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Telephone Counseling in Employee Assistance Programs:

Is It Effective? Is It Legal?

Summary: The emergence of telephone counseling in EAPs raises compelling and complex questions for Human Resources and Compensation and Benefits professionals who oversee these programs or evaluate providers. This article will provide readers with valuable background and insight on evaluating the effectiveness of telephonic EAP services and understanding the legal issues surrounding the licensure of the individuals providing these services.

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The telephone has been an obvious and important tool for Employee Assistance Providers (EAPs) for many years. It is routinely used for intakes, scheduling, crisis intervention, follow ups, case consultations, and 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 in EAP, and is a core part of contemporary practice. EAP assessment and counseling by telephone has been quietly gaining acceptance, and is now viewed as a viable alternative to face-to-face counseling for numerous reasons:

- Less stigmatizing than going to an office waiting room.
- Can be used with those who have difficulty traveling to a counselor office.
- Some clients will disclose more as it can be anonymous.
- Some clients reject face-to-face but will accept a telephone session.
- Provides greater flexibility in scheduling and eliminates travel time.
- Less expensive for the EAP vendor than paying an affiliate counselor an hourly rate.

The use of the telephone for professional intervention with common EAP type concerns may help overcome barriers that hinder access to conventional face-to-face services, such as transportation, child or elder care, scheduling conflicts, and perceptions of stigma. It now seems that EAP providers are increasingly using the telephone to *replace* in-person clinical intervention rather than *supplement* it. The emergence of telephone counseling in EAP raises compelling and complex questions related to its far reaching value along with its potential for misdirection. Human

Resources or Benefits representatives who oversee EAPs and Benefit Consultants who evaluate vendors need to examine two essential questions:

1. Is telephone counseling effective?
2. Is telephone counseling legal?

A Primer on EAPs

It's essential to more fully understand the overall origins, evolution, delivery models, and potential benefits of EAPs in the workplace in order to be able to effectively analyze issues regarding both the effectiveness and legal implications of telephone counseling.

EAPs, as an employer-sponsored benefit, help employees and dependents with work, personal, and behavioral health concerns such as marital, family, emotional, job stress, drug and alcohol, legal and financial problems. EAPs typically offer some form of professional support, assessment, brief counseling, and referral services using easy access and work-performance issues to drive those in need to seek help at the earliest possible time. EAPs are a first entry point for millions of American employees seeking professional assistance, predominantly provided to employers by outsourced vendors. **According to the Society for Human Resource Management, in 2008 about three-fourths of businesses in the U.S. offered some form of EAP services to their employees and usually dependents.**

These outsourced employee assistance (EA) vendors' predominant delivery model is a telephone call center as a "central" access point for service requests, along with the decentralized network of subcontracted, professional clinicians for face-to-face counseling in locations where the EA vendor has covered employees. EA vendors typically sell this model to employers at a capitated "per-employee-per-month" (PEPM) rate and then pay subcontracted clinicians (also know as "affiliates" or "network providers") at a fixed hourly rate, when they are used. Employees or dependents who request assistance with a personal problem usually endure a process similar to making a hotel reservation. They place a call and provide demographics to an intake counselor and, if phone counseling is deemed inappropriate, the client is given another phone number or transferred to a subcontracted clinician in or near his or her community of residence.

Many organizations adopt and maintain EAPs out of a widely-held perception that they yield positive results, which may or may not be the case, depending on the vendor, the EAP model, and numerous other variables. The theory of an EAP is to provide help in areas where employee personal problems and employer performance and productivity concerns overlap. This theory assumes that employee personal problems, which may not necessarily be a diagnosable mental-

health disorder, can progress into a disorder and result in higher medical, disability, workers' compensation, absenteeism and lost productivity costs over time. If employees (and eligible dependents) are encouraged and invited to access an EAP at the earliest possible time, before the problem worsens, the organization will mitigate or avoid unnecessary financial and human capital costs. The goal is to encourage employees to "self-refer" to an EAP before unresolved personal problems affect job performance issues. Since EAPs are "free" and confidential to covered employees, the absence of copayments, deductibles, and out-of-pocket expenses makes them attractive to employees who like "hassle-free" access and do not want to file a claim or pay for services.

A segment of marginally performing employees who are unresponsive to normal supervisory action and do not "self-refer" to an EAP may have underlying personal, family, or behavioral health problems interfering with effective job performance. These "troubled" employees may begin to face their problems when constructively confronted with the facts of unsatisfactory performance, a clear demand for improvement, and a sincere offer of help through an EAP referral. In this situation, supervisors can confront employees on the basis of declining performance and motivate "in denial" employees or employees who are reluctant to ask for help to voluntarily pursue the use of a "free and confidential" service. This "supervisor referral" approach relieves supervisors of inappropriate diagnostic responsibilities and allows management to deal with employees with unresolved personal problems fairly and, at the same time, leave the decision to seek help via the EAP entirely up to the employee. In both the "self" and the "supervisor" referral, the EAP's mission is to help employees who are distracted by a range of personal problems to better cope with these problems, ultimately enhancing job performance, safety, and productivity.

The context of EAP intervention is not necessarily the personal restructuring associated with psychotherapy or addiction treatment, but the effects of problems on individual coping and occupational life. The theory of EAP intervention contends that EAPs can and do contribute to expense reduction and effective risk management, beyond the subjective testimony of improved clients and satisfied HR managers. Organizations with effectively implemented EAPs should eventually see outcomes such as reduced absenteeism, decreased workers' compensation and disability claims, fewer disciplinary problems, and enhanced productivity. Despite the growth and popularity of EAPs among U.S. organizations, Human Resources and Compensation and Benefits professionals have generally not studied these programs with the same intense scrutiny as other employer-sponsored health and welfare programs.

Is Telephone Counseling Effective?

The success rates for professional counseling among clients with common mental health problems is quite high. Meta-analysis reviews of the results of thousands of studies have concluded that outpatient mental health counseling is largely effective at improving many aspects of client functioning and work performance. However, all of these studies analyzed the traditional model of in-person contact between the client and counselor. Can and should we assume these findings automatically transfer to a different modality, one where the counselor cannot directly observe the client? Using a new service modality is, without a doubt, a confounding variable.

The use of the telephone as a counseling intervention has been prevalent since the early 1970s, and the phone is the primary mode for community-based crisis hotlines and emergency sessions. But solid research comparing its effectiveness to traditional face-to-face is nearly nonexistent. The expansive use of the phone as a counseling intervention has not been matched with a corresponding examination of its effectiveness.

Only a small handful of studies have compared the experiences of EAP cases from the two most common delivery channels: face-to-face delivery of clinical sessions or telephone delivery of clinical sessions. The results of these studies found small or no differences between the two delivery channels in terms of clinical or workplace outcomes, suggesting they are basically equivalent. However, no studies have randomly assigned cases to receive either in-person or telephone counseling. Rather, clients who received telephone counseling were determined by intake counselors as appropriate for telephone counseling, and the clients themselves selected the telephone modality. So both conditions had clients who received EAP counseling in the modality they preferred and the counselor judged to be the most appropriate. This self-selection bias is a major threat to validity, and can only be eliminated when clients are randomly assigned to receive either telephone or face-to-face counseling.

No published studies conducted to date directly compared in-person versus telephone EAP services using the “gold standard” of research design - random assignment of cases to the two different delivery models. Until this “gold standard” of research is deployed, we cannot definitively claim that telephone counseling is “about as good” as face-to-face. **If randomized trials are seen as too difficult or a threat to generalizability, then at least greater attention to the issue of selection and sample bias should play a central role in future research.**

Is Telephone Counseling Legal?

Licensure issues

All states require mental health professionals, including counselors, social workers, psychologists, and marriage & family therapists to be licensed in the state(s) where they

practice.¹ However, telecounseling can occur in more than one location. Before the advent of telecounseling, the client and counselor were, by necessity, in the same location. Now, with the advent of telecounseling, the client and counselor may be in two different cities, or in two different states. So what are the requirements, for example, when a counselor is licensed in California but provides telecounseling to a client in Illinois? Does the counseling take place where the client resides, where the counselor resides, or somewhere else? Given the trend in EAP to “centralize” intake and telecounseling services at a single call center in a particular state, this is a pertinent question when interstate telecounseling in EAP is growing and becoming more commonplace.

Since the law is often behind current practice trends and technology, there is a dearth of published case law that definitively determines which state – the counselor’s or the client’s – 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, although these statutes and corresponding regulations usually apply only to physicians and not necessarily to non-psychiatrist mental health professionals like 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.²

In addition, there are states that either require by regulation or “recommend” that a telecounselor be licensed in the state where the telecounseling client resides. For example, Arkansas requires an Arkansas license for any Technology-Assisted Distance Counseling service that occurs within the state, whether by an Arkansas counselor or an out-of-state counselor.³ 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.⁴ In Massachusetts, mental health professionals licensed outside of Massachusetts who provide services to clients within Massachusetts are considered “unlicensed” by the Massachusetts Board of Registration.⁵ The Louisiana State Board of Social Work Examiners requires state licensure for social workers providing “distance therapy” to Louisiana consumers.⁶ There are many other states whose specific laws and regulations the authors have not yet investigated.

¹ For example, in Illinois mental health professionals may be licensed through the Marriage and Family Therapy Licensing Act (225 ILCS 55), Clinical Social Work and Social Work Practice Act (225 ILCS 20), or the Professional Counselor and Clinical Professional Counselor Licensing Act (225 ILCS 107).

² Cal. Bus. & Prof. Code §2060

³ Arkansas Code Annotated §17-27-101

⁴ Arkansas Code Annotated §17-27-101-9.2

⁵ Policy on Distance, Online, and Other Electronic-Assisted Counseling, The Massachusetts Consumer Affairs and Business Regulation; Policy No. 07-03

⁶ LA R.S. 37:2709 and LA R.S. 37:2714.C and see <http://www.labswe.org/distancetx.htm>

Therefore, considering the lack of clear guidance in many states, as well as the hodgepodge of laws governing telemedicine, providing telecounseling services across state lines is likely a legal or compliance risk management issue, as it is unclear which state – the client’s or the counselor’s - has ultimate legal control. Since there is no agreement regarding standards for interstate counseling, the conservative approach is to ensure that your EAP provider uses counselors that are licensed in the state where the client resides. Using this guidance, it appears that counseling is considered to have taken place in the state where the client is located. Furthermore, using telemedicine law as a guide, if a telecounselor provides counseling to clients within a particular state, generally the telecounselor would be considered to fall under the jurisdiction of that state, regardless of where the telecounselor is located. This is probably the safest way to comply with legal obligations that are controlled by individual state laws, such as:

- 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.

This is admittedly a controversial issue as some EAPs have clearly decided to proceed and defend as necessary that counseling takes place where the counselor is licensed.

There are professional associations such as the American Psychological Association who have chosen not to address telecounseling or teletherapy directly in their ethics codes.⁷ Other associations, such as the Employee Assistance Professionals Association, have only vaguely approached the subject, and by this omission, seem to be admitting they are not yet able to develop agreed upon ethics rules to govern the practice of telecounseling.⁸

What about EAPs that characterize telephone intervention as “consultation” or “coaching” and not “counseling” or “therapy”?

Is there a line, using statutes, regulations, or case law, that has been drawn between providing clients with support, case management, or coaching versus counseling or therapy? In short, there is no case law or legal opinions that make such a distinction. This is likely because telecounseling is not yet heavily regulated. Perhaps the most instructive distinction is to examine state specific

⁷ <http://www.apa.org/ethics/stmnt01.html>

⁸ <http://www.eapassn.org/files/public/codeofethics0106.pdf>

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 persons who are “coaches” and who serve clients specifically as a professional coach are exempt from the requirements of maintaining mental health licensure.⁹

Therefore, as a rule of thumb, if the 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 personal problems and issues, then its likely counseling and not coaching. If the case is counted in your EAP Utilization or Activity Report, then the service is also likely “counseling” and not something else. **The authors recommend that human resources or benefits staff require their EAP vendors to submit reports that separate EAP “counseling cases” from “supportive services” such as work-life consultation, information, referrals, web hits, or wellness/life coaching sessions. Be cautious of programs that provide “counseling” but call it coaching to try and skirt the controversial issue of where counseling takes place.**

What about EAP counseling over the Internet?

Although not addressed in the article, issues with EAP counseling over the Internet are parallel to those discussed in the context of telecounseling. Some EAPs are routinely using e-mail, real-time chat, secure web-based messaging, and even videoconferencing to provide counseling interventions.

In addition to face-to-face and telephone, future studies could add a third condition of Internet-based EAP counseling. Future research should also emphasize how and when to combine face-to-face with the phone and internet to expand the continuum of services. How do these different modalities affect attrition, or client “drop out”? Does the common 50 minute counseling session change to 15-30 minutes over the phone or internet? The Internet can be used in conjunction with face-to-face and telecounseling in numerous ways.

⁹ Colorado Mental Health Practice Act §12-43-215

Conclusion

The current regulatory framework, built on a model of state-by-state licensure and geographic boundaries, was put in place before the wide spread practice of telecounseling. There are no real federal mechanisms to regulate the practice of interstate counseling. The potential for liability as a vehicle for accountability may be diminished for those EAP vendors who take the stance that counseling takes place in the state where the counselor is licensed. The practical obstacles for clients to assert a claim in a different state may be insurmountable. The patchwork of legal standards is tied to state geography, and as a result, EAPs that permit counselors to practice counseling across state boundaries may risk engaging in an unauthorized practice, depending on the state.

The authors anticipate that more legislation and policy guidance will emerge, but it will take time. In the meantime, employers, EAP vendors, and the consultants who advise them should examine applicable State “telehealth” or “telemedicine” laws and consider the legal implications for interstate counseling by their EAP. **The use of the telephone to practice counseling within the provision of EAP services calls for a new regulatory paradigm to ensure accountability, client protections, and distinguish “counseling” over the phone from other functions such as intake, follow-up, information sharing, coaching, and case management.** In short, nudging the telecounseling movement forward in a constructive way will only be possible if purchasers and consultants motivate providers to confront these questions and support more rigorous evaluation.

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