

# *Journal of* **Employee Assistance**

The magazine of the Employee Assistance Professionals Association

VOL. 40 NO. 2 • 2ND QUARTER 2010

## **Improving Treatment Outcomes through Drug Interventions**



Also inside:

**The McDonnell Douglas  
Study: 20 Years Later**

**Telephonic Counseling and  
State Licensing Laws**



Employee Assistance  
Professionals Association



# Journal of Employee Assistance

The magazine of the Employee Assistance Professionals Association

VOL. 40 NO. 2 • 2ND QUARTER 2010

## Cover Stories

### **Improving Treatment Outcomes through Drug Interventions** 9

by *Fred Newman*

Many people with mental health conditions receive care in general medical settings. EAPs can help improve their treatment and decrease symptoms.

### **Telephonic Counseling and State Licensing Laws** 12

by *David A. Sharav, Ph.D., Renée Popovits, J.D., and Elizabeth Donohue, J.D.*

State laws differ on the need for EA professionals to be licensed if they provide telephone-based services to clients in other states.

### **EAP Cost-Benefit Research: 20 Years after McDonnell Douglas** 14

by *Mark Attridge, M.A., Ph.D.*

The landmark study of the costs and benefits of an internal EAP is still raising questions among current-day researchers.

## Features

### **The Economic Recession and Intimate Partner Violence** 17

by *Sheetal Ranjan, Ph.D., and Chitra Raghavan, Ph.D.*

Imbalances in the traditional roles of men and women can put women at risk of violence from men, and the current recession is exacerbating this risk.

### **The Evidence-based Practice Continuum in Employee Assistance** 20

By *Wolfgang Seidl, M.D., DipC., MBACP*

Describing our profession's knowledge base and proving its value will help establish employee assistance as a unique profession.

## DEPARTMENTS

**EAPA Learning Center Offerings** 5

**Front Desk** 2

**Info Sources** 28

**News Briefs** 26

**Technology Trends** 24

*“The emergence of telephone counseling in EAPs raises compelling and complex questions related to its far-reaching value and its potential for liability.”*

“Telephonic Counseling and State Licensing Laws”

—page 12

**Index to Advertisers** 4

# Building a Better Magazine

by Maria Lund, LEAP, LPC, CEAP



Maria Lund

In my previous column, I mentioned that the EAPA Communications Advisory Panel was developing a survey about the *Journal of Employee Assistance* and would post it on the EAPA Website. The goal of the survey was to solicit ideas on how the *Journal* can best meet your information needs and help you raise your level of professionalism.

As with many surveys, this one likely appealed to those who are most and least satisfied with the current format and content. As we reviewed the responses, several themes emerged that suggested future editorial directions. Below is a list of what we were asked to add:

1. Synopses of recent research;
2. Articles and/or columns devoted to EAP best practice;
3. More content from non-U.S. EA professionals and/or articles that touch on issues of global interest;
4. Information related to workplace and human resources issues;
5. Coverage of legal issues in EA practice;
6. Regular articles devoted to counseling topics; and
7. Information on how EA professionals can better make use of information technology.

On March 15, the advisory panel conducted a teleconference to discuss the survey results and develop recommendations for improving the *Journal*. Before delving into specific content considerations, we agreed that the *Journal* is really about the practice of employee assistance, whether in the running of the business or in the provision of services.

Having reached that conclusion, we discussed content enhancements. In response to the survey requests for

more information about technology, Marina London, EAPA's Website administrator, volunteered to write a regular column about communication technologies. Her first "Technology Trends" column, discussing social networking tools and their applications, appears in this issue on page 24. To satisfy the request for legal content, the committee has reached an agreement with Sandra Nye, author of the popular *Employee Assistance Law Desk Book*, to write a standing column about legal issues affecting EAPs and EA professionals. The column will make its debut later this year.

Several panel members are looking into ways to solicit research synopses to publish in the *Journal*; others are considering ways to encourage non-U.S. authors to write articles or to solicit more articles with global themes. I'll keep you posted about our progress in both of these areas.

In addition to these changes, the advisory panel agreed that the magazine should contain articles emphasizing both the business aspects of running an EAP (management, marketing, selling, product lines, and so on) and the provision of EAP services (best practices, counseling issues, work-life concerns, intervention, and so forth). We will be soliciting articles to fit these basic themes.

One of the more interesting suggestions was that we should launch a "Narrative Matters" section that features a first-person account from someone in the field. The narratives should say something insightful and provocative about the practice of employee assistance and the challenges that EA professionals face on a daily basis.

Finally, we talked about developing a section about EAP value that features

examples of actual programs and clients. We also discussed adding a column about industry trends and/or an annual "future trends" article.

As our discussion makes clear, we are committed to providing EA professionals—whether experienced practitioners or those new to the field, whether in management positions with large EAP providers or in affiliate roles—with a magazine they look forward to receiving and reading. If you have additional thoughts about how to improve the *Journal*, please contact me or any other member of the advisory panel. ■

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## INDEX TO ADVERTISERS

American Professional Agency	3
American Substance Abuse Professionals	IBC
Daybreak EAP Software	15
EAPA Learning Center	4
EAPA's World Conference	BC
Family Credit Management	8
InfoMC, Inc.	IBC
National SAP Network	11
Performance Resource Press	IFC, 25
SAPlist.com	13, 25
The SASSI Institute	16
TAG, The Alexander Group	19

BC: Back cover  
IBC: Inside back cover  
IFC: Inside front cover



### EAPA Mission Statement

To promote the highest standards of practice and the continuing development of employee assistance professionals and programs.

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# EAPA LEARNING CENTER OFFERINGS

EAPA's Learning Center is an innovative online learning system that hosts the largest collection of EA-specific professional development resources in the world. The Learning Center features multimedia re-creations of EAPA's Annual World EAP Conferences, EAPA-designed ethics and CEAP exam prep courses, live and archived Webinars, and FAA/FMCSA e-learning courses.

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Following is a partial listing of current EAPA Learning Center offerings:

Online Courses	Presenters	PDH	Domain
Online CEAP Exam Prep Course	Ed Jones, Chet Taranowski, Sooze Hickman	6	Domain I, II, III
Elevating Ethical Awareness—Online Edition	Lisa Cooper-Lucas, Henri Menco, Marilyn Rumsey	2	Domain I
2009 Conference Online	Presenters	PDH	Domain
Emerging Opportunities for EAPs: MH Parity and Consumer Driven Health Plans	Daniel McCarthy	1.5	Domain I
Developing a Strategic Plan During Turbulent Times	James Duffy	1.5	Domain I
Ethics: A Musical Comedy	Tim Anderson, Meredith Jeppson, Gordon Leeman	1	Domain I
How to Measure and Manage the Sales Activities of Your EA Program	Shelley Plemons	1.5	Domain I
Launching a New EA Product in Turbulent Times: Steps to Success	Jeri Davis	1.5	Domain I
Organizational Change: How Can Global EAP Add Value?	Nicholas Malhomme	1.5	Domain I
Empirical (Yet Friendly) Approaches to Selecting and Measuring Outcomes in EAP	Richard Lennox, Dave Sharar	1.5	Domain I
Keeping Your EAP Relevant in an Ever-Changing Environment	Liz McBride-Chambers, Kristin Welsh-Simpson	1.5	Domain I
Crucial Issue Forum: New Policies and Priorities under the Obama Administration: Opportunities and Challenges for EAPs	Elena Carr, Patrice M. Kelly, Tom McLellan, Robert L. Stephenson II	1.5	Domain I
Making the EAP Case in Difficult Times: A Data-Driven Look at the Opportunities!	Daniel J. Conti	1	Domain I, II
World Update	Dirk Antonissen, Elena Carr, Anastasia Rush, Julia Yang	1.5	Domain I, II
Internet Secrets for EA Professionals: Boost Your Organization and Your Practice	Marina London, Michael Klaybor	1.5	Domain I, II
Demonstrating EA Outcomes in the Era of Accountability	Brendan Madden	1.5	Domain I, II

## E A P A L E A R N I N G C E N T E R O F F E R I N G S

2009 Conference Online	Presenters	PDH	Domain
Engaging Managers in an Economic Crisis: EAP as a Resource	Dan Pitzer	1.5	Domain I, II
New Tools for EAPs to Deliver Higher Levels of Value	W. Dennis Derr, Eric Goplerud, Tracy McPherson, Judith Mickenberg	1.5	Domain II
Responding to Critical Incidents in Healthcare Settings	Allison Lilly, Henrietta Menco	1.5	Domain II
A Case Study: Will Your Employees Be Ready... When You Need Them?	Gerald Lewis	1.5	Domain II
On-Line Consultation...The Key to the Door of Change!	Kerri E Lawrence Johnson, Jeffrey Sensenig	1.5	Domain II
Meeting Critical Challenges in Today's Changing Workplaces	Bob VandePol, Jim Nestor, Gerald Lewis, Dottie Blum, Jim O'Hair, Jan Paul	1.5	Domain II
Builders, Boomers, Xers and Ys, Oh My!	Phyllis Cohn	1.5	Domain II, III
Online Resources for Managing Teen Behavioral Issues and for Divorcing Parents	Donald Gordon, Sheila Troy	1.5	Domain II, III
When the Dust Settles: Casting a Vision of Hope and Change After a Downsizing	Jeff Gorter, Beth Lundholm	1.5	Domain II, III
Research Roundtable: Young Adults in the Workplace	Joel Bennett, Deborah Galvin	1.5	Domain II, III
Linking Workplace Characteristics, Policies and Promotions with EAP Utilization	Ariene Darick, Bernie McCann	1.5	Domain II, III
Crossing the Digital Divide: A Guide for EA Professionals	Ron North, Lee Rosati	1.5	Domain II, III
APs Role in Providing Comprehensive Consultation During a Reduction in Force	Cal Paries, Scott Rosthauser	1.5	Domain II, III
End-of-Life Issues: A Comprehensive Practical Model	Sarah Steck, Gwynn Sullivan	1.5	Domain III
Working with Employees in Early Recovery	Jim Seckman	1.5	Domain III
Addressing Domestic Violence in the Workplace: An Employer/EAP Partnership	John Cantrell, Kerrie Sterken Loyde, Bob McCullough, Keshia M. Pollack	1.5	Domain III
An Interactive Web-Based Approach to Preventing Relapse and Supporting Recovery	Rebekah Hersch	1.5	Domain III
Eldercare and the Effects of Employee Caregiving on the Workplace	David Parris, Janis Robinson, Paula S. Pelissero	1.5	Domain III
Sexual Health and Addiction: Insights for EA Professionals	Weston Edwards	1.5	Domain III
Balancing Work & Eldercare	Barbara E. Friesner	1.5	Domain III
EAPs and Domestic Violence: Whose Problem Is It?	Patrick Tiner	1.5	Domain III
Strategies for Supporting Financially Stressed Employees	Reeta Wolfsohn, CMSW	1.5	Domain III
Women @ Work: EAP as a Critical Resource to Meet Professional and Personal Challenges	Karuna Baskar	1.5	Domain III

## E A P A L E A R N I N G C E N T E R O F F E R I N G S

2009 Conference Online	Presenters	PDH	Domain
Telemedicine: Live Online Substance Abuse Treatment	Thomas Brady	1.5	Domain III
Depression and Denial in the Executive Suite: The EA Profession's Challenge and Opportunity	Philip Burguieres	1	Domain III
Domestic Violence as a Workplace Issue: Partnerships for Response and Prevention	Leonard DeBenedictis, Janet T. Loughlin	1.5	Domain III
Everything You Wanted to Know About Generation Y, But Were Afraid to Google	Abby Medcalf	1.5	Domain III
Global Warming of the Human Kind: The Case for Emotional Climate Change	Patrick Williams	1.5	Domain III
Beyond the Stress Management Brown Bag Lunch	Markus Dietrich	1.5	Domain III
Life Stage and Gender Specific Treatment	D. John Dyben	1.5	Domain III
Strategies to Support Families of Children with Autism Spectrum Disorders	Richard Martin	1.5	Domain III
Archived Webinars	Presenters	PDH	Domain
Ethical Considerations for the EAP	Jeff Christie	1	Domain I
Generating Strategies for Profitable Lead Generation	Shelley Plemons	1	Domain I
Should I Tweet, Friend or get LinkedIn? An EA Professionals Guide to Social Networking	Marina London, Jan Price	1	Domain I
The RFP Process—What Employers Want To See In EA Program Proposals	Sandra Routledge	1	Domain I
Assisting Companies with Workplace Mediation	Martina Moore, Tanya Dominick	1	Domain I, II
Best Practices for Providing EA Services via Email Exchange	DeeAnna Merz Nagel	1	Domain I, II
EA Assessments: The Essential First Step to Finding Solutions	Patricia Vanderpool	1	Domain I, II
EAP Strategies for Performance Enhancement: Using a Presence-based Coaching Model to Develop Employee Leadership	Patrick Williams	1	Domain I, II
Managing Workplace Conflict	Ron Wean	1	Domain I, II
Ethics: Building Core Virtues of an EA Professional—Courage and Compassion	Brad Pendergraft	1.5	Domain I, III
Evolution of Crisis Response in the Workplace	Bob VandePol	1	Domain II
Psychological and Psychiatric Fitness for Duty	David Fisher	1	Domain II
The Power of One: Managing in an Anxious Organization	Sandra Caffo, Annette Kolski-Andreaco	1	Domain II
EA Professionals Assisting Managers: Coaching for Performance, Motivation and Engagement	Mickey Parsons	1	Domain II, III

## E A P A L E A R N I N G C E N T E R O F F E R I N G S

Archived Webinars	Presenters	PDH	Domain
Hunters and Howlers: Using the Calhoun—Weston Model for Workplace Violence Threats and Behaviors	Steve Albrecht	1	Domain II, III
Introduction to Workplace Substance Abuse	Tara Haskins, Jan Price	1	Domain II, III
Psychological First Aid	George S. Everly, Jr.	1	Domain II, III
Are We Managing Pain, But Fueling Addiction?	Stephen Grinstead	1	Domain III
Opioid Addiction Treatment Update for EAPs	Tara Haskins	1	Domain III
US DOT Compliance E-Learning Courses	Presenters	PDH	Domain
FAA Drug and Alcohol Testing Program Training for Employees	FedReady	1.5	Domain II
FAA Drug and Alcohol Testing Program Training for Supervisors	FedReady	1.5	Domain II
DOT/FMCSA Alcohol Misuse and Controlled Substances Use Training for Drivers	FedReady	1.5	Domain II
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# Improving Treatment Outcomes through Drug Interventions

Many people with mental health conditions receive care in general medical settings. EAPs can help improve their treatment and decrease symptoms.

by Fred Newman

**A**lthough many people assume that the increasing prescription of antidepressants and certain other psychotropic drugs is a positive trend and reflects the fact that more people are seeking treatment for depression and other mental health conditions, the reality is that most mental health patients today are receiving sub-optimal care. As the use of these drugs has increased over the past decade, the percentage of patients with behavioral health issues being seen by mental health professionals has decreased, not increased.

The regulations that were developed to implement the Mental Health Parity and Addiction Equity Act of 2008 outline this problem. The regulations reference a study that found that only 12.7 percent of individuals received minimally adequate mental health treatment in general medical settings. Unfortunately, the regulations do not address the root cause of this problem: a lack of access to appropriate mental health care in the early stages of the condition.

Most psychiatrists have full patient loads and do not have the capacity to

expand their practices to handle more patients (many are already unable to spend the time necessary to appropriately treat the patients they currently have). Therefore, the majority of mental health care will continue to be provided within general medical settings for the foreseeable future. This will lead to or exacerbate the following quality issues:

- Lack of quality assessments of mental health problems;
- Lack of ongoing screenings to evaluate the effectiveness of treatments;
- Lack of medication management;
- Lack of patient education about the condition(s) being treated;
- Lack of psychotherapy for those dealing with mental health stressors; and
- Lack of feedback to patients regarding improvement in their condition.

Individuals who face stressors they cannot manage will typically receive prescriptions for antidepressants from a non-psychiatrist. But without combining short-term psychotherapy with their drug therapy, only the symptoms of their condition will be treated.

Moreover, because most medical doctors receive little or no training in psychiatry, they often are not aware of the withdrawal symptoms associated with stopping the use of antidepressants too quickly. What seems like a relapse of a depressive disorder may in fact be a withdrawal symptom resulting from the patient not properly tapering (reducing the dosage of) the drug. This can lead to a recommendation of long-term drug therapy when it may not be appropriate.

## THE SOLUTION? EAPS

EAPs are in a unique position to address this lack of quality treatment. Studies

report that if patients receive appropriate treatment within the first six months of the onset of a depressive disorder, they have better than a 50 percent probability of achieving remission. If they do not receive appropriate treatment until one year after the onset, the odds of remission drop to less than 20 percent.

## The majority of depressed patients receiving care within general medical settings will experience worsening symptoms.

Thus, it is imperative that individuals dealing with depression engage in screenings and treatment modifications as soon as possible based on their medical history and scoring of symptoms. Influencing these individuals to take such actions requires innovative programs that encourage participation in results-oriented treatment solutions.

My company, Interface EAP, developed such a program in 2004. The program, known as Pharmacy Intervention Protocol (PIP),\* has proven to improve outcomes and reduce costs. The key components of PIP are as follows:

- A two-way secure data feed to the pharmacy benefit manager (PBM) to exchange drug and compliance information;
- Filtering of drug data from the PBM, using proprietary software;
- Outreach to potential candidates based on filtering of drug data;
- Financial incentives involving drug co-pays to encourage greater



*Fred Newman is the founder and chief executive officer of Interface EAP and Coordinated Health Solutions. He previously served as chief financial officer of a public company that owned and managed psychiatric*

*hospitals. He recently completed four-plus years on the board of the Texas Association of Benefit Administrators (TABA) and the Benefits Committee for the Self Insurance Institute of America (SIIA) and was recently elected to the board for Mental Health America of Texas.*

- participation;
- Telephonic screenings to determine candidates for participation;
- Daily electronic reporting of compliance/noncompliance to the PBM;
- Outreach to and partnering with prescribing physicians to improve treatment outcomes;
- Results of ongoing standardized screenings provided to patients and physicians;
- Educational materials provided to patients so they better understand the conditions for which they are being treated;
- Recommendations for medication management and other treatment modifications based on screening outcomes and treatment history;
- Coordination with the EAP for short-term psychotherapy when appropriate;
- Outcome reporting on quality improvement and cost savings; and
- Compliance with the Health Insurance Portability and Accountability Act (HIPAA) and the Americans with

Disability Act (ADA) per established legal opinions.

#### PIP CASE STUDY

On June 15, 2009, Interface EAP and Aetna completed an initial outcome study reviewing medical claims costs across two years of data for workers covered under a self-funded health plan provided by an Arizona hospital system. The purpose was to evaluate overall medical claims costs and other data resulting from PIP.

The study looked at plan members who filled prescriptions for predetermined target drugs, which were identified from the plan's drug data. Every two weeks, PIP received drug data from the PBM (Express Scripts) through the plan administrator (Schaller/Anderson-Aetna). Based on defined criteria, the drug data were filtered by Interface EAP to identify plan members as potential PIP candidates.

A financial motivator was used by the health plan to encourage candidates to complete a telephonic screening. If

a plan member did not complete the screening, his/her co-pay for this group of drugs was doubled; if a plan member completed the screening but chose not to participate in PIP, his/her co-pay was doubled. Those who completed the screening and participated in PIP for up to 18 months received prescriptions at the normal co-pay level. If a member did not complete the program, his/her co-pay was doubled.

Using this process, PIP identified a compliant group and a noncompliant group by unique member ID. The compliant group was defined as plan members who had filled a target prescription, completed the screening, participated in the protocol for the required time period, and were covered by the health plan for both 12 months prior to the intervention date and 12 months after the intervention date.

The noncompliant group was defined as plan members who had filled a target prescription but failed to complete the screening, declined participation after completing the screening, or

### Mental Health Care: What the Media are Saying

**"A significant proportion of individuals with behavioral health problems are treated exclusively in the general medical setting, which has become the de-facto mental healthcare system...significant quality problems have been found with general medical providers' screening, treatment, and monitoring practices."**

*"An Employer's Guide To Behavioral Health Services," National Business Group on Health, 2005*

**"Although access to psychotropic medications is available due to non-psychiatrists' prescriptions, concerns remain that patients still receive treatment in accordance with evidence-based guidelines, psychotherapy, adequate medication monitoring, and appropriate intensity of treatment."**

*An article in Open Minds on September 24, 2009, reporting on a study in which researchers reviewed 472,173 prescriptions filled between*

*August 2006 and July 2007 from the IMS National Prescription Audit Plus database. The researchers reported that 79 percent of prescriptions for antidepressants were written by non-psychiatrists and 87 percent of prescriptions for anxiolytics were written by non-psychiatrists.*

**"The effectiveness of a dozen popular antidepressants has been exaggerated by selective publication of favorable results."**

**"... doctors unaware of the unpublished data are making inappropriate prescribing decisions that are not in the best interest of their patients."**

**"There is a view that these drugs are effective all the time ... I would say they only work 40 percent to 50 percent of the time based on reviews of the research at the FDA."**

*Excerpts from a January 17, 2008, Wall Street Journal article regarding*

*a review published the same week in The New England Journal of Medicine.*

**"More Americans are being prescribed multiple psychiatric medications for use at the same time, but most people diagnosed with recent depression don't get adequate treatment, according to two independent studies published Monday."**

*"Studies: Mental Ills Are Often Overtreated Or Undertreated," Wall Street Journal, January 5, 2010*

**"There is little evidence to suggest that (antidepressants) produce specific pharmacological benefit for the majority of patients with less severe acute depression," researchers wrote.**

*Excerpt from a January 6, 2010, Wall Street Journal article regarding a study published the same week in The New England Journal of Medicine.*

dropped from the protocol prior to completion. Like the members of the compliant group, they must have been covered by the health plan for both 12 months prior to the intervention date and 12 months after the intervention date.

The intervention date was defined as the date that a compliant group member began participating in PIP or the date a noncompliant group member was reported noncompliant to the PBM. For purposes of the study, the health plan administrator reported medical claims data by member ID for the year prior to the intervention date and the year after.

For the 24-month period, the following results were reported:

- **Compliant Group** (142 members): A decrease in average annual claims costs of \$5,674 per plan member, or a 29.4 percent overall decrease in claims costs for the year after the intervention date versus the year before the intervention date.
- **Noncompliant Group** (272 members): An increase in average annual claims costs of \$16 per member, or a 0.1 percent overall increase in claims costs for the year after the intervention date versus the year before the intervention date.

In addition, the following outcomes were reported:

- Nearly two-thirds (63 percent) of members who had completed multiple standardized screenings scored a reduction in their symptoms within the first 15 months of the program.
- EAP utilization increased to an annual average of 21 percent in the first year of PIP. In the years before PIP was introduced, the annual average EAP utilization rate was 5 percent. For the second year of PIP, annual EAP utilization was 14.8 percent, a significant increase in utilization over the years prior to PIP.
- Drug spending for the target drugs declined by 30 percent within 15 months of the start of PIP as calculated on a per employee, per month (pepm) basis. Documented reduced drug spending exceeded the pepm cost of PIP by 59 percent.

#### BECOMING THE GATEWAY

It is a clinical fact that depression, if not properly treated, will worsen and become more resistant to treatment. Therefore, the majority of depressed patients receiving care within general medical settings will experience worsening symptoms and, once exposed to direct consumer marketing by psychiatric facilities, will encounter more restrictive and costly levels of care. Expanded mental health benefits under the new health insurance parity law will only magnify the cost impact to employers.

EAPs can become the gateway to early treatment and help reduce the number of chronic patients. Through a program like PIP, EAPs can use their assessment and counseling resources to bridge the gap in quality care.


Although the parity law regulations generally prohibit imposing any non-quantitative treatment limits on mental health or substance use disorders that are not also applied to medical/surgical benefits in the same classification, they do allow for variations to the extent that

recognized clinically appropriate standards of care may permit a difference. Therefore, the regulations should permit a difference in drug plan design for PIP, since it applies clinically appropriate standards of care not utilized in the general medical setting to achieve significant outcome improvements. For example, the study presented in the regulations reported that only 12.7 percent of individuals treated in general medical settings received minimally adequate mental health care, while 63 percent of PIP members seeking mental health treatment in general medical settings reduced their symptoms.

It is only logical for EAPs to evolve into population management roles for mental health, given the current lack of quality treatment for so many. The total cost of not properly treating mental health issues extends to increased medical claims, increased disability claims, and reduced productivity (as the regulations also report). ■

\* Patent pending

## National Substance Abuse Professionals Network



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# Telephonic Counseling and State Licensing Laws

State laws differ on the need for EA professionals to be licensed if they provide telephone-based services to clients in other states.

by David A. Sharar, Ph.D., Renée Popovits, J.D., and Elizabeth Donohue, J.D.

The telephone has been an important tool for employee assistance programs (EAPs) for many years and has routinely been used for intake, scheduling, crisis intervention, follow-up, and case consultation activities and for providing information. Historically, the telephone in EAP work was used as a tool to facilitate or augment traditional in-person contact between an EAP client and counselor. Today, the telephone is routinely used for professional assessment and brief counseling and is a core part of contemporary EAP practice.

EAP assessment and counseling by telephone have been quietly gaining acceptance and are now viewed as viable alternatives to face-to-face assessment and counseling for numerous reasons, including the following:

- They are less stigmatizing than visiting an office waiting room;
- They can be used with clients who have difficulty traveling to a counselor's office;

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- Some clients will disclose more information over the telephone because they find comfort in its anonymity;
- Some clients will reject a face-to-face meeting but will accept a telephone session;
- The telephone provides greater flexibility in scheduling and eliminates travel time; and
- Telephonic assessment and counseling services are less expensive for the EAP vendor than paying an affiliate counselor an hourly rate.

It now seems that EAP providers are increasingly using the telephone to replace in-person clinical interventions rather than supplement them. The emergence of telephone counseling in EAPs raises compelling and complex questions related to its far-reaching value and its potential for liability. This article will provide an overview of the current state of legal issues surrounding the use of telecounseling in EAPs.

## LICENSURE ISSUES

All states require mental health professionals, including counselors, social workers, psychologists, and marriage and family therapists, to be licensed in the state(s) where they practice. Before the advent of telecounseling, the client and counselor were, by necessity, in the same location. Now the client and counselor may be in two different cities or even two different states.

What legal issues are raised if, for example, a counselor is licensed in California but provides telecounseling to a client in Illinois? Is the counseling considered to have taken place where the client resides or where the counselor resides (or somewhere else)? Given the

trend in employee assistance to "centralize" intake and telecounseling services at a single call center in a particular state, these are pertinent questions.

Since the law often lags behind practice trends and technological changes, there is a dearth of published case law that defines which state should license the counselor when the counselor and client live in different states. Many states have specific laws regarding "telemedicine" that fall under applicable state medical practice acts, but these statutes and their corresponding regulations usually apply only to physicians and not necessarily to non-psychiatrist mental health professionals such as social workers or counselors. California, for example, requires full licensure in California for physicians in call centers who have "ultimate authority" over the primary diagnosis and care of a California patient, unless the out-of-state physician is in actual consultation with a California-licensed physician.

In addition, some states either require or "recommend" that a counselor be licensed in the state where the client resides. For example, Arkansas requires an Arkansas license for any "technology-assisted distance counseling" service that occurs within the state, whether delivered by an Arkansas-based counselor or an out-of-state counselor. Any telecounseling that is provided in Arkansas is deemed to have occurred in Arkansas, even if provided by an out-of-state counselor licensed in another state. In Massachusetts, mental health professionals who are licensed elsewhere and who provide services to clients within Massachusetts are considered "unlicensed" by the Massachusetts Board of

Registration. The Louisiana State Board of Social Work Examiners requires state licensure for social workers who provide “distance therapy” to Louisiana consumers. These states probably represent only the tip of the iceberg—there are many other states whose specific laws and regulations the authors have not yet investigated.

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**Counseling should be considered, for legal purposes, to have taken place in the state where the client is located.**

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Given the lack of clear guidance in some states and the hodgepodge of laws governing telemedicine in others, providing telecounseling services across state lines may well pose a legal or compliance risk management issue, since it is unclear which state—the client’s or the counselor’s—has ultimate legal control. Because there is no agreement regarding standards for interstate counseling, the safe approach is to ensure that your program uses counselors who are licensed in the state(s) where their clients reside.

Using this approach, counseling should be considered, for legal purposes, to have taken place in the state where the client is located. Furthermore, using telemedicine law as a guide, if a counselor provides telecounseling to clients within a particular state, the counselor generally would be considered to fall under the jurisdiction of that state regardless of where she or he is located.

This approach is probably the safest way to comply with legal obligations that are controlled by individual state laws. These obligations include the following:

- Determining required elements of informed consent;
- Complying with mandated reporting and duty-to-warn statutes;
- Determining the impact of subpoena

power;

- Maintaining and storing client files;
- Complying with business registration requirements;
- Verifying the age and identity of clients; and
- Maintaining client confidentiality.

Oddly, some professional associations, such as the American Psychological Association, have chosen not to address telecounseling or teletherapy directly in their ethics codes; others, including the Employee Assistance Professionals Association, have only vaguely broached the subject. By this omission, these groups seem to be admitting they are not yet able to develop agreed-upon ethics rules to govern the practice of telecounseling.

What about EAPs that characterize telephone intervention as “consultation” or “coaching” and not as “counseling” or “therapy”? Has a line been drawn, using statutes, regulations, or case law, between providing clients with support, case management, or coaching versus counseling or therapy?

In short, there is no case law or set of legal opinions that makes such a distinction. This is probably because telecounseling is not yet heavily regulated. Perhaps the most instructive distinction is to examine state-specific definitions of counseling and psychotherapy to determine if there is an intent to carve out a specialized service.

Although many states do not draw a clear distinction between counseling and coaching or consultation, most do have a descriptive definition of counseling. For instance, a few states, such as Colorado, carve out “coaching” as an exemption from mental health licensure. This means individuals who are “coaches” and who serve clients specifically as a professional coach are exempt from the requirements of maintaining mental health licensure.

**NUDGING TELECOUNSELING FORWARD**

As a rule of thumb, if a telephone worker in your EAP call center applies “mental health, psychological, or human development principles through cognitive, affective, behavioral, or systemic intervention techniques” to address per-

sonal problems and issues, she or he is probably providing counseling and not coaching. If the case is counted in your EAP utilization or activity report and not separated out as “coaching” or “supportive services,” then the service is also likely “counseling” and not something else. In other words, if it looks like a duck, walks like a duck, and quacks like a duck, it must be a duck.

The authors anticipate that more legislation and policy guidance will emerge over time. In the meantime, employers, EAP providers, and consultants who advise them should examine applicable state “telehealth” or “telemedicine” laws and consider the legal implications for interstate counseling. Only if we collectively confront these questions and support more rigorous evaluation of the legal implications will we start nudging the telecounseling movement forward in a constructive way. ■

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# EAP Cost-Benefit Research: 20 Years after McDonnell Douglas

The landmark study of the costs and benefits of an internal EAP is still raising questions among current-day researchers.

by Mark Attridge, M.A., Ph.D.

It has been two decades since the seminal study of the financial costs and benefits of the employee assistance program at the McDonnell Douglas Corporation (Smith and Mahoney 1989, 1990). This study is credited with significantly advancing the business case for the field of employee assistance. Although it is considered a classic research work in the field, the study was not published in a scientific journal and therefore did not undergo a critical peer review.

In this article, I will revisit the methodology and major findings of the McDonnell Douglas study and raise some critical questions about it. In upcoming articles, I will reflect on the progress of the field in the 20 years since the study and describe the current state of research on outcomes and cost-benefit analyses of EAP services, then offer some remedies for future practices that take two different but promising paths to examining the costs and benefits of EAPs.

## STUDY CONTEXT AND METHODOLOGY

The cost-benefit study of the McDonnell Douglas EAP was conducted because the company decided to expand the mission of its internal program to emphasize not just substance abuse but also mental health and family- and work-related kinds of problems. To support the decision to expand the EAP's services, a financial offset study was developed.

The study design featured a two-

group model, with a "study group" of employees who had used the EAP in 1985 for chemical dependency or psychiatric conditions and then were followed over a four-year period from 1986-1989. Employees who had not used the EAP but had filed medical claims for alcoholism and chemical dependency or for psychiatric conditions were tracked as the "non-EAP" group and were used for comparison.

The groups were assembled in two steps. The first step involved using claims data to find employees who had filed medical claims for substance abuse or psychiatric conditions. The second step involved matching these employees with EAP records to see who had also used the EAP.

Note that in this design, employees in need of help were not randomly assigned to use or not use the EAP. Instead, the design used naturally occurring groups and thus was a quasi-experimental study with a longitudinal follow-up. Analyses comparing the two groups on various outcomes statistically controlled for group differences in certain demographic and occupational factors. Thus, this study used a strong research design methodology with archival outcome data from company records and health care claims.

## COST BURDEN AND EAP IMPACT

Using data only from the non-EAP group, the study first documented the heavy cost burden to the organization stemming from employees with substance abuse and mental health problems. Over the course of five years after starting treatment, these employees differed from the statistical averages across

all employees at the company in the following ways:

- Much higher rates of absence (113 more absence days for chemical dependency and 56 more days for psychiatric conditions);
- Higher rates of termination from the company;
- Higher overall medical costs (\$23,095 for chemical dependency and \$13,019 for psychiatric conditions); and
- Higher overall medical costs for dependent family members (\$37,398 for chemical dependency and \$27,626 for psychiatric conditions).

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**If the study had ended after two years rather than five, it would have concluded that the EAP was associated with increases (not decreases) in missed workdays and health care costs.**

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Next, the study concluded that the sample of employees who had used the EAP for treatment fared relatively better than those with similar problems who did not use the EAP. Compared to the non-EAP control group, employees in the study group experienced the following outcomes over a five-year period:

- Fewer missed workdays (29 percent fewer for those with chemical dependency and 25 percent fewer for those with psychiatric conditions);
- Fewer job terminations (42 percent fewer for those with chemical depen-

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- gency and 28 percent fewer for those with psychiatric disorders);
- Lower five-year average per-person medical costs (\$7,150 less for chemical dependency-related problems and \$3,975 less for psychiatric problems); and
  - Lower five-year average medical costs for family members of the affected employee (\$14,728 less for chemical dependency problems and \$8,762 less for psychiatric disorders).

A year-by-year examination of the findings revealed important differences over time in absences and medical costs, with EAP cases having higher rates in the first couple of years after starting treatment and then lower rates for later years. This pattern indicates the chronic and long-term nature of these conditions and shows that if the study had ended after two years rather than five, it would have concluded that the EAP was associated with increases (not decreases) in missed workdays and health care costs.

#### FINANCIAL IMPLICATIONS

These results, however, were not used to determine the financial cost offset of the EAP; rather, they were used as average impacts to estimate the amount of future savings for one year's worth of EAP cases. In 1988, the total caseload for the EAP at McDonnell Douglas was approximately 5,800 cases. Of this group, 602 had substance abuse or psychiatric conditions serious enough to be "impacted by the EAP." Thus, only about one in every 10 EAP cases qualified for a potential financial cost offset.

Given the differences in the outcomes between the EAP study group and the non-EAP control group over the years 1985-1989, the study authors projected that for the relevant EAP cases in 1989, the EAP would yield a total of \$6.0 million in cost-offset effects over the five-year period 1989-1993. The factors underlying this estimation included the following:

- \$3.0 million (50 percent of total savings) in health care medical savings for family dependents of the employee;
- \$2.1 million (35 percent) in health care medical claims for the employee

EAP cases; and

- \$0.9 million (15 percent) in avoided missed workdays for the EAP employee cases.

[Note: the number of these cases was not reported, but presumably was similar to that from 1988.]

### The McDonnell Douglas study has some strengths, but it also has several deficits of omission and threats to internal validity.

To put these statistics into perspective, if we assume that the EAP use rate in 1988 was the same as the cost-benefit analysis year of 1989 (i.e., approximately 600 high-severity treatment cases), this works out to about \$10,000 in savings per case over five years, or \$2,000 per case per year based on 1989 dollars. In 2010 dollars, this is \$3,460 in average annual savings. The amount invested in the EAP was not disclosed, however, and thus a return-on-investment (ROI) figure was not provided for the McDonnell Douglas study. In an interview, however, the study authors stated the EAP had provided an ROI in excess of 4:1 (ALMACAN 1989).

#### LIMITATIONS OF THE STUDY

As a scientific merit reviewer for the workplace division of the U.S. government's National Registry of Evidence-based Programs and Practices, I have been trained to evaluate the scientific quality of research studies. In my opinion, the McDonnell Douglas study has some strengths, but it also has several deficits of omission and threats to internal validity. It did not report many of the basic elements of the study methodology, thereby leaving readers with many questions, such as the following:

- How many employees worked at the company, and how many used the EAP?
- How many employees were in the EAP and non-EAP groups?
- How were the EAP users with chemical dependency or psychiatric condi-



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tions identified and selected for the EAP study group?

- What were the extent and clinical merit of the "treatment" provided by the EAP?
- What was the level of clinical improvement in the EAP study cases?
- How much contact did the EAP have with these cases over the five years?
- How many cases dropped out of treatment from the EAP or from the control group?
- What interventions and clinical care did the EAP and non-EAP cases receive other than from EAP staff?
- To what extent did the study outcomes result from the actions of the EAP relative to the actions of other care providers (e.g., doctors, psychiatrists, mental health professionals, and substance abuse specialists)?
- Why were health care claims dollars analyzed but not the utilization rates of health care services, which are less prone to skewed data and outlier effects?
- Why was employee work productivity excluded from the outcomes?

- What kinds of treatment and health care were the dependent family members receiving?
- Why were cost-offset figures estimated for the future, when the study already had real data on outcome rates and cost values for the five-year period when EAP services were actually delivered?
- Why were only the high-severity cases studied, leaving the vast majority of the cases served by the EAP (the other 90 percent) unexamined for outcomes and cost offset?

#### **MANY QUESTIONS REMAIN**

The McDonnell Douglas EAP study was a pioneering effort. It applied more rigorous research methods than prior works (including a comparison group and long-term follow-up of cases over five years), measured "hard data" for outcomes (health care costs, absence records, and employee turnover), and explored the effects on family members of employees who suffer from substance abuse and serious mental health conditions. It clearly demonstrated that sub-

stance abuse and psychiatric conditions were chronic conditions that were very costly to the company.

The study results showed sizable cumulative reductions in several outcome areas of interest to business leaders. In retrospect, though, its reputation exceeded its rigor, and many questions remain about how the study was conducted that simply make some of the findings difficult to understand and properly interpret. Twenty years later, a lot about the study remains a mystery. ■

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# The Economic Recession and Intimate Partner Violence

Imbalances in the traditional roles of men and women can put women at risk of violence from men, and the current recession is exacerbating this risk.

by Sheetal Ranjan, Ph.D., and Chitra Raghavan, Ph.D.

**T**he economic recession is affecting families in many ways. For example, recent job loss data indicate that men are losing jobs at a faster pace than women. According to the U.S. Bureau of Labor Statistics (BLS), 10.3 percent of males were unemployed in 2009, compared to 8.1 percent of females (BLS 2010).

In addition to stressors directly related to job loss, the disproportionate ratio of male to female unemployment has created an imbalance in families that may challenge traditional gender roles. Traditionally, men are expected to provide for the family economically, while women are supposed to play other roles. Taken together, these stressors and the unemployment imbalance can amplify an already tense relationship, potentially leading to partner violence.

The U.S. Centers for Disease Control (CDC) defines “intimate partner violence” (IPV) as physical, sexual or psychological harm by a current or former partner or spouse. IPV varies in frequency and severity and can range from one hit or slap to chronic, severe battering (CDC 2010).

A considerable amount of research has been conducted on factors related to IPV. The first section of this paper discusses these factors, while the second section discusses the relevance of these

factors in a recessionary economy. The third section discusses the problematic outcomes of intimate partner violence and how they may affect employees, and the final section describes how employees can deal with this situation and the role that EAPs can play.

## FACTORS RELATED TO IPV

Many factors—being young, being female, belonging to an ethnic or racial minority or being an immigrant, having a low level of education, and being divorced or separated or living with a boyfriend or girlfriend—are associated with IPV. Social and psychological factors such as alcohol and substance abuse, exposure to parental violence, and jealousy are also associated with IPV. In addition, studies have observed a strong relationship between low income, high debts, job instability, perceived economic distress and IPV (Benson, Woolledge, Thistlethwaite, and Fox 2004; Firestone, Lambert, and Vega 2000). A low income increases not only the likelihood of victimization but also the seriousness of the IPV (Van Wyk, Benson and Fox 2003).

In general, researchers agree that the discrepancy between earning level and need, rather than absolute income, is a better indicator of stress and subsequent violence. They also agree that partner violence is highest among couples where the male has no college education and the female is college educated and least likely among couples who are both college educated (Van Wyk et al. 2003). In a study on employment, men were found to use more coercive control tactics when they were unemployed and their wives were employed. The same

study found that being employed triples a woman’s risk of being systematically abused when her husband is unemployed (Gartner and Macmillan 1999).

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**Employment is a “symbolic resource” in relationships and is directly related to the status of each partner in the relationship.**

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Alcohol use by either the perpetrator or the victim is a strongly supported risk factor in IPV literature (Coker, Smith, McKeown, and King 2000; Cunradi, Caetano, and Schafer 2002; Schafer, Caetano, and Cunradi 2004). Research reports have indicated that IPV may be up to eight times more likely with alcohol use (Lipsky, Caetano, Field, and Bazargan 2005; Cunradi 2007; Walton-Moss, Manganello, Frye, and Campbell 2005). Increased risk of IPV with substance abuse has also been commonly reported (Coker et al. 2000; Cunradi, Caetano, and Schafer 2002), with an odds ratio of 1.94 (Walton-Moss, Manganello, Frye, and Campbell 2005).

In a recession, when job instability, the risk of losing one’s home, and indebtedness levels are all high, many individuals find it difficult to cope. If a man loses his job while his wife or girlfriend still has hers, complications can arise because employment is a “symbolic resource” in relationships (Macmillan

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and Gartner 1999) and is directly related to the status of each partner in the relationship. In such situations, women may become the dominant decision makers, shifting the balance of the relationship during an already emotionally stressful period. A study by Macmillan and Gartner (1999) found that women's labor force participation lowers the risk of spousal abuse when their male partners are also employed but substantially increases it when their male partners are not employed. This finding has been found to be most relevant for traditional households (Atkinson, Greenstein, and Lang 2005).

Also, when a man is out of work, he is likely to spend more time at home, thereby increasing the risk of violence. Women, on the other hand, may feel trapped in abusive relationships because of financial uncertainties. In an abusive relationship, the abuser often financially enslaves the victim by "seizing paychecks" and/or taking control of the finances; in a recession, this is more likely given shrinking income levels and the fact that unemployed people can assert more control at home through their physical presence. In a tough economy, unfortunately, social services of all types are likely to be reduced because of lack of funding, further exacerbating the victim's feeling of helplessness.

#### **THE CONSEQUENCES OF IPV**

The CDC reports that victims of severe IPV lose nearly 8 million days of paid work—the equivalent of more than 32,000 full-time jobs—and almost 5.6 million days of household productivity each year (CDC 2003). The Bureau of Justice Statistics (2007) reports that in 2005, 329 males and 1,181 females were murdered by an intimate partner.

While homicide is the most severe outcome of IPV, partner violence takes its toll on victims in a variety of other ways. Besides physical injuries such as bruises and scratches (Tjaden and Thoennes 2000), the constant stress associated with IPV can have an impact on the immune system and endocrine functions of the victim (Crofford 2007; Leserman and Drossman 2007; Pichta 2004; Wuest et al. 2008). The CDC mentions the fol-

lowing as some of the disorders associated with IPV:

- Fibromyalgia;
- Irritable bowel syndrome;
- Gynecological disorders;
- Pregnancy difficulties like low birth weight babies and perinatal deaths;
- Sexually transmitted diseases, including HIV/AIDS;
- Central nervous system disorders;
- Gastrointestinal disorders; and
- Heart or circulatory conditions.

The psychological outcomes of IPV, like the physical outcomes, are primarily related to stress. Different studies report that psychopathological factors are both predicted by and predictive of IPV. The CDC mentions several psychological outcomes related to IPV (Mercy, Krug, Dahlberg, and Zwi 2003), including the following:

- Depression;
- Antisocial behavior;
- Suicidal behavior in females;
- Anxiety;
- Low self-esteem;
- Inability to trust men;
- Fear of intimacy;
- Emotional detachment;
- Sleep disturbances; and
- Flashbacks to and mental replays of the assault.

In addition to physical and psychological outcomes, IPV affects the overall quality of the victim's life. Economically, women may find it harder to keep jobs or be successful at work. Additionally, they may become a victim of stalking at the workplace by their intimate partners. IPV victims may find that the victimization results in strained relationships with their health care providers (Pichta 2004) and isolation from their social networks (Raghavan et al. 2009). Moreover, IPV victims are more likely to engage in behaviors that have negative health outcomes, such as risky sexual behaviors, substance abuse or unhealthy diet behaviors (Coker et al. 2000; Roberts, Klein, and Fisher 2003).

#### **THE ROLE OF THE EAP**

As the research makes evident, IPV has serious ramifications for employees and, thus, their employers. One of the core goals of employee assistance programs is

providing confidential and timely problem assessment and referral services for employee clients with personal concerns that may affect job performance. EAPs also provide consultation to work organizations to encourage the availability of, and expand employee access to, health benefits covering medical and behavioral problems including, but not limited to, alcoholism, drug abuse, and mental and emotional disorders.

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### **EAPs should routinely build relational satisfaction and abuse dynamics into their screenings.**

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Within this context, EA professionals should understand that employees may be reluctant to talk about IPV. In part, this is because IPV is still considered by most as a private matter. Employees may fear employer retaliation, may be embarrassed, may blame themselves, and/or may not identify abuse as such.

Accordingly, EAPs should routinely build relational satisfaction and abuse dynamics into their screenings. EA professionals may want to preface the screening with a general set of instructions, such as, "Now I am going to ask you a variety of questions about both good and bad things about your current relationship." Once the satisfaction questions are completed, the EA professional can transition naturally into abuse dynamics.

Abuse screening should address emotional, physical, sexual, and control abuse tactics. The screening should also cover stalking and harassment tactics the violent partner may use to obstruct the employee from carrying out his or her job satisfactorily. If the latter is indicated, the EAP should discuss strategies with the employee and employer to protect/minimize the employee from harassment.

If the employee answers affirma-

tively to particular abuse statements or questions, the EA professional should provide an extended screening and devise a safety plan if warranted. For example, the Dangerousness Assessment (Campbell, Sharps, and Glass 1999) will enable the EA professional to communicate danger more clearly to the employee.

EAPs should also consider that recent mandatory arrest/reporting policies have tempered the willingness of victims to report violence. In general, psychologists and mental health professionals are not required to report IPV. Nevertheless, EA professionals should familiarize themselves with mandatory arrest/report laws in their jurisdiction and fully inform employees of their legal responsibilities before the assessment begins. Finally, if an EA professional suspects partner violence but the employee is reluctant to discuss it, the EA professional should suggest a second visit or make a referral to appropriate external resources, including domestic violence hotlines and violence counselors. ■

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# The Evidence-based Practice Continuum in Employee Assistance

Describing our profession's knowledge base and proving its value will help establish employee assistance as a unique profession.

By Wolfgang Seidl, M.D., DipC., MBACP

**E**mployee assistance programs face several key challenges. A lack of research evidence and outcome measures, commoditization, and doubts about the true purpose of EAPs have called into question their professional status and the true value of their services.

With the purchasers of EAP services asking that providers prove the value of their services, there is more need than ever to demonstrate, beyond question, the return on investment (ROI) associated with EAPs. Not only does this require the production of an independent body of research evidence on the effectiveness of EAPs, but also the development of specific metrics to measure the effectiveness of workplace counseling (cf Seidl 2001).

I have argued elsewhere (cf. Seidl 2003) that clinical effectiveness and cost-benefit analysis are linked and that the EA profession has to research and develop the tools required to assess the financial impact of EAP services on the organization as a whole. Rigorous commercial analysis is the primary means by which we may demonstrate that an EAP is a professional, systematically applied intervention that yields a return beyond its cost.

Only by developing and consis-

tently applying such outcome metrics can we start to combat the trend toward looking at EAPs as a commodity that has reached a stage where providers and purchasers focus on price rather than quality and value added to the organization. Unless employee assistance is recognized for its unique expertise in human behavior in the workplace (Maynard 2005) and its unique set of core technologies (cf. Blum 1985), it risks losing its position as a profession in its own right. At the same time, EAPs must demand a seat at the strategic decision-making table of an organization to continue evolving and being successful in the workplace.

It is the aim of this article to show that (1) the challenges associated with demonstrating the value of EAP services, fully establishing the professional status of employee assistance, preventing the commoditization of the industry and becoming a true strategic partner to the organization are interlinked and connected; (2) the problems associated with the absence of robust research evidence for employee assistance, the low profile of a commoditized product and the fragmented status of the profession are the result of a lack of professional coherence; and (3) employee assistance needs a coherent model that connects theory, practice and outcome measures.

## THE MODEL OF EMPLOYEE ASSISTANCE

The concept of an evidence-based practice continuum (Seidl 2007) sets out to capture the essence of our profession. It argues that a true profession has a theory and a code of practice and is able to quantify outcomes. In addition, it highlights the importance of connecting the-

ory with practice, establishing a "theory of practice" to ensure that theoretical research does not remain abstract academic reflection (see Figure 1).

As an EA professional, I appreciate knowing that, in practice, EAPs work

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**Can you prove that an EAP works? You might know you have helped a client or an organization, but what variables would you measure to demonstrate that?**

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and that thousands of EA professionals have made a genuine and positive difference in people's lives. After 10 years of managing EA programs and struggling to contribute practical suggestions in papers and everyday work, I would very much like to see a theoretical model that structures the connection of these practical initiatives.

Many would argue that we don't need an evidence-based practice continuum to explain why our work has made such a great difference. So why is it that parts of the profession are thriving and others are in decline, with so-called free EA-type services seemingly offering a replacement for a truly professional and vocational intervention?

It would appear that this is the right time to talk about the "professionalization" of employee assistance. I postulate a "professional space" that employee assistance ought to occupy to have credibility. The professional space is where we



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operate in the workplace, in collaboration with—and separate from—other professions within the workplace, such as human resource management, occupational health, and others.

The professional space is defined by our definition of work, the purpose and jurisdiction of employee assistance, the cultural and organizational environment in which we operate, occupational regulation, training, marketing and so forth. The professional space is also a creative space, where employee assistance professionals develop responses to new challenges in the workplace (cf. Winnicott's "potential space" 1971).

### ESTABLISHING OUTCOME MEASURES

As noted at the outset, in order to fully professionalize employee assistance, we must be able to quantify outcomes. With this in mind, I want to concentrate on the simple, almost self-evident elements of evidence-based practice. The first, and most in demand, is outcome metrics.

Can you prove that an EAP works? You might know you have helped a client or an organization, but what variables would you measure to demonstrate that? The first step is to identify variables, such as clinical improvement, utilization rates, satisfaction rates, stress levels, engagement levels, and so on. The next step is to refine them and make them "measurable."

There are useful tools to measure clinical improvement, such as Beck's Depression or Anxiety Inventory, Clinical Outcomes in Routine Evaluation (CORE), and others (cf. Barkham et al. 2001). Most of them are *effectiveness measures*, which can be carried out in a natural practice environment, rather than efficacy measures requiring controlled laboratory experiment. This means we don't have to become academic researchers to provide evidence of positive outcomes of EAPs.

The use of effectiveness measures allows us to become a reflective practitioner in everyday practice. Furthermore, it is these effectiveness metrics (regarding impact, efficiency and return on investment) that are most in demand by organizations. It can also be argued that a strict scientific, evidence-based practice

paradigm needs to be complemented by a practice-based evidence model.

The EA field has struggled for years to live with and overcome the dearth of hard evidence in this area. Return on investment (ROI) calculators (e.g., Seidl 2003) have been discussed and new models are emerging. It is beyond the scope of this article to present a detailed critique of these models, but suffice to say that most EA programs are under pressure to justify any investment in them. Consequently, most programs are distilling some evidence from the utilization and feedback data they collect to present more or less sophisticated ROI metrics to the purchasers of EA services.

### DEVELOPING A THEORY

We couldn't constitute a coherent profession in our own right were we to borrow all of our concepts from other professions. We need an evolving theory that maintains the momentum of the EA profession.

The first EA interventions, particularly alcohol programs, generated momentum on the practical level, but they were also based on theoretical knowledge of the issues. Consequently, we are now discussing screening and brief intervention because we have advanced our understanding of these problems. There is much research—ultimately, a body of theoretical concepts—behind this.

This is just one example of how fruitful the relationship between theory and practice can be, demonstrating that a true profession does not stand still. A profession that stands still risks falling behind in terms of expertise and losing influence in the field. Other professions could then enter the professional space occupied by employee assistance and reduce its jurisdiction (Abbot 1998).

Some would argue that the EAP Core Technology (Roman and Blum 1985) is our theory, but consultation, problem identification, constructive confrontation, referral of employee clients, interventions regarding alcohol and other substance abuse problems, and the identification of EAP effects on performance are a *code of practice*, not a theory. A theory is different—less practical, if

you like—yet a coherent theory is the most powerful basis for good practice. As Kurt Lewin said, "There is nothing more practical than a good theory."

A theory, in the scientific sense, is an analytic structure designed to explain a set of empirical observations. The word "theory," in its philosophical sense and in the humanities, may be defined as a system of laws or hypotheses with explanatory power based on ideas rather than pure empirical data. A good theory consists of a theoretical framework, basic assumptions (philosophical, methodological and others), axioms, definitions and so on.

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**If we are to demonstrate  
the value of our profession,  
we want healthy utilization,  
not suppressed utilization.**

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We need to develop our expertise—both theory and practice—in the assessment of mental health problems. For example, what is our current theory of recovery? What is our knowledge base for trauma work?

### PROFESSIONAL POSITIONING

It would be naïve for us to assume that our actions and outcomes speak for themselves. We must be clear about who we are and where we are going. Are we a part of human resource management? Occupational health? Something distinctively different? Are we successful at explaining who we are and what we do as a profession to customers, clients, employees, society, and regulators? Is the EA profession distinctive?

Positioning is about the theory of a profession as a profession. It is also the theoretical basis for good marketing and public relations. In an age where so-called EA-type interventions are being delivered as a commodity by some who want to keep utilization as low as possible, we need to position ourselves as experts with distinction. If we are to

demonstrate the value of our profession, we want healthy utilization, not suppressed utilization.

### **THEORY OF PRACTICE**

A theory, by definition, has to be abstract and general, a set of basic assumptions from which we derive our guidelines for practice. There is a wide gap between theory and the EAP Core Technology. I propose to fill this gap with activities that describe the transformation of theory into practice, which can be called a theory of practice.

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## **If we define EA professionals as experts in human behavior in the workplace, we are beginning to acknowledge a very transferable skill set.**

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A theory of practice is the link between theoretical models and practice, insofar as it helps translate theory into practical applications. Because of a lack of information in the EA literature about the self-understanding of the profession, I'm deliberately highlighting professionalization, professional space, needs analysis, market research, and ethics in the pillar titled Theory of Practice (see Figure 1).

Employee assistance is under attack from delivery mechanisms that see an EAP as an add-on to another product, a hardly visible benefit described in the small print of another product. This development has been possible because employee assistance, as a profession, is often lacking in confidence and has yet to fully "professionalize" (in the sense that its jurisdiction is blurred and it doesn't fully own its conceptual framework, training requirements and needs for regulation). These characteristics are normally more in line with the description of a young, developing profession, whereas employee assistance has seemingly already reached the later stages in the life cycle of its "products."

In his book *The System of Professions: An Essay on the Division of Expert Labor*, Andrew Abbott (1988) describes professions as interdependent systems. Within this systems theory-inspired framework, professions emerge, cooperate or compete with each other, and gain influence or disappear.

The tasks of professions are defined as providing expert services to amend human problems. These problems are subject to change and resulting boundary disputes between competing professions and their changing jurisdictions.

A profession diagnoses and categorizes problems and builds up a knowledge system. By defining problems in this way, it is determined which profession should be dealing with a specific problem. Clearly, the process of professional definition is charged with power, and ascending professions usually build an academic research and knowledge base to harness the power of problem definition.

According to Abbott, professional interventions ("treatment") are derived from the knowledge base. However, treatment ought to be acceptable to the client and empirically successful. If it is not, the profession is open to attacks from other professions that may seek to develop the expertise to deal with these problems and absorb them into their jurisdiction. For instance, modern surgeons took over from the so-called barber-surgeons who practiced in Europe in the Middle Ages.

Nowadays, a professional dispute may well arise between counseling and coaching, with coaching acting as the "challenger brand." A similar dispute may arise between managed behavioral health care and employee assistance.

It follows that a successful profession needs a knowledge base that is powerful enough to annex new areas of work but not too abstract to be jurisdictionally challenged. In his article "EA Practice as Knowledge Work," Dan Hughes (2007) argues that, "A knowledge-based understanding of employee assistance practice both facilitates and requires continuous research and development."

If we define EA professionals as experts in human behavior in the workplace, we are beginning to acknowledge a very transferable skill set, much as a business degree covers a broad range of transferable skills and allows its owners a great deal of autonomy and discretion in choosing their area of work. Taking a historical perspective, we can see a shift away from the social or religious legitimization of professions and toward a reliance on science or rationalization of technique and on efficiency of service (cf. Abbott 1988). Successful, ascending professions reflect this—and that takes us back to the beginning of this article, where we talked about the need for evidence-based outcome metrics.

The tasks in the second pillar of the proposed model (see Figure 1) are to conduct a needs analysis and market research and to position EA work as a distinctive field with a body of research evidence behind it, a code of professional ethics, and the confidence to occupy a unique position, or "space," within an organization. John Maynard (2005), in my opinion, alludes to professionalization and the need for appropriate marketing communication when he states, "Of course, having the tools to make a difference and making sure workplace decision-makers know we have the tools are two different issues."

In summary, I believe the professional model of employee assistance needs a theoretical framework to draw from and a theory of practice to help translate theory into common practice. The theory of the EA profession evolves in connection with practical challenges.

### **STANDING THE TEST OF TIME**

What we do and how this is immensely relevant to the workplace has been epitomized in the EAP Core Technology. Although some authors (e.g., Bennett and Attridge 2008) have argued that prevention should be added as a core technology, the essence of the EAP Core Technology has not changed much since its conceptualization in the 1980s, which demonstrates that it has stood the test of time and become the backbone of our profession. We are in the fortunate position to be able to build

on these practices.

Employee assistance is now at a crossroads. We may choose the path of professionalization, building on the foundations of an evidence-based practice model and confidently owning and developing a distinctive knowledge system, which translates into a code of ethics and practice that meets our clients' evolving needs and produces measurable outcomes. Alternatively, we may find that new technologies developed outside the EA profession will drive new applications that replace the expertise of employee assistance professionals.

I call upon my colleagues to fill each of the pillars of the evidence-based practice continuum with explanations and evidence, to create a coherent system that properly defines and credentializes our profession. Being able to describe

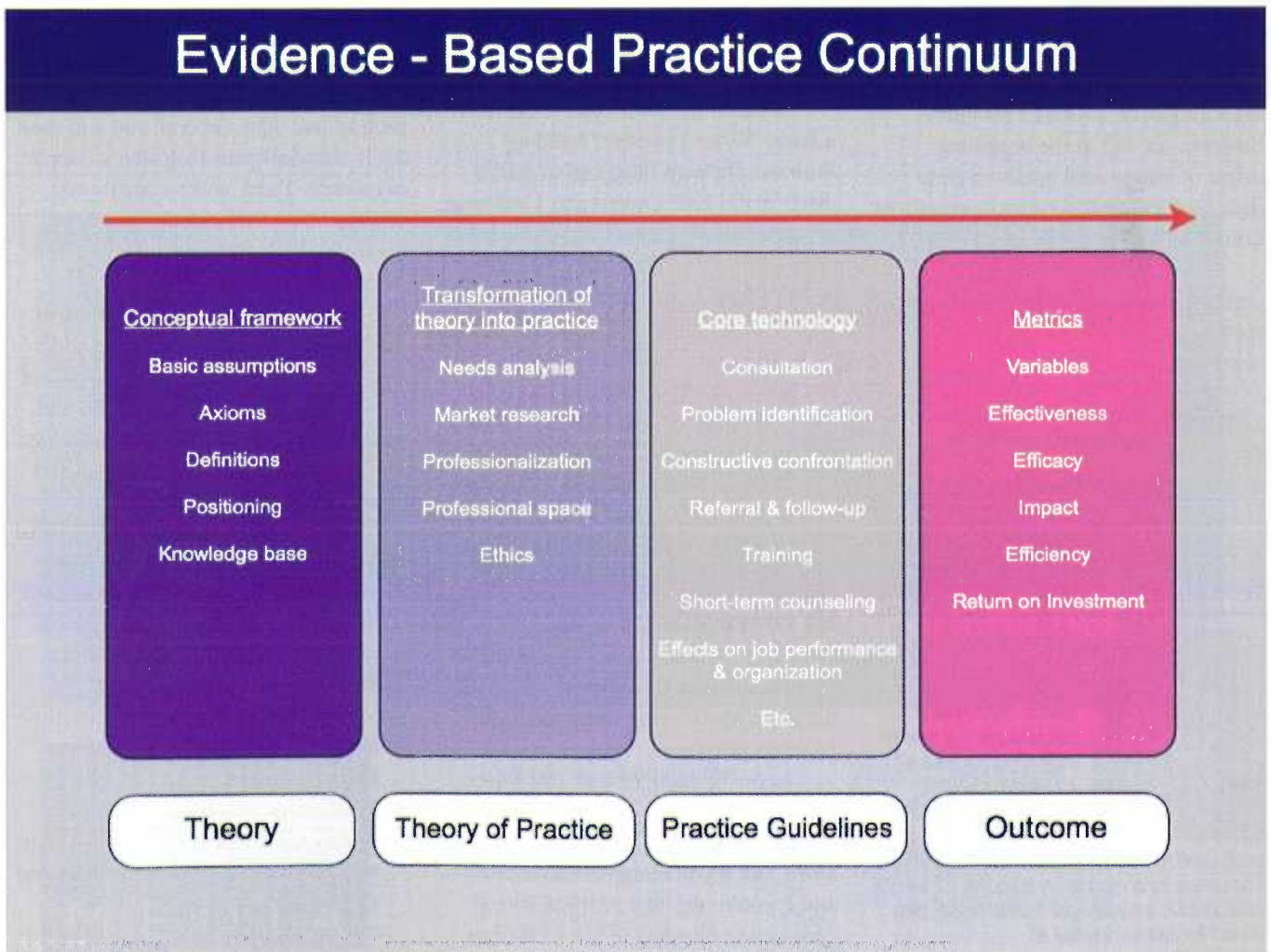
our profession's knowledge base in a systematic way and demonstrate the value of employee assistance will go a long way to combat commoditization and establish EA work as a unique profession alongside medicine, jurisprudence and human resource management. ■

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Figure 1



# Social Media: How Many Should You Use?

By Marina London, LCSW, CEAP

A recent study (Burson-Marsteller 2010) found that 79 percent of the largest 100 companies in the world are using at least one of the four most popular social media platforms: Twitter, Facebook, YouTube and corporate blogs. Of these, Twitter is the social media platform of choice—65 percent of the largest 100 companies have active accounts on Twitter, 54 percent have a Facebook fan page, 50 percent have a YouTube channel, and 33 percent have corporate blogs.

One in five of the major international companies are utilizing all four platforms to engage with stakeholders. Most employee assistance programs, however, are still in the beginning stages of using social media to grow their business and/or promote employee utilization.

Social media guru Jeff Bulla (Jeffbullas Blog 2009) believes that social media channels can be organized into seven major categories:

1. Blogging;
2. Social networking (e.g., Facebook);
3. Micro blogging (a combination of social networking and blogging, such as Twitter.com);
4. Social bookmarking (encompasses



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directories such as Digg and Technorati);

5. Discussion forums (one of the earliest forms of social media; includes EAPAs own "Employee Assistance Research Forum");
6. E-mail marketing (Constant Contact is a prime example); and
7. Video (e.g., YouTube).

Bulla believes that whether and how much you use social media depend on the time and money you have available. He also thinks that if you can use only one social media channel, it should be a blog.

I do not entirely agree with him.

Without question, time is definitely a factor. When I present "Building Business Through Blogging" at EAPAs 2010 World EAP Conference, I will urge those in the audience to be honest with themselves about how much time they really have to blog, tweet, or write on their Facebook wall.

But money? I'm not so sure it's much of a factor—that is, unless you're a major corporation like Starbucks, which uses 11 different social media "channels" and employs six full-time social media staff to make it happen (Jeffbullas Blog 2009). Social media are free, so lack of capital is not necessarily an issue.

## THE EXPERTISE FACTOR

But what about expertise? To me, that's the critical factor that should inform all decisions about using social media for business purposes.

In my opinion, and as a beginning premise, 90 percent of bloggers have no business blogging. That may sound harsh, but if you disagree, ask yourself—and I would urge any EA professional considering blogging to ask himself or herself—the following questions:

- Can I write?
- Can I write something clever, useful, and/or witty?
- Can I write something clever, useful, and/or witty at least once a week?
- Can I write something clever, useful, and/or witty at least once a week for an indefinite period of time?

Most people will answer "no" to one or more of these questions. And if you answer "no" to any of these questions, do not blog.

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**If you're itching to get involved in the blogosphere, start by finding and reading the best blogs in your field(s) of interest.**

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Why not? First, you will not present yourself or your EAP in a positive and professional light. Second, you will most likely abandon your blog after a couple of months. Third, and perhaps worst, you may blog haphazardly, which will make you look amateurish and uncommitted.

If you're itching to get involved in the blogosphere, start by finding and reading the best blogs in your field(s) of interest. Next, post your judicious and well-reasoned comments on these blogs. This is a great way to give yourself and your organization exposure.

An employee assistance professional might consider following these blogs:

- HR Web Café ([www.hrwebcafe.com](http://www.hrwebcafe.com)), a workplace Weblog about employment issues, people matters, and work trends;
- Where the Client Is ([www.wheretheclientis.com](http://www.wheretheclientis.com)), an excellent practice-building resource; and
- The Online Therapy Institute Blog ([www.onlinetherapyinstituteblog.com](http://www.onlinetherapyinstituteblog.com)), which brings together technology and mental health issues.

What about Twitter, you ask? Before considering using Twitter for professional