EMPLOYEE ASSISTANCE REPORT

supporting EAP professionals

Volume 11, No. 10
October 2008

EAPs & Eating Disorders:

Complex Opportunities and Challenges

By Mark Cohen, DSW, MPH and CEAP

EAP core technology describes numerous functions that make our profession unique. One of them is the assessment and referral of employees into cost-effective treatment settings and/or community-based resources.

However, assisting workers in getting help for eating disorders has been a missed opportunity in the services we provide to corporate clients and their employees.

Historically, the number of eating disorder cases assessed and referred by EA professionals has been extremely low. Exceptions include an employee who comes to the EAP with concerns about an anorexic child, a co-worker or supervisor who expresses concern about "an employee who looks sickly" or a co-worker who hears an employee vomiting in the bathroom.

If we added up all of these cases, the total would represent only a miniscule fraction of all EA referrals in a given year — even though as many as 10 million females and 1 million males are fighting a deadly battle with anorexia or bulimia.

> ***"...talking about weight issues cannot continue to be 'off limits' for EA professionals."***

Compulsive overeating, binge eating, and yo-yo dieting have similarly not been addressed by EA professionals to date. Those who suffer from these conditions rarely come to the EAP, and when they do, it's usually for a different problem, such as a marital concern. Like alcoholic employees, these individuals nearly always deny they have a problem.

And yet, America's obesity crisis has an adverse impact on workers' sick time, accident rates, disability costs, workers' compensation costs, presenteeism, and productivity. Surveys indicate that approximately two-thirds of Americans are overweight, more than half of which are obese or morbidly obese. Since most obese people are employed, they collectively cost their employers large sums of money.

As a result, EAP's ability to identify employees with eating disorders (whether they're overweight or underweight) and motivate them to get help — along with educating the workforce about the addictive nature of eating disorders — offers a significant opportunity for EAPs to increase their usefulness to corporate clients.

Obesity: An Addictive Disorder

Most Americans see obesity as a self-control issue. As a result, we are sometimes critical of people who struggle with their waistlines. Similarly, few health-care professionals view anorexia, bulimia, or morbid obesity as an addictive disorder with physical, psychological, and spiritual characteristics.

continued on Page 2

FEATURED INSIDE

 continued from Page 1

The term addiction is used to describe a recurring compulsion by an individual to engage in some specific activity despite harmful consequences to the individual's physical health, mental health, and/or social life. All eating disorders meet this definition.

And yet, the majority of treatment facilities for eating disorders have traditionally limited their treatment protocols to physical and psychological services. This grim reality parallels the way we viewed and treated alcoholism 60 years ago!

Although few studies have examined the relapse rates for people with eating disorders, I submit that *not* addressing eating disorders as an addictive disease contributes to the already difficult challenge of remaining in recovery for those suffering from these problems.

Addressing Eating Disorders

Health-care practitioners are expected to assess a wide range of pathologies, and determining the existence of an eating disorder is no different. However, it is often a tricky "diagnosis" to make since most clients are in denial and reluctant to talk about their eating behaviors. This is especially true for EA professionals since we often see our clients for only a few sessions.

As stated, another problem in addressing eating disorders is that employees rarely go to their EAP for help with eating issues. Similarly, they rarely contact the EAP for assistance with alcohol and/or drug concerns unless these problems pertain to someone else. These are the unfortunate realities for EA professionals in addressing any addictive disorder.

Comparing Alcohol and Eating

Consequently, the challenge and mandate for us as EA professionals is to engage in conversations that allow us to secure the information necessary to make recommendations to help our clients.

If, in our professional judgment, we believe that an eating disorder may exist but we can't confirm a diagnosis, we have an obligation to refer our client to a professional resource that can either confirm or refute our suspicions. After all, EA professionals commonly provide this exact same service for clients we suspect have a drinking or drug problem.

When clients come to the EAP for help with relationship issues, mood swings, problems with their boss or co-workers, or stress, we determine whether drinking is contributing to the problem. If it is, we recommend treatment for alcohol abuse.

But when clients come to the EAP with the same issues, and they are significantly overweight, obese, or shockingly underweight, do we explore whether these physical conditions (and eating behaviors) are adding to their difficulties?

In this regard, isn't the morbidly obese client "identical" to the client who smells from alcohol use? And if so, don't we need to discuss how obesity may be contributing to the client's problem? As a result, talking about weight issues cannot continue to be "off limits" for EA professionals. We need to become more comfortable and skilled in speaking about eating disorders so that we are not depriving clients of our unique skills as a first source of potential help.

Intervention & Eating Disorders

Intervention techniques have been part of the "EAP Toolbox" since the early days of our profession. These techniques work well for clients with eating disorders — just as they do for clients with drug and/or alcohol problems. Recommending to a family with a loved one with an eating disorder, that they seek help from an interventionist can help everyone affected by the illness to begin the recovery process.

EA professionals will be extremely helpful to their clients when they think of eating disor-

continued on Page 3

EMPLOYEE ASSISTANCE REPORT

Editor - Mike Jacquart
Publisher - Jennifer Heisler
Design - Kay Christensen

Editor's Notebook

Thanks go out to Mark Cohen for addressing the topic of eating disorders in this month's newsletter. The author states that weight issues (whether overweight or shockingly underweight) cannot continue to be "off limits" for EA professionals. I believe it's a point well made. More importantly, what do *you* think? Could this area be an overlooked niche for *your* EAP?

Thanks also to Janet Heiner for closely tracking the mental health parity issue for this month's *EAR*. No one knows when the recently passed parity legislation will be enacted. Moreover, some people believe that mental health coverage should be left to the insurer and the insured, and it isn't clear how that part of this issue might play out.

However, opponents of this legislation appear to be a minority. Most people believe that mental health parity is a step in the right direction to alleviate insurance disparities that have existed in too many cases, and for far too long. Until next month. ■

Mike Jacquart, Editor
(715) 258-2448
mikej@impact-publications.com

EAPs *continued from Page 2*

ders as an addictive disease that can be best helped by using the techniques that work with other addictive illnesses.

Helping the Corporate Client

Emerging corporate wellness programs have been recognizing and addressing the interdependency of behavioral and physical health. EAPs can contribute to a company's wellness efforts by explaining the addictive nature of eating disorders, by distributing literature, and by linking resources that clients are unaware of and/or do not have easy access to. By working collaboratively with wellness departments, HR professionals, and health-care practitioners, EAPs can be a vital resource in addressing obesity and other eating disorders.

Summary

Eating disorders are increasingly prevalent, addictive, and they cost companies a tremendous amount of money. Given EA professionals' expertise in addiction, we can play a unique role in addressing these problems. But in order to do so, we must change the ways in which we approach clients, refine our skills in assessing and referring EA clients, and we need to understand the resources that are available. ■

Dr. Mark Cohen is an interventionist at Addiction Intervention Resources (AIR), a national behavioral-health consulting firm known for its success in recovery management. He has served as a consultant on addiction issues to more than 100 workplace organizations and to hundreds of individuals and families. Dr. Cohen has also directed several drug and alcohol treatment programs, and he created and directed the Employee Assistance Program at American Express. For more information, visit www.AddictionIntervention.com. For a list of references used in this article, contact the author at Mark@AddictionIntervention.com.

Resources

📖 ***Public Lies***, by Brenda Youngerman, $15.95 list price, www.brendayoungerman.com. This book gives the reader an insider's view of turmoil, a mother's love, and her struggle to do what she thinks is right.

📖 ***Surviving Ben's Suicide, A Woman's Journey of Self-Discovery***, by C. Comfort Shields, $29.95, iUniverse, www.iuniverse.com. The author candidly shares her story as a suicide survivor, encouraging others to come forward and express, not suppress, their feelings.

The Employee Assistance Research Foundation has an online survey to generate feedback to the EARF Board regarding its proposed Mission Statement and priorities. Visit www.surveymonkey.com/s.aspx?sm=MbFTozoSbFsBtTbwBYxE6w_3d_3d

📖 ***Turn Good People into Great Employees: Performance Reviews That Work***, $99, .pdf download, PBP Executive Reports, www.pbpexecutivereports.com, (800) 220-5000. Turn performance reviews from dreaded experiences into valuable evaluations and goal-setting sessions. ■

These 'Food Fights' are Good Ideas

Mention "food fight" to someone, and visions of uncontrollable children hurling meatballs and French fries at each other will likely come to mind. But not all "food fights" are bad. Other "food fights," as in fighting obesity and other eating problems, are *good* ideas.

According to the Centers of Disease Control and Prevention (CDC), the percentage of young people who are overweight has more than tripled since 1980. And obesity, the CDC says, is clearly tied to numerous health problems such as high blood pressure, diabetes, heart disease, etc.

An often overlooked fact is that extra pounds not only weigh people down literally, but emotionally as well. Whether we want to admit it or not, many overweight people are teased or shunned, which hurts self-esteem and can lead to depression or other psychological problems.

Eating Disorders

While overeating on a regular basis may signal emotional problems that need to be addressed, it should be noted that the opposite — *under*eating to achieve what youth in particular consider a "desirable" body image — may also occur. (**Editor's note**: See cover article and this month's *Brown Bagger*.)

Summary

In helping an adult or youth through an emotional problem or eating disorder, don't be judgmental. Offer love and support. Assure the individual that you don't care for him/her any less because of the problem — rather, you are concerned about his/her health.

While overeating is often more in the "spotlight," eating too little isn't healthy either. Adults and youth with either problem may need help to stop unhealthy eating behaviors and find the proper balance. ■

Sources: KidsPeace, American Academy of Child & Adolescent Psychiatry, HealthDay.

DOMESTIC VIOLENCE AWARENESS MONTH

In Harm's Way: *'Domestic' Problem has Vast Scope*

Violence against women pervades all aspects of society, including the workplace. The U.S. Department of Justice estimates that intimate partners — husbands, ex-husbands, and current and former boyfriends — commit violent crimes against nearly 1 million women every year.

"Domestic violence," commonly thought of as occurring only in the home, affects the workplace when an abuser attacks, stalks, or harasses his partner at work, or intentionally sabotages the ability to work productively. Domestic violence also occurs when intimate relationships between co-workers escalate to harassment, battering, sexual assault, or other violence at work.

But wherever violence occurs, it affects the workplace:

☒ The Bureau of National Affairs estimates that domestic violence costs employers at least $3 billion to $5 billion annually in lost days of work and reduced productivity.

☒ Studies of battered women have found that 50% to 85% of abused women missed work because of abuse — over 60% reported arriving to work late due to abuse.

☒ A Congressional report revealed that nearly 50% of rape victims lose their jobs or are forced to quit in the aftermath of the crime.

Legal Issues for Employers

Companies may be held liable for sexual assaults or harassment by co-workers or customers if a supervisor knew of, or should have known about, assaults, potential assaults, or other harassment and failed to take appropriate action. Even a single case of assault on the job could be enough for an employer to be considered liable for resulting damages.

As a result, if it doesn't have one already, the company needs a written, clear, and effectively enforced anti-harassment/domestic violence policy, as well as an effectively implemented complaint procedure. The EAP may be able to help.

If a policy *is* in place, it never hurts to review it periodically to make sure there are no loopholes that could negatively impact an employee or employer.

Summary

Employers increase the safety of their workplaces and reduce their liability by taking reasonable steps to prevent or stop violence-related problems. Ignoring threats of violence or hoping that they will go away will not make a problem disappear. ■

Source: NOW Legal Defense & Education Fund.
Editor's note: *October is Domestic Violence Awareness Month. For more information, contact an organization like the National Coalition Against Domestic Violence at www.ncadv.org.*

More than the Blues: *Recognizing Depression in Employees*

By Eric Hipple

Since his wife filed for divorce several months ago, Mike has lost a lot of weight; his suits hang off his once-bulky frame. Mike's face looks hollow and gaunt, and he's having trouble getting his work done.

Jessica keeps complaining of headaches and stomachaches. She has called in sick seven times over the last month. Today, when she returned from a two-hour lunch, you could have sworn you smelled alcohol on her breath.

Mike and Jessica are showing possible symptoms of depression, which costs businesses tens of billions of dollars each year, mostly due to reduced productivity. But not only are Mike's and Jessica's careers in jeopardy, their very lives may be in danger. Depression is one of the strongest risk factors for attempted suicide. How *do* you help a potentially depressed employee or co-worker?

➢ **Educate yourself about depression**. Contrary to traditional thinking, depression is not a personal failing; it is a clinically defined mental disorder that occurs when the brain's chemistry becomes unbalanced.

Although each situation is unique, common depression risk factors and symptoms include: *recent loss*, through death, divorce, loss of job, etc.; *change in personality*, sadness, withdrawal, anxiety, etc.; and *change in behavior*, inability to concentrate on work, chronic tardiness, etc. (**Editor's note**: The EAP and related resources can help identify additional warning signs and risk factors.)

➢ **O.K., you see some symptoms. Now what?**

1) If the company has an EAP, remind the employee that it is a free resource. An EAP counselor can also offer advice on how best to approach the employee.
2) Keep an open mind and be flexible. Education is the best way to reduce the stigma associated with depression.

➢ **Referred to the EAP, the employee is now receiving treatment. What does this mean? How can you help?**

Depending on the severity of the depression, treatment may include therapy and/or medication. During the employee's recovery, keep in mind:

☑ Antidepressant medication usually takes a few weeks to take effect. Don't expect dramatic results right away.
☑ The sufferer may need to switch medications and/or dosage levels several times to find the right "fit" for his or her unique brain chemistry.
☑ In severe cases, including those of sufferers who attempt suicide, hospitalization may be required. The employee may also need to take a disability leave.

➢ **In other cases, the employee may need a flexible work schedule as he/she recovers**. The structure and distractions of work can often help the healing process. Work with the employee to determine the right amount of work as he/she heals.

➢ **Be sensitive to the employee's right to privacy**. Consult with an EAP practitioner about the best way to handle the situation with co-workers and/or clients.

Summary

Despite mounting evidence that depression is a medical condition, just like diabetes and high blood pressure, stigma still surrounds mental illness. Employers and co-workers often feel uncomfortable addressing the subject with colleagues. But for the sake of the business, and for the employee, intervention often is necessary. Remember, silence can be deadly. ■

Eric Hipple is a former NFL quarterback with the Detroit Lions, who experienced a debilitating downward spiral after his 15-year-old son died of suicide. Today, he works as an outreach coordinator with the University of Michigan Depression Center. He is the author of "Real Men Do Cry: A Quarterback's Inspiring Story of Tackling Depression and Surviving Suicide Loss." For more information, visit www.QoLpublishing.com.

Identity Theft:

Pros and Cons of Identity Scoring vs. Credit Monitoring — Part II

Editor's note: *In today's technological society, identity theft has become an increasing concern. Could it be an overlooked EAP niche? A leading authority on the subject addresses the matter in part two of a two-part article.*

By Jim Collins

There are major deficiencies in relying on credit card monitoring for identity theft.

If you are an ID theft victim with a stolen Social Security number that was used in concert with other data that does not belong to you, such as a different address or date of birth, you will not be alerted. Potential victims are only contacted if their *exact* identity, including full name, date of birth, etc. was used to apply for a new mortgage, credit, or other loan.

Most importantly, any credit monitoring report will arrive days after the criminal activity has transpired. One has to hope that the criminal hasn't done too much damage in those few days. Credit card monitoring also does not catch any *non*-financial use of your stolen identity which can, in fact, damage your credit rating even further!

If you are given one tiny piece of a giant puzzle, your odds of being able to determine the whole picture are slim. But with identity scoring, you get an accurate and *comprehensive* picture of the person's credit-related activity. Identity score systems tap into a broad set of consumer data that judge a person's authenticity.

Components used by identity scoring companies include government and public records, corporate data, credit records, and predicted behavior patterns based on empirical data.

Gartner Research defines identity scoring as "scoring the behavior of an identity's or a criminal ring's activities over time and across enterprises. Suspect patterns of behavior that show up across different organizations would not necessarily appear if the activity within only one organization was being monitored."

Credit report monitoring is not able to identify criminal activity or individual records linked by stolen data. Identity scoring takes into account far more attributes that clearly define the individual and his/her behavior over a significant period of time.

The basic identity score components a company uses in their ID scoring include name and address components; Internet monitoring of personal information found online on websites, newsgroups and blogs; fraudulent information; behavioral pattern analysis; synthetic identity information — the information used to create a fake identity; and predictive analytics, which weighs behavioral data against earlier set patterns of behavior.

Identity Recovery

Recovery after an identity is stolen is very important and very complex. There are many calls to make and steps to take. Unfortunately for the victim, identity theft is often much simpler, and quicker, than the recovery.

Help is available in the identity recovery process in two ways — companies can either assist victims during the *resolution* process or manage the *entire* process on their behalf. For instance, companies can provide resolution process guidance, including advice for avoiding future complications, with access to victim assistance specialists trained in identity theft recovery.

On the other hand, consumers who wish to avoid the time and hassle involved in the recovery process may elect to have a company manage the entire process on their behalf.

It is important to treat one's financial and personal information with care and discretion and to be vigilant about checking statements and accounts. When you are proactive about protecting yourself, your chances of being the next identity theft victim are reduced dramatically. For more information on identity theft, visit:

www.consumer.gov/idtheft;
www.idtheftcenter.org;
www.privacyrights.org/identity.htm;
and/or
http://www.alliedbarton.com/security-resource-center/security-awareness-tips.aspx. ■

Jim Collins is president of HR Plus, www.hrplus.com, a premier provider of background screening and pre-employment services, and a division of AlliedBarton Security Services, www.alliedbarton.com, a leading provider of highly trained security personnel.

Parity Advocacy Pays Off; Bill in Place

By Janet Heiner

Perseverance has paid off for mental-health advocates. An end to discriminatory insurance practices is now in place for people with mental-health disorders.

This is largely due to public awareness and persistent advocacy for parity legislation, which is designed to even the playing field between treatment for physical and mental-health and substance-abuse disorders.

According to the Suicide Prevention Action Network (SPAN) USA, the U.S. Senate and House of Representatives agreed to terms on a final mental-health parity bill. The cost to the federal government is yet to be determined, but the resolution reportedly became law in July.

SPAN USA issued this statement on its website: "On July 15, 2008, President George W. Bush vetoed the *Medicare Improvements for Patients and Providers Act of 2008* (H.R. 6331). However, the U.S. House of Representatives and the U.S. Senate voted to override the President's veto, and the bill now becomes law. The Senate voted to override the President 70-26, and the House vote was 383-41."

It is not yet known when the legislation will be enacted.

All Parity isn't Created Equal

It helps to take a look back to realize how far mental-health advocates have come on this issue. Health insurance parity between treatment physical and mental impairments was first signed into law in 1991 when, although of a limited nature, Texas passed insurance parity for state and local government employees for severe mental illness. That same year, North Carolina passed comprehensive parity for state and local employees.

Both states revised their laws in 1997 — North Carolina to more limited parity, and Texas to more extensive coverage for those with mental-health needs. However, as has been the case elsewhere, exemptions to mental-health treatment remained in place.

In fact, definitions of what mental-health treatment is — and isn't — covered are very specific under state mental health parity laws. In other words, the types of parity laws in place have varied nationally:

➢ **Comprehensive parity** — Equal coverage of a broad range of mental health conditions, including substance abuse disorders. It does not exempt significant policy groups.

➢ **Broad-based parity —** Equal coverage of a broad range of mental health conditions. It may include some limitations or exemptions.

➢ **Limited parity** — Limits equal coverage to a specific list of mental health conditions and/or excludes equal coverage for significant policy groups; and/or limits equal coverage to certain durational or financial limits or cost-sharing requirements; and/or allows plans to opt out of parity due to cost-increase provisions.

➢ **Mandated if offered** — Requires that mental health overage be equal to other medical conditions if the plan offers mental health coverage.

➢ **Mandated offering** — Requires a plan to offer an option of mental health coverage that is equal to coverage for other medical conditions.

➢ **Minimum mandated benefit —** Mandates minimum mental health coverage that is not required to be equal to other medical conditions.

➢ **Minimum benefit if offered —** Requires a minimum benefit if the plan offers mental-health coverage.

➢ **Minimum benefit offering** — Requires a plan to offer a minimum benefit.

Covered Conditions

In addition to stringent treatment definitions, the mental-health conditions covered by health insurance providers have also been quite specific to date. For instance:

☑ **Serious mental illness —** Serious mental illness is used to refer to coverage of major mental illnesses, typically defined as schizophrenia, psychotic disorders, bipolar disorder, major depression, panic disorders, and obsessive-compulsive disorder.

☑ **Broad-based mental health disorders** — This term refers to coverage of a relatively broad range of mental disorders.

☑ **Substance abuse disorders —** The term substance abuse disorder is used to refer to coverage of alcoholism and chemical dependency.

Around the Nation

Twenty-five out of 36 states with some kind of parity legislation possess only a limited type of insurance coverage. Most limited parity laws cover those under the definition of serious mental illness —

continued on Page 8

Employee Assistance Report is published monthly. For subscription information contact: Employee Assistance Report, 1439 Churchill Street, Unit 302, Crystal Plaza, P.O. Box 322,Waupaca, WI 54981. This publication is designed to provide accurate and authoritative information in regard to the subject matter covered. It is sold with the understanding that the publisher is not engaged in rendering legal, accounting, or other professional services. If legal advice or other expert assistance is required, the services of a competent professional should be sought. (From a Declaration of Principles jointly adopted by a committee of the American Bar Association and a Committee of Publishers.) *Employee Assistance Report* does not necessarily endorse any products or services mentioned.

continued from Page 7

although six states include anorexia/bulimia and Post-traumatic Stress Disorder.

Six states have parity laws that are "not quite comprehensive" — either having exemptions, limitations, or both. On the other hand, the five states with the most comprehensive parity laws (with dates of enactments) are: Maryland, 1994; Minnesota, 1995; Vermont, 1997; Connecticut, 1999; and Oregon, 2005.

There are currently 12 states with no mental health parity laws in place, although they do allow for mandated coverage. (See definitions covered on page 7.) These states are: Alabama, Alaska, Florida, Georgia, Kansas, Michigan, Mississippi, Ohio, Pennsylvania, New York, North Dakota, Wisconsin; and the District of Columbia. Idaho and Wyoming have neither parity nor mandate laws.

Summary

The federal parity law will put an end to insurance discrimination against mental-health and substance-abuse benefits, affecting over 100 million Americans. That is where we've been, and this is where we're going — forward. ■

Janet Heiner is a former certified mental-health technician with over 15 years experience, and she is an advocate of national mental-health reform. She may be reached at Yogihead@earthlink.net.

On the Job

EAP Emails: *Peril or Opportunity?*

Is it a good idea to use email on EAP websites? One website lists an email address, but then uses an oversized, red font, to warn: *"This email address should be used ONLY for general inquiries. Existing clients should contact us at the phone number listed above."*

Despite this caveat, the EAP reports that a number of clients have emailed very personal information, rather than calling.

Psychiatrist Richard Friedman illustrated this point in a recent article in the *New York Times*. He wrote:

"The minute I started giving out my address to my patients, I fantasized about how much time I would save on routine phone calls." Everything went well in the beginning: "Could I change a Monday appointment to Wednesday? Of course. Would I phone in a renewal of Prozac? With pleasure."

Then things became complicated. "Dear Dr. Friedman," one patient e-mailed at 3 a.m. "I am having dark thoughts and wonder if I should increase my antidepressant. Can you let me know what you think?" It was 8:30 a.m. when I opened my email and read her message with alarm. What exactly were "dark thoughts"? I wasn't sure, but I had to assume the worst — suicidal thoughts — and so I called her immediately.

> ***"For all the convenience and clarity of email, it can be perilous for a clinician..."***

She came in later that afternoon and explained that she thought she and her family might be better off with her dead. "Why didn't you call me right away?" I asked. "It was the middle of the night, and I didn't want to disturb you," she replied. I noted that being disturbed is what I do for a living. Considering the volume of messages, and how many of them are spam, I was lucky I did not miss her email. I began to worry about what I had gotten myself into.

"For all the convenience and clarity of email, it can be perilous for a clinician — as part of the written record of patients' treatment, it can be subpoenaed just like chart notes in case of legal action," Friedman noted. "Email must also comply with the *Health Insurance Portability and Accountability Act* (*HIPAA*), which has complex rules to safeguard patient privacy and confidentiality. Your psychiatrist could not, for example, send you a reassuring message about your recent lithium blood level — unless you e-mailed first and specifically asked for it.

"Being an impatient person, I love the speed of email," he added. "But being a psychiatrist, I am leery about

the quality of information it conveys. How can I tell whether my patient is being humorous or sarcastic? Smiley faces are no substitute for the real thing."

Friedman concluded by saying: "So here is what email with my patients has taught me: If you need to reschedule an appointment or need a routine medication refill, please push 'send.' But if you have something on your mind you want to talk about, please call me — the old-fashioned way."

Summary

What do you think? Email or no email? ■

Source: Reprinted with permission from the Employee Assistance Professionals Association (www.eapassn.org).

a look ahead

UPCOMING EAR FEATURES...

- Fitness for Duty
- Gambling
- Stress Management