and discussion by our profession.

By the time this copy of the *Journal* reaches you, the economy may have begun to stabilize, some of the world's hot spots may have begun to cool, and employment may have begun to increase. Then again, maybe a new cause for uncertainty will have arisen—a health crisis, for example, or a political scandal. We can't change what we don't know will happen. But we can change the outcome as it relates to our challenges and opportunities. If you have some ideas about how the EAP industry can excel in this economy or about any new opportunities for EA professionals, please share your thoughts.

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Prevention Needs to Be Clearly Delineated in EAPs

I would like to offer kudos to Joel Bennett and Mark Attridge for addressing the idea that a new preventive health services component should to be added to the EAP Core Technology (4th quarter 2008, pp. 4-6). They have touched on a subject very near and dear to my heart and past work—prevention.

The public health model continuum separates prevention into primary, secondary and tertiary components. Only the primary component is targeted toward preventing medical/health problems, such as diseases, illnesses and public health emergencies. Vaccines, nutrition programs and health education are common forms of primary health prevention.

In my view, EAPs evolved out of alcoholism treatment, or tertiary prevention. They have since been stretched in many new directions, such as responding to critical incidents in the workplace, natural disasters of unprecedented magnitude, and, now, the stressors of economic recession.

So, how did EAPs get started and funded? Was the intent in establishing EAPs to prevent problems or treat them?

Nearly four decades ago, Congress passed the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970, which came to be known as the Hughes Act in honor of the law's chief author and sponsor, Sen. Harold Hughes, a recovering alcoholic truck driver. The bill authorized the creation of the National Institutes on Alcohol Abuse and Alcoholism (NIAAA), which became and is today the lead federal public health agency conducting and funding alcohol research.

The Hughes Act authorized NIAAA to provide funding for each state to hire two occupational program consultants (OPCs), who were tasked with "spreading the word" about alcohol abuse to employers within their state and helping develop workplace-based programs. These occupational (alcoholism) programs soon found a new name: EAPs. They developed into three early models based on consultation, assessment and referral to treatment.

Today, a "good" EAP should have some measurable primary preventative outcomes. One of the more obvious would be preventing workplace violence.

I provide this history to demonstrate that EAPs evolved mainly from the tertiary prevention concept—to intervene (often through constructive confrontation) with poorly performing employees experiencing alcohol-related problems. Most interventions focused on motivating the employee to seek treatment to prevent job loss.

EAPs have evolved from those early years and now provide an ever-increasing range of counseling and support services to employees and their families. It has been argued that EAPs have become the primary source of counseling for mental disorders. Some in the field complain that this ever-broadening scope, combined with the increased focus on counseling, has watered down core EAP services. Many have concluded that today's EAPs have become just an alternative mental health benefit.

So, where is the organizational wellness component? Who is providing any meaningful or measurable employee education or supervisory training?

I have always believed that employee education and supervisory training, both core EAP components, should and can have a measurable primary prevention impact. The medical health model of waiting until people get sick and then treating them is flawed and very expensive. It also consumes a ton of resources on inadequate and insufficient tertiary treatment.

Primary prevention does have a role in today's EAP, but that role is rarely measured. Today, a "good" EAP should have some measurable primary preventative outcomes. One of the more obvious would be preventing workplace violence. But if an EAP does not have a significant organizational presence with employers, it tends to become merely a telephone hotline with few significant measurable organizational outcomes.

A major shift from tertiary to primary prevention is needed and necessary for both our health system and for EAP providers. The research shows that if you provide good preventive services, you will also identify those who need treatment much earlier in the disease process (secondary prevention) and thus enhance chances for recovery. EAPs need to embrace primary prevention, and for that to occur prevention must become an integral and distinct component and should at least incorporate some techniques developed in health and wellness and occupational health programs.

Employers buying an EAP product should ask how much money it can save them by helping employees be healthier (eliminating tobacco use is a start) and productive, mentally well, able to deal with stress, emotionally stable and mature. They also should ask whether